Barnsley Hospital NHS
NHS Foundation Trust

Annual Report and Accounts

2010/11

Barnsley Hospital NHS Foundation Trust

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

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

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

The hospital was built in the 1970s, and covers a site of 8.2 hectares. It has 570 beds, and employs 2963 staff (at 31 March 2011). We serve a population of approximately 226,000 across an area which matches the same the geographical boundaries as Barnsley Metropolitan Borough Council and our main commissioner, NHS Barnsley.

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

Chairman & Chief Executive overview

Stephen Wragg Chairman

Against the backdrop of a challenging economic climate and fast paced political changes, we experienced the busiest year ever in our emergency department at Barnsley Hospital. This combination made 2010/11 our most challenging year to date – but was marked by our resilience, flexibility and commitment to providing first class health care.

Paul O'Connor Chief Executive

"Overall performance has continued to improve - a true mark of the professionalism and dedication of the teams throughout the hospital."

It was the first of several years in which the NHS will no longer receive significantly above inflation funding. The running costs of the hospital rise every year and the impact of less funding required us to look closely at how we could provide better services for less money. As a result, our cost improvement programme included a range of plans to make us more efficient and which reduced overall staff numbers.

In partnership with our staff and trade union representatives, we redesigned some services and offered staff more flexibility in their roles. This resulted in greater patient-centred care and treatment, more efficient ways of working and no compulsory redundancies.

We also invested in services and improving patient care. We recognise that consistent high quality care requires evidence based approaches and partnership working, new models of providing care and ensuring our clinicians are at the heart of redesigning services.

Strong leadership is vital to the ongoing success of an organisation, and we supported our clinical leaders to strengthen their strategic involvement. Progress in patient care and services, as well as how we have developed our staff, can be found in more detail on pages 12 to 22.

As a result of all these actions, we ended the year in a stable financial position with a modest surplus and Financial Risk Rating of 3. Next year will be equally as tough, which is why our plans have been developed by and will be driven by our staff. You will see in Dawn Hanwell's finance review on page 27 that our work to improve the hospital's efficiency and value for money remains a priority, alongside achieving the highest possible quality of service.

Our performance

2010/11 was the busiest year on record for our emergency department. In December and January, unprecedented numbers of patients needed urgent and unplanned care. Where we usually see about 200 patients a day, our emergency department was treating more than 300 a day at very busy times. This increased activity was during the extreme winter weather and the knock on effects of 'flu and diarrhoea and vomiting outbreaks among our staff and patients meant our high standards of service were severely tested.

And yet our overall performance has continued to improve - a true mark of the professionalism and dedication of the teams throughout the hospital. If we can improve outcomes for our patients and satisfy the robust monitoring of external agencies during times of such immense challenge, we have shown we are ready for the challenges that lie ahead. Our staff and volunteers showed their dedication, loyalty and commitment beyond any reasonable expectations not just during the busy winter period but also throughout the year.

David Peverelle's performance report on page 9 demonstrates the robust approaches we take to make sure we are providing the

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best healthcare for all, including introducing innovative ways of checking our progress – such as patient stories and regular matrons' reports at Board meetings.

Strengthening our business approach

As a NHS Foundation Trust, we work in accordance with a code of governance set by our regulator, Monitor. Throughout 2010/11, we put new systems and structures in place to help strengthen accountability, objectivity and integrity in the business. This included taking integrated performance reports to the Governing Council sub-committees, surveying members for their views on communications and engagement and developing our Board listening programme. The work of our Governors and progress around governance is highlighted in more detail in the governance section on pages 64 to 88.

Partnerships

We have always worked closely with partner organisations to ensure seamless care and treatment for patients moving between the hospital and the community. It was because of the natural synergy between our teams and those in the community that we put in a bid to run community services, as part of the national directive for primary care trusts to divest provider-run services from their portfolios. Although we were unsuccessful, we have learned lessons from the bidding process, preparing us well for the future. We also remain committed to improving patient care and will be working with the chosen partner, South West Yorkshire Partnership NHS Foundation Trust, to continue to improve services between acute and community care.

We also forged a stronger working relationship with our commissioner, NHS Barnsley, and started to develop greater connection and links with GPs. Strengthening our relationships with the community and our members is also fundamental to our approach and in addition to our ongoing communication programme, our Governors will be running a series of events across the borough to build the connections in the coming year.

Some of the developments in our most highly rated services – such as cancer, stroke, maternity and pathology – are those which are provided in partnership with other hospitals and community services. Such partnerships offer our patients high quality services and we are committed to improving and expanding alliances wherever they bring greater benefits.

Quality

Last year, we made significant progress and improvements on the quality and safety of our services, building on our previous years' successes in relation to infection rates and reduction in incidents. Sharon Linter's quality review on pages 32 to 63 outlines our commitment to providing safe, evidence based and outcomes focused services.

Looking ahead

The scale and pace of change the NHS is now undergoing is unparalleled. The broad principles of the reforms are fully supported by the Trust. We welcome more patient centred care, clinical leadership, NHS treatment outcomes being the best in the world and quality, not process, at the heart of what we do.

2011/12 is a further year of no inflation uplift increase in our budget – and this means an unprecedented challenge for the hospital. Our cost improvement programme last year identified areas where we could make immediate savings and many of those have now been made. As we look for greater efficiencies, we must take a much wider view of how services are provided if we are to achieve our programme for this year.

We are continually improving relationships with our many partners but the consequential effects of some of the efficiencies and reduced funding in other public sector agencies and the voluntary sector means that we must make them stronger. Barnsley Hospital does not work in isolation. We are part of a complex health and social care jigsaw and the impact of structural and funding changes with any one of our partners has a direct effect on the care and treatment we provide.

As we constantly look at how we can improve models of care, we must also consider if and where providing them in partnership could bring greater benefits for our patients. To continue to provide the best healthcare for all, we will need to be more radical in our thinking.

In developing our plans for the next three years, we involved our partners and our staff. We listened to their aspirations and ambitions, took account of the political and economical uncertainties, and the hospital's unique strengths and weaknesses - and shaped our business plan and strategy around them.

Our resulting plans for the immediate future are built on firm foundations and a thorough understanding of the opportunities and threats. As we look further ahead, our plans must continue to be flexible if we are to remain resilient to the uncertainties and changes created by the reforms.

The Board of Directors

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

The management team

The hospital's management team is made up of executive directors from the Board and other directors who support the day to day running of the hospital.

Sandra Taylor held the role of Chief Executive until her departure in June 2010. Paul O'Connor joined the management team as Interim Chief Executive in June 2010 and after open competition to the post in December, he was appointed as substantive Chief Executive. Paul brings leadership and a strong strategic approach to the team, having held chief executive positions in hospitals in London and Birmingham, and more recently the Quality and Innovation Programme for NHS North West.

The management team also benefits from the now separate role of director of quality and standards. Sharon Linter has been instrumental in improving the hospital's performance in these vital areas.

In January 2011, Helen Stevens joined the Trust, bringing strategic communications and marketing expertise to the team.

Going concern statement

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

Stephen Wragg Chairman
Date: 26 May 2011

Paul O'Connor Chief Executive
Date: 26 May 2011

The Board of Directors

Chief Executive - Sandra Taylor (1 April to 13 June 2011), Paul O'Connor from 14 June. (Paul was Interim Chief Executive between 14 June 2010 and 28 February 2011 and substantive from 1 March 2011)
Medical Director - Dr Jugnu Mahajan
Director of Finance and Information - Dawn Hanwell
Chief Nurse - Juliette Greenwood
Chief Operating Officer - David Peverelle

Chairman - Stephen Wragg

Non-executive directors
Anne Arnold
Linda Christon
Francis Patton
Paul Spinks
Sarah Wildon

The management team

Paul O'Connor - Chief Executive
Hilary Brearley - Director of Human Resources and Organisational Development
David Bullimore - Divisional Director for Emergency and Integrated Medicine
Matthew Chobbah - Director of Strategy and Business Development
Juliette Greenwood - Chief Nurse
Dawn Hanwell - Director of Finance and Information
David Hicks - Divisional Director for Women's, Children's and Diagnostics
Elaine Jeffers - Divisional Director for Surgery and Critical Care
Sharon Linter - Director of Quality and Standards
Dr Jugnu Mahajan - Medical Director
David Peverelle - Chief Operating Officer
Helen Stevens - Associate Director of Communications and Marketing

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Performance

Performance overview by David Peverelle

David Peverelle Chief Operating Officer

Last year we cared for 57,929 patients in the hospital, saw 264,343 in clinic appointments and treated 75,097 in our emergency department. We also carried out 481,485 tests – such as investigating blood samples, x-rays, scans and other tests that help our doctors and GPs diagnose patients' conditions.

"We eliminated cases of MRSA and our targets in 2010/11 for reducing Clostridium Difficile (C.Diff) were exceeded."

The number of patients attending the hospital as emergencies not only increased in number but also the severity of illness was more acute than in previous years - placing increased challenge on the hospital. During the year we saw the increase in the number of patients that were treated as day cases instead of an inpatient admission. This showed as a slight reduction against the planned contract for the year with NHS Barnsley for planned inpatient activity but was made up by the increased number of day cases.

During December and January, when the weather brought snow, ice and freezing temperatures, our emergency department treated 1,000 more patients than during the same period the previous year. On some days, the emergency team was seeing and treating up to 100 patients more than they usually would.

The extreme weather, the worst for 100 years, coupled with diarrhoea and vomiting and influenza outbreaks with both our staff and patients, meant we faced an unprecedented period of pressure on the hospital. It is testament to the dedication and commitment of our staff that we were able to continue to provide services around the clock.

We met the national full year A&E target for patients waiting four hours or less. We also met the waiting time targets for 18 week referrals and 31 and 62 day targets urgent referrals for cancer treatment.

Quality

We eliminated cases of MRSA and our targets in 2010/11 for reducing Clostridium Difficile (C.Diff) were exceeded. We worked hard to eliminate mixed sex accommodation but we did declare three breaches in the year.

A range of national commissioning for quality and innovation (CQUiNs) targets were also met. These are additionally agreed local targets with our commissioners and meeting them demonstrated how well we are doing to improving quality. These related to how we involve patients in decisions about their treatment and care, availability of our staff to talk about concerns, privacy when discussing treatment, information about medications.

Despite the unprecedented pressures placed on the hospital the number of complaints reduced slightly. See below for more details of the actions we have taken to as a result of the complaints.

In 2010/11 we introduced extra measures to help in our understanding of day to day activity and performance. These included the introduction of monthly reports from our matrons – outlining key themes and action plans – and patient stories at our Board meetings.

We also had an inspection by the Care Quality Commission (CQC) on 31st March for Dignity and Nutrition for older people and following the formal report from the CQC we will

make any changes necessary in the next financial year.

The Board reviewed the Trust's compliance with the CQC standards against evidence from service leads and frontline staff and was assured the core standards were fully met. It was also assured that there had been no significant lapses in meeting core standards during the year.

Read more about our performance and quality in the section on pages 32 to 63.

Workforce

During the year, the Trust invested in training up to 12 advanced nurse practitioners. These are skilled and experienced nurses who have had additional training to enable them to undertake a much broader role. This gives us an excellent opportunity to extend the career path for some of our most experienced nurses, and provides a more flexible service for our patients.

In recognition of the Trust's ongoing commitment to ensuring equality and diversity in all of our services, and across our workforce, we were awarded Equality and Diversity Partner status by NHS Employers. This endorses our ongoing work programme to ensure that the services we provide are accessible to every member of our community, and confirms that we strive to create a workplace which gives equality of treatment and opportunity to all our employees.

In order to rise to the challenges of the past year, the Trust delivered a significant change programme. This involved considerable changes in ways of working, redesigning roles and re-shaping our workforce. This was achieved without the need for compulsory redundancy, or any significant disruption to our services. Throughout the change we continued to minimise the impact on our frontline services, and have agreed to make a major investment to expand our nursing workforce over the coming year.

Throughout the year, the Trust remained committed to developing its e-learning facilities as a flexible alternative to more traditional training methods. We have extended the range of training available via e-learning, and worked with our provider to improve the programmes already in place. Barnsley is one of the top 10 Trusts in the country for e-learning, with more than 3000 training programmes delivered via this system to date.

Looking forward

The new NHS Operating Framework determines how the hospital is paid for the services it provides as part of its contracts with its commissioners (principally NHS Barnsley). As part of these arrangements the Trust will only receive partial or non payment under a range of circumstances, for example if a patient is re-admitted to hospital soon after discharge. This requirement is challenging and we will ensure that these occasions are avoided but this is also an opportunity to strengthen our work with all of our health care partners, such as GPs and Social Services, to make sure that suitable services are available to help reduce re-admissions.

These arrangements come at a time of significant financial challenge for all public services and the Trust will again be working with health care colleagues to maintain and develop services despite the financial challenge.

David Peverelle
Chief Operating Officer

Performance against our plans

Key performance indicators

National targets

We met all our national targets

- 95% patients to be seen within four hours in the emergency department. We achieved 95.45%
- 90% patients treated within 18 weeks of referral for admitted patients. We achieved 96.73%
- 95% patients treated within 18 weeks of referral for non-admitted patients. We achieved 98.72%
- 94% patients to have a maximum waiting time of 31 days from diagnosis to treatment. We achieved 99.3%
- 85% of all patients to have a maximum waiting time of 62 days from urgent referral to treatment of all cancers. We achieved 91.3%
- 100% patients to be seen within a maximum two week wait standard for rapid access chest pain clinics. We achieved 100%
- 100% patients to have access to a genito-urinary medicine clinic within 48 hours of contacting the service. We achieved 100%
- All patients who have operations cancelled for non-clinical reasons to be offered another binding date within 28 days, or the patient's treatment to be funded at the time and hospital of the patient's choice. Our target was 0% and we achieved 0%
- 0% patients to have delayed transfer of care. We achieved 0.11%, which is within target.

Infection control

- There were no cases of MRSA in the year
- There were 49 cases of C.Difficile. Our target was 65.

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Handling complaints

The Trust received 285 formal complaints during 2010/11. This represents a reduction of 15 from the previous year. 283 were acknowledged within the three working day standard.

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

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

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 2010/11:

- Complaints are discussed within each department and at divisional governance meetings so learning points can be disseminated to all staff as appropriate.
- The named nurse for Safeguarding Adults uses anonymised examples of complaints as part of mandatory Safeguarding Adults training.
- Introduced new complaints process in the Medical Division to provide improved internal tracking and response times.
- 'Check all lines removed' - statement added to the electronic discharge letter to ensure patients do not accidently get discharged with cannulas in place.
- Trust-wide implementation of new inflatable boots for those at risk to prevent pressure sores on heels.
- Community midwives will send a recorded delivery letter to women who were not available when visited for post-natal visits.
- Add choice of place of postnatal care to checklist for bereavement services.
- Increased the number of spot checks on cleanliness.
- Mobility of patient to be reviewed, and assessment to take place where required, before discharge from the Emergency Department.
- Nursing documentation audit has taken place in the Emergency Department with follow up action for staff not complying with standards.
- Training for Emergency Department nursing staff for basic plaster application.
- Skills 'passport pack' has been developed for Health Care Assistants and Auxiliaries. This pack is used as a development tool for staff where issues have been highlighted and demonstrates competency in practical skills including infection control, essence of care and communication skills.
- Number of staff able to carry out 'swallow tests' has increased.
- Pathway for screening coordinator in obstetrics has been reviewed; this will help improve coordination of follow up appointments for patients receiving this service.
- Improved procedure for coordinating ambulance transport on discharge.
- Improvements in process for reporting safeguarding adult concerns in the Emergency Department.
- When unlabelled samples are received in the laboratory from phlebotomy this is immediately highlighted to the relevant staff member and recorded.
- New software has been introduced to improve the layout and content of out-patient and day case letters, information can now be personalised more easily to make it more relevant and accurate for each patient.
- Printing and enveloping out-patient and day case letters has been outsourced to free up administrative staff time, this has also made a saving for the Trust overall.
- The average length of time patients on the Medical Assessment Unit are waiting to be seen by a doctor for an initial review has reduced.

Business Review

How we invested in high quality, safe services

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

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

Stroke services

A Care Quality Commission (CQC) report highlighted stroke aftercare services in Barnsley as among the very best in the country.

The review placed NHS services across Barnsley as the third best in England and top in Yorkshire and the Humber for the care experienced by people who have had a stroke or transient ischaemic attack (TIA) - from the point people prepare to leave hospital, to the long-term care and support they may need to cope with stroke-related disabilities.

The results, shown against 15 indicators or areas, highlight Barnsley as best performing in arrangements for early supported discharge, review and assessment after transfer home, the range of information provided and signposting to other services.

Since 2001 a number of improvements have been achieved largely through the work of a local stroke strategy group – and includes representatives from all local organisations involved in planning for and providing stroke services. It is actively supported by a team of clinicians including doctors, nurses, therapists and psychologists. Stroke survivors, their carers and families are also involved in the development of services through the Barnsley Stroke Club and through events that are hosted to discuss specific topics and issues.

Last year in Barnsley 400 people experienced a stroke and nearly 5,000 people were living with disabilities resulting from a stroke.

Maternity services

Our maternity services go from strength to strength, with increasing numbers of women choosing the Trust for their care and treatment.

Understanding what mums-to-be want was at the centre of one of the developments last year.

The midwives introduced a new service – called HypnoBirthing®. Sometimes known as the Mongan method, the programme teaches self hypnosis, relaxation and breathing techniques. The techniques allow the mother to use her natural instincts and help her to have her baby easily in an atmosphere of calm. Severe discomfort does not need to be part of labour and childbirth.

Hypnobirthing® is intended to help expectant mums have the most positive childbirth possible, and can be used whatever kind of birth they're planning - homebirth, hospital or birthing centre. Research has shown that women who use the techniques have less caesarean sections, less pre term labours and less postnatal depression.

Following a successful pilot programme in 2009 with 28 couples, it was agreed to incorporate HypnoBirthing® into the hospital's services. Seven Barnsley Hospital midwives have now completed the training to become specialist practitioners.

Cancer services

A nationally commissioned survey of cancer patients' experience showed that Barnsley patients rate our services highly. 58% put us in the top 20 quartile and the remaining 42% put us in medium (nothing in bottom) – and 95% of all responses were higher than national average. As with all surveys, there were areas where we can improve, such as outpatient waiting times and we'll be concentrating on these in the coming year.

Complementary therapies

The Well for Wellbeing – a centre offering complementary therapies for cancer patients – also opened at The Core in Barnsley town centre.

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

Development in the high dependency unit

Work to refresh the high dependency unit - wards 31 and 32 – started in the year. Due to be completed in 2011, the scheme will create a larger four bed high dependency unit with state of the art equipment such as more energy efficient lighting systems, new ward furniture including the Design Council bedside cabinet which is part of the 'Design Bugs Out' furniture range, new drug suites using more efficient storage systems and a new nurse call system.

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Specialist nurse for organ donation

The Trust created the new post of specialist organ donation nurse, based in the intensive care unit, in response to the national strategy to increase organ donation rates.

Christian Brailsford, who took up the post, provides advice and support to patients, staff and relatives as well as helping promote the greater donation of organs.

His initial focus has been within the Critical Care Unit and Emergency Department but his aim is to gradually spread awareness of the campaign out into other areas, such as the wards and into the local community.

Quality governance

The Trust has prepared an Annual Governance Statement (AGS) as part of this year's Annual Report. The document provides more commentary on quality governance than the Statement on Internal Control document provided in the Trust's previous Annual Reports. The AGS outlines how the Trust delivers its systems of internal control, details the Trust's appetite and capacity to handle risk, specifically in relation to Monitor's Quality Governance Framework. This document also summarises how quality governance is organisationally managed, including the development and compilation processes of the Trust's Quality Report. Additionally it takes consideration of the annual and quarterly board statements required by Monitor's Compliance Framework (see also page 87 for the governance and finance risk ratings). The AGS can be found on page 92 of the Annual Report, and the Quality Report on page 32.

Our local health and social community

The community of Barnsley faces many health challenges. These are largely due to socioeconomic deprivation, a growing ageing population and increasing morbidity as a result of lifestyle choices. While local life expectancy is improving, the gap between Barnsley and the rest of the country is widening. There is also an above average number of people receiving disability and other benefits – impacting on the already heavy reliance of people on Barnsley's health and social care provision.

The major health issues facing Barnsley people include:

- Life expectancy is improving but the gap between Barnsley and the rest of the country is not narrowing
- Cancer is the major cause of premature death
- Major causes of chronic ill health include
  - Stroke
  - High blood pressure
  - Diabetes
  - Dementia
  - Chronic obstructive airway diseases
- The population of Barnsley is growing and is expected to increase by 16% by 2031 and the percentage of older people will grow by 67% in the same period
- The high number of people receiving disability and other benefits means that a large number of the people will continue to rely on the health and social care provision in the area
- The percentage of minority ethnic groups is also growing and has more than doubled from 1.9% in 2001 to 4.1% in 2007.

How we improved our patient care

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

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

Red jug and beaker scheme

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

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

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

Real time information

We introduced the 'real time' collection of patient experiences during the year, helping our matrons to collect and theme the feedback from across the wards.

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

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

The result is monthly reports and action plans which the matrons use to understand where they need to place greater focus in the coming weeks. This development was part of our actions to improve responsiveness to the personal needs of patients.

The touch screen system enables them to rate hospital services with, for example, a smiley face indicating a short wait in the emergency department; a glum face suggests too long a wait.

Productive wards and theatres

We invested in a productive ward lead nurse who has helped to rapidly progress our plans to release more time to care for nurses. The productive ward programme – led by Tracey Bostwick – aims to improve the experience of patients, their safety and reliability of care, the wellbeing of staff and the efficiency of care.

Last year we introduced 'patient status at a glance' – visual cues which show patient information at a glance and help nurses and other clinical staff with handovers and patient safety.

The productive ward programme has been so successful that we are now introducing the scheme into operating theatres.

Paging system

Nursing staff came up with the idea of offering pagers to women attending the hospital's antenatal clinics. It allows mums-to-be to go to the restaurant or café, visit the hospital shops or take a stroll in the hospital grounds without worrying about missing their appointment.

The system alerts women that their appointment is next in line, giving them plenty of time to return to the antenatal unit. If the trial is successful, the pager system could be rolled out across the hospital for other types of appointments.

The pager system was introduced using the hospital's charitable funds.

Patient safety week

In November, we celebrated national Patient Safety Week. Posters, quizzes and other activities were used to heighten awareness of issues such as falls risk awareness, making sure bed heights are correct for patients, and the use of "slipper socks" to help prevent slips and falls.

Single sex accommodation

We declared compliance with the Government's requirement to eliminate mixed-sex accommodation in March, demonstrating that we have the necessary facilities, resources and culture to ensure that patients admitted to the hospital will only share the room where they sleep with members of the same sex, and same-sex toilets and bathrooms will be close to their bed area.

Sharing with members of the opposite sex will only happen when clinically necessary (for example where patients need specialist equipment such as in Intensive Care Unit, Coronary Care Unit and Surgical High Dependency Unit), or when patients actively choose to share.

Dignity for older people

The hospital's research and development team is taking part in a European project to research new ways to support elderly people with continence problems.

The research aims to improve the quality of life for older people and the results will be shared with families, charities, local government, health services and public service providers.

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The work is one of several projects in Barnsley to improve services for older people which also includes a comprehensive service for patients with strokes, unexplained falls and syncope, a day hospital, inpatient rehabilitation, rapid response care and hospital at home services. You can read more about our research and development work on page 24.

Improvements for Ward 19

Ward 19 at Barnsley Hospital underwent a facelift after a successful bid to the hospital's charitable funds and specific fundraising events.

Ward 19 is a medical ward, specialising in care of the elderly. The bid for almost £1,000 was made to help improve the ward environment and to create a welcoming and calming space.

The money was used to buy accessories for the ward to colour code different areas. Brightly-coloured visitor chairs were bought for patient areas that are in the same colour as other accessories in the same room to help vulnerable patients find their way around. New signs were also put up for bathroom and toilet facilities, using pictures rather than words to help with visual recognition.

Safeguarding patients

As part of our measures to ensure the safeguarding of patients, we carried out Criminal Record Bureau renewal checks on frontline staff. These were first introduced in the Trust in 2007 and in line with our three yearly checks, repeated in 2010.

We also audited staff awareness and understanding of safeguarding, privacy and dignity and found that in the last year there was increased confidence in the staff on how to deal with issues in this area.

A new training strategy was launched for safeguarding children and the child protection policy was reviewed and updated.

You can read about our progress and performance on quality in our services and how we measure it in the Quality Report on pages 32 to 63.

Improving care for vulnerable groups

Safeguarding adults

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

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

Learning disabilities

The Trust continues to make progress in the work on improving the experience of patients within the Trust who have learning disabilities. Progress continues in the development of a 'Hospital Passport' that patients carry so that their care, treatment and preferences are known. Work has also been taking place to produce information leaflets in easy read format.

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

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

Dementia strategy

Implementation of the dementia strategy is taking place and a Trust group is overseeing actions to help patients with dementia to receive high quality care and treatment that is delivered in environments that are proved to help keep patients calm and eliminate anxiety related to a change of circumstance.

Ethnicity needs

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

Improvements in carer and patient information

Patient appointment letters have been reviewed and redesigned to give clear information regarding hospital attendance. These letters also include a message in several different languages signposting where the information can be obtained in other languages.

A large number of patient information leaflets have been produced by clinical staff to help patients make informed decisions about their care and treatment and others have been updated to reflect any changes and improvements. These leaflets include a wide variety of advice from physiotherapy, nutrition, scans and tests to treatment options.

NHS Constitution

Last year, we reviewed our legal obligations to the NHS Constitution and completed a state of readiness document in relation to the rights and pledges of patients, public and staff. The review showed that we were compliant and updates on how we are doing are now regularly taken to the Board.

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How we developed our people

Barnsley Hospital's biggest and best asset is its staff, who are often referred to as "friendly and caring" by our patients. With almost 3000 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

At 31 March, the Trust employed 2963 employees. A breakdown of the Trust's workforce is shown below.

Employee profile table (age profile by staff group)		
Age	Staff	%
16 - 20	109	4%
21-30	659	22%
31-40	715	24%
41-50	855	29%
51-60	520	18%
61+	105	4%
Ethnic Origin		
British White	2735	92%
White - Other	44	1%
Mixed	15	1%
Asian and Asian British	89	3%
Black and Black British	40	1%
Other Ethnic	18	1%
Not Stated	22	1%
Gender		
Male	548	18%
Female	2415	82%
Disability		
Yes	101	3%
No	2616	88%
Not Stated/ unknown	246	8%

Gender profile table		
Staff Group	Female	Male
Additional Professional Scientific and Technical	70	32
Additional Clinical Services	622	60
Administrative and Clerical	542	113
Allied Health Professionals	107	19
Estates and Ancillary	33	58
Healthcare Scientists	60	36
Medical and Dental	88	149
Nursing and Midwifery Registered	883	77
Students	10	4
	2,415	548

E-learning

The hospital offered more eLearning as an alternative to stand-up delivery classes last year. E-learning can be a more efficient way to deliver mandatory training as it helps to reduce the number of hours away from the work place.

The list of courses available online is continually expanding, with more than 2000 courses completed at the hospital and we are consistently in top ten trusts nationally for number of training completions via e-learning.

HEART awards

In March the hospital held its HEART Awards, which recognise the skills, professionalism and hard work of Barnsley Hospital staff. More than 60 nominations were received and winners included staff and teams from stroke, midwifery and nursing, intensive care, pathology, security, estates and governance. This was the second year of the HEART Awards, which are sponsored by local businesses.

Staff survey

The National Staff Survey was undertaken by Quality Health on behalf of the Trust between September 2010 and January 2011.

The official sample size for Barnsley Hospital NHS Foundation Trust was 776 in total, with 428 completed questionnaires returned from this sample. The Trust's response rate to the survey was therefore 55%, which is in line with the NHS national average.

Overall Trust scores, compared with the previous year, have been maintained. Positive findings indicate that employees believe that their manager helps them to find a good work/life balance and that they have received Equality & Diversity and Infection Control training within the last 12 months. These are all results which exceed the national average for acute trusts.

Improvements in the 2010 results indicate that staff believe that their manager gives them clear feedback on their work and that they consider that they have clear, planned, goals & objectives. These are scores which compare favourably with the Trust's 2009 Annual Staff Survey.

Staff survey 2009/2010: key comparisons					
	2010	**2010**	**2009**	**2009**	**Trust improvement/ deterioration**
Response Rate	Trust	Nat Av	Trust	Nat Av	
	55%	54%	52%	55%	
Top four ranking scores (2010)					
Staff experiencing discrimination at work in the last 12 months	7%	13%	7%	7%	**No change**
Staff using flexible working options	71%	63%	69%	70%	**2% improvement**
Staff saying hand washing materials are always available	75%	67%	72%	69%	**3% improvement**
Effective team working	3.77/5	3.69/5	n/a*	n/a*	**n/a***
Bottom four ranking scores (2010)					
Staff appraised in the last 12 months	59%	78%	56%	70%	**3% improvement**
Staff having well structured appraisals in last 12 months	24%	33%	24%	30%	**No change**
Staff receiving job-relevant training, learning or development in last 12 months	73%	78%	74%	78%	**1% deterioration**
Staff motivation at work	3.73/5	3.83/5	3.68/5	3.84/5	**.5/5 improvement**

*Due to changes to the format of the survey questions this year, comparisons with the 2009 score are not possible

Future priorities and targets

The key priority areas arising from the 2010 staff survey are to:

- Improve staff perception of the priority of patients to the Trust
- Improve senior management engagement with staff
- Increase staff appraisal delivery rates

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

Key priority areas and actions for improvement			
Key priority area	**Action/target**	**Monitoring**	**Measure of success**
Improve staff perception of the priority of patients to the Trust	To change employee perception by increasing the focus of patients in business processes and Trust management 1. Establish staff focus group to address issue & to propose practical solutions 2. Establish dedicated agenda item in PPI Meetings in 2011/12	Bi-monthly staff focus group Bi-annual report to the Board Monthly PPI Meetings	Achievement of target Business processes enhanced Improvements noted & measured via Patient Public Involvement (PPI) Meetings Measurable improvement in 2011 Staff Survey results Acknowledgement of improvement in 2011 Investors in People (IIP) Review

Key priority area	Action/target	Monitoring	Measure of success
Improve senior management engagement with staff	To increase senior management engagement with staff by enhancing current communication methods 1. Establish staff focus group to address issue & to propose practical solutions 2. Establish a programme of Executive Team actions to improve contact and visibility across the Trust business plan 3. To deliver road show events to present to staff the Trust 2011 business plan 4. To deliver the Service Leadership Model Project to include a staff engagement work stream	Bi-monthly staff focus group Bi-annual report to the Board	Achievement of target Improved communication channels between staff and senior managers Increased staff motivation & enhanced staff engagement Measurable improvement in 2011 Staff Survey results Acknowledgement of improvement in 2011 IIP Review Successful delivery of Service Leadership Model Project Trust 2011 business plan review

Key priority area	Action/target	Monitoring	Measure of success
Increase staff appraisal delivery rates	To increase staff appraisal delivery rates whilst maintaining quality outcomes 1. Establish staff focus group to address issue & to propose practical solutions 2. Continue to increase KSF Appraisal delivery rates in line with business plan targets 3. Implementation of Simplified KSF process 4. Continue delivery of Trust Appraisal Action Plan as approved at the August 2010 Trust Board	Bi-monthly staff focus group Bi-annual report to the Board KSF appraisal quality audit Sharepoint appraisal target status monthly data Periodic KSF Steering Group Meetings	Achievement of target Target of 80% compliance for Knowledge and Skills Framework (KSF) appraisal delivery Consistency in quality in appraisal/revalidation outcomes KSF appraisal quality audit results Measurable improvement in 2011 Staff Survey results Acknowledgement of improvement in 2011 IIP Review

Consulting and communicating with our staff

Throughout the year we used all our regular channels of communication with staff – including the intranet, email, newsletters, weekly bulletins, Team Brief cascade, development sessions and appraisals, staff roadshows and open Chief Executive meetings – to keep our staff informed about issues relevant to them. We also encouraged staff to use these channels, as well as routine meetings with their managers, to raise issues and put forward ideas.

