Barnsley Hospital NHS
NHS Foundation Trust

Annual Report and Accounts

2009 - 2010

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

Barnsley Hospital NHS Foundation Trust Annual Report and Accounts 2009/10

Contents

Chairman's statement

I am pleased to introduce this Annual Report of the Barnsley Hospital NHS Foundation Trust for the year ending 31 March 2010.

This has been another year of excellent achievement by the Trust, tackling the challenges we face with the enthusiasm and professionalism which is the hallmark of everyone involved here.

The vision and purpose of the Trust is to be the hospital of choice for the people of Barnsley, efficiently delivering high quality and innovative healthcare in a 21st century environment.

As a public sector organisation funded by the taxpayer we are accountable for delivering and achieving the targets set by Parliament for the NHS. We fully support this accountability which is embedded into our vision and informs our ongoing improvement in services for our patients. We met all of our key targets in 2009/10. We also cared for 71,891 patients through the Emergency Department, a slight increase over the previous year's record attendance; 59,776 inpatients and 263,703 outpatients. We also undertook over half a million diagnostic tests.

On finance, the Trust's 2009/10 budget ended entirely as set out in our Financial Plan, delivering a small surplus. Our consistency in achieving our plan is reflected in the Health Care Commission's last rating published in October 2009 of 'excellent' for our financial management. This will stand us in good stead as we plan for achieving the challenging NHS savings targets over the next three years.

2009/10 was a year in which poor performance in hospitals was exposed in both Regulator publications and in the media. Most notably the Mid Staffordshire Foundation Trust inquiry gave rise to considerable concerns about governance and the role of Boards and Governors in listening to and acting on patient experience, and in scrutinising carefully the clinical standards of the hospital, and this was the subject of many national reports. Arising from this the Trust has redesigned the hospital's governance and patient safety arrangements and this will give further support to our work to build strong and confident relationships with our patients, their families and carers and our staff as well as assurance to the public about our commitment to the very highest standards of care.

Over the last year the Trust has won numerous national awards and accolades and I'm proud to congratulate our staff on winning the Health Business magazine award for the 'Cleanest hospital in the country', and Trust midwife Sally Wilson, who won the Northern Midwife of the Year in the Royal College of Midwives awards.

This Annual Report, naturally, lists our many achievements but also recognises the issues we in Barnsley, along with the rest of the NHS, need to address to

Stephen Wragg
Chairman

secure a successful future. The financial challenges arising from the national debt will mean considerable stringency in public services at a time that the public have higher expectations of both access to and standards of care. Consequently it will be necessary to redesign services across separate organisations to reduce duplication and to be focussed on ever increasing efficiency and productivity. The hospital has made a good start in tackling areas where improved productivity can ensure better value for money, but our experience with our surgery and critical care division and theatre utilisation in 2009/10 demonstrates that we still have some way to go in changing working practices so that we can benefit from using very expensive assets to the full.

In 2009/10, and as part of our remodelled approach to good governance, we have reformed our working relationship with the Trust's Internal Audit service. This has enabled us to look with a critical eye at areas where we know we can improve our efficiency and effectiveness. Examples where we have identified deficit, and then addressed it rapidly, include our

sickness absence policies and performance; our Information Technology services; our overview of consultant contracts and activity; and our clinical coding services. These 'process' and 'back office' areas critical to the efficient running of the hospital have received full Board scrutiny in our determination to preserve front line clinical services and reduce any unnecessary cost or inefficiency in support services. We have also looked with the support of Internal Audit at our overall financial processes, systems, and awareness throughout by clinical and non clinical staff. This has led us to make significant strides to improve our business acumen and this will continue into the coming years.

As part of our approach to deliver high quality and innovative healthcare to meet our patients' current and future needs, we continued to work closely with Barnsley Metropolitan Borough Council (MBC) and NHS Barnsley, actively contributing to the One Barnsley shared vision. This aims to promote health and well being, ensuring that local people make the lifestyle choices that enable them to remain healthy and live at home and avoid unnecessary hospital admissions. Strong working relations with other partner organisations and wider networks have also been invaluable in our aim to provide quality healthcare across the community.

One of the most noticeable results from our joint work with NHS Barnsley last year was the Cancer Awareness bus which we launched in January 2010 to actively promote knowledge of various forms of cancer and cancer prevention to our local community.

I would like, also, to mention two specific examples which I think reflect the community spirit and 'can do' attitude which prevails at Barnsley Hospital.

In August, on behalf of the Board of Directors, I took part in the renaming ceremony of the Cardiology Department, organised by Jayne Horton, the Chief Technician, as the Walter Rhoden Department of Cardiology. It was a very moving event and an excellent way of honouring the memory of cardiologist Dr Walter Rhoden and his GP wife, Dr Kathryn Phipps who died in a motorcycle accident while on holiday in 2008. Dr Rhoden had been a consultant at the hospital for 15 years and was instrumental in introducing new services including coronary angiography and pacemaker implants. Dr Phipps was a longstanding and popular GP in the Barnsley and Rotherham area.

In typical Barnsley fashion, we went one step further by establishing a bursary in their name for improving clinical services. The Rhoden/Phipps bursary is available to individuals or groups of clinical staff from the hospital and NHS Barnsley to research new ways of providing services that maximise the quality of life of patients.

Secondly, the year saw more than 260 guests attend the hospital's first ever HEART (Helpfulness, Excellence, Achievement, Resourcefulness and Talent) awards scheme to celebrate the achievements and excellence of our staff and volunteers.

It was a fitting tribute to everyone involved. But its biggest success was in celebrating the excellence of Barnsley Hospital - something we can and should be taking forward as we strive to continue to deliver the services the people of Barnsley deserve.

As I said earlier, the Annual Report lists our many achievements - but none of them could have been achieved without the wholehearted support, professionalism and dedication of our staff, volunteers, Governors and Board of Directors.

The Board is very aware of the valuable contribution from staff throughout the hospital. We have developed a non-executive team programme to visit departments across the Trust with an open invitation for staff to drop in and talk to us about their views, experiences, concerns, and suggestions so that together we can continue to make good progress in a challenging future

And finally, on behalf of the Board of Directors, I would like to record a particular thanks to our Chief Executive Sandra Taylor, who in March announced she would be stepping down.

Sandra has done a terrific job in helping develop the hospital and the services it provides over the last two and a half years. We wish her well in the future and thank her for the excellent job she has done in improving our performance in a range of areas.

Stephen Wragg
Chairman

Chief Executive's statement

I write this statement with great pride in the hospital, but inevitable sadness to be shortly leaving such a super, high performing hospital with many staff colleagues who are real stars. It has been a privilege to lead the Trust and to have been able to inspire significant improvements in performance especially in our infection control and in our emergency services and unscheduled patient pathways.

I am exceptionally proud of what has been achieved, and Barnsley people can know with the confidence guaranteed by external inspection that they have care in one of the best, and in some respects the best performing, hospitals in the country.

Over the time I have been here, there have been significant changes to improve services for local people and to ensure the environment and clinical practice is of the highest standard of cleanliness and safety. We have achieved full compliance with the Hygiene Code and have received unconditional and full registration with the new Care Quality Commission.

As the Chairman has indicated, the following pages detail the many successes of our staff, who are the Trust's biggest asset. Our staff will continue to strive to be the very best they can be in their dedicated public service to patients from Barnsley and beyond. This will, I am sure, act as an enormous aid to the Trust in the forthcoming further challenging period for the public sector.

Foundation Trusts are held to account by various regulators and are monitored against a range of measures covering patient safety, access to and standards of services, performance, and compliance with legislation. We constantly strive to improve our services in every respect. Of the 72 hospitals in England that have achieved Foundation Trust status, only 26 have achieved consistent and acceptable performance on finance, mandatory services and governance across 2009/10, and Barnsley is one of these Trusts, maintaining full performance on every domain as validated by Monitor, the Foundation Trust regulator.

The Trust's ratings for 2009/10 equate to the 'excellent/excellent' standard previously awarded by the Health Care Commission (now replaced by the Care Quality Commission). More importantly our patients rate Barnsley amongst the very best hospitals in the country as demonstrated on the NHS Choices web site. This very high performance reflects the enormous effort that staff and volunteers make to place our patients and their families at the very heart of all we do. Very good examples of just how high the standard of our current services are is that the national NHS Institute for Innovation and Improvement and the Yorkshire and Humber Strategic Health Authority have cited Barnsley as an exemplar in implementation of national best practice in fractured neck of femur and we have been selected, by NHS Employers, as one of only 23 hospitals nationally to be recognised as a model organisation for our work on equality and diversity.

Sandra Taylor
Chief Executive

We have continued across the last year to determinedly drive ongoing reductions in the incidence of healthcare acquired infections (HAIs) and have bettered all of our targets resulting in our rating as the top regional performer for Methycillin Resistant Staphylococcus Aureus (MRSA) reduction and incidence, and top quartile performance for the incidence of Clostridium Difficile (C. Diff), with a further and sustained reduction in our overall infection rates. Norovirus was a problem for many hospitals in our region and beyond, and whilst Barnsley did have the presence of this for a short period the scrupulous attention to detail quickly eradicated the outbreak and ensured that it was not transmitted across wards. The massive reduction in HAIs in our hospital is a remarkable achievement of our clinical and ancillary staff given the levels experienced up to 2007. I know that our staff will remain absolutely committed to the further reduction of healthcare acquired infections in the knowledge that every infection can pose a serious hazard to our patients.

The Strategic Health Authority regularly overviews performance of all hospitals in Yorkshire and Humber and their figures show Barnsley also

consistently featured as a top performer in the region for our emergency department performance and for achieving all our 18 week wait access targets for every clinical specialty. If and when we do underperform, we act rapidly to deal with the issues. An example in this last year is that when we did not achieve the improvement targets set for our surgery division and theatres we took immediate corrective measures and brought in external expertise to support rapid improvements. The lessons learned and new arrangements for improved theatre and hospital efficiencies will continue to be part of the hospital's mainstream objectives in 2010/11.

The Trust enjoyed a very successful year in attracting a variety of external awards and accolades in recognition of its commitment to excellence in the delivery of both clinical and non clinical services. The awards included the 'Cleanest hospital in the country' award by Health Business magazine and our catering services chef won the prestigious ISS Masterchef award. The Trust also received very positive comments from within NHS and the region generally due to the BBC national TV coverage of the hospital's continuation of high standards of patient care and performance during the exceptional cold weather. We also received a national Patient Safety First Campaign award for our staff's innovation in designing and using stick men symbols to help prevent patient falls, and for our commitment to patient safety demonstrated through our 'Board to Ward' approaches such as the Chief Executive's, executive directors' and non-executive directors' walk-rounds. Finally the Trust received the European Commission accolade for the Healthy Workplace initiative.

Some of the other notable features of this year have included: the strong focus that we give to patient safety for example the introduction of new dressings to avert post operative infections; the Trust investing £500,000 in cardiac catheterisation equipment, a multi-purpose machine that can help diagnose, examine and treat a range of coronary illnesses including fitting pace makers and angiography; becoming the first Trust to have designed and worked with the NHS Institute to create an overall programme using all the Institutes key tools for improving clinical and managerial efficiency, undoubtedly a significant development opportunity for staff and the Trust; and as part of UNICEF's Baby Friendly Initiative, the health community across Barnsley achieved stage 1 accreditation for the prestigious Baby Friendly Breast Feeding scheme. This latter award is nationally recognised as a quality measurement for standards of infant feeding in organisations.

The Trust recognises that collaboration with other public, private and voluntary sector agencies is critical to maximising our efforts to deliver high quality services and with this in mind we have proactively contributed throughout 2009/10 to the One Barnsley shared vision by working closely with partners across the community. During the year the Trust contributed to developing implementation plans in response to the recommendations of the Health Inequalities National Support Team and worked with the local authority and other partners to deliver the recommendations from the Comprehensive Area Assessment. We have built and maintained a very positive relationship with our university and Learning and Skills Council colleagues and enjoy a very constructive relationship with Barnsley MBC and the Overview and Scrutiny Committee.

The Trust has continued to develop values which seek to embed the NHS Constitution in the organisation. These values are even more relevant today as the NHS Constitution is enshrined in law giving rights to both staff and patients. Patients' experience of healthcare delivery has rightly become a major determinant of success and is used in judging the quality of care that the Trust delivers through the Quality Accounts which, for the first time, Trusts were required to produce in 2009/10.

The Trust has developed its strategic aims to embed the concept of improving quality and productivity through innovation and prevention. This framework of 'quality, innovation, productivity and prevention' is the golden thread that runs through the Trust's strategic aims.

As a practical expression of the Trust's commitment to ensure that the people of Barnsley can access the right care in the right place at the right time, we have actively participated in the whole health economy Quality, Innovation, Productivity, Prevention, (QIPP) group that, as well as the Trust, includes NHS Barnsley, Barnsley MBC the community healthcare provider Care Services Direct and Practice Based Commissioners. Working with these partners to prevent illness and avoid unnecessary hospital admissions, the Trust will support the care of patients closer to their own homes in the community. We will continue to work collaboratively to prevent ill health through promoting healthy lifestyles and offering a greater range of early

diagnosis and treatment services whilst also continuing to redesign our services to ensure they align with new care pathways and also modern clinical practices.

As can be seen in this report, despite the challenges of new legislation, new standards and increasing expectations of higher performance, efficiency and financial savings the Trust has excelled in 2009/10.

I would like to thank not just all our staff for their hard work during the course of the year but also those who have contributed their time and commitment, our terrific army of volunteers, and the members of our various service user groups who give us such valuable feedback. I would also like to thank the Governors for giving their very valuable time and for helping to steer the hospital over the last year. I would also pay a personal tribute to them all for their unstinting and generous support to myself during my period as Chief Executive.

Hospitals will need to continue to work hard in the coming period with colleagues from all sectors to ensure services are provided in the right place at the right time. This will inevitably bring more change which will require preparedness to continue to move with the times to ensure that the patients are genuinely at the centre of all that we do. That's the philosophy we have been developing in Barnsley and the philosophy which will act as a strong foundation to support the Trust in its future endeavours. I leave the Trust as a strong performer with much strength to support the next phase of its development.

I wish you all well.

Sandra Taylor
Chief Executive

2009/10 Board of Directors.
(Missing from photograph: Pat Newman).

Directors' report

Introduction

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). It was one of the first hospitals in the country to become a Foundation Trust, and having that status is intended to give us more flexibility and freedom to develop and improve services to suit the needs of our local community.

The Hospital was built in the 1970s, and covers a site of 8.2 hectares. It has 570 beds, and employs 3197 staff (at 31 March 2010). We serve a population of approximately 226,000, across an area coterminous with NHS Barnsley (the primary care trust) and Barnsley MBC.

The health of people in Barnsley is improving. Nevertheless we face a number of socio-economic inequalities across the community, with deaths from smoking, heart disease, stroke and cancer all higher than the England average.

Principal activities of the Trust

In 2009/10, the Trust continued to provide a full range of district hospital services to the local community and surrounding area. These included emergency department, outpatient clinics, inpatient services, maternity and children's services.

The Trust also provides a number of specialised services, including cancer and surgical services, in conjunction with the Sheffield Teaching Hospitals.

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

About our Trust

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 based on the members' views.

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 eight partner organisations, which range from Barnsley MBC and the Sheffield Universities to the Joint Trade Unions Committee and Voluntary Action Barnsley.

You can read more about our directors, governors and members later in this report.

Our directors

Our executive and non-executive directors for the year 2009/10 were:

Chairman - Stephen Wragg

Chief Executive - Sandra Taylor

Medical Director - Dr David Hicks to September 2009
Dr Jugnu Mahajan, from September 2009

Director of Finance and Information - Dawn Hanwell

Chief Nurse and Director of Quality and Standards - Juliette Greenwood and Sharon Linter from 1/1/09 (see notes below)

Chief Operating Officer - David Peverelle

Non-executive directors
Anne Arnold
Linda Christon (from 1st January 2010)
Pat Newman (to 31 December 2009)
Francis Patton
Paul Spinks
Sarah Wildon

Notes: Sharon Linter served as acting Chief Nurse and Director of Quality and Standards throughout the year, to cover this important role during Juliette Greenwood's paid sickness absence. Sharon was seconded from Leeds Teaching Hospitals NHS Trust. Juliette returned to work on a phased basis from 1st January 2010.

Pat Newman retired as a non-executive director after nearly eight years in post, latterly also taking on the role of Deputy Chair and Senior Independent Director. The Board of Directors and Governing Council subsequently agreed that the two roles of Deputy Chair and Senior Independent Director should be separated to give further support to the Trust's internal governance arrangements, and also agreed to align the role of Senior Independent Director with that of Chair of the Audit Committee. Mr Francis Patton was appointed as Deputy Chair from January 2010 and Miss Anne Arnold (as Chair of the Audit Committee) has assumed the role of Senior Independent Director.

Companies' Act Disclosures

In addition to the Companies Act disclosures below, you can also find more public interest disclosures on pages 82 to 85.

Market values/fixed assets

The main assets of the Trust in value terms are the Land and Buildings and these have been revalued at 31/03/2010 by the District Valuation service and were based on current market values, that is, a 15% reduction in building value due to the current economic climate.

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.

Likely future developments

The Trust has identified a number of likely future developments which you can read about within the Directors' report.

Research and development

There have been a number of significant activities in the field of research and development throughout 2009/10 which are contained within the Directors' report.

Branches outside the UK

There are no branches of Barnsley NHS Foundation Trust outside the UK.

Disabled employees - general

An equality Toolkit has been agreed and implemented in the past year. This means all our policies are robustly and systematically equality checked. Notwithstanding this, Managers are provided with equality impact assessment training, which covers disability, discrimination, and positive action, key parts of ensuring our disabled staff and service users are treated with respect fairly and with dignity.

The Trust has a Disability Equality Scheme which sets out how we will monitor, support and engage with our staff and service users. A specific action plan of work is built into the scheme. The scheme is available to staff on the HR intranet and Trust internet.

The Trust holds the disability two ticks symbol, which confirms that the Trust positively manages the recruitment and employment of disabled employees. The Trust's policy on employment and the retention of employees with disabilities sets out our clear commitment and intent to support staff who have become disabled in the course of their employment through training, redeployment, flexible working options and continuing support.

Disabled employees - training and opportunities

Employees with disabilities are supported in their access to training, promotion and development opportunities. This is achieved through the individual's personal development review with their manager. This review is used to create a personal development plan which includes disability issues when appropriate.

Communicating with staff

Throughout the year we have used all our usual channels of communication with staff - intranet, email, newsletters, weekly bulletins, team briefs, development sessions, appraisals, and meetings between the Chief Executive and staff. These channels of communication inform staff about issues relevant to them and how their work and ideas could have an impact on the Trust's performance. The monthly team brief sent to all departments informs staff about the financial and economic status of the Trust and the Trust's performance.

Consulting with staff

As well as our regular channels of communication with all staff with opportunities to feedback, staff side representatives are involved in frequent meetings with managers to discuss issues that affect staff interest and take into account the views of employees in decision making.

Financial risk

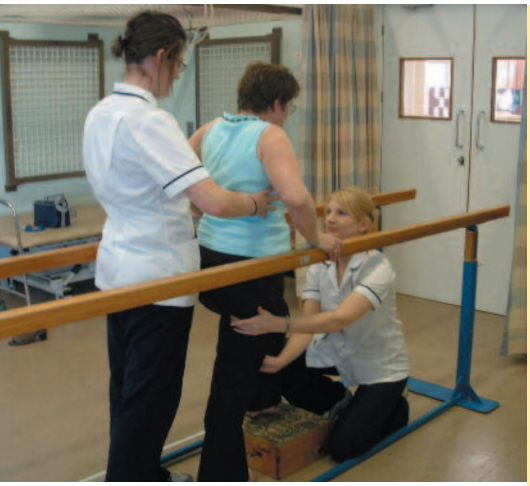
In assessing the financial position of the Trust, the Board does not consider there is exposure to any significant financial risk with regard to financial instruments.

Payment of creditors

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.


Barnsley Hospital
NHS

Directors' report - business review



What our partners say

"We have seen significant improvements in infection control rates and a reduction in patients who fall."

NHS Barnsley

A review of the Trust's business

2009/10 overview

The Trust achieved all its key targets with one exception - the delivery of 100% retinopathy screening for registered patients with diabetes.

The Trust significantly reduced its cases of healthcare acquired infections (C.Diff and MRSA) to well below the national average.

The financial year ended with a surplus of £643,000, which was marginally better than the planned position of £600,000. Additional financial information is contained in the Operating and Financial Review later in this report.

The Trust saw 71,891 patients through the Emergency Department, a slight increase over the previous year's record attendance; 59,776 inpatients and 263,703 outpatients. We also undertook over half a million diagnostic tests.

Activity against contract

The Trust achieved the national four hour target for patients attending the Emergency Department, reflecting continuing improvement to management arrangements by the Trust to ensure patients are seen and treated promptly when attending or admitted to the hospital.

The Trust also:

- established a new walk-in centre based in the town centre in partnership with private sector provider Primecare, which opened last summer. Non-registered patients are able attend the service for primary care consultations: these complement the services provided by the Hospital's Emergency Department; and

- worked closely with its health community providers both for winter plans and for the flu pandemic.

For the surgical specialties, there was a complex situation where there was under- and over-performance against elective and non-elective activity: income did not match the expected levels because of the case-mix (type of patients treated). The corresponding income resulted in a significant deficit (linked to over-expenditure because of needing to recruit locum junior doctors to meet the European Working Time Directive, reduced hours of work, and unfunded new High Dependency Unit facility). As a result, the hospital had to take corrective measures by bringing in an external Turnaround Team to initiate improvements in theatre utilisation. The arrangements for improved theatre and hospital efficiencies will continue to be part of the mainstream objectives in 2010/11.

GP referrals

GP referrals have continued to grow during the last year with a 4% increase on 2008/09 (1,723 extra referrals). Most notably there have been significant increases in the surgical specialties with ENT seeing nearly 10% more (494 patients), and orthodontics seeing a 42% increase (157 patients).

The Trust remains a national leader for the 'choose and book' system with 100% compliance with electronic booking systems and all slots available to Choose and Book. We are currently in the top 5% of trusts regarding utilisation of the system. Some of the main benefits are reduced patient 'do not attends' (DNA) at clinics, reflecting the benefit of patients of being able to choose their appointment time.

Unscheduled care: Emergency Department attendance

Attendance in the Emergency Department (A&E) in Barnsley is quite high and reflects the national and regional trend. In 2009/10 there were 71,891 Emergency Department attendances and 33,926 emergency admissions. Many of these were for patients with long term chronic diseases, mainly chronic obstructive pulmonary disease (COPD), coronary heart diseases and frail older people.

In spite of the establishment of a walk-in centre in the centre of Barnsley, attendance at the Emergency Department has continued to increase. The increasing growth in attendance and unscheduled care is a clear indication of the urgent need for a joined up approach between the Trust and its Commissioners, Primary Care and Community and Social Care partners to improve health and social care arrangements in the community to support care at home, especially for people with long term illness.

NHS Barnsley's intention to move more care into the community is supported by the Trust. But this also creates the risk of an increase in unscheduled care, especially for patients with long term chronic conditions, unless all the partners in health and social care services work together to provide adequate arrangements in the community to care for this group.

This need to manage the growth of unscheduled care is even more urgent because the Trust will be paid a fraction (30%) of the full tariff if it exceeds the contracted activity for unscheduled care.

Controlling Healthcare Acquired Infections

The standard of cleaning in the hospital has been recognised nationally by the Trust being given the accolade of 'Cleanest hospital in the country' in the renowned Health Business Magazine Awards 2009. In the Care Quality Commission inspection, the Hospital scored the maximum possible points for safety and cleanliness and for patient dignity and respect.

Screening for MRSA has continued in 2009/10. The significant impact of this is reflected in the fact that hospital acquired MRSA has been virtually eliminated in the hospital - only two cases in the last year. Following an agreed action plan to achieve further sustained reductions a considerable improvement in the rate of C. Diff cases has been made in the last year. The aim was to achieve the 2010/11 target for C. Diff cases (105 cases) in 2009/10, which was more stringent than the Strategic Health Authority's target of 145 for the same period. In 2009/10, Barnsley Hospital had just 49 cases.

Risks and uncertainties

Over the next financial year, the Trust recognises that there are a number of risks and uncertainties facing it.

The direction of the NHS towards disinvestment in acute care and the transfer of care into the community, together with the requirement for significant reduction in the funds for healthcare delivery, have necessitated a complete review of the strategic direction of the Trust.

However, the prescribed national agenda of improving the quality of care and productivity through the use of innovation and prevention of disease and early intervention clearly fits with the strategic aims of the Trust.

More detail on our performance and finances can be found in later sections of this report.

LiFELiNES

Yorkshire and Humber Strategic Health Authority cited Barnsley as an exemplar in implementation of national best practice in fractured neck of femur.

Delivering our promises

Barnsley Hospital is a small but successful acute NHS Foundation Trust with a strong reputation for achieving its service delivery requirements. The Trust has an excellent record of achieving its national, local and financial targets and has made significant progress towards delivering its Cost Improvement Programmes.

In 2009/10 the Trust set itself three strategic aims to support the delivery of its vision to be the hospital of choice for the people of Barnsley through the provision of high quality services, efficiently delivered in a 21st Century environment.

The three strategic aims of High quality, efficiency and 21st Century environment were further supported by a number of objectives that were organised into five strategic programmes to facilitate the implementation of the actions needed to achieve the objectives:

1. **Strategic Programme 1:** Deliver the Quality Agenda
2. **Strategic Programme 2:** Develop adequate bed capacity to deliver anticipated activity levels at required quality and access standards
3. **Strategic Programme 3:** Develop an efficient and productive workforce
4. **Strategic Programme 4:** Deliver more efficient processes, better use of assets and expand market reach
5. **Strategic Programme 5:** Delivery of the capital plan and estate strategy

Strategic programme 1: Delivering the Quality agenda was made up of 12 objectives including:

- to reduce the number of inpatient falls;
- reduce the number of patients readmitted within 28 days of discharge;
- reduce the number of patients whose operations are cancelled prior to the day of surgery;
- reduce the number of hospital cancelled appointments;
- reduce the incidence of Healthcare Associated Infections (MRSA and Clostridium Difficile infection);
- achieve waiting times targets (including the A&E maximum 4 hour wait and 18 week referral to treatment targets);
- the introduction of Acuity tools and Nursing Quality Assessment tools.

All of the Quality Agenda targets were achieved with the exception of the target to reduce the number of patients who were readmitted within 28 days of discharge from the hospital. In spite of the commendable strides that were made towards achieving this objective, the Trust fell short of meeting its own ambitious target of reducing readmissions by 20% of the prior year's number (Readmissions were reduced by 8.5% against a target reduction of 7.77%). The Trust will continue to focus on achieving significant reductions in readmissions within 28 days of discharge in 2010/11 and beyond.

Strategic programme 2: to develop adequate bed capacity to deliver anticipated activity levels, made up of the three objectives to:
Produce real time bed capacity plans, reduce the number of elective operations that were cancelled due to the unavailability of beds and to reduce the unnecessary use of beds by reducing length of stay. All of these targets were achieved and winter pressures were accommodated. The Trust will continue to maintain the success in the coming years.

Strategic programme 3: consisted of five objectives that were aimed at improving the productivity of the Trust's workforce including achieving compliance with the European Working Time Directive (EWTD). The objectives included the reduction of the level of sickness and absence among staff, increase the level of staff appraisals, increase the level of staff training and reduce the costs of back office functions and maintain compliance with the European Working Times Directives. The Trust was successful in introducing the required EWTD compliant rotas, however, the national shortage of available junior doctors meant that, in some specialties, reliance on locum doctors was required which resulted in some operational problems and significant financial pressures. The Trust anticipated problems in the General Medical and Paediatric services and applied successfully for derogation. However, in the event, these were not required for these specialties but difficulties were encountered with the surgical services. Despite making significant progress towards reducing sickness and absence levels among staff the Trust fell marginally short of reaching its ambitious target. Absence was reduced from 6% in the previous year to 4.6% against a stretch target of 4.3%. The Trust did not achieve the levels of recorded staff appraisals that it had targeted. The continued reduction of staff sickness and absence levels and the drive to increase the number of staff appraisals are key components of the targets for 2010/11 and beyond.

Strategic programme 4: consisted of six objectives including the "Better Care Better Value" metrics to increase the number of day case surgeries, reduce the number of preoperative days, achieve cost efficiencies in procurement, improve the utilisation of outpatient clinics, improve the utilisation of theatre (including the implementation of the "Productive Theatre" and Lean initiatives, and expand reach into new markets. The Trust achieved its objectives within the Better Care Better Value metrics but fell short of its day case targets despite improvements through the year. It also improved the utilisation of outpatient facilities but did not fully achieve improvement targets for theatre utilisation and had to take corrective measures through an external Turnaround Team to initiate improvements in theatre utilisation. The arrangements for improved theatre efficiencies and the better care better value metrics will continue to be part of the main stream objectives in 2010/11 going forward.

Strategic programme 5: was made up of five objectives that focussed on the Trust's capital programme and estates strategy. The proposed capital programme was delivered on time and within budget, meanwhile work on the Estates Strategy continues.

What our patients say

"I was an inpatient on ward 14 in Dec 2009. I had a hysterectomy and received excellent care throughout. The ward was very well run and well staffed. The staff were very helpful and treated patients with respect and dignity. The ward was very clean and daily cleaning occurred as per the standards set out and displayed. Thanks to all the staff for making my stay a positive one."

J Hutchinson, December 2009

LiFELiNES

We cared for 71,891 patients through the Emergency Department, a record.

Research and development

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

And - nationally and internationally - we play a much bigger role than our modest 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 is an increasing requirement, both locally and nationally, to ensure more and better care is delivered within the community. The Trust's research and development department has been working on this for several years and more emphasis is being applied resulting in several studies either underway or in the planning phase.

The Trust plays a major part in national research networks - stroke, cancer, diabetes - where collaboration in regional research ensures better results.

The Collaboration for Leadership in Applied Health Research and Care (CLAHRC) is now delivering high-quality research focussed on the needs of patients and translating this research into practice to improve patient care.

Enabling more effective self management in adolescent diabetes is a joint project between Barnsley Hospital, University of Sheffield and Sheffield Hospitals NHS Foundation Trust to gather information from sufferers of type 1 diabetes, aged 11-21, and their families. Patients will be recruited from the paediatric clinic and young adult clinic.

This study is part of the South Yorkshire-wide Diabetes Theme from CLAHRC, which has £1.89m of funding to support a variety of research into this topic.

Director of research and development at Barnsley Hospital, Professor Stuart Parker, secured £385,148 to research new ways to support elderly people with continence problems.

He is the Barnsley lead for Tackling Ageing Continence Through Theory, Tools and Technology (TACT3) - a joint research project funded by the Economic and Social Research Council (ESRC). He will be working with experts from at Sheffield Trust and University, and Brunel University. TACT3 aims to improve the quality of life for older people in many ways.

The results of the research will be shared with a variety of interested parties including families, charities, local government, health services and public service providers.

Quality care

The Trust has made huge progress over the last year and experienced significant improvements in key quality measures.

The Trust continued to maintain the maximum waiting time of four hours in the Emergency Department from arrival to admission, transfer or discharge and aimed to achieve above 98% with a 'stretch' to 99% for 2009/10, in which it succeeded.

Consistent with the trend in the country, unscheduled activity continued to rise against the commissioners' prediction of volumes for 2009/10 and this was particularly the case with the increase in Emergency Department Admissions.

New electronic discharge forms were introduced in every ward to ensure all medical care agencies get the same information in a more efficient and timely manner which has a positive impact on patient care.

Mortality rates fell during the year, according to the hospital standardised mortality ratio (HSMR). The rate of 91.1% against a national average of 100% meant the Trust had significantly fewer deaths than expected and is performing better than the national and regional average.

Keeping our patients safe

Patient safety is at the top of our agenda at Barnsley Hospital. We have made significant steps to improve our care and keep our patients safe while they are in our care.

Reducing healthcare acquired infections (HAIs)

The standard of cleaning in the hospital has been recognised nationally by the Trust being given the accolade of 'Cleanest hospital in the country' in the renowned Health Business Magazine Awards 2009.

Judges highlighted a number of successful initiatives introduced at the hospital over the last few years. These include a new cleaning contract which started in April 2009 and saw extra cleaners and a significant increase in hours spent cleaning each

week, work to reduce C. Diff cases each year, and ensuring the Barnsley rates for MRSA were below the average level. MRSA screening was also instigated for all patients being admitted to the hospital, including all emergency patients from 1 August 2009.

