York Hospitals NHS
NHS Foundation Trust

York Hospitals NHS Foundation Trust

Annual Plan 2009/10

Index **Page**

Section 1: Past Year Performance 4

1.1 Chief Executive's summary of the previous year 4

1.2 Summary of financial performance 7

1.2.1 Income and Expenditure 8
1.2.2 The Management of In-year Budgetary performance 9
1.2.3 Income and Expenditure Deficit of £5.59m 9
1.2.4 Liquidity 10
1.2.5 Balance Sheet 10
1.2.6 Private Patient Cap 10

1.3 Other major issues 11

Section 2: Future Business Plans 12

2.1 Overall vision 12

2.1.1 Vision statement 12

2.2 Strategic overview 13

2.2.1 National and local challenges 13
2.2.2 Quality 18
2.2.3 Key actions 21
2.2.4 Service development plans 21
2.2.5 Summary of key service developments 22

2.3 Summary of financial forecasts 23

2.3.1 How the plan was built 23
2.3.2 The impact of IFRS 24
2.3.3 Key financial assumptions 24
2.3.4 Phasing 29
2.3.5 Investment and disposal plan 29
2.3.6 Loan and working capital 31
2.3.7 Cost improvement plans 31
2.3.8 Risk rating 34

Section 3 Risk Analysis 35

3.1 Governance risk 35

3.1.1 Governance commentary 35
3.1.2 Significant risks 44
3.1.3 HCAI targets 44

3.2 Mandatory service risk 44

3.2.1 Mandatory services 44
3.2.2 Significant risks 44

3.3 Financial risk 45

3.3.1 Commentary on financial risk rating 45
3.3.2 Significant financial risks 45
3.3.3 Risk of any other non-compliance with the terms of authorisation 46

3.4 Presentation of risk 47

Section 4 Declaration and Self-certification 50

4.1 Self-Certification and Board statement 50

Section 5 Membership 53

5.1 Membership 53

5.1.1 Public membership – size and membership 53
5.1.2 Staff membership – size and membership 55
5.1.3 Patient/carer membership – size and membership 56
5.1.4 Socio-economic grouping 56
5.1.5 Analysis of election turnout 58

5.2 Membership commentary – current position 58

5.3 Membership management 60

5.3.1 Developing a representative membership 61

SECTION 1: PAST YEAR PERFORMANCE

1.1 Chief Executive's summary of the previous year

I am pleased to introduce the Annual Plan for 2009/10 with a brief reflection on what has been a challenging but extremely rewarding year for this Foundation Trust, what this means for our priorities in the coming year, and our ambitions for the future.

Having experienced a hugely difficult winter in 2007/08 with an unprecedented level of non-elective demand for our services, we began the financial year 2008/09 with a number of significant challenges. Particularly, the high level of demand continued unabated well into the summer and further increased in the final quarter of the year, resulting in a 23% growth in admissions during January and February 2009 compared with the previous year. This directly contributed to difficulties with consistently delivering the 4 hour target and presented us for the first time with a deteriorating position in terms of reported infections. The reported levels of clostridium difficile (CDiff) were above trajectory and we experienced a small, but nevertheless significant, "spike" in MRSA blood stream infections in May. There also continued to be a high level of GP referrals compared with our commissioners' plans that applied significant pressure on our elective capacity and performance against the 18 week waiting time target.

I am pleased that despite these burgeoning pressures we were able to report that the Foundation Trust met all of its key targets for the year overall and reported an improved underlying surplus of £2.2m (reporting a net deficit of £5.6m after technical adjustments) for 2008/09. Our performance on infection control was, in many respects, stunning, with only 1 post-48 hour MRSA being reported after May 08 and the incidence of CDiff being significantly below trajectory. This result reflects and rewards the hard work of all our staff and importantly their collective ambition, spirit and commitment in directly addressing the risks the prevalence of infection presents to our patients, staff and our reputation within the community.

This operational and financial success has enabled us to make significant investments in staff (particularly in nursing) and in services in order to support and sustain our provision overall. We have also completed several capital projects this year, including the refurbishment of three operating theatres, the opening of a new haematology and oncology ward and the development of high dependency facilities on our children's ward, a project made possible through the support of a local press appeal.

A further reward and a boost to all our staff was the achievement of an "excellent" rating for both the quality of services and the use of resources by the Healthcare Commission in the summer. Despite the continued operational challenges we faced, our services continued to enjoy excellent and very welcome feedback from patients, both through patient surveys and other less formal channels.