These methods of communication are also used to ensure staff are made aware of the financial and economic factors affecting the Trust and at service level, encouraged to be involved in the Trust's performance – in particular via Team Brief and other routine staff meetings. In the coming year, the introduction of a service leadership model will enhance this involvement.

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

Management of organisational change

As the result of organisational change, the Trust identified the reduction of up to 156 posts in June 2010. As a result, we carried out a 90 day consultation with staff. No compulsory redundancies were made.

In partnership with trade union representatives, we refined a number of policies and procedures to support the management of organisational change, including pro-active vacancy management and redeployment process, staff communication and consultation protocol.

We are also working towards putting a service leadership model in place across the Trust in the coming year.

Family friendly policies

We revised and introduced controls to monitor usage of several of our family friendly policies – that is, policies to support staffs' work life balance. These included emergency dependant leave, bereavement leave and carer leave.

We also introduced exit questionnaires to gather information from leavers to help inform recruitment and retention strategies.

Electronic staff records

The Trust was a pilot for the integration of Electronic Staff Records ESR (the HR and payroll system) and Registration Authority RA (the smartcard system) last year. This has enabled processes to be integrated to reduce duplication of effort for HR and staff joining the Trust.

Some of the features mean that staff details do not have to be entered into both systems manually, as the ESR sends the data to RA automatically. The integration also removes the need for paper forms, as it is all electronic. This speeds up the process and is kind to the environment and storage space.

Health and wellbeing

There was an increase in the number of referrals to the service for stress last year. The Health and Wellbeing Team continues to support these staff and those experiencing emotional difficulties, mental health problems or mental illness with one to one sessions, cognitive interventions, assessment and crisis interventions.

There are also courses and workshops available for staff which include stress management techniques as part of the sessions.

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Sickness absence data

The table below shows the sickness absence rates for 2010/11. Overall performance of 4.46% during the year was marginally better than the previous year (2009/10 was 4.65%).

	Apr-10	May-10	Jun-10	Jul-10	Aug-10	Sep-10	Oct-10	Nov-10	Dec-10	Jan-11	Feb-11	Mar-11	Cumulative % Abs Rate (FTE)
	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	% Abs Rate	
Barnsley Hospital	4.40%	3.87%	3.87%	4.04%	4.20%	4.46%	4.92%	4.71%	5.09%	4.98%	4.54%	4.49%	4.46%
Corporate Functions & Operational Support	3.20%	2.01%	2.00%	2.93%	3.37%	3.32%	3.26%	2.87%	3.58%	2.88%	2.84%	2.67%	2.91%
Diagnostics, Clinical Support & Outpatients Division	4.07%	3.74%	3.15%	3.08%	2.97%	3.55%	4.73%	4.18%	4.51%	5.36%	4.92%	5.11%	4.11%
Integrated Medicine and A&E Division	4.24%	3.80%	4.77%	5.24%	6.15%	6.18%	5.70%	6.25%	5.32%	5.40%	4.75%	5.05%	5.24%
Surgery and Critical Care Division	4.41%	4.19%	4.34%	4.75%	4.87%	4.43%	5.09%	5.17%	6.41%	5.37%	4.93%	4.63%	4.87%
Women's & Children's Services & GU Medicine Division	6.45%	5.66%	4.65%	3.44%	2.44%	4.25%	5.44%	4.14%	5.03%	5.28%	4.77%	4.30%	4.65%

Learning and development corporate curriculum review

We reviewed our corporate curriculum to ensure our statutory and mandatory programmes met the changes in legislation. We focused particularly on how the training is delivered and adopted a tailored approach, offering for example training during quiet periods (such as between Christmas and New Year) so that staff could complete training when they could be released from duties.

Management of information to enable monitoring and increasing compliance with key performance indicators

We worked with the human resources projects team to change monthly reporting of statutory and mandatory training and appraisal compliance. We also set up a shared internet based site to enable managers to access reports directly and re-designed reports to enable managers to raise compliance

Appraisals

The hospital raised the overall appraisal compliance from 29% to 58% during the year. We put in place a series of changes to support staff appraisal and reporting, including the re-design of training packages and the use of shared internet based site to enable electronic recording of appraisal.

Medical education service

We established a dedicated medical education service to enable more support for undergraduate and postgraduate medical education. We also reviewed the library service to ensure it was meeting the learning and development needs of Trust staff.

We worked with consultant medical staff to set up procedural training courses for juniors, including CPV line insertion and chest drain insertion. We also established a surgical skills lab in theatres to improve junior doctors' surgical skills.

Management masterclasses

We continued to deliver the management masterclass series of workshops to equip managers with skills and knowledge required to be effective. We also worked in conjuction with Sheffield Children's Hospital to deliver two Leading and Empowered Organisation (LEO) programmes for Trust staff.

Clinical skills training

We developed an e-learning package for venepuncture which has been supported on a regional basis and will be adopted by other Trusts. We also set up an infusions training course at the request of clinical nursing staff.

Equality and diversity

We are committed to providing equal access to all our services and ensuring that they meet the needs of everyone. We have a duty to eliminate discrimination and to promote equality and our work in this area is extensive.

In particular, we have a Single Equality Scheme, progress on which is reported through our governance structures. The scheme helps us to ensure we are:

- actively promoting equality of opportunity.
- eliminating unlawful discrimination.
- fostering good relations between others.
- demonstrating a consistent process which shows consultation has taken place with diverse groups.
- monitoring and reviewing equality schemes, and publishing a report annually.

We have continued to embed new initiatives and improve partnership engagement in a number of ways. Just a few of the areas where we have made progress in the last year include:

- Increasing access to our public website with the introduction of Disabled Go – this means all areas of the website are assessed for disabled access with information then uploaded onto our site
- A number of diversity awareness raising events in the out-patient Department over the last twelve months have been promoted
- Widening the membership on our Equality and Diversity Steering Group - with community groups to help support and provide workforce guidance and best practice.
- Embedding our equality toolkit throughout the organisation, to enable equality assurance of all its policies and processes classes
- Joining a range of local equality groups, i.e. Barnsley Black and Ethnic Minority Initiative ladies strategic group, Barnsley Council's multi agency group (MAP), Local Lesbian, Gay, bi-sexual and Transgender group, Disability Forum
- Through staff briefings, staff equality training we continued to raise awareness raising of the Equality Act 2010 and its impact
- We invested in and supported two day staff deaf awareness training sessions, led by a deaf consultant for clinical and front line staff
- Designing and delivering Master Class Specific training
- Running ten Equality Impact Assessment workshops

Equality and Diversity training has been delivered to 31% of the Trust's workforce this year - an improvement on last year (21%).

There have been a number of new national equality legislation changes in the last year which impact on the Trust and which we will consider within our Equality and Diversity Group in the next year.

In line with our statutory duties, we publish annual data on age, ethnicity and disability in relation to staff in post, applicants for jobs, promotion and training as well as the outcomes of employee grievances, disciplines and harassment. This is published to our Board and is available on our website or on request.

We support employees with disabilities and have a Disability Equality Scheme which sets out how we will monitor, performance manage, support and engage with our staff and patients. A specific action plan is build into the scheme, which is available on our intranet and internet.

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

Equality and diversity partner

The hospital was one of only 23 hospitals in Britain to become an NHS Employers Equality and Diversity Partner for 2010-11. Partner status means that the hospital is seen as a leading example in the field of equality, diversity and human rights, whether working with staff, patients or the community.

Equality and diversity partners are expected to offer advice, guidance and demonstrations of good practice in equality and diversity management to the NHS. They share their good work through communication with other NHS employers and partners, support equality and diversity related activities and commit to helping to develop the 'Partners' programme.

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How we made the best use of resources

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

Working in partnership

We recognise that we cannot provide services in isolation. We work together with other organisations to provide services locally and where complex care is needed. We are also part of strategic partnerships working across the public and private sectors.

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

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

Sheffield Teaching Hospitals NHS Foundation Trust

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

Specialised Commissioning Group

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

Local Medical Committee (LMC)

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

A senior consultant from Barnsley Hospital attends the committee and reports back regularly to the Trust's own medical staff committee where issues can be dealt with by the senior medical cohort, medical director and chief executive.

Sheffield University

Barnsley Hospital has a long standing arrangement with the University for the training of medical students and is recognised as an associate teaching hospital. Our research and development programme is headed by a professor from the Department for the Elderly.

Local authority services

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

In 2009/10, the hospital continued to work closely with NHS Barnsley (the local Primary Care Trust) and BMBC to provide an integrated emergency and business continuity service team to ensure effective co-ordination and response across the whole health community in the event of a major incident or emergency.

Our chief executive also attends BMBC's Overview and Scrutiny Committee (OSC), on request, to discuss services, issues and proposed developments in the health community and, along with the Chairman of the Trust, participates in the local strategic partnership, One Barnsley.

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.

E-rostering

We started the rollout of an e-rostering system in April. It is now in use on 22 wards, ten outpatient settings and several other areas, including the Emergency Department.

E-rostering is an electronic method of managing clinical and non-clinical staffing requirements. It helps managers to quickly build rosters and define the required number and skill-mix of employees. It helps to improve productivity and make better use of substantive and temporary workforces.

During the next 12 months, it will be rolled out to a further 25 areas and link to the hospital's payroll, helping to manage all the workforce and reducing administration.

Research and development

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

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.

This year we have been successful in attracting support from the National Institute for Health Research (NIHR) physical environment research programme. This research will support development of the Trust's estates strategy by investigating the design of inpatient care environments for frail older people and people with dementia.

Our partnership with the NIHR Collaboration for Leadership in Applied Health and Research (CLAHRC) for South Yorkshire continues to bring benefits for service improvement and care pathways across South Yorkshire. For example, this year in Barnsley, CLAHRC researchers have been working with members of the Stroke team to facilitate the development of inter-professional working.

The Trust continues to play a part in national research networks - stroke, cancer, diabetes - where our collaboration helps to ensure that Barnsley NHS patients have the opportunity to participate in and benefit from a wide range of research.

Volunteers

Over the last year our volunteer numbers have grown and we have been able to expand on the already existing services we offer as well as starting three new areas.

We have just started a service helping the Audiology department. They are to hold monthly outreach clinics, where patients can go to change their hearing aid batteries or get their ear moulds repaired or refitted and volunteers are being given training to be able to assist the audiologist in these procedures. This service means that patients will not have to travel to the hospital as much.

There is also a new service for cancer patients. Volunteers are helping the beauty therapist and the alternative therapist, who offer treatments to patients who have cancer by escorting them to and from the treatment room, making refreshments and checking equipment supplies as part of their role. These treatments are offered at The Well, in The Core building in Barnsley.

The third new area this last year is within the X-Ray department. Again the role of the volunteer is in escorting, making refreshments and just being the patient's friend if that is what is required.

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Paperless ordering

Electronic requesting for some tests in the hospital is now in place across the Trust.

Staff can now electronically request pathology tests – replacing the old manual request form process for chemistry, haematology and microbiology tests. It means test ordering, scheduling and results reporting is now done through one system. As there is no paperwork it makes more efficient use of clinicians' time together and a reduction in time spent on clerical duties.

The system is also used for clinical correspondence with discharge summaries being sent electronically to GPs. It has been successfully put in place across all areas of the hospital, including in-patient and out-patient services and the Emergency Department.

The hospital is the first in the country to deploy 'order communications' together with clinical correspondence in a secondary care setting.

Site improvements

More than £300,000 was spent on a Minor Injuries Unit in the Emergency Department and a facelift for the back entrance at the hospital.

Due to open in the summer of 2011, the £240,000 Minor Injuries Unit will provide purpose-built facilities for the assessment and treatment of a wide range of urgent conditions, minor injuries and illnesses.

The unit, which is being built as part of a refurbishment, will have purpose built facilities for assessment and treatment of a wide range of urgent (non-emergency) conditions, minor injuries and illnesses and ready access to a comprehensive range of support services within the hospital and community, including x-ray, pharmacy, outpatient clinics, social work and Intermediate Care Teams.

The unit will be staffed by highly experienced nurse practitioners and junior doctors within the Emergency Department, and supported by consultant emergency physicians who will oversee the work of the unit and who will be available for advice if required.

A further £73,000 is being spent on the other side of the hospital where visitors will notice that entrance A3, near the Assessment and Rehabilitation Unit (ARU), is undergoing a facelift.

When finished, a new extended canopy will match the existing ARU canopy and have glass screens to provide extra shelter from wind and rain. Access for vehicles to drive up to and reverse will be available, providing a covered way when visitors and patients are taken in and out of ambulances and vehicles. There will also be extra external entrance mats to help prevent excess water and mud being brought into the hospital corridors.

One of the Trust's buildings, on the corner of the site at Gawber Road and Pogmoor Road, was demolished during the year. The building had previously been used by the primary care trust but the services were moved. It required significant investment to keep it safe and bring it in line with modern standards. As the ward space was not needed, the Trust felt demolition was the best value for money option.

New car park

Visitors to the hospital are now benefitting from a new 200 space car park. It has eased congestion and eliminated previous parking issues around the hospital.

£1million ventilation system upgrade

A £1million programme to upgrade the whole of the hospital's ward ventilation system has been ongoing throughout the year. The project finished in the summer 2011.

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.

During the year, we installed additional access control systems to the medical wards and the high dependency unit. There were several successful prosecutions in relation to violence against staff. We also created two gated security compounds to improve the security of the hospital's basement and maintenance facilities and installed three extra CCTV cameras.

Sustainability

This year the Trust has continued to build on its drive to become more carbon neutral and has been investing in initiatives that have seen energy consumption reduce, this process will roll forward year on year.

The Trust has an approved Sustainable Development Management Plan and this has been supported with a comprehensive action plan; this will be monitored by the Sustainability Committee and reported bi-annually to the Board of Directors on progress against set targets.

The Trust has registered with the Carbon Reduction Commitment Energy Efficiency Scheme (CRC) as a participant and is working towards delivery and submission of its annual report and footprint submission required by 29 July 2011.

The Trust is also working hard to reduce its impact on the environment. Initiatives such as paperless ordering and e-rostering – detailed earlier in the report – are examples of how we are achieving this.

We have also committed to being a participant in the Good Corporate Citizenship where we will be able to share experiences within our community and assess our success against other similar organisations. At present the Trust is ahead of the targets set within the guidelines of the assessment criteria and will continue with further improvements.

Projects that have been completed in 2010/11 and include energy efficiency benefits are:

1. New roof coverings to the outpatients roof area to the latest building regulation standards
2. New circulation corridor lighting, this has reduced energy levels per light by 52% and in some areas as high as 62%.
3. A new lift fitted in the area feeding Dermatology and Pre-operative Assessment
4. A refurbished energy efficient ventilation system feeding medical and surgical block, we will be following on this year to replace the systems feeding the Emergency Department and Outpatients Department
5. We continue to replace heating and domestic hot water storage facilities with energy efficient plate heat exchangers

Next year, we will invest in a combined heat and power unit, helping to reduce the Trust's carbon emissions under the Carbon Reduction Commitment scheme by 22%. This will also help to reduce our operating costs.

Other initiatives planned include voltage optimisation (a way of reducing unwanted power usage), and the potential or automatically closing down PCs that are idle for periods of time.

Area		**Non-financial data (applicable metric)**	**Non-financial data (applicable metric)**		**Financial data (£K)**	**Financial data (£K)**
Year		**2009/10**	**2010/11**		**2009/10**	**2010/11**
Waste minimisation & management	Absolute values for total amount of waste produced by the Trust	1,016.80 tonnes	906.91 tonnes	Expenditure on waste disposal	£215,264.46	£215,658.70
Finite resources	Water	99,183m3	98,796m3	Water	£97,065	£91,151
	Electricity	9,638,906 KWhr	9,329,002 KWhr	Electricity	£747,142	£712,796
	Gas	22,742,232 KWhr	22,000,445 KWhr	Gas	£508,374	£525,544
	Other energy consumed (gas oil)	18,000 litres	8,691 litres	Other energy consumed (gas oil)		£6,057

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Financial Review

Dawn Hanwell Director of Finance and Information

"Achieving our financial plan meant we retained our financial risk rating of 3."

Summary of Financial Performance

The Trust achieved a modest net surplus of £0.04million for 2010/11, against a break-even (zero surplus) plan. Achieving our financial plan meant we retained our financial risk rating of 3. This rating is set by Monitor, the regulatory body for Foundation Trusts, and is based on a range of indicators. The table below shows the performance against these key financial metrics. The scale for rating Trusts is 1 to 5 (a score of 1 being high risk and 5, lowest risk). Maintaining a risk rating of 3 demonstrates the Trust has good financial management and governance, but has potential to improve. In this tight economic climate we are committed to staying at or above a financial risk rating of 3. We are forecasting a 3 rating in our 2011/12 plans.

Financial Criteria	Weight	Metric to be scored	Rating categories					Calculated Position	Rating	Weighting
			5	4	3	2	1			
Achievement of Plan	10%	EBITDA achieved (% of plan)	100	85	70	50	<50	104.6%	5	0.50
Underlying Performance	25%	EBITDA Margin (%)	11	9	5	1	<1	5.6%	3	0.75
Financial	20%	Return on Assets excluding dividend (%)	6	5	3	-2	<-2	4.21%	3	0.60
Efficiency	20%	I & E Surplus margin net of dividend (%)	3	2	1	-2	<-2	0.7%	2	0.40
Liquidity	25%	Liquidity ratio** (days)	60	25	15	10	<10	30	4	1.00
Financial risk rating weighted average of financial criteria scores										**3.25**

Income from activities

In 2010/11 our income from our patient activities was £133.5 million, broadly the same as the previous year (£133.3 million). This partly reflects the fact that the tariff prices, on which are income is based, were not uplifted by any inflation. We were, however, eligible and received an element of payment linked to quality, representing 1.5% of our patient care income (previous year this was 0.5%). Our overall activity in the year was affected by the unprecedented winter pressures, which meant that we did less planned elective activity than we anticipated but experienced higher volumes of emergency activity, including a significant increase in accident and emergency attendances. This unplanned swing in activity was recognised nationally and we were compensated financially by our main commissioner NHS Barnsley, due to the additional financial risk and resource impact over the winter period. The table below shows the actual activity in 2010/11 compared to the previous year. The increase in other activity is largely primary care pathology tests activity which continues to grow in volume but is low in unit prices, so does not reflect any significant change in income.

Other Operating Income

The Trust generated £20.1m income from other activities (approximately 13% of its total income). This income relates mainly to education and training, research and development, services provided to other bodies and other non clinical activities. The income from these sources has been relatively stable and consistent year on year (a fuller breakdown is provided at note 4 of the financial statements).

Type of Activity	2009/10 Outturn	2010/11 Outturn	% Change
Elective admissions	5,817	4,773	-17.9%
Day Case admissions	20,023	19,666	-1.8%
Emergency admissions	33,926	33,490	-1.3%
Out-patients	263,649	264,343	0.3%
A&E attendances	71,891	75,099	4.5%
Other activity	2,158,009	2,480,468	14.9%

Expenditure

Overall expenditure (our operating costs) remained fairly static year on year. This is a very positive position, given ongoing inflation and other cost pressures. This reflects the Trust's commitment to continually driving efficiency and value for money (see below). Included in the expenditure for the year is a significant one off impairment of £1 million related to the downward valuation of the new car park. This is because we incurred expenditure in building the car park, for example road widening and other related works, which have not significantly added to the final value of it once completed. This is a technical accounting adjustment.

In the year the Trust has reviewed the value of its asset base including its new car park which was previously classified as an asset under construction. Although the value of the Trust's other assets have remained consistent there has been an impairment recognised on the new carpark. An impairment (as noted above) was recognised due to the scheme costs being lower than the independent valuation carried out by the District Valuer. The Trust feels that this cost is more than outweighed by the benefits that this new facility provides to the patients and visitors.

Our largest single cost is the staff paybill, which in 2010/11 overall stayed broadly the same as the previous year. After taking into account the impact of national pay inflation, this represents a real decrease of approximately 3.5%. This reduction reflects the work we continually do to improve productivity and efficiency in our workforce. There are also been significant improvements in reducing reliance on agency staff, where we have saved £1.5million compared to the expenditure last year.

Efficiency targets

The Trust is committed to meeting the annual efficiency requirements, designed to ensure ongoing value for money is achieved. In 2010/11 the Trust delivered £5.4million of efficiency savings (of which £4.5 million related to workforce efficiencies). These included re-profiling and skill mix changes designed to reflect the changing patterns of service delivery and aligning the workforce capacity accordingly. Significant savings were made in support functions and non direct patient care functions. This links to some of the national efficiency workstreams around "back office". The Trust made some investment in technology to support improved efficiency which resulted in some administrative cost savings. The use of technology to underpin clinical service and administrative efficiency is a key theme for our efficiency plans going forward.

Capital Expenditure	£,000
Ventilation Upgrade	578
Replace Calorifiers	117
Security	122
Roofing	671
Stroke Unit Upgrade	227
Wards 31/32 Upgrade	512
Minor Injuries Unit	74
Digitial Dictation	194
Desktop Replacement	190
Wireless Network additional	217
Data Warehouse Phase II	95
Hardware and Software Upgrades	144
Medical & Surgical Equipment	616
Other Minor Estates Works	622
Total	4,380

Capital expenditure

During 2010/11 the Trust invested £4.4 million in new capital. The table above provides a summary of the main projects, some of which have been described in other sections of this report.

In addition to the schemes above some major projects were commenced, but no significant costs expended during the year. These include the procurement of a combined heat and power unit and an electronic patient flow system. The budgets for these schemes are provided in the 2011/12 plans.

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.

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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 payments (eg councils, universities etc).

Contracts

The key sources of income to the Trust are from NHS Barnsley, NHS Kirklees, NHS Rotherham, NHS Wakefield District, Sheffield Teaching Hospitals NHS Foundation Trust, The Rotherham NHS Foundation Trust and the Yorkshire and the Humber Strategic Health Authority.

The key sources of expenditure are staff costs, clinical and general supplies and services, drug costs, premises, depreciation on property, plant and equipment and clinical negligence. Both income and expenditure costs are referenced in the accounts section.

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 on page 82 in the Remuneration Report.

Forward look

The financial challenge for the NHS, equating to £20bn savings over four years is of an unprecedented scale. This is in the context of the unrelenting commitments to improving quality and outcomes and maintaining existing access standards and targets. Whilst the NHS is deemed protected from the wider public sector budget reductions, there will be an inevitable knock on impact to NHS services, as difficult decisions are made in partner public sector organisations. The future commissioning landscape and framework is uncertain as the scale and pace of change outlined in the Health and Social Care bill is still unclear. All of these factors inevitably increase the level of potential financial risk to the organisation.

The Trust enters 2011/12 in a stable financial position having signed contracts with our current commissioners and having a clear deliverable financial plan in place for the year. The level of our efficiency requirement is 5%, only 1% above the minimum national efficiency requirement and we have plans in place to meet these. There is some challenge within these plans, the most significant being the ability of the organisation, in partnership with the wider health system, to control and try to reduce demand for unscheduled urgent care. There are nationally set expectations that are built into our contract to reduce the levels of patients re-admitted to hospital. We are working very closely with our partners to improve on this key issue and ultimately realise the efficiency savings that reducing avoidable admissions to hospital should achieve.

2011/12 has seen the continuation of the clear direction of travel to increase the quality of the patient experience. Commitments such as further reductions to hospital infection rates and eliminating mixed sex accommodation are absolutely high priorities for the Trust. Financially these generate a degree of risk as contractual penalties are imposed should the Trust fail to meet its commitments. The Trust has robust processes and measures in place to ensure the wide range of patient experience indicators are achieved. In total, 1.5% of our income is dependent on meeting ten specific quality indicators and we have committed new investment in 2011/12 to contribute to the delivery of these.

Beyond 2011/12 the Trust recognises that the scale of the financial savings challenge will require us to look more radically and innovatively at new ways of working, to continue to deliver the quality outcomes for patients and maintain our financially viability. The Trust has a strategic capital investment plan to support service improvement and clinical pathway redesign but this will require some external financing. The Trust is cognisant of the risks of making significant capital commitments and has a clear financial strategy to ensure underlying cash requirements/ liquidity is not compromised. The capital plans are expected to realise significant service improvement benefit, as well as making significant contributions to the efficiency requirements.

In addition to driving change through new models of clinical service, the Trust is committed to an improvement plan for its "back office". This is in line with a nationally recognised efficiency work-streams to optimise and streamline efficiency in support services. Continuing investment in technology will underpin some of this, as well as looking at opportunities for partnering and sharing services where appropriate to gain economies of scale and efficiency.

Overall the Trust is in a robust financial position for 2011/12, but recognises that the deliverability of strong financial outturns with significant surpluses is an increasing challenge in the current climate. The Trust has set itself clear financial goals and has plans in place to manage within its expected resources for the next three years (medium term plan). The key financial uncertainties and risks relate primarily not to the internal plans and efficiencies, but the wider health and social care community challenges and how these will impact on the Trust's services and how these services will need to adapt and change over the longer term. The Trust's financial plans will be modified and adjusted accordingly over the period to mitigate the risks faced.

Dawn Hanwell
Director of Finance and Information

Principal risks and uncertainties

Our risk assessment process is designed to identify, manage and mitigate business risks. The table below gives examples of risks from 2010/11 and 2011/12 associated with achieving our business plan and what we did and are doing to manage them. The risks listed do not comprise all those associated with Barnsley Hospital NHS Foundation Trust and are not set out in any order of priority. Additional risks not currently known to the management team and Board, or deemed to be less material, may also have an adverse effect on the business of the hospital.

Risk and impact	Mitigating activities
Service performance	
Targets Failure to achieve targets impacts on our financial and operational performance and our reputation	- Regular integrated performance reports to Board - Regular monitoring of activity, including divisional dashboards - Analysis of cancellation and follow up ratios
Patient flow and discharge Failure to manage the flow of patients and patient discharge impacts on our financial and operational performance and our reputation	- Regular integrated performance reports to Board - Daily performance monitoring - Patient satisfaction monitoring - Electronic discharge system in place - Daily reports to chief operating officer - Escalation procedures in place
IT infrastructure Failure to maintain and develop IT infrastructure impacts on operational and financial performance	- Project management in place - Regular updates on investment portfolio - Weekly performance reports - Steering Committee in place
Clinical quality & governance	
EWTD Failure to comply with the European Working Time Directive impacts on patient safety and financial performance	- Regular audits and monthly reviews - Roll out of 'hospital at night' programme & nurse practitioner model
Infection prevention & control Failure to meet healthcare acquired infection standards impacts on patient safety	- Ongoing publicity and awareness campaigns - Deep clean programme - Included in mandatory training
Clinical coding Failure to operate effective clinical coding system impacts on our financial performance	- Appointment of head of clinical coding - Monthly performance monitoring
Data quality Insufficient data quality procedures impacts on reporting	- Policy development - Monthly performance reporting
Patient safety Lack of systems to keep patients safe leads to increased incidents, complaints and litigation	- Monthly performance reporting - Bi-weekly reviews of risks - Online monitoring
Clinical handovers and observations Failure to meet external standards impacts on training and safety of patients	- Audits of handovers and patient observations - Updates to senior managers
Care Quality Commission registration Failure to meet CQC requirements would lead to poor quality and risk profile	- Monthly performance monitoring - Internal audits

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Financial stability	
Cost improvement programme Failure to deliver cost improvement programme impacts on the Trust's financial stability	- Monthly performance monitoring - Divisional dashboards
Carbon emissions Failure to achieve carbon emissions regulations will result in financial penalties and reputational damage	- Monthly performance monitoring - Good Corporate Citizenship registration - Sign up to carbon reduction commitment scheme
Estate	
Failure to align estates strategy with business strategy will impact on the Trust's future	- Detailed business cases - Monthly monitoring
Workforce	
Resistance to workforce changes will impact on right skills and capacity to deliver high quality services	- Workforce plan in place - Policies and procedures to manage vacancies, bank staff, appraisals and sickness in place
Organisational development	
Failure to respond to challenges rising from scale and pace of NHS reform and economic situation for us and our partners	- Scoping work to explore different models of care and provision - Strengthen and build partnership relationships

2010 - 2011

Quality Report

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Welcome to the Quality Account for 2010/11 for Barnsley Hospital NHS Foundation Trust.

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

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

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

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

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

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Part 1

Chief Executive's Statement

Paul O'Connor Chief Executive

At Barnsley Hospital NHS Foundation Trust our vision is to provide the best healthcare for all.

"The Board of Directors has reviewed the overall vision and strategic aims and objectives of the Trust that has led to our simple and clear vision of "provide the best healthcare for all"."

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

Last year the Trust made significant progress and improvements on the quality and safety of our services in 2010/11. We have continued to build on our previous years' successes in regards to infection rates and reduction in patient safety incidents.