Hospital staff responsible for the cleaning and sterilisation of medical equipment were also praised after winning a handful of prestigious contracts to provide their services to other hospitals in the region. The sterile services team based at Barnsley Hospital now cleans and sterilises thousands of pieces of medical equipment every week for all three hospitals in Barnsley as well as all of the GP practices, health centres, dentists and podiatrists.

The team has also won tenders to provide services to Lincoln, Grantham and Gainsborough Hospitals, Bradford and Pontefract GPs, and private sector hospitals in Rotherham and Wakefield. The team received praise from Airedale NHS Trust after Barnsley's sterile services team were able to provide emergency support and save the day when Airedale's unit broke down.

And in the Care Quality Commission inspection, the Hospital scored the maximum possible points for safety and cleanliness and for patient dignity and respect.

MRSA screening

Screening for MRSA has continued in 2009/10. The significant impact of this is reflected in the fact that hospital acquired MRSA has been virtually eliminated in the hospital - only two cases in the last year.

Infection control - C. Diff

Following an agreed action plan to achieve further sustained reductions a considerable improvement in the rate of C. Diff cases has been made in the last year.

The aim of the plan was to achieve the 2010/11 target for C. Diff cases (105 cases) in 2009/10, which was more stringent than the Strategic Health Authority's target of 145 for the same period. In 2009/10 Barnsley Hospital had just 49 cases.

Human Tissues Authority

The Human Tissue Authority (HTA) was established in April 2005 under the Human Tissue Act (2004) following a number of high profile cases - Alder Hey and Bristol inquiries - where organs and tissue had been removed, stored, and used post mortem without the knowledge and consent of the relatives. The role of the HTA is to regulate the removal, storage, and use of human bodies, body parts, organs, tissues, and cells for a number of specific uses.

The hospital's submission of a self-assessment compliance report to the HTA for a licence to carry out post mortems at the Trust was followed by an inspection

What our partners say

"The Commission is aware that the hospital has received an award for the cleanest hospital in the country and was impressed with the priority given to combating hospital acquired infections. Use of hand-cleaning gels by staff and visitors and improved signage in this respect was in evidence when Commission Members visited the hospital."

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visit from the HTA. The visit focussed on the suitability of the premises, review of documentation, audit of stored material to assess traceability, and interviews with key individuals within the organisation.

The feedback at the end of the inspection visit was very positive: the inspectors were very impressed by the Trust's policies and procedures and felt that there was an excellent service in place. The final report was received with one minor condition being applied to the licence: the departmental disposal policy must be finalised within the Trust as either a stand alone policy or incorporated into the Trust's general disposal policy.

Breast screening quality assurance

In May, the Breast Screening Unit received a quality assurance visit. Staff who were interviewed over the course of the day felt it went exceptionally well and was the best visit they had ever had. Feedback to the team confirmed that they had met all their targets, and that nationally the service is placed fourth in the country.

Baby Friendly Initiative (UNICEF)

In August the health community across Barnsley undertook a joint assessment for accreditation at stage 1 of the prestigious UNICEF Baby Friendly Breast Feeding initiative. This award is nationally recognised as a quality measurement for standards of infant feeding in organisations. The team subsequently received confirmation that it had been awarded stage 1.

The team is already looking at how to progress towards attaining stage 2 in 2010, if possible, and going on to stage 3 in 2011.

Organ donation

Steps have been taken to improve the Trust's activities in response to the recommendations of the national Organ Donation Taskforce (2008 report Organs for Transplants). The ongoing programme includes:

- focus on heart beating donation and non-heart beating donation rates from the intensive care department;
- retrospective and prospective auditing of potential and actual donations from the emergency department;
- liaison with the regional Donor Transplant Coordination (DTC) team;
- reimbursement of the costs of donation to the Trust;
- tissue donation from other areas of the hospital (wards, neo-natal unit, emergency department); and
- publicity surrounding donation and the role of the DTC within the Trust and wider community.

Protecting the vulnerable

The Named Nurse for Safeguarding Adults post is firmly established, becoming an integral partner with social and other healthcare agencies in identifying individuals that may be suffering the many different forms of abuse.

The work around learning disabilities within the Trust has led to the continued improvement in the general care of all patients with learning disabilities. This has resulted from effective communication between the Trust and the many different agencies representing people with learning disabilities.

Meeting our targets

National targets

Target achieved?	Target (2009/10 report)
✓	98% of patients to be seen within four hour maximum wait in the emergency department from arrival to admission, transfer or discharge. **Achieved - 98.91%**
✓	90% of patients to be treated within 18 weeks of referral for admitted patients. **Achieved - 97.5%**
✓	95% of patients to be treated within 18 weeks of referral for non-admitted patients. **Achieved - 99.25%**
✓	Patients to be seen within a maximum two week wait standard for Rapid Access Chest Pain clinics. **Achieved - 99.26%**
✓	100% guaranteed access to a genito-urinary medicine clinic within 48 hours of contacting the service. **Achieved**
✓	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. **Achieved**
✓	Delayed transfers of care at a minimum level. 0.28% of bed occupancy (393 actual delayed discharges)
✓	96% of patients to have a maximum waiting time of 31 days from diagnosis to treatment for all cancers. **Achieved - 100%**
✓	85% of all patients to have a maximum waiting time of 62 days from urgent referral to treatment of all cancers. **Achieved - 91.2%**
X	100% of registered patients with diabetes to be offered screening for the early detection (and treatment if needed) of diabetic retinopathy. **Not achieved.** Retinal screening services suspended in November 2009 following external review. Staff required retraining and new clinical lead appointed - service recommenced February 2010.

Local targets

The Trust was also set a number of targets by its local commissioner, NHS Barnsley, which were achieved:

Target achieved?	Target (2009/10 report)
✓	Achieve a three-year reduction in C. Diff figures. Reduce incidences of C. Diff target to 105 cases. **Achieved - 49 cases**
✓	Reduce MRSA target to 8 cases. **Achieved - 2 cases**
✓	Improve breastfeeding initiation rate by 60.5%. **Achieved - 61.88%**

What our patients say

"From beginning to end my experience was brilliant. When I was delayed in clinics (not long) I was told why. I was terrified pre - and during surgery but I was calmed and treated with dignity. The courtesy call the day after discharge was - for me - a lovely touch. The whole experience was as good as it could be given the circumstances. 'As for the staff - I could not in fairness name one over the other. Everyone - and I mean EVERYONE - was friendly, caring and helpful.

Thank you."

June Chivers, November 2009

Performance

During the year the Trust delivered commendable performance in all dimensions of service delivery and performance measures including:

- achievement of 98.91% of the four hour maximum wait in the Emergency Department;
- achievement of the 18 week and two week cancer referral to treatment targets;
- 100% achievement of the two week rapid access chest pain waits;
- 100% achievement of the 48 hour access to genito-urinary medicine clinic; and
- 100% achievement of the target for screening of all elective inpatients.

Through the Trust's effective capacity and business continuity planning there were few operational issues throughout the year and significantly lower hospital acquired infections than in previous years.

There have also been laudable reductions in the incidence of healthcare associated infection rates. MRSA infections fell from eight in 2008/09 to just two in 2009/10, and similarly incidences of C. Diff infections fell from 138 in 2008/09 to 49 in 2009/10.

The Trust successfully delivered almost all of the underpinning strategic objectives and made significant progress towards achieving the targets that were not met. The objectives that were not achieved include targets set to reduce rates of readmissions, increased day case rates and a reduction in pre-operative bed days, and others relating to its workforce issues and estates strategy. Although those specific targets were not met, the Trust still made significant improvements over the previous year's performance.

External assessment

External assessment in 2009/10 provided assurance for our patients and the community that Barnsley Hospital continues to focus on delivering high quality, safe care and meets or exceeds national standards. Amongst the accreditations and inspections were:

- the Trust received a first class report from the Healthcare Commission (latterly Care Quality Commission (CQC)) in its annual rating for 2008/09. The hospital was rated 'excellent' for its Quality of Financial Management and 'good' for Quality of Services and scored the maximum in all key compliance domains except records management, which has since been rectified;
- the European Working Time Directive (EWTD) was implemented on August 1st, limiting staff working hours to 48 a week. Patient care was maintained by plans to recruit more junior doctors and provide additional training for existing staff;
- an unannounced hygiene inspection by the CQC praised the high standards of cleanliness across the hospital and particularly in the Emergency Department and wards 22, 33 and 34; and
- a PEAT (patient environment action team) inspection of ward 11 in Maternity Services achieved excellent results with a normal delivery rate of 73-74% and rates for caesarean sections and epidurals below the national average.

The Trust delivered all of its key targets in 2009/10.

Previously, the Trust had to ensure that eligible patients received thrombolysis within 60 minutes of a heart attack. Thrombolysis is a specific treatment of clot dissolving drugs that can be administered to certain patients, and works by restoring blood supply in the coronary arteries that supply the affected part of the heart. This service transferred to Sheffield in 2009.

Response to regulators

Using the CQC guidance, the Board of Directors has been through a rigorous and systematic programme of reviewing evidence involving both service leads and front line staff.

The Board carefully reviewed the Trust's compliance with the required domains, taking into consideration the conditions being applied by the CQC in assessing whether the standards had been met. After a review of the evidence, the Board has reasonable assurance that the Trust was fully compliant with all core standards at the end of the year.

LiFELiNES

The Trust's 2009/10 budget ended as set our in our Financial Plan, delivering a small surplus and earning the Healthcare Commission's rating of 'excellent' for financial management.

The Board of Directors also has reasonable assurance that there have been no significant lapses in meeting the core standards during the period 1st April 2009 to 31st March 2010.

The Board will continue to keep compliance to the Standards for Better Health under active review.

Looking forward to 2010/11

Looking forward to 2010/11 the Trust aims to be the healthcare provider of first choice. All the Trust's activities and services will demonstrate high quality, innovation, productivity, and prevention. The Trust will ensure in all that it does it strives to achieve:

Quality: high quality services; high quality care
The Trust will deliver high quality services and high quality care using evidence-based pathways and clinical standards that assure the best outcomes for our patients, promote their safety and give them the best experience of care while upholding their dignity and respect.

Innovation
The Trust will develop new pathways and models of care and harness the boundless potential and opportunities presented by medical and digital technology to improve the outcomes and experience of care for its patients, to deliver care at the right place and right time and enhance efficiencies.

Productivity
The Trust will maintain and sustain financial viability by maximising productivity through optimising the efficiency of its physical and human resources, reducing unnecessary overheads, and, where this is required, use efficiency enhancing arrangements such as integration of services, clinical networking, and partnership to achieve clinical and commercial viability.

Prevention
The Trust will continue to work with its health and social care partners to prevent illness and avoid unnecessary hospital admissions and support the care of patients closer to their own homes in the community. The Trust will support enhanced prevention through earlier diagnosis and treatment.

The Trust has developed a detailed business plan which will set out the aims for the financial year 2010/11. This will be available from the Trust's website.

Trends and factors affecting the Trust in the next financial year

In 2010/11, the Trust faces a number of challenges, as does the NHS and the wider public sector. Some of these are outlined below.

Primary Care Trust commissioning strategy

NHS Barnsley's vision for commissioning services for the people of Barnsley described in its five year Commissioning Strategy *Healthy expectations: supporting the population of Barnsley to maximise their health and well being* is founded on three declared principles:

- to help the people to control their own health;
- to enable and support independence and well being; and
- to ensure that people have rapid and convenient access to high quality and cost effective services.

These fundamental principles, which quite rightly reflect the path being taken nationally, are translated into practice through NHS Barnsley's emphasis on promoting and facilitating the implementation and development of the concepts of self directed and self managed care, increasing patient choice, personalised budgets, and care navigation through primary care providers.

These models and concepts of self care and self determined care, individualised care, choice, and personalised budgets underpin the delivery of NHS Barnsley's recent *Commissioning strategy for primary and community services: transforming community services*. The declared priorities within the strategy include:

- moving care closer to people's homes;
- personalised care that is tailored to the individual needs of the patient;
- empowering people to make the right decisions about their care and to be more involved and have a say in what happens to them when they are ill or need support from local services;
- people's right to be listened to, and to dignity and respect;
- facilitating seamless, whole-systems delivery of health and social care especially for those with long term chronic conditions;
- upholding the concept of self care and self directed care in planning and contracting local services to enable and support people to asses their own needs and take responsibility for their care;
- promoting personalised budgets;
- developing a system of care navigation in which local GP practices coordinate the care of the individual but the patients have the

What our partners say

"Patients are asked about their experience in hospital and this information is then used to improve and redesign services. The Commission feels that the hospital should be commended for listening to patients and ensuring that their views are acted upon."

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right advice and support of the primary care team to enable them to access the right services when they need to do so;
- promoting new ways of working such as the use of telemedicine to fully support patients and service users when they are ill; and
- promoting the ability of patients to refer themselves to into services that meet their needs.

NHS Barnsley's declared strategic intent in commissioning acute care services reflects and reinforces the national approach of moving care closer to the homes of patients and ensuring that the people of Barnsley receive the right care at the right place at the right time. The strategy also reiterates the national cultural shift away from perceiving the health service as a treatment service to one where more effective prevention and better support for healthier lifestyle choices can result in healthier outcomes.

The Trust supports the move to bring services closer to the homes of patients and provide the right care in the right place at the right time. However, this also creates the urgent need for the Trust to work together with NHS Barnsley, primary care and community health and social care partners to put in place effective arrangements and alternative pathways in the community to enable the retention of care within the community and prevent unscheduled admissions to the hospital.

Urgent care/admissions for older people above the age of 75

Barnsley is above the national average for emergency admission for people above the age of 75 years. The continuing increase in emergency admissions of this category of patients clearly suggests a need to improve access to services in the community for older people and people with long term chronic illness.

Compared with national and regional averages, Barnsley is on the low end in terms of supporting older and frail elderly people to live at home. These people also frequently stay longer when admitted to the hospital, mostly because it often takes longer to arrange the facilities they need in the community to support their independent stay at home or in a supported care environment.

Recurrent service users

A small category of recurrent service users ('frequent users') are patients with long term chronic conditions who repeatedly present themselves to the hospital for treatment. This group of patients do not appear to be aware of the services that are available in the community to support their care at home, or just choose to continually rely on acute care services. The cost of their multiple readmissions was £1.5m in the 2008/09 financial year which can be avoided if robust arrangements are put in place in the community and primary care environment to avert their recurrent use of acute care services.

Whole health economy

As a practical expression of the Trust's commitment to ensure that the people of Barnsley can access the right care in the right place at the right time, it has signed up to the whole health economy Quality, Innovation, Productivity, Prevention (QIPP) group that, as well as the Trust, includes NHS Barnsley, Barnsley MBC, the community healthcare provider

Care Services Direct and Practice Based Commissioners.

The Trust fully embraces the principle that all agencies should work collaboratively to ensure that care pathways are integrated and aligned to offer appropriate and safe care; to prevent unnecessary hospital admissions (especially those emergency admissions resultant from long term conditions management); and enable swift discharge into high quality community based resources.

The Trust is using this forum to work together with its community health and social care partners to redesign care pathways and new models of care delivery that will enable patients to make maximum use of the services that are available in the community to support their care at home. The Trust will provide the necessary support to enable people to receive care closer to their homes and only attend the hospital where the hospital is the right place for them to receive the care that they need at that particular time.

The Trust has proposed a number of actions for a collaborative and whole systems approach by the QIPP team to resolve issues such as demand management of patients in the community, delayed discharges, provision of mental health care such as dementia care, end of life pathways and contracting for acute services.

The proposed actions which have been endorsed by the group are to:

- establish a group to design rapidly urgent care pathways and identify how patients are to be both served and kept safe;
- urgently identify how frail, older people are to be supported in an effective pathway of care beyond hospital and define appropriate end of life pathways. The group needs to establish where else these patients will receive their care if they are not admitted into hospital; and
- advise where the patients, who are supported by the high dependency unit, will be cared for if the unit cannot be sustained as a result of the lack of funding.

The Trust is a major employer in Barnsley, employing over 3,000 people, and about 90% of these live in the borough of Barnsley. The continued viability of the Trust is vital for the economy of Barnsley and this is acknowledged through the Trust's membership of the Local Strategic Partnership. To this end, the Trust is seeking a strategic alignment with the whole health economy approach by the QIPP group to address the health deficits in Barnsley and also ensure that it remains a stable and viable employer.

Emergency preparedness

Emergency planning and business continuity management continue to be prioritised in the 2010/11 NHS Operating Framework. The local work completed over the past 18 months proved invaluable during the swine flu outbreak and formed the basis for Barnsley Hospital's response. A full training and exercise programme is in place with all incidents that could impact on the Trust's key services being the subject of a full debriefing and report. The close cooperation between the hospital and NHS Barnsley emergency planning officers continues to pay real dividends.

Change of government and policy

The Trust must be mindful of possible changes to national government and policy, and any effects that this might have on the future direction of the NHS in general and on local health and social care service provision in particular.

Our community

Barnsley Hospital NHS Foundation Trust is coterminous in its local boundary with NHS Barnsley (the Primary Care Trust) and Barnsley MBC and they serve a population of about 226,000 people.

Barnsley's population is set to increase by 16% by 2013. Ranked 43rd in the Index of Multiple Deprivation in 2007, Barnsley is an area with high levels of deprivation.

The Barnsley Joint Strategic Needs Assessment 2010 by the Director of Public Health reveals that:

- 11% of the working age population are claiming incapacity/severe disablement benefits compared with 6.3% in England (2008);
- 18.9% of the population are under 16 years and 19.6% are of pensionable age, and the number of people over the age of 65 years is projected to increase by 67% by 2031, and life expectancy is growing;
- over 50,000 adults in Barnsley are smokers and one in five of all new mothers are smokers at the time of delivery;
- only 19.5% of the population consume five or more portions of fruits and vegetables a day. The national average is 26.3%;
- 28.5% of adults and 20% of year 5 children in Barnsley are obese – higher than the national average;
- 18.9% of adults are drinking alcohol at hazardous levels. A health survey showed that 34.4% of school children in year 10 (14 to 15 year olds) are daily smokers and 32.3% drank alcohol regularly;
- only 19% of the adult population in Barnsley take part in some form of regular sport and recreation;
- there is a significant number of drug users and the number of sexually transmitted infections is steadily increasing;
- cancer is the major cause of premature death in Barnsley and chronic conditions such as dementia, stroke, diabetes and high blood pressure are major causes of ill health and disability; and
- the main causes of emergency admission for children and young people are viral infections, and chronic obstructive pulmonary disease for adults.

These translate into serious healthcare needs and inequalities that the hospital, as a care provider, local employer and member of the Local Strategic Partnership, commits to work in collaboration with its partners to resolve.

NHS Barnsley is the hospital's main commissioner and commissions about 90% of the hospital's services. It continues to express its intention to support the delivery of acute care services locally for the people of Barnsley where the treatment is the right care and the acute setting is the right place.

The Trust acknowledges and supports the principle of delivering care closer to the homes of patients, and in using its beds and resources to treat only those patients who need high levels of care that can only be available in the acute hospital.

To this end, the Trust has worked, and continues to work, with its local partners including NHS Barnsley, Barnsley MBC and Care Services Direct to model services and redesign care pathways around the needs of patients; and to ensure that the hospital works collaboratively with all other providers and stakeholders to deliver seamless and high quality care for patients in the most appropriate locations.

Improving our services

Patient care

As a Foundation Trust we are directly accountable to local people and take pride in listening to their views, identifying where we can do better and supporting our staff to provide the very best care in an excellent hospital.

The NHS Constitution - which details the commitments, rights and responsibilities for the public, patients and staff - drives the work of the Trust. Focus continues to be on delivering these priorities and we have made a number of important strides in all these areas.

It is notable that the wards within the productive ward programme have showed significant improvement in the nursing metric - for example, decrease in number of complaints relating to nursing care, number of falls and number of patients acquiring C. Diff.

The Trust has also commenced on the productive theatres programme. This programme follows a similar theme to productive wards but concentrates on the patient pathway from pre-admission through to discharge following surgery. Work has already commenced on improving baseline metrics such as late start reductions, theatre utilisation and ensuring patients arrive at theatres from wards at the correct time.

In 2009/10, the Trust:

- became one of only three in the UK to offer a unique new method of thoracoscopy that can be performed under local anaesthetic making it safer and faster to treat and diagnose serious lung conditions including lung cancer;
- invested £500,000 in cardiac catheterisation equipment which is a multi-purpose machine that can help diagnose, examine and treat a range of coronary illnesses including fitting pace makers and angiography; and
- acquired two Optiflow machines on the general ward to benefit patients with respiratory problems and reduce intensive care admissions.

Care for the elderly

In December the Acute Rapid Intervention for the Frail Elderly (ARIFE) multi-disciplinary clinic launched to support independence and prevent hospitalisation by providing rapid access to a range of services for elderly people.

Treatment for Age-Related Macular Degeneration (AMD) is now available in Barnsley. It is the main cause of blindness in the over 60s, affecting 500,000 people in the UK each year.

And we've introduced patient identifiers ('stick men') to give a visual indication of patients who are at risk of falling.

Cancer services

A complementary therapist has been employed following fundraising efforts by the Barnsley Cancer Aftercare support group. Cancer patients can access free massages and other therapies following chemotherapy treatment.

Passport to Relaxation was launched, offering women, who are recovering from breast cancer surgery, five free swimming lessons and complementary therapies to help them rebuild confidence and recover physically and emotionally from their illness. The service has been made possible by the generosity of a former patient who has offered the use of her private pool to thank the department that cared for her. Volunteers from the Red Cross are giving therapeutic hand and arm massages to elderly patients to aid relaxation and ease problems such as arthritis or rheumatism.

The breast unit has joined forces with charity Breakthrough Breast Cancer to improve services to patients in a number of ways including gathering feedback and cutting waiting times.

A Mobile Cancer Unit was launched in January 2010 as a joint project between the Trust and NHS Barnsley to bring an innovative and proactive approach to cancer services.

Pregnancy, maternity and support for children

The creation and appointment of a nurse advisor post for children's and young people's care has enabled the Trust to review its services and involve children and their families in developing the department.

A specialist counselling service is now available for women in Barnsley who are facing an unplanned pregnancy or who have lost a child following a miscarriage or abortion. It involves confidential sessions to provide support and advice.

What our patients say

"My son was treated for a condition in the new wing of childrens A&E and I must say it looks superb. The staff were great, from the doctors and nurses to the auxillary staff. He was treated very quickly, put at ease and we were kept informed all the time what was happening.
Brilliant!!

'I am extremely happy with the service of my local hospital!"

Simon, October 2009

Barnsley Hospital is included in a regional scheme to provide 'Dad Cards' containing useful information and advice for new fathers on supporting their partners and dealing with some of the challenges of new parenthood.

Maternity services have a new birthing pool, further improving the labour and delivery services for expectant mums. The department has a lead midwife for water births who provides training to her colleagues and expert support and advice to women on their birthing options.

Listening to our patients

Barnsley Hospital is always looking at ways to improve the patient experience so that patients in our care and their families leave feeling happy about the service they received here.

Public and patient involvement

Involving members of the public and our patients in the planning or redesigning of services is a key way of improving patient experience. Following the setting up of a public and patient involvement group, led by a non-executive director, to examine how the hospital involves patients and the public and to assist departments in making meaningful and appropriate changes to patient services, the group has helped develop a number of our services.

Patient experience is of paramount importance to the Trust and forms part of our patient involvement strategy. Involving patients and the public is key to planning and improving services. The patient and public involvement group, originally established in 2008, has been redesigned as the patient experience group which covers all aspects of patient involvement and experience by looking at information gathered from surveys, complaints, letters of appreciation and issues raised through our well established health community-wide patient advice and liaison service. The Trust has appointed a Patient Involvement Officer specifically to assist with this work and help co-ordinate and report patient experiences across the hospital.

Regular reports are now created from the results received from the investment the Trust made last year in the system purchased through Customer Research Technology, *Beyond Question*. This is a touch screen facility situated strategically around the hospital to gather patient feedback of the care provided. This versatile system is also available on hand held touch screen tablets used regularly by our matrons to gather important inpatient feedback direct from patients at the bedside.

The Trust is constantly updating and reviewing its patient involvement strategy and action plans in line with changes in the service and patient experiences and expectations. A patient panel is to be established in early 2010 which will work alongside health professionals on specific issues key to both patients and the Trust's agenda.

The Trust will continue to work with patients, patient groups and our governors in order to develop services in line with the modern NHS.

We continue to work closely with the Barnardo's Voice and Influence Ambassador Project to ensure the hospital's services better meet the needs of young people. The Barnsley Black and Ethnic Minority Initiative (BBEMI) also continues to be consulted and to consult on our behalf the minority and hard-to-reach groups in the area and ensure their views are heard.

This work has included the Chairman attending social events hosted by community groups under the BBEMI umbrella and meeting key staff for further discussions about working together and encouraging membership and candidates for governor seats from within minority ethnic groups. This has resulted in increased membership applications via BBEMI.

The Trust is committed to working with patients in order that patient and public involvement can influence change and developments throughout the organisation.

Patient experience

The Hospital is constantly looking at ways to improve patient experience so that its patients leave not only recovered but also satisfied with the service they have received whilst in our care. Working with patients and the public, a number of initiatives were developed to improve patient experience in 2009/10:

The website
In October the Trust's new website celebrated its first birthday with more than 100,000 users logging on in the first year, and we have plans to make more improvements based on user feedback.

Access to services
A survey on access was carried out in outpatients following two incidents on the hospital escalator. The escalators were slowed down and the

survey found that most patients and visitors were satisfied with the signage and the options for access to the department.

Great food
Jack Raynes was named ISS Mediclean/Knorr Chef of the Year in a national competition for chefs from hospitals, prisons, education and MOD kitchens managed by the company, after proving his culinary skills against 15 other contestants.

Customer care
The Trust set out its customer care standards following a successful six month trial in the outpatient department. The standards emphasise treating people, patients, visitors and colleagues with the highest quality of care. A training DVD, developed based on a patient's personal experience, was made available across the Trust. The standards are regularly reviewed by a staff forum of customer change champions and three Customer Care Assistants have been recruited through the future jobs fund to provide support to hospital visitors.

Patients' dignity and privacy
The hospital received £38,000 from the Department of Health to fund improvements to support privacy and dignity for patients. The money was spent on patient information, facilities, and equipment to support patients who - based on clinical need and by exception - have to be treated in mixed sex accommodation (such as on initial admission to the Medical Admission Unit).

Improvements to the hospital environment
The hospital's main entrance was improved to enhance safety for patients and visitors. Works included upgrading the pedestrian access and creating a one-way system to make it more accessible for ambulances, and creating designated pick-up points and more disabled parking spaces.

A new hospital car park for patients, their relatives, and visitors has been created.

Stop smoking
In May 2009 a 'stop smoking shop', sited in our outpatients department, was officially opened. This initiative is managed by NHS Barnsley and is a good example of our shared aims to promote public health issues in Barnsley.

Patient safety
The Trust was successful in its application to be part of the next wave of the national Institute for Innovation and Improvement programme, Leading Improvement in Patient Safety (LIPS). LIPS is based on delivering the national patient safety agenda outlined in the operating framework and on transforming good ideas into workable solutions.

The Chief Executive and all members of the Executive Team were actively involved in patient safety walkabouts across the national Patient Safety week. The week also included excellent exhibitions and there was demonstrable energy and commitment from staff to continue to promote and drive initiatives to improve safety. Other activities involved posters covering Communication; Falls; Medicines Management; Staffing; and Nutrition. The posters moved around set sites and were staffed during peak times of the day in order that the teams engaged both colleagues and patients.

A series of initiatives were launched on patient safety. These included the introduction of stick men on wards - part of the plan to reduce inpatient falls; two minute safety briefing of nursing staff at each handover; and a safety book used daily to document those patients at risk.

The national patient safety campaign commissioned a training video comprising of six selected Trusts where it was deemed excellent progress had been made - one of which was Barnsley - and a number of the executive, including the Chief Executive, were videoed. The Trust will receive back all the footage and may find opportunities to utilise this for internal training/promotion;

Barnsley leading the way
The NHS Institute and the regional Strategic Health Authority cited Barnsley as an exemplar of implementation of national best practice in fractured neck of femur in the regional publication *Delivering Healthy Ambitions - Better for Less.* As well as noting the major impact on quality of life for frail older people, the publication majors on the quality and cost effectiveness of care and the

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We have been selected by NHS Employers as one of only 23 hospitals nationally as a model organisation for equality and diversity.

variability across the country and region. Barnsley is in the top 10% of trusts nationally for the length of stay of such patients and has the lowest emergency readmission rates. Best practice means that more patients will live with less disability and will retain their independence for longer. Barnsley provides training for nursing assistants to enable the staff to continue mobilising patients over the weekend when physiotherapy staff are not available.

Health, Innovation and Education Cluster (HIEC) for Yorkshire & Humber
National funding has been awarded to establish a new initiative within NHS Yorkshire and the Humber (Y&H) to ensure patients receive better care across the region through innovation and improved quality and productivity. The Y&H HIEC is the largest of 17 new nationally funded initiatives that will combine the expertise of the NHS, universities and industry. The application for this region's HEIC was co-ordinated by Bradford Teaching Hospitals NHSFT and Barnsley Hospital is among the 27 core partners supporting the initiative. The HEIC focuses on three key themes initially: long term conditions, maternal and infant health, and patient safety.

Complaints 2009/10

Formal complaints received: 309
Complaints responded to within agreed timeframe: 248
Complaints responded to outside agreed timeframe: 61
Complaints acknowledged within the three working day standard: 309

The Parliamentary and Health Service Ombudsman undertakes independent reviews of complaints under stage 2 of the complaints procedure.

The Trust was notified of three requests for information to support the stage 2 review by the Ombudsman in the past year, the outcome being that all three have been assessed by the Ombudsman with a decision not to conduct an investigation and take no further action.

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 2009/10:

- a Trust Wide Dementia Working Group is to be formed to look at the implementation of the dementia strategy;
- wider access from hospital professionals to the referral process to memory services, to improve access for support and advice;
- patients with dementia who are admitted and wear dentures are now issued with a bright yellow denture pot to remind staff to be extra vigilant;
- care enablers have been introduced on orthopaedic and general surgery wards as extra support to nursing staff in the delivery of care, assisting at meal times and observations of patients;
- surgery dates are now given by the pre-assessment nursing team who can ensure the date is given in a timely manner and without the need for further pre-assessment visits;
- a new 300-space car park opened in early 2010 at the junction of Pogmoor Road and Summer Lane to relieve congestion and waiting times for visitor parking;
- customer care training is to be rolled out to all front line staff within the Trust to improve patient experience and better facilitate the journey through the hospital;
- a leaflet, *Maintaining Comfort*, has been designed to give to relatives of those who have expressed a wish to spend their final time at home and are on the end of life care pathway;
- handover of care, at the end of a ward shift, has been formalised and is now recorded in a ward handover book which is available to all staff; and
- in addition to individual patient nursing handover, two-minute safety briefings are now in place at the start of every shift to pass on all serious safety issues on the ward, including patient safety and environmental issues.

Response to feedback from members, governors and local partners

We have feedback from a variety of local partners, members and governors in response to the Care Quality Commission (formerly Healthcare Commission) Health Care Standards request.

Some examples are:
- more wheelchairs needed at the entrance to the emergency department;
- answering of the main hospital telephone promptly; and
- elimination of mixed sex accommodation.

We will consider the appropriate initiatives to deal with these concerns, and continue to ask the necessary questions to identify the care processes that may require improvement.

Feedback from partners

Additional feedback from our partners can be found in the Quality Report.

Our team

Barnsley Hospital's biggest and best asset is its staff who are often referred to as 'friendly and caring' by our patients. With over 3,000 staff, 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

As at 31 March 2010, the Trust employed 3,197 employees. A breakdown of the Trust's workforce is shown below.

Training

The Trust is committed to ensuring that all of its staff have the right skills

Employee profile

Age profile by staff group of Barnsley Hospital NHS Foundation Trust as at 31 March 2010.

Staff Group	16 - 20	21 - 25	26 - 30	31 - 35	36 - 40	41 - 45	46 - 50	51 - 55	56 - 60	61 - 65	66 - 70	71 & above	Total
Add Prof Scientific and Technical	1	9	14	17	20	14	13	8	5	3	1	0	105
Additional Clinical Services	89	118	86	85	87	118	101	53	36	19	5	0	797
Administrative and Clerical	66	75	83	58	68	92	79	97	58	28	6	1	711
Allied Health Professionals	0	10	30	13	16	18	16	9	10	2	0	0	124
Estates and Ancillary	2	4	11	3	9	9	22	16	15	7	0	0	98
Healthcare Scientists	0	3	21	11	10	16	17	14	7	2	0	0	101
Medical and Dental	0	21	33	21	34	42	37	25	12	10	1	1	237
Nursing and Midwifery Registered	0	91	133	152	152	183	142	93	46	16	2	0	1,010
Students	3	7	1	1	0	2	0	0	0	0	0	0	14
Total	161	338	412	361	396	494	427	315	189	87	15	2	3,197

Gender profile

Gender profile by staff group of Barnsley Hospital NHS Foundation Trust as at 31 March 2010.