Our Healthcare Commission staff survey results were also encouraging, showing that, on the whole, staff felt positive about their jobs and working for the Trust, a fact reflected in our place among the Health Service Journal's top 100 healthcare employers. I believe this has been enhanced by the quality of our "celebrations", including a series of events to mark the 60th anniversary of the NHS and presentations to recognise a huge number of staff for their long service. We also held our first open event, throwing open our doors to Trust members and the public and inviting them to find out more about who we are and what we do. We will build on this with an even bigger event this year and look to establish a real sense of "community" within the hospital year-round for all staff to enjoy.

Looking forward, we are committed to further raising the standards of care provided by the hospital and to develop appropriately our services for the benefit of the community. We must make every penny count!

We will continue to be ambitious both in our investments and service redesign, particularly for acute patients and to realise our aspirations for improving patient safety, quality of service and the patient experience. We continue to enhance the quality and safety of our services through our participation in the Safer Patient Initiative, which is key to sustaining a change in ethos, behaviour and culture in the organisation.

A priority for the Trust will be the need to continue to plan the development of our estate to ensure it is fit for purpose in the future. Importantly, the greater financial freedoms afforded to us as a Foundation Trust will enable us to fund the build of the new car park, which we plan to begin later in 2009.

The Trust continues to be commended for its contribution to the Hull and York Medical School and we look forward to realising the benefits of appointing increasing numbers of our "own" doctors in the future. We will also continue to build our reputation as a willing leader, and partner, in initiatives to improve learning and its application at all levels in the hospital, through our own efforts and in collaboration with institutions such as York St John University and York College.

I must also put on record my appreciation of the Foundation Trust's governors who embrace their developing contribution and individual and collective roles with enthusiasm and commitment. I look forward to further developing this relationship both within the Trust and supporting our Governor's in developing robust links with their communities, other agencies and representative bodies for the benefit of the Trust and its membership.

The year ahead will continue to test us. We continue to see what seems to be an ever-increasing demand for our services, and the Board is focussing on how we can better manage patient flow through the hospital ensuring it is both safe and efficient for patients and staff. Reduced levels of growth in NHS funding and even more ambitious national performance targets will require the collaborative and vigorous management of radical change throughout the organisation, including ongoing consultation with our governors and members. We are determined to be a high quality organisation further improving the quality and quantity of care we offer our patients and ensuring our performance where possible is in the top quartile of NHS organisations.

These quality gains will be achieved with staff focus being always on the patient, their welfare, and that of their relatives and friends. We must at all times place these needs and expectations at the centre of every decision we make. However, this drive must be balanced with the reality of delivering a significant efficiency programme in the coming year (and beyond) in light of

economic forecasts and the inevitable implications this will have for the NHS and public sector overall.

Lastly, I would like to thank all of our community partners for their help and co-operation during the year. I firmly believe that effective relationships with all partners, both in the public and private sector, are essential to securing a vibrant future for the Trust and I look forward to leading our contribution to this in the coming months.

Patrick Crowley
Chief Executive

1.2 Summary of financial performance

The Trust's financial plan formed a key part of the Annual plan 2008/09, and was originally approved by the Board of Directors in March 2008, with a further revision in May 2008.

Performance against key elements of the plan for 2008/09 are summarised below.

Plan	Actual
Deficit I&E position of £1.77m, after estimated impairment costs of £3.0m	Deficit I&E position of £5.59m, after impairment costs of £7.79m
Underlying surplus I&E position of £1.2m before impairment costs	Underlying surplus I&E position of £2.2m before impairment costs
Efficiency savings of £3.95m	Savings of £3.95m achieved
Financial Risk rating of 4	Provisional year end rating of 4

The impact of the associated income and expenditure requirements to meet the 2008/09 contract activity, were incorporated in the Trust's financial plan for the year. In addition the Trust estimated impairment costs associated with revaluation of assets totalling £3.0m. This resulted in a planned financial deficit of £1.8m for the year. To deliver the plan the Trust put in

place a challenging cost reduction programme to release savings of £3.95m. The planned level of savings was fully achieved.

The increase in activity beyond the contracted levels resulted in additional income being paid to the Trust by PCTs. However, higher than estimated impairment costs associated with the closure of Bootham Park Court and the revaluation of other assets contributed to the Trust achieving a deficit for the year of £5.59m against the planned deficit of £1.8m.