We have continued to actively reduce our infection rates particularly for C.Difficile infections. This has been a sustained effort by all professionals and support staff, and we have concluded the year with zero MRSA, and have achieved the Strategic Health Authority's target for C.Difficile.

The Trust has continued the work of "Leading in Patient Safety" which started in 2009/10. This has culminated in monthly safety walkabouts with Directors and other members of staff, and has resulted in changes to the environment and practice which have impacted both on patients' and staff's experience.

The Trust held another patient safety week in November 2010, focusing on the work of preventing falls. This work saw the introduction of "slipper socks" for patients who do not have appropriate footwear with them whilst in hospital. In addition we re-visited areas such as the review of "Safety Briefings" and training for other staff such as medical staff on the bed height when examining patients.

Reduction of in-patient falls continues to be a priority for the Trust and although in 2009/10 we saw a dramatic decrease of 24%, we saw a further 18.2% decrease in 2010/11. In addition, our local CQUINN target set by NHS Barnsley for decreasing the number of patients who repeatedly fall has shown we need to assess patients regularly and ensure we use clear communication with them and their relatives. For this, we have created a short patient information leaflet for use by patients and their relatives to understand and prevent falls occurring. This is just one example of how we are taking different approaches to reducing the risk of harm to our patients.

Overall, clinical effectiveness has been enhanced by our participation in a number of National Clinical Audits. The Trust has performed well in regard to the national Sentinel Stroke Audit and was rated third best in England.

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

The Board of Directors has reviewed the overall vision and strategic aims and objectives of the Trust that has led to our simple and clear vision of "provide the best healthcare for all". We are seeking to continually improve our patients' experiences by listening to them, working with our Governors, Foundation Trust members, partners and others to learn from what has gone well, and more importantly how we can improve our services.

We are moving in the right direction and are proud of our achievements in 2010/11 particularly in:

- Reducing the number of in-patient falls
- Delivering same sex accommodation plans in order to improve patients' experiences and thereby declare compliance with Department of Health guidance
- Improving patient experience through the results of the Care Quality Commission In-patient Survey and use of our "real time" collection systems
- Improvement in our Staff Survey results

We are not complacent, however, and still have much more to do. Our patients have told us they want to see:

- A reduction in the time waiting for medication on discharge
- Improvements in communication from the hospital
- Continued sustained progress on prevention of falls

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

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

Paul O'Connor Chief Executive

Part 2

Priorities for improvement and statements of assurance from the Board

How did we do in 2010/11 against our priorities?

Priority 1: Reduction in the number of falls experienced by patients whilst in hospital by 10%

Significant progress has been made against this priority. The status in 2009/10 showed the number of falls decreased by 24%. This year the reporting falls has been measured in a number of ways:

- Fall rate per 10,000 bed days (this demonstrates number against number of admissions to the hospital)
- Number of patients who have fallen more than once whilst in hospital (requirement of NHS Barnsley CQUINN)
- Number of falls (requested by Governors)

The Trust introduced a number of initiatives over this period. These have included:

- An orthro-static (standing and sitting) observation chart
- Introduction of patient observation and activity chart for those patients identified as being at high risk of falling
- Introduction of a falls pathway to enable patients attending the Emergency Department to be directed to the appropriate services
- Introduction of "red slipper socks" for patients who are admitted and who do not have appropriate footwear for mobility

These initiatives had a further impact on our previous year's decrease in falls and has resulted in a reduction of 18.2% on last year's figures.

Priority 2: To reduce the number of patients who are readmitted as an Emergency admission within 14 days of a previous discharge

The goal of this priority for 2010/11 was to reduce the percentage rate of admission to 4.4%. This was a 0.61% reduction on 2009/10 rate. Achievement of this priority depends on working collaboratively with community services and General Practitioners (GPs) in order to ensure patients have the required information, understand their medication and are aware of services available to them through "care navigation".

Achievement in regards to this has been measured on a monthly basis however, as indicated in the chart below this has been difficult to achieve, particularly in the winter months of December and January 2010/11. The end of year achievement was 4.76%, which was a reduction of 0.25% from 2009/10.

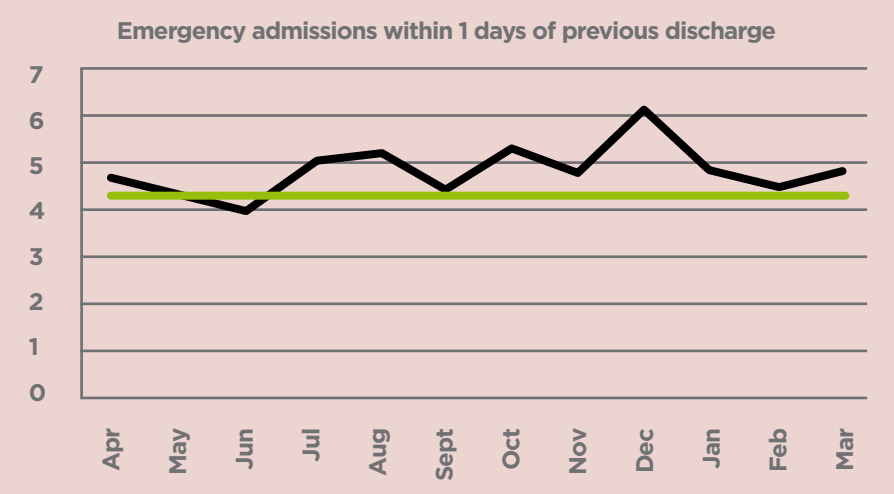
Further work on discharge is required, and this will be progressed within one of the Trust priorities in 2011/12.

Priority 3: To improve responsiveness to personal needs of patients

Progress against this priority was based on the national CQUINN goal of improvement against five survey questions from the CQC nationally coordinated patient survey programme.

These questions are known to be important to patients and where past data indicates significant room for improvement. They are:

- 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



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The Trust's target for this priority was to increase the baseline indicator value by 3.5% to 67.6%. This was from 64.1% baseline indicator for 2009/10.

This we aimed to do by introducing "real time" patient information collection system and a review of patient bedside information. Throughout 2010/11, the "real time" patient experience collection system has been used by Matrons and, in conjunction with the free standing devices placed in strategic areas across the Trust, has produced information to indicate where our priorities in relation to patient experience lie. This information is presented monthly to the Trust Board of Directors, together with key messages from the Matrons. We feel this wealth of information available has enabled us to actively direct resources into areas where patients are telling us they are required.

The results from our 2010/11 CQC in-patient survey have indicated that this has had an impact, as our baseline indicator is now 68.3% against the five composite questions. This is 4.2% increase on 2009/10, and a 0.7% increase on our target.

In summary, we feel we have made good progress against all of our priorities for 2010/11, but recognise we still have further work to improve in regards to our emergency readmissions. However, as part of the NHS Operating Framework for 2011/12, a focus on readmissions is a priority for the Trust due to the financial implications that under performance presents.

What are we going to do? Our three priorities for 2011/12

For 2011/12, as a Trust, we wanted to gain further understanding of what our patients wanted in regards to improving the quality of our services. In order to gain this effectively we sent a Quality Survey (Appendix 1) to approximately 12,400 members. In addition, an email post box on line was developed in order that the staff and public could contribute via the internet.

A total of 225 responses were received. These were analysed and a range of themes presented to Board of Directors, Governing Council and Local Involvement Network (LINk), in order to gain an overall understanding of which of these themes would be the Trust's priorities for 2011/12.

In addition, we have examined our patient surveys, complaints and incidents, and identified common themes to utilise in deciding our identified priorities to further improve the quality and safety of care we deliver to our patients.

Each of the priorities reflects the three Quality themes of:

- Safety
- Effectiveness
- Experience

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

The three priorities will be detailed in the following pages.

Priority 1
To improve our knowledge of individual patients nutritional status

Why this priority?

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

But, we still recognise that we could improve further, and the weight of patients is required for both measurements during admissions to assess weight gain or loss and for drug calculations.

Therefore, weighing patients on admission contributes to our knowledge of individual patient's nutritional status.

What's our aim/goal?

To ensure all eligible patients are weighed on admission.

How are we going to do this?

1. Establish criteria for which patients will be weighed.
2. Be clear about where on the patient's records this is documented.
3. Continue to assess all patients on admission with the malnutrition screening tool.
4. Communicate to all staff about the importance of patient's weight on admission.

Target 2011/12

To achieve 90% of all eligible patients weighed on admission through a quarterly spot audit of patient notes.

What does this mean for you?

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

How will you know we are improving and monitoring?

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

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Priority 2
Reduce the incidence of hospital acquired pressure ulcers

Why this priority?

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

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

What's our aim/goal?

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

How are we going to do this?

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

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

Target 2011/12

Indicator 1: 8% reduction from baseline at end of year
Indicator 2: 100% achievement
Indicator 3: 100% achievement

What does this mean for you?

On admission you will be:

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

How will you know we are improving and monitoring?

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

Priority 3
Ready to go – no delays

Why this priority?

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

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

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

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

What's our aim/goal?

To create a seamless approach to discharge.

How are we going to do this?

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

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

Target 2011/12

To achieve a 1% decrease on two key composite questions from the CQC Inpatient Survey. These are:

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

2009 & 2010 results were:

Question 1	51 & 45%
Question 2	28 & 19%

(lower scores are better)

In addition we want to see a 4% decrease in the number of complaints relating to discharge of patients.

Number of complaints 2010 where discharge featured was 14 = 4.9% of all complaints.

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

What does this mean for you?

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

How will you know we are improving and monitoring?

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

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Statements of Assurance from the Board

Review of Services

During 2011/12 Barnsley Hospital NHS Foundation Trust provided one sub-contracted NHS service.

Barnsley Hospital NHS Foundation Trust has reviewed all the data available to them on the quality of care in the 36 services (see list below). This has been considered as part of the monthly Integrated Performance Report which is discussed by the Trust Board of Directors monthly.

The income generated by the NHS Services reviewed in April 2010-March 2011 represents 100 per cent of the total income generated from the provision of NHS services by Barnsley Hospital NHS Foundation Trust for April 2011-March 2012.

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

Patient Safety

Preventing and Controlling Infection

This year we have had zero MRSA and 49 C.Difficile. The number of C.Difficile cases are within the Strategic Health Authority's target (65), and 2 more than our own stretch target (47) as detailed in 2010/11 Quality Account.

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

Overall compliance with hand hygiene currently rests at 99.4% which demonstrates the efforts required to raise the standards to our 100% target. Hand hygiene compliance is reported monthly to the Board of Directors, and quarterly reports from Infection, Prevention and Control are provided quarterly for the Board.

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

Patient Safety Walkabouts

During 2010/11 these have continued on a monthly basis. Directors and Senior Managers have visited a wide range of clinical areas to discuss their incidents, complaints and compliments and talk to staff about their issues, and has also helped to increase the visibility of senior staff in the Trust.

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

"Listening NEDS"

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

Global Trigger Tool – Adult

The Global Trigger Tool is used to audit patient records for tracking harm to adult inpatients. This project has been ongoing from February 2009 to November 2010. In all, 20 sets of records from across general medicine, surgery, obstetrics and gynaecology have been audited every month. This totals 430 sets of notes from across the Trust.

Summary of findings

No harm events were found in 353 (82%) of records audited.

Across the Trust 87 harm events were found during this audit.

The main two events recorded were:

- 32 events - Readmission to hospital within 30 days
- 29 events - Complication of procedure or treatment (including 2nd degree tears)

Each Clinical Division has been asked to consider the data collected as part of their governance work.

Effectiveness – checking and assuring we are changing, monitoring and improving practice

During 2010/11, BHNFT participated in 37 national clinical audits and two national confidential enquiries covered NHS services that Barnsley Hospital NHS Foundation Trust (BHNFT) provides.

During 2010/11 BHNFT participated in 68% of the national clinical audits and 100% of the national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that BHNFT was eligible for and participated in during 2010/11 are as follows.

The national clinical audits and national confidential enquiries that BHNFT participated in, and for which data collection was completed during 2010/11, are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry:

Area/ National Audit title	Applicable to BHNFT	Participated in	% cases submitted
Peri- & Neonatal			
Perinatal mortality (CEMACH)	✓	✓	100%
Neonatal intensive and special care (NNAP)	✓	✓	100%
Children			
Paediatric pneumonia (British Thoracic Society)	✓	✗	
Paediatric asthma (British Thoracic Society)	✓	✗	
Paediatric fever (College of Emergency Medicine)	✓	✓	100%
Childhood epilepsy (RCPH National Childhood Epilepsy Audit)	✓	✓	Registered and will be able to input data form May 2011.
Diabetes (RCPH National Paediatric Diabetes Audit)	✓	✓	100%
Acute care			
Emergency use of oxygen (British Thoracic Society)	✓	✗	Local baseline 2011/12
Adult community acquired pneumonia (British Thoracic Society)	✓	✗	

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Area/ National Audit title	Applicable to BHNFT	Participated in	% cases submitted
Non invasive ventilation (NIV) - adults (British Thoracic Society)	✓	✗	Commence data collection February 2011
Pleural procedures (British Thoracic Society)	✓	✗	
Cardiac arrest (National Cardiac Arrest Audit)	✓	✓	100%
Vital signs in majors (College of Emergency Medicine)	✓	✗	
Adult critical care (Case Mix Programme)	✓	✓	100%
Potential donor audit (NHS Blood & Transplant)	✓	✓	100%
Long term conditions			
Diabetes (National Adult Diabetes Audit)	✓	✗	Not part of NCAPOP
Heavy menstrual bleeding (RCOG National Audit of HMB)	✓	✓	Data collection started 1 February 2011
Ulcerative colitis & Crohn's disease (National IBD Audit)	✓	✓	Finishes September 2011
Parkinson's disease (National Parkinson's Audit)	✓	✗	Not part of NCAPOP
COPD (British Thoracic Society/European Audit)	✓	✓	At data collection stage
Long term conditions			
Adult asthma (British Thoracic Society)	✓	✗	Not part of NCAPOP
Bronchiectasis (British Thoracic Society)	✓	✗	Not part of NCAPOP
Elective procedures			
Hip, knee and ankle replacements (National Joint Registry)	✓	✓	100% hips and knees
Elective surgery (National PROMs Programme)	✓	✓	100%
Cardiovascular disease			
Acute Myocardial Infarction & other ACS (MINAP)	✓	✓	100% of CCU patients
Heart failure (Heart Failure Audit)	✓	✓	20 cases per month
Stroke care (National Sentinel Stroke Audit)	✓	✓	100%

Area/ National Audit title	Applicable to BHNFT	Participated in	% cases submitted
Renal disease			
Renal colic (College of Emergency Medicine)	✓	✓	100%
Cancer			
Lung cancer (National Lung Cancer Audit)	✓	✓	100%
Bowel cancer (National Bowel Cancer Audit Programme)	✓	✓	100%
Head & neck cancer (DAHNO)	✓	✓	100%
Trauma			
Hip fracture (National Hip Fracture Database)	✓	✓	Data not yet available
Severe trauma (Trauma Audit & Research Network)	✓	✓	Data not yet available
Falls and non-hip fractures (National Falls & Bone Health Audit)	✓	✓	98%
Blood transfusion			
O neg blood use (National Comparative Audit of Blood Transfusion)	✓	✓	35% 14/40 cases
Platelet use (National Comparative Audit of Blood Transfusion)	✓	✓	35% 14/40 cases

The reports of 37 national clinical audits were reviewed by the provider in 2010/11 and BHNFT took the following actions to improve the quality of healthcare provided:

Examples where we have made changes to our practice following National Audit are:

National Confidential Enquiries (NCEPOD) A Mixed Bag: An enquiry into the care of hospital patients receiving parenteral nutrition

We have taken the action of setting up a working group chaired by the Trust's Medical Director to review the report. This entails policies and procedures for nutrition being reviewed and amended in order to meet this guidance.

The reports of 208 local clinical audits were reviewed by the provider in 2010/11 and BHNFT took the following actions to improve the quality of healthcare provided:

Examples where we have made changes to our practice following Local Audit are:

Monitoring of Amiodarone Therapy

This audit indentified failings in service provision and resulted in the introduction of a specific record sheet for the initiation and monitoring of amiodarone.

Audit of Computed Tomography Pulmonary Angiogram Service

This project highlighted the delay from clinician to x-ray particularly over a weekend period, which has an impact on the patient's length of stay. It also highlighted the lack of senior clinicians input in the requests for the test. The introduction of an upgrade to electronic requesting saves the Trust financially in both radiographers time by enabling reporting from home and reducing the length of stay for some patients.

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Audit of the use of re-transfusion drains following Total Knee Replacement

This led to a reduction in the cost of using donor blood by using Stryker drains which allow the re-transfusion of the patient's own blood and will also minimise the risk of infection and complications for patients.

Trust wide Essence of Care – Nutrition

Patient care is improved by ensuring that their nutritional needs are better met.

UNICEF Baby Friendly Initiative Section 2 (May 2010)

This audit highlighted improvements in staff education in the Trust.

Information on participation in clinical research

The number of patients receiving NHS services provided, or sub-contracted, by Barnsley Hospital NHSFT during the year April 2010 – March 2011 that were recruited during that period to participate in research approved by a research ethics committee was 828.

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

Barnsley Hospital NHSFT was involved in conducting 137 clinical research studies in 2010/11.

There were 35 clinical staff participating in research approved by research ethics committees during April 2010 – March 2011. These staff participated in research covering 15 specialties within the Trust.

In addition, in the last three years 129 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

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

- Our work in Testosterone therapy has led to an international reputation and one where the results of our research has changed practice locally, nationally and worldwide. This work along with research into diabetes has led to improved quality of life, improved diabetic control and probably morbidity.

- Our work in tele-health and tele-care has produced improvements in care for vulnerable clients nationally, leading to one of our key researchers assisting with Department of Health policy and service delivery.

- A project called 'Voice-input voice-output communication aids 2' together with 3 industry partners. The project is expected to result in an innovative voice-output communication device for disabled people which should be on the market and available to the NHS by 2015.

- A Flexibility and Sustainability Funded researcher has been working to refine a speech recognition device for disabled people to help them control their own homes. This extends a HTD funded project and is expected to result in a new device for disabled people on the market and available to the NHS by the end 2011.

- A device entered by the Assistive Technology department to the Medipex Innovation Awards has been put forward to the finals of the event. The device is the Speech-controlled Environmental Control System (SPECS), which can help severely disabled people control their homes and therefore remain independent.

- Research and Development is a key player in the regional CLAHRC stream of funding for which we receive a large share of £20m of matched funding over a 5 year period. Our main streams of research work associated with this source are in the Obesity, Assistive Technology and Diabetes arms of the research.

- Our work in elderly care is recognised and is changing practice from a local level to an international level:

  - Further work into stroke research has found that the use of TED stockings in stroke patients has minimal impact therefore the practice nationally has ceased.

  - Stroke research has proven in a study of over 10 years duration that vitamin supplements following stroke had minimal effect. Further work into oxygen therapy following stroke has proved that benefit is gained from giving oxygen at night as a routine for the first 48hrs post stroke, this work is continuing. The HIBS study will show if homeopathy helps in Irritable Bowel Syndrome.

Information on the use of the CQUINN framework

A proportion (1.5%) of Barnsley Hospital NHS Foundation Trust income in 2010/11 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 (CQUINNs). Further details of the agreed goals for 2010/11 and for the following 12 month period are available online at: http://www.monitor-nhsft.gov.uk/sites/all/modules/fckeditor/plugins/ktbrowser/openTKFile.php?id=3275

The CQUINNs for 2010/11 covered a range of national, regional and local goals from VTE to decreasing length of stay of patients undergoing breast surgery. The monetary total for the amount of income in 2010/11 conditional upon achieving quality improvement and innovation goals was £1.9 million.

NHS Barnsley and the Trust have agreed on the local CQUINN scheme for 2011/12. The areas we are going to focus on are:

- Tissue Viability – Pressure Sores
- Patient Experience
- Nutritional Screening
- Safeguarding Training (Adult and Child)
- Dementia
- Catheter Associated Urinary Tract Infections (CAUTIs)
- Falls
- Colorectal – Enhanced Recovery

These are in addition to the National CQUINN goals of VTE and improving patient experience.

Further details of the agreed goals for 2010/11 and for the following 12 month period are available from sharon.linter@nhs.net

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Regulation and Compliance

Care Quality Commission (CQC)

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

The CQC has not taken enforcement action against BHNFT during 2010/11.

Barnsley Hospital NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period of 2010/11.

The Trust was subject to an inspection on 31st March 2011 for Dignity and Nutrition for older people.

This inspection was a targeted inspection programme of NHS hospitals looking at whether older people are treated with respect and how they are helped with food and drink when they need it. It is covering 100 hospitals in England, including 10 in Yorkshire and Humber SHA region.

CQC were seeking our compliance against:

Outcome 1 (respecting and involving people)
Outcome 5 (meeting nutritional needs)

They visited Ward 23 and 22, both 28 bed elderly care wards. Formal feedback is yet to be received.

NHSLA (National Health Service Litigation Authority)

We were assessed by NHSLA in March 2010, and achieved level 1. We will maintain this level for the next two years until March 2012 when we will be re-assessed.

CNST (Clinical Negligence Scheme – Maternity Services)

We were assessed by CNST in September 2010, and achieved level 1. We will maintain this level for the next two years, and whilst working towards attainment of level 2 (we require one year of evidence collected from notes to demonstrate our practice).

Information on the quality of data

Secondary Uses

BHNFT submitted records during 2010/11 to Secondary Uses service (SUS) for inclusion in Hospital Episode Statistics which are included in the latest published data of April 2010 – January 2011.

The percentage of records in the published data:

- which included the patient's valid NHS number was: 98.7% for admitted patient care; 99.4% for out patient care; and 96.6% for accident and emergency care.

- which included the patient's valid General Medical Practice Code was: 100% for admitted patient care; 100%for outpatient care; and 100% for accident and emergency care.

Information Governance

Barnsley Hospital NHS Foundation Trust Information Governance Assessment Report overall score for 2010/11 was 81% and was graded green.

Data Quality

In 2010/11, we progressed the action plan relating to data quality following the dry run of the External Assurance of our Quality Account 2009/10 in August 2010. We had 44 actions, of which 38 are now completed, giving a compliance of 86%.

BHNFT will be taking the following actions to improve data quality:

- Major Information Asset Owner & Administrator accountable for the quality of information held in the system (paper or electronic) included in roles and responsibilities.
- Review of all training programmes (all Major Information Assets).
- Implementation of a robust programme of internal and external data quality/clinical coding audit in line with the requirements of the Audit Commission and NHS Connecting for Health.
- Ensure designate work space and access to PAS on or adjacent to the wards if clinical coders are to code outside of the Coding Department.
- Implement an internal audit programme that is carried out regularly during the year.
- Review the batch process – procurement of a Patient Flow Management System

Clinical Coding

BHNFT was not subject to the Payment by Results Clinical Coding Audit during 2010/11 by the Audit Commission.

What everyone is saying about us?

CQC In-Patient Survey 2010

This is a national randomised postal survey carried out by the CQC. As previously stated on page 37 the Trust achieved its national CQUINN target in relation to the five composite questions. However, there are areas in which we can further improve and where we scored in the lowest 20% of Trusts. These are:

1. Doctors: when you had important questions to ask a doctor, did you get answers that you could understand?
2. Your care and treatment: how much information about your condition or treatment was given to you?
3. Operations and procedures: Did member of staff explain what would be done during the operation or procedure?

An action plan has been formulated to address these issues and monitored through our Patient Experience Group which has staff, Governor and patient involvement.

CRT (Real time) Patient Experience Collection System

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

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

Patient Stories to Board

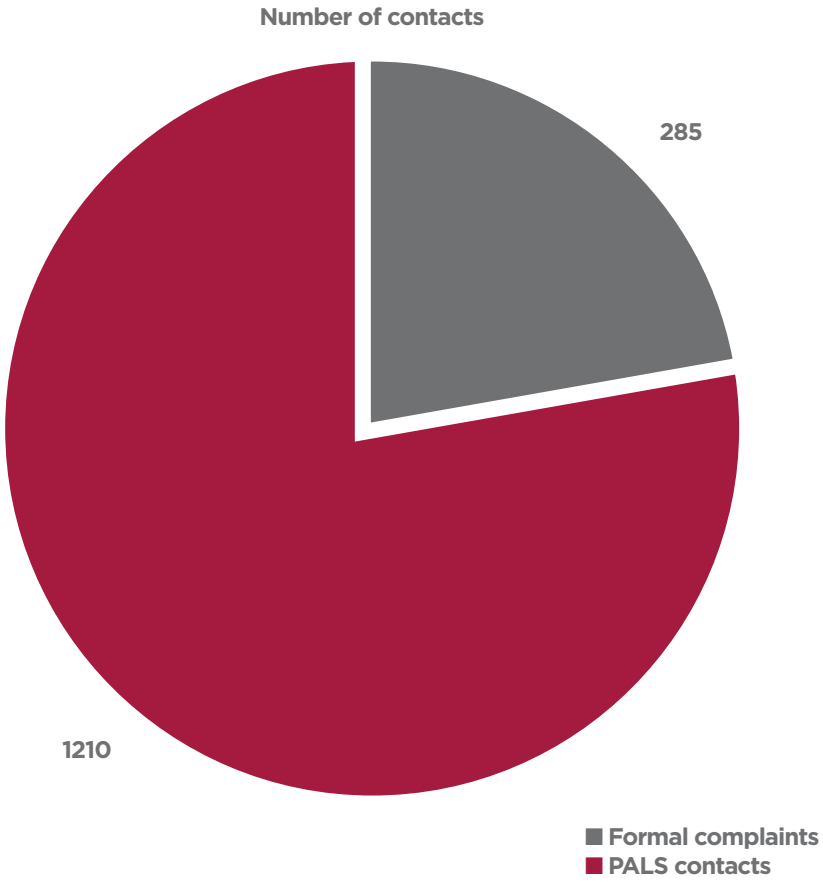
During 2010/11, we commenced using patient stories at the start of the Board meetings. These have been sourced from complaints, associated responses and patients talking to the Trust Board.

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

Complaints & Patient Liaison Service (PALS)

The information below gives an overview of the formal complaints received by Barnsley Hospital NHS Foundation Trust between April 2010 and March 2011, along with the informal complaints dealt with by the PALS team in the same period.