Staff Group	Female	Male
Add Prof Scientific and Technic	75	30
Additional Clinical Services	720	77
Administrative and Clerical	589	122
Allied Health Professionals	104	20
Estates and Ancillary	37	61
Healthcare Scientists	64	37
Medical and Dental	86	151
Nursing and Midwifery Registered	926	84
Students	10	4
Total	2,611	586

What our partners say

"The Trust continues to help support groups such as the stroke club, cancer support group and complementary therapy services, etc, although Governors and the Trust are trying to build on these - and other - links with groups across the community."

Governing Council of Barnsley Hospital NHS Foundation Trust

and expertise to deliver a first class service. The Trust has continued to invest in providing a professional learning and development team who can deliver all aspects of learning and development to meet the needs of the business and our staff. The provision includes training to support the ongoing development of both clinical and support staff. In addition, the Trust has continued to support Barnsley's local young people by providing apprenticeship training opportunities in health and administration support roles. Many of the apprentices have gone on to obtain permanent employment with the Trust.

This year the Trust has also started implementation of a major programme of customer service training in the organisation. Its aim is to ensure the Trust and its staff delivers excellence in customer service. This has included the development of Trust customer service standards, training for staff and managers and the establishment of customer care champions in Trust departments.

Healthy Workplace
The Healthy Workplace Programme, launched in spring 2009, has gone from strength to strength throughout the year. The scheme offers free access for staff to a range of programmes which encourage healthy lifestyles and support a positive work/life balance including fitness classes and sports activities, smoking cessation, healthy eating advice and slimming clubs, stress management support, and complementary therapies. There are special events, and ongoing support, throughout the year that are well publicised to all staff. The scheme was given an 'excellent' rating by the European Agency for Safety and Health at Work.

Improvements to sickness/absence procedures
A new sickness/absence procedure was introduced in the summer following consultation with the trade unions to reduce the high levels and save the Trust £5m. The new approach includes focussing on the health and wellbeing of staff and reducing workplace stress.

Employee engagement
The Trust has been awarded an NHS Social Partnership Award for £35,000 to develop the employee engagement strategy and take forward a draft staff charter to establish the rights and responsibilities of all people working for the Trust.

Staff roadshow events were held throughout the hospital to engage staff in the Trust's plans and highlight the important role they will play. The events were well attended and provided a chance for people to ask questions of the senior management team on the plans. The events were supported by a special edition of staff magazine Bdi, which set out the different work programmes in detail and looked forward to the next few years. The Chief Executive and Chairman were also featured in a video on the Annual Plan which was made available to all staff and placed on the Trust's intranet.

Medical and senior nursing staff briefings
As part of an overall engagement effort, the Chief Executive has held monthly briefing sessions for medical and senior nursing staff. These sessions provide an opportunity to be able to share thinking on the operating framework and the likely

implications for the Trust, along with other relevant issues.

Our stars
The Trust launched the first ever independent staff awards scheme the Helpfulness, Excellence, Achievement, Resourcefulness and Talent or HEART awards. The event praised the achievements of staff who were nominated by their colleagues.

Community midwife Sally Wilson reached the finals of the Mamas and Papas Midwife of the Year competition and was Northern winner of the Johnson's Midwife of the Year competition. She was nominated by a mum in her care for her outstanding support.

Angela Earnshaw from the Trust's Learning and Development Team was nominated for a Medipex Yorks and Humber NHS Innovations Award in the Publications and Training Materials category for her work on the *Your Choice, Their Choice* programme that has helped to shape our customer care standards.

The Advisory Committee on Clinical Excellence Awards wrote to advise that both Professor Stuart Parker and Dr Adewale Adebajo have had their Bronze National Clinical Excellence Awards renewed - a superb recognition of their work.

Long service
One of our key partnerships is with our staff and both the Chairman and Chief Executive have attended various long service awards through the year. The numbers of staff receiving 20, 25, 30, 35 and even 40 year awards speaks volumes about the many dedicated and committed people working in the hospital.

Jobs for the future
Barnsley Hospital was the first Trust in the country to take on new staff as part of the Future Jobs Fund that aims to get the long term unemployed back into work. Seventeen fixed term jobs have been created including several new posts that will boost the workforce and improve patient care.

Staff learning
The Chief Executive attended the Celebration of Learning event to formally celebrate the completion of a one year leadership course undertaken by 14 managers in the Trust. The programme offered support and development of excellent leadership, management and clinical standards based on continuous improvements in our services to patients. The programme required participants to undertake a structured learning event across the year including workshops, project and action learning sets and a specific change project sponsored by the participant's service department.

Training doctors for the future

As an established associate teaching and research hospital affiliated with the University of Sheffield, we are proud of our excellent reputation for training the doctors of the future.

The Trust continues to be rated as excellent in its teaching of medical students from the University of Sheffield and successfully co-hosted the Final Year Medical Student Examinations in 2009. In addition, feedback from the University of St Matthews Medical School in Florida is that Barnsley Hospital provides world class placements for their students

The training is checked each year to ensure standards are met and the doctors themselves are happy with the teaching.

The Deanery commented: "The Trust should be commended for the general quality of training provided - it is clear that education and training is important to this Trust".

Improving our HR support

Building a better business relies heavily on our people and in 2009/10 much was done to attract and retain excellent staff:

- the Trust working in partnership with Barnsley Council and Barnsley JobCentre appointed 17 people as part of the Government's Future Jobs Fund scheme to get long term unemployed people back into work;
- the Trust further strengthened its links with Barnsley JobCentre when it became a Local Employment Partnership Partner in December 2009;
- the Trust widened the number of enhanced CRB checks its undertakes in line with the new

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Director of research and development Professor Stuart Parker secured £385,148 to research new ways to support elderly people with continence problems.

national vetting and barring scheme introduced in October 2009;
- the UK Border Agency approved the renewal of the Trust's licence in January 2010 to sponsor Tier 2 migrant workers under the new points based immigration system;
- new recruitment and selection procedures were introduced in September 2009 to speed up the appointments process, including the introduction of a CRB portability scheme and to ensure compliance with the NHS employment check standards;
- the Trust began the roll out of the National Learning Management System (NLMS) to enable staff to complete most mandatory training on line via e-learning;
- work commenced on devising new nursing rotas to ensure EWTD compliance for health and safety rest provision;
- the Trust has continued to refine junior doctors' rotas to ensure EWTD compliance and undertook a detailed study and analysis in February 2010;
- the Healthy Workplace Programme continued throughout the year with many initiatives introduced including a staff self-referral service to physiotherapy, staff fitness classes on site; and
- the Trust commenced work to identify and train key trainers in moving and handling across all departments to ensure safe practice and minimise risk.

Equality and diversity

Summary of approach to equality and diversity

Since the appointment of the Trust's Equality and Diversity Advisor, the Trust has continued to embed equality mechanisms and new processes in the area of equality, diversity, and human rights. Over the last twelve months the E&D Advisor, supported by the Diversity Steering Group, has developed and delivered a robust action plan of work. As a result of this, Barnsley Hospital has become one of only 23 hospitals in Britain to become an NHS Employers Equality and Diversity Partner for 2010/11 something determined on an annual basis. Partner status means that the Trust can be held up as an exemplar in the field of equality, diversity and human rights, whether working with staff, patients or the wider community.

Publication duties

In line with the specific duties of the Race Relations (Amendment) Act 2000, the Trust has a statutory responsibility to publish annually the results of ethnicity monitoring of staff in post, applicants for jobs, promotion and training as well as the outcomes of employee relations activities including grievances, disciplinaries and harassment. This is published in a report to the Trust's Board and is available either from our website or on request.

Our staff

The employee profile of the Trust is as follows:

	Staff 2008/09	%	Staff 2009/10	%
Age				
16-20	140	5%	161	5%
21-30	723	23%	750	23%
31-40	776	25%	757	24%
41-50	859	28%	921	29%
51-60	499	16%	504	16%
61+	89	3%	104	3%
Ethnic origin				
White	2759	89%	2941	92%
White - other	40	1%	51	2%
Mixed	13	0%	16	1%
Asian	79	3%	79	2%
Black	31	1%	35	1%
Other	28	1%	27	1%
Not stated	136	4%	48	2%
Gender				
Male	571	19%	586	18%
Female	2515	81%	2611	82%
Disability				
Yes	53	2%	87	3%
No	2295	74%	2723	85%
Not stated/unknown	738	24%	387	12%

The Trust carried out a data validation exercise during 2009 and as a result the volume of 'not stated' returns was reduced leading to more meaningful quality data.

Diversity steering group

With the retirement of Pat Newman who chaired the Diversity Steering Group, the Steering Group will now be chaired by the Trust Chairman. This is a strong indication of the Trust's commitment to the equality and diversity agenda.

Industrial relations

Part of having NHS Employers Partnership status means that we have to evidence our work in various areas. Partnership work between staff side representatives and the equality and diversity lead has grown over the last year, with regular equality updates and support and guidance on equality matters and processes being given. Staff have taken up the opportunity to undertake self development courses and attend in-house equality impact assessment master classes to help them understand key concepts around potential indirect and direct discriminatory practices and the equality bill and human rights.

Operational 'back to floor'

The introduction of the nursing and midwifery strategy to be implemented over three years has provided a good opportunity for clinical divisions and departments to work alongside the equality and diversity advisor to progress the dignity agenda throughout the hospital. The 'back to floor' work involves looking at specific areas of how the hospital works and finding out what can be altered to maintain and improve our patients' dignity. This could include consideration of appropriate clothing for staff, or how we undertake infection control.

Equality and diversity training

A series of master classes and senior management equality training sessions have been successfully delivered this year. This is a Department of Health (DH) requirement. A new e-learning training package is now in operation and helped increase our equality training data from last year.

Equality impact assessments

The process for undertaking equality impact assessments has been revised. A programme of training with a tool kit of new quality impact assessment policy, check list and flow chart together with master class training has been delivered over the last 12 months. Evaluations of the session notes revealed it has been useful to the attendees and still forms part of the curriculum.

Community partnerships

A number of vital partnerships have been developed over the last 12 months, arising both from the equality bill and by listening to patients, families and visitor feedback. This is in line with DH recommendations and recent Race for Health reports and briefings. The Trust is represented at the following community groups by the equality and diversity advisor:

- lesbian gay bisexual and transgender group;
- ethnic minority ladies group (BBEMI);
- local equality and diversity leads;
- SHA equality and diversity leads;
- multi-agency planning project;
- Barnsley disability group;
- BME mental health;
- strategic partnerships - South Yorkshire Police;
- Barnsley MBC; and
- local college mentorship.

Disability Discrimination Act

A full disability review of the Trust is currently taking place. A disability week, in partnership with audiology and other internal departments, is to be presented to the Diversity Steering Group to help raise awareness both for staff and patients' disability. A deafened training consultant (someone who originally had hearing but is now totally deaf) has been selected to deliver a day's training to staff.

Initiatives for 2010

Initiatives include a disability week, support for Barnsley Gay Pride and a diversity study day hosted by the Trust, proposed for October, to combine black history month, lesbian gay bisexual issues, mental health and disability.

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Barnsley consistently featured as a top performer for achieving all our 18 week wait access targets for every clinical specialty.

DisabledGo

The Trust Executive Team agreed to sign up to DisabledGo, a national organisation working with disabled people and the public sector to detail accessibility through a national website accessible to people with various forms of disability. Both NHS Barnsley and Barnsley MBC had already signed up, and with the Trust joining the area will be the first in the country to have the three main organisations in one area all signed up. DisabledGo intend to publicise this widely nationally and this will add to the credibility of all organisations in Barnsley in their commitment to ensure equity in access.

Equality and diversity in 2010/11

Equality and Diversity is everyone's business and we need to continue to build on the work undertaken in 2009/10. What we do must make a difference and the challenge we have is to embed equality across the organisation and to evidence significant and positive change for Barnsley people.

In 2010/11 we will:

- continue to meet our equality duties to ensure that the requirements of these schemes are met through effective work processes;
- update our race equality scheme, gender equality scheme and disability scheme;
- provide training and support on how to undertake an effective equality impact assessment and to help officers understand their importance;
- ensure that service delivery planning and consultation processes take account of the diversity of the population the Trust serves when undertaking any engagement;
- improve existing data collection and analysis recognising that good quality information is vital;
- work with partners to look at how we might align our intelligence gathering, identify any gaps and explore how we could build information requirements into our contracting arrangements;
- develop an overarching action plan for equality and diversity to demonstrate our progress in a more transparent way, covering all six strands;
- continue underpinning equality and diversity work by engaging at local meetings which have an agenda for the six strands of diversity, seek best practice from local colleagues and SHA, and link closely with the Patient and Public Engagement Group as a full member and report in with equality updates;
- offer up-to-date equality, diversity and human rights training at senior management level, ensuring that all new board and non-executive members are offered the opportunity to take part in the training; and
- develop a set of initiatives for 2010: single equality scheme, black history month, LGBT month, diversity week, Ramadan /Eid, Chinese new year, disability week, and international women's week

The last 12 months has been productive and yielded some successes. It is recognised that, with financial constraints and staffing levels, there will be real challenges to maintain this level of progress into 2011 as we see both new, emerging groups residing in Barnsley and areas of further health inequality and socio-economic disadvantage. We will need additional effort to ensure the impact of the Equality Act and single equality scheme action plan support our CQC and legislative requirements.

2009 staff survey

The national staff survey was undertaken by Quality Health for the Trust between September 2009 and January 2010.

The response rate to the official sample taken in the Trust was 52%. The Trust also undertook an additional sample on a larger group of staff (1,801), the response rate for the additional sample being 51%. This is comparable with the national response rate across the acute Trust sector.

Overall Trust scores, compared with the previous year, have improved, in particular in relation to staff receiving essential health and safety training.

There are some key achievements and areas for future improvement to note and these are outlined on the table opposite.

LiFELiNES

The standard of cleaning in the hospital has been recognised nationally - we were given the accolade of 'Cleanest hospital in the country' in the renowned Health Business Magazine Awards 2009.

Staff survey 2008/2009: key comparisons

	2009		2008		Trust improvement /deterioration
Response rate	Trust	National average	Trust	National average	
	52%	51%	51%	52%	1% improvement
	2009		**2008**		
Top four ranking scores (2009)	Trust	National average	Trust	National average	
Received training in equality and diversity in last 12 months	48%	39%	37%	31%	9% improvement
Received training in infection control in last 12 months	80%	73%	82%	71%	2% deterioration
Have experienced discrimination in last 12 months	4%	8%	8%	8%	4% improvement
They or colleague reported an incident that could hurt staff	92%	89%	90%	89%	2% improvement
	2009		**2008**		
Bottom four ranking scores (2009)	Trust	National average	Trust	National average	
Had appraisal in last 12 months	56%	68%	57%	63%	1% deterioration
Trust communicates clearly what it is trying to do	46%	52%	36%	50%	10% improvement
Satisfied to the extent to which the Trust values their work	27%	33%	27%	31%	Remained static
They or colleague reported physical violence	55%	63%	66%	64%	11% deterioration

Note: the above top four and bottom four issues have been identified by ranking them in relation to Trust 2009 performance against the national average for that issue. The 2008 figures have then been added as a comparison.

Future priorities and targets

The key priority areas arising from the 2009 staff survey are to:

- increase the quantity and quality of staff appraisal and feedback;
- continue the good progress made on provision of key mandatory training;
- enhance communication functions to ensure that key messages both upwards and downwards are clearer; and
- analyse feedback on near misses, errors, incidents to minimise alleged clinical errors.

Information technology

Information technology continues to play an important part in the Trust's day to day operations. Overall, systems have proved reliable and stable during the last reporting period.

A number of new solutions have been deployed which have improved efficiency and further underpin the management of clinical risk, notably:

- a system that records and produces an electronic discharge summary letter was successfully deployed. This is in line with a national mandate; and
- a system for electronic distribution of pathology results was implemented across the Hospital. As well as improving audit trail and traceability, it eliminates the need for paper records and the problems associated with moving them around the hospital. The second phase currently underway will automate the requesting of pathology tests and complete the automation of these key processes within the hospital.

The action plan outlining action to address the key priority areas is outlined in the table below.

Staff survey 2009: key priority action for improvement

Key priority area	Action/target	Monitoring	Measure of success
Increase the quantity and quality of staff appraisal and feedback	To increase staff KSF appraisal, working towards a 90% target for 2013 1. Revised training for managers and staff on appraisal delivery to include feedback skills 2. Agreed appraisal targets for divisions monitoring to enable achievement of targets	Quarterly monitoring and support to divisions provided by learning and development team to enable achievement of targets Local records to be reconciled to ESR to enable accurate reporting and monitoring of performance	Achievement of target Improved quality of appraisal experience for staff Effective feedback to enable effective staff performance
Continue the progress made on provision of key mandatory training	To increase performance against Trust target of 90% for key mandatory training by implementing: 1. alternative training delivery methods 2. adoption of best practice policy on categorisation of mandatory training topics 3. proportionate risk based assessment to ensure unnecessary training is reduced	Monthly monitoring and reporting to divisions Corporate reporting undertaken by Executive Team	Achievement of targets Reduction in complaints, incidents and litigation
Enhance communication functions to ensure that key messages both upwards and downwards are clearer	To deliver key messages by roadshows on the strategic vision of the Trust Ensure team brief and other communication mechanisms are fully embedded Proactive engagement of staff side representatives in the delivery of the strategic agenda	Communication audits Appraisals Ad hoc focus communication groups	Increased staff motivation More effective objective setting and appraisal being linked to Trust goals and objectives Enhanced employee and staff side engagement in key issues
Analyse feedback on near misses, errors, incidents to minimise alleged clinical errors	Strengthen feedback processes on near misses, errors and incidents Analyse the feedback to ensure action plans developed and cascade of learning	Non clinical audit/risk committee	Reduction in incidents and clinical errors. Reduction in litigation Enhanced reputation on quality of services and patient safety

Significant progress has also been made with the implementation of a central data warehouse solution which houses a large range of patient data. This solution will lead to improved automation of certain standard reports required within and outside the Trust. Importantly, it also provides a resource which can be used to enhance the availability of management information across the Trust.

A key focus for 2010/11 is to understand and progress the nationally led options to replace the current patient administration system. This is largely in response to the announcement by the supplier McKesson that the current system is at the end of its life. The Trust continues to monitor the suitability of the Lorenzo system delivered by the national programme but will also consider alternatives given the protracted issues faced by this programme.

The imperative to replace the current system has relaxed following the extension of maintenance support from McKesson until 2014.

The costs associated with a new system are significant. However, the Trust remains committed to progressing a replacement with all key preparations now underway.

Working with others

The continued viability of the Trust is vital for the economy of Barnsley and this is acknowledged through the Trust's membership of the Local Strategic Partnership. The Trust works in partnership with Barnsley MBC and Barnsley JobCentre and appointed 17 people as part of the government's Future Jobs Fund scheme to get long term unemployed people back into work. The Trust further strengthened its links with Barnsley JobCentre when it became a Local Employment Partnership Partner in December 2009.

The hospital prides itself on its partnership work with other health providers to offer the best healthcare possible in Barnsley. We work on this with a range of NHS partners and associated healthcare providers - for example close cooperation with the Barnardo's Voice and Influence Ambassador Project to ensure the hospital's services better meet the needs of young people. The BBEMI is both consulted and consults on our behalf the minority and hard-to-reach groups in the area ensuring their views are heard.

Joint activities with expert support groups have resulted in improved services to patients with Breakthrough Breast Cancer and a complementary therapist has been employed following fundraising efforts by the Barnsley Cancer Aftercare support group. We joined with the health community across Barnsley as part of UNICEF's Baby Friendly Initiative.

Rotherham NHS Foundation Trust

The Trust continues to hold a concordat of agreement for partnership working with Rotherham NHS Foundation Trust. This has provided the basis for our trusts to work together on the formal partnership of our pathology services.

Investment in a unified pathology information system provided an integrated pathology service to Barnsley and Rotherham during 2009/10 and work is continuing to develop an agreement to allow these services to be offered to neighbouring trusts and generate additional income and activity for both organisations.

Sheffield Children's Hospital

Sheffield Children's Hospital provides a number of its surgical services on an outreach basis at Barnsley Hospital ensuring more local access for younger patients and their families.

Clinical networks

The hospital continues to work well with its main tertiary services provider, Sheffield Teaching Hospitals, and also with a number of clinical networks in the region to ensure the smooth provision of more specialist services when needed for the residents of Barnsley. Wherever possible, and supported by the clinical networks, we are bringing back services to which patients used to have to travel. This year has seen an increase in services provided locally through the Cancer Network. The Trust also continues to work closely with its provider colleagues across South Yorkshire to explore service partnership opportunities of possible mutual benefit.

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In the Care Quality Commission inspection, the Hospital scored the maximum possible points for safety and cleanliness and for patient dignity and respect.

This has included a Mobile Cancer Unit which was launched in January as a joint project between the Trust and NHS Barnsley to bring an innovative and proactive approach to cancer services. A dedicated cancer information manager travels the town in a branded bus offering support and advice on cancer prevention and healthy lifestyles to young people and the general public and existing patients and carers. The project, Healthwise, aims to encourage people to take steps to reduce the risks of cancer.

South Yorkshire Specialist Commissioning Groups (SCG)

The Trust is a member of a number of SCG commissioning and planning 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 LMC 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. The Trust also has a significant research and development programme in place, see earlier section on Research and Development. 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 MBC, especially in relation to safeguarding of adults and children's services.

In 2009/10, the hospital continued to work closely with NHS Barnsley and Barnsley MBC 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.

Our Chief Executive also attends Barnsley MBC'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.

The local authority's OSC for Health and Adult Services visited the hospital in September. A full day's inspection focussed on infection prevention and control (IP&C); the use of modern technologies in the hospital (including a visit to the pharmacy); care of the elderly including stroke services; and our plans for the future (estates strategy).

Private sector partnerships

Barnsley Hospital teamed up with the out-of-hours GP service provider for Barnsley, Primecare, and won a contract from NHS Barnsley to establish a town centre walk-in health centre.

The NHS Barnsley Health Centre opened in the Gateway Plaza in summer 2009 offering a new approach to health care provision for people in Barnsley. The centre has drop-in and bookable appointments with GP services, minor injuries clinics and services offering an alternative to going to the hospital's Emergency Department. It is seen as a significant step forward in increasing vertical integration within the NHS whilst providing exciting new development opportunities.

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.

During the year the Trust contributed to developing implementation plans in response to the recommendations of the Health Inequalities National Support Team and worked with the local authority and other partners to deliver the recommendations from the Comprehensive Area Assessment.

Besides our own work on the health and wellbeing priorities, the other main areas of the hospital's contribution are:

- economic regeneration: through the planned construction, investment, service repatriation and development of new business opportunities, we bring jobs and money to Barnsley; and
- sustainable employment: of the 3,197 staff employed at the Trust, over 2,400 are Barnsley residents. According to national sources, each £1 of NHS spending has a 3.5x multiplier benefit in the local economy.

Community engagement and participation

The Trust currently has over 13,000 members, including 9,500 public and patient members. Through the patient and public involvement programme and membership initiatives, the Trust is increasingly engaging the public with healthcare provision and, through outreach and targeting of hard-to-reach areas, is increasing awareness of, and access to, health.

Work shadowing

The Chief Executive was pleased once again to offer a 'shadowing' opportunity to two students from abroad undertaking the Nuffield Healthcare Management course at Leeds University. Each year the Trust hosts a number of students on the course for a three week placement. Student feedback is very positive on the opportunity offered by the Trust and the experience and learning provided.

Yorkshire and the Humber Deanery assessment

The Deanery quality assurance annual visit took place in September with the Chief Executive being given immediate feedback from the Deputy Dean. There was considerable praise for the obstetrics and gynaecological training, and a full satisfaction rating from the Deanery for the standard and range of training in this department.

Strategic Health Authority

Mr Bill McCarthy, Chief Executive of the Strategic Health Authority, visited the Trust in the summer and spent several hours with the Chief Executive touring wards and engaging with staff, as well as having confidential discussions with the Chief Executive about a number of strategic change issues. The Trust staff were informed, engaging and extremely personable, impressing the SHA Chief Executive. He was also very impressed by the evident cleanliness of corridors and wards and by the design of the new children's Emergency Department. The Chairwoman of the SHA also visited and was escorted around the Trust by the Chairman and Chief Executive.

Sustainability and climate change

The Trust has a commitment to reduce the carbon and greenhouse gas emissions it produces in line with the Climate Change Act 2008 and at the rates as set out in the Budget of 2009. The targets - known as budgets - are set out in three five-yearly targets, and the aim is to reduce our emissions from a 1990 baseline by 34% by 2022.

What our partners say

"The Trust has an increasingly proactive approach to seeking patients' views following treatment on discharge."

Governing Council of Barnsley Hospital NHS Foundation Trust

What our patients say

"I liked the quick, efficient, and sympathetic service I received on arrival. I fell on the ice/snow at home and broke my wrist! The nurses were excellent, I was out within two hours.

'One point: my niece couldn't find anywhere to park after she dropped me off."

Linda, December 2009

The Trust is currently developing an overall sustainability strategy and Sustainable Development Management Plan to be produced by the new Sustainability Committee to consider this agenda during 2010/11. The Committee will be led by the Chief Operating Officer and the areas under consideration include:

- carbon reduction through energy and facilities management;
- a review of procurement strategies, policies and procedures;
- emergency and business continuity planning; and
- human resource strategies.

The Sustainability Committee will report to the Trust's Executive Team and the non-clinical Risk Governance Committee, a formal sub committee of the Trust's Board of Directors.

Being green

The Trust continues with its commitment to increase energy efficiency and carbon reduction in accordance with the Climate Change Plan published March 2010 by the Department of Health and the Climate Change Act 2008. The Trust's total carbon footprint comprises 22% energy, 18% travel and 60% procurement.

The Trust has been set three targets from the baseline carbon usage of 1990 and work is continuing to ensure that these are achieved:

- from 2008-2012, with a reduction of 22%;
- from 2013-2017, with a further reduction of 6%; and
- from 2018-2022, with a further reduction of 6%.

The Trust has successfully undertaken the following capital investment schemes during 2009/10, all of which are anticipated to improve energy efficiency:

- upgrade of the building management system;
- installation of all-site metering;
- new energy efficient roof coverings; and
- a continued programme of plate heat exchanger installation.

The Trust has also created a better and more efficient environment for patients and staff with the following additional capital upgrade schemes completed in 2009/10:

- a new Paediatric Emergency Department has been designed and constructed;
- the intensive Therapy Unit has been extended and upgraded;
- the air tube conveyor system has been upgraded;
- the Recovery Unit and renal dialysis have been refurbished;
- the site-wide car parking barrier systems have been replaced;
- a new car park has been created on the Helensburgh Close site, offering about 300 additional spaces. This has significantly reduced congestion within the locality of the hospital;
- a new traffic layout was created at the front of the hospital to improve safety

and to increase the number of parking spaces available for blue badge holders;
- completion of the Trust's investment in new electrically adjustable beds; and
- a new system for management of fire alarm services.

Summary performance

The Trust has continued to make significant progress in relation to reductions in energy, recycling and waste management. Further work will develop agendas regarding procurement (in line with national and regional as well as local initiatives) and business continuity planning (heat plan). Some of these are detailed below:

Waste minimisation and management
Hospitals inevitably produce large amounts of waste and we take a responsible approach to minimise this and contribute positively to our environmental targets. The Trust generated 1,016.80 tonnes of various types of waste throughout the year and recycled over 21.97% (183.16 tonnes), which included paper, cardboard, plastics, glass, metals, electrical equipment, wood and solvents.

Use of finite resources
The Trust has experienced a rise in its utility costs due to world market increases. However, we continue to invest in modern technologies in an attempt to reduce our energy consumption and carbon emissions. Registration with the Carbon Reduction Commitment (CRC) is required by September 2010 so that Trusts can demonstrate the commitment of progressive carbon reduction to reach the targets described. Work is progressing to meet this target. The Trust hopes to look at modern technologies for further carbon reduction; this year should see a feasibility study undertaken for the potential installation of a combined heat and power unit (CHP). The table below outlines our waste minimisation figures and our use of finite resources for 2009/10.

Future priorities

The Trust has made good progress regarding energy and waste management. The priorities for 2010/11 relate to procurement and business continuity planning. Progress to date is summarised below.

Procurement
Some 80% of the Trust's non-pay expenditure is processed under some form of national or regional contract arrangements. Our key collaborative procurement partners are NHS Supply Chain, the NHS Yorkshire and Humber Commercial Procurement

Area		Non-financial data (applicable metric)	Non-financial data (applicable metric)		Financial data (£K)	Financial data (£K)
Year		2008/09	2009/10		2008/09	2009/10
Waste minimisation and management	Absolute values for total amount of waste produced by the Trust	908.99 tonnes	1,016.80 tonnes	Expenditure on waste disposal	£192,477.12	£215,264.26
Finite resources	Water	96,152m^3	99,183m^3	Water	£91.170	£97.065
	Electricity	9,460,817 KWhr	9,638,906 KWhr	Electricity	£989.995	£747.142
	Gas	23,900,569 KWhr	22,742,232 KWhr	Gas	£721.102	£508.374
	Other energy consumed (gas oil)	0	18,000litres	Other	0	£8.64

What our partners say

"All medicines are recorded and any errors in medication are reported monthly both to the Board and to the National Patient Safety Agency."

Health & Adult Services Scrutiny Commission

Collaborative (NHS YHCPC) and the Office of Government Commerce Buying Solutions Division. The NHS Supply Chain has developed and implemented a strategy and policy on sustainable procurement and the NHS Yorkshire and Humber Commercial Procurement Collaborative, of which we are a member, is committed to developing a strategy with their member Trusts during 2010/11. In recognition that our leverage on the supply chain is maximised through collaborative procurement, the Trust will seek to embed sustainability into its procurement practices by supporting and adopting the best practice techniques offered by our national and regional procurement partners.

Business continuity planning
Elements of the Trust's resilience arrangements relate to areas of emergency planning closely associated to business continuity planning. Areas addressed include:

- the preparation of resilience plans for adverse events or incidents. These arrangements are reported under Estates Returns Information Collection (ERIC) and the Emergency Preparedness and Civil Contingencies survey;
- the Trust buildings and general site were assessed under the Business Continuity Framework for risks associated with climate change to minimise impacts to key service areas;
- the Trust has prepared a heatwave plan for summer 2010 to identify cool areas and ensure the protection of vulnerable patient;
- business continuity risk assessments include the possibility of both surface water flooding relating to the effects of climate change and evacuation issues relating to an east coast tidal surge. The Trust tested and validated these planning arrangements during Exercise Nirvana in September 2009;
- planning details incorporate working in partnership with our multi-agency stakeholders to assess the resilience of critical supply chain issues for the Trust to the effects of climate change and energy availability. The Trust currently requires a second level assurance from suppliers; and
- business continuity planning includes arrangements to address staff shortfalls and enhance the flexibility of workforce planning.

Patient Environment Action Team (PEAT)

The fortnightly PEAT inspections have continued throughout 2009/10 and have successfully brought about various improvements for the benefit of our patients. The teams frequently include governors, senior management and nurses. Examples of key improvements arising from PEAT inspections over the last year include:

- identification of the need to purchase small polyester cellular blankets. This was in response to patients and staff commenting that during the very cold spell this winter these would provide additional comfort. These covers

LiFELiNES

Achieved the four hour maximum wait in the Emergency Department in 98.91% of cases.

now replace more cumbersome large bed covers. This change has also reduced the risk of trips by patients when rising from their chair; and
- the introduction of specially-designed nightwear and gowns as well as dignity covers that are used by patients being transferred to other parts of the hospital has also proved to be a great success.

The Trust continues to use a new database which has been purchased to improve the monitoring of cleaning throughout the Trust. The Credits for Cleaning (C4C) database is the only ward management system commissioned by the Department of Health.

The C4C database is pre-loaded with the national standards and hospital room data and allows the operator to check each area using palm held computers. The data are then exported to the system and any action required is reported to the relevant staff for action. This system can also be used to undertake a compliance audit.