The Trust's cash position at the start of the year was exceptionally high, at £22.1m, due to the North Yorkshire & York PCT paying cash in March 2008 that related to April 2008. During 2008/9 the cash balance reverted to more normal levels. At the end of the year, the balance was lower than originally planned, due to higher than planned spending on capital, and increased levels of debtors linked to over trading with local PCTs.

1.2.1 Income and Expenditure

The Trust's activity and income plans for 2008/09 were based on the Trust's own assumptions and estimates of activity in order to deliver access targets and meet anticipated growth in demand for non-elective services. In addition, specific agreed service developments with PCTs were accommodated, most notably Lucentis and the provision of the North Yorkshire Retinopathy Screening Programme. Expenditure plans were developed to meet the cost of delivering activity, and in meeting underlying cost and service pressures including inflationary pressures resulting from pay awards and significant anticipated increases in energy and food prices.

The summary table below shows movements from the 2008/09 plan.

Income & Expenditure	Plan 2008/09	Actual 2008/09	Variance
	£m	£m	£m
Income			
Clinical income	184.24	190.04	5.80
Non-clinical income	24.82	30.01	5.19
Total income	209.06	220.05	10.99
Expenses			
Pay costs	-136.24	-139.79	-3.55
Non-pay costs	-60.78	-68.18	-7.40
EBITDA	**12.04**	**12.08**	**0.04**
Net Interest	0.45	0.48	0.03
Profit on Disposal	0.00	-0.04	-0.04
Depreciation	-7.04	-6.10	0.94
PDC Dividend	-4.22	-4.22	0.00
Exceptional items	-3.00	-7.79	-4.79
Net surplus/(deficit)	**-1.77**	**-5.59**	**-3.82**

1.2.2 The Management of In-year Budgetary Performance

During the year a number of budgetary pressures were experienced primarily linked to inpatient and outpatient activity being significantly ahead of plan. In order to deliver the increased activity the Trust incurred increased costs on both premium rate working by its own medical staff, and through the use of private providers. In addition, the Trust received £5m non-recurrent income for various one-off projects, which had a corresponding impact on both pay and non-pay expenditure.

1.2.3 Income and Expenditure Deficit of £5.59m

The Trust delivered a technical income and expenditure deficit for the year after accounting for £7.79m impairment costs associated with the writing down of fixed assets.

Excluding impairments the Trust achieved an underlying surplus of £2.2m mainly due to inpatient and outpatient activity being significantly ahead of plan. In order to deliver the additional activity the Trust found it necessary to source additional elective capacity from other providers and by using out of normal hours working at premium cost. This cost was offset by delaying the implementation of various planned developments where a full year impact had been planned, and this assisted in controlling planned expenditure.

1.2.4 Liquidity

The Trust's cash balance at the end of the year totalled £4.7m, which was less than the original planned balance of £10.7m. The difference was due to higher than planned capital spend, and a higher level of debtors reflecting an overtrade position with PCTs at the end of the year.

These unplanned events account for the movement from plan shown in the cash flow analysis below.

Cash Flow	Plan 2008/09	Actual 2008/09
	£m	£m
EBITDA	**12.04**	**12.08**
Movement in NHS Debtors	-1.05	-4.42
Other Working balance movements	-11.88	-12.23
CF from Operations	**-0.89**	**-4.57**
Capital receipts	0.20	0.01
Capital expenditure	-7.00	-9.18
CF before Financing	**-7.69**	**-13.74**
Movement in long term creditors	-0.02	0.00
Interest	0.45	0.50
Dividends paid	-4.22	-4.22
Net cash inflow(outflow)	**-11.48**	**-17.46**
Opening cash balance	**22.14**	**22.14**
Closing cash balance	**10.66**	**4.68**

1.2.5 Balance Sheet

The main change in the Balance Sheet compared with plan, was a reduction in fixed assets of £30.4m due to a revaluation at the end of the year using a modern equivalent asset basis.

1.2.6 Private Patient Cap

During 2008/09 the Trust remained well within its private patient income cap of 0.8% of total patient related income. Income from private patients has been reducing over the last two years as waiting times in the NHS have reduced leading to less demand for quicker access to healthcare, and the number of patients with insurance cover has reduced.