We assess and monitor the improvements we action from every single complaint. We carry out quarterly analysis and reviews of our complaints in order to learn and improve from the feedback and experiences of our service users and here are just some of the improvements we have made in 2010/11:



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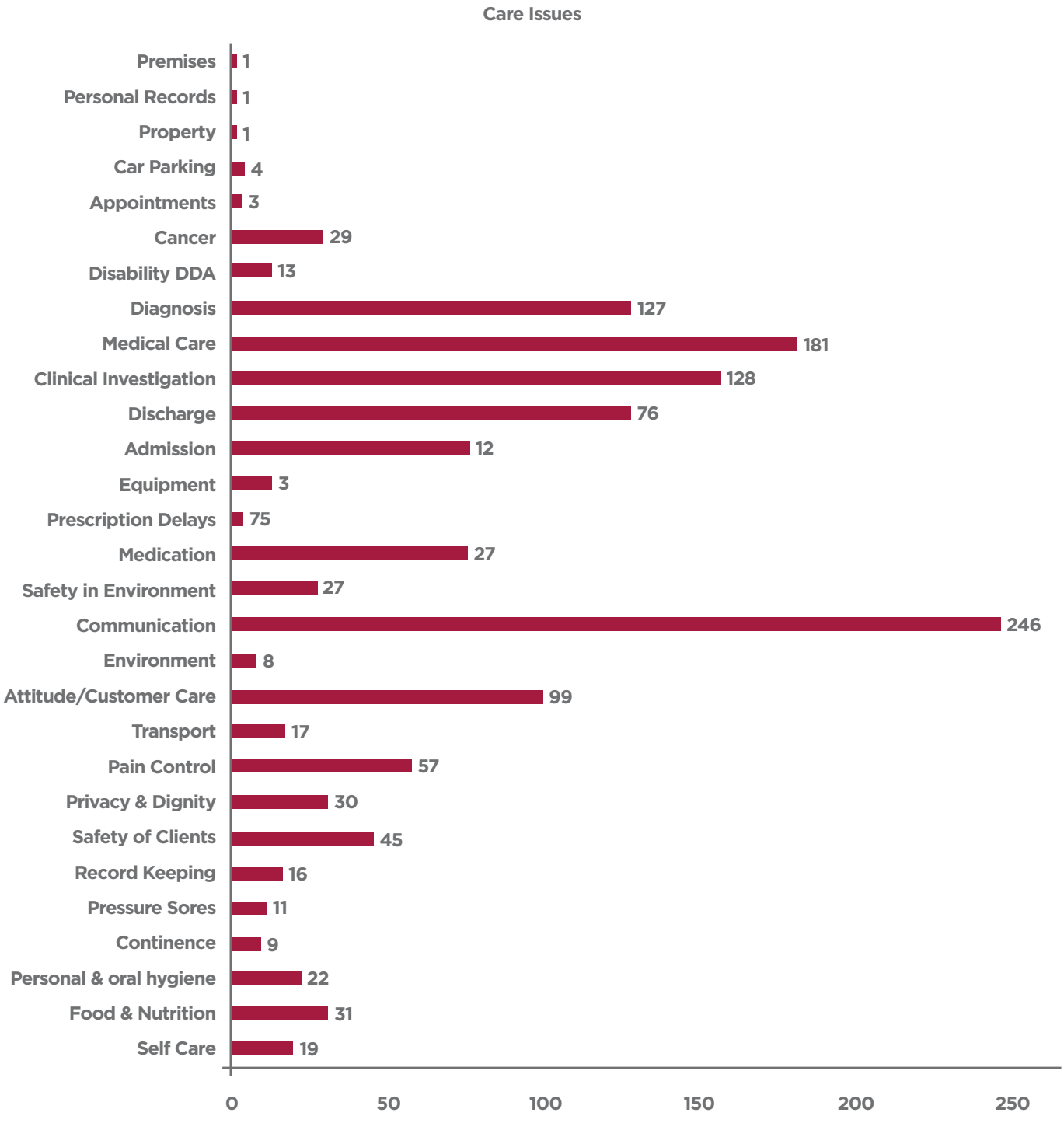
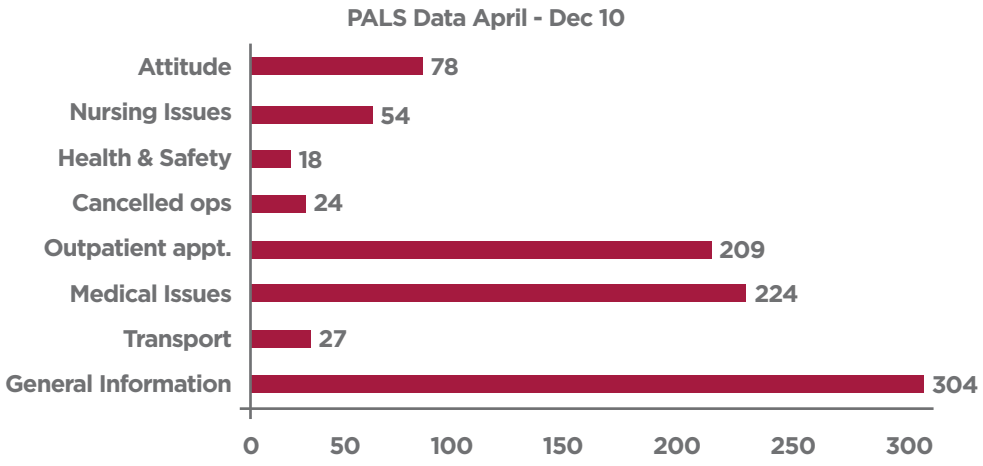
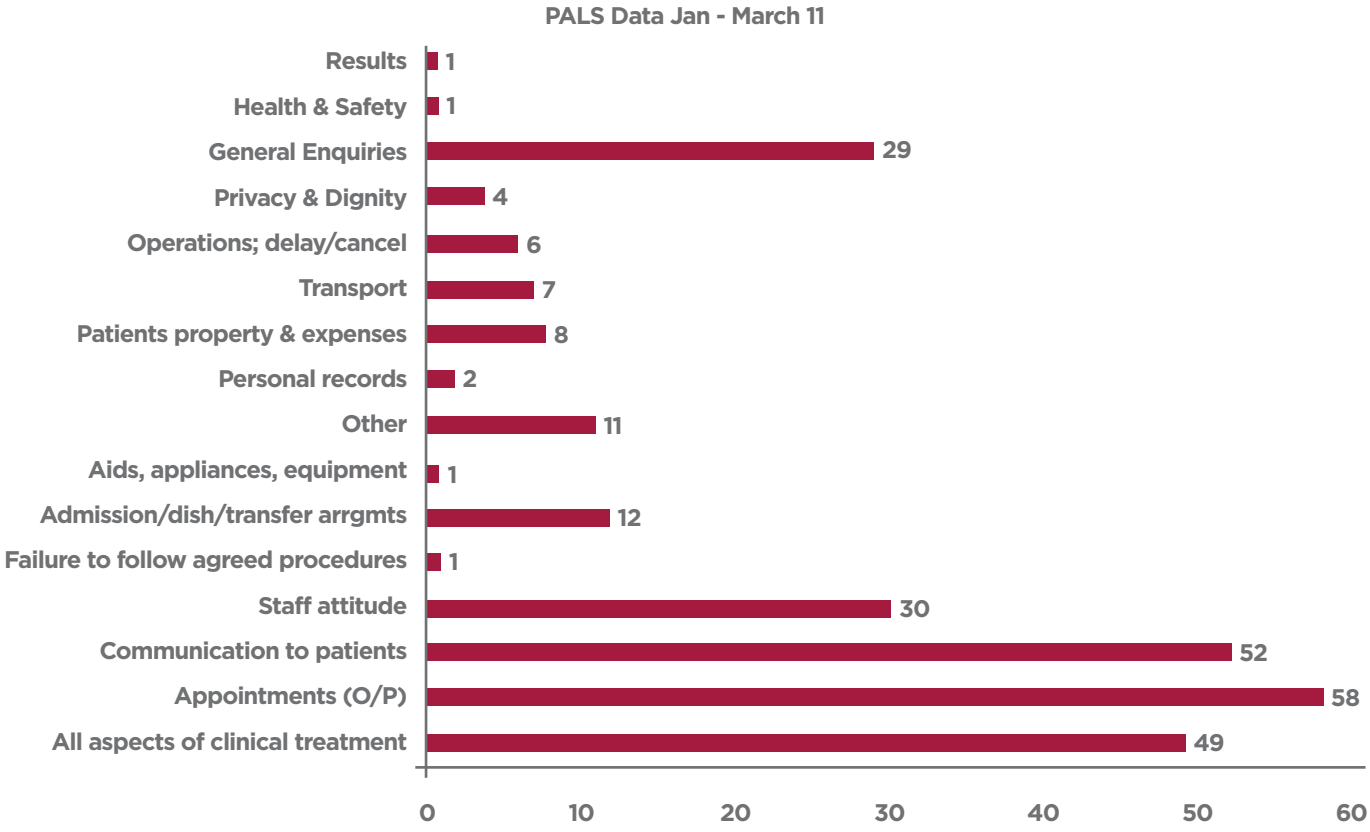
The following graph provides further detail behind the complaint categories and only relates to the formal complaints received.



The PALS data is split into two graphs; the first noting the subjects between April and December 2010 and the second noting the subjects between January and March 2011.

In January 2011 the PALS team changed its reporting mechanism to use the same subject headings used by formal complaints. This is to ensure each Divisional area is able to look at any concerns raised; be it formally or informally to identify themes/trends and any areas for improvement.





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- The named nurse for Safeguarding Adults uses anonymised examples of complaints as part of mandatory Safeguarding Adults training.
- Introduced a new complaints process in the Medical Division to provide improved internal tracking and response times.
- Trust-wide implementation of new inflatable boots for those at risk to prevent pressure sores on heels.
- Community midwives will send a recorded delivery letter to women who were not available when visited for post-natal visits.
- Mobility of patient's to be reviewed, and assessment to take place where required, before discharge from the Emergency Department.
- Training for Emergency Department nursing staff for basic plaster application.
- Skills 'passport pack' has been developed for Health Care Assistants and Auxiliaries, and is used as a development tool for staff where issues have been highlighted and demonstrates competency in practical skills including infection control, essence of care and communication skills
- Number of staff able to carry out 'swallow tests' has increased.
- The pathway for the screening coordinator role in obstetrics has been reviewed. This will help improve coordination of follow up appointments for patients receiving this service.
- When unlabelled samples are received in the laboratory from phlebotomy this is immediately highlighted to relevant staff member, and recorded.
- New software introduced to improve the layout and content of out-patient and day case letters, information can now be personalised more easily to make it more relevant and accurate for each patient.
- The average length of time patients on the Medical Assessment Unit are waiting to be seen by a doctor for an initial review has reduced.

Staff survey

The 2010 Staff Survey results, published in a report entitled "Listening to staff", show how the hospital scored across 10 areas compared to 2009/10.

Scores improved for the areas of:
- Work life balance
- About individual staff jobs
- Harassment, bullying and violence

Scores remained about the same for:
- Training learning and development
- Managers and appraisals (support to do a good job)
- A worthwhile job and the chance to develop
- Occupational health and safety
- Infection control and hygiene

Areas where improvements are needed include communication with senior managers and perception of staff to the hospital priorities.

To this end the Trust has launched a project called "Together we will make it: better?"

In 2011/12, we are taking at a different approach, one where staff are in control, where they tackle an issue or theme by coming up with ideas. The difference is that staff are catalysts, or agents, for change.

In order for this to happen, Divisions are putting forward nominations of people who they think will be able to act as Agents for Change in the focus groups. The groups, which will run bi-monthly for a two hours will be facilitated by the learning and development team and include an executive sponsor and staff side colleagues.

Part 3

Other information

How are we performing?

Performance Improvement 2010/11

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

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

We have chosen to measure our performance against the following metrics:			
Patient Safety	**2009-10/2010-11 Performance**	**Target 2011/12**	**Comments**
Patients with MRSA bacteraemia	0/0	0	Target set by SHA
Patients with C.Difficile infection	49/49	31	Target set by SHA
Serious Incidents (SIs) that occur within the Trust	No target but wish to monitor		Board wish to monitor indicator of Quality of Care
Medication errors	182/137	130	Target 5% decrease
Hospital In-Patient falls (patients who have fallen more than once)	Non available/158	Baseline to be set by NHS Barnsley	Local CQUINN
Hospital In-Patient falls (previous priority in 2009/10 and 2010/11) measured in number of falls and fall rate per 10,000 bed days	2009/10 = 1117 / 72.6 2010/11 = 914 / 54.8	No target but wish to monitor	Board wish to monitor indicator of Quality of Care
VTE Assessment Compliance	Non available/ 88.39% (June 2010 – March 2011 only)	90%	Achievement of National Indicator value of CQUINN
These indicators have not changed from 2009/2010 Quality Report. 2010/11 data shown above has been obtained from the monthly integrated performance report presented to Board; this will continue to be the key source in 2011/12			
Clinical Effectiveness	**2010/11 Performance**	**Target 2011/12**	**Comments**
To reduce the incidence of Catheter Associated Urinary Tract Infections (CAUTIs)	N/A	2% reduction in incidence of CAUTIs	Local CQUINN
Improvement in numbers of staff who are eligible receive Safeguarding Training (Adult and Child)		91% (Adult & Children)	Local CQUINN
Patients will be able to expect early diagnosis of Dementia to facilitate access to and provision of a seamless service that is patient centered, delivered safely with privacy & dignity, and with appropriate sedation	N/A	75% of all eligible patients have had score completed 40 staff have completed training	Local CQUINN

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2009/10 Indicators	2009/10 Performance	Target 2010/11	Comments
Delayed Discharges (measured % of occupied bed days)	0.28% (n= 393)	n = 353 Target 10% reduction	Performance 2010/11 n = 114 Achieved
To reduce the number of patients readmitted as an emergency admission within 14 days of a previous discharge	5.01%	4.40%	Performance 2010/11 4.76% now part of Operating Framework on re-admissions
Increase participation rates in Patient Reported outcome measures (PROMS) for the following: • Varicose veins • Hernia repair • Hip replacement • Knee replacement	42% 39% 57% 66%	Increase to 70% in all areas	Performance 2010/11 Varicose veins = 53.2% Hernia repair = 75% Hip replacement = 83.8% Knee replacement = 81.4%
These have been changed completely from the 2009/10 Quality Account, this is to reflect the Trust's locally agreed CQUINNs, based on local needs of the population and performance achieved in 2010/11. 2010/11 data shown above reflects Department of Health figures (DH website refers)			
Patient Experience	**2010/11 Performance**	**Target 2011/12**	**Comments**
Was your sleep disturbed by avoidable noise at night?	Average No = 59%	Increase average of No to 64%	Monitored via Trust's real time patient experience tracking system
Staffing levels (in your opinion , were there enough nurses on duty to care for you in hospital)	Average Yes = 77%	Increase average of Yes to 80%	
To improve responsiveness to personal needs of patients, 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 who to contact if worried about condition after leaving hospital	68.3%	69% (National CQUINN) 72% (Local CQUINN)	CQC In-patient Survey
One indicator has been deleted from 2009/2010 Quality Report, "information on Discharge" as this is covered in our Priority (3) page 40 and within the CQC In-patient Survey as detailed above. The data shown above is regularly presented to the Board via the Matrons' report			

Overview of Performance in 2010/11 against the key national priorities from the Department of Health's Operating Framework and against the Department of Health's National Core Standards

Improving cleanliness and reducing healthcare-associated infections (HCAI)

This year we have had zero MRSA and 49 C.Difficile. The number of C.Difficile cases are within the Strategic Health Authority's target (65), and 2 more than our own stretch target (47) as detailed in 2010/11 Quality Account.

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

Overall compliance with hand hygiene currently rests at 99.4% which demonstrates the efforts required to raise the standards to our 100% target. Hand hygiene compliance is reported monthly to the Board of Directors, and quarterly reports from Infection, Prevention and Control are provided quarterly for the Board.

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

Improving access

Below are a few examples of where the Trust has worked on improving access for different groups of patients:

Safeguarding adults

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

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

Learning disabilities

The Trust continues to make progress in the work on improving the experience of patients within the Trust who have learning disabilities. Progress continues in the development of a 'Hospital Passport' that patients carry so that their care, treatment and preferences are known. Work has also been taking place to produce information leaflets in easy read format.

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

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

Dementia strategy

Implementation of the dementia strategy is taking place and a Trust group is overseeing actions to help patients with dementia to receive high quality care and treatment that is delivered in environments that are proved to help keep patients calm and eliminate anxiety related to a change of circumstance.

Ethnicity needs

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

Improvements for Ward 19

Ward 19 at Barnsley Hospital underwent a facelift after a successful bid to the hospital's charitable funds and specific fundraising events.

Ward 19 is a medical ward, specialising in care of the elderly. The bid for almost £1,000 was made to help improve the ward environment and to create a welcoming and calming space.

The money was used to buy accessories for the ward to colour code different areas. Brightly-coloured visitor chairs were bought for patient areas that are in the same colour as other accessories in the same room to help vulnerable patients find their way around. New signs were also put up for bathroom and toilet facilities, using pictures rather than words to help with visual recognition.

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Keeping adults and children well, improving health and reducing inequalities

Below are a few examples of where the Trust has worked on keeping Adults and children well, improving health and reducing inequalities:

Maternity services

Our maternity services go from strength to strength, with increasing numbers of women choosing the Trust for their care and treatment.

Understanding what mums-to-be want was at the centre of one of the developments last year.

The midwives introduced a new service – called HypnoBirthing®. Sometimes known as the Mongan method, the programme teaches self hypnosis, relaxation and breathing techniques. The techniques allow the mother to use her natural instincts and help her to have her baby easily in an atmosphere of calm. Severe discomfort does not need to be part of labour and childbirth.

Hypnobirthing® is intended to help expectant mums have the most positive childbirth possible, and can be used whatever kind of birth they're planning - homebirth, hospital or birthing centre. Research has shown that women who use the techniques have less caesarean sections, less pre term labours and less postnatal depression.

Following a successful pilot programme in 2009 with 28 couples, it was agreed to incorporate HypnoBirthing® into the hospital's services. Seven Barnsley Hospital midwives have now completed the training to become specialist practitioners.

Cancer services

A nationally commissioned survey of cancer patients' experience showed that Barnsley patients rate our services highly. 58% put us in top 20 quartile and the remaining 42% put us in medium (nothing in bottom) – and 95% of all responses were higher than national average. As with all surveys, there were areas where we can improve, such as outpatient waiting times and we'll be concentrating on these in the coming year.

Complementary therapies

The Well for Wellbeing – a centre offering complementary therapies for cancer patients – also opened at The Core in Barnsley town centre.

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

Improving patient experience, staff satisfaction and engagement

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

Red jug and beaker scheme

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

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

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

Real time information

We introduced the 'real time' collection of patient experiences during the year, helping our matrons to collect and theme the feedback from across the wards.

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

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

The result is monthly reports and action plans which the matrons use to understand where they need to place greater focus in the coming weeks. This development was part of our actions to improve responsiveness to the personal needs of patients.

The touch screen system enables them to rate hospital services with, for example, a smiley face indicating a short wait in the emergency department; a glum face suggests too long a wait.

Preparing to respond in a state of emergency, such as an outbreak of a new pandemic

The Trust has in conjunction with the health Community has reviewed all of its business continuity and flu pandemic plans. In addition, has undertaken a number of live exercises throughout the year to demonstrate the robustness of its business continuity and resilience plans.

Indicator	Target 2011/12	Performance			
		2010/11		2009/10	
		Target	Actual	Target	Actual
C. Difficile	31	65	49	145	49
MRSA	0	1	0	11	2
All Cancers 31 Days - subsequent treatments (Surgery)	94%	94%	100%	94%	100%
All Cancers 31 Days - subsequent treatments (Drug Treatments)	98%	98%	100%	98%	100%
All Cancers 31 Days - Radiotherapy	N/A	N/A	N/A	N/A	N/A
All Cancers 62-day GP urgent referral to treatment	85%	85%	91.3%	85%	91.3%
All Cancers 62 Days - Consultant Upgrades	85%	85%	88.5%	85%	100%
18-week referral-to-treatment target: Admitted patients treated	90%	90%	96.73%	90%	97.5%
18-week referral-to-treatment target: Non-admitted patients treated	95%	95%	98.72%	95%	99.73%
All Cancers: 31-day diagnosis to treatment	96%	96%	99.3%	96%	100%
All Cancers: two week wait	93%	93%	96.5%	93%	96.3%
Symptomatic Breast Patients - two week wait (non cancer referrals)	93%	93%	95.3%	93%	76.2%
Screening all elective in-patients for MRSA	100%	100%	100%	100%	100%
Total time in A&E: four hours or less	95.00%	95%	95.54%	98%	98.91%
People suffering heart attack to receive thrombolysis within 60 minutes of call	68%	N/A	N/A	>69%	N/A
Other Indicators that are monitored:					
Audiology patients treated within 18 weeks	95%	95%	100%	95%	100%
Delayed Transfer of Care - as %age of bed occupancy	< = 3.5%	0	0.09%	0	0.28%
No. of inpatients waiting longer than standard (26 weeks)	0	0	0	0	0
No. of outpatients waiting longer than standard (13 weeks)	0	0	0	0	0
All Cancers 62 Days - Screening Programme Upgrades	90%	90%	94.7%	90%	99%
Two week Rapid Access Chest Pain Waits	100%	100%	100%	100%	99%
Operations cancelled for non- clinical reasons					
1) Number of cancelled operations as a percentage of FFCEs	< = 0.8%	0	0.67%	0	0.53%
2) Percentage not given a binding date within 28 days	0%	0	0%	0	0%
48 Hour Access to GUM clinics	100%	100%	100%	100%	100%
Infant health & inequalities					
1) increase number of non-smokers during pregnancy	> 76.2%	>76.21%	77.75%	>76.21%	77.5%
2) increase in breastfeeding initiation rates on previous year	> 56.9%	>56.9%	62.47%	>56.9%	61.9%
Contraceptive advice to all patients using abortion services	100%		100%		100%
Choose & Book - Insufficient Appointments	-		17%		-
Self-certification against compliance with requirements regarding access to healthcare for people with a learning disability	90%	90%	90%	N/A	N/A

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Annex 1
Statements from Primary Care trusts, Local Involvement Networks and Overview and Scrutiny Committees and Governing Council

Governing Council Comments – received 18th May 2011

The Governors have also reflected on comments and discussions raised at their meetings throughout 2010/11 in order to provide a reflective view on the quality of the Trust's services over the past year, not just at this present moment, and would like to comment as follows:

- Overall we believe that the Trust continues to provide high quality, safe and efficient services for patients as evidenced to us by:
  - the integrated performance reports presented to the Board each month and now regularly shared with the Governing Council
  - good progress against the Trust's key priorities from the 2010/11 Quality Account and Business Plan, delivery against which has been monitored by the Governing Council sub-groups throughout the year as part of its system of holding the Board to account
  - the Board's increasing focus on patient safety and quality of services, borne out by the reports presented to the Board at its public meetings (all of which are usually attended by at least one Governor) – starting with a regular "patient's story" to reinforce that patients are, and must always be, at the centre of the Trust's work
  - the balance of compliments vs complaints (and the actions which the Governors are aware are taken in response to every one of the latter).

- **Safety:**

This is clearly an important issue for the Board of Directors and the Trust as a whole and we have been pleased to note the improvements aimed for and largely achieved through the key priorities identified in the 2010/11 Quality Account including:

- the notable reduction of inpatient falls (work on which we are pleased to note will continue in the 2011/12 Quality Account)
- 90% achievement of risk assessments re VTE
- zero incidence of MRSA in 2010/11 alongside the significant year on year reduction in C.Difficile
- improved outcomes in the latest national PEAT inspection.

Governors have also noted and welcomed a number of other reports presented to the Board throughout the year to provide assurance on the Trust's continuing compliance with and/or progress on areas such as elimination of mixed sex accommodation and continuing work across areas highlighted by national inquiries such as the Francis Report.

- **Effectiveness:**

The Trust's continuing drive towards improved efficiency and the delivery of high standards were again demonstrated in the key priorities monitored by the Governing Council sub-groups throughout 2010/11 as well as in the performance reports shared with the Governing Council regularly. Not all targets were fully met at all times of the year (eg a number of breaches of the "under 4 hours" target in A&E during the peak winter pressure periods) but the Governors appreciated the fast and effective responses against any shortfalls, ensuring no sense of complacency was allowed to creep in.

- **Experience:**

As both governors and members of the public many of us have experience of the hospital's services be it personally, via our family and friends or on behalf of the members we represent. We bring reports of these to our meetings to share in terms of both patient experience and the Trust's response. It is encouraging to be able to confirm that the clear majority of these are very positive, with the staff's helpful attitude, quality of care, and cleanliness across the whole hospital being recurring themes. Equally, however, it is good to note how the Trust encourages complaints so that they can learn from patients' experience in order to avoid repetition.

It is encouraging that the Trust also takes account of patients' perceptions in terms of experience. An individual's perception of the treatment and care they receive is very personal; it is not always objective nor necessarily completely accurate (as evidenced by one report in 2010/11 of a breach of single sex accommodation requirements on one of the maternity wards) but if it is real to the patient, it must also be – and is – real to the Trust.

The Governors have welcomed the introduction of the monthly Matrons' reports (which are also shared with one of our sub-groups), giving real opportunity for ward-to-board-to-ward sharing of patients' experiences, early identification of trends and recurring themes, patient and ward-level feedback, and, with the Board's support, development and implementation of action plans.

Governors are aware that the Trust's services and thus patients' experiences are also subject to external review. It is very encouraging to see the Trust's good work being recognised more widely, as illustrated in the recent national report by MacMillan Cancer Support, which identified Barnsley as the third best in England in their latest Cancer Patient Experience Survey, and the Care Quality Commission's review of stroke care, in which this Trust came top within our Strategic Health Authority and joint third in England across a range of indicators.

Governors have also been pleased to note throughout the year that the Trust recognises staff's contribution to all of the above aspects – safety, effectiveness and experience. The incredibly harsh recent winter was particularly challenging for staff, who faced increased demands but still delivered a safe, quality service throughout this period despite significantly increased numbers of patient attendances and staff shortages when colleagues could not get into work due to the hazardous road conditions or their own experience of winter illness. The award of the 29th April as an extra holiday was a great way of sharing that recognition with all staff.

Health & Adult Service Scrutiny Commission (Barnsley Metropolitan Borough Council) Comments – Received 16th May 2011

These comments are based on the personal experiences of Scrutiny Commission Members who have attended the Hospital either as visitors or patients; issues raised in Elected Members' surgeries; regular attendance at Commission meetings by the Chief Executive of the Hospital; formal requests for information submitted by the Scrutiny Commission to the Trust and direct contact with the Chief Executive, Paul O'Connor.

Patient Safety

The Commission is satisfied that patient safety in terms of combating MRSA and C. Difficile remains a priority for the hospital. The hospital has received numerous awards for being the cleanest hospital in the country and this is to be commended. Use of hand-cleaning gels by staff and visitors and improved signage in this respect was in evidence when Commission Members visited the hospital.

Priority 1 for 2010/11 for the hospital was to reduce the number of falls experienced by patients whilst in hospital. The hospital, once again, surpassed this target and decreased the number of falls by 18.2%, which is to be commended. The Commission was pleased to hear about the innovative 'slipper socks' initiative introduced at the Hospital to reduce the incidence of falls, as part of patient safety week.

The hospital environment itself is well lit, all staff have individual identity badges and after 10 p.m. the hospital premises are fully patrolled by safety personnel. All of this has a positive impact on patient safety and on patients actually feeling safe when they are in hospital, which is very important.

Clinical Effectiveness

During the winter of 2010/11 the Commission is aware that the hospital performed extremely well under difficult circumstances (as in the previous year) and this was also reported in the local and national media. Once again, the hospital had an increased number of fracture admissions due to the exceptionally bad weather. Staff at the hospital worked double shifts and stayed over at the hospital so that patients were cared for in an appropriate and timely manner. The Chair of the Scrutiny Commission wrote a letter of thanks to the Chief Executive, on behalf of Elected Members, asking that staff be thanked for their dedication and for going the 'extra mile'. The Commission is pleased to note that delays in discharge will be a priority for the coming year and staff will no doubt strive to achieve the desired improvements in performance.

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Patient Experience

The Commission is of the opinion that patients are treated with dignity and respect when in hospital. 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. The Trust carried out an in-patient survey in 2010/11 which showed that patient experience has improved by 4.2% over 2009/10. This indicates that the initiatives introduced at the hospital to improve patient experience, such as the 'real time' patient information system, are working well.

The Commission has no concerns to raise in any of the areas listed above.

Barnsley Local Involvement Network (LINk) – Received 25th May 2011

Barnsley Local Involvement Network (LINk) communicates with the public as often as they can by doing outreach activities in the community. We ask a wide range of people there opinions on Health and Social Care services, taking into account standard of care, dignity and respect, appointment waiting times, communication, customer service, venue accessibility and Overall Service received.

During 2010 / 2011 Barnsley LINk collected 104 patient views on BDGH. Of those 104 patients surveyed the following information has been collected.

79.4% Felt that the standard of care and treatment they had received was of a high standard.
88.3% Said that staff had always maintained their privacy
80.4% Said that their dignity had always been respected
62.2% Felt that the time that they had waited for appointments / treatment had been of an acceptable length of time.
80.4% Said that the information that they had been provided either verbally or in writing had been useful and of relevance.
82.7% Felt that staff were always friendly and helpful
87.4% Said that BDGH is clean and tidy
82.2% Felt that the hospital was accessible
65.4% said that overall the service they have received has exceeded their expectations.

From this information and the additional comments received from the survey Barnsley LINk has found that NHS Foundation Trust is performing well and the LINk agrees with the trusts priorities for 2010 / 11.

NHS Barnsley – Received 25th May 2011

NHS Barnsley welcomes the opportunity to comment on the Quality Account for Barnsley Hospital NHS Foundation Trust.

Patient Safety

By the monitoring undertaken through the contract and quality review groups and other mechanisms it is noted that the Trust has worked hard to reduce its infection rates during the year and has achieved zero MRSA rates for the period. This includes a 100% compliance rate for screening patients for MRSA on admission or prior to surgery. In addition it has continued to reduce the number of Cdifficle cases this year which will continue to be a challenge for the Trust moving forward.

In addition the Trust has achieved the reduction in the number of falls and particularly the number of patients who fall more than once, they have achieved this by looking at the way patients are holistically assessed and they proactively include patients and relatives in the process to minimise the risk of falling to patients. NHS Barnsley looks forward to this work continuing in 2011/2012.

Clinical Effectiveness

NHS Barnsley has noted the number and diversity of clinical audits undertaken within the Trust, this will have an impact on patients experience and clinical practice particularly when included with the potential benefits that participation in research bring, this the PCT feels is encouraging.

Patient Experience

NHS Barnsley has noted how the Trust have continued with the use of patient safety walkabouts, which gives the opportunity for patients, relatives and staff to help senior members of staff to have an understanding of issues that affect both the experience of patients and staff alike. This coupled with the listening NEDs programme ensure that patients voices are heard from 'Ward to Board' and changes to the patients experience can be instigated both at local level and supported by the Senior Team.

NHS Barnsley welcomes the introduction of patient stories to the Board which ensures the leaders of the organisation are aware of patient's experience of using the service.

The Trust has recognised that timely discharge was one of the top themes of complaints particularly in relation to medications within the Trust, and should be congratulated in addressing this area of the patients experience as a priority for 2011/2012.

Annex 2
2010/11 Statement of Directors' Responsibilities in Respect of the Quality Report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports (which incorporate the above legal requirements) and on the arrangements that foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
  - Board minutes and papers for the period April 2010 to June 2011;
  - Papers relating to Quality reported to the Board over the period April 2010 to June 2011;
  - Feedback from the commissioners dated 25th May 2011;
  - Feedback from governors dated 18th May 2011;
  - Feedback from LINKs dated 25th May 2011;
  - Feedback from Health & Adult Services Scrutiny Commission dated 16th May 2011;
  - The Trust's complaints report to be published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, in July 2011 taking into account the quarterly complaints reports from April-June 2010, July – September 2010; October – December 2010; January – March 2011.
  - The CQC national patient survey April 2011;
  - The CQC national staff survey March 2011;
  - The Head of Internal Audit's annual opinion over the Trust's control environment dated May 2011;
  - Care Quality Commission quality and risk profiles dated April 2011;
- The Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- The performance information reported in the Quality Report is reliable and accurate;
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice;
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and the Quality Report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the Board

Stephen Wragg Chairman
Date: 26 May 2011

Paul O'Connor Chief Executive
Date: 26 May 2011

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Appendix 1
Quality Survey 2010

Quality of care and patient safety are part of the Trust's highest priorities. Over 2009/10 and 2010/11, we have focussed on a number of areas, including:

- Reducing healthcare acquired infections such as MRSA and C.Diff.
- Reducing the number of inpatient falls
- Addressing dignity and respect including making progress towards providing identifiable same sex accommodation
- "Time to Care" initiatives which releases staff time to do more direct care with patients (Productive Ward & Theatres)

The Trust has produced a quality account for 2009/10, which provides information on our quality of care. All Trusts are required to produce this again for 2010/11. The Quality Account outlines the quality of service the Trust has to offer, our priorities for improvement and actions we intend to take to secure these improvements.

We need to continue to drive improvements in the hospital, and as part of this process it is important to listen to views about the quality of service we provide from our members, the Governing Council, patients, staff, members of the public and other healthcare providers.

So, we are asking, **"What are the most important quality issues you think we should be looking to improve in the future?"**

We would be grateful if you could take a few minutes to think about quality, and let us know your views or thoughts. You can email us at: quality.barnsley@nhs.net, let us know through the feedback form on our website – www.barnsleyhospital.nhs.uk, or write to us.