The National Patient Safety Agency (NPSA) wrote to the Chief Executive in May confirming the Trust's PEAT scores for 2009 for:
- environment - acceptable
- food - good
- privacy and dignity - good

Security

The Trust's local security management specialist, the local police, the police community support officers and the security team all work closely together to enhance the safety of patients, visitors and staff and jointly promote a pro-security culture.

The Trust continues to follow national security requirements, including in the following areas:
- tackling violence against staff;
- protecting NHS property and assets;
- ensuring the safety and security of drugs, prescription forms and hazardous substances; and
- protecting all high risk areas, for example maternity and paediatric areas.

The Trust is also a member of the Old Town Crime and Safety Group, which meets on a monthly basis. This group includes South Yorkshire Police, local councillors and local residents.

During the year, we have installed additional access control systems to the Emergency Department (including paediatrics area), outpatients and wards 27/28. As part of our programme to ensure a better and safer environment for patients and staff, an additional 10 CCTV cameras have been installed; there are now more than 80 cameras covering all areas of the Trust.

Financial review

Summary of financial performance

The financial year ended with a surplus of £643,000, which was marginally better than the planned position of £600,000. The Trust achieved its overall financial risk rating of 3. This is determined through a range of indicators set by Monitor, our regulator, who oversee and assess the financial performance of the organisation. The table below shows the performance against the key financial metrics for the year.

Financial risk rating - compliance framework

Financial criteria	Weight %	Metric to be scored	Rating					YTD calculated position	YTD actual rating
			5	4	3	2	1		
Achievement of plan (% of plan)	10%	EBITDA achieved	100	85	70	50	<50	98.1%	4
Underlying performance	25%	EBITDA Margin (%)	11	9	5	1	<1	5.4%	3
Financial efficiency	20%	Return on asset excluding dividend (%)	6	5	3	-2	<-2	3.7%	3
Liquidity	20%	Surplus margin net of dividend (%)	3	2	1	-2	<-2	0.4%	2
	25%	Liquidity ratio (days)	60	25	15	10	<10	35	4
		Financial risk rating weighted average of financial criteria scores							3.2

Income from activities

The income for the year from patient care activity was £133.3 million, compared with £125.3 million in the previous year, representing a 6.4% increase. In 2009/10 there was a significant change to the commissioning framework and the tariff payment structure, which also included for the first time an element of payment for quality measures (known as CQUIN - Commissioning for Quality and Innovation). The Trust achieved all the required quality standards set and has received the full 0.5% quality payment, which rises to 1.5% of total patient care income in 2010/11.

The table below shows the change in overall patient care activity between 2008/09 and 2009/10, which is reflected in the overall increase in income. Predominantly the key areas of increased activity across the year were day case (8.9%) and emergency admissions (8.5%). The increase in other activity is due, largely, to primary care pathology tests activity that is high volume but very low financial value, and so the 9.8% increase did not contribute significantly to the overall income increase.

Type of activity	2008/9	2009/10	% change
Elective admissions	6,059	5,817	-4.0%
Day case admissions	18,386	20,023	8.9%
Emergency admissions	31,263	33,926	8.5%
Outpatient attendances	259,075	263,649	1.8%
A&E attendances	71,698	71,891	0.3%
Other activity	1,965,137	2,158,009	9.8%

The increase in day case activity reflects a general trend to treat more patients in a day care setting and avoid unnecessary overnight hospital stays. Overall, however, the Trust still performed a lot less elective surgery than had been anticipated and the case mix of patients was less complex than expected. These factors led to the overall income level for the Surgery and Critical Care Division to be much lower than planned in the combined area of elective and day case activity. The Division did see and treat a lot more outpatients than planned, which largely offset this position.

The rise in emergency admissions included a significant increase in general medicine admissions but also a rise in obstetric and neonatal activity. The increasing birth rate has translated to good growth in the business of the Women and Children's Division as, increasingly, Barnsley is the preferred hospital of choice for pregnant ladies. The scale of rise in general medicine admissions (approximately 10% on previous year), whilst reflective of national trend, is an area of activity that the Trust, working very closely with the local health community, is trying to reduce as alternative services to avoid unnecessary admissions are developed. Work is ongoing to look at the right clinical pathways for emergency care and this will have an impact on the level of service and resources flowing into the hospital in future years.

Other operating income

The Trust generated approximately 14% of its total income in 2009/10 from other non-patient care activities, mainly education and training, research and development, and services provided to other bodies. Overall the increase in this type of income compared with the previous year was 23%. The most significant changes have been in the area of services provided to other NHS bodies (mainly Commissioners), including services that the Trust provides to the local Primary Care Trust such as information technology and dietetics. During 2009/10 the Trust implemented a number of new contracts for sterile services generating a rise in income from just under £0.5million to over £1.2million.

Expenditure

Overall expenditure increased in the year by 9.3%, and this was broadly in line with increases in capacity required to meet the service changes, in both clinical and non-clinical areas of activity.

The pay bill increased by 9.4%. After taking into account all factors, including national pay inflation, this was still slightly higher than expected due to much higher spend on agency and contract staff than the Trust anticipated. During the year the Trust experienced some staffing pressure and shortages, in key areas such as medical staffing. Compliance with European Working Time Directive legislation from August 2009 increased this pressure; there have been national shortages in some specialities; and recruitment to some junior doctor rotations has proved difficult locally. The Trust has made good progress in reducing overall sickness absence in the workforce and this has had a positive impact on reducing the use of agencies in all other staff groups.

In terms of non-pay, as forecast, the Trust experienced a doubling of its insurance on the premium for the clinical negligence scheme for Trusts, but has offset some non-pay expenditure pressure in the year by the non-recurrent benefit of a reduction in Valued Added Tax. The financing charges have reduced in the year due mainly to the accounting change to valuation of the estate on the modern equivalent asset basis.

Efficiency targets

As part of demonstrating on going value for money, each year the NHS, overall, is required to achieve efficiency savings and there is a nationally set minimum requirement of 3%. During 2009/10 the Trust planned to meet a total efficiency target of £6.2m (4.4%). This was largely achieved with the main exception of some income related efficiency opportunities, related to increased volume of work for the sterile services department, that were not fully realised.

Capital expenditure

The capital programme for 2009/10 included a significant amount of spend on projects that had been deferred from the previous year, the result of a comprehensive estate strategy and detailed survey of the estate undertaken to ensure that capital investment would be targeted in the right way. Estate expenditure was carefully balanced between improvements to layout and functionality of the environment to ensure modern efficient service provision as part of the business plans of the Trust; and the need for ongoing necessary critical maintenance of the building infrastructure. In addition, during 2009/10, the Trust continued to invest in information technology as part of

the drive to use technology as an enabler to the business of the Trust in as many ways as possible. New and replacement medical and surgical equipment purchases comprised the other element of expenditure. In total £8.2million was spent on capital, summarised below:

- development of a new 300 space car park - £1m;
- improvements in road layout around the entrance to the hospital - £ 0.1m;
- redesign of A&E to provide dedicated childrens area - £0.5m;
- various ward upgrades including Intensive Treatment Unit - £0.6m;
- further improvement work on the mortuary - £0.2m;
- replacement of pathology information system £0.4m;
- data warehousing - £0.3m;
- e-rostering system - £ 0.1m;
- other Information management and technology - £0.6m;
- various medical and surgical equipment - £2.6m; and
- critical maintenance - £1.8m.

A similar balance of priorities between the emerging estate strategy, information management and technology (as well as new and replacement medical and surgical equipment) continued into the 2010/11 capital plan which is planned at £6.6 million. In the medium term the funding requirements for capital investment are set to rise significantly if the Trust is to realise the potential of its strategic plan for the overall estate. However, this continues to be developed and reviewed as part of the overall business plans and direction for the Trust.

Forward look

The general economic climate will undoubtedly have significant implications for future public spending. 2010/11 will be the last year of the three year comprehensive spending review which has provided real term growth in NHS resources. It is widely understood that funding for the NHS will, at best, remain static or, in real terms, be reduced over the next few years. Barnsley Hospital is fully cognisant of the impending financial constraints and has been continuing to develop its vision and strategy explicitly within what is clearly expected to be a much more modest funding position.

The Trust has been developing forward plans which take into account the expected changes through national, regional and local responses to the financial challenges of the NHS. As referred to previously the overarching framework is Quality, Innovation, Productivity and Prevention (QIPP). This encompasses a range of work streams specifically aimed at getting better value from the limited resources which will be available over the next few years. In financial terms what this means, simply, is that the emphasis needs to be the continued reduction of unnecessary waste and increased efficiency, and looking at new models of care which may appropriately shift services and financial resources from secondary to primary care. One of the major impacts for the Trust will be the future strategy of Commissioners in relation to acute secondary care, as there is an expectation that significant reductions in some areas of hospital activity can be achieved. The Trust is already actively working with our main commissioner NHS Barnsley and other local partners on a whole system QIPP agenda, which includes looking at ways in which services can be improved and redesigned.

This future direction is reflected in the financial plans of the Trust for 2010/11. The level of activity commissioned has remained reasonably consistent with the previous year but this is expected to be a maximum level with the emphasis on reducing activity particularly in the area of unscheduled emergency care. The overall income for the Trust in 2010/11 is therefore expected to be lower as, nationally, there has been no overall uplift in the tariffs (prices) which fund activity. The combined effect of lower income and the inflationary pressures of national pay awards and other costs means that the Trust's efficiency targets are quite challenging. The Board has therefore taken the decision to plan to break even on its income and expenditure for the year, as a surplus will be difficult to achieve. The efficiency plans require some significant changes to the way the hospital has been operating and this needs to be managed very carefully to ensure services continue to be delivered at the right level and quality.

The capital investment plans for 2010/11 are also intrinsically linked with the requirements of the business plan to improve efficiency and harness technology to enable change and improvement to patient care. The estate investment in 2010/11 will be prioritising critical backlog maintenance and preparation for the next major phase of the emerging strategy, which is to develop a case for a purpose-built women's and children's facility. The Trust currently has a reasonable cash position, however, significant new investment in capital assets will be a challenge in

the foreseeable future, as the ability to achieve significant surpluses is tempered by the overall financial constraints. This position is kept under continuous review and is recognised as one of the key risks to the Trust's future strategy.

Financial declarations

So far as the Directors are aware, there is no relevant audit information of which the Auditors are unaware and the Directors have taken all of 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.

These 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.

The main assets of the Trust in value terms are the land and buildings. These have been revalued at 31/03/2010 by the District Valuation service based on current market values, that is, a 15% reduction in building value due to the current economic climate.

There were no political or charitable donations in the year.

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.

There have been no post balance sheet events that would affect the Trust.

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.

Accounting policies, pensions and other retirement benefits

Accounting policies for pensions and other retirement benefits are set out in note 1.3 to the accounts and details of senior employees' remuneration can be found in the Remuneration Report.

Dickie Bird and the Mayor of Barnsley, Councillor John Parkinson, supporting Bowel Cancer Awareness Month.

Quality reports

Part 1: Statement on Quality from the Chief Executive – Sandra Taylor

The Trust has made significant progress and improvements on key quality issues in 2009/10. We have continued to actively reduce our infection rates both from MRSA and C.Difficile infections, and were successful at being named the "Cleanest Hospital of the Year"at the end of 2009 by the renowned Health Business Magazine Awards 2009. The Trust has also, during 2009/10, been part of the "Leading in Patient Safety" programme. This has included Executives, Non-executives and Matrons attending a series of days to enable them to analyse patient safety and work towards a long-term goal. The Trust's long-term aim was to significantly reduce the number of healthcare acquired infections to zero by end of 2011.

The work in regard to the Patient Safety First Campaign has continued and in September 2009, the Trust held Patient Safety week. This week promoted the culture of putting patient safety at the forefront and introduced a number of initiatives that have impacted on the quality and safety of patient care. These initiatives include the reduction of inpatient falls and introduction of "Safety Briefings" at the start of every handover throughout the clinical areas.

Reduction of inpatient falls continues to be a priority for the Trust, and, although in 2009/10 we have seen a dramatic decrease of 24%, we would like to see further improvement on the decrease on numbers.

We do, however, recognise that we still face some challenges. Readmission rates within 14 days of discharge are remaining above the level expected in *Better Care, Better Value* metrics, and this requires partnership working with NHS Barnsley to ensure the patients pathway from admission to discharge back into the community is supported.

The other areas where we face challenge are issues surrounding the discharge of patients. This is not only our inpatients but also our outpatients. The Trust, over the coming year, will be focusing on all aspects of discharge in order to ensure that patients feel part of, are communicated with and that delays in the system at discharge are minimised. This is an area that our Inpatient and Outpatient Care Quality Commission Patient Surveys indicate requires improvement.

The following report gives a comprehensive overview of our Quality Account 2009/10, and provides the priorities and indicators to illustrate how we intend to further improve our Quality of Care in 2010/11.

Sandra Taylor
Chief Executive

Part 2: Priorities for Improvement and Statements of Assurance from the Board

Priorities for Improvement: Performance against 2009/10 priorities identified in the 2008/9 Quality Report.

These were:

Priority 1: To reduce our number of falls within inpatients by 15% in 2009/10.

Significant progress has been made against this priority. The status in 2008/09 showed the number of falls as being 1201. This was 2.1% of all inpatient admissions.

The Trust has introduced a number of initiatives over this period. These have included the introduction of patient identifiers, stick men. These have enabled staff to recognise which patients are at risk, and those who have previously fallen. These identifiers are placed by the patient's bedside. The identifiers in conjunction with posters indicate that it is everyone's responsibility for patient safety.

In addition, we have reviewed the assessment and documentation of patients at risk of falls, utilising a FRAT (Falls Risk Assessment Tool). This tool allows the nurse to assess the risk for individual patients and leads them to a care plan that offers 33 potential interventions that can be utilised to reduce the risk of the patient falling.

These two initiatives have had a dramatic impact and have seen a reduction of 24% on last year's numbers. The number of inpatient falls for 2009/10 was 915.

Priority 2: To reduce the number of patients who are readmitted after 28 days following discharge by 20%.

Re-admissions rate for April 2008 – March 2009 was 7.77%.
Target was 6.16%

The Trust has conducted some in-depth analysis of this group of patients and has discovered that the Trust has approximately twelve patients termed "Revolving Door" patients who present at the hospital multiple times through a 28 day period. These patients have long-term conditions, and are admitted to the Trust commonly during out of hours. This is when community support appears to be decreased. The Trust is working with NHS Barnsley to increase support to these patients and this work will continue into 2010/11.

Achievement for 2009/10 was 7.45% (this was 1.29% under the target, however was an improvement on 2008/09 by 0.32%).

Priority 3: To reduce the number of patients who are cancelled prior to surgery by 10%.

Patients who are cancelled prior to surgery disrupt their experience of hospital. This in turn has many effects, both physical and psychological, and can delay their known recovery time following surgery.

The original aim was to reduce the number of patients who are cancelled prior to surgery by 10%.

On further discussion this was divided into two areas where a decrease was required that was:

- 10% reduction on the 2008/09 rate – cancelled on day for non medical reasons. Rate for 2008/09 was 1.01%. Target set was 0.91%;
- Reduction in number of patients arriving and not having their intended procedure carried out (S22).
  Number of S22 for 2008/09 was 797.

Significant progress has been made in both these areas with achievement of the targets.

- 2009/10 rate for cancellation on day for non medical reasons was 0.53%;
- Number of S22 for 2009/10 was 719.

Priorities for Improvement: Our three priorities for 2010/11

The selection of the three priorities has consisted of a continuous discussion with the following:

- Trust Board;
- Executive Team;
- Staff;
- Governors;
- Patients;
- PCT; and
- Associated groups such as LiNks and Overview and Scrutiny Committee.

In addition, we have examined our Patient Surveys, complaints and incidents and identified common themes in order that we are utilising this process to further improve the quality and safety of care we deliver to our patients.

Each of the three priorities will be identified in the following pages.

Priority 1 - Reduction in the number of falls experienced by patients whilst in hospital

Description of issue and rationale for prioritising
Although we have had a decrease in the number of inpatient falls in 2009/10, as a Trust we feel a further decrease can be achieved. Falls is a focus within our locally agreed CQUIN (Commissioning for Quality and Innovation Schemes) with NHS Barnsley, and in addition is a focus of priority of the Strategic Health Authority in response to the Chief Nursing Officer of England *"High Impact Actions for Nursing and Midwifery (2009)*. We are aware that a patient having a fall in hospital prolongs their inpatient episode, utilises further resources and does not provide a good experience.

Therefore, we feel as this impacts on a range if issues such as patient safety, patient experience and use of resources. A reduction in the number of falls can make a marked improvement to quality care, patient experience and efficient use of resources.

Aim/Goal
To reduce further reduce the number of falls in inpatients by 10% in 2010-11.

Current status
Number of falls for 2008/09 was 1201.
Number of falls for 2009/10 was 915.
Fall rate 2009/10 = 69.2

Identified areas for improvement
- Further detailed observation of patients;
- Footwear of patients in hospital; and
- Development of a Falls pathway.

Current initiatives in 2009-10
- Use of stick men across the Trust for patient identification of falls;
- Introduce a 2-minute safety handover at the start of every shift; and
- Introduction of a Falls Risk Assessment Tool (FRAT).

New initiatives to be implemented 2010/11
- Introduction of an orotho-static observation chart;
- Introduction of patient observation and activity chart for those patients identified as being of high risk of falling;
- Development of a falls pathway to enable patients attending Accident & Emergency to be directed to the appropriate services; and
- Review of footwear for patients available on ward areas.

Target 2010/11
To measure number of falls in a systematic manner to be rate of falls per 10,000 bed days. Target = 62.3 Measured monthly on Quality Report to Trust Board.

Priority 2 - To reduce the number of patients readmitted as an emergency admission within 14 days of a previous discharge.

Description of issue and rationale for prioritising
The current number of patients who are readmitted is high. Patients who are re-admitted have their recovery time extended, and this in turn impacts on home life, return to work and even quality of life following hospitalisation. Readmission to hospital can due to a variety of issues, however, improvement in rates will indicate that our patient pathways are coordinated and will ensure that patients receive a good experience of our hospital.

Patient Surveys have indicated that patients judge us as weak on information given at discharge in regards GPs, District Nursing and medication.

Aim/Goal
To reduce the number of patients readmitted on as an emergency admission within 14 days of a previous discharge to 4.4%.

Current status
Rate for 2009-10 = 5.01%.

Identified areas for improvement
- Clear discharge policies to ensure patients are ready for discharge home;
- Patients are receiving the correct information on discharge and understand it;
- Patients and relatives are involved in discharge planning at every stage; and
- Patients receive information regarding their medications.

Current initiatives in 2009/10
- Development of an electronic letter for GPs in order that they are aware of discharge on the day;
- Review of present Discharge Policy;
- Document patient and relative involvement in discharge planning; and
- Joint working with NHS Barnsley to ensure smooth transfer of care for those patients receiving care at home.

New initiatives to be implemented 2010/11
- Introduced nurse led discharge criteria in order to ensure referral to appropriate services in community;
- Work in partnership with NHS Barnsley to develop care navigation systems in order that patients are directed to appropriate level of care and assessment in the community; and
- Introduce processes to ensure patients receive the required information regarding their medication on discharge.

Target 2010/11
To reach 4.4% rate, measured monthly on Quality Report to Trust Board, this has been agreed as part of contract with NHS Barnsley.

Priority 3 - To improve responsiveness to personal needs of patients.

Description of issue and rationale for prioritising
The indicator will be a composite, calculated from 5 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; and
- Informed who to contact if worried about condition after leaving hospital.

The indicator incorporates questions, which are known to be important to patients and where past data indicates significant room for improvement.

This composite indicator is taken from the adult inpatient survey from the CQC (Care Quality Commission) nationally coordinated patient survey programme.

Aim/Goal
To increase the baseline indicator value by 3.5% to 67.6%.

Current status
The baseline indicator value is 64.1%.

Current initiatives in 2009/10
- Introduction of CRT Beyond Question (Real Time Patient Information System); and
- Review of patient bedside information.

New initiatives to be implemented 2010/11
- Analysis of all information given to patients via:
  - Letter;
  - Verbal;
  - Email;
  - Patient information leaflets; and

- Analyses of real time information and identification of key projects to influence patient's views and experience of Barnsley Hospital NHS Foundation Trust.

Target 2010/11
- To increase the baseline indicator value by 3.5% to 67.6%; and
- To be monitored on an annual basis as part of CQUINs with NHS Barnsley.

Statements of Assurance from the Trust Board

Review of Services

During 2009/10 Barnsley Hospital NHS Foundation Trust provided one sub-contracted NHS service.

The income generated by the NHS Services reviewed in April 2009-March 2010 represents 0.007% (£97,000) per cent of the total income generated from the provision of NHS services by Barnsley Hospital NHS Foundation Trust for April 2009 - March 2010.

Barnsley Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care. This was considered as part of the monthly Performance and Clinical Dashboards which are discussed by the Trust Board of Directors.

The Performance dashboard includes the Trust's position on national and local targets (for example, 18 week referral to treatment waiting times), and existing indicators (such as Emergency Care 4 hour waiting time).

The Clinical (renamed in 2010/11 Quality) dashboard includes the Trust's position on its progress against safety (for example infection rates), effectiveness (delay in discharge) and patient experience (for example Noise at Night).

The Trust is proactive in reviewing its services by meeting with both patients and staff. This is achieved through:
- Patient Safety Walkabouts – Directors and Senior Managers visiting areas to discuss their incidents, complaints and compliments and talk to staff about issues they have. This in turn increases the visibility of senior staff in the Trust;
- Real Time Patient Experience monitoring – The Trust purchased in 2009/10 both hand held and free standing monitors to capture patient experience. These can be loaded with tailor made questionnaires and provide the trust with a detailed response to questions/areas of concerns; and
- "Talking Non-Executive Directors" (Talking NEDs) – This provides both the Chairman and NEDs the opportunity to visit areas within the hospital and talked to staff and patients, and discuss issues which they can then feedback to the Board of Directors.

Information on participation in Clinical Audits and National Confidential Enquiries

During 2009/10, 22 national clinical audits and two national confidential enquiries covered NHS services that Barnsley Hospital NHS Foundation Trust provides.

In 2009/10 Barnsley Hospital NHS Foundation Trust participated in 19 (86%) of national clinical audits and two (100%) of national confidential enquiries.

The national clinical audits and national confidential enquires that Barnsley Hospital NHS Foundation Trust and participated in during 2009/10 are as follows:

National and Confidential Enquiries Clinical Audits

Collection of data is interacted as either:

(a) Continuous, with no planned end date;

(b) Intermittent, with samples recruited according to time period or sample size; and

(c) One off, with no plan to repeat patient recruitment in the future.

The reports of nine National Clinical audits were reviewed in 2009/10 and Barnsley Hospital NHS Foundation Trust intends to take actions to improve the quality of health care provided. These audits consisted of:

- National depression audit (Occupational Health);
- National COPD audit;
- National Falls & Bone Health Organisational Audit;
- Older Peoples Experiences of falls and bone health services;
- Sentinel Stroke audit;
- National IBD audit;
- MINAP; and
- 2009 DNAR audit.

To illustrate this further the following represents an example of an action taken from a National Audit:

National (Sentinel) Stroke Audit
One of the indicators was screening for swallowing within 24 hours. The action to be taken was to increase first line assessment skills to all senior nurses on the stroke unit. This was incorporated into the specialist ward training for that group of staff.

The reports of 175 local clinical audits were reviewed by provider in 2009/10 and Barnsley Hospital NHS Foundation Trust intends to take actions to improve the quality of health care provided.

To illustrate the following represents an example of an action taken from a Local Audit:

A Trust Wide Audit of drug prescription and administration charts was conducted during 2009/10. One of the actions was to alert and re-enforce legal requirements to the junior medical staff to completion of prescription charts and the charts associated issues. This has been assigned to a senior Consultant to complete by including this within Junior Doctor teaching sessions.

Information on participation in clinical research

The number of patients receiving NHS services provided or sub-contracted by Barnsley Hospital NHS Foundation Trust that were recruited during that period to participate in research approved by a research ethics committee was 550.

These patients were part of a variety of clinical research trials. These trials are both commercial and non-commercial sources. All are approved and documented through the South Yorkshire Ethics Committee and Barnsley Hospital NHS Foundation Trust Research Governance systems.

National Audit	Collection of data
NDA: National Diabetes Audit	Continuous
ICNARC: adult critical care units (network)	Continuous
National Elective Surgery PROM's: four operations	Continuous
CEMACH: perinatal mortality	Continuous
NJR: hip and knee replacements	Continuous
NLCA: Lung Cancer	Continuous
NBOCAP: bowel cancer	Continuous
DAHNO: head and neck cancer	Continuous
MINAP (Myocardial Infarction)	Continuous
Heart Failure Audit	Continuous
NHFD: hip fracture	Continuous
TARN: severe trauma	Continuous
NAPTAD: anxiety and depression	Continuous
National Sentinel Stroke Audit	Intermittent
National Audit of Dementia care	Intermittent
National falls and Bone Health Audit	Intermittent
National Mastectomy and Breast Reconstruction Audit	One off
National Oesophago-gastric Cancer Audit	One off
RCP Continence Care Audit	One off
National Confidential Enquiries	
National Confidential Enquiry into Patient Outcome & Death (NCEPOD)	
Centre for Maternal and Child Enquiries (CMACE)	

Information on the use of the CQUIN framework

A proportion of Barnsley Hospital NHS Foundation Trust income in 2009/10 was conditional upon achieving quality improvement and innovation goals agreed between Barnsley Hospital NHS Foundation Trust and NHS Barnsley and associated Commissioners entered into a contract for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework. Further details of agreed goals for 2009/10 and for the following 12-month period are available on request from Sharon Linter, Director of Quality and Standards.

The monetary total for the amount of income in 2009/10 conditional upon achieving quality improvement and innovation goals was £634,000.

Information relating to registration with the Care Quality Commission (CQC) and periodic/special reviews

Barnsley Hospital NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is as of 31 March 2010 as without conditions.

Barnsley Hospital NHS Foundation Trust was not subject to periodic review by the Care Quality Commission, nor has it participated in any special reviews or investigations during this reporting period.

Information on the quality of data

Information Governance

Barnsley Hospital NHS Foundation Trust score for 2009/10 for Information Quality and Records Management assessed using the Information Governance Toolkit was:

- Secondary use Assurance (Data Quality) 54% (Amber)
- Corporate Information Assurance (Records) 100% (Green)
- Overall Score = 81% (Green)

Information on hospital episode statistics

Barnsley Hospital NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period by the Audit Commission and the error rates reported in the latest published audit for that period for diagnosis and treatment coding (clinical coding) was 8.3%.

The audit covered 300 Finished Consultant Episodes (FCEs), of which 100 were selected from the national theme, Trauma and Orthopaedics. The other 200 FCEs were selected based on the findings from the national benchmarking system and agreed with the Trust and host Primary Care Trust, Barnsley Primary Care Trust (see table below).

Summary of findings and conclusions from report

There were 25 episodes of care with errors which have changed the Health Resource Group (HRG) representing 8.3% of the total cases tested.

Compared with the national results from last year, the Trust is in the middle 50% of trusts where the lowest percentage reflects the smallest amount of HRG's that are incorrect and therefore the smallest number of errors in payments.

Due to the targeted nature of these audits and the small sample of activity audited it is not recommended that these results be extrapolated further than the actual sample audited.

There were a number of areas where the Trust had good arrangements in place to support accurate coding. These included:

- the recruitment of two new clinical coders to increase the number to an accepted ratio of clinical coders to Finished Consultant Episodes; and
- all clinical coders having training and development plans.

The audit also identified a number of areas where improvements can be made which may reduce coding errors. These included:

- improving the case notes;
- review the discharge summaries; and
- review the arrangements for coding on wards.

Area audited	Specialty/Chapter/HRG size	Sample	Reason for selection
Theme	Trauma Orthopaedics	100	National Theme
Specialty	General Medicine	100	Benchmarking
Chapter	C Mouth Head Neck and Ears	70	Benchmarking
HRG	E32 Syncope and Collapse	30	Benchmarking

Part 3: Other Information

Performance Improvement 2010/11

We have chosen our areas for performance improvement through engagement with patients, staff and the Trust Board. This has involved discussions of last year's areas for improvement and consideration of areas that the aforementioned groups would like to see improvement on.

Each domain has at least three indicators and associated metrics for improvement. These will be reported to the Board on a monthly basis as part of the Board's Quality Dashboard. These indicators are also aligned to the QIPP (Quality, Innovation, Productivity and Prevention) agenda.

We have chosen to measure our performance against the following metrics:	2009/10 Performance	Target 2010/11	Comments
3.1.1 Patient Safety			
1. Patients with MRSA bacteraemia	2	0	Local target set by NHS Barnsley = 1
2. Patients with C.Difficile infection	49	47	Local target set by NHS Barnsley = 65. Trust aiming for a further 5% decrease
3. Serious Untoward Incidents (SUIs) that occur within the Trust	9	No target but wish to monitor	Board wish to monitor indicator of Quality of Care
4. Medication errors	182	172	Target 5% decrease
5. Hospital inpatient falls (measured rate of falls per 10,000 bed days)	69.2	62.3	Target 10% decrease
6. VTE Assessment Compliance*	No data	90% collected	Achievement of National Indicator value of CQUIN's

These indicators have not changed from 2008/09 Quality Report, however there is one additional indicated by.*

We have chosen to measure our performance against the following metrics:	2009/10 Performance	Target 2010/11	Comments
3.1.2 Clinical Effectiveness			
7. Delayed Discharges (measured % of occupied bed days)	0.28% (n= 393)	n = 353	Target 10% reduction
8. To reduce the number of patients readmitted as an emergency admission within 14 days of a previous discharge	5.01%	4.40%	
9. Increase participation rates in Patient Reported outcome measures (PROMS) for the following: • Varicose veins • Hernia repair • Hip replacement • Knee replacement	42% 39% 57% 66%	Increase to 70% in all areas	

These indicators have completely changed from 2008/09 Quality Report. The Trust Board feel we need to focus on specific issues of Clinical Effectiveness particularly in relation to discharge, and that is the reason for inclusion of 7 & 8 indicators.
Indicator 9 – the Trust feel is an area for improvement and reflects on the Trust and NHS Barnsley in relation to patient perception and outcome information. Thereby increasing our participation rates will provide both the Commissioner and provider with more detailed data to improve these services.
Indicators that were part of the 2008/09 Quality Report are integral to the Trust's standard practice and are monitored on the Trust performance dashboard monthly.

3.1.3 Patient Experience			
10. Was your sleep disturbed by avoidable noise at night?	54% (No)	59% (5% increase in "No")	Using CRT Beyond Question (Real Time Patient Information System) on a monthly basis via Matrons.
11. Staffing levels (in your opinion, were there enough nurses on duty to care for you in hospital)	73% (yes)	78% (5% increase in "Yes")	
12. Information given to patients on discharge (Were you given enough Information on discharge from hospital?)	2005-2009 (CQC Inpatient Survey) average score = 6.5 out of 10	To achieve 8 out of 10	
13. 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	64.1%	67.6%	Increase of 3.5% To be monitored on an annual basis as part of CQUIN's with NHS Barnsley.

These indicators have completely changed from 2008/09 Quality Report. The Trust wish to focus on issues of Patient Experience, where we repeatedly receive feedback, and have drawn from complaints both formal and informal, incidents and scores from the Care Quality Commission Inpatient and Outpatient Surveys. Indicators 10, 11 & 12 represent key issues for the Trust where we need to improve on Patient Experience.
Indicator 13 is part of the CQUIN's scheme nationally and will be monitored on an annual basis.
Indicators that were part of the 2008/09 Quality Report are integral to the Trust's systems and processes for example monitoring arrangements for Single sex Accommodation.