	2008/09	2002/03
Private Patient Income (£m)	0.69	0.90
Total Patient Related Income (£m)	190.99	113.16
Proportion as a Percentage	0.36%	0.80%

1.3 Other major issues

1.3.1 The trust appointed new external auditors in 2008/09 with Grant Thornton replacing Price Waterhouse.

1.3.2 There were no other major issues which arose during the year and no unplanned changes to governance arrangements or clinical delivery

1.3.3 There were changes to board membership during 2008/09. The Trust appointed two new non-executive directors Philip Ashton and John Longworth. John Longworth resigned in January 2009 to take up a director role at another Trust.

The Trust appointed Elizabeth McManus, Chief Nurse as an Executive Director of the board.

The Members' Council reappointed Alan Maynard as Chairman of the Trust until 31 March 2010.

Mr P Crowley was appointed to the post of Chief Executive in June 2008.

Mr A Bertram was appointed as Director of Finance in January 2009.

SECTION 2: FUTURE BUSINESS PLANS

2.1 Overall Vision

2.1.1 Vision statement

The Trusts through its patients, members and governors sees itself as the primary provider of hospital care for the local community and visitors to York. It provides high quality services that are safe and clinically effective. Increasingly our emphasis is on improving patient experience and safety, staff wellbeing, engagement with our community, and continually improving efficiency to ensure top quartile performance in all that we do.

The Trust vision set out in our application to become a Foundation Trust. We aim to

- Place the patient voice at the heart of all that we do.
- Deliver continuous improvements in the quality of care we offer to patients
- Transform how we work by working in partnership with other agencies across the health economy.
- Ensure that we have a flexible, valued and skilled workforce
- Deliver appropriate, modern facilities for healthcare provision in the 21st century

2.2.1 Formation of our vision

The Trust is a successful medium to large hospital and provides a wide range of clinical services to a population of 350,000 people across North Yorkshire and beyond. We have undertaken a Trust wide review of clinical services in order to understand the key opportunities and challenges presented at a national, regional and local policy level going forward. This includes consideration of national strategies and the Darzi review. All specialties have been involved and we have a better understand of our portfolio of services and what choices we might make. We have engaged our Commissioners and our Governors in the

process. The vision we set out as part of our Foundation Trust application largely still stands and is outlined above.

2.2 Strategic overview

2.2.1 National and local challenges

In developing its future business plans the Trust has been mindful of, and has sought to mitigate the following national and local challenges:

- We are facing significant increases in acute admissions and we are limited in our ability to continue to accommodate ever increasing numbers of patients. We recognise that this element of our business requires a very different focus and we will be changing the way we work to reflect this.

- To respond to the 'High Quality for All' initiative we are working with commissioners to identify areas for development and ensure that we have appropriate, sustainable and clinically safe services locally.

- The impact of the introduction of the new national tariff based on HRG version 4 has been fully assessed by the Trust and its Commissioning PCTs during the planning and contracting process. The overall financial impact of the new tariff is assessed as marginal for both the Trust and its main commissioners. During the contracting process for 2009/10 the Trust and its commissioners have agreed risk management arrangements for the three most contentious areas of the new tariff. For outpatient procedures it is agreed that the Planned Same Day tariff will not be used and the 2008/09 outpatient procedure tariffs will continue to be used. For the Radiology Outpatient tariff it is agreed that this will be a fixed payment for 2009/10 to allow for better understanding of the information and local tariff requirements of this. For Chemotherapy services it is agreed that delivery health resource group (HRGs) will not be used to allow better understanding of these during 2009/10. All other aspects of the new national tariff are being introduced during 2009/10 and income will vary directly with the activity undertaken as in previous years.

- The international and national economic climate has resulted in unprecedented levels of public sector borrowing within the UK during peacetime. Although the most recent budget by the Government has sought to preserve the commitment given to the NHS during the last comprehensive spending review, it is clear that in real terms the NHS is facing the prospect of the lowest levels of funding growth than it has faced in well over a decade. This business plan is predicated on the receipt of the growth levels indicated in the budget, coupled with the challenge of delivering high annual levels of efficiency saving.

- Notification of significant increased fees from the NHS Litigation Authority has presented the Trust with a further cost pressure of £1m on its existing premiums. Whereas this additional cost has been factored into its financial plans, the Trust is vigorously examining requirements to improve its rating and thereby qualify for improved discount rates on its premium payments.

- The increased focus on the development of commissioning capabilities and contracts is welcomed by the Trust and is viewed as a benefit rather than a threat. This will provide opportunities for the Trust to discuss strategic service developments with PCTs on a more informed basis. The contracting discussions for 2009/10 have already demonstrated greater clarity than in previous years and many long standing contentious issues have already been resolved.