Should we look at (tick 3 that are most important to you)...
O Infection control and cleanliness
O Falls
O Privacy and dignity
O Discharge information
O Admission information
O Communication between the hospital and you

Any other suggestions / comments

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Address for correspondence:
Sharon Linter, Director of Quality and Standards
Barnsley Hospital NHS FT, Freepost BY1 84, Barnsley, S75 2BR

Glossary of Terms

ACS	Acute Coronary syndrome
CABG	Coronary Artery Bypass Graft
CEMACH	Confidential Enquiry into Maternal and Child Health (Ceased to exist from 31/03/10)
DAHNO	Data for Head and Neck Oncology
HQIP	Healthcare Quality Improvement Partnership
IBD	Inflammatory Bowel Disease
MINAP	Myocardial Ischaemia National Audit Programme
NAS	National Audit of Schizophrenia
NCAPOP	National Clinical Audit Patient Outcome Programme
NHSBT	NHS Blood and Transplant
NICOR	National Institute for Clinical Outcome Research
NIV	Non Invasive Ventilation
NNAP	Neonatal Audit programme
PICANet	Paediatric Intensive Care Audit Network
POMH	Prescribing Observatory for Mental Health
PROMs	Patient Related Outcome Measures
RCOG	Royal College of Obstetricians and Gynaecologists
RCPH	Royal College of Paediatric Health
SINAP	Stroke Improvement national Audit Programme
VSGBI	Vascular society of Great Britain & Ireland
CQUINN	Commissioning for Quality and Innovation
GP	General Practitioner
CQC	Care Quality Commission
LINks	Local Involvement Networks
NICE	National Institute of Clinical Excellence
MRSA	Methicillin-resistant Staphylococcus aureus
NCEPOD	National Confidential Enquiry into Patient Outcome and Death
SPECS	Speech-controlled Environmental Control System
CLAHRC	Collaboration for Leadership in Applied Health Research and Care
TED	Thrombo Embolus Deterrent
VTE	Venous Thrombo-embolism
NHSLA	NHS Litigation Authority
CNST	Clinical Negligence Scheme for Trusts
SUS	Secondary Uses Service
PALS	Patient Advice and Liaison Service
QIPP	Quality, Innovation, Productivity and Prevention
CAUTIs	Catheter Associated Urinary Tract Infections
GUM	Genito-Urinary Medicine
PEAT	Patient Environment Action Team

Sharon Linter
Director of Quality and Standards
May 2011

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Independent Auditor's Report to the Board of Governors of Barnsley Hospital NHS Foundation Trust on the Annual Quality Report

We have been engaged by the Board of Governors of Barnsley Hospital NHS Foundation Trust ("the Trust") to perform an independent assurance engagement in respect of the content of Barnsley Hospital NHS Foundation Trust's Quality Report for the year ended 31 March 2011 (the "Quality Report").

Scope and subject matter

We read the Quality Report and considered whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual, and consider the implications for our report if we become aware of any material omissions.

Respective responsibilities of the Directors and auditors

The Directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual 2010/11 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual or is inconsistent with the documents.

We read the other information contained in the Quality Report and considered whether it is inconsistent with:

- Board minutes for the period April 2010 to June 2011
- Papers relating to quality reported to the Board over the period April 2010 to June 2011
- Feedback from the commissioners dated 25/05/2011
- Feedback from governors dated 18/05/2011
- Feedback from LINKS dated 25/05/2011
- Feedback from Health & Adult Services Scrutiny Commission dated 16/05/2011
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Compliance Regulations 2009, through quarterly reports between 1 April 2010 and 31 March 2011;
- The CQC national patient survey April 2011;
- The CQC national staff survey March 2011;
- The Head of Internal Audit's annual opinion over the Trust's controls environment dated May 2011; and
- CQC quality and risk profiles dated April 2011.

We considered the implications for our report if we became aware of any apparent misstatements or material inconsistencies with those documents (collectively, the "documents"). Our responsibilities do not extend to any other information. This report, including the conclusion, has been prepared solely for the Board of Governors of Barnsley Hospital NHS Foundation Trust as a body, to assist the Board of Governors in reporting Barnsley Hospital NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2011, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the Quality Report. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of Governors as a body and Barnsley Hospital NHS Foundation Trust for our work or this report save where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) - 'Assurance Engagements other than Audits or Reviews of Historical Financial Information' issued by the International Auditing and Assurance Standards Board CISAE 3000'). Our limited assurance procedures included:

- Making enquiries of management;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

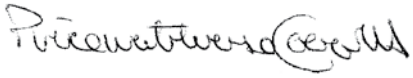
A limited assurance engagement is less in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

It is important to read the Quality Report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2011, the content of the Quality Report is not in accordance with the NHS Foundation Trust Annual Reporting Manual.



PricewaterhouseCoopers LLP
Chartered Accountants
Leeds
31 May 2011

Governance

Our approach to governance

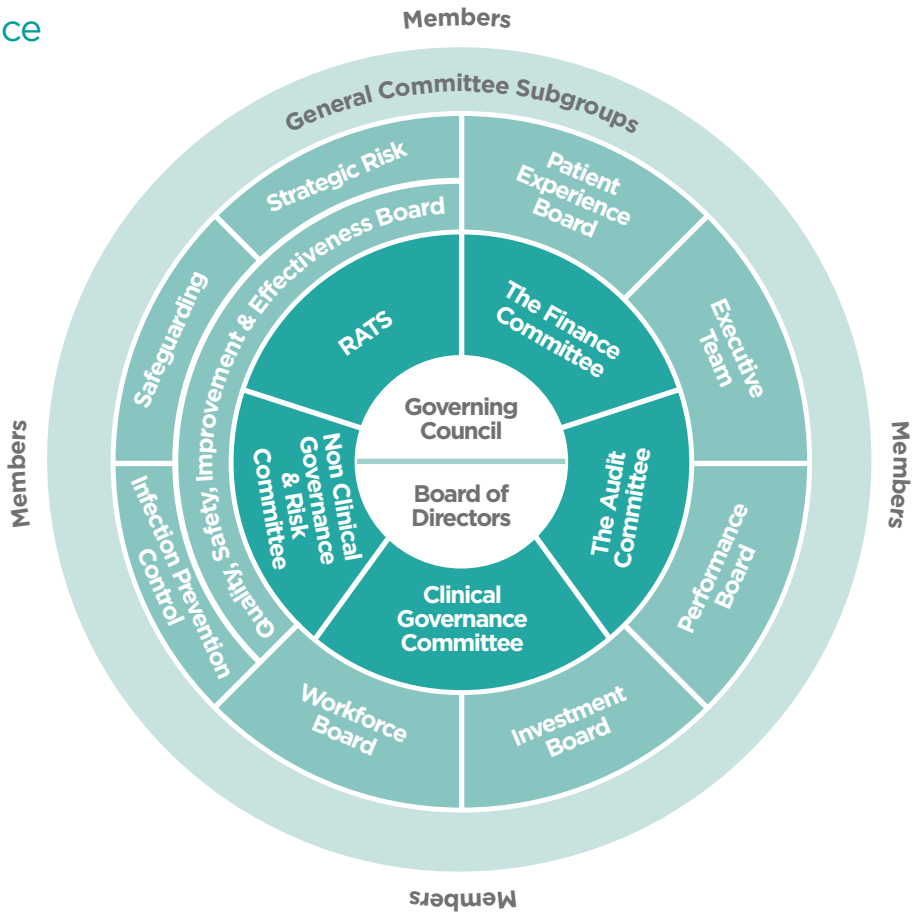
Corporate governance

Our governance structure

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

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

We have an integrated approach to governance. You can read more about our committee structure on page 80.



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The Governing Council

The Governing Council is made up of 20 public governors elected by members of the Trust, and six staff governors elected by hospital staff. These governors are supported by representatives from nine partner organisations, which include Barnsley MBC, Barnsley Black & Ethnic Minorities Initiative, the Sheffield Universities, Barnsley College, the Joint Trade Unions Committee, and Voluntary Action Barnsley.

The Governing Council has dealt with a range of issues charged to it under legislation (eg appointment of the Chairman, Non Executive Directors and auditors) and supports the Trust in its strategic development (business plan, etc). The Board of Directors has authority for all operational issues, the management of which is delegated to operational staff, in line with the Trust's standing orders.

In the course of the year the composition of the Governing Council was reviewed and revised, with the approval of Monitor, the independent regulator for NHS Foundation Trusts. From September 2010, the Council has benefitted from an additional partner governor – Barnsley Black & Ethnic Minority Initiative (BBEMI) and a change of representation for young people when Barnsley College joined the Governing Council in place of Barnsley Youth Council. The Trust appreciated its links with Barnsley Youth Council and will continue to work closely with them. The changes were intended to help the Governing Council be more representative of groups and fellow health and social care organisations across the region.

As well as welcoming the input of our new Partner Governors from BBEMI and Barnsley College, the Trust would like to repeat its sincere thanks to Barnsley Youth Council, who worked alongside the Governors from birth of the Council in shadow form in 2004 and throughout its early development years as an authorised Foundation Trust

The Governing Council is made up as follows:

Public governors

Constituency A

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

Keith Hinchliffe. First appointed 1 September 2010. Term ends 31 December 2012 (first term).

Bruce Leabeater. First appointed 1 January 2008. Term ends 31 December 2013 (second term).

Carol Robb. First appointed 1 January 2006. Term ends 31 December 2011 (second term)

Joseph Unsworth (Lead Governor). First appointed 1 January 2005. Term ends 31 December 2013 (third term).

Constituency B

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

Tony Alcock. First appointed 1 January 2011. Term ends 31 December 2013. (first term).

Pauline Buttling. First appointed 1 January 2010. Term ends 31 December 2012 (first term).

Eric Livesey. First appointed 1 January 2009. Term ends 31 December 2011 (first term).

Julie Smith. First appointed 1 January 2009 (first term). Resigned 31 August 2010 for personal reasons (health and/or family).

Constituency C

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

Ann Frost. First appointed 1 September 2010. Term ends 31 December 2012 (first term).

Sharon Hodgson. First appointed 1 January 2005. Term ends 31 December 2012 (third term).

Bob Ramsay. First appointed 1 January 2005. Term ends 31 December 2011 (third term).

Constituency D

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

Pauline Brown. First appointed 1 January 2005 (third term). Resigned 31 October 2010 for personal reasons (health and/or family).

Michael Dunlavey. First appointed 1 January 2010. Terms ends 31 December 2012 (first term).

Glyn Etherington. First appointed 1 January 2008. Term ends 31 December 2013 (second term).

David Thomas. First appointed 1 January 2005. Term ends 31 December 2011 (third term).

John Townend. First appointed 1 January 2008 (first term). Resigned 31 December 2010 for personal reasons (health and/or family).

Constituency E

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

Michael Edwards. First appointed 1 January 2010 (first term). Early end of term at 1 May 2010 as left the area/constituency.

Denis Gent. First appointed 1 January 2005. Term ends 31 December 2013 (third term).

Wayne Kerr. First appointed 1 January 2005. Terms ends 31 December 2012 (third term).

Trevor Smith. First appointed 1 September 2010. Term ends 31 December 2012 (first term).

Constituency O

Covering out of area/England & Wales

Bill Joice. First Appointed 1 January 2005. Term ends 31 December 2013 (third term).

Staff governors

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

Dr Jon Maskill. Medical and dental. First appointed 1 January 2008 (second term). Early end of term at 1 May 2010 as left the area/constituency.

Mr Ray Raychaudhuri. Medical and dental. First appointed 1 September 2010. Term ends 31 December 2012 (first term).

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

Viv Mills. Clinical support. First appointed 1 January 2005. Term ends 31 December 2011 (third term).

Debby Horbury. Nursing and midwifery. First appointed 1 January 2008. Term ends 31 December 2013 (second term).

Ann O'Brien. Nursing and midwifery. First appointed 1 January 2009. Term ends 31 December 2011 (first term).

Joyce Rhodes. Volunteers. First appointed 1 January 2009. Term ends 31 December 2011 (first term).

Partner governors

Pauline Acklam, MBE. NHS Barnsley

Professor Nigel Bax. University of Sheffield

David Brannan. Voluntary Action Barnsley

Councillor Jenny Platts. Barnsley Metropolitan Borough Council

Jim Holliday. Barnsley Arena (from March 2010 until 30 April 2011).

Karen Lovatt. Barnsley Youth Council (until August 2010). Youth seat moved to Barnsley College from July 2010.

Kay Phillips. Sheffield Hallam University

Martin Jackson. Joint Trade Unions Committee

Harshad Patel. Barnsley Black & Ethnic Minority Initiative (BBMEI) (from September 2010)

Alex Whitely. Barnsley College (from September 2010)

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

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

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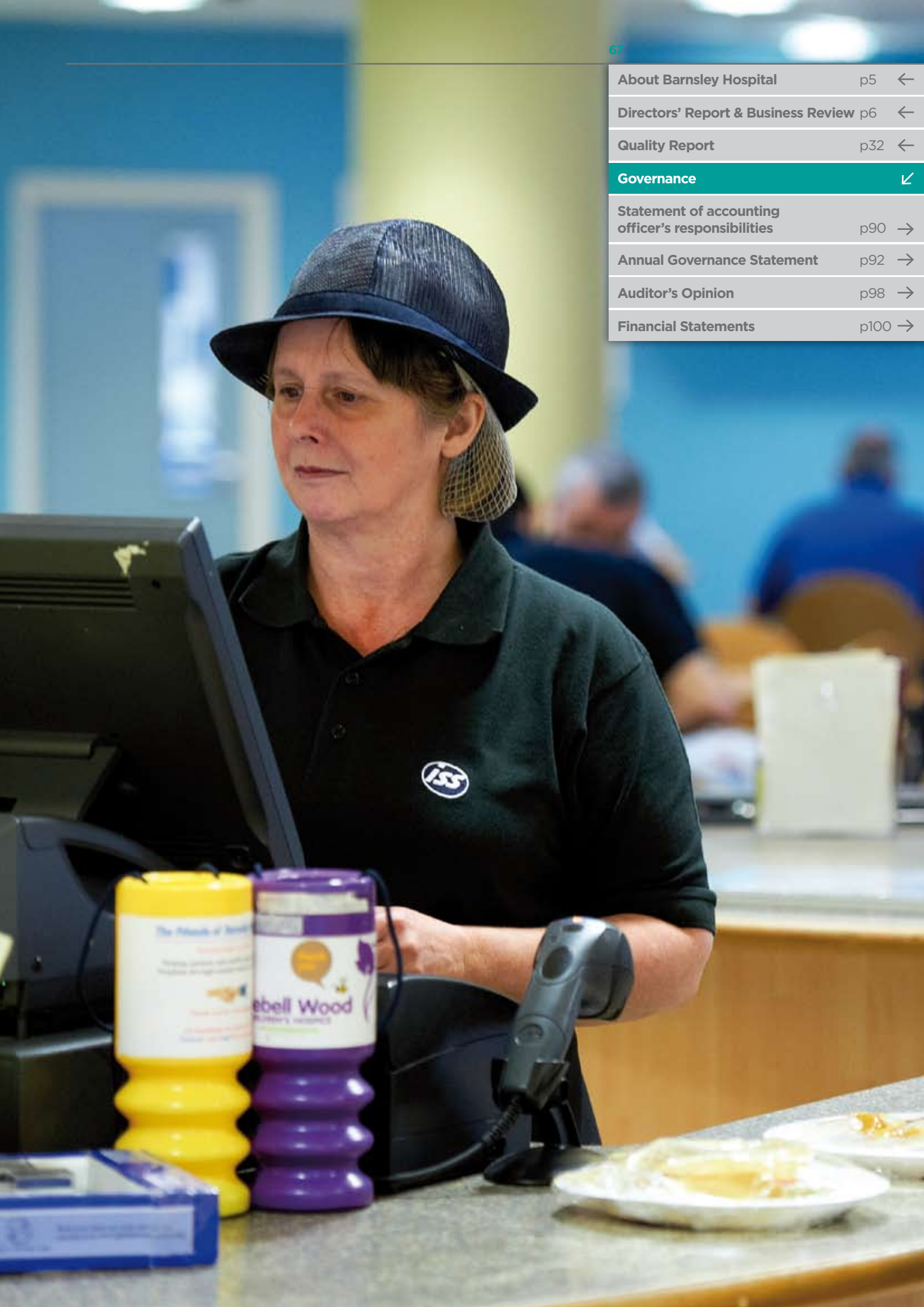

Governing Council and Board member attendance at Governing Council table

Name		Term of office				
		1st appointed	Expiry date	Term	Note	Constituency
Public Governors						**Public Constituency**
Keith	Hinchliffe	01.09.2010	31.12.2012	first		A: Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham
Bruce	Leabeater	01.01.2008	31.12.2013	second		A: Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham
Carol	Robb	01.01.2006	31.12.2011	second		A: Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham
Joseph	Unsworth (Lead Governor)	01.01.2005	31.12.2013	third		A: Dodworth, Hoyland Milton, Penistone East, Penistone West and Rockingham
Tony	Alcock	01.01.2011	31.12.2013	first		B: Darton East, Darton West and Old Town
Pauline	Buttling	01.01.2010	31.12.2012	first		B: Darton East, Darton West and Old Town
Eric	Livesey	01.01.2009	31.12.2011	first		B: Darton East, Darton West and Old Town
Julie	Smith	01.01.2009	31.08.2010	first	1	B: Darton East, Darton West and Old Town
Ann	Frost	01.09.2010	31.12.2012	first		C: Stairfoot, Central, Kingstone and Worsbrough
Sharon	Hodgson	01.01.2005	31.12.2012	third		C: Stairfoot, Central, Kingstone and Worsbrough
Bob	Ramsay	01.01.2005	31.12.2011	third		C: Stairfoot, Central, Kingstone and Worsbrough
Pauline	Brown	01.01.2005	31.10.2010	third	1	D: St Helens, North East, Cudworth, Monk Bretton and Royston
Michael	Dunlavey	01.01.2010	31.12.2012	first		D: St Helens, North East, Cudworth, Monk Bretton and Royston
Glyn	Etherington	01.01.2008	31.12.2013	second		D: St Helens, North East, Cudworth, Monk Bretton and Royston
David	Thomas	01.01.2005	31.12.2011	third		D: St Helens, North East, Cudworth, Monk Bretton and Royston

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General Meetings (inc AGM)		Sub Groups			Joint meeting with Board	Nominations Committee	
		Patient & Access	Staff & Environment	Strategy & Performance			
Total eligible	Attended	Total = 6 Attended	Total = 6 Attended	Total = 6 Attended		Total eligible	Attended
5	4			3	Ð		
7	4	1	4	4	Ð	6	6
7	5	2	2		Ð		
7	6	6	6	6	Ð	6	6
1	1		1				
7	4			3	Ð		
7	2						
2	0						
5	4	3			Ð		
7	5						
7	6	5	6	3	Ð	6	6
4	2		1				
7	2						
7	6	6	1		Ð		
7	6			3			

Name		Term of office				
		1st appointed	Expiry date	Term	Note	Constituency
Public Governors						**Public Constituency**
Wayne	Kerr	01.01.2005	31.12.2012	third		E: Darfield, Dearne North, Dearne South and Wombwell
Trevor	Smith	01.09.2010	31.12.2012	first		E: Darfield, Dearne North, Dearne South and Wombwell
Bill	Joice	01.01.2005	31.12.2013	third		O: Out of area/England & Wales
Staff Governors						**Staff Constituency**
Dr Jon	Maskill	01.01.2008	01.05.2010	second	2	Medical & Dental
Mr Ray	Raychaudhuri	01.09.2010	31.12.2012	first		Medical & Dental
Jill	Marshall	01.01.2007	21.12.2012	second		Non Clinical Support
Viv	Mills	01.01.2005	31.12.2011	third		Clinical Support
Debby	Horbury	01.01.2008	31.12.2013	second		Nursing & Midwifery
Ann	O'Brien	01.01.2009	31.12.2011	first		Nursing & Midwifery
Joyce	Rhodes	01.01.2009	31.12.2011	first		Volunteers
Partner Governors						**Partner Organisation**
Pauline	Acklam, MBE	October 2006				NHS Barnsley
Professor Nigel	Bax	January 2005				University of Sheffield
David	Brannan	January 2005				Voluntary Action Barnsley
Councillor Jenny	Platts	October 2009				Barnsley MBC
Jim	Holliday	March 2010				Barnsley Arena
Karen	Lovatt	January 2009	August 2010		3	Barnsley Youth Council
Kay	Phillips	June 2007				Hallam Sheffield University
Martin	Jackson	January 2008				Joint Trade Unions Committee
Harshad	Patel	September 2010				Barnsley Black & Ethnic Minority Iniative (BBEMI)
Alex	Whitely	September 2010				Barnsley College
Wragg	Stephen	1st January 2009	31st December 2011			Chairman

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		Patient & Access	Staff & Environment	Strategy & Performance			
Total eligible	Attended	Total = 6 Attended	Total = 6 Attended	Total = 6 Attended		Total eligible	Attended
7	4				Ð		
5	4		2	1			
7	7	3	3	1			
0	0					1	0
5	3	1		1	Ð	2	2
7	7		5		Ð		
7	7		5		Ð		
7	4	1	2				
7	2						
7	5	5	5	5	Ð		
7	6						
7	1			6			
7	7	6	6		Ð	6	5
7	4						
7	4						
2	1						
7	5					6	4
7	7		1				
4	2						
4	2						
7	7	5	4	1		5	5

Chairs denoted by shading

Name		Term of office				
		1st appointed	Expiry date	Term	Note	
Board and Management Team attendance:						
Chobbah	Matthew					Director of Strategy & Business Development
Hanwell	Dawn					Director of Finance & Information
Linter	Sharon					Director of Quality, Standards & Governance
O'Connor	Paul					Chief Executive
Patton	Francis					Non Executive Director
Peverelle	David					Chief Operating Officer
Spinks	Paul					Non Executive Director
Wildon	Sarah					Non Executive Director

Notes
1 Resigned due to personal reasons (health and/or family commitments)
2 Early end of term when no longer eligible as Governor for the constituency (ie left area/constituency)
3 In July 2010, youth seat changed to Barnsley College; close working relationship continued with Barnsley Youth Council
4 Whilst appointed by nomination rather than election, Partner Governors are subject to re-appointment/nomination at 3 year intervals
5 Sub-group meetings are an open forum for Governors. As well as regular attendees, several governors attend on a more ad hoc basis and are welcome to do so.

Notes:

a) Where a governor is unable to attend two consecutive general meetings, the tenure of office may be terminated unless the absence was due to a reasonable cause; and he/she will be able to start attending meetings of the Trust again within such a period as the wider Governing Council considers reasonable

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

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General Meetings (inc AGM)		Sub Groups			Joint meeting with Board	Nominations Committee	
		Patient & Access	Staff & Environment	Strategy & Performance			
Total eligible	Attended	Total = 6 Attended	Total = 6 Attended	Total = 6 Attended		Total eligible	Attended
	5			4			
	1						
	3	1					
	2						
				3			
	2		1				
				1			
	2						

Governing Council – meetings

For the joint meeting between the Governing Council and Board of Directors in November 2010, the Board opened up one of its private meetings (hence the Directors' attendance is not recorded separately in the table) and invited all governors to attend. The format for the annual joint meeting, which was introduced in 2009/10, proved to be successful and was repeated in 2010/11. The meeting is in addition to the many other routes by which Governors and Directors communicate throughout the year.

Committees and sub-groups

Nominations Committee

The Nominations Committee is a formal committee of the Governing Council. It comprises the Chairman, three public governors, two partner governors and a staff governor to consider and make recommendations to the Governing Council for the appointment and terms of service of non-executive directors, including the Trust's Chairman. The Lead Governor (as elected by the Governing Council) holds one of the seats for public governors.

The Committee was joined by Mr Ray Raychaudhuri in January 2011, following the vacancy that arose in May 2010 (vacancy held pending annual governor elections).

Membership in 2010/11 included:

- Mr David Brannan, Partner Governor
- Mr Bruce Leabeater, Public Governor
- Dr Jon Maskill, Staff Governor (to May 2010)
- Mrs Kay Phillips, Partner Governor
- Mr Bob Ramsay, Public Governor
- Mr Ray Raychaudhuri, Staff Governor (from January 2011)
- Mr Joseph Unsworth, Public and Lead Governor
- Mr Stephen Wragg, Trust Chairman (Committee Chair)

When the appointment or performance of the Chairman is under consideration by the Committee, the Chairman is excluded from the Committee's discussions.

The meetings of the Nominations Committee were supported by internal Human Resources advisors and the Secretary to the Board throughout the year. The Committee retains the right at all times to seek internal or external expert advice at any time.

The Committee led the reappointment of one non-executive director in 2010/11 and started the process for consideration of appointments in 2011/12, in readiness for the terms of office of two Non Executive Directors and the Trust Chair's which will expire on 31st December 2011 (and had been updated – see page 78). During 2010/11, the Committee working closely with the Senior Independent Director and assisted with the further development of the comprehensive appraisal process for the Chairman. It also 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 to respond to governors' questions. The sub-groups are used by the governors as a forum for in depth reviews of any issues, as well as information gathering and training. In 2010/11 the governors appreciated the non-executive team's continuing commitment to ensuring Chair and/or non-executive director regular attendance at all sub-group meetings to give governors more opportunity to hold the Board to account directly.

The structure of the sub-groups 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 2010/11 the governors:

- looked at the published guidance from Monitor in terms of both their own roles and responsibilities and implications for the Trust, and led the review of the Trust's Constitution, which was approved by Monitor in July 2010;
- independently submitted commentary on the Trust's performance and services to the Care Quality Commission;
- continued to develop their own roles as governors,
- continued to focus on improving membership engagement and issued a survey to over 1200 members, asking for their views about the hospital and its services – now and for the future
- commented on and contributed to the annual planning process.

Further progress of each of the sub-groups in 2010/11 is highlighted below:

Patients & Access

This sub-group has continued to focus on a number of key issues that affect our patients when they come to hospital or try to access our services: from the food provided to them on the wards and in the restaurant, to the comments and complaints registered through a range of routes. To extend its focus on the latter, the group requested and now receives a copy of the monthly summary of complaints and compliments, and

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the group's Chair regularly attended the Trust's Complaints Review group at which the report was scrutinised in more detail. The sub-group also continued to monitor and where appropriate question the Trust's work on issues that affect inpatients, eg improving (reducing) avoidable noise at night and discharge arrangements. Throughout the year the group welcomed presentations, briefings, and question and answer sessions with matrons and senior directors leading on these diverse areas of work.

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 was delighted with the opening and impact of the new car park on Summer Lane, benefiting patients, public and staff alike, which it supported throughout the development. It also worked through the year to promote – and get - better signage on site for those patients who need to come on sight for daily treatment (eg chemotherapy and cardiology). The group particularly values the input of staff governors, who help to ensure that governors are aware of staff's views on changes and challenges throughout the year and the impact on staff, enabling the Governors to ask pertinent questions of, or share important information with, the Board of Directors. It has strong links with the estates, facilities and HR teams.

Strategy & Performance

This sub-group's key focus this year has been to support the appointment process of the Trust's external auditors (a key responsibility of the Governing Council); gain access to the performance reporting data more regularly (which is shared with all Governors for information and reviewed in more detail at the group's meetings), and continue, through its Task & Finish Group, to drive forward the governors' work on improving engagement with members. In response to the members' survey issued in September, the group has devised a series of "medicine for members" meetings, the pilots of which will be held in the spring and summer of 2011/12 in partnership with a cross-section of the community that the governors represent.

Funding & Finance Committee

The remit of this group is to consider funding requests to support the work of the governors but did not meet in 2010/11.

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. The Trust held its first by-election in 2010 due to an unexpected vacancy when a governor moved out of his constituency and thus had to step down as Governor.

Expenses

Governors may claim expenses and other reasonable expenses incurred on Trust business at 40p per mile, in line with national guidance. They are not remunerated by the Trust in any other way.

The Board of Directors

Below left to right
1. Francis Patton
2. David Peverelle
3. Dr Jugnu Mahajan
4. Juliette Greenwood
5. Anne Arnold
6. Paul Spinks
7. Paul O'Connor
8. Sarah Wildon
9. Stephen Wragg
10. Dawn Hanwell
11. Linda Christon.

The Board of Directors is responsible for setting and driving forward the strategic direction of Barnsley Hospital. The Board comprises of six non-executive directors (including the Chairman) and five executive directors.

The skills and strengths provided by the non-executive and executive directors throughout the year continued to ensure that the Trust benefited from a good, well-balanced Board. The balance is reviewed throughout the year as well as whenever any director level vacancies – executive or non executive - arise.

The following were the executive and non-executive directors for the year 2010/11:

Chairman	Stephen Wragg
Chief Executive	Sandra Taylor (to 13th June 2010) Paul O'Connor (interim from 14th June 2010, substantive from 1 March 2011)
Medical Director	Dr Jugnu Mahajan
Director of Finance and Information	Dawn Hanwell
Chief Nurse	Juliette Greenwood
Chief Operating Officer	David Peverelle
Non-executive directors	Anne Arnold Linda Christon Francis Patton (Deputy Chairman) Paul Spinks Sarah Wildon

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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 78 for further details.

The terms of office of one non-executive director expired in 2010/11: Mr Paul Spinks, on 31 December 2010. With the support of the Governing Council and the Nominations Committee, he was reappointed to 31st December 2011. This one year term was determined primarily to mitigate the risk of four non executive director posts coming to term in 2012.

The processes for all non executive director appointments continued to be 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.

Executive directors

Paul O'Connor, Chief Executive – from June 2010

Paul started as Chief Executive in March 2011, having held the position on an interim basis from June 2010. He has previously held chief executive roles in hospitals in London and Birmingham, and also led the QIPP (Quality, Innovation, Performance and Prevention) Programme for NHS North West before joining Barnsley Hospital NHS Foundation Trust.

Sandra Taylor, Chief Executive

Sandra was the Trust's Chief Executive until June 2010. 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.

Dr Jugnu Mahajan, Medical Director

Dr Jugnu Mahajan became the Trust's new Medical Director and Consultant Paediatrician in September 2009. Dr Mahajan, MBBS, MD, FRCPCH, Med (Med Ed), took up the post after moving from Rotherham Hospital, where she worked for 12 years as consultant paediatrician and where she was also Clinical Director for five years. Her specific areas of interest are clinical leadership, improving patient safety and professional standards.

Juliette Greenwood, Chief Nurse

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.

Dawn Hanwell, Director of Finance and Information

Dawn was appointed director of finance from 1 January 2008. She started work in the NHS in 1986 as a financial management trainee in Rotherham where she went on to gain her CIPFA qualification in 1990. Dawn has worked across the NHS in Sheffield, Wakefield, Derby and Leeds. She has worked predominantly in mental health but has also worked, for a short while, in a primary care trust and for the Department of Health. Dawn joined the Board in 2008 having been deputy director of finance at Leeds Partnerships NHS FT, a mental health/ learning disability trust, where she was part of a team that successfully achieved Foundation Trust status.