Overview of performance in 2009/10 against the key national priorities from the Department of Health's operating framework and against the Department of Health's National Core Standards

Indicator	Target	09/10 Performance
Cancer Waiting Time Commitments		
All cancer two week wait	93%	96.3%
31-day diagnosis to treatment	96%	100.0%
62-day GP urgent referral to treatment	85%	91.3%
31 Days - subsequent treatments (Surgery)	94%	100.0%
31 Days - subsequent treatments (Drug Treatments)	98%	100.0%
62 Days - Screening Programme Upgrades	90%	99.0%
62 Days - Consultant Upgrades	85%	100.0%
Symptomatic Breast Patients - two week wait (non cancer referrals)	93%	76.2%
Operations cancelled for non clinical reasons		
1) Number of cancelled operations as a percentage of FFCEs	0%	0.53%
2) Percentage not given a binding date within 28 days	0%	0%
Delayed Transfer of Care - as %age of bed occupancy	0%	0.28%
No. of inpatients waiting longer than standard (26 weeks)	0	0%
No. of outpatients waiting longer than standard (13 weeks)	0	0%
Total time in A&E: four hours or less	98.00%	98.91%
18-week referral-to-treatment target		
1) Admitted patients treated within 18 weeks	90%	97.50%
2) Non-admitted patients treated within 18 weeks	95%	99.73%
3) Audiology patients treated within 18 weeks	95%	100%
4) Admitted data completeness	100%	87.6%
5) Non-admitted data completeness	100%	106.90%
6) Audiology data completeness	100%	132.8%
Two week Rapid Access Chest Pain Waits	100%	99%
48 Hour Access to GUM clinics	100%	100%
Infant health & inequalities		
1) increase number of non-smokers during pregnancy	>76.2%	77.5%
2) increase in breastfeeding initiation rates on previous year	>56.9%	61.9%
Screening all elective inpatients for MRSA	100%	100.0%
Choose & Book - Insufficient Appointments	-	6440
Contraceptive advice to all patients using abortion services	100%	100%

Declaration against the core standards for Care Quality Commission

The essential standards of quality and safety consist of 28 regulations (and associated outcomes) that are set out in two pieces of legislation: the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

For each regulation, there is an associated outcome – the experiences people have as a result of the care they receive.

The Care Quality Commission (CQC) focus on the 16 regulations (out of the 28) that come within Part 4 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 – these are the ones that most directly relate to the quality and safety of care. As a provider Barnsley Hospital NHS Foundation Trust must provide evidence to the CQC that we meet theses outcomes.

These 16 regulations are set out below. (Note that the outcome numbers are different from the regulation numbers because CQC have grouped the outcomes into six overall themes).

Regulation*	Outcome	Title and summary of outcome
9	4	**Care and welfare of people who use services** People experience effective, safe and appropriate care, treatment and support that meets their needs and protects their rights.
10	16	**Assessing and monitoring the quality of service provision** People benefit from safe, quality care because effective decisions are made and because of the management of risks to people's health, welfare and safety.
11	7	**Safeguarding people who use services from abuse** People are safeguarded from abuse, or the risk of abuse, and their human rights are respected and upheld.
12	8	**Cleanliness and infection control** People experience care in a clean environment, and are protected from acquiring infections.
13	9	**Management of medicines** People have their medicines when they need them, and in a safe way. People are given information about their medicines.
14	5	**Meeting nutritional needs** People are encouraged and supported to have sufficient food and drink that is nutritional and balanced, and a choice of food and drink to meet their different needs.
15	10	**Safety and suitability of premises** People receive care in, work in or visit safe surroundings that promote their wellbeing.
16	11	**Safety, availability and suitability of equipment** Where equipment is used, it is safe, available, comfortable and suitable for people's needs.
17	1	**Respecting and involving people who use services** People understand the care and treatment choices available to them. They can express their views and are involved in making decisions about their care. They have their privacy, dignity and independence respected, and have their views and experiences taken into account in the way in which the service is delivered.

Regulation*	Outcome	Title and summary of outcome
18	2	**Consent to care and treatment** People give consent to their care and treatment, and understand and know how to change decisions about things that have been agreed previously.
19	17	**Complaints** People and those acting on their behalf have their comments and complaints listened to and acted on effectively, and know that they will not be discriminated against for making a complaint.
20	21	**Records** People's personal records are accurate, fit for purpose, held securely and remain confidential. The same applies to other records that are needed to protect their safety and wellbeing.
21	12	**Requirements relating to workers** People are kept safe, and their health and welfare needs are met, by staff who are fit for the job and have the right qualifications, skills and experience.
22	13	**Staffing** People are kept safe, and their health and welfare needs are met, because there are sufficient numbers of the right staff.
23	14	**Supporting workers** People are kept safe, and their health and welfare needs are met, because staff are competent to carry out their work and are properly trained, supervised and appraised.
24	6	**Cooperating with other providers** People receive safe and coordinated care when they move between providers or receive care from more than one provider.

Barnsley Hospital NHS Foundation Trust in 2009/10 declared compliance against all the above regulations, and continues to monitor the evidence against each of these.

* Regulation of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Part 4: Statements from primary care trusts, Local Involvement Networks and Overview and Scrutiny Committees

We have received comments from the following groups:

- Governing Council of Barnsley Hospital NHS Foundation Trust;
- NHS Barnsley (PCT Commissioners); and
- Health & Adult Services Scrutiny Commission.

The Trust asked for comments on Quality Account priorities and also on how the Trust delivers Quality in relation to the three indicators of Safety, Effectiveness and Experience. These are illustrated as "sound bites" to show what people say about us. Contributors are identified in italics.

Safety

- "We have seen significant improvements in infection control rates and a reduction in patients who fall." *NHS Barnsley*
- In the Quality Accounts, introduced in the 2008/09 annual report, the Trust outlined its plan to reduce slips and trips, particularly for elderly or unstable patients. Governors have been able to monitor the good progress of this work through the Clinical Dashboard now presented to public Board meetings quarterly (available on the website, within the published Board papers) as well as receiving updates on this key objective by the Chairman/Non Executive Directors and has

welcomed the introduction of initiatives such as lower beds (or beds that can be lowered more than previously); stick men (to identify vulnerable patients and ensure they receive appropriate support); extended handover reports (between nursing teams). *Governing Council of Barnsley Hospital NHS Foundation Trust*

- In terms of falls, the Commission is aware that the introduction of the stick men patient identifier has had a dramatic effect on falls in the hospital and were able to see the system in evidence when visiting the hospital. This is also an important initiative in terms of patient safety as well as clinical effectiveness. *Health & Adult Services Scrutiny Commission*
- The Commission is aware that the hospital has received an award for the cleanest hospital in the country and was impressed with the priority given to combating hospital acquired infections. Use of hand-cleaning gels by staff and visitors and improved signage in this respect was in evidence when Commission Members visited the hospital. *Health & Adult Services Scrutiny Commission*
- The Governors frequently take part in the Trust's internal PEAT (patient environment action team) inspections; these are led by the Trust's facilities group and closely scrutinise a range of issues that relate to patient safety and security, nursing practices (eg medicine distribution). The Chair of the Staff & Environment sub-group also receives action reports, showing how and when any issues identified are followed up. *Governing Council of Barnsley Hospital NHS Foundation Trust*
- In terms of staffing levels, this was queried (re nurses) by both Governors and members of the public at the Trust's AGM and Governors were pleased to receive assurance from the Board (shared with public as well as the Governors). *Governing Council of Barnsley Hospital NHS Foundation Trust*
- All medicines are recorded and any errors in medication are reported monthly both to the Board and to the National Patient Safety Agency. *Health & Adult Services Scrutiny Commission*

Effectiveness

- During the winter of 2009/10 the Commission is aware that the hospital performed extremely well under difficult circumstances and this was also reported in the local and national media. The hospital had an increased number of fracture admissions due, in part, to the exceptionally bad weather but nonetheless patients were treated in a timely and appropriate manner. Staff within the Accident and Emergency Department went the 'extra mile' to ensure this was the case. The Commission requested, and was provided with, information about levels of hospital admissions during this period of bad weather. The Commission is also aware that the hospital is a best practice site for treatment for fractured neck of femur. *Health & Adult Services Scrutiny Commission*
- The PCT's "stop smoking" service opened on the Trust's premises in 2009. *Governing Council of Barnsley Hospital NHS Foundation Trust*
- The Trust continues to help support groups such as the stroke club, cancer support group and complementary therapy services, etc, although Governors and the Trust are trying to build on these – and other – links with groups across the community. *Governing Council of Barnsley Hospital NHS Foundation Trust*

Experience

- The Trust has an increasingly proactive approach to seeking patients' views following treatment (on discharge); reports on this have been presented to the Governing Council's Patient & Access sub-group as have outcomes such as the Hospital at Night action plan, developed by the modern matrons. *Governing Council of Barnsley Hospital NHS Foundation Trust*
- When Members visited the hospital they were pleased to find that wards are single sex whenever possible and felt that this was important in maintaining dignity and respect. They were also pleased that the hospital has been looking at creating 'adolescent environments' within A & E specifically for young people as this is more appropriate for them (being neither children nor adults) and again, maintains their dignity. *Health & Adult Services Scrutiny Commission*
- The Trust has protected mealtimes to ensure patients are not disturbed whilst eating; it has a diverse menu (which is currently under review) and also introduced a "red tray" system to make ward staff aware of patients who might need assistance/observation with their meals – both in terms of ordering and eating them. Patients who need assistance are also helped by volunteers and/or relatives. *Governing Council of Barnsley Hospital NHS Foundation Trust*

- Support the Trust's development in all aspects of this work – from introduction of the red tray, to the increased single sex accommodation, and the work of the Children's safeguarding committee etc. *Governing Council of Barnsley Hospital NHS Foundation Trust*
- Patients are asked about their experience in hospital and this information is then used to improve and redesign services. This has certainly been the case in cancer services and alternative therapies have been introduced for recovering breast cancer patients because of patient involvement. The Commission feels that the hospital should be commended for listening to patients and ensuring that their views are acted upon. *Health & Adult Services Scrutiny Commission*

Areas for Improvement

- When Members of the Commission visited the hospital they were pleased to see that patients who were undergoing treatment for certain types of cancer were able to have treatment at their local hospital, rather than having to travel to Sheffield. However, they were concerned to note that the amount of space for this treatment was insufficient and gave a feeling that the department was overcrowded. Members felt that the hospital should work with the NHS Barnsley, as commissioners, to resolve this whilst ensuring that patients do not have to travel out of the area for treatment. *Health & Adult Services Scrutiny Commission*

- Members expressed concern at staffing levels within the hospital and were aware that there are a number of staff vacancies. However, plans are in place to recruit to the vacancy posts and it is hoped that this situation will soon be resolved. The Commission will be keeping a watchful eye on the situation as time progresses. *Health & Adult Services Scrutiny Commission*

Remuneration report

Remuneration and Terms of Service Committee (RATS)

The Remuneration and Terms of Service Committee (RATS) continues to be 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 twice in 2009/10. 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 Linda Christon, non-executive director (from 1st January 2010)
- Mrs Pat Newman, non-executive director (to 31st December 2009)
- Mr Francis Patton, non-executive director
- Mr Paul Spinks, non-executive director
- Ms Sarah Wildon, non-executive director

Attendances are shown on the table of Board and committee meetings on page 78.

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.

Remuneration of executive directors and senior managers

The Chief Executive has signed a statement to confirm that in respect of the declaration in the annual accounts and annual report for the year ended 31st March 2010, senior managers are defined as the executive and non-executive directors of the Trust.

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 executive directors (and other senior employees) to ensure that they are fairly rewarded for their individual contribution to the Trust - having proper regard to the Trust's financial circumstances and performance and to the provisions of any national arrangements for such staff, where appropriate. Executive directors of the Trust have defined annual objectives agreed with the Chief Executive. The committee receives a report on their performance annually.

The Directors do not receive performance-related bonuses.

Recruitment of executive directors

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 (senior managers) covered by this report hold appointments that are permanent until they reach the normal retiring age. The period of notice for the Chief Executive and all other executive directors is six months and any termination payment would take account of national guidance.

Contracts, notice periods and termination payments

Overall, the Trust uses substantive contracts, and limits its use of interim and fixed term contracts on the basis of cost. Contract notice is six months All director positions are subject to approval of the Remuneration Committee, who are able to approve a recruitment and retention premium in addition to a standard director salary, based on up to date post comparisons. Flexibilities within the Agenda for Change framework are also applied.

Salary and pension entitlements of senior managers

Senior managers are defined as the executive and non-executive directors of the Trust and the Trust has not paid any 'golden hellos' or 'golden goodbyes'.

The Trust has not paid any third parties for the services of a senior

manager, nor has it paid any compensation amounts to former 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 below has been subject to audit.

Name and title	Year ended 31 March 2010			Prior year		
	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other remuneration (bands of £5000) £000	Benefits in kind Rounded to the nearest £100
Dr D Hicks, Medical Director and Deputy Chief Executive[1]	55-60	25-30	0	110-115	50-55	0
Dr J Mahajan, Medical Director[2]	65-70	0	0	0	0	0
Ms S Taylor, Chief Executive	120-125	0	0	120-125	0	0
Mr D Peverelle, Chief Operating Officer	90-95	0	0	65-70	0	0
Ms D Hanwell, Director of Finance and Information	85-90	0	0	85-90	0	0
Mrs J Greenwood, Chief Nurse and Director of[3] Quality and Standards	90-95	0	0	90-95	0	0
Mrs S Linter, Acting Chief Nurse and Director[4] of Quality and Standards	90-95	0	0	20-25	0	0
Mr S Wragg Chairman	35-40	0	0	5-10	0	0
Mrs P Newman, non-executive director[5]	5-10	0	0	5-10	0	0
Mrs L Christon, non-executive director[6]	0-5	0	0	0	0	0
Miss A Arnold, non-executive director	5-10	0	0	5-10	0	0
Ms S Wildon, non-executive director	5-10	0	0	5-10	0	0
Mr P Spinks, non-executive director	5-10	0	0	5-10	0	0
Mr F Patton, non-executive director	5-10	0	0	5-10	0	0

1. Dr D Hicks retired from the post of Medical Director and Deputy Chief Executive in September 2009
2. Dr J Mahajan, Medical Director was appointed as Medical Director on 14th September 2009
3. Mrs J Greenwood resumed in post as Chief Nurse and Director of Quality and Standards from January 2010 (phased return to work)
4. Mrs S Linter Acting Chief Nurse and Director of Quality and Standards, ceased this role in March 2010
5. Mrs P Newman left the Trust on 31st December 2009 after nearly eight years' terms of office
6. Mrs L Christon commenced as a non-executive director on 1st January 2010

Sandra Taylor
Chief Executive

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 (bands of £5000)	Cash equivalent transfer value at 31 March 2010 £000	Cash equivalent transfer value at 1 April 2009 £000	Real increase in cash equivalent transfer value £000	Employers' contribution to stakeholder pension To nearest £100
Ms S Taylor, Chief Executive	5.0-7.5	15.0-20.0	87	48	38	0
Mr D Peverelle, Chief Operating Officer	5.0-7.5	140.0-145.0	815	723	74	0
Ms D Hanwell, Director of Finance and Information	2.5-5.0	100.0-105.0	436	396	30	0
Mrs J Greenwood, Chief Nurse and Director of Quality and Standards	2.5-5.0	125.0-130.0	555	501	42	0
Mrs S Linter, Acting Chief Nurse and Director of Quality and Standards	25.0-27.5	120.0-125.0	545	396	139	0
Dr J Mahajan, Medical Director	5.0-7.5	90.0-95.0	445	372	35	0

As non-executive directors do not receive pensionable remuneration, there are no entries in respect of pensions for non-executive directors. In the year to 31 March 2010,Dr D Hicks became a re-employed pensioner and his pension is in payment.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.

Further details

For further information about remuneration, see the Notes to the Accounts.

Sandra Taylor
Chief Executive

Board of Directors and Governing Council

Board of governors

Working together

Since establishment as a Foundation Trust, the Board of Directors and Governing Council have enjoyed a strong working relationship, based on honesty and transparency. This continued to grow throughout 2009/10 with the governors revising their committee structure to better facilitate their key responsibility of holding the Board to account. The Trust's Chairman chairs both boards and acts as a link between the two. Each board is kept advised of the other's progress through a number of formal and informal mechanisms, including attendance at each other's public meetings and governor sub-group or corporate groups; receipt of questions from the Governing Council and full responses thereto; verbal or written reports from the Board to the governors on current issues: and exchange of meeting minutes, etc. The boards meet together at least once annually for a joint business meeting - in November 2009, the Board opened up one of its private meetings for this purpose. The governors welcomed the opportunity and readily accepted the Board's offer to repeat this in 2010/11.

In terms of decisions taken by each Board, the Governing Council has to date dealt with a range of issues charged to it under current legislation (e.g., appointment of the Chairman and non-executive directors and auditors) and supports the Trust in its strategic development (business plans, etc). The Board of Directors retains authority for all operational issues, the management of which is delegated to the Trust's operational staff in accord with its standing orders.

The Governing Council is made up of 20 public governors, elected by members of the Foundation Trust. It also has six staff governors elected by hospital staff. They are supported by nominated representatives from our eight partner organisations.

In 2009, ten of the 20 public and staff seats were eligible for election, including two vacancies arising from resignation at the time of the elections due to personal commitments. Two governor seats were appointed following election (one public, one staff); five other public governors were appointed unopposed. The remaining three seats will be carried forward to a further election in 2010/11.

Governance Code

The Trust 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. The Trust complied fully with the provisions of the Code in 2009/10 with the exception of the (then) requirement that executive directors should be subject to reappointment at intervals of no more than five years. This is no longer a requirement in the revised Code of Governance, effective from 1 April 2010.

Board and committee meetings

The attendance of individual Directors at Board and Committee meetings during 2009/10 is shown on page 78.

When Directors have not been able to attend meetings they receive and read the papers for consideration at that meeting and have opportunity to relay any comments and, if necessary, follow up with the relevant Chairman of the meeting.

Register of interests

The register of interest for Governors and Directors is available from Carol Dudley, the secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP. Tel: 01226 435000.

The Governing Council

Whilst the Trust is managed by the Board of Directors, the Board is accountable to the Governing Council who act as the 'voice' of local people.

The Governing Council, their terms of office and their attendance at Trust meetings is as follows:

Table of attendance of Governors and Directors at Governing and sub group meetings
(Figure in brackets indicates number of meetings held in the year)

Governors	Term of office	Governing Council (7 meetings – including the AGM)	Joint meeting with Board	Nominations Committee (7 meetings)	Sub-groups		
					Patient & Access (6 meetings)	Strategy & Performance (includes earlier 'Futures' group) (9 meetings)	Staff & Environment (6 meetings)
Pauline Acklam OBE - Partner Governor NHS Barnsley	Nominated, from April 2008 (2nd term, non-consecutive)	4					
Jan Anderson - Public Governor Constituency C	01.01.2007 - 31.12.2009 (2nd term)	3 (of 5)	1		3	3 (of 7)	5
Professor Nigel Bax - Partner Governor, University of Sheffield	Nominated, January 2008 (2nd term)	4					
Councillor David Bostwick -Partner Governor Barnsley MBC	Nominated, June 2006 to July 2009	1 (of 1)					
David Brannan - Partner Governor Voluntary Action Barnsley	Nominated, from January 2008 (2nd term)	7	1	7	5	8*	6
Pauline Brown - Public Governor Constituency D	01.01.2010 - 31.12.2012 (3rd term)	1					5
Mrs Pauline Buttling - Public Governor Constituency B	01.01.2010 - 31.12.2012	2 (of 2)			1 (of 2)	2 (of 2)	1 (of 1)
John Cale - Public Governor Constituency E	01.01.2007 - 31.12.2009 (2nd term, non consecutive)	5 (of 5)	1		2 (of 4)		
Sue Carter - Public Governor Constituency B	01.01.2007 - 31.12.2009 (2nd term)	1 (of 5)					
John Davies - Public Governor Constituency E	01.01.2007 - 31.12.2009 (2nd term, non-consecutive)	0					
Michael Dunlavey - Public Governor Constituency D	01.01.2010 - 31.12.2012	1 (of 2)					
Michael Edwards - Public Governor Constituency E	01.01.2010 - 31.12.2012	2 (of 2)				1 (of 2)	

Governors	Term of office	Governing Council (7 meetings – including the AGM)	Joint meeting with Board	Nominations Committee (7 meetings)	Sub-groups		
					Patient & Access (6 meetings)	Strategy & Performance (includes earlier 'Futures' group) (9 meetings)	Staff & Environment (6 meetings)
Lynne Elliott - Partner Governor Barnsley Participation Process (Barnsley Arena)	Nominated, February 2007 - March 2010	2 (of 6)					
Glyn Etherington - Public Governor Constituency D	01.01.2008 - 31.12.2010	5	1		6*	7	4
Denis Gent - Public Governor Constituency E	01.01.2008 - 31.12.2010 (2nd term)	6	1			5	
Malcolm Ginn - Public Governor Constituency A	01.01.2009 - 31.10.2009	3 (of 3)			2 (of 4)	5 (of 6)	2
Sharon Hodgson - Public Governor Constituency C	01.01.2010 - 31.12.2012 (3rd term)	3					
Jim Holliday - Partner Governor Barnsley Arena	Nominated, from March 2010	0 (of 1)					
Deborah Horbury - Staff Governor Nursing & Midwifery	01.01.2008 - 31.12.2010	3			1	1	3
Martin Jackson - Partner Governor Joint Trade Unions Committee	Nominated. from January 2008	2	1				4
Bill Joice - Public Governor Constituency O	01.01.2008 - 31.12.2010 (2nd term)	3	1		3	4	3
Wayne Kerr - Public Governor Constituency E	01.01.2010 - 31.12.2012 (3rd term)	5			2		
Bruce Leabeater - Public Governor Constituency A	01.01.2008 - 31.12.2010	5	1	4 (of 6)	3	5	1
Eric Livesey - Public Governor Constituency B	01.01.2009 - 31.12.2011	4					1
Karen Lovatt - Partner Governor Barnsley Youth Council	Nominated, from January 2009	1					

Governors	Term of office	Governing Council (7 meetings – including the AGM)	Joint meeting with Board	Nominations Committee (7 meetings)	Sub-groups		
					Patient & Access (6 meetings)	Strategy & Performance (includes earlier 'Futures' group) (9 meetings)	Staff & Environment (6 meetings)
Jill Marshall - Staff Governor Non Clinical Support	01.01.2010 - 31.12.2012 (2nd term)	5	1				6
Dr Jon Maskill - Staff Governor Medical & Dental	01.01.2008 - 31.12.2010 (2nd term)	6	1	5			
Viv Mills - Staff Governor Clinical Support	01.01.2009 - 31.12.2011 (3rd term)	5	1			1	3
Ann O'Brien - Staff Governor Nursing & Midwifery	01.01.2009 – 31.12.2011	2					
Kay Philips - Partner Governor Sheffield Hallam University	Nominated, from June 2007	2		6			
Councillor Jenny Platts - Partner Governor Barnsley MBC	Nominated, from October 2009	2 (of 3)					
Bob Ramsay - Public Governor Constituency C	01.01.2009 - 31.12.2011 (3rd term)	5	1	5	5	6	5*
Joyce Rhodes - Staff Governor Volunteers	01.01.2009 - 31.12.2011	5	1		5	8	6
Carol Robb - Public Governor Constituency A	01.01.2009 - 31.12.2011 (2nd term)	4					
Julie Smith - Public Governor Constituency B	01.01.2009 - 31.12.2011	4				2	1
David Thomas - Public Governor Constituency D	01.01.2009 - 01.01.2011 (3rd term)	6				5	
Kay Thomas - Public Governor Constituency C	01.01.2007 - 31.12.2009	4 (of 5)					
John Townend - Public Governor Constituency D	01.01.2008 - 31.12.2010	5			2	4	4

Governors	Term of office	Governing Council (7 meetings – including the AGM)	Joint meeting with Board	Nominations Committee (7 meetings)	Sub-groups		
					Patient & Access (6 meetings)	Strategy & Performance (includes earlier 'Futures' group) (9 meetings)	Staff & Environment (6 meetings)
Joe Unsworth - Public Governor Constituency A & Lead Governor	01.01.2008 - 31.12.2010 (2nd term)	5	1	7 (chaired 1)	5	7	4
Chairman: Stephen Wragg	01.01. 2009 31.12.2011	7*	1	6*	5	7	4

*Chair of meeting

Board of Director attendance at Governor meetings	Governing Council General meetings[3]	Nominations Committee	Sub-groups		
			Patient & Access	Strategy & Performance	Staff & Environment
Anne Arnold Non-executive director				1	2
Linda Christon Non-executive director (01 January 2010)	1				
David Hicks Medical Director & Deputy Chief Executive (to September 2009)	1			1	
Sharon Linter Acting Chief Nurse & Director of Quality and Standards	1			2	
Pat Newman Non-executive director and Deputy Chair (to 31 December 2009)	3	1 (attended part by invitation)		1	1
Francis Patton Non-executive director	1			2	
David Peverelle Chief Operating Officer	1				
Sandra Taylor Chief Executive	1	1 (attended part by invitation)		1	
Sarah Wildon Non-executive director	4		1		

For the joint meeting between the Governing Council and Board of Directors in November 2009, the Board opened up one of its private meetings (hence their attendance is not recorded separately in the above table) and invited all governors to attend. This was welcomed by both governors and Directors and will be repeated in 2010/11.

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) The sub-groups are informal groups of the Governing Council (rather than formal committees) and are open to all governors. They are often attended by executive and non-executive directors, managers, staff and external speakers, to provide briefings on key issues and/or response to governors' questions. The sub-groups are used by the Governors as a forum for general discussion, information and training.

c) Directors attendance at the Annual General Meeting is recorded separately in the table of Board Meetings and Attendance.

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. In 2009 the Governing Council agreed that the Lead Governor (as elected by the Governing Council) should assume one of the seats for public governors.

The Committee was joined by Mr Leabeater in May 2009, following the vacancy that arose in January 2009.

Membership in 2009/10 included:
- Mr David Brannan, Partner Governor;
- Mr Bruce Leabeater, Public Governor;
- Mrs Kay Phillips, Partner Governor;
- Mr Bob Ramsay, Public Governor;
- Mr Joseph Unsworth, Public and Lead Governor; and
- 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 Committee's discussions.

The meetings of the Nominations Committee were supported by internal HR 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 did not elect to use external assistance in 2009/10 and this was supported by the wider Governing Council.

In 2009/10 the committee reappointed two non-executive directors and appointed one new, non-executive director. It also further developed the comprehensive appraisal process for the Chairman and received and considered the appraisals of the non-executive directors prior to presenting its recommendations on same to the Governing Council.

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/or response to governors' questions. The sub-groups are used by the governors as a forum for general discussion, information and training. In 2009/10 the governors welcomed the non-executive team's commitment to ensuring Chair and/or non-executive director regular attendance at sub-group meeting to give governors more opportunity to hold the Board to account directly.

Additionally in 2009 the structure of the groups was revised to give further support to the governors' role of holding the Board of Directors to account. The "Futures" group was replaced by the Strategy & Performance group and the Terms of Reference for all of the sub-groups were revised and reviewed, with each of the sub-groups taking on responsibility for monitoring the Board's delivery of key objectives from the Trust's business plan for 2009/10.

The new structure of the sub-groups has enabled 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 2009/10 the governors:
- looked at the published guidance from Monitor in terms of both their own roles and responsibilities and possible implications for the Trust's Constitution (due for review in 2010/11);
- independently submitted commentary on the Trust's performance and services to the Care Quality Commission (for the first time, this does not have to be done through or reviewed by the Trust's management);
- considered and submitted responses to the Department of Health's consultation on NHS car parks;
- developed formal strategies for their own roles as governors and in terms of membership liaison, and will continue to use this to support their input to the annual planning process; and
- held a focus group with a small but representative group of members to develop a questionnaire for distribution to a wider group of members, inviting views on the Trust's service.

Further progress of each of the sub-groups in 2009/10 is highlighted below:

Patients & Access
Over the past year 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 (including discharge questionnaires, Matrons' report, national surveys etc). The group also led a drive on membership, encouraging a commitment from all of the Governors to personally recruit a number of new members each year.

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. The group supports the latter by its proactive engagement in the Trust's internal inspection programme and questioned the Board constantly to ensure that car parking arrangements on site and across the new car park developed on Hospital-owned land offered the best options for public and staff alike.

Strategy & Performance
This sub-group took over much of the work of the previous group - the Futures group - and supported the Governing Council's growing focus on one of its core responsibilities of holding the Board of Directors to account. It led the work on identifying 3-4 key objectives from the 2009/10 business plan for each of the sub-groups to monitor closely and encouraged regular updates from the Chairman or a member of the non-executive team personally on the key objectives at the respective sub-group meetings. It also presented two strategies to the Governing Council: a revised Membership Strategy and a governors' strategy, the latter to underpin the future direction of the Governing Council.

Funding & Finance Committee
Whilst this did not meet formally in 2009/10, it is intended to consider funding requests to support the work of the governors. The Governing Council recently reviewed the aim and purpose of this group and decided to revive it in the year ahead.

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.

Board of Directors

The Board of Directors continues to be responsible for setting and driving forward the strategic direction of Barnsley Hospital, in a challenging environment. The Board comprises of six non-executive directors (including the Chairman) and five executive directors, and is accountable to the Governing Council.

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 arise. The strengths and skills of the Board were subject to further review in 2009/10 as part of a Board Development Programme. The programme, which was extended to encompass the Trust's Divisional Directors as well, gave assurance that the Trust had the right balance of skills, strengths and experience at both Board and senior management level.

The following were the executive and non-executive directors for the year 2009/10:

Chairman	Stephen Wragg
Chief Executive	Sandra Taylor
Medical Director	Dr David Hicks to September 2009 Dr Jugnu Mahajan from 14th September 2009
Director of Finance and Information	Dawn Hanwell
Chief Nurse and Director of Quality and Standards	Juliette Greenwood Sharon Linter (Mrs Linter served as acting Executive Director during Mrs Greenwood's sickness absence)
Chief Operating Officer	David Peverelle
Non-executive directors	Anne Arnold Linda Christon (from 1st January 2010) Pat Newman (to 31 December 2009) Francis Patton Paul Spinks Sarah Wildon

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 page 72 for further details.

The terms of office of three non-executive directors expired in 2009/10: Miss Arnold (31st October 2009), Mrs Newman (31st December 2009) and Mr Patton (31st December 2009), all of whom were eligible for reappointment.

As reported earlier, Mrs Newman chose to retire after nearly eight years with the Trust.

Mr Patton had served one term of office (two years) and was eligible for re-appointment subject to satisfactory appraisal. With the support of the Governing Council and the Nominations Committee, he was reappointed to 31st December 2012.

Two appointments were referred to open competition. Miss Arnold had served as a non-executive director at Barnsley Trust since December 2004. She successfully reapplied and was appointed for a further term of office, to 31st October 2012.

Mrs Christon was appointed from 1st January 2010, for an initial three year term of office.

The processes for each appointment were supported and monitored by internal human resource specialists, although the Committee retained 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.

Meet the Board of Directors

Executive directors

Sandra Taylor, Chief Executive
Sandra commenced her role as Chief Executive in October 2007. She joined the Trust after six years working with the NHS in an executive director capacity in Surrey and Sussex Strategic Health Authority and East Berkshire health economy (joint PCT, Foundation Trust and Local Authority post). Prior to that she was Executive Director of Health and Social Care consecutively with Nottinghamshire, Leicester and Birmingham Councils.

Sandra has extensive academic qualifications having lectured in her early career at both Hull University and University College London. She is a Trustee of Friends of the Elderly, a national charity providing care and support services for elderly people, and has provided advice to a number of government departments on issues of social inclusion and care services. She has a special interest in patient centred service redesign and productivity, on which she led across Surrey and Sussex, and in ensuring services are responsive to and appropriate for the needs of patients and their carers.

Dr David Hicks, Medical Director and Deputy Chief Executive
David became the Trust's medical director in 2002, having been associate medical director since 1997. He has held positions as a consultant in genito urinary medicine at the Trust and the Royal Hallamshire Hospital since 1983. David is also a Fellow of the Royal College of Obstetricians and Gynaecologists and the Royal College of Physicians.

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. Dr Mahajan, who has had 20 years in the NHS, is married with one son and lives in Derbyshire.

Juliette Greenwood, Chief Nurse and Director of Quality and Standards
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.

Sharon Linter, Acting Chief Nurse and Director of Quality and Standards
Sharon joined the Trust in January 2009 from Leeds Teaching Hospitals NHS Trust where she was the deputy chief nurse and divisional nurse manager for women, children's, head and neck and dental divisions. Her career started in the NHS in 1980 and she has held a variety of roles in nursing, management and education. Her specific areas of interest are patient safety, leadership development and introducing new roles such as nurse consultants. Sharon also has an interest in management of change and organisational development.

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 ITC & eBusiness at Business Link South Yorkshire and Head of ITC at Barnsley and Doncaster TEC from 1997 to 2001.

Prior to his appointment Steve was a non-executive director of NHS Barnsley; a position he held since April 2006. He was also vice president of the local Chamber of Commerce and held several other non-executive posts in Barnsley including Barnsley Development Agency, Barnsley Rotherham Chamber and Barnsley Enterprise Agency.

Steve's current appointment is from 1 January 2009 until 31 December 2011.

Anne Arnold
Anne joined the Trust in December 2004. She has extensive experience working with the NHS as a senior manager and more recently 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, and was reappointed as a NED this year and her current term of office is from 1 November 2009 until 31 October 2012.