- The Trust has assessed the increased risk of non-payment for over activity against contracts for 2009/10. The risk of non payment is assessed as low due to the improved financial position of its commissioning PCTs, the inclusion of some growth above the 2008/09 activity outturn leading to realistic contract values, no in year activity reduction plans and the protection against non payment that the legally binding national contract gives.

- The Yorkshire and Humber SHA, in consultation with local providers and commissioners, has devised an SHA wide quality improvement incentive scheme which should result in the Trust receiving £1m for compliance with the scheme. The final details of the scheme have recently been published and

The introduction of the Care Quality Commission during the year saw the requirement for the Trust to complete an application for registration as a service provider in relation to healthcare associated infection. The Healthcare Commission undertook an inspection in the Trust during November 2008 where some issues were identified. The Trust created an action plan to resolve the issues and submitted an application to the Care Quality Commission. The Trust received an unconditional licence from 1 April 2009.

The Standards for Better Health Declaration completed each year by the Trust will be completed in November 2009 for the final time. It is expected that the Care Quality Commission will introduce a process for addressing both the annual declaration and the requirement for registration during the year. We await further clarity and guidance on next year's requirements for overall registration with CQC. A number of areas need further work to ensure compliance with these standards during 2009 and we have action plans in place to address this.

- The Trust is on target to achieve EWTD compliance for junior doctor rotas by August 2009 however challenges remain around the recruitment of medical staff and the availability of locums to fill any subsequent gaps. The Trust is focusing on developing consultant establishments to address these issues in the areas of most need along with a review of where and how it attracts locums. In addition it has put in place an intake strategy designed to minimise gaps in the junior rotas. For other groups the organisation is embarking on a programme to ensure that all staff achieve compliance against the WTD. Equally the organisation will need to robustly monitor working hours both internally and for staff who have secondary roles outside the organisation. The Trust is currently developing supporting policies, guidance for managers and a monitoring system to support implementation

- Higher levels of unemployment are expected locally due to the economic situation and this will bring a number of benefits as well as challenges, we find that recruitment and retention to some of our support posts improves during downturns, but that health services are used more by those who are unemployed. This particularly impacts upon primary care. We will monitor the situation closely. We are working with Yorkshire Forward to increase local procurement opportunities has a knock on benefit for local employment. We are also ensuring that local suppliers receive payment as soon as is possible.

- The Trust has an agreed Quality & Safety Strategy with clear objectives of reducing harm and overall Hospital Standardised Mortality Rates (HSMR). The Quality Accounts for 2009/10 reflect these priorities which have been informed through local and national work. The Board of Directors will receive regular monthly reports on the primary drivers in the strategy and quarterly reports on the key indicators.

- The Trust has assessed the implications of competition over the 3 year planning period. The main local competitive services include:

  Local GPs have set up a provider service (Ebor Consortium) in response to some of the Primary Care reforms which are now being introduced, and in particular competition from the private sector. The Consortium plans to provide some services which have traditionally been provided in a hospital setting and the Trust is working collaboratively with them to identify these. This is anticipated to have a limited effect in 2009/10.

  The Clifton Park Centre (an Independent Sector Treatment Centre) was opened in 2006 and continues to provide Orthopaedic services locally. A significant amount of the Trust's consultant Orthopaedic resource is spent at the centre and routine orthopaedic work which was previously undertaken at the Trust is now performed at this centre. The Trust has made provision for this change in activity and income over a number of years and the centre is now considered to be at contract capacity with North Yorkshire and York Primary Care Trust (NYYPCT) limiting any further

competitive threat to the Trust in the short term. The Trust continues to provide Anaesthetic and Orthopaedic Consultants to the Clifton Park Centre. The current contract ends on the 31st March 2010 and the NYYPCT are assessing the options for renewing the contract from that date which could include an expansion of current services. This could have an impact on the Trust's activity and income although at this stage no assumption has been made regarding this.

On the periphery of the Trust's catchment area to the West difficulties in meeting and sustaining the 18 week target in Leeds may potentially provide an opportunity for the Trust to continue to increase activity from Leeds PCT.

- The Board of Directors has committed to the NHS carbon reduction strategy and during 2009 work is being undertaken to ensure that we are able to meet our target reductions in emissions. The Trust has a huge opportunity to influence not only its staff behaviours but also that of the many hundreds of thousand patients and visitors that pass through our doors. Over the next five years we intend to be seen as leading this agenda locally and already have ambitious travel and waste management plans in place.