David Peverelle, Chief Operating Officer

David was appointed as Chief Operating Officer in July 2008 having held a number of senior management posts in the Trust - latterly as the Director of Clinical Services. David has extensive experience of working in acute and specialist hospitals. He started his career in Barnsley as an administration trainee in 1978. Since then he has held a range of senior posts in acute and specialist hospitals which include Sheffield Children's Hospital, General Hospital Nottingham, Queens Medical Centre Nottingham and Royal Hallamshire Hospital before returning to Barnsley.

Non-executive directors

Stephen Wragg, Chairman

Stephen was appointed as the Trust's Chairman in January 2009. He is a self-employed management consultant, before which he was technical director at W2Networking where he was responsible for customer technical solutions, customer service and satisfaction and the development of commercial data centre strategy. From 2001 to 2007 he was Head of Information and Communications Technology (ICT) & eBusiness at Business Link South Yorkshire and Head of ICT at Barnsley and Doncaster TEC from 1997 to 2001.

Prior to his appointment Stephen was a non-executive director of NHS Barnsley; a position he held since April 2006. He 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.

Stephen's current term of office was due to expire on 31 December 2011. In acknowledgement of the period of challenge and change ahead, the Governing Council has already considered this and reappointed him for a further term – to run from 1 January 2012 to 31 December 2015.

Anne Arnold

Anne joined the Trust in December 2004. She has extensive experience working with the NHS as a senior manager and as a management consultant. She now works primarily in education and is a carer. Anne is an MBA graduate and qualified accountant. She is Chair of the Trust's Audit Committee and is also the Senior Independent Director. She was reappointed as a Non Executive Director in 2009 and her current term of office runs until 31 October 2012.

Linda Christon

Linda joined the Trust Board in January 2010. Linda is a former Regional Director of the Commission for Social Care Inspection, the body which regulated social care prior to the Care Quality Commission. She has a Law degree and a Masters degree in Business Administration. She has had a varied career in housing and social care and has experience of working across health and social care partnerships.

Linda is the Non Executive lead for Emergency Planning and Sustainability and is a member and Deputy Chair of the Clinical Governance Committee, and also a member of the Non Clincial Governance and Audit Committees

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 2011.

Francis Patton

Francis joined the Trust in January 2008. He has spent the last 20 years working in the pub retailing sector in areas such as operational management, customer services, marketing, public relations, purchasing, investor relations, communications, human resources, learning and development and recruitment. He holds a number of non-executive roles and teaches part time at Leeds Metropolitan University. Francis was appointed on 1 January 2008 until 31 December 2009 and was subsequently reappointed. Francis' current term is until December 2012. He is the Deputy Chairman and since January 2010 he has chaired the Trust's Non Clinical Governance & Risk Committee.

Register of interests

The register of Director's interests is available from Carol Dudley, the Secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP. Telephone 01226 435000.

There are no company directorships held by the Directors where companies are likely to do business or are seeking to do business with the Trust, other than those highlighted in the related party note in the financial statements. Where there are directorships with companies the Trust may do business with, we have mechanisms to ensure there is no direct conflict of interest and those directors would not be involved.

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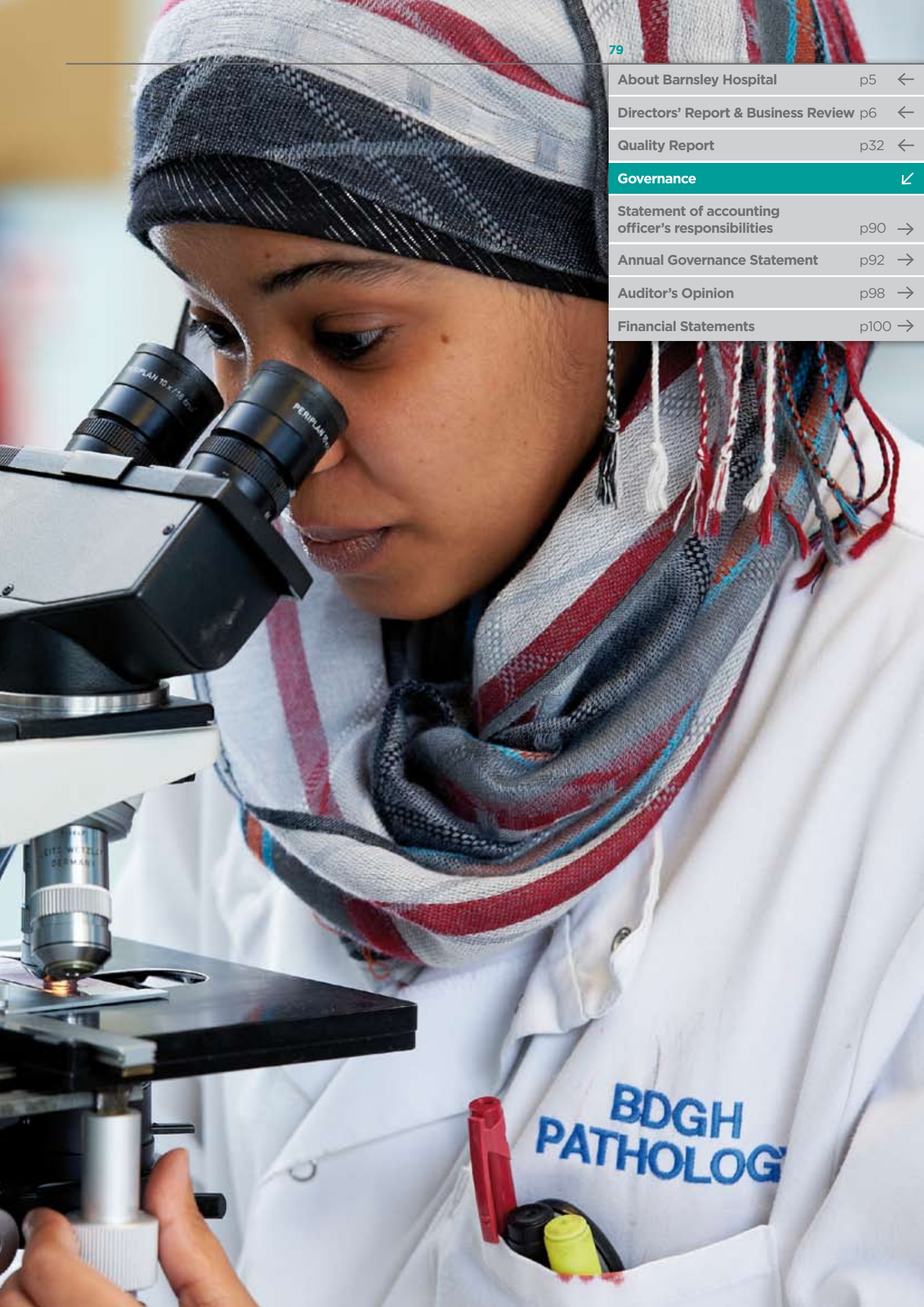

Integrated governance – committees of the Board

Good governance is about making sure our Board is well informed and assured that the right systems and processes are in place. The Trust does this through its five committees which report to the Board. The Committees are also monitored through the Trust's audit processes and regular reports from each are presented to the Board.

Audit Committee

The Audit Committee's purpose is to provide the Board of Directors with assurance on the effectiveness of processes around corporate objectives. This assurance is validated through the annual governance statement.

The Committee also provides the Board with an independent commentary of the fitness for purpose of the Board Assurance Framework and the effectiveness of the governance, risk management and internal control mechanisms. It focuses on the work of the Internal Audit Annual Plan and liaises with external audit in relation to the findings.

What achievements have there been in 2010/11

- Compliance with the revised Monitor Code of Governance
- Embedded and established the revised integrated governance arrangements – now providing a robust infrastructure to support and deliver effective integrated governance
- Developed strengthened and standardised divisional governance arrangements
- Introduced a systematic monthly review of Trust wide risk registers, improving content and consistency of the trusts' electronic risk repository
- Introduced an electronic system for incident reporting to refine incident information, pinpoint trends and improve incident transparency and learning.

Membership of the Committee in 20010/11 comprised the following non-executive directors:

- Miss Anne Arnold, (Committee Chair)
- Mrs Linda Christon
- 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 and were appointed by the governing Council from 1 April 2007 for five years and then re-appointed for the five-year period starting 1 April 2011. The audit fee for the statutory audit was £52,632 (20010/11) excluding VAT. This was the fee for an audit in accordance with the Audit code issued by Monitor in October 2007.

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 ensures that the financial plans of the Trust are realistic and open and all financial risks have been identified and mitigated. In addition, the Committee provides assurance on financial reporting to the Board and an overview of Treasury Management issues. It reviews financial plans and issues, approves reports to Monitor, approves the development of financial reporting consistent with the Foundation Trust's financial regime, oversees the development and implementation of the financial information systems strategy and approves financial policies

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

In 2010/11 membership comprised :

- Ms Dawn Hanwell, Director of Finance & Information
- Dr Jugnu Mahajan, Medical Director
- Mr David Peverelle, Chief Operating Officer
- Mr Paul Spinks, non-executive director (Committee Chair)
- Ms Sandra Taylor, Chief Executive (replaced by Paul O'Connor)
- Mr Stephen Wragg, Chairman

Governance Committees

Both the Clinical Governance Committee and the Non-clinical Governance & Risk Committee are chaired by non-executive directors and include executive and non-executive directors amongst their members, as well as key managers from across the Trust to ensure that they have face-to-face liaison with the pertinent staff to enable them to seek and obtain the information, actions and assurances they need to be able to report upwards to the Board.

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Between them these two Committees ensure that the structures, processes and policies and procedures are in place to provide a framework to support a hospital environment in which excellent clinical and non-clinical care flourishes. It also ensures that any risk issues are identified, managed and escalated appropriately and that actions are taken.

Clinical Governance Committee
Members:
- Mrs Linda Christon, non-executive director
- Juliette Greenwood, Chief Nurse
- Mrs Sharon Linter, Director of Quality & Standards
- Dr Jugnu Mahajan, Medical Director
- Ms Sarah Wildon, non-executive director (Committee Chair)

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

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

Non Clinical Governance & Risk Committee
Members:
- Ms Dawn Hanwell, Director of Finance & Information
- Mr Francis Patton, non-executive director (Committee Chair)
- Mr David Peverelle, Chief Operating Officer
- Mr Stephen Wragg, Trust Chairman until 10 January 2011
- Mrs Linda Christon, non-executive director, from 10 January 2011.

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
- Associate Director of Estates & Facilities
- Risk representative
- Head of Governance
- Representatives from each of the four core service divisions

The Remuneration and Terms of Service Committee (RATS)

Remuneration report

The Remuneration and Terms of Service Committee (RATS) is responsible for the appointment of the Chief Executive and, together with the Chief Executive, other executive members of the Board of Directors.

It reviews and recommends the terms and conditions of service for the executive directors, and other directors and senior managers not subject to the 'Agenda for Change' conditions, and reviews the performance of these staff annually. The committee's recommendations are reported to the Board of Directors. The committee is able to call upon internal and external human resources advice as required.

The Committee met eight times in 2010/11. 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
- 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 below.

During 2010/11 the Committee was responsible for the appointment of a new Chief Executive in June (interim) and December (substantive appointment, with a start date of March 2011). The substantive appointment was subject to open competition with external specialist human resources support as well as the Trust's internal expertise. The Lead Governor was involved with the appointment from start to finish and several governors participated in the stakeholder focus groups, and the appointment was approved at a General Meeting of the Governing Council in December. The interview panel also included an independent party, Mr Eric Morton, Chief Executive of Chesterfield Royal Hospital NHS Foundation Trust, whose support was greatly appreciated.

The Committee is supported by the Chief Executive* and Director of

Attendance at Board and committee meetings			Board of Directors		Audit Committee	
			Eligible	Attended	Eligible	Attended
Arnold	Anne	Non Executive Director & Senior Independent Director	12	10	6	4
Christon	Linda	Non Executive Director	12	10	6	6
Patton	Francis	Non Executive Director & Deputy Chairman	12	12		
Spinks	Paul	Non Executive Director	12	10	6	6
Wildon	Sarah	Non Executive Director	12	11		
Wragg	Stephen	Chairman	12	12		
Greenwood	Juliette	Chief Nurse	12	11		
Hanwell	Dawn	Director of Finance & Information	12	12	6	6
Mahajan	Jugnu	Medical Director	12	11		
O'Connor	Paul	Chief Executive (wef 14th June 2010)	10	9		
Peverelle	David	Chief Operating Officer	12	12		
Taylor	Sandra	Chief Executive (to 13th June 2010)	2	2		

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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. As indicated above, the Committee also accessed external support for the appointment of the Chief Executive.

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 of their performance annually. The Directors do not receive performance related bonuses.

Executive directors are appointed through open competition in accordance with the Trust's recruitment and selection policies and procedures and NHS guidance, including the requirement for external assessors as appropriate. All executive directors covered by this report hold appointments that are permanent until they reach the normal retiring age. The notice period for the Chief Executive is three months and all other executive directors are six months. Any termination payment would take account of national guidance.

The Trust pays due consideration to what is happening in the financial environment and with its other employees when determining Director's remuneration.

Non Executive Directors are appointed by the nominations committee, a sub group of the Governing Council. The committee is supported by appropriate advice and guidance from a human resources specialist. If appropriate, the nomination process may also include the services of another external agency and such other independent expert as may be considered necessary.

Clinical Governance Committee		Finance Committee		Non Clinical Governance & Risk Committee		Remuneration & Terms of Service Committee (RATS)	
Eligible	Attended	Eligible	Attended	Eligible	Attended	Eligible	Attended
						8	5
10	9			2	2	8	8
				9	9	8	7
		4	4			8	5
10	9					8	5
		3	2	6	2	8	8
10	7						
		4	4	9	5		
10	7	4	4				
		3	3			1	1
		4	4	9	8		
						CEO attendance by invitation	

*except where discussions relate to the appointment or appraisal of the Chief Executive
**Senior managers are defined as the Executive and Non Executive Directors of the Trust

Salary and pension entitlements of senior managers

The Trust paid a third party for the services of an interim chief executive between June 2010 and February 2011.

There were no early terminations during the year that required provisions to be made in respect of compensation or other liabilities.

The accounting policy for pensions and other retirement benefits are set out in note 1 to the accounts and details of the senior manager's remuneration can be found below. The information contained in the table has been subject to audit.

* Subject to audit Name and Title	Year ended 31 March 2011			Prior Year		
	Salary	Other Remuneration	Benefits in Kind	Salary	Other Remuneration	Benefits in Kind
	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100	(bands of £5000) £000	(bands of £5000) £000	Rounded to the nearest £100
Dr J Mahajan, Medical Director	120-125	20-25	0	65-70	10-15	0
Ms S Taylor, Chief Executive 1	70-75	0	0	120-125	0	0
Mr P O' Connor, Chief Executive 3	10-15	0	0	0	0	0
Mr D Peverelle, Chief Operating Officer	90-95	0	0	90-95	0	0
Ms D Hanwell, Director of Finance and Information	90-95	0	0	90-95	0	0
Mrs J Greenwood, Chief Nurse	80-85	0	0	90-95	0	0
Mr S Wragg Chairman	35-40	0	0	35-40	0	0
Mrs L Christon, Non Executive Director	10-15	0	0	0-5	0	0
Miss A Arnold, Non Executive Director	10-15	0	0	5-10	0	0
Ms S Wildon, Non Executive Director	10-15	0	0	5-10	0	0
Mr P Spinks, Non Executive Director	10-15	0	0	5-10	0	0
Mr F Patton, Non Executive Director	10-15	0	0	5-10	0	0

Notes:

1. Ms S Taylor resigned from post of Chief Executive wef 13th June 2010 and her salary includes pay in lieu of the normal notice period.
2. An amount of £298,000 was paid to an agency regarding services until 28 February 2011. This figure includes the recruitment agency commission rates, recruitment agency fees, expenses and VAT and is not the direct remuneration paid to the individual. From 1 March 2011, remuneration was from the Trust's payroll, as detailed above.
3. Mr P O' Connor acted as Interim Chief Executive and following open competition was appointed as Chief Executive from 1st March 2011.

Paul O'Connor Chief Executive
Date: 26 May 2011

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Salary and Pension entitlements of senior managers
B) Pension Benefits

* Subject to audit Name and Title	Real increase in pension and related lump sum at age 60 (bands of £2500)	Total accrued pension and related lump sum at age 60 at 31 March 2011 (bands of £5000)	Cash Equivalent Transfer Value at 31 March 2011 £000	Cash Equivalent Transfer Value at 1 April 2010 £000	Real Increase in Cash Equivalent Transfer Value £000	Employers Contribution to Stakeholder Pension To nearest £100
Ms S Taylor, Chief Executive	n/a	15.0-20.0	0	87	n/a	0
Mr P O' Connor, Chief Executive	n/a	140.0-145.0	654	0	n/a	0
Mr D Peverelle, Chief Operating Officer	2.5-5.0	145.0-150.0	775	815	(40)	0
Ms D Hanwell, Director of Finance and Information	5.0-7.5	105.0-110.0	400	436	(36)	0
Mrs J Greenwood, Chief Nurse and Director of Quality and Standards	2.5-5.0	130.0-135.0	505	555	(50)	0
Dr J Mahajan, Medical Director	10.0-12.5	100.0-105.0	449	445	3	0

n/a - Figures not available for Ms Taylor as pension in payment in the year.
n/a - The real increase in pension is not available, as Mr O' Connor was not in NHS employment for the year ended 31.3.10

As Non-Executive Directors do not receive pensionable remuneration, there are no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Paul O'Connor Chief Executive
Date: 26 May 2011

Relations with members

Becoming a member

- Helps people find out how we are performing.
- Keeps them up-to-date with changes through our regular members-only newsletter.
- Lets them have a say in how things are run.
- Allows access to hundreds of discounts usually only accessed by NHS employees.
- For more information about our members, please see below.

Our members provide a local voice and have a say in how the hospital is run. To be eligible for membership, people must either:

- be employed by the Trust with a permanent contract or have worked at the hospital for at least 12 months or on a series on short-term contracts which total more than 12 months. Becoming a staff member is automatic, with a choice to opt out if they wish. Volunteers are included within the staff constituency and contracted staff have the chance to opt in; or
- live within the Barnsley Metropolitan Borough which is broken into five constituencies; or
- live in any other area of England and Wales (our 'out of area' public constituency).

Anyone at and over the age of 14 is eligible to become a member.

Hospital Membership

Our members provide an important local voice and have a say in how the hospital is run. Members are mainly local people, but can include people from the whole of England & Wales, who elect the governors on the Governing Council and help to shape services in Barnsley to benefit local people. Members can raise their concerns and interests with the members' office or with any of the governors.

Membership as at 31 March 2011 was 12,451 members - made up of 9,250 public and 3,201 staff and volunteers.

Membership at the end of the year breaks down as:

Public
Constituency A – 2072
Constituency B – 1493
Constituency C – 1734
Constituency D – 2080
Constituency E – 1313
Constituency O – 558

Staff
Medical & Dental – 246
Nursing & Midwifery – 1477
Clinical Support – 516
Non Clinical – 724
Volunteers – 238

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

In 2010/11, public members received quarterly editions of the members' newsletter, FTi. Members were surveyed in September and in response to the feedback, governors devised a series of "medicine for members" meetings, the pilots of which will be held in the spring and summer of 2011/12 in partnership with a cross-section of the community that the governors represent. The feedback has also helped to shape changes to the newsletter, which was re-launched in May 2011.

Staff members were kept informed through routine internal communications and the hospital's volunteers produced their own newsletter throughout the year. The Trust's website is also well used and through an online poll, members helped to decided the name of the new magazine to replace FTi.

Membership is spread across the constituencies, largely mirroring the overall constituency populations. Membership levels have dropped slightly in the last year and plans are in place with governors to develop greater engagement in the community. Monitoring of membership activity takes place every quarter.

Members can contact governors or director via Carol Dudley, the Secretary to the Board at Barnsley Hospital NHS Foundation Trust, Gawber Road, Barnsley S75 2EP. Telephone 01226 435000.

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Other disclosures

Freedom of information

The Trust continues to meet its duties under the Freedom of Information Act, meeting requests for information from the public, politicians and the media. The majority of these requests are received by email and are responded to electronically within the 20 working day deadline. The Trust continues to provide the information, where it exists, free of charge if the information can be gathered at a reasonable cost. In the financial year 2010/11 the Trust received a total of 203 requests, for which none received a payment.

Market Values / fixed assets

The main assets of the Trust in value terms are the Land and Buildings and these have not been revalued at 31/03/2011 (with the exception of Helensburgh Close car park which was an asset under construction at the time of the last revaluation) as the building indices between 31/3/2010 and 31/3/2011 have not changed as advised by the District Valuer.

Political or charitable donations

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

Balance sheets

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

Branches outside the UK

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

Financial risk

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

Disclosure to Auditors

So far as the Directors are aware, there is no relevant information of which the auditors are unaware and the Directors have taken all the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The accounts have been prepared under a direction issued by Monitor and recorded in the accounting officer's statement later in this report. The Directors are responsible for ensuring that the accounts are prepared in accordance with regulatory and statutory requirements.

A Director is regarded as having taken all the steps that they ought to have taken as a director in order to do the things mentioned above, and:

- made such enquiries of his/her fellow directors and of the company's auditors for that purpose and
- taken such other steps (if any) for that purpose, as are required by his/her duty as a director of the company to exercise reasonable care, skill and diligence.

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.

Monitor ratings

Our Monitor ratings for 2010/11 were green for governance (which now includes mandatory services) and 3 for finance, in accordance with the annual plan. Last year, we were green for governance, green for mandatory services and 3 for finance. Full details of the Trust's ratings can be seen at Monitor's website http://www.monitor-nhsft.gov.uk/.

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.

The Trust was inspected in April 2010 and February 2011 by the Health & Safety Executive. There have been no HSE Improvement Notices or Prohibition Notices served during the year.

Occupational health

The occupational health service has continued to provide a service to the Trust and other health providers in Barnsley.

Last year, the team worked with colleagues in physiotherapy on a pilot study that enables staff to have access to a designated physiotherapist, to support staff either remaining on duty or reducing their sickness absence time. The study is due to finish in June 2011.

They were also involved in a national study on depression which will enable the service to bench mark and work to evidence based practice.

Occupational Health and Human Resources continue to work together in preventing and or reducing sickness absence.

Countering fraud

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 appropriately dealt with and steps are taken to recover any assets lost due to fraud.

Embedded and effective counter fraud arrangements are in place. The Trust has a nominated Local Counter Fraud Specialist (LCFS) carrying out a range of activities that are overseen by the Audit Committee. Compliance with Secretary of State's directions on fraud and corruption is assessed on an annual basis by NHS Counter Fraud Services with the Trust currently performing effective completion of work across the range of counter fraud generic areas.

During the reporting year, the activities of the LCFS have sought to focus promotion of the anti-fraud culture within specific areas of the Trust, and survey results demonstrate effective improvements in awareness levels amongst targeted staff groups.

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

The Annual Counter Fraud Report concludes that staff are supportive of counter fraud work across the organisation and have demonstrated through the survey and fraud awareness engagement that they embrace the NHS Counter Fraud Strategy and the requirements of the Secretary of State for Health and NHS Counter Fraud Services. The LCFS now looks forward to progressing with the work plan and responding to the Trust's needs in the counter fraud arena in what will be a turbulent year for the NHS as a whole.

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	32,162
Number of Bills paid within 30 days	31,275
Percentage of bills paid within 30 days	97.24%

Early retirement on ill-health grounds during the year

There were 8 retirements, at an additional cost of £888,137.99.

These retirements represented 3.18 per 1,000 active scheme members.

Cost allocation and charging requirements

The NHS foundation trust has complied with the cost allocation and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Serious incidents

No serious incidents involving data loss or confidentiality breaches were recorded in the financial year 2010/11.

Paul O'Connor Chief Executive
Date: 26 May 2011

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Statement of accounting officer's responsibilities

Paul O'Connor Chief Executive

"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."

The NHS Act 2006 states that the Chief Executive is the accounting officer of the NHS foundation trust. The relevant responsibilities of accounting officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the NHS Act 2006, Monitor has directed Barnsley Hospital NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of Barnsley Hospital NHS foundation trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- prepare the financial statements on a going concern basis.

The accounting officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS foundation trust and to enable him/her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The accounting officer is also responsible for safeguarding the assets of the NHS foundation trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Paul O'Connor Chief Executive
Date: 26 May 2011

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By Paul O'Connor, Chief Executive

Annual Governance Statement

Annual Governance Statement (AGS)

1. Scope of responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS Foundation Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS Foundation Trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2. The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Barnsley Hospital NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Barnsley Hospital NHS Foundation Trust for the year ended 31 March 2011 and up to the date of approval of the Annual Report and accounts.

3. Capacity to handle risk

The overall responsibility for the management of risk lies with the Chief Executive as Accounting Officer. The Board of Directors, collectively and individually, ensures that robust systems of internal control and management are in place. This responsibility is supported through the assurance committees of the Board of Directors under the chairmanship of a Non Executive Director, with appropriate membership or input from members of the Executive team.

As part of the Board's continuing commitment to risk management, the Trust's Governance infrastructure was comprehensively reviewed in 2009 and the revised arrangements were effected in January 2010. These structures were strengthened and supported through the appointment of a Head of Governance from July 2010. An interim review and full evaluation of these revised governance arrangements was undertaken in order to appraise the implementation, effectiveness and outputs of the changes. The Head of Governance position also provides the leadership and management for the risk management function within the Trust.

The Board of Directors has, therefore, sought assurance through monthly scrutiny of the Board Assurance Framework and the receipt of reports to the Board from the five Board/Assurance Committees. The assurance committees and in particular the Clinical Governance and Non Clinical Governance & Risk Committee, receive exception reports from a number of sub committees that closely monitor areas of risk including: the Quality and Safety Improvement and Effectiveness Board, Infection Prevention and Control Committee, Safeguarding Adults and Children's Committees, the Health and Safety and Information Governance Committees. All these groups have a role to provide regular monitoring for best practice as well as to identify themes and trends for learning and sustained improvements.

The Risk Management Strategy for the Trust clearly outlines the leadership, responsibility and accountability arrangements. This document is currently being further updated by the Trust's Risk Manager and Head of Governance to reflect improved arrangements following the governance review. The updated document will clearly differentiate between the Trust's risk management arrangements and the governance and assurance framework, and will detail the Divisional governance infrastructure, which has been both strengthened and standardised.

A strategic risk forum headed by the Director of Quality, Standards & Governance provides the leadership, supervision and monitoring of all serious incidents, complaints, claims and Coroner's inquests. This forum provides the overview, enquiry and challenge to ensure consistency; appropriate levels of investigation; root cause analysis and that key learning is delivered. A Quality Assurance Officer has been included as part of this process in order to ensure that all actions and recommendations identified as part of the process are completed; this post also provides an interface with the Clinical Effectiveness Department, which monitors ongoing compliance. The lessons learnt from these processes are communicated trust-wide through the risk management team's quarterly news publication "Risky Business".

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The annual review of the Corporate Curriculum has also been undertaken to ensure that the Trust's training programmes are aligned to statutory and mandatory requirements, and that training continues to support the embedding of risk management policies and procedures throughout the organisation.

Capacity is developed across the Trust through a series of training events commensurate with staff's duties and responsibilities. This includes risk management training for all new staff and regular involvement in risk management practices and awareness through monthly risk reviews and their appraisal at divisional governance forums.

Sharing the learning throughout the organisation from risk related issues, incidents, complaints, claims and significant events is key to maintaining the risk management culture within Barnsley Hospital NHS Foundation Trust. Learning is acquired from a variety of sources, including:

- Analysis of incidents, complaints and claims and acting on root cause analysis
- External inspections
- Health and safety issues
- National Patient Safety Agency data
- Assurance from Internal and External audit reports
- Clinical Audit
- Divisional Governance meetings

4. The risk and control framework

Governance Structure and Risk Management

The revised governance arrangements introduced in January 2010 has led to improvements in Trust wide engagement with the risk agenda and controls assurance.

These revised arrangements manage risk and provide assurance to the Board through five Board committees namely: Clinical Governance, Non Clinical Governance and Risk, Finance, Audit and, finally, the Remuneration of Terms of Service Committee. The Board committee structures reporting through to Board have been clearly defined following a comprehensive review of Terms of Reference and reporting arrangements, led by the committees.

The Risk Management Strategy and the Meeting and Assurance Reporting Framework that were approved by the Board in February 2010 and December 2010 respectively clearly outline the strategic intent and the committee structures that support the Board of Directors and provide the framework for risk control.

The Strategy covers risk identification, evaluation, recording risk, control, review and assurance. It also defines the structures for the management and ownership of risk and clearly identifies the Trust's attitude and appetite for risk and at what level a risk is tolerated, clearly defining processes for Board Committee review and escalation through to the Board of Directors meeting.

The Board Assurance Framework together with other reporting mechanisms provided to the Board, provides the evidence that the effectiveness of controls that manage the risks to the organisation achieving its principle objectives, have been reviewed. The Board of Directors has approved the Assurance Framework confirming that the risk control measures that are in place are reasonable and that action plans have been developed to improve the controls and assurance processes where appropriate.

The Assurance Framework is reported monthly to the Board of Directors, having undergone a detailed monthly review at the Board's governance committees. The Framework is continually updated in order to ensure that it covers all areas on which the Board should be seeking assurance. This information is supplemented and enhanced by the other performance management tools presented, including the Integrated Performance Report. This report provides a comprehensive performance overview to the Board on adherence with regulatory targets, quality indicators, financial delivery and workforce metrics.

The Audit Committee performs the key role of reviewing and monitoring the systems of internal control. This committee receives regular reports on the work and findings of the internal and external auditors. This committee is chaired by a Non Executive Director. An assurance report and minutes following each meeting, along with an annual report, are provided to the Board of Directors.

The Board of Directors takes an overarching role in assurance and monitoring of performance and has monitored the delivery of the 2010/11 Business Plan throughout the year. Further assurance is given through ongoing Board committee reviews in relation to financial management and governance through the assessment process for quarterly self certification to Monitor.

The risk management function, risk registers and the Board Assurance Framework have all been considerably developed in 2010/11 by managers within the Quality and Standards Directorate, led by the Director of Quality, Standards & Governance and the Board committees. These enhanced practices have all been robustly reviewed in year by the Trust's Internal Audit team, the results of which have demonstrated significant improvements in the Trust's controls assurance processes.