Linda Christon
Linda is the newest recruit to the Board, having been appointed from 1st January 2010 for a three year term. She has had a varied career in public sector housing and social care. Before retiring, she was a regional director (North East Region) for the Commission for Social Care Inspection. Linda is looking forward to getting involved in the work of the Board and the Trust.

Pat Newman

Pat worked in both private industry and the public sector over her working career specialising in business administration, human resources and quality management, principally in the housing service of Barnsley Council.

Pat's interest in health, learning and the environment is evident through her involvement in community projects over many years, including serving as chair of governors in primary and secondary schools and her involvement in setting up the Neighbourhood Learning Net that encourages adults into education.

She was elected to serve on Barnsley Council and represented the people of Athersley for a number of years. She is also a Trustee of the Cooper Gallery.

Pat was Deputy Chair of the Board and senior independent director, and chaired the Governance Committee. She has a special interest in women and children's services, public and patient involvement, and patient dignity. Pat was re-appointed on 1 January 2008 for two years and retired on 31 December 2009.

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.

Since January, Sarah has served as Chair of the newly formed Clinical Governance Committee. Her current term of office as a non executive director with the Trust is until 31 December 2011.

Paul Spinks

Paul joined the Trust in January 2007 and chairs 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.
Paul's current term is until 31 December 2010.

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. Since January 2010 he has Chaired the Trust's Non Clinical Governance & Risk Committee.

Table of board and committee attendances 2009/10

Directors	Board of Directors (13)	Annual General Meeting	Audit Committee (6)	Finance Committee (4)[1]	Governance Committee (5)	Non Clinical Governance (3)	Clinical Governance (2)	Remuneration & Terms of Service Committee - RATS (2)
Anne Arnold. Non-executive director	9	1	6	2 of 3				2
Linda Christon Non-executive director (from 01 January 2010)	3 of 3		2 of 2				1	
Juliette Greenwood, Chief Nurse & Director of Quality and Standards	2 of 3							
Dawn Hanwell Director of Finance & Information	11	1	6	3	4	2	1	
David Hicks Medical Director & Deputy Chief Executive (to September 2009)	4 of 6	1		1 of 2	3 of 3			
Sharon Linter Acting Chief Nurse & Director of Quality and Standards	13		1[2]	1[1]	3		2	
Jugnu Mahajan Medical Director (from September 2009)	6 of 7			1 of 2	1 of 2		1	
Pat Newman Non-executive director (to 31 December 2009)	10 of 10	1	3 of 4		5*			2
Francis Patton Non-executive director	13	1		1[1]	3	3*		2
David Peverelle Chief Operating Officer	13			3	4	3		
Paul Spinks. Non-executive director	13	1	6	3*				2
Sandra Taylor Chief Executive	13	1	1[3]	4	5			2
Sarah Wildon. Non-executive director	12	1		1[1]			2*	2
Stephen Wragg Trust Chairman	13*	1	2[4]	2	4	2		2*

(Figure in brackets indicates number of meetings held in the year)
* denotes Chair of Board/Committee
1 In addition to members, several Directors attended the Finance Committee meeting by invitation in October 2009 to take part in the mid-year financial review
2 Mrs Linter was invited to attended part of an Audit Committee meeting, in May 2009 to provide information in response to an audit report
3 The Chief Executive attended part of one meeting in 2009/10 by invitation
4 The Chairman attended part of two Audit Committee meetings in 2009/10, by invitation

Register of interests

Based on the register of directors' interests and known circumstances, there was nothing to preclude all of the current non-executive directors from being declared as independent. At the time of his appointment, Mr Wragg (1st January 2009) also met the criteria to be declared as independent.

There are no company directorships held by directors where companies are likely to do business or are seeking to do business with the Trust.

The register of directors' interests is available from Carol Dudley, the secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP. Tel: 01226 435000.

The Committees of the Board

In light of the national report on the Mid Staffordshire NHS Foundation Trust, the Committee structure of the Board was reviewed. Whilst the Board was confident in the extant structure, changes were introduced from 1st January 2010 to give further support to its integrated governance arrangements for the Board and across the Trust. The effectiveness of the new structure is monitored via regular reports presented to the Board of Directors. The Committees are also monitored through the Trust's audit processes.

Remuneration Committee

Information about this committee is included earlier in the report (see page 63.

Audit Committee

The Audit Committee's main duties are to review the Trust's governance, risk management and internal control systems, review the work of the internal and external auditors, review assurance functions, request and review reports and assurance, approve accounting policies and review the draft annual financial statements before submission to the Board of Directors.

Membership of the Committee in 2009/10 included the following non-executive directors:

- Miss Anne Arnold, (Committee Chair);
- Mrs Linda Christon (from 1st January 2010);
- Mrs Pat Newman (to 31st December 2009); and
- Mr Paul Spinks.

The Committee is supported at every meeting by the Trust's Director of Finance & Information.

The Trust's internal Audit function is provided by South Yorkshire and North Derbyshire Audit Service.

The Trust's External Auditors are Pricewaterhouse Coopers who were appointed by the Governing Council on 1st April 2006 (contract extended in 2008/09). During 2009/10 Pricewaterhouse Coopers provided additional audit services in respect of International Financial Reporting Standards (IFRS) and Auditors Local Assessment (ALE) Review. 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.

Finance Committee

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

In 2009/10 membership comprised :

- Miss Anne Arnold, non-executive director (to 31st December 2009*);
- Ms Dawn Hanwell, Director of Finance & Information;
- Dr David Hicks, Medical Director (to September 2009);
- Dr Jugnu Mahajan, Medical Director (from September 2009);
- Mr David Peverelle, Chief Operating Officer;
- Mr Paul Spinks, non-executive director (Committee Chair);
- Ms Sandra Taylor, Chief Executive; and
- Mr Stephen Wragg, Chairman.

**membership realigned at internal restructure of governance*

It continues to provide assurance to the Board of Directors that Board members have sufficient information to ensure an adequate understanding of key financial issues. In particular 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.

Governance Committee

This was the Committee most directly affected by the new governance arrangements and, from 1st January 2010, was replaced by two Committees: the Clinical Governance Committee and the Non-clinical

Governance & Risk Committee. Both 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.

Membership of the Governance Committee to 31st December 2009 was:

- Mrs Pat Newman, non-executive director (Committee Chair);
- Ms Dawn Hanwell, Director of Finance & Information;
- Dr David Hicks, Medical Director (to September 2009);
- Mrs Sharon Linter, acting Chief Nurse and Director of Quality & Standards;
- Dr Jugnu Mahajan, Medical Director (from September 2009);
- Mr David Peverelle, Chief Operating Officer;
- Ms Sandra Taylor, Chief Executive; and
- Mr Stephen Wragg, Trust Chairman

In addition the Committee membership included staff from across the Trust - and a patient representative - to ensure it had robust representation from all aspects of risk and patient safety, including:

- Deputy Chief Nurse;
- Director of Human Resources & Organisational Development;
- Head of Midwifery;
- non-clinical risk adviser (Health & Safety lead);
- patient representative;
- Risk Manager; and
- staff side representative.

It is timely to record our thanks to all members of this Committee for their valuable contribution.

Clinical Governance Committee (from 1st January 2010)

Members:

- Mrs Linda Christon, non-executive director;
- Mrs Sharon Linter, acting Chief Nurse and Director of Quality & Standards;
- Dr Jugnu Mahajan, Medical Director; and
- Ms Sarah Wildon, non-executive director (Committee Chair).

Like the Governance Committee beforehand, membership of this Committee has been extended to include staff from across the Trust, giving it direct input from a range of key disciplines. Further members include:

- Chief Pharmacist;
- Head of Clinical Audit;
- Director of Education/College Tutor;
- Risk Manager; and
- senior clinical representatives from each of the four core service divisions.

Non Clinical Governance & Risk Committee (from 1st January 2010)

Members:

- Ms Dawn Hanwell, Director of Finance & Information;
- Mr Francis Patton, non-executive director (Committee Chair);
- Mr David Peverelle, Chief Operating Officer; and
- Mr Stephen Wragg, Trust Chairman.

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;
- Director of Strategy & Business Development;
- Head of Estates & Facilities;
- Health & Safety Officer; and
- Risk Manager representatives from each of the four core service divisions.

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, and staff from all walks of life) 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.

In November 2009, the Governing Council reviewed the membership strategy and developed a revised version to take forward into 2010/11. Our membership is drawn from patients, their families and friends, our staff, and anyone with an interest in health and promoting better services for Barnsley. The Governors and the Trust are conscious of the need not only to recruit members but also to engage with them more and the revised membership strategy underpins that aim. As a starting point before the year end, over 200 public and staff members were invited to attend the first focus group (due to meet in April 2010), so that we can learn from them direct about how they - our members - want us to engage with them; what they do and don't know about their governors and the hospital; what more they want to know; and what are the best ways to share information with them. Future stages include a questionnaire to all members; more focus groups, and building more links with social groups across the community to widen our membership and public awareness of the good work and reputation of Barnsley Hospital.

Becoming a member

- Helps people find out how we are performing;
- Keeps people up-to-date with changes through our regular members-only newsletter, FTi;
- Lets people have a say in how things are run;
- Allows access to hundreds of great discounts usually only accessed by NHS employees.

Maintaining our membership

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 2010 had a slight increase to 13,188 (from 13,073 in 2008/09). 9,458 public members and 3,730 were past and present staff and volunteers.

Membership at the end of the year breaks down as:

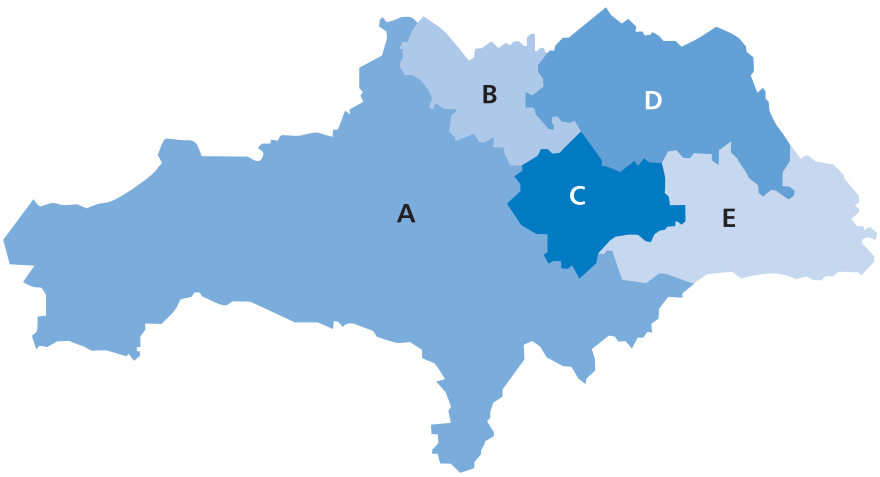
Public

Constituency A 2,136
Constituency B 1,531
Constituency C 1,763
Constituency D 2,139
Constituency E 1,338
Constituency O 551

Staff

Medical 301
Nursing 1,729
Clinical support 561
Non clinical support 909
Volunteers 230

Membership constituencies



The governors and the Trust have continued to focus on maintaining and engaging a diverse and representative membership, which reflects our local population.

Public members received quarterly editions of the members' newsletter FTi. Members were asked through FTi to encourage their friends and neighbours to become members too. Staff members were kept informed through internal communications and the hospital's volunteers produced their own newsletter, *Vibes*, four times during the year. The Trust's website also continues to be well used.

Membership is spread across the constituencies, largely mirroring the overall constituency populations. Membership levels are maintained through recruitment activity in the hospital, via the governors and through FTi.

Ethnic minority membership is still proportionately slightly lower than the census data and work with BBEMI continues to help address this to increase balanced membership and engagement across all community groups. Monitoring of membership activity takes place quarterly.

Members may contact governors or directors via Carol Dudley, the Secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP by telephoning 01226 435000 or e-mailing carol.dudley@nhs.net

Other disclosures

Regulatory ratings

Healthcare Commission/Care Quality Commission

The hospital watchdog, the Healthcare Commission (latterly the Care Quality Commission), has given Barnsley Hospital a first class report in its annual rating for 2008/9. The hospital has been rated as 'excellent' for its Quality of Financial Management and 'good' for its Quality of Services. The hospital scored the maximum possible in all key core compliance domains, including for safety and cleanliness and for patient dignity and respect

Performance ratings (published in October 2009) for 2008/9 for the Hospital were:

- safety and cleanliness - 14/14
- waiting to be seen - 11/12
- standard of care - 7/8
- dignity and respect - 9/9
- keeping the public healthy - 4/5
- good management - 17/18

The full ratings for Barnsley Hospital and all NHS organisations can be seen at the Care Quality Commission website: http://www.cqc.org.uk/

Monitor ratings

In addition the Trust delivered its risk ratings of 'green' (for governance), 'green' (for mandatory services) and '3' - that is, medium - (for finance) against the 2009/10 plan submitted to and closely monitored throughout the year by Monitor, independent regulator of NHS Foundation Trusts. Full details of the Trust's ratings can be seen at Monitor's website: http://www.monitor-nhsft.gov.uk/

Other public interest disclosures

As a public benefit corporation, Barnsley Hospital NHS Foundation Trust discloses the following about its activities and policies:

Communicating with staff

Throughout the year, we used all our usual channels of communication with staff - intranet, email, newsletters, weekly bulletins, team briefs, development sessions, appraisals, and Chief Executive meetings - to inform staff about issues relevant to them and how their work and ideas could have an impact on the Trust's performance.

As well as these regular channels of communication, staff side representatives are also involved in frequent meetings with managers and discuss issues that affect staff interests.

Equality and diversity

Information about our equality and diversity approach, workforce statistics and future priorities and targets is included within the Our Team section of the Directors' Report on page 33, where information about our policies in relation to disabled employees and equal opportunities can also be found.

Health and safety

Barnsley Hospital continues to take an active approach to health and safety with the Health and Safety Committee and Health and Safety Governance Steering Group, combined with regular staff training and induction sessions.

Regular fire safety, handling and personal safety training sessions are held and health and safety is a regular part of every new starter's induction training.

There have been no HSE Improvement Notices or Prohibition Notices served on the Trust during the year. The Trust was inspected by the Health and Safety Executive in November 2009.

Countering fraud

Whilst the majority of people who work in and use the NHS are honest, a minority will seek to defraud it of its valuable resources.

Barnsley Hospital fully subscribes to mandatory requirements to counter 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 suitably 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 to counter fraud on a local level. An annual counter fraud work programme is in place that is overseen by the Audit Committee to ensure compliance with Secretary of State's directions on fraud and corruption.

During the reporting year, the activities of the LCFS have sought to continue the trend of increasing the anti-fraud culture and fraud awareness amongst staff. The Annual Counter Fraud Report concludes that all staff have firmly supported counter fraud work across the organisation and have demonstrated they embrace the NHS Counter Fraud Strategy and the requirements imposed upon them by the Secretary of State for Health.

In the last year the LCFS has formally investigated two cases of fraud at the hospital.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to aim to pay all its invoices by the due date, or within 30 days of receipt of goods or a valid invoice, whichever is the later. Our performance in the year is as follows:

Number of bills paid: 38,842.
Number of bills paid within 30 days: 37,431.
Percentage of bills paid within 30 days: 96.37%.

Patient and public involvement

Touch screen facilities are situated strategically around the hospital to gather patient feedback of the care provided. This versatile system is also available on hand held touch screen tablets used regularly by our matrons to gather important inpatient feedback direct from patients at the bedside.

Over the coming year, staff will be consulted on various matters as part of the workforce strategy.

Primary care, community health and social care services and commissioners will be consulted in this next year to agree on new models of care.

The Trust is committed to working with patients in order that their involvement can influence change in the Trust.

Staff survey

Information about the staff survey carried out through the year is included within the Our Team section of the Directors' Report on page 36.

Management costs

The management cost calculated in accordance with the Department of Health's definitions was £7,581,000.

Early retirement on ill-health grounds during the year

There were three retirements during the financial year at an additional cost of £329,054.35. These retirements represented 1.19 per 1,000 active scheme members.

Occupational health

The occupational health service has continued to provide a service to the health providers of Barnsley as well as the Trust.

The last year has been an exceptionally busy year mainly because of the increase in sickness absence referrals and the implications of the swine flu alongside the usual programme of pre-employment, health surveillance, immunisation programme, and work place visits. The Health and Wellbeing team have continued to have an increase of referrals, group facilitation, and mediation. Stress control workshops and management master classes on stress have been run. Meetings such as Healthy Hospital and Stress group have been attended to enable HSE management standards for stress to be met.

The Manual Handling team have trained 77% of the work force. Additional training of trainers is taking place this year so that we can increase the number of staff who undertake manual handling training next year.

Sickness absence

A new sickness absence policy was introduced in August 2009 to improve staff attendance at work. The table below shows the sickness absence rates for 2009/10:

Sickness Absence Rates for 2009/10

	Apr-09	May-09	Jun-09	Jul-09	Aug-09	Sep-09	Oct-09	Nov-09	Dec-09	Jan-10	Feb-10	Mar-10	Cumulative % April 09 - March 10
Barnsley Hospital NHS Foundation Trust	**4.84%**	**5.05%**	**4.95%**	**4.92%**	**4.88%**	**4.86%**	**4.92%**	**4.29%**	**3.75%**	**4.10%**	**4.54%**	**4.74%**	**4.65%**
Corporate functions & operational support	4.62%	4.80%	4.16%	3.86%	3.90%	3.40%	3.51%	2.20%	2.11%	3.07%	2.80%	3.05%	3.45%
Diagnostics, clinical support & outpatients division	4.23%	4.45%	3.83%	4.59%	4.70%	4.56%	5.03%	5.26%	4.10%	4.04%	4.33%	4.25%	4.45%
Integrated medicine and A&E division	5.51%	5.45%	5.74%	5.57%	6.25%	6.37%	6.23%	4.56%	3.82%	3.67%	4.19%	4.81%	5.18%
Surgery and critical care division	5.41%	5.38%	5.34%	5.50%	5.11%	5.41%	4.89%	4.44%	4.06%	4.28%	5.35%	5.45%	5.04%
Women's & children's services & GU medicine division	3.86%	4.99%	5.49%	4.47%	3.38%	3.29%	4.02%	4.24%	4.30%	5.79%	5.96%	5.91%	4.63%

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.

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 2009/10 the Trust received a total of 225 requests, for none of which payments were received.

Serious untoward incidents

No serious untoward incidents involving data loss or confidentiality breaches were recorded in the financial year 2009/10.

Sandra Taylor
Chief Executive

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 accounting officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts (Monitor).

Under the NHS Act 2006, Monitor has directed the 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 Financial 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.

Sandra Taylor
Chief Executive

Statement on internal control

2009/10 Annual Accounts of Barnsley Hospital NHS Foundation Trust

Statement on Internal Control 1st April 2009 - 31st March 2010

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 the NHS Foundation Trust is administered prudently and economically and that the resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust's Accounting Officer Memorandum.

As the Accounting Officer, I work closely with NHS Barnsley, which is the main commissioner of our acute services. The Trust also works closely with NHS Barnsley Provider Services in the delivery of a wide range of hospital and community health care. The Foundation Trust has processes in place by which it works with partner organisations including Sheffield Teaching Hospitals, Sheffield Children's Hospital, Rotherham Hospital NHS Foundation Trust and Doncaster & Bassetlaw NHS Foundation Trust in continuing to provide a range of outreach and satellite services for Barnsley patients.

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 risks of failure to achieve polices, 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 to 31st March 2010 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, ensure that sound systems of internal control and management are in place. This responsibility is supported through 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, in 2009/10 the Board of Directors through the Chief Executive undertook a full review of the NHS Foundation Trust's governance arrangements effected in January 2010, and has revised its Board Committee structure introducing separate governance arrangements for clinical and non-clinical risk. These changes need to be fully embedded during 2010/11. The following five Board level committees have been established under the new arrangements:

- Clinical Governance Committee;
- Non Clinical Governance and Risk Committee;
- Finance Committee;
- Audit Committee; and
- Remuneration and Terms of Service Committee.

The risk management strategy (revised in February 2010) sets out an effective risk management system and supporting risk management procedures which will continue to be embedded during 2010/11 at both corporate and divisional level. The strategy includes:

- Policy framework;
- Organisational management and governance Committee Structures;
- Risk management processes and risk registers; and
- Learning and Development processes.

To better support the risk and control framework, Corporate and Divisional Risk registers have been revised in accordance with the new risk assessment matrix (National Patient Safety Agency - NPSA) and steps taken to provide an on-line risk register for accessible and timely updating of the risk registers, and for immediate management scrutiny. Risks that cannot be effectively controlled at a local management level are escalated in accordance with the process for prioritised management action to the Executive Team or individual Directors. These systems need to be embedded further during 2010/11.

In 2009/10, the Trust adopted the NPSA Risk Matrix (January 2008) and this provides a qualitative risk assessment matrix and procedures, with associated prioritisation process for risk treatments and escalation of management action. The procedures also provide for cognisance of relevant legal requirements and definition for acceptable levels of risk.

A Strategic Risk Committee has also been established to provide additional supervision of serious untoward incidents, complaints, claims and Coroner's Inquests providing overview and scrutiny, and ensuring processes for appropriate levels of investigation, root cause analysis and lessons learned from serious incidents is achieved. Wider learning is shared through use of Clinical Audit Programmes, quarterly risk management analysis reports for incidents, complaints and claims, and patient experience through the PALS and Complaints analysis reports, and the sharing of patient and staff and matrons surveys.

During the same period, the Trust has also undertaken a comprehensive review of its broader risk management policy framework, part of its ongoing work plan for continued compliance with the NHSLA risk management standards which was again achieved at Level 1 in March 2010.

The Trust has also reviewed its risk department structure and created two posts, that of Director of Quality, Standards & Governance and Head of Governance with effect from 1st April 2010. These two posts have accountability and responsibility for the delivery of compliance and regulatory frameworks across the Trust.

The annual review of the Corporate Curriculum has also taken place to ensure that training programmes are in place to meet mandatory and statutory needs and assist with embedding policy into the culture of the Trust's organisation. This is supported by Leadership Training Programme, Corporate and Local Induction, and appraisal systems (Knowledge and Skills Framework).

4. The risk and control framework

Organisational Framework and the Board

Specific responsibilities outlined in the Trust's Risk Management Strategy are incorporated into the Trust's Executive Committee Structures that supports the Board of Directors and provides the framework for risk control. Leadership is given to the risk management process through specific directors having lead responsibility. In addition this year some Directors and Managers have taken part in the Leading Improvement in Patient Safety Programme (LIPS), part of the Patient Safety First Campaign. Key reporting roles within the organisation included:

Patient Safety and Strategic Risk	Chief Nurse and Director of Quality & Standards
Clinical Performance/ Caldicott Guardian	Medical Director
Staff Safety	Director of Human Resources & Organisational Development
Financial & Information Governance, including the role of Senior Information Risk Officer (SIRO) and Board Assurance	Director of Finance & Information

The Board of Directors has sought assurance by the Board Assurance Framework, regular Board reports, scrutiny and holding the Executives to account for a number of key areas of risk. The Trust also has a range of sub groups to the Board Committees that monitor areas of risk. Some key groups include the Patient Safety Board, Health & Safety Committee, Information Governance and Clinical Guidelines. All groups have a role to provide regular monitoring for best practice and identifying themes and trends for sustained learning and improvement to our services. In response the Board has, in 2009/10, taken a range of actions to support both ongoing assurance and scrutiny, and specific actions to reduce risks; examples are:

- Overseeing the review of Integrated Governance arrangements;

- Compliance with regional and local Infection Prevention and Control targets, and local strategy & action plan;
- Assurance on the delivery of the Business Plan Objectives;
- Monitoring Performance and Clinical Dashboards to ensure reduction in risk (e.g. patient falls);
- Compliance with requirements for single sex accommodation;
- Developing and improving the Patient and Public Involvement Strategy;
- Privacy and Dignity Steering Group reporting to the Trust Board;
- Equality and Diversity performance monitoring;
- Ongoing review and testing of Emergency Preparedness and Contingency Planning;
- Review of Information Governance and action plans derived from the Information Governance Toolkit; and
- Certificate of progress awarded for the National Patient Safety First Campaign.

Compliance with Standards
The Trust declared full compliance against the core standards for Better Health for 2009/10 under the Healthcare Commission. This includes significant progress with the Records Management Standard from the previous year. Actions have included establishing and training Records Guardians, a Corporate Inventory of records in place, and a range of corporate templates to standardise record keeping. This work has continued under the more recent Care Quality Commission regulations, and regular audit programmes take place to ensure ongoing compliance.

The Trust was required to register with the Care Quality Commission in 2010 and its current registration status is as of 31st March 2010 as without conditions.

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, employers' 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. The Trust has a range of policies, impact assessments, and monitoring processes with governance arrangements operating through the Equality & Diversity Board reporting to the Board of Directors.

The Trust has also developed robust emergency planning and preparedness plans including business continuity and pandemic flu (swine flu). These were tested over the winter period due to the inclement weather conditions.

Sustainability and Carbon Reduction
The NHS Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in progress in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaption Reporting requirements are complied with.

The Board Assurance Process
The Board Assurance Framework, together with other reporting mechanisms provided to the Board, provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed.

The Board of Directors takes an overarching role in assurance and monitoring of performance and has monitored delivery of the 2009/10 Business Plan throughout the year. The Board of Directors has approved the Assurance Framework confirming that the risk control measures in place are reasonable; action plans have been developed to improve the controls, and the assurances processes where appropriate.

The Assurance Framework is reported monthly to the Board of Directors. The Board of Directors accepts that the Framework did not include all areas that the Board should be seeking assurance on, for example in relation to IT Strategy. These issues, however, are presented to the Board via other routes, and monitored by other performance management tools such as the monthly performance Dashboard.

The Audit Committee performs the key role of reviewing and monitoring the system 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 and minutes of the Audit Committee along with an annual report from the Committee are provided to the Board of Directors.

Further assurance is given through ongoing reviews in relation to

financial management and governance through the assessment process for self certification to Monitor.

Obtaining assurance through partnership and public stakeholders

The Trust's Assurance Framework has been informed by partnership working across the healthcare region and locally, 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 Safeguarding Board and other district-wide patient and public involvement initiatives;
- Membership of the Foundation Trust Network;
- Membership of the Foundation Trust Governors Association;
- Undertaking consultation with the NHS Barnsley, local Overview and Scrutiny Committee, NHS Yorkshire & Humber, Governing Council and Patient Participation Initiative (PPI) Forum on the Annual Health Check declaration and also on other areas of interest;
- Collaborative working between the Governing Council and the Board of Directors; and
- Membership of the Local Health Community IT network.

Gaps in Control and Assurance

The Assurance Framework and governance processes, have identified gaps in control and assurance requiring action plans to provide additional control measures. These have been derived from serious risks arising from a risk based audit programme monitored by the Audit Committee or other assessment processes:

IM&T Governance and Effectiveness – An audit review identified a number of strategic weaknesses within Information Management and Technology. The Trust appointed a new Interim Chief Information Officer, and a detailed action plan was developed to overhaul the Trust's IT Strategy, and prioritisation of its objectives. Progress is being closely monitored by the Non-Clinical Governance Committee and Board of Directors.

European Working Time Directive (EWTD) – Recommendations were made in relation to the risks associated with ensuring EWTD compliance with regard to Doctors rotas, which became effective in August 2009. The Trust has progressed in a range of actions to address this, and declared derogation on a small number of key rotas.

Agency Staff – The management of Agency costs was identified as an area which needed addressing and a range of actions have been implemented, and significant improvements have been made.

Third Party Providers of Clinical Services

The Trust has identified a need to improve the management and governance of sub contracting processes, where, on a limited basis, there is a need to utilise such arrangements.

The Trust also acknowledges areas of risk identified through external review processes during the year. These include the requirements to respond to H M Coroner following findings made at two inquests during 2009/10. This has resulted in the Trust amending its procedure for assessing the mobility and safety of patients at the point of discharge; and reviewing the coordination of its multiple trauma team. Other issues concerned a review of nursing records and handover of care both of which had been completed the previous year and has since shown substantial improvement.

5. Review of economy, efficiency and effectiveness of the use of resources

The Trust produces an annual plan that includes an assessment of the operational requirements (capacity and financial resources) required to deliver its financial targets ensuring that resources are used economically, efficiently and effectively. The plan incorporates the national requirements to continuously improve productivity and efficiency, to manage resources within a national tariff structure that implicitly drives economic use of resources.

Financial plans are approved by the Board of Directors, supported by its Finance Committee. In year use of resources is monitored operationally by a system of detailed budgetary management reporting which ensures the active management of resources appropriately at the right level of delegation. Performance Management is undertaken through monthly performance reviews with each divisional management team, which reviews financial performance alongside a range of detailed indicators and metrics that ensure robust assessment of the effective use of over all resources. The Trust has continued to develop a model of

service line reporting and is increasingly using this tool along with benchmarking information, to assess the viability and efficiency of individual services. Action plans to improve productivity and contribute to cost improvements are identified through these processes. It is recognised that optimal performance will be better achieved by aligning full service line management across the organisation; this is currently under review and scoping of options to approach this. The Trust is also developing an additional on-line performance accelerator tool to better coordinate plans and actions required from a range of work streams to ensure timely delivery of objectives.

The Board is provided with assurance on the use of resource through a monthly report, and the Finance Committee undertakes detailed scrutiny and review on a quarterly basis. Reports are also submitted on a quarterly basis to Monitor, from which a financial risk rating is assigned. Any concerns on the economy, efficiency and effectiveness in the use of resources are well monitored and any concerns raised are acted upon.

6. Annual Quality Report

The Directors of Barnsley Hospital NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of annual Quality Reports which incorporate the above 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, Standards & Governance, with the full support of the Board of Directors and Governing Council. As a Foundation Trust, we were required by Monitor to formulate a Quality Account for 2008/09, this we did and have been monitoring the process and performance at Trust Board on a monthly basis since April 2009.

The formulation of the Trust's Quality Report for 2009/10 commenced in August 2009, with discussion with Trust Board members, Directors, staff, patients and Governors to determine the Trust's priorities and areas for improvement (Quality metrics). These Quality metrics were refined and discussed, and involved reviewing or introducing new policies around aspects of patient care such as Infection Prevention and Control and Safe Handover to ensure these were underpinned by clinical evidence and were achievable in 2010/11. In addition, they were analysed to ensure they met the direction of travel within the NHS, for example reflected goals within the Chief Nursing Officer's *High Impact Actions for Nursing and Midwifery (2009)*.

This work has ensured that our Quality Report presents a balanced view and there are appropriate controls in place to ensure the accuracy of data.

Driving quality is of vital importance to all of our staff, both clinical and non-clinical, and it is important that they continue to be fully engaged with the quality agenda and are equipped to deliver it. The Trust has developed an information strategy to ensure that each member of staff is aware of the new internal governance structure and, through our education and development programme, has access to appropriate training (including revised programmes on customer care services).

The data used within the Quality Report has been analysed using robust systems and processes that exist within the Trust, which provide the necessary assurance required by the Trust Board. Our data collection systems are extensive, ranging from performance metrics, to Matrons' questionnaires at ward level, to trust-wide freestanding units across the site inviting feedback from patients and public, to patient feedback via compliments and complaints, to national surveys. Collectively this data provides the Trust with information to enable key departments to monitor progress; measure improvements; identify existing or potential weaknesses; take swift and informed actions where necessary, and plan ahead for service improvements. The quality agenda is monitored closely through the newly established Clinical Governance and Non Clinical Governance & Risk Committees, chaired by Non Executive Directors who in turn are able to report to the Board to provide assurance or alert them to any required actions in a timely manner.

7. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS Foundation Trust who have responsibility for the development and maintenance of the internal control framework, and 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 of Directors, Governance, Finance and Audit Committees, and, also, the Independent Auditor's Report and opinion. From these ongoing reviews and advice I am able to take reasonable assurance that the systems in place are effective.

Work has been commissioned from the Internal Audit Service as noted within the statement to review the adequacy of the control and assurance systems in place and to develop improvements with the governance processes. The Head of Internal Audit has formally noted with the Chief Executive the positive changes to the Trust's governance arrangements and how they support the ongoing monitoring of the Assurance Framework and describes this is a "significant improvement".

My review of the effectiveness of the system of internal control is also informed by external risk management assessments undertaken during the year or within external specified timescales if longer.