All risk registers for the Trust have been centralised onto an electronic database. This system is supported through monthly risk review processes led by the risk management team; risk register reports are then scrutinised at both Clinical and Non Clinical Governance meetings. Risks that are not being successfully mitigated and controlled are escalated and discussed at the Board of Directors' meetings in order to prioritise management action appropriately.

The Trust continues to use the National Patient Safety Agency (NPSA) risk matrix introduced in 2008 in order to assess the likelihood and severity of identified risks. Risk awareness training on the use of this matrix has been refreshed to all members of the Board and senior managers throughout the Trust. Additional training on the risk register database has also been cascaded throughout the organisation.

In March 2011 the Trust introduced an electronic system of incident reporting, to further refine incident information, identify emerging risks, pinpoint trends and improve organisational transparency and access to incident information.

Quality governance

The Directors of Barnsley Hospital NHS Foundation Trust are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS Foundation Trust Boards on the form and content of the Annual Quality Reports which incorporate the legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The formulation of the Trust's Quality Report has been led by the Director of Quality, Standards & Governance, with the full support of the Board of Directors and the Governing Council. The formulation commenced in September 2010, with discussion and consultation with the Board, Directors, staff, patients, Governors and stakeholder groups to determine the Trust's priorities and areas for improvement. These quality metrics were refined and discussed, and involved reviewing or introducing new policies involving aspects of patient care including infection prevention and control and patient falls management.

The Trust's strategy comprises of a number of Trust wide "Quality Goals", to address the three quality themes of patient safety, clinical outcomes and patient experience.

The Trust's priorities for 2010/11 were to:

- Reduce the number of falls experienced by patients whilst in hospital
- Reduce the number of patients re-admitted as an emergency admission within 14 days of a previous discharge
- To improve the responsiveness to personal needs of patients

These priorities were communicated through a number of trust-wide working groups including; the Falls Steering Group, the Quality, Safety Improvement and Effectiveness Board (QSIEB), the Executive Team, the divisional governance committees, and through targeted communication articles in staff weekly news bulletins.

The Board tracks the performance of these priorities through review of the quality section of the integrated performance report that is presented monthly. In addition the quality agenda is integrated within the Board Assurance Framework, ensuring that control measures are in place to deliver the quality priorities. Additionally the CQC quality outcomes are monitored and controlled through identified CQC outcome leads, compliance against the requirements is routinely reported to the Executive Team and to the Board of Directors.

All proposed efficiency/cost saving initiatives are clinically and quality impact assessed by both the Medical Director and Chief Nurse against an evaluation matrix, in order to ensure that implementation of proposed schemes will not directly impact on Patient Safety/Quality. A number of additional quality initiatives have been introduced in order to improve quality in the widest sense, these improvements include the implementation of:-

- The Clinical Assessment Tool (CAT) to assess nursing quality
- The Pressure area care patient pathway
- Refined best practice end of life care processes
- The Productive Ward Programme – releasing time to care
- Enhanced recovery patient pathways
- Mental heath care pathway within maternity services

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The nursing dashboard monitors and reviews the progress and performance against these wider quality programmes. Additionally the Trust has met both the National and local CQUINN quality incentives.

The Board is actively engaged in quality improvement and has fully supported a number of new quality tools for clinical assessment, global risk triggers and fall risk patient identifiers.

The Board is assured that quality governance is subject to rigorous challenge through Non Executive Director engagement and the chairmanship of the key governance committees. Non Executive Directors also actively engage with staff on quality by visiting wards and departments on a monthly rotation.

Data security

There have been no incidents related to the loss of data in 2010/11. Barnsley Hospital NHS Foundation Trust has implemented the NHS Information Risk Management Guidelines by establishing a register of key information assets, allocating each one to an information asset owner who reports to the Senior Information Risk Owner. Information risk management is reviewed and monitored by the Information Governance Group. The Trust has implemented and rigorously enforced the Information Risk and Information Security Policy to control where personal information is stored and to protect personal information that is stored on all portable data storage devices from unauthorised access, through the encryption of all portable devices and remote access personal computers.

Our major risks

In 2010/11 the Board took a range of actions to support both ongoing assurance and scrutiny and specific actions to reduce risks; examples being:

- Refining the revised governance arrangements and evaluating the implementation and effectiveness of these changes
- Closely monitoring compliance with challenging national and local infection prevention and control targets
- Assurance on the delivery of the Business Plan objectives
- Monitoring performance through an integrated performance dashboard report to ensure reduction in risk and adherence with the Trust's quality priorities
- Ongoing review and testing of emergency preparedness and resilience planning
- Review of the Information Governance Toolkit

The most significant Risks facing the Trust looking forward are:-

Generic risks

- Delivering the challenging cost improvement programme to meet the financial pressures faced across the NHS and public sector, and the impact and challenge that the comprehensive spending review presents to the Hospital
- Channelling staff engagement to deliver the significant service changes required to deliver both the Trust's business plan and the wider NHS reform agenda
- As patient choice, qualitative performance measures and provider competition become more open, the Trust will be required to demonstrate to both patients and commissioners that it consistently delivers high quality services
- The re-admission and intermediate care drivers that will impact significantly across the interfacing health care providers

Specific Trust risks include managing:-

- The wider impact of the Trust's challenging capital expenditure programme, to deliver the Women's and Children's estate requirements
- The workforce instability and disruption arising from the significant organisational change required to deliver the Trust's Business Plan
- Development of the IT capacity and capability to deliver a comprehensive new patient information system
- Failure to achieve Trust targets impacts on financial and operational performance.

This list is not exhaustive and more details can be found on pages 30 to 31 of the Annual report.

The challenges outlined will be managed through existing Governance and Assurance structures as outlined above.

Engagement with stakeholders

The Trust's Assurance Framework has been informed by partnership working across the health care region and through working with other foundation trusts, giving independence and robustness to its assurance framework including:

- Consulting with the local community and engaging with members of the Foundation Trust, including active involvement in the Local Involvement Network (LINks), the community-wide Safeguarding Boards and other district-wide patient and public involvement initiatives

- Membership of the Foundation Trust Network

- Membership of the Foundation Trust Governors Association

- Undertaking consultation and meeting with NHS Barnsley, the local Overview and Scrutiny Committee, NHS Yorkshire and Humber Strategic Health Authority, the Governing Council and Patient Partnership Initiative (PPI), and other interested bodies/organisations

- Collaborative working between the Governing Council and the Board of Directors; and

- Membership of the local Health Community IM&T network.

The Trust informs and engages with its key stakeholders in relation to risk through a number of forums which include a regular joint contract/clinical quality review meeting with the Trust's host commissioners; the sharing of performance reports including key risks with the Trust's Governors and presentation of the Trust's Board Assurance Framework reports at public Board meetings.

Compliance with standards

The Foundation Trust was fully compliant with the registration requirements of the Care Quality Commission at the year end.

The Trust did receive an unannounced visit from the Care Quality Commission on the 31st March 2011 as part of their national assessment programme. The Trust received an initial draft report in May on which comments on the factual accuracy of the content of the report were invited, a response has been returned accordingly. The Trust has not yet received the final report but is already responding to the draft report by progressing certain actions.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with; these requirements are complied with.

Sustainability and carbon reduction

The Foundation Trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on the UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and Adaptation Reporting requirements are complied with. Further information can be found on page 25 in this report.

5. Review of economy, efficiency and effective use of resources

The Trust produces detailed Annual Plans reflecting its service and operational requirements and its financial targets in respect of income and expenditure and capital investments. These plans incorporate the Trust's plan for improving productivity and efficiency in order to minimise income losses, meet the national efficiency targets applied to all NHS providers and fund local investment proposals. Financial plans are approved by the Board, supported by the Finance Committee.

An Annual Plan is submitted to Monitor, reflecting finance and governance (including both service and quality aspects), each of which is ascribed a risk rating by Monitor. The Plan incorporates projections for the following two years which facilitates forward planning in the Trust.

The in year resource utilisation is monitored by the Board and its committees via a series of detailed reports covering finance, activity, capacity, human resource management and risk. Monthly performance reviews are undertaken with each divisional and corporate team where their performance is assessed across a full range of financial and quality matrices, which in turn forms the basis of the monthly integrated performance report to the Board of Directors. The Trust is committed to the use of service line reporting as a way to assess and measure effective utilisation of resources.

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

6. Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the managers and clinical leads within the NHS Trust that have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report incorporated within the Annual report and other performance

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information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, the Finance Committee, the Clinical Governance Committee and the Non Clinical Governance & Risk Committee. A plan to address weaknesses and ensure continuous improvement of the system is in place.

Work has been commissioned from the Internal Audit service as noted within the statement to review the adequacy of the controls and assurance processes in place and to develop improvements within the governance processes. The Head of Internal Audit and the Chair of the Audit Committee have formally noted the significant improvements to the Trust's governance processes and infrastructure. The Trust is committed to the continuous improvement of its risk management and assurance systems and processes, to ensure improved effectiveness and efficiency. My review is also informed by:

- Opinion and reports by Internal Audit, who work to a risk-based annual plan with topics that cover governance and risk management, service delivery and performance, financial management and control, human resources, operational and other reviews
- Opinion and reports from our external auditors
- Quarterly performance management reports to Monitor
- Department of Health performance requirements/indicators
- Full compliance with the Care Quality Commission essential standards for quality and safety for all regulated activities across all locations
- NHS Litigation Authority (NHSLA) assessments against risk managements standards and Clinical Negligence Scheme for Trusts (CNST) for maternity
- Information governance assurance framework including the Information Governance Toolkit
- Results of national patient and staff surveys
- Investigation reports and action plans following serious incidents
- Governing Council reports and
- Clinical audit reports

The Trust has proactively recognised the need for ongoing development of the robustness of its systems of control and assurance and the monitoring of its risk registers and Assurance Framework to ensure they identify the changing impact and likelihood of risk and better support the delivery of business objectives.

During 2010/11, the Trust's Assurance Framework and governance processes identified gaps in control in the following areas:

- 62 Day Cancer Target for patients requiring to be seen following attending a cancer screening service was narrowly missed in the 3rd quarter. Actions were taken to revise the monitoring in respect of this target and the required improvements were in place for the final quarter of the year.

- The severe inclement weather had an adverse impact on the Trust's achievement of the national 4 hour target in respect of Accident and Emergency. The Trust produced an escalation plan to address this, sharing it with Monitor, NHS Barnsley and the Strategic Health Authority. Additional actions taken to address this issue included a full review of excessive winter pressures, the lessons from which have been incorporated into the Trust's Business Continuity Plans. The actions taken resulted in an improvement in performance by the end of the financial year.

- Following breaches in respect of single sex accommodation, the Trust initiated and communicated an awareness programme to address the related issues. Additionally processes and protocols have been revised as part of the action to ensure compliance with requirements.

- The Trust has identified a need to improve the management and governance of subcontracting and service level agreements processes where there is a need to utilise such arrangements. The Trust acknowledges areas of risk identified through internal auditing processes throughout the year and is responding in a proactive way in order to address the risks and strengthen the governance infrastructure.

- The Government's Transparency Agenda in Procurement presented a challenge for the Trust this year. A steering group was quickly established in order to progress a number of workstreams to deliver the compliance requirements.

Conclusion

As Accounting Officer and based on the review process outlined above, the Trust has identified and is taking action on the control issues arising in year which have been identified in detail in the body of the Annual Governance Statement (AGS) above.

Paul O'Connor Chief Executive
Date: 26 May 2011

Auditor's Opinion

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 2011 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement 01 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 and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, 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 other 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

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

whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

Opinion on 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 201 1 and of its income and expenditure and cash flows for the year then ended to 31 March 201 1; 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

In our opinion

- 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 the Annual Governance Statement 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. We are not required to consider, nor have we considered, whether the Accounting Officer's Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls ;
- 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; or
- we have qualified our report on any aspects of the Quality Report.

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Certificate

We certify that we have completed the audit of the accounts in accordance 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 .

Ian Looker (Senior Statutory Auditor)
For and on behalf of
PricewaterhouseCoopers LLP
Chartered Accountants and
Statutory Auditors
Benson House, 33 Wellington Street,
Leeds
31 May 2011

Notes:

(a) The maintenance and integrity of the Barnsley Hospital 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 have occurred 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.

Financial Statements

Paul O'Connor Chief Executive

"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".

Foreword to the accounts for the year ended 31 March 2011 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).

Paul O'Connor Chief Executive
Date: 26 May 2011

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STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	2010/11 £000	2009/10 £000
Operating income	3-4	153,736	154,547
Operating expenses	5	(151,973)	(152,114)
OPERATING SURPLUS		1,763	2,433
FINANCE COSTS			
Finance income	9	129	77
Finance expense	10	(251)	(274)
Public Dividend Capital dividends payable		(1,670)	(1,853)
NET FINANCE COSTS		(1,792)	(2,050)
Share of Profit of Joint Ventures	1.1	71	228
SURPLUS FOR THE YEAR		42	611
Other comprehensive income			
Revaluation losses and impairment losses property, plant and equipment		(115)	(5,250)
Increase in the donated asset reserve due to receipt of donated assets		0	24
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets - reclassification adjustment		(97)	(99)
Other recognised gains and losses		0	12
TOTAL COMPREHENSIVE EXPENSE FOR THE YEAR		(170)	(4,702)

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

		31 March 2011	31 March 2010
	NOTE	£000	£000
NON CURRENT ASSETS			
Intangible assets	11	2,003	2,526
Property, plant and equipment	12	59,317	61,364
Trade and other receivables	14	426	708
TOTAL NON CURRENT ASSETS		61,746	64,598
CURRENT ASSETS			
Inventories	13	1,605	1,624
Trade and other receivables	14	4,082	5,679
Cash and cash equivalents	15	17,923	14,045
Total current assets		23,610	21,348
CURRENT LIABILITIES			
Trade and other payables	16	(12,909)	(15,468)
Borrowings	17	(122)	(107)
Provisions	20	(565)	(378)
Other liabilities	18	(3,741)	(1,894)
Total current liabilities		(17,337)	(17,847)
TOTAL ASSETS LESS CURRENT LIABILITIES		68,019	68,099
NON CURRENT LIABILITIES			
Borrowings	17	(1,066)	(1,203)
Provisions	20	(307)	(181)
Other liabilities	18	(2,359)	(2,258)
TOTAL NON CURRENT LIABILITIES		(3,732)	(3,642)
TOTAL ASSETS EMPLOYED		64,287	64,457
FINANCED BY:			
TAXPAYERS' EQUITY			
Public dividend capital		45,855	45,855
Revaluation reserve	21	10,397	10,566
Donated asset reserve		605	702
Income and expenditure reserve		7,430	7,334
TOTAL TAXPAYERS' EQUITY		64,287	64,457

The financial statements on pages 101 to 137 were approved by the Board on 26 May 2011 and signed on its behalf by:

Paul O'Connor Chief Executive
Date: 26 May 2011

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY

	Public Dividend Capital	Revaluation reserve	Donated asset reserve	Income and expenditure reserve	Total taxpayers' equity
2010/11	**£000**	**£000**	**£000**	**£000**	**£000**
Taxpayers' Equity at 1 April 2010	45,855	10,566	702	7,334	**64,457**
Total Comprehensive Expense for the year					
Surplus for the year	0	0	0	42	**42**
Revaluation losses and impairment losses property, plant and equipment	0	(115)	0	0	**(115)**
Reduction in the donated asset reserve in respect of depreciation, impairment, and/or disposal of donated assets - reclassification adjustment	0	0	(97)	0	**(97)**
Transfers to the income and expenditure reserve in respect of assets disposed of	0	(54)	0	54	**0**
Taxpayers' Equity at 31 March 2011	**45,855**	**10,397**	**605**	**7,430**	**64,287**
Prior year : 2009/10					
Taxpayers' Equity at 1 April 2009	45,855	15,835	816	6,653	**69,159**
Total Comprehensive Income for the year					
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**

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.
- The Revaluation Reserve is used to record revaluation gains/losses and impairment reversals on property plant and equipment that are recognised in Other Comprehensive Income. An annual transfer is made from the reserve to Retained Earnings of amounts representing the excess of current cost depreciation over historic cost depreciation for each item of PPE. When an asset is sold, or otherwise disposed of, any remaining revaluation reserve balance for the asset is transferred to Retained Earnings. The balance in the reserve is wholly in respect of property, plant and equipment.
- The Donated Asset Reserve is used to record transactions in respect of donated assets and is operated so as to ensure that there is no net cost or credit recognised in the surplus/deficit for the year. At all times, the balance on the donated asset reserve matches the carrying value of the donated assets.
- The surplus or deficit for the year is recognised in income and expenditure, together with any other gain or loss for the financial year that is not recognised in any other reserve.

STATEMENT OF CASHFLOWS FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	2010/11 £000	2009/10 £000
Cash flows from operating activities			
Operating surplus		1,763	2,433
Non-cash income and expenses			
Depreciation and amortisation		5,697	5,598
Impairments		1,011	0
Transfer from the donated asset reserve		(97)	(99)
Amortisation of PFI credit		(29)	(29)
Decrease in Trade and Other Receivables		1,879	581
Decrease/(Increase) in Inventories		19	(253)
(Decrease)/Increase in Trade and other Payables		(2,559)	3,851
Increase/(Decrease) in Other Liabilities		1,948	(810)
Increase/(Decrease) in Provisions		313	(282)
Other movements in operating cash flows	15	26	185
NET CASH INFLOW FROM OPERATING ACTIVITIES		9,971	11,175
Cash flows from investing activities			
Interest received	9	129	77
Purchase of intangible assets		(180)	(1,205)
Purchase of Property, Plant and Equipment		(4,098)	(6,963)
Net cash outflow from investing activities		(4,149)	(8,091)
Cash flows from financing activities			
Capital element of Private Finance Initiative Obligations		(122)	(94)
Interest element of Private Finance Initiative Obligations		(251)	(262)
PDC Dividend paid		(1,642)	(1,966)
Cash flows from other financing activities	1.1	71	228
Net cash outflow from financing activities		(1,944)	(2,094)
Increase in cash and cash equivalents	15	3,878	990
Cash and Cash equivalents at 1 April	15	14,045	13,055
Cash and Cash equivalents at 31 March	15	17,923	14,045

Barnsley Hospital NHS Foundation Trust - Notes to the Accounts

General Information

Barnsley Hospital NHS Foundation Trust (' the Trust') is a public benefit corporation authorised, in England, by Monitor in accordance with the National Health Act 2006. The trust provides healthcare mainly to the region. The address of the Trust is Gawber Road, Barnsley, S75 2EP.

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 2010/11 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.

The financial statements have been prepared in accordance with EU endorsed International Financial Reporting Standards and IFRICs.

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.

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 cash flows 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 from commissioners in respect of healthcare services. Income relating to patient care treatments (also known as spells) that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay. Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The Trust also received income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for the unsuccessful compensation claims and doubtful debts.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met. It 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. 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 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. Accounting policies and other information (continued)

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.

Land and buildings used for the Trust's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed, by a professional valuer periodically but at least every three years. Valuations are performed more frequently where there is evidence that the carrying amounts for land and buildings may be materially different from fair value. Fair values are determined as follows:

- Land, non-specialised buildings and non-operational buildings - in accordance with the FT ARM, this is determined to be market value for existing use.
- Specialised buildings - depreciated replacement cost, based on providing a modern equivalent asset. Where it would meet the location requirements of the service being provided, an alternative site is valued.
- Buildings in the course of construction are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as permitted by IAS 23 in respect of assets measured at fair value.

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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that future economic benefits deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of replacement is capitalised if it meets the criteria for asset recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure incurred after items of property, plant and equipment have been put into operation, such as repairs and maintenance, is charged to operating expenses in the period in which it is incurred.

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 and machinery 2 to 15 years
- Transport Equipment over 7 years
- Information Technology 2 to 5 years
- Furniture and Fittings 3 to 10 years
- Intangibles - software 5 to 8 years

Freehold land is considered to have an infinite life and is not depreciated. The District Valuer (an external body to the Trust) 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.

The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from it. This period is specific to the Trust and may be shorter than the physical life of the asset itself.

1. Accounting policies and other information (continued)

Revaluation and impairment

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

Impairments that arise from a clear consumption of economic benefit are charged to operating expenses in the period that they occur. At the period end, a transfer is made from the revaluation reserve to the income and expenditure reserve for the amount of the impairment (or the remaining balance in the revaluation reserve relating to the asset if this is a lower amount).

Decreases in asset values and all other 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".

At each reporting period end, the Trust checks whether there is any indication that any of its property, plant or equipment have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount.

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.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in operating income or operating expense respectively. On disposal, the balance for the asset in the revaluation reserve is transferred to income and expenditure.

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.

Service concessions - 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 by HM Treasury's FReM, are accounted for as 'on-Statement of Financial Position'. The Trust therefore recognises the underlying assets as property, plant and equipment at their fair value. An equivalent financial liability is recognised and measured 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.

1. Accounting policies and other information (continued)

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. Revaluations and impairments of intangible assets are recognised and accounted for in the same manner as that for property, plant and equipment.

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 inventories.

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 below.

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 cash flows 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'.

1. Accounting policies and other information (continued)

Financial liabilities are classified as 'Other Financial liabilities'.

The classification depends on the nature and purpose of the financial assets and is determined at the time of the initial recognition.

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 receivables, accrued income and 'other receivables'.

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.

Other financial liabilities

The Trust's financial liabilities are categorised as 'other' financial liabilities. The classification depends on the nature and purpose of the financial liability and is determined at the time of initial recognition.

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.

Where an available for sale financial asset has declined in value and there is objective evidence of impairment, the net cumulative loss for the asset that has been recognised in reserves is transferred out of reserves and recognised in Finance Costs within the Statement of Comprehensive Income. An equal and opposite reclassification adjustment is shown within Other Comprehensive Income.

1.10 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the 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. Thereafter the asset is accounted for as an item of property plant and equipment. 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.

The annual rental is split over the repayment of the liability and a finance cost so as to produce a constant rate of finance over the life of the lease. The finance cost for each financial year is then calculated by applying this finance rate to the opening lease liability for the financial year. The finance cost is recognised in Finance Costs in the Statement of Comprehensive Income.

Contingent rentals are recognised as an expense in the period in which they are incurred. The liability is derecognised when the liability is discharged, cancelled or expires.

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.

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

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. Accounting policies and other information (continued)

1.11 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date 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 . Early retirement pension provisions are discounted using HM Treasury pensions discount rate of 2.9%.

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

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the Trust. However , the Trust only recognises a provision for the net amount that it will have to pay in respect of these claims. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 20 but it is not recognised in the Trust's financial statements.

Non-clinical risk pooling

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

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

- Contingent liabilities are not recognised, but are disclosed in note 24 (page 131) , 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 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 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 Trust are outside the scope of value added tax and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable value added tax is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input value added tax is recoverable, the amounts are stated net of value added tax.

1.15 Corporation Tax

The Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to disapply the exemption in relation to specified activities of a Foundation trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988). Accordingly, the Trust is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the exemption is disapplied then the Trust has no corporation tax liability.

1. Accounting policies and other information (continued)

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

No new accounting standards or revisions to existing standards have been early -adopted in 2010/11.

1.19 Standard issued but not adopted

IASB standard and IFRIC interpretations

The following accounting standards have been issued but have not yet been adopted. The Trust cannot adopt new standards unless they have been adopted in the FT ARM issued by Monitor. The FT ARM generally does not adopt an international standard until it has been endorsed by the European Union for use by listed companies.

In some cases, the standards may be interpretated in the FT ARM and therefore may not be adopted in their original form. The analysis below describes the anticipated timetable for implementation and the likely impact on the assumption that no interpretations are applied by the FT ARM.

IFRS 7 - Financial Instruments : Disclosures

This is an amendment to the standard to require additional disclosures where financial assets are transferred between categories (e.g. 'Fair Value through Profit and Loss', Loans and Receivable etc). It is applicable from 2011/12. The change should not have any significant impact on the Trust because it does not generally transfer financial assets between categories.

IFRS 9 - Financial Instruments

This is a new standard to replace – eventually – IAS 39 Financial Instruments: Recognition and Measurement. Two elements of the standard have been issued so far: Financial Assets and Financial Liabilities. The main changes are in respect of financial assets where the existing four categories will be reduced to two Amortised Cost and 'Fair Value through Profit and Loss'. At the present time it is not clear when this standard will be applied because the EU has delayed its endorsement.

IAS 24 (revised) - Related Party disclosures

This new standard seeks to reduce the extent of disclosures required by government entities whose transactions are principally with other government entities. It is due for adoption in 2011/12. This may potentially relieve the Trust from providing some of its related party disclosures with other entities within the Whole of Government Accounts boundary, unless Monitor chooses to adapt the standard in the FT ARM to retain the existing disclosures.

IASB Annual Improvement 2010

The document makes minor changes to 6 standards and one IFRIC Interpretation. Two of the standards amended (IFRS 1 and IAS 34) do not apply to foundation trusts. The IFRIC Interpretation amended (13) is not relevant to foundation trusts. The remaining changes are to IAS 1 and IAS 27 and IFRS 3 and IFRS 7. These changes are minor in nature and should have little or no impact for the Trust.

IFRIC 14 -IAS19 - The Limit on a Defined Benefit Asset, Minimum Funding Requirements and their Interaction.

This is an amendment to the IFRIC that applies from 2011/12.

IFRIC 19 - Extinguishing financial liabilities with equity instruments

This new IFRIC applies from 2011/12 but will have no impact because the Trust has no equity instruments and therefore cannot issue them to settle financial liabilities.

1.20 Segmental Reporting

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the segments, has been identified by the Board of Directors.

2. Operating segments

2010/11	Total	Integrated medicine	Surgery and critical care
	£000	£000	£000
Operating Income	**153,807**	56,410	45,587
Employee benefits expenses	**97,964**	26,067	25,977
Agency costs	**3,299**	1,890	432
Drug costs	**9,270**	5,437	1,654
Clinical supplies and services	**12,286**	5,707	7,156
Misc other operating expense excluding depreciation	**22,430**	782	1,202
Total costs	**145,249**	39,883	36,421
EBITDA	**8,558**	16,527	9,166
Loss on asset disposals	**13**	1	4
Fixed Asset Impairments	**1,011**	0	0
Depreciation and Amortisation - owned assets	**5,637**	290	666
Depreciation and Amortisation - PFI assets	**55**	0	0
OPERATING SURPLUS	**1,842**	16,236	8,496
Finance Income	**129**	0	0
Finance expense	**0**	0	0
Total interest payable on Loans and leases	**0**	0	0
PFI Interest Expense	**(181)**	0	0
PFI Contingent Rent	**(70)**	0	0
PDC Dividend payable	**(1,670)**	0	0
NET FINANCE COSTS	**(1,792)**	0	0
CONTRIBUTION reported to CODM	**50**	16,236	8,496
Audit adjustments	**(8)**		
SURPLUS FOR THE YEAR	**42**		

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 operating segments and the types of services provided from which each segment derives its revenues are as disclosed in note 2 (page 112).

The Trust is an acute NHS hospital providing services for the population of Barnsley and its surrounding area. All activity of the Trust is for healthcare. The Trust receives income through contracts negotiated with its primary commissioners being 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. Contracts are based on payment by results under which the Trust is paid for healthcare services as it delivers them. Income from the English PCTs provide over 90% of the Trust's total income.

Material items of income and expenditure and depreciation are as detailed in the tables of note 2 (page 112) and note 12 (page 122). 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 116) and note 4 (page 117).

Women's and Children's	Diagnostics/ Outpatients	Facilities and Estates	Corporate	Joint Venture
£000	£000	£000	£000	£000
27,354	9,826	1,571	12,988	71
15,874	17,729	2,631	9,686	0
222	278	0	477	0
1,237	932	6	4	0
1,736	(2,936)	467	156	0
512	2,221	9,176	8,537	0
19,581	18,224	12,280	18,860	0
7,773	(8,398)	(10,709)	(5,872)	71
0	8	0	0	0
0	0	0	1,011	0
152	1,307	2,601	621	0
0	0	55	0	0
7,621	(9,713)	(13,365)	(7,504)	71
0	0	0	129	0
0	0	0	0	0
0	0	0	0	0
0	0	(181)	0	0
0	0	(70)	0	0
0	0	0	(1,670)	0
0	0	(251)	(1,541)	0
7,621	(9,713)	(13,616)	(9,045)	71

2. Operating segments (continued)

Prior year : 2009/10	**Total**	**Integrated medicine**	**Surgery and critical care**
	£000	£000	£000
Operating Income	**154,766**	53,596	47,049
Employee benefits expenses	**97,584**	25,795	26,922
Agency costs	**4,796**	1,206	1,966
Drug costs	**9,370**	5,121	2,162
Clinical supplies and services	**12,404**	5,551	6,859
Misc other operating expenses excluding depreciation	**21,899**	561	1,157
PFI Specific Costs	**356**	0	0
Total costs	**146,409**	38,234	39,066
EBITDA	**8,357**	15,362	7,983
Loss on asset disposals	**72**	0	0
Fixed Asset Impairments	**0**	0	0
Depreciation and Amortisation - owned assets	**5,544**	274	720
Depreciation and Amortisation - PFI assets	**60**	0	0
OPERATING SURPLUS	**2,681**	15,088	7,263
Finance Income	**77**	0	0
Finance expense	**(262)**	0	0
PDC Dividend payable	**(1,853)**	0	0
NET FINANCE COSTS	**(2,038)**	0	0
CONTRIBUTION reported to CODM	**643**	15,088	7,263
Audit/ IFRS adjustments	**(32)**		
SURPLUS FOR THE YEAR	**611**		

Women's and Children's	Diagnostics/ Outpatients	Facilities and Estates	Corporate	Joint Venture
£000	£000	£000	£000	£000
27,551	11,856	1,486	13,000	228
15,242	17,611	2,688	9,326	0
318	564	38	704	0
1,044	1,013	6	24	0
1,768	(2,538)	509	255	0
310	2,192	9,032	8,647	0
0	0	356	0	0
18,682	18,842	12,629	18,956	0
8,869	(6,986)	(11,143)	(5,956)	228
0	72	0	0	0
0	0	0	0	0
139	1,175	2,756	480	0
0	0	60	0	0
8,730	(8,233)	(13,959)	(6,436)	228
0	0	0	77	0
0	0	(262)	0	0
0	0	0	(1,853)	0
0	0	(262)	(1,776)	0
8,730	(8,233)	(14,221)	(8,212)	228

3. Income from activities

3.1 Income from activities comprises

	2010/11	2009/10
	£000	£000
Primary Care Trusts	132,112	131,923
Local Authorities	156	163
Department of Health	0	66
Non NHS:		
- Private Patients	6	20
- NHS Injury Scheme*	1,105	986
- Other **	169	122
	133,548	133,280

*NHS injury scheme income is subject to a provision for doubtful debts of 9.6% to reflect expected rates of collection.

**** Analysis of Income from activities: Non-NHS Other**

Other government departments and agencies	23	16
Other	146	106
	169	122

3.2 Analysis of income from activities

	£000	£000
Inpatient - elective	23,587	25,344
Inpatient - non elective	51,285	52,262
Outpatient income	25,845	26,379
Other activity income	26,186	23,207
A & E income	6,639	6,068
Private Patient Income	6	20
Income from activities	133,548	133,280

Included within total income is income for non-mandatory services totalling £1,182,000, comprising private patients income £6,000; Joint Venture Income £71,000 and Road Traffic Accident Income for £1,105,000. The balance of the total income is for mandatory services.

3.3 Private patient income

	2010/11	2009/10	2002/03 Base Year
	£000	£000	£000
Private patient income	6	20	50
Total patient related income	133,548	133,280	75,607
Proportion (as a percentage)	0.004%	0.015%	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 2011, the Trust received 0.004% of its patient related income from private patients, which is within the limit which Monitor has set at 0.1%.

4. Other Operating Income

	2010/11	2009/10
	£000	£000
Research and Development	1,209	1,158
Education and Training	4,713	4,858
Charitable and other contributions to expenditure	34	29
Transfers from donated asset reserve	85	99
Amortisation of PFI Main scheme - deferred credit	29	30
Non-patient care services to other bodies	1,157	1,208
Other income*	12,961	13,885
	20,188	21,267
* Further details of 'other income' are as follows:		
Car parking	771	620
Estates recharges	140	126
Staff recharges	1,336	1,243
IT recharges	1,034	1,327
Staff accommodation rentals	156	179
Clinical tests	301	92
Property rentals	101	106
Community Paediatrics	874	861
Cytotoxic Drugs Recharge	770	711
Musculo Skeletal Services	136	134
Neurology Recharge	202	172
Occupational Health Recharge	205	195
Oncology Recharge	206	206
Pharmacy Issues	808	891
Renal Satellite Unit Recharge	142	142
Rotherham Ophthalmology	2,387	2,852
Voluntary Services Income	205	219
Waiting List Initiatives Clinic	128	360
Miscellaneous items	3,059	3,449
	12,961	13,885

5. Operating Expenses

5.1 Operating expenses comprise:

	2010/11	2009/10
	£000	£000
Services from NHS Foundation Trusts	1,163	990
Services from other NHS Trusts	72	1,177
Services from other NHS bodies	356	675
Purchase of healthcare from non NHS bodies	777	234
Executive Directors' costs **Note 1**	892	705
Non Executive Directors' costs **Note 1**	94	92
Staff costs	100,276	101,585
Drugs	9,270	9,370
Supplies and services - clinical	12,286	12,403
Supplies and services - general	6,356	6,218
Establishment	2,444	2,403
Research and Development	236	546
Premises	5,064	5,157
Increase in bad debt provision	144	14
Depreciation on property, plant and equipment **Note 2**	4,991	5,058
Amortisation on intangible assets	706	540
Impairments on property plant and equipment	1,011	0
Audit services - statutory audit **Note 3.1**	56	58
Other auditor's remuneration - further assurance services **Note 3.2**	12	31
Clinical negligence	3,326	3,000
Loss on disposal of other property, plant and equipment	13	72
Legal Fees	382	255
Consultancy Costs	695	244
Losses, ex gratia and special payments	316	200
Other	1,035	1,087
	151,973	152,114

Note 1 - As required by the Companies Act 2006, further disclosures of Directors' remuneration and other benefits are detailed in note 26 (page 132) to these accounts and further details available in the remuneration report of the Annual Report for the Trust in which the highest paid director can be identified.

Note 2 - Depreciation of property plant and equipment are inclusive of PFI operating costs for depreciation.

Note 3.1 - Auditor's remuneration

The Board of Governors appointed PricewaterhouseCoopers LLP (PWC) as external auditors of the Trust for the 5 year period commencing 1 April 2007, and re-appointed for the 3 year period commencing 1 April 2011. The audit fee for the statutory audit was £52,632 (2009/10 £52,632) excluding VAT. This was the fee for an audit in accordance with the Audit Code issued by Monitor in October 2007.

Note 3.2 - Other auditor's remuneration - further assurance services

	2010/11	2009/10
	£000	£000
Counter Fraud	1	0
IFRS Review	0	4
ALE Review	0	4
Quality accounts review	6	20
	7	28
Sterile Services Audit - charged by Lloyds Register Quality Assurance Ltd	5	3
	12	31

5.2 Operating leases

5.2/1 Operating expenses include:

Payments recognised as an expense	2010/11 £000	2009/10 £000
Minimum lease payments	**677**	679

5.2/2 Total future minimum lease payments

Total future minimum lease payments	2010/11 £000	2009/10 £000
No later than one year.	**667**	2
Later than one year and no later than five years.	**2,007**	20
Later than five years.	**1,325**	4,638
	3,999	4,660

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 £000	Permanently Employed £000	Other £000	2009/10 £000
Salaries and wages	**82,941**	82,941	0	82,768
Social Security Costs	**5,529**	5,529	0	5,460
Employer contributions to NHSPA	**9,383**	9,383	0	9,264
Agency/Contract Staff	**3,315**	0	3,315	4,798
	101,168	**97,853**	**3,315**	102,290

In the year ended 31 March 2011, there were no staff costs capitalised in property, plant and equipment (for year ended 31 March 2010 - £Nil).

Director and staff costs charged to operating expenses are disclosed in note 5.1 (page 118).

6.2 Average number of persons employed

	Total Number	Permanently Employed Number	Other Number	2009/10 Number
Medical and dental	**275**	275	0	279
Administration and estates	**574**	574	0	598
Healthcare assistants and other support staff	**187**	187	0	191
Nursing, midwifery and health visiting staff	**930**	930	0	942
Nursing, midwifery and health visiting learners	**13**	13	0	14
Scientific, therapeutic and technical staff	**416**	416	0	433
Bank and agency staff	**66**	0	66	115
Other	**1**	1	0	4
Total	**2,462**	**2,396**	**66**	2,576

Within Medical and Dental staff numbers are 64 whole time equivalent recharges from other NHS Trusts, a cost of £4,781,000 in salaries and wages - other (66 WTE in 2009/10), 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 8 early retirements (3 in 2009/10) from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £888,137 (£329,054 in 2009/10). 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. Loss on Disposal of property plant and equipment

	2010/11	2009/10
	£000	£000
Loss on disposal of other property plant and equipment	**(13)**	(72)
	(13)	(72)

9. Finance Income

	2010/11	2009/10
	£000	£000
Interest on loans and receivables	**129**	77

10. Finance expenses

	2010/11	2009/10
	£000	£000
Finance Costs in PFI obligations		
Main Finance Costs	**181**	213
Contingent Finance Costs	**70**	61
	251	274

11. Intangible Assets

2010/11:	Software Licences	Assets under Construction	Total
	£000	£000	£000
Gross cost at 1 April 2010	4,029	645	4,674
Reclassifications	641	(638)	3
Additions purchased	187	(7)	180
Gross cost at 31 March 2011	**4,857**	**0**	**4,857**
Accumulated Amortisation at 1 April 2010	2,148	0	2,148
Provided during the year	706	0	706
Accumulated amortisation at 31 March 2011	**2,854**	**0**	**2,854**
Net book value			
- Purchased at 1 April 2010	1,861	645	2,506
- Donated at 1 April 2010	20	0	20
- Total at 1 April 2010	**1,881**	**645**	**2,526**
- Purchased at 31 March 2011	1,987	0	1,987
- Donated at 31 March 2011	16	0	16
- Total at 31 March 2011	**2,003**	**0**	**2,003**

Prior year : 2009/10	Software Licences	Assets under Construction	Total
	£000	£000	£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**
Accumulated amortisation at 1 April 2009	1,608	0	1,608
Provided during the year	540	0	540
Accumulated 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**

12. Property, plant and equipment

12.1 Property, plant and equipment at the Statement of Financial Period date comprise the following elements:

2010/11:	Land	Buildings excluding dwellings
	£000	£000
Cost or valuation at 1 April 2010	4,715	53,136
Additions purchased	0	2,441
Reclassifications	0	7
Revaluation loss **Note 1**	(115)	(988)
Disposals	0	0
At 31 March 2011	**4,600**	**54,596**
Accumulated depreciation at 1 April 2010	0	6,393
Provided during the year	0	2,499
Impairments **Note 1**	0	1,011
Reclassifications	0	7
Revaluation loss **Note 1**	0	(988)
Disposals	0	0
Accumulated depreciation at 31 March 2011	**0**	**8,922**
Net book value		
Purchased at 1 April 2010	4,715	46,241
- Donated at 1 April 2010	0	502
Revised Total at 1 April 2010	**4,715**	**46,743**
- Purchased at 31 March 2011	4,600	45,194
- Donated at 31 March 2011	0	480
Total at 31 March 2011	**4,600**	**45,674**
Analysis of Property, plant and equipment, net book value		
- Protected assets at 31 March 2011	3,398	42,132
- Unprotected assets at 31 March 2011	1,202	3,542
- Total at 31 March 2011	**4,600**	**45,674**

Note 1 - Impairment due to car park scheme costs being lower than independent valuation carried out by the District Valuer and also revaluation on PFI scheme reflected in year.

	Car park impairment	PFI Revaluation	Total
Cost			
Revaluation loss	(1,044)	56	(988)
Depreciation			
Impairment	1,011	0	1,011
Revaluation loss	(1,044)	56	(988)
Total Impairment Loss	(1,011)	0	(1,011)

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
789	494	22,122	70	2,821	659	84,806
1	872	408	0	376	0	4,098
(7)	(589)	354	0	232	0	(3)
0	0	0	0	0	0	(1,103)
0	0	(651)	0	0	0	(651)
783	**777**	**22,233**	**70**	**3,429**	**659**	**87,147**
86	0	14,874	0	1,596	493	23,442
36	0	2,095	10	313	38	4,991
0	0	0	0	0	0	1,011
(7)	0	0	0	0	0	0
0	0	0	0	0	0	(988)
0	0	(626)	0	0	0	(626)
115	**0**	**16,343**	**10**	**1,909**	**531**	**27,830**
703	494	7,068	70	1,225	166	60,682
0	0	180	0	0	0	682
703	**494**	**7,248**	**70**	**1,225**	**166**	**61,364**
668	777	5,781	60	1,520	128	58,728
0	0	109	0	0	0	589
668	**777**	**5,890**	**60**	**1,520**	**128**	**59,317**
0	0	0	0	0	0	45,530
668	777	5,890	60	1,520	128	13,787
668	**777**	**5,890**	**60**	**1,520**	**128**	**59,317**

12. Property, plant and equipment

12.1 Property, plant and equipment at the Statement of Financial Period date comprise the following elements:

Prior year : 2009/10	**Land**	**Buildings excluding dwellings**
	£000	**£000**
Cost or valuation at 1 April 2009	4,715	53,549
Additions purchased	0	1,726
Impairments charged to revaluation reserve **Note 1**	0	(6,191)
Reclassifications	0	2,895
Revaluation surpluses **Note 1**	0	1,157
Disposals	0	0
At 31 March 2010	**4,715**	**53,136**
Accumulated depreciation at 1 April 2009	0	3,479
Provided during the year	0	2,666
Reclassifications	0	7
Revaluation surpluses	0	241
Disposals	0	0
Accumulated depreciation at 31 March 2010	**0**	**6,393**
Net book value		
- Purchased at 1 April 2009	4,715	49,502
- Donated at 1 April 2009	0	568
Revised Total at 1 April 2009	**4,715**	**50,070**
- Purchased at 31 March 2010	4,715	46,241
- Donated at 31 March 2010	0	502
Total at 31 March 2010	**4,715**	**46,743**
Analysis of Property, plant and equipment, net book value		
- Protected assets at 31 March 2010	3,398	42,161
- Unprotected assets at 31 March 2010	1,317	4,582
- Total at 31 March 2010	**4,715**	**46,743**

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.

Dwellings	Assets under construction and payments on account	Plant and Machinery	Transport Equipment	Information Technology	Furniture and fittings	Total
£000	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
897	1,314	20,271	0	2,189	659	83,594
100	2,717	2,201	0	509	0	7,253
(54)	0	0	0	0	0	(6,245)
(248)	(3,537)	188	70	123	0	(509)
94	0	0	0	0	0	1,251
0	0	(538)	0	0	0	(538)
789	**494**	**22,122**	**70**	**2,821**	**659**	**84,806**
37	0	13,267	0	1,356	455	18,594
41	0	2,073	0	240	38	5,058
(7)	0	0	0	0	0	0
15	0	0	0	0	0	256
0	0	(466)	0	0	0	(466)
86	**0**	**14,874**	**0**	**1,596**	**493**	**23,442**
860	1,314	6,756	0	833	204	64,184
0	0	248	0	0	0	816
860	**1,314**	**7,004**	**0**	**833**	**204**	**65,000**
703	494	7,068	70	1,225	166	60,682
0	0	180	0	0	0	682
703	**494**	**7,248**	**70**	**1,225**	**166**	**61,364**
0	0	0	0	0	0	45,559
703	494	7,248	70	1,225	166	15,805
703	**494**	**7,248**	**70**	**1,225**	**166**	**61,364**

12.2 Property, plant and equipment (continued)

Of the totals at 31 March 2011 there were no assets valued at open market value (As at 31st March 2010 - none)

For on-statement of financial position PFI contracts, the NBV of assets held as at 31st March 2011 was £1,722,000 (for 31 March 2010 - £1,725,000) - refer note 19 (page 128) 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 2011 and 31 March 2010.

13. Inventories

13.1 Inventories comprise

	31 March 2011	31 March 2010
	£000	£000
Raw materials and consumables	**1,605**	1,624
TOTAL	**1,605**	1,624

The Trust held consignment stock of £113,000 not recognised in the accounts as at 31 March 2011, (£183,000 as at 31 March 2010).

13.2 Inventories recognised in expenses

	31 March 2011	31 March 2010
	£000	£000
Inventories recognised as an expense in the period	10,096	9,573
Write down of inventories (including losses)	0	0
Reversal of write-downs that reduced the expense	0	0
	10,096	9,573

14. Trade and other receivables

	31 March 2011	31 March 2010
	£000	£000
Non current assets		
Other receivables	**426**	708
Current assets		
NHS receivables	**2,007**	3,675
Prepayments	**477**	254
Other receivables	**1,835**	1,843
Provision for impaired receivables	**(237)**	(93)
Sub Total	**4,082**	5,679
TOTAL non current trade and other receivables	**4,508**	6,387

The majority of note is with PCTs as commissioners for NHS patient care services.

Credit rating is not applied to other receivables. However all receivables are reviewed during the year and provisions for potential impairments are made on an invoice by invoice basis.

Ageing of non impaired receivables past their due date	31 March 2011	31 March 2010
	£000	£000
Up to 3 months	**12**	826
In 3 to 6 months	**22**	61
Over six months	**15**	14
	49	901

Provision for impairment of receivables	31 March 2011	31 March 2010
	£000	£000
Balance at 1 April	93	79
Increase in provision	144	14
Balance at 31 March	**237**	93

15. Cash and cash equivalents

	31 March 2011	31 March 2010
	£000	£000
At 1 April	**14,045**	13,055
Net change in year	**3,878**	990
At 31 March	**17,923**	14,045
Made up of:		
Cash at commercial banks and in hand	**100**	50
Cash with Office of HM Paymaster General and Government Banking Service.	**17,823**	13,995
Cash and cash equivalents as in statement of financial position	**17,923**	14,045

Other movements in operating cashflows for the year of £26,000 are due to the loss on disposal of property plant and equipment for £13,000 and £13,000 for the disposal of a donated asset.

The Trust has a working capital facility with a commercial bank for £8,000,000.

16. Trade and other payables

	31 March 2011	31 March 2010
	£000	£000
Current		
NHS payables	**4,021**	5,166
Trade payables - capital	**1,173**	833
Other payables	**4,876**	6,522
Accruals	**2,839**	2,947
	12,909	15,468

Other payables balance as at 31 March 2011 includes £2,022,000 tax and social security costs (as at 31 March 2010 - £1,988,000).

17. Borrowings

	31 March 2011	31 March 2010
	£000	£000
Current liabilities		
Obligations under Private Finance Initiative contracts	**122**	107
Total Other Current Liabilities	**122**	107
Non-current liabilities		
Obligations under Private Finance Initiative contracts	**1,066**	1,203
Total Other Non-current Liabilities	**1,066**	1,203

For further details of Private Finance Initiative contracts, refer note 19 (page 128).

18. Other liabilities

	31 March 2011	31 March 2010
	£000	£000
Current liabilities		
Deferred income	**3,357**	1,483
Deferred PFI credits	**176**	205
Deferred Government Grant	**208**	206
Total Other Current Liabilities	**3,741**	1,894
Non-current liabilities		
Deferred income	**615**	320
Deferred Government Grant	**1,744**	1,938
Total Other Non-current Liabilities	**2,359**	2,258

19. 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.

19.1 Total obligations for on-statement of financial position PFI contracts due:

Gross PFI liabilities	**31 March 2011**		31 March 2010	
	£000		£000	
Minimum lease payments	**Future**	**Present value**	**Future**	**Present value**
of which liabilities are due:				
- not later than one year;	**288**	342	303	312
- later than one year, not later than five years	**1,043**	817	1,083	913
- later than five years.	**401**	464	649	499
	1,732		2,035	
- Less : interest element	**544**		725	
	1,188		1,310	

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.

19.2 Charges to expenditure

The total charged in the year in respect of the service element of on-statement of financial position PFI contracts was £1,628,185 (for year ended 31 March 2010 £1,588,000).
Deferred income of £29,358 was credited to income during the year (for year ended 31 March 2010 £29,000) and the balance remaining at the year end is £176,145 (for the year ended 31 March 2010 £205,000).

19.3 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 2011**	31 March 2010
	£000	£000
of which liabilities are due:		
- not later than one year;	**0**	0
- later than one year and not later than five years;	**0**	0
- later than five years.	**1,888**	1,842
	1,888	1,842

The Trust had no PFI schemes off the statement of Financial position.

20. Provisions for liabilities and charges

	31 March 2011	31 March 2010
	£000	£000
Non current		
Pensions relating to other staff	**307**	181
Total	**307**	181

	31 March 2011	31 March 2010
	£000	£000
Current		
Pensions relating to other staff	**17**	38
Other legal claims	**78**	121
Other	**470**	219
Total	**565**	378

	Totals	Pensions relating to other staff	Legal claims	Other
	£000	£000	£000	£000
At 1 April 2010	**559**	**218**	**122**	**219**
Arising during the year	**612**	**146**	**97**	**369**
Utilised during the year	**(181)**	**(40)**	**(69)**	**(72)**
Reversed during the year	**(118)**	**0**	**(72)**	**(46)**
At 31 March 2011	**872**	**324**	**78**	**470**
Expected timing of cashflows:				
Current : Within one year	**565**	**17**	**78**	**470**
Non current :				
Between one and five years	**72**	**72**	**0**	**0**
After five years	**235**	**235**	**0**	**0**

Closing balance of Other Provisions consist of £166,000 Agenda for Change, £255,000 EWTD on call cost, £44,000 for Syringe Drivers and £5,000 for HR Liabilities.

The above provision does not include £35,851,699 (£31,975,747 in 2009/10) included in the accounts of the NHS Litigation Authority as at 31 March 2011 in respect of clinical negligence liabilities of the Trust.

21. Revaluation Reserve

	Total Revaluation Reserve	Revaluation Reserve Intangibles	Revaluation Reserve Property Plant and Equipment
2010/11	**£000**	**£000**	**£000**
Revaluation reserve at 1 April 2010	**10,566**	**141**	10,425
Transfer to Income and Expenditure Reserve re assets disposed of	**(54)**	**0**	(54)
Other transfers between reserves	**0**	**(4)**	4
Revaluation losses and impairment losses property, plant and equipment	**(115)**	**0**	(115)
Revaluation reserve at 31 March 2011	**10,397**	**137**	**10,260**
Prior year : 2009/10			
Revaluation reserve at 1 April 2009	**15,835**	**141**	15,694
Transfer to Income and Expenditure Reserve re assets disposed of	**(58)**	**0**	(58)
Revaluation losses and impairment losses property, plant and equipment	**(5,211)**	**0**	(5,211)
Revaluation reserve at 31 March 2010	**10,566**	**141**	**10,425**

22. Capital Commitments

Commitments under capital expenditure contracts at the Statement of Financial Position date were £1,241,000. (2009/10 £886,000). The main capital schemes were:

Property, Plant and Equipment - total £1,225,000 (2009/10 £822,000)
- £502,000 - Ventilation Upgrade
- £210,000 - Wards 31/32 Upgrade
- £194,000 - Minor Injuries Unit
- £123,000 - Combined Heat and Power Installation
- £82,000 - Replace Calorifiers
- £20,000 - Desk Top Replacement
- £8,000 - Medical & Surgical Equipment
- £7,000 - Electrical Testing
- £5,000 - Lifts 23
- £5,000 - Theatre Plant Dehumidification
- £5,000 - Other

Intangible Assets - total £16,000 (2009/10 £64,000)
- £16,000 - Digital Dictation

23. Events after the reporting period

There have been no events after the reporting period.

24. Contingent Liabilities

	31 March 2011	31 March 2010
	£000	£000
Gross value *	(285)	(365)
Amounts recoverable	0	0
Net value of contingent liability	(285)	(365)

* The contingent liability is for personal injury claims, transitional points and perceptorship . The timing of cash outflows is unknown.

25. Prudential Borrowing Limit

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements;

- the maximum cumulative amount of long-term borrowing. This is set by reference to the four ratio tests set out in the Prudential Borrowing Code for NHS Foundation Trusts. The financial risk rating set under Monitor's Compliance Framework determines one of the ratios and therefore can impact on the long term borrowing limit; and

- the amount of any working capital facility approved by Monitor.

Further information on the Prudential Borrowing Code for NHS Foundation Trusts and Compliance Framework can be found on Monitor's website.

The Trust has a Total Prudential Borrowing Limit of £35.6 million in 2010/11 (£38.4 million in 2009/10). As the Trust did not require any loans in 2010/11, only the minimum dividend forecast ratio is applicable. This was also the case in 2009/10.

The Trust has remained within its required Prudential Borrowing Limit ratios during the year.

	Actual ratio	Approved PBL ratio	Actual ratio 2009/10	Approved PBL ratio 2006/07
Minimum Dividend cover ratio	4.44	>1	4.35	>1

Included within the Total Prudential Borrowing Limit, the Trust has a working capital facility of £8 million (£8 million 2009/10), The Trust has not had to draw down any of its working capital facility as at 31 March 2011. This was also the case for 2009/10.

26. 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 97% of all income is received from Department of Health bodies. Details of this income can be found at notes 3 (page 116) and note 4 (page 117).

During the period ended 31st March 2011, Barnsley Hospital NHS Foundation Trust did not have any material transactions with members of the Board nor with key management personnel and senior managers who are considered to be related parties.

During the period ended 31st March 2011, Barnsley Hospital NHS Foundation Trust had a significant number of transactions with entities which are considered to be related parties, material transactions are as listed below. No outstanding balances are secured and will be settled in the normal course of debt collection.

	Income		Expenditure	
	2010/11	2009/10	**2010/11**	2009/10
	£000	£000	**£000**	£000
WGA Related Parties				
Sheffield Teaching Hospitals NHS Foundation Trust	**2,331**	2,159	**5,091**	5,099
The Rotherham NHS Foundation Trust	**3,250**	3,348	**108**	213
Yorkshire and The Humber Strategic Health Authority	**4,364**	4,617	**79**	56
NHS Litigation Authority	**0**	0	**3,327**	2,996
NHS Purchasing & Supply Agency	**0**	16	**5,764**	6,235
NHS Barnsley	**126,467**	126,654	**377**	696
NHS Kirklees	**3,570**	3,789	**0**	0
NHS Rotherham	**1,665**	1,890	**0**	0
NHS Wakefield District	**3,929**	3,391	**0**	0
Department of Health *	**408**	0	**0**	0
Sheffield PCT *	**810**	0	**16**	0
Doncaster & Bassetlaw NHS Foundation Trust *	**68**	0	**329**	0
Sheffield Childrens Hospital NHS Foundation Trust *	**71**	0	**1,024**	0
Rotherham Doncaster & South Humber Mental Health NHS Foundation Trust *	**0**	0	**108**	0
National Blood Authority *	**22**	0	**925**	0
NHS Professionals *	**0**	0	**110**	0
Department for Work and Pensions *	**1,105**	0	**0**	0
Other	**1,199**	0	**1,066**	0
Total	**149,259**	**145,864**	**18,324**	**15,295**
Non - WGA Related Parties				
Barnsley Premier Leisure *	**0**	0	**84**	0
Channel 3 *	**0**	0	**71**	0
	0	0	**155**	0

	Amounts due from related party		Amounts due to related party	
	31 March 2011	31 March 2010	**31 March 2011**	31 March 2010
	£000	£000	**£000**	£000
WGA Related Parties				
Sheffield Teaching Hospitals NHS Foundation Trust	**727**	329	**2,644**	2,946
The Rotherham NHS Foundation Trust	**742**	1,281	**25**	448
Yorkshire and The Humber Strategic Health Authority	**35**	11	**7**	7
NHS Litigation Authority	**0**	0	**1**	1
NHS Purchasing & Supply Agency	**0**	0	**(6)**	0
NHS Barnsley	**467**	770	**72**	255
NHS Kirklees	**(101)**	335	**0**	0
NHS Rotherham	**(163)**	0	**0**	6
NHS Wakefield District	**77**	129	**0**	0
Department of Health *	**0**	0	**0**	0
Sheffield PCT *	**(24)**	0	**0**	0
Doncaster & Bassetlaw NHS Foundation Trust *	**9**	0	**98**	0
Sheffield Childrens Hospital NHS Foundation Trust *	**50**	0	**372**	0
Rotherham Doncaster & South Humber Mental Health NHS Foundation Trust *	**0**	0	**0**	0
National Blood Authority *	**0**	0	**0**	0
NHS Professionals *	**0**	0	**0**	0
Department for Work and Pensions *	**426**	0	**0**	0
Other	**181**	0	**2,871**	0
Total	**2,426**	2,855	**6,084**	3,663
Non - WGA Related Parties				
Barnsley Premier Leisure *	**0**	0	**0**	0
Channel 3 *	**0**	0	**0**	0
	0	0	**0**	0

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.

* Amounts in relation to parties marked with an asterisk were not disclosed for the year ending 31 March 2010.

26. Related Party Transactions (continued)

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:

	2010/11	2009/10
	£000	£000
Short-term employee benefits: directors remuneration		
- Executive Directors	832	`617
- Non Executive Directors	94	92
	926	709
Post-employment benefits: Employer contribution to a pension scheme in respect of directors		
- Executive Directors	60	88
Aggregate of remuneration and other benefits receivable by the directors	986	797
	Number	Number
Number of Directors having benefits accruing under a defined benefit pension scheme (all Executive Directors)	6	6

27. 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 liabilities 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:

27. Financial Instruments (continued)

Financial Assets by category	Loans and Receivables 31 March 2011 £000	Loans and Receivables 31 March 2010 £000
Receivables	**3,024**	4,917
Cash and cash equivalents	**17,923**	14,045
Total	**20,947**	18,962

Receivables comprise trade and other receivables less prepayments.

Financial liabilities by category	Other	Other
Payables	**10,887**	13,480
PFI Finance lease obligations	**1,188**	1,310
Total	**12,075**	14,790

Payables comprise NHS and capital trade payables, accruals and other payables.

There is a provision for impaired receivables (refer note 14, page 126) which relates to non-financial assets, which relates to the NHS Injury Scheme Recovery.

28. Third Party Assets

The Trust held £2,880 cash and cash equivalents at 31 March 2011 (£1,650 as at 31 March 2010) 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.

29. Intra-Government and Other Balances

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £000
Balances with other Central Government Bodies	**32**	**426**	**2,063**	**0**
Balances with NHS Trusts and Foundation Trusts	**1,922**	**0**	**4,021**	**0**
Balances with Local Government	**46**	**0**	**0**	**0**
Balances with bodies external to government	**2,082**	**0**	**11,253**	**3,732**
At 31 March 2011	**4,082**	**426**	**17,337**	**3,732**

	Current receivables £000	Non-current receivables £000	Current payables £000	Non-current payables £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 Local Government	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

30. Losses and Special Payments

There were 2124 cases (2,027 in 2009/10) of losses and special payments totalling £466,374 (£238,978 in 2009/10) approved during the financial year. These amounts are reported on an accruals basis but excluding provisions for future losses. The costs mainly relates to personal injury claims and various other write offs. Also, 1,558 of the write offs are promissory notes (prescription charges) which are small in value (1,744 in 2009/10).

31. 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 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 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. These accounts will also include information on principal actuarial assumptions used and a reconciliation of the present value of the pension obligation between the beginning and end of the year for the plan as a whole. This information is not included in these accounts due to the timing of publication.

Scheme provisions

In 2010/11 the NHS Pension Scheme provided defined benefits, which are summarised below.

This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained.

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

Annual Pensions

The scheme is a 'final salary' scheme. Annual pensions are normally based on 1/80th of the best of the last three years pensionable pay for each year of service, for the 1995 section, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as 'pension commutation'.

Pensions Indexation

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971. Up to 2009/10 these increases were based on changes in the Retail Prices Index in the twelve months ending 30 September in the previous calendar year. From 2010/11, the increases are based on changes in the Consumer Prices Index in the twelve months ending 30 September in the previous calendar year.

Lump Sum Allowance

A lump sum is payable on retirement which is normally three times the annual pension payment.

Ill-Health Retirement

Early payment of a pension, with enhancement in certain circumstances, is available to members of the Scheme who are permanently incapable of fulfilling their duties or regular employment effectively through illness or infirmity.

Death Benefits

A death gratuity of twice their final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

Additional Voluntary Contributions (AVCs)

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

Transfer Between Funds

Scheme members have the option to transfer their pension between the NHS Pension Scheme and another scheme when they move into or out of NHS employment.

Barnsley Hospital NHS
NHS Foundation Trust

If you would like this information in another language or another format, such as large print, please call 01226 432430.

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