The Trust is subject to a wide range of inspections and the following selection provides some of the key compliances:

- NHS Litigation Authority: Ongoing compliance with NHSLA Risk Management Standards (Level 1) assessed and achieved in March 2010;
- Ongoing CNST (Clinical Negligence Scheme for Trusts) standards compliance (Level 2) for Maternity Services last assessed in July 2007;
- Healthcare Commission (subsequently the Care Quality Commission (CQC)) Performance rating (for 2008/09) of good for quality and excellent for resource management;
- A declaration of full compliance for CQC Standards in 2009/10;
- Full Registration of services with the CQC without condition;
- Thrombosis and Thrombo-prophylaxis Team;
- National PEAT inspection; the Trust achieving good standards for food and Privacy and Dignity; and acceptable score for the overall environment;
- Quality Assurance Reference Centre (QARC) – all targets met or exceeded for the Assessment of Breast Screening Services;
- Care Quality Commission - unannounced visit on Hygiene Code in May 2009 confirming full compliance. The Trust received a national award for being the cleanest hospital; and
- Barnsley Council Overview & Scrutiny Committee informal visit was reported to be very positive.

There are robust and effective systems, procedures, and practices to identify information risks. Although the Board of Directors is ultimately responsible for information governance it has delegated

responsibility to the Information Governance Group which is accountable to the Non Clinical and Risk Governance Committee, a committee of the Board. The Information Governance Group is chaired by the Medical Director who is also the Caldicott Guardian. There have been no serious untoward data security breaches in 2009/10.
The Information Governance Strategy & Policy, along with a range of associated documents including Information Security, Confidentiality and Data Protection, were updated and approved by the Board in February 2010. These documents, outline frameworks, and procedures bring together all the statutory requirements, standards and best practice in information governance identified at that time.

The process that has been applied in maintaining and reviewing the effectiveness of the systems of internal control in relation to the Quality Report is continuous in nature. The Quality metrics that are contained within it are reviewed on a monthly basis at Trust Board; this includes both private and public Board meetings. The Quality metrics form two dashboards, which are Performance and Clinical (to be named Quality 2010/11). The data used to populate these dashboards is drawn from systems from informatics and risk management. Each dashboard goes with an accompanying paper to illustrate those exceptions in detail. These exceptions are discussed and appropriate actions required of named individuals, thereby addressing exceptions at a strategic and operational level. However, although the Trust recognises these systems as being effective, we strive to continuously improve our processes.

We recognise with the Trust's new Governance arrangements the Quality report requires further embedding in the Trust. Thereby, we will be asking Clinical, Non-Clinical Governance and Risk Committees and the Governors to review the Quality Report during their meetings.

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 Register and Assurance Framework to ensure they identify the changing impact and likelihood of risk and better support the achievement of business objectives.

Conclusion

As Accounting Officer, and based on the review process outlined above, the Trust has identified, and are taking action on, four significant control issues arising in the year which have been identified in detail within the body of the statement of internal control above.

Sandra Taylor
Chief Executive

Annual Accounts

Independent Auditors' Report to the Board of Governors of Barnsley Hospital NHS Foundation Trust

We have audited the financial statements of Barnsley Hospital NHS Foundation Trust for the year ended 31 March 2010 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, The Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Respective responsibilities of directors and auditors

As explained more fully in the Directors' Responsibilities Statement the directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. Our responsibility is to audit the financial statements in accordance with relevant statute, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practises Board's Ethical Standards for Auditors.

This report, including the options, has been prepared for and only for the Board of Governors of Barnsley Hospital NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

Scope of the audit of the financial statements

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual, of the state of the NHS Foundation Trust's affairs as at 31 March 2010 and of its income and expenditure and cash flows for the year ended; and

- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual.

Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts

- the part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual; and

- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if, in our opinion:

- adequate accounting records have not been kept, or returns adequate for our audit have not been received from locations not visited by us; or
- the financial statements are not in agreement with the accounting records and returns; or
- we have not received all the information and explanations we require for our audit; or
- the Statement on Internal Control does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual or is misleading or inconsistent with information of which we are aware from our audit; or
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Certificate

We certify that we have completed the audit of the accounts with the requirements of Chapter 5 of Part 2 to the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

For and on behalf of PricewaterhouseCoopers LLP
Chartered Accountants and Statutory Auditors
Benson House, 33 Wellington Street, Leeds, LS1 4JP

(a) The maintenance and integrity of the Barnsley Hospital NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may occured to the financial statements since they were initially presented on the website.

(b) Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

Foreword to the Accounts for the year ended 31 March 2010

Barnsley Hospital NHS Foundation Trust

Barnsley Hospital NHS Foundation Trust ("Trust") is required to "keep accounts in such form as Monitor (The Independent Regulator for NHS Foundation Trusts) may with the approval of Treasury direct" (Paragraph 24 (1) Schedule 7 of the National Health Service Act 2006 ("the 2006 Act")). The Trust is required to "prepare in respect of each financial year annual accounts in such form as Monitor may with the approval of the Treasury direct" (Paragraph 25 (1) Schedule 7 to the 2006 Act). In preparing their annual accounts, the Trust must comply with any directions given by Monitor, with the approval of the Treasury, as to the methods and principles according to which the accounts are to be prepared and the information to be given in the accounts (Paragraph 25 (2) Schedule 7 to the 2006 Act).

Sandra Taylor
Chief Executive

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2010

	NOTE	2009/10 £000	2008/09 £000
Operating income	3-4	**154,547**	**142,901**
Operating expenses	5	**(152,114)**	**(140,182)**
OPERATING SURPLUS		**2,433**	**2,719**
FINANCE COSTS			
Finance income	9	**77**	**658**
Finance expense - financial liabilities	10	**(274)**	**(298)**
Public Dividend Capital dividends payable		**(1,853)**	**(2,407)**
NET FINANCE COSTS		**(2,050)**	**(2,047)**
Share of Profit of Joint Ventures	1.1	**228**	**0**
SURPLUS/(DEFICIT) FOR THE YEAR		**611**	**672**
Other comprehensive income			
Revaluation gains/(losses) and impairment losses on intangible assets		**0**	**62**
Revaluation losses and impairment losses property, plant and equipment		**(5,250)**	**(1,785)**
Increase in the donated asset reserve due to receipt of donated assets		**24**	**182**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets - reclassification adjustment		**(99)**	**(91)**
Other recognised gains and losses		**12**	**24**
TOTAL COMPREHENSIVE INCOME/(EXPENSE) FOR THE YEAR		**(4,702)**	**(936)**

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2010

	NOTE	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
NON CURRENT ASSETS				
Intangible assets	11	2,526	1,632	1,676
Property, plant and equipment	12	61,364	65,000	66,727
Trade and other receivables	14	708	334	616
TOTAL NON CURRENT ASSETS		64,598	66,966	69,019
CURRENT ASSETS				
Inventories	13	1,624	1,371	1,194
Trade and other receivables	14	5,679	6,634	4,410
Cash and cash equivalents	16	14,045	13,055	12,452
Total current assets		21,348	21,060	18,056
CURRENT LIABILITIES				
Trade and other payables	17	(15,468)	(11,617)	10,982)
Borrowings	18	(107)	(94)	(82)
Provisions	21	(378)	(780)	(1,358)
Other liabilities	19	(1,894)	(3,636)	(2,332)
Total current liabilities		(17,847)	(16,127)	14,754)
TOTAL ASSETS LESS CURRENT LIABILITIES		68,099	71,899	72,321
NON CURRENT LIABILITIES				
Borrowings	18	(1,203)	(1,323)	(1,428)
Provisions	21	(181)	(61)	(78)
Other liabilities	19	(2,258)	(1,356)	(720)
TOTAL NON CURRENT LIABILITIES		(3,642)	(2,740)	(2,226)
TOTAL ASSETS EMPLOYED		64,457	69,159	70,095
FINANCED BY:				
TAXPAYERS' EQUITY				
Public dividend capital		45,855	45,855	45,855
Revaluation reserve	22	10,566	15,835	17,740
Donated asset reserve		702	816	727
Income and expenditure reserve		7,334	6,653	5,773
TOTAL TAXPAYERS' EQUITY		64,457	69,159	70,095

The financial statements on pages 94 to 131 were approved by the Board on 27 May 2010 and signed on its behalf by:

Signed: (Chief Executive)

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	Total
2009/10	**£000**	**£000**	**£000**	**£000**	**£000**
Taxpayers' Equity at 1 April 2009	45,855	15,835	816	6,653	**69,159**
Total Comprehensive Income for the year					
Retained surplus for the year	0	0	0	611	**611**
Revaluation losses and impairment losses property, plant and equipment	0	(5,211)	(39)	0	**(5,250)**
Increase in the donated asset reserve due to receipt of donated assets	0	0	24	0	**24**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets - reclassification adjustment	0	0	(99)	0	**(99)**
Transfers to the income and expenditure reserve in respect of assets disposed of	0	(58)	0	58	**0**
Other recognised gains and losses	0	0	0	12	**12**
Taxpayers' Equity at 31 March 2010	**45,855**	**10,566**	**702**	**7,334**	**64,457**
Prior year: 2008/09					
Taxpayers' Equity at 1 April 2008	45,855	17,740	727	5,773	**70,095**
Total Comprehensive Income for the year					
Retained surplus for the year	0	0	0	672	**672**
Revaluation gains/(losses) and impairment losses on intangible assets	0	62	0	0	**62**
Revaluation losses and impairment losses property, plant and equipment	0	(1,815)	30	0	**(1,785)**
Increase in the donated asset reserve due to receipt of donated assets	0	0	182	0	**182**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets - reclassification adjustment	0	0	(91)	0	**(91)**
Transfers to the income and expenditure reserve in respect of assets disposed of	0	(184)	0	184	**0**
Other transfers between reserves - UK GAAP error	0	32	(32)	0	**0**
Other recognised gains and losses	0	0	0	24	**24**
Taxpayers' Equity at 31 March 2009	**45,855**	**15,835**	**816**	**6,653**	**69,159**

Nature and function of classes of Taxpayers' Equity

Public Dividend Capital - is a type of public sector equity finance, it represents the Government's net investment in the Trust, this is notionally repayable.
Revaluation reserve - reflects the movements in Property, Plant and Equipment due to economic and market fluctuations.
Donated asset reserve - represents the financing associated with the receipt of a donated asset and provides a mechanism for neutralising depreciation for donated assets.
Income and expenditure reserve - is the cumulative surplus position.

STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 MARCH 2010

	NOTE	2009/10 £000	2008/09 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**2,433**	**2,719**
Non-cash income and expenses			
Depreciation and amortisation		**5,598**	**6,251**
Transfer from the donated asset reserve		**(99)**	**(91)**
Amortisation of PFI credit		**(29)**	**(31)**
(Increase)/Decrease in Trade and Other Receivables		**581**	**(1,923)**
(Increase)/Decrease in Inventories		**(253)**	**(177)**
Increase/(Decrease) in Trade and other Payables		**3,851**	**635**
Increase/(Decrease) in Other Liabilities		**(810)**	**1,949**
Increase/(Decrease) in Provisions		**(282)**	**(595)**
Tax (paid)/received		**0**	**0**
Other movements in operating cashflows		**185**	**48**
NET CASH GENERATED FROM/(USED IN) OPERATIONS		**11,175**	**8,785**
Cash flows from investing activities			
Interest received	9	**77**	**658**
Puchase of intangible assets		**(1,205)**	**(253)**
Purchase of Property, Plant and Equipment		**(6,963)**	**(5,833)**
Net cash generated from/(used in) investing activities		**(8,091)**	**(5,428)**
Cash flows from financing activities			
Capital element of Private Finance Initiative Obligations		**(94)**	**(94)**
Interest element of Private Finance Initiative Obligations		**(262)**	**(253)**
PDC Dividend paid		**(1,966)**	**(2,407)**
Cash flows from (used in) other financing activities	1.1	**228**	**0**
Net cash generated from/(used in) financing activities		**(2,094)**	**(2,754)**
Increase/(decrease) in cash and cash equivalents	16	**990**	**603**
Cash and Cash equivalents at 1 April	16	**13,055**	**12,452**
Cash and Cash equivalents at 31 March	16	**14,045**	**13,055**

Barnsley Hospital NHS Foundation Trust - Notes to the Accounts

1 Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2009/10 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Consolidation

NHS Charities accounts are not consolidated due to the HM Treasury dispensation of the application of IAS 27 (Consolidated and Separate Financial Statements) by NHS Foundation Trusts until 2010/11.

Joint operations

Joint operations are activities which are carried on with one or more other parties but which are not performed through a separate entity. The Trust includes within its financial statements its share of the activities, assets and liabilities. The Trust has entered into a contractual Joint Venture agreement with Nestor Primecare Services Ltd to provide certain primary medical services to NHS Barnsley. The statement of cashflows includes the net cashflow of the joint operation in other financing activities.

1.2 Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

1.3 Expenditure on Employee Benefits

Short-term Employee Benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

NHS Pension Scheme Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the NHS foundation trust to identify its share of the underlying scheme liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due. Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.4 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.5 Property, Plant and Equipment

Recognition

Property, Plant and Equipment is capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;

- the cost of the item can be measured reliably; and
- individual items:
  - have a cost of at least £5,000; or
  - form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000 where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
  - form part of the initial setting-up cost of a new building or refurbishment of a ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives e.g. plant and equipment, then these components are treated as separate assets and depreciated over their own useful economic lives.

Measurement

Valuation

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

All land and buildings are revalued using professional valuations at a frequency as necessary to keep valuations up to date. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual.

The valuations are carried out primarily on the basis of modern equivalent asset ('MEA') on specialised operational property and existing use value for non-specialised operational property. The land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at fair value based on alternative use.

Assets in the course of construction are valued at cost and are subsequently valued by professional valuers as part of the valuations for land and buildings or when they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment is indexed using the indicators provided by the Department of Health. Equipment surplus to requirements is valued at net recoverable amount.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is added to the asset's carrying value. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised.

Depreciation

Items of Property, Plant and Equipment are depreciated on a straight line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. Asset lives fall into the following ranges:

- Buildings excluding dwellings 15 to 90 years;
- Dwellings 15 to 90 years;
- Plant & machinery 2 to 15 years;
- Transport Equipment over 7 years;
- Information Technology 2 to 5 years;
- Furniture & Fittings 3 to 10 years; and
- Intangibles - software 5 to 8 years.

Freehold land is considered to have an infinite life and is not depreciated. The District Valuer considers that the remaining lives of the Buildings and Dwellings is 18 years.

Property, Plant and Equipment which has been reclassified as 'Held for Sale' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use or reverts to the Trust, respectively.

Revaluation and impairment

Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

De-recognition

Assets intended for disposal are reclassified as 'Held for Sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable i.e.:
  - management are committed to a plan to sell the asset;
  - an active programme has begun to find a buyer and complete the sale;
  - the asset is being actively marketed at a reasonable price;
  - the sale is expected to be completed within 12 months of the date of classification as 'Held for Sale'; and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be dropped or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged and the assets are not revalued, except where the 'fair value less costs to sell' falls below the carrying amount. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'Held for Sale' and instead is retained as an operational asset and the asset's economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated assets

Donated fixed assets are capitalised at their current value on receipt and this value is credited to the donated asset reserve. Donated fixed assets are valued and depreciated as described above for purchased assets. Gains and losses on revaluations are also taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to the income and expenditure account. Similarly, any impairment on donated assets charged to the income and expenditure account is matched by a transfer from the donated asset reserve. On sale of donated assets, the net book value of the donated asset is transferred from the donated asset reserve to the Income and Expenditure Reserve.

Private Finance Initiative (PFI) transactions

The PFI is the catering department scheme for the provision of a kitchen and dining facility for the production of patient, staff and visitors meals. PFI transactions which meet the IFRIC 12 (Service Concession Arrangements) definition of a service concession, as interpreted in HM Treasury's FReM, are accounted for as 'on-balance sheet' by the Trust. The underlying assets are recognised as Property, Plant and Equipment at their fair value. An equivalent financial liability is recognised in accordance with IAS 17 (Leases). The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The finance cost is calculated using the implicit interest rate for the scheme. The service charge is recognised in operating expenses and the finance cost is charged to Finance Costs in the Statement of Comprehensive Income. PFI assets are held at fair value under IAS 16 (Property Plant and Equipment).

Contingent Rent

An element of the annual unitary payment increase is due to cumulative indexation allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as part of the finance costs in the Statement of Comprehensive Income.

Lifecycle Replacement Costs

For each year of the contract, an element of the unitary payment is allocated to lifecycle replacement based on the capital costs that the operator expects to incur for that year. Subsequently in each year, the actual capital cost incurred by the operator is recognised as an asset and, to the extent that the capital is funded by the unitary payment, an equivalent amount of the unitary payment is treated as a cash payment by the Trust to pay for the asset.

Depreciation

PFI transactions are depreciated on a straight line basis over their remaining useful economic lives in a manner consistent with the consumption of economic or service delivery benefits. The asset lives of these assets held by the Trust is 33 years.

1.6 Intangible assets

Recognition

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

be measured reliably. Where internally generated assets are held for service potential, this involves a direct contribution to the delivery of services to the public.

Internally generated intangible assets

Internally generated goodwill, brands, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Software

Software which is integral to the operation of hardware e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware e.g. application software, is capitalised as an intangible asset.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income. Decreases in asset values and impairments are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses. Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Intangible assets held for sale are measured at the lower of their carrying amount or 'fair value less costs to sell'.

Amortisation

Intangible assets are amortised over their expected useful economic lives in a manner consistent with the consumption of economic or service delivery benefits.

1.7 Government grants

Government grants are grants from Government bodies other than income from primary care trusts or NHS trusts for the provision of services. Grants from the Department of Health, including those for achieving three star status, are accounted for as Government grants as are grants from the Big Lottery Fund. Where the Government grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

Where the grant is used to fund capital expenditure the grant is held as deferred income and released to operating income over the life of the asset in a manner consistent with the depreciation charge for that asset.

1.8 Inventories

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

1.9 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described opposite.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cashflows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Loans and receivables' or 'Available-for-sale financial assets'.

Financial liabilities are classified as 'Other Financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments with are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: current investments, cash and cash equivalents, NHS debtors, accrued income and 'other debtors'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Available-for-sale financial assets

Available-for-sale financial assets are non-derivative financial assets which are either designated in this category or not classified in any of the other categories. They are included in long-term assets unless the Trust intends to dispose of them within 12 months of the Statement of Financial Position.

Available-for-sale financial assets are recognised initially at fair value, including transaction costs, and measured subsequently at fair value, with gains or losses recognised in reserves and reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'. When items classified as 'available-for-sale' are sold or impaired, the accumulated fair value adjustments recognised are transferred from reserves and recognised in 'Finance Costs' in the Statement of Comprehensive Income.

Other financial liabilities

All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the Statement of Financial Position, which are classified as long-term liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to Finance Costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

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

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS Foundation Trust, the asset is recorded as Property, Plant and Equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the

interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires. The annual rental is split between the repayment of the liability and a finance cost. The annual finance cost is calculated by applying the implicit interest rate to the outstanding liability and is charged to Finance Costs in the Statement of Comprehensive Income.

Operating leases

Other leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately. Leased land is treated as an operating lease.

1.11 Provisions

The NHS Foundation Trust provides for legal or constructive obligations that are of uncertain timing or amount at the end of the reporting period on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 21 (page 121).

Non-clinical risk pooling

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

1.12 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed where an inflow of economic benefits is probable.

- Contingent liabilities are not recognised, but are disclosed in note 25 (page 123), unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:
  - possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
  - present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

1.13 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance it represents the Government's net investment in the Trust, this is notionally repayable. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32 (Financial Instruments: Presentation).

A charge, reflecting the cost of capital utilised by the NHS Foundation Trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for (i) donated assets, (ii) net cash balances held with the Government Banking Services and (iii) any PDC dividend balance receivable or payable. In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the 'pre-audit' version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.14 Value Added Tax

Most of the activities of the NHS Foundation Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.15 Corporation Tax

The Trust does not undertake any activities that are subject to taxation. Consequently the Trust has had no corporation tax liability in 2009/10, 2008/09 and 2007/08.

1.16 Cash and cash equivalents

Cash and cash equivalents includes cash in hand, deposits held at call with banks and other short-term highly liquid investments with original maturities of three months or less.

1.17 Critical accounting judgements, estimates and assumptions

The preparation of financial statements in conformity with IFRS requires the use of estimates and assumptions that affect the reported amounts of assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Although these estimates are based on management's reasonable knowledge of the amount, event or actions, actual results ultimately may differ from those estimates. The Trust does not consider that there are any critical accounting judgements, estimates and assumptions that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.18 Accounting standards that have been adopted early

The accounts include the early adoption for 2009/10 of the amendment to IFRS 8 set out in the IASB's 'Improvements to IFRS' issued in April 2009.

1.19 Standard issued but not adopted

The following standards and interpretations have been adopted by the European Union but are not required to be followed until 2010/11. None of them are expected to impact upon the Barnsley Hospital NHS Foundation Trust's financial statements.

Amendment to IAS 24 Related Party Disclosures
IAS 27 (Revised) Consolidated and separate financial statements
Amendment to IAS 32 Financial instruments: Presentation on classification or rights issues
Amendment to IAS 39 Eligible hedged items
IFRS 1 (Revised) First time adoption of IFRS
Amendments to IFRS 1 (revised) on first time adoption of IFRS additional exemptions
IFRS 2 Share based payments - Group cash-settled share based payment transactions
IFRS 3 (Revised) Business combinations
IFRS 9 Financial Instruments
Amendment to IFRIC 14, IAS 19 - Prepayments of a minimum funding requirement
IFRIC 17 Distributions of Non-cash Assets to Owners
IFRIC 18 Transfer of assets from customers
IFRIC 19 Extinguishing financial liabilities with equity instruments
Annual Improvements 2009
Annual Improvements 2010

2. Operating segments

2009/10	Total	Integrated medicine	Surgery & Critical	Womens & Childrens	Diagnostics/ Outpatients	Facilities & Estates	Corporate	Joint Venture
	£000	£000	£000	£000	£000	£000	£000	£000
Operating Income	**154,766**	53,596	47,049	27,551	11,856	1,486	13,000	228
Employee benefits expenses (Pay)	**97,584**	25,795	26,922	15,242	17,611	2,688	9,326	0
Agency costs	**4,796**	1,206	1,966	318	564	38	704	0
Drug costs	**9,370**	5,121	2,162	1,044	1,013	6	24	0
Clinical supplies and services	**12,404**	5,551	6,859	1,768	(2,538)	509	255	0
Misc other operating expenses (excl Dep'n)	**21,899**	561	1,157	310	2,192	9,032	8,647	0
PFI Specific Costs	**356**	0	0	0	0	356	0	0
Total costs	**146,409**	38,234	39,066	18,682	18,842	12,629	18,956	0
EBITDA	**8,357**	15,362	7,983	8,869	(6,986)	(11,143)	(5,956)	228
(Profit)/loss on asset disposals	**72**	0	0	0	72	0	0	0
Fixed Asset Impairments	**0**	0	0	0	0	0	0	0
Depreciation & Amortisation - owned assets	**5,544**	274	720	139	1,175	2,756	480	0
Depreciation & Amortisation - PFI assets	**60**	0	0	0	0	60	0	0
OPERATING SURPLUS	**2,681**	15,088	7,263	8,730	(8,233)	(13,959)	(6,436)	228
Finance Income	**77**	0	0	0	0	0	77	0
Finance expense - financial liabilities	**(262)**	0	0	0	0	(262)	0	0
Total interest payable on Loans and leases	**0**	0	0	0	0	0	0	0
PDC Dividend payable	**(1,853)**	0	0	0	0	0	(1,853)	0
NET FINANCE COSTS	**(2,038)**	0	0	0	0	(262)	(1,776)	0
CONTRIBUTION reported to CODM	**643**	15,088	7,263	8,730	(8,233)	(14,221)	(8,212)	228
Audit adjustments	(32)							
SURPLUS/(DEFICIT) FOR THE YEAR	**611**							

The Trust has identified its segments based upon the reporting presented to the Chief Operating Decision Maker (CODM), which it considers is the Board. The Trust is continuing to develop its internal reporting procedures with regards to this disclosure. The operating segments and the types of services provided from which each segment derives its revenues are as disclosed in note 2.

All activity of the Trust is for healthcare. Major customers of the Trust are NHS Barnsley, NHS Kirklees, NHS Rotherham, NHS Wakefield District, Sheffield Teaching Hospitals NHS Foundation Trust, The Rotherham NHS Foundation Trust, Yorkshire and The Humber Strategic Health Authority.

Material items of income and expenditure and depreciation are as detailed in the tables of note 2.

The basis of accounting for transactions between segments is at cost.

Due to the early adoption for 2009/10 of the amendment to IFRS 8 (Operating Segments) set out in the IASB's 'Improvements to IFRS' issued in April 2009, total assets attributable to each operating segment are not disclosed since this information is not regularly provided to the CODM.

Further income details relating to the operating segments are as disclosed in notes 3 (page 110) and note 4 (page 111).

Operating segments (continued)

Prior year: 2008/09	Total	Integrated medicine	Surgery & Critical	Womens & Childrens	Diagnostics/ Outpatients	Facilities & Estates	Corporate	Joint Venture
	£000	£000	£000	£000	£000	£000	£000	£000
Operating Income	**143,656**	51,694	44,212	24,660	7,168	1,593	14,329	0
Employee benefits expenses (Pay)	**89,551**	23,966	25,365	13,865	15,236	2,540	8,579	0
Agency costs	**4,274**	1,566	1,597	282	323	0	506	0
Drug costs	**7,414**	4,014	1,512	856	1,011	5	16	0
Clinical supplies and services	**10,550**	4,206	5,664	1,051	(886)	387	128	0
Misc other operating expenses (excl Dep'n)	**22,508**	917	1,774	412	3,182	9,987	6,236	0
PFI Specific Costs	**0**	0	0	0	0	0	0	0
Total costs	**134,297**	34,669	35,912	16,466	18,866	12,919	15,465	0
EBITDA	**9,359**	17,025	8,300	8,194	(11,698)	(11,326)	(1,136)	0
(Profit)/loss on asset disposals	**49**	0	0	0	49	0	0	0
Fixed Asset Impairments	**0**	0	0	0	0	0	0	0
Depreciation & Amortisation - owned assets	**6,176**	251	865	129	1,078	3,576	277	0
Depreciation & Amortisation - PFI assets	**0**	0	0	0	0	0	0	0
OPERATING SURPLUS	**3,134**	16,774	7,435	8,065	(12,825)	(14,902)	(1,413)	0
Finance Income	**659**	0	0	0	0	0	659	0
PDC Dividend payable	**(2,407)**	0	0	0	0	0	(2,407)	0
NET FINANCE COSTS	**(1,748)**	0	0	0	0	0	(1,748)	0
CONTRIBUTION reported to CODM	**1,386**	16,774	7,435	8,065	(12,825)	(14,902)	(3,161)	0
Audit/IFRS adjustments	(714)							
SURPLUS/(DEFICIT) FOR THE YEAR	**672**							

3. Income from activities

3.1 Income from activities comprises	2009/10 £000	2008/09 £000
Primary Care Trusts	**131,923**	119,578
Local Authorities	**163**	166
Department of Health*	**66**	4,353
Non NHS:		
- Private Patients	**20**	45
- NHS Injury Scheme**	**986**	1,026
- Other ***	**122**	99
	133,280	125,267

*For 2009/10 Market Forces Factor is via primary income rather than through the Department of Health.
**NHS injury scheme income is subject to a provision for doubtful debts of 7.8% to reflect expected rates of collection.
***Analysis of Income from activities: Non-NHS Other

Other government departments and agencies	**16**	17
Other	**106**	82
	122	99

3.2 Analysis of income from activities	£000	£000
Inpatient - elective	**25,344**	25,159
Inpatient - non elective	**52,262**	47,729
Outpatient income	**26,379**	25,229
Other activity income	**23,207**	21,307
A & E income	**6,068**	5,798
Private Patient Income	**20**	45
Income from activities	**133,280**	125,267

3.3 Private patient income	Reporting Period £000	2008/09 £000	2002/03 Base Year £000
Private patient income	**20**	45	50
Total patient related income	**133,280**	125,267	75,607
Proportion (as a percentage)	0.015%	0.036%	0.1%

Under its terms of authorisation the Trust must ensure that the proportion of patient related income derived from private patients does not exceed the proportion received as an NHS Trust in 2002/03 (the base year). During the year ended 31 March 2010, the Trust received 0.015% of its patient related income from private patients, which is within the limit which Monitor has set at 0.1%.

4. Other Operating Income

	2009/10 £000	2008/09 £000
Research and Development	**1,158**	1,029
Education and Training	**4,858**	4,662
Charitable and other contributions to expenditure	**29**	28
Transfers from donated asset reserve	**99**	91
Amortisation of PFI Main scheme - deferred credit	**30**	29
Non-patient care services to other bodies	**1,208**	474
Other income*	**13,885**	11,321
	21,267	17,634

* Further details of 'other income' are as follows:

Car parking	**620**	575
Estates recharges	**126**	323
Staff recharges	**1,243**	1,248
IT recharges	**1,327**	1,147
Pharmacy sales	**3**	13
Staff accommodation rentals	**179**	169
Clinical tests	**92**	102
Property rentals	**106**	96
Community Paediatrics	**861**	895
Cytotoxic Drugs Recharge	**711**	409
Musculo Skeletal Services	**134**	110
Neurology Recharge	**172**	192
Occupational Health Recharge	**195**	161
Oncololgy Recharge	**206**	181
Pharmacy Issues	**891**	873
Renal Satellite Unit Recharge	**142**	139
Rotherham Ophthalmology	**2,852**	1,957
Voluntary Services Income	**219**	164
Waiting List Initiatives Clinic	**360**	210
Other	**3,446**	2,357
	13,885	11,321

5. Operating Expenses

5.1 Operating expenses comprise:

	2009/10	2008/09
	£000	£000
Services from NHS Foundation Trusts	**990**	934
Services from other NHS Trusts	**1,177**	1,071
Services from other NHS bodies	**675**	1,739
Purchase of healthcare from non NHS bodies	**234**	319
Executive Directors' costs **Note 1**	**705**	627
Non Executive Directors' costs **Note 1**	**92**	88
Staff costs	**101,585**	93,121
Drugs	**9,370**	7,414
Supplies and services - clinical	**12,403**	11,506
Supplies and services - general	**6,218**	5,377
Establishment	**2,403**	2,074
Research and Development	**546**	336
Premises	**5,157**	5,965
Increase/(decrease) in bad debt provision	**14**	13
Depreciation on property, plant and equipment **Note 2**	**5,058**	5,833
Amortisation on intangible assets	**540**	416
Audit services - statutory audit	**58**	57
Other auditor's remuneration - further assurance services **Note 3**	**31**	37
Clinical negligence	**3,000**	1,573
Loss on disposal of other property, plant and equipment	**72**	49
Legal Fees	**255**	222
Consultancy Costs	**244**	661
Losses, ex gratia and special payments	**200**	204
Other	**1,087**	546
	152,114	140,182

Note 1 - As required by the Companies Act 2006, further disclosures of Directors' remuneration and other benefits are detailed in note 27 (page 124) to these accounts.
Note 2 - Depreciation of property plant and equipment are inclusive of PFI operating costs for depreciation.
Note 3 - Other auditor's remuneration - further assurance services

	2009/10	2008/09
	£000	£000
IFRS Review	**4**	18
ALE Review	**4**	16
Quality accounts review	**20**	0
	28	34
Sterile Services Audit - charged by Lloyds Register Quality Assurance Ltd	**3**	3
	31	37

5.2 Operating leases

5.2/1 Operating expenses include: Payments recognised as an expense	2009/10 £000	2008/09 £000
Minimum lease payments	**679**	612

5.2/2 Total future minimum lease payments Total future minimum lease payments	2009/10 £000	2008/09 £000
Expiring within one year	**2**	5
Expiring between two and five years inclusive	**20**	29
Expiring in over five years	**4,638**	4,638
	4,660	4,672

The trust has various operating leases, which include arrangements for a forklift truck, lease cars and other equipment. The most significant operating lease arrangement is for a managed service, Siemens Pathology Analyser which is due to expire in March 2017.

6. Staff costs and numbers

6.1 Staff costs

	Total	Permanently Employed	Other	2008/09
	£000	£000	£000	£000
Salaries and wages	**82,768**	76,355	6,413	75,846
Social Security Costs	**5,460**	5,460		5,192
Employer contributions to NHSPA	**9,264**	9,264		8,436
Agency/Contract Staff	**4,798**		4,798	4,274
	102,290	**91,079**	**11,211**	**93,748**

6.2 Average number of persons employed

	Total	Permanently Employed	Other	2008/09
	Number	Number	Number	Number
Medical and dental	**279**	213	66	268
Administration and estates	**598**	598		558
Healthcare assistants and other support staff	**191**	191		162
Nursing, midwifery and health visiting staff	**942**	942		928
Nursing, midwifery and health visiting learners	**14**	14		7
Scientific, therapeutic and technical staff	**433**	433		358
Bank and agency staff	**115**	60	55	89
Other	**4**	4		8
Total	**2,576**	**2,455**	**121**	**2,378**

Within Medical and Dental staff numbers are 66 whole time equivalent recharges from other NHS Trusts, a cost of £6,413,000 in salaries and wages - other (65 WTE in 2008/09), which do not appear on the Trust's payroll, but which appear in the total staff costs for the Trust.

6.3 Retirements due to ill-health

During the year there were 3 early retirements (9 in 2008/09) from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £329,054 (£311,236 in 2008/09). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

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

There was no late payment of commercial debt interest.

8. Profit/(Loss) on Disposal of Fixed Assets

Profit/loss in the disposal of fixed assets is made up as follows:

	2009/10 £000	2008/09 £000
Loss on disposal of plant and equipment	**(72)**	(49)
	(72)	(49)

9. Finance Income

	2009/10 £000	2008/09 £000
Interest on loans and receivables	**77**	658

10. Finance expenses

	2009/10 £000	2008/09 £000
Finance Costs in PFI obligations		
Main Finance Costs	**213**	246
Contingent Finance Costs	**61**	52
	274	298

11. Intangible Assets

2009/10:	Software Licence £000	Assets under Construction £000	Total £000
Gross cost at 1 April 2009	3,240	0	3,240
Reclassifications	690	(181)	509
Additions purchased	75	826	901
Additions donated	24	0	24
Gross cost at 31 March 2010	**4,029**	**645**	**4,674**
Amortisation at 1 April 2009	1,608	0	1,608
Provided during the year	540	0	540
Amortisation at 31 March 2010	**2,148**	**0**	**2,148**
Net book value			
- Purchased at 1 April 2009	1,632	0	1,632
- Donated at 1 April 2009	0	0	0
- Total at 1 April 2009	**1,632**	**0**	**1,632**
- Purchased at 31 March 2010	1,861	645	2,506
- Donated at 31 March 2010	20	0	20
- Total at 31 March 2010	**1,881**	**645**	**2,526**

Prior year: 2008/09	Software Licences £000	Assets under Construction £000	Total £000
Gross cost at 1 April	**2,876**	**0**	**2,876**
Reclassifications	72	0	72
Revaluation surpluses	137	0	137
Additions purchased	253	0	253
Disposals	(98)	0	(98)
Gross cost at 31 March 2009	**3,240**	**0**	**3,240**
Amortisation at 1 April 2008	1,200	0	1,200
Reclassifications	12	0	12
Revaluation surplus	75	0	75
Provided during the year	416	0	416
Disposals	(95)	0	(95)
Amortisation at 31 March 2009	**1,608**	**0**	**1,608**
Net book value			
- Purchased at 1 April 2008	1,676	0	1,676
- Donated at 1 April 2008	0	0	0
- Total at 1 April 2008	**1,676**	**0**	**1,676**
- Purchased at 31 March 2009	1,632	0	1,632
- Donated at 31 March 2009	0	0	0
- Total at 31 March 2009	**1,632**	**0**	**1,632**

Under IAS 38 (Intangible Assets) a review has been carried out by the Trust on Intangible assets to assess their fair value. This involved reviewing the licences with the software provider, the significant assumption being that fair value should equate to market value. The results are summarised below.

Intangible assets - software licences	Effective dates of Revaluation	
	31st March 2009	1st April 2008
Carrying amount if assets held at cost	1,504	1,610

12. Property, plant and equipment

12.1 Property, plant and equipment at the balance sheet date comprise the following elements:

2009/10:	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	4,715	53,549	897	1,314	20,271	0	2,189	659	83,594
Additions purchased	0	1,726	100	2,717	2,201	0	509	0	7,253
Additions donated	0	0	0	0	0	0	0	0	0
Impairments charged to revaluation reserve - **Note 1**	0	(6,191)	(54)	0	0	0	0	0	(6,245)
Reclassifications	0	2,895	(248)	(3,537)	188	70	123	0	(509)
Revaluation surpluses - **Note 1**	0	1,157	94	0	0	0	0	0	1,251
Disposals	0	0	0	0	(538)	0	0	0	(538)
At 31 March 2010	**4,715**	**53,136**	**789**	**494**	**22,122**	**70**	**2,821**	**659**	**84,806**
Depreciation at 1 April 2009	0	3,479	37	0	13,267	0	1,356	455	18,594
Provided during the year	0	2,666	41	0	2,073	0	240	38	5,058
Reclassifications	0	7	(7)	0	0	0	0	0	0
Revaluation surpluses	0	241	15	0	0	0	0	0	256
Disposals	0	0	0	0	(466)	0	0	0	(466)
Depreciation at 31 March 2010	**0**	**6,393**	**86**	**0**	**14,874**	**0**	**1,596**	**493**	**23,442**
Net book value									
- Purchased at 1 April 2009	4,715	49,502	860	1,314	6,756	0	833	204	64,184
- Donated at 1 April 2009	0	568	0	0	248	0	0	0	816
Revised Total at 1 April 2009	**4,715**	**50,070**	**860**	**1,314**	**7,004**	**0**	**833**	**204**	**65,000**
- Purchased at 31 March 2010	4,715	46,241	703	494	7,068	70	1,225	166	60,682
- Donated at 31 March 2010	0	502	0	0	180	0	0	0	682
Total at 31 March 2010	**4,715**	**46,743**	**703**	**494**	**7,248**	**70**	**1,225**	**166**	**61,364**
Analysis of tangible fixed assets, net book value									
- Protected assets at 31 March 2010	3,398	42,161	0	0	0	0	0	0	45,559
- Unprotected assets at 31 March 2010	1,317	4,582	703	494	7,248	70	1,225	166	15,805
- Total at 31 March 2010	**4,715**	**46,743**	**703**	**494**	**7,248**	**70**	**1,225**	**166**	**61,364**

Note 1 The Trust on 31 March 2009 proceeded with a single block Modern Equivalent Asset revaluation (MEA), therefore the revaluation on 31.3.10 albeit on schemes completed in 2009/10 had to be a full revaluation of the MEA single block. Due to the economic climate the building indices dropped by 15% between 31.3.09 and 31.3.10, hence the impairment of £6,245,000 that was offset against the existing revaluation reserve. The impairments are charged to the revaluation reserve gross and are mitigated by surpluses of £1,251,000.

12.1 Property, plant and equipment at the balance sheet date comprise the following elements:

Prior year: 2008/09	**Land**	**Buildings excluding dwellings**	**Dwellings**	**Assets under construction and payments on account**	**Plant and Machinery**	**Transport Equipment**	**Information Technology**	**Furniture & fittings**	**Total**
	£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
Cost or valuation at 1 April 2008 - **Note 1**	7,215	51,848	844	107	18,204	0	3,498	642	82,358
Additions purchased	0	1,681	53	1,287	2,280	0	513	0	5,814
Additions donated	0	0	0	0	182	0	0	0	182
Impairments charged to revaluation reserve	(2,500)	0	0	0	0	0	0	0	(2,500)
Reclassifications	0	20	0	(80)	0	0	(12)	0	(72)
Revaluation surpluses	0	0	0	0	475	0	0	17	492
Disposals	0	0	0	0	(870)	0	(1,810)	0	(2,680)
At 31 March 2009	**4,715**	**53,549**	**897**	**1,314**	**20,271**	**0**	**2,189**	**659**	**83,594**
Depreciation at 1 April 2008 - **Note 1**	0	434	0	0	11,788	0	3,002	407	15,631
Provided during the year	0	3,533	90	0	2,007	0	165	38	5,833
Impairments	0	(488)	(53)	0	0	0	0	0	(541)
Reclassifications	0	0	0	0	0	0	(12)	0	(12)
Revaluation surpluses	0	0	0	0	308	0	0	10	318
Disposals	0	0	0	0	(836)	0	(1,799)	0	(2,635)
Depreciation at 31 March 2009	**0**	**3,479**	**37**	**0**	**13,267**	**0**	**1,356**	**455**	**18,594**
Net book value									
- Purchased at 1 April 2008	7,215	50,807	844	107	6,296	0	496	235	66,000
- Donated at 1 April 2008	0	607	0	0	120	0	0	0	727
Revised Total at 1 April 2008	**7,215**	**51,414**	**844**	**107**	**6,416**	**0**	**496**	**235**	**66,727**
- Purchased at 31 March 2009	4,715	49,468	860	1,314	6,756	0	833	204	64,150
- Donated at 31 March 2009	0	602	0	0	248	0	0	0	850
Total at 31 March 2009	**4,715**	**50,070**	**860**	**1,314**	**7,004**	**0**	**833**	**204**	**65,000**
Analysis of tangible fixed assets, net book value									
- Protected assets at 31 March 2009	3,398	46,505	0	0	0	0	0	0	49,903
- Unprotected assets at 31 March 2009	1,317	3,565	860	1,314	7,004	0	833	204	15,097
- Total at 31 March 2009	**4,715**	**50,070**	**860**	**1,314**	**7,004**	**0**	**833**	**204**	**65,000**

Note 1 - For further details of transition from UK GAAP to IFRS refer Note 33 (page 129).
Of the totals at 31 March 2010 there were no assets valued at open market value (As at 31st March 2009 and 31st March 2008 - none)
For on-statement of financial position PFI contracts, the NBV of assets held as at 31st March 2010 was £1,725,000 for 31 March 2009 £1,793,000 and 1 April 2008 £1,861,000 - refer notes 20 (page 121) and 33 (page 129) for further details.
There were no other assets held under finance leases and hire purchase contracts as at the reporting period dates of 31 March 2010, 31 March 2009 and 1 April 2008.

13. Inventories

13.1 Inventories comprises

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Raw materials and consumables	**1,624**	1,371	1,194
TOTAL	**1,624**	1,371	1,194

The Trust held consignment stock of £183,000 not recognised in the accounts as at 31 March 2010, (£109,000 as at 31 March 2009 and £173,000 as at 1 April 2008).

13.2 Inventories recognised in expenses

	31 March 2010 £000	31 March 2009 £000
Inventories recognised as an expense in the period	**9,573**	7,615
Write down of inventories (including losses)	**0**	0
Reversal of write-downs that reduced the expense	**0**	0
	9,573	7,615

14. Trade and other receivables

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Non current assets			
Other receivables	**708**	334	616
Current assets			
NHS receivables	**3,675**	4,173	2,738
Prepayments	**254**	880	943
Other receivables	**1,843**	1,660	1,155
Provision for impaired receivables	**(93)**	(79)	(426)
Sub Total	**5,679**	6,634	4,410
TOTAL non current trade and other receivables	**6,387**	6,968	5,026

Ageing of non impaired receivables past their due date

	31 March 2010 £000	31 March 2009 £000
Up to 3 months	**826**	492
In 3 to 6 months	**61**	14
Over six months	**14**	10
	901	516

15. Other Financial Assets

The Trust held no financial assets as at 31 March 2010 (£Nil as at 31 March 2009 and £Nil at 1 April 2008).

16. Cash and cash equivalents

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
At 1 April	**13,055**	12,452	11,388
Net change in year	**990**	603	1,064
At 31 March	**14,045**	13,055	12,452
Made up of:			
Cash at commercial banks and in hand	**50**	420	902
Cash with National Loans Temporary Deposit Facility	**0**	0	7,000
Cash with Office of HM Paymaster General and Government Banking Service.	**13,995**	12,635	4,550
Cash and cash equivalents as in statement of financial position	**14,045**	13,055	12,452

17. Trade and other payables

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current			
NHS payables	**5,166**	2,445	3,342
Trade payables - capital	**833**	888	267
Other payables	**6,522**	4,691	5,391
Accruals	**2,947**	3,593	1,982
	15,468	11,617	10,982

Other payables balance as at 31 March 2010 includes £1,988,000 tax and social security costs (as at 31 March 2009 - £1,859,000 and 1 April 2008 - £1,828,000).

Annual leave provisions have been restated as accruals from provisions (refer note 21, page 121) for £351,000 as at 31 March 2009 and £410,000 at 1 April 2008.

18. Borrowings

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current liabilities			
Obligations under Private Finance Initiative contracts	**107**	94	82
Total Other Current Liabilities	**107**	94	82
Non-current liabilities			
Obligations under Private Finance Initiative contracts	**1,203**	1,323	1,428
Total Other Non-current Liabilities	**1,203**	1,323	1,428

For further details of Private Finance Initiative contracts, refer note 20 (page 121).

19. Other liabilities

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Current liabilities			
Deferred income	**1,483**	3,288	2,068
Deferred PFI credits	**205**	235	264
Deferred Government Grant	**206**	113	0
Total Other Current Liabilities	**1,894**	3,636	2,332
Non-current liabilities			
Deferred income	**320**	697	720
Deferred Government Grant	**1,938**	659	0
Total Other Non-current Liabilities	**2,258**	1,356	720

20. Private Finance Initiative contracts

The Trust had one PFI scheme on-Statement of Financial Position. The arrangement of the PFI is the Catering Department scheme for the provision of a kitchen and dining facility for the production of patient, staff and and visitors meals.

The contract had a start date of 2 January 2002 and an end date of 1 January 2017. The annual uplift of the scheme is based on RPI.

20.1 Total obligations for on-statement of financial position PFI contracts due:

Gross PFI liabilities	**31 March 2010 £000**		**31 March 2009 £000**		**1 April 2008 £000**	
Minimum lease payments	**Future**	**Present value**	**Future**	**Present value**	**Future**	**Present value**
of which liabilities are due:						
- not later than one year;	**331**	**341**	341	341	351	351
- later than one year, not later than five years	**946**	**795**	1,136	954	1,182	1,019
- later than five years.	**1,086**	**836**	1,181	909	1,420	1,137
	2,363		2,658		2,953	
- Less: interest element	**1,702**		1,903		2,104	
	661		755		849	

The PFI asset value is matched by a combination of the liability and the deferred income balance.

There are no rights to acquire the assets at the end of the contract and there are no contract renewal or termination options.

20.2 Charges to expenditure

The total charged in the year in respect of the service element of on-statement of financial position PFI contracts was £1,588,000 (for year ended 31 March 2009 £1,550,000).
Deferred income of £29,000 was credited to income during the year and the balance remaining at the year end is £205,000.

20. Private Finance Initiative contracts (continued)

20.3 The Trust is committed to make the following payments for on SoFP PFI obligations during the next year in which the commitment expires:

Gross PFI liabilities	**31 March 2010 £000**	**31 March 2009 £000**	**1 April 2008 £000**
of which liabilities are due:			
- not later than one year;	**0**	0	0
- later than one year and not later than five years;	**0**	0	0
- later than five years.	**1,842**	1,797	1,753
	1,842	1,797	1,753

The Trust had no PFI schemes off the statement of Financial position.

21. Provisions for liabilities and charges

	31 March 2010 £000	**31 March 2009 £000**	**1 April 2008 £000**
Non current			
Pensions relating to other staff	**181**	61	78
Total	**181**	**61**	**78**

	31 March 2010 £000	**31 March 2009 £000**	**1 April 2008 £000**
Current			
Pensions relating to other staff	**38**	14	16
Other legal claims	**121**	154	228
Other	**219**	612	1,114
Total	**378**	**780**	**1,358**

	Totals	**Pensions relating to other staff**	**Legal claims**	**Other**
	£000	**£000**	**£000**	**£000**
At 1 April 2009	**841**	75	153	613
Arising during the year	**402**	166	96	140
Utilised during the year	**(144)**	(21)	(74)	(49)
Reversed during the year	**(540)**	(2)	(53)	(485)
At 31 March 2010	**559**	**218**	**122**	**219**
Expected timing of cashflows:				
Current: Within one year	**378**	37	122	219
Non current:				
Between one and five years	**181**	181	0	0
After five years	**0**	0	0	0

Annual leave provisions have been restated as accruals (refer note 17, page 119) for £351,000 as at 31 March 2009 and £410,000 at 1 April 2008.

Closing balance of other Other Provisions consist of £125,000 Agenda for Change, £25,000 Legal fees and £69,000 regarding a provision for the replacement of dilapidated matresses.

The above provision does not include £31,975,747 (£20,596,077 in 2008/09) included in the accounts of the NHS Litigation Authority as at 31 March 2010 in respect of clinical negligence liabilities of the Trust.

22. Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve Intangibles	Revaluation Reserve Property Plant and Equipment
2009/10	**£000**	**£000**	**£000**
Revaluation reserve at 1 April 2009	**15,835**	141	15,694
Transfer to Income and Expenditure Reserve re assets disposed of	**(58)**	0	(58)
Other transfers between reserves	**0**	0	0
Revaluation gains/(losses) and impairment losses property, plant and equipment	**(5,211)**	0	(5,211)
Revaluation reserve at 31 March 2010	**10,566**	141	10,425
Prior year: 2008/09			
Revaluation reserve at 1 April 2008	**17,740**	75	17,665
Revaluation gains and impairments on intangible assets	**62**	66	(4)
Transfer to Income and Expenditure Reserve re assets disposed of	**(184)**	0	(184)
Other transfers between reserves	**32**	0	32
Revaluation gains/(losses) and impairment losses property, plant and equipment	**(1,815)**	0	(1,815)
Revaluation reserve at 31 March 2009	**15,835**	141	15,694

23. Capital Commitments

Commitments under capital expenditure contracts at the balance sheet date were £886,000 (2008/09 £3,115,000).

The main capital schemes were as follows:

- £236,000 - Demolition of DPM
- £51,000 - DDA Compliance KL Block Toilets
- £289,000 - AB Block Roof
- £169,000 - Stroke Unit
- £24,000 - Pathology Air Conditioning
- £36,000 - Pathology System Upgrade
- £13,000 - Ordercomms Pathology
- £14,000 - Building Management System
- £54,000 - Balance of outstanding orders on several schemes

24. Events after the reporting period

There have been no events after the reporting period.

25. Contingent Liabilities

	31 March 2010 £000	31 March 2009 £000	1 April 2008 £000
Gross value*	**(365)**	(259)	(614)
Amounts recoverable	**0**	0	14
Net value of contingent liability	**(365)**	(259)	(600)

- The contingent liability is for personal injury claims, transitional points and perceptorship .

26 Prudential Borrowing Limit

The Trust has a Total Prudential Borrowing Limit of £38.4 million in 2009/10 (£38.0 million in 2008/09). As the Trust did not require any loans in 2009/10, only the minimum dividend forecast ratio is applicable. This was also the case in 2008/09.

	Actual ratio	Approved PBL ratio	Actual ratio 2008/09	Approved PBL ratio 2006/07
Minimum Dividend cover ratio	4.35	>1	4.14	>1

Included within the Total Prudential Borrowing Limit, the Trust has a working capital facility of £8 million (£8 million 2008/09), The Trust has not had to draw down any of its working capital facility as at 31 March 2010. This was also the case for 2008/09.

27. Related Party Transactions

Barnsley Hospital NHS Foundation Trust is a public benefit corporation which was established by the granting of authorisation by the Independent Regulator for NHS Foundation Trusts, Monitor.

Barnsley Hospital NHS Foundation Trust is inherently still part of the NHS family and 93% of all income is received from Department of Health bodies. Details of this income can be found at notes 3 (page 110) and note 4 (page 111).

During the period ended 31st March 2010, Barnsley Hospital NHS Foundation Trust did not have any material transactions with members of the Board and senior managers who are considered to be related parties.

During the period ended 31st March 2010, Barnsley Hospital NHS Foundation Trust had a significant number of material transactions with entities for which the Department of Health is regarded as the parent. These entities are listed below.

	Income		Expenditure	
	2009/10	2008/09	2009/10	2008/09
	£000	£000	£000	£000
Sheffield Teaching Hospitals NHS Foundation Trust	**2,159**	1,345	**5,099**	4,439
The Rotherham NHS Foundation Trust	**3,348**	2,184	**213**	248
Yorkshire and The Humber Strategic Health Authority	**4,617**	4,290	**56**	88
NHS Litigation Authority	**0**	0	**2,996**	1,563
NHS Purchasing & Supply Agency	**16**	0	**6,235**	3,984
NHS Barnsley	**126,654**	117,960	**696**	1,774
NHS Kirklees	**3,789**	2,270	**0**	0
NHS Rotherham	**1,890**	1,617	**0**	0
NHS Wakefield District	**3,391**	2,700	**0**	0
Total	**145,864**	**132,366**	**15,295**	**12,096**

	Amounts due from related party			Amounts due to related party		
	31 March 2010	31 March 2009	1 April 2008	31 March 2010	31 March 2009	1 April 2008
	£000	£000	£000	£000	£000	£000
Sheffield Teaching Hospitals NHS Foundation Trust	**329**	587	139	**2,946**	1,907	1,392
The Rotherham NHS Foundation Trust	**1,281**	256	44	**448**	17	308
Yorkshire and The Humber Strategic Health Authority	**11**	98	692	**7**	10	45
NHS Litigation Authority	**0**	0	0	**1**	0	15
NHS Purchasing & Supply Agency	**0**	0	0	**0**	0	150
NHS Barnsley	**770**	2,194	687	**255**	109	798
NHS Kirklees	**335**	521	51	**0**	0	0
NHS Rotherham	**0**	0	0	**6**	8	1
NHS Wakefield District	**129**	99	609	**0**	0	0
Total	**2,855**	**3,755**	**2,222**	**3,663**	**2,051**	**2,709**

27. Related Party Transactions (continued)

In addition, Barnsley Hospital NHS Foundation Trust has had a number of material transactions with other Government Departments and other central and local government bodies. Most of these transactions have been with the Department of Works and Pensions, for the year ended 31st March 2010, the total value was £1,438,000.

Barnsley Hospital NHS Foundation Trust has also received revenue payments from a number of charitable funds, certain of the Trustees for which are also members of the Board.

The audited accounts of the Funds Held on Trust will be made available separately.

The Trust considers its key management personnel to be the same as the Senior Managers who are defined as the Executive and Non- Executive Directors of the Trust.

The total of key management personnel compensation is as follows:

	2009/10 £000	2008/09 £000
Short-term employee benefits: directors remuneration		
- Executive Directors	**617**	553
- Non Executive Directors	**92**	88
	709	641
Post-employment benefits: Employer contribution to a pension scheme in respect of directors		
- Executive Directors	**88**	74
Aggregate of remuneration and other benefits receivable by the directors		
	797	715
	Number	**Number**
Number of Directors having benefits accruing under a defined benefit pension scheme (all Executive Directors)	**6**	6

28. Financial Instruments

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

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

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

Credit Risk
Exposure to risk - The majority of the Trust's income is due from NHS commissioners and is subject to legally binding contracts which limits credit risk. Non-NHS customers form only a small proportion of total income and the majority of those customers are organisations that are unlikely to cease trading in the short term or default on payments (e.g. councils, universities, etc).

Managing risk - To manage credit risk, the Trust has documented debt collection procedures that ensures its finance staff are adequately trained and resourced. Potential payment defaulters are identified at an early stage and appropriate action is taken on a timely basis.

Liquidity risk
The Trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

Interest-Rate Risk
100% of the Trust's financial assets and 100% of its financial liabilities carry nil or fixed rates of interest. Barnsley Hospital NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk. The following two tables show the interest rate profiles of the Trust's financial assets and liabilities:

Financial Assets by category	**Loans and Receivables 31 March 2010**	**Loans and Receivables 31 March 2009**	**Loans and Receivables 1 April 2008**
Receivables	**4,917**	5,152	3,662
Cash and cash equivalents	**14,045**	13,055	12,452
Total	**18,962**	18,207	16,114

Receivables comprise trade and other receivables less prepayments.

Financial liabilities by category	**Other**	**Other**	**Other**
Payables	**13,480**	9,758	9,154
PFI Finance lease obligations	**1,310**	1,417	1,510
Total	**14,790**	11,175	10,664

Payables comprise NHS and capital trade payables, accruals and other payables.

There is a provision for impaired receivables (refer note 14, page 118) which relates to non-financial assets, which relates to the NHS Injury Scheme Recovery.

29. Third Party Assets

The Trust held £1,650 cash and cash equivalents at 31 March 2010 (£Nil as at 31 March 2009) which relates to monies by the Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the held accounts.

30. Intra-Government and Other Balances

	Debtors: amounts falling due within one year	Debtors: amounts falling due after more than one year	Creditors: amounts falling due within one year	Creditors: amounts falling due after more than one year
	£000	£000	£000	£000
Balances with other Central Government Bodies	1,871	0	297	0
Balances with NHS Trusts and Foundation Trusts	1,678	0	4,072	0
Balances with Whole of Government Bodies	519	0	2,773	0
Balances with bodies external to government	1,611	708	6,306	3,284
At 31 March 2010	5,679	708	13,448	3,284

31. Losses and Special Payments

There were 2027 cases (2,186 in 2008/09) of losses and special payments totalling £238,978 (£204,041 in 2008/09) approved during the financial year. This mainly relates to personal injury claims and various other write offs. Also, 1,744 of the write offs are promissory notes (prescription charges) which are small in value (1,973 in 2008/09).

32. Pension Costs

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

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date.

The conclusion from the 2004 valuation was that the Scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004. However, after taking into account the changes in the benefit and contribution structure effective from 1 April 2008, the Scheme actuary reported that employer contributions could continue at the existing rate of 14% of pensionable pay. On advice from the Scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Up to 31 March 2008, the vast majority of employees paid

contributions at the rate of 6% of pensionable pay. From 1 April 2008, employees contributions are on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

b) Accounting valuation

A valuation of the Scheme liability is carried out annually by the Scheme Actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the Scheme Actuary. At this point the assumptions regarding the composition of the Scheme membership are updated to allow the Scheme liability to be valued.

The valuation of the Scheme liability as at 31 March 2008, is based on detailed membership data as at 31 March 2006 (the latest midpoint) updated to 31 March 2008 with summary global member and accounting data.

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

Scheme provisions

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final year's pensionable pay less their retirement lump sum for those who die after retirement, is payable.

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

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement the employee/member can make contributions to enhance an employee's pension benefits. The benefits payable relate directly to the value of the investments made.

Scheme provisions from 1 April 2008

From 1 April 2008 changes were made to NHS Pensions Scheme contribution rates and benefits. Further details of these changes can be found on the NHS Pensions website www.pensions.nhsbsa.nhs.uk

33. Transition to IFRS

These are the Trust's first Accounts prepared under IFRS. The Trust previously reported under UK generally accepted accounting practice (GAAP) in its previous Accounts for the year ended 31 March 2009. Provided below is a reconciliation of Taxpayers' Equity and surplus as reported under UK GAAP for the year ended 31 March 2009 to Taxpayers' Equity and surplus for the financial year under IFRS, as reported in these Accounts. A reconciliation of net assets under UK GAAP to IFRS at the transition date for the Trust at 1 April 2008, is also provided.

The Trust's IFRS accounting policies have been applied for the years ended 31 March 2009 and 31 March 2010, the effect of adopting IAS 20, IAS 38 and IFRIC 12 for these years are as detailed below.

Reconciliation of Tax Payer's Equity as at 31 March 2009 :

		Total	Public Dividend Capital	Revaluation Reserve	Donated asset reserve	Income and expenditure reserve
		£000	£000	£000	£000	£000
Taxpayers' Equity at 31 March 2009 under UK GAAP		**69,662**	**45,855**	**15,675**	**848**	**7,284**
Adjustments for IFRS changes:						
IAS 20 - Government Grant Liability	**Note 1**	(772)	0	0	0	(772)
IFRIC 12 - PFI Catering Contract	**Note 2**	141	0	0	0	141
IAS 38 - Intangible assets	**Note 3**	128	0	128	0	0
Adjustments for UK GAAP errors		0	0	32	(32)	0
Taxpayers' Equity at 1 April 2009 under IFRS		**69,159**	**45,855**	**15,835**	**816**	**6,653**

Reconciliation of surplus for the year ended 31 March 2009

		£000
Surplus/(deficit) for 2008/09 under UK GAAP		**1,414**
Adjustments for		
IFRIC 12 - PFI Catering Contract	**Note 2**	30
IAS 20 - Government Grant Liability	**Note 1**	(772)
Surplus/(deficit) for 2008/09 under IFRS		**672**

The UK GAAP 2008/09 cash flow statement included net movements in liquid resources of £7,000,000. The net movement is included in the bottom line cash and cash equivalents figure in the 2009/10 statement of cash flows under IFRS.

Note 1 - The Trust has identified a balance as relating to future capital expenditure under Government grants. This reflects the additional requirement in accordance with IAS 20 (Accounting for Government Grants and Disclosure of Government Assistance) to incorporate the whole of government accounts.
Note 2 - Under IFRIC 12 - the Trust has identified an arrangement being a PFI Scheme on-Statement of Financial Position. The arrangement if the PFI is the Catering Department Scheme - refer to Note 22 for further details.
Note 3 - This is the accounting entry to restate the Intangible assets to be held at fair value under IAS 38.

33. Transition to IFRS (continued)

Reconciliation of Tax Payer's Equity as at 1 April 2008 :

		Total	Public Dividend Capital	Revaluation Reserve	Donated asset reserve	Income and expenditure reserve
		£000	£000	£000	£000	£000
Taxpayers' Equity at 1 April 2008 under UK GAAP		**69,942**	**45,855**	**17,674**	**727**	**5,686**
Adjustments for IFRS changes:						
IFRIC 12 - PFI Catering Contract	**Note 2**	**87**	0	0	0	87
IAS 38 - Intangible assets	**Note 3**	**66**	0	66	0	0
Taxpayers' Equity at 1 April 2008 under IFRS		**70,095**	**45,855**	**17,740**	**727**	**5,773**

Further notes on transition to IFRS:
In accordance with IAS there have been various reclassifications - the most significant of these are as follows:

For the Year ended 31 March 2009:

In the Statement of Comprehensive Income:
- £18,377,000 Other operating income reallocated to Income from Activities.
- £49,000 Profit and Loss on disposal of fixed assets reallocated to Operating expenses.

In the Statement of Financial Position
- £334,000 Current asset debtors reallocated to Non- Current Assets Trade and Other Receivables.
- £3,288,000 Creditors falling due within 1 year reallocated to Current Liabilities - Other Liabilities.
- £697,000 Creditors falling due after more than one year reallocated to Non Current Liabilities - Other Liabilities.

IFRS adjustments to the Income and Expenditure Reserve comprised of the identified balance relating to future capital expenditure in relation to Government Grants in accordance with IAS 20 and the arrangement to account for the PFI scheme on the Statement of Financial Position under IFRIC 12.

33. Transition to IFRS (continued)

Under IFRIC 12 - the Trust has identified an arrangement being a PFI Scheme on-Statement of Financial Position.

The arrangement is the Catering Department Scheme - refer to notes 12 (page 116) and note 20 (page 121) for further details.

Property, plant and equipment reconciliation from UK GAAP to IFRS

Prior year: 2008/09	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
UK GAAP									
Cost or valuation at 1 April 2008	7,215	49,553	844	107	18,204	0	3,498	642	80,063
IFRIC 12 adjustment IFRS - refer Note 12 (page 116)	0	2,295	0	0	0	0	0	0	2,295
Revised Cost or valuation at 1 April 2008	**7,215**	**51,848**	**844**	**107**	**18,204**	**0**	**3,498**	**642**	**82,358**
UK GAAP									
Cost or valuation at 1 April 2008	0	0	0	0	11,788	0	3,002	407	15,197
IFRIC 12 adjustment IFRS - refer Note 12 (page 116)	0	434	0	0	0	0	0	0	434
Revised Depreciation at 1 April 2008	**0**	**434**	**0**	**0**	**11,788**	**0**	**3,002**	**407**	**15,631**

Under UK GAAP, the Trust prepared its cash flow statement in accordance with UK Financial Reporting Standard 1 (Revised 1996) 'Cash flow statements'. Its objective and principles are similar to those set out in IAS 7 (Statement of Cash Flows).

FRS 1 (Revised 1996) defines cash as cash and bank balances, net of bank overdrafts repayable on demand. IAS 7 in addition includes 'cash equivalents' which are defined as short-term highly liquid investments, which are held for the purpose of meeting short-term cash commitments rather than for investment, that are both convertible to known amounts of cash, and so near their maturity that they present an insignificant risk of changes in value. The inclusion of cash equivalents in the definition of reported cash flows had no significant effect on the reported cash flows for the year to 31 March 2009.

The other principal differences between IFRS and UK GAAP are in respect of classification:

UK GAAP Cashflows:
- Operating Activities;
- Returns on investments and servicing of finance;
- Capital Expenditure;
- Dividends paid;
- Management of Liquid Resources;
- Financing.

IFRS Cashflows:
- Operating;
- Investing;
- Financing.

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