- Pandemic Flu will be an obvious challenge if and when it becomes widespread. Work is being undertaken across the health economy to ensure maximum resilience. A moderate provision has been made for this preparation and once work is completed by the DH on the impact and recovery issues more financial modelling will be undertaken.

- The Trust does not foresee any major workforce issues in the next year and anticipates a slight increase in workforce numbers as part of service development plans and the resizing of the hospital to match contractual activity. The Agenda for Change process now underpins job evaluation and banding and the Trust continues to ensure that the process enhances its ability to operate as a competitive local health service. In anticipating the effect of future financial difficulties to Trust is reviewing the impact of wage standstills or worse, and the implications of managing labour contracts locally.

During 2007/08 the Board of Directors approved investment in Human Resources support to reduce long term sickness. This work was implemented throughout the year, and had a real impact on reducing sickness rates and significantly reducing the number of staff on long term sick. This work will continue to progress during 2009/10 and will provide a dedicated resource to assist in managing staff sickness appropriately. The Trust will achieve the 2009 European Working Time Directive junior doctor targets, with a current compliance rate of 93%. This is being achieved largely through a cost neutral approach by changing working practices and rotas.

During 2008/09 the new Centre for Occupational Health and Wellbeing based at Clifton Moor was opened by the Secretary of State for Health, Alan Johnson. There will continue to be a strong focus on the health and wellbeing agenda during the coming year, assisted by the recent appointment of the Trust's first Occupational Health consultant.

There is evidence that electronic rostering can improve not only the financial performance of a workforce, primarily through better demand management and use of core and temporary staff, but also improve and smooth the skill mix available. The Trust will exploit both the technology and accumulated knowledge available to ensure that it is delivering the best staffing solutions across its business.

Finally, it is recognised that the Trust through the risk management processes is improving the attendance at statutory and mandatory training. In 2009/10 additional focused effort will be made to ensure this continues.

2.2.2 Quality

The Trust has an agreed Quality & Safety Strategy with clear objectives of reducing harm and overall Hospital Standardised Mortality Rates (HSMR). The Quality Accounts for 2009/10 reflect these priorities which have been informed through local and national work.

High level measures of harm are reported to the Board on a monthly basis and more detailed reports on a quarterly basis. The approach taken to benchmarking, audit and validation

of the accounts ensures that the measures are specific, provide greater assurance that the data used is both accurate and timely so ensuring improved public accountability and engaging boards in the quality improvement agenda.

The following pathways are to be fully implemented (based on the CQUIN framework and Advancing Quality Collaborative):

Evidence Based Practice Measures

- Acute myocardial infarction
- Heart failure
- Stroke
- Hip replacement
- Knee replacement
- Nursing and midwifery metrics eg pressure ulcers, privacy and dignity
- Maternity dashboard

Patient experience Measures

- Patient Reported Outcome Measures
- Patient Reported Experience Measures
- Nursing & Midwifery Metrics
- Patient feedback

HSMR & Adverse event rates

- Management of deteriorating patients
    - Reduction in crash call rate by a further 20%
- Health care associated infections (HCAI)
    - Reduction in C Diff by 10% from baseline from 2006/07 i.e. x cases per year
    - Central line sepsis 0 (or 300 days)
    - VAP 0 (or 300 days)
    - Maintain MRSA bacteraemia trajectory
- Early detection, prevention & management of falls
    - Reduce harm from falls by 50%
- Adverse drug events
    - Reduce medication errors by 50%
    - 100% medicine reconciliation in 24 hours
- Reducing harm from high risk medicines
    - Reduce out of range INRs by 50%
    - Reduce opiate overdosage evidenced by naloxone use by 50%

    - Reduce use of strong dextrose to treat hypoglycaemia by 50%
    - Reduce midazolam overdose (evidenced by use of flumazenil by 50%)
- Open channels of communication
    - Safety briefings
    - Use of SBAR
- Leadership and culture
    - Continual development of organisational safety culture measured via a safety climate survey
    - Leadership walk rounds

We will also identify more proactively patient feedback measured and managed using a variety of tools and techniques, such as:

- PROMS (Patient reported outcomes measures)
- Complaints
- Feedback from governors and volunteers
- Using patient stories

The Trust is committed to giving patient quality and safety the highest priority and this strategy builds on the positive outcomes in the reduction of measurable harm, already proven through the Safer Patient Initiative (SPI), while making arrangements to continue to improve patient outcomes and experience. The drivers in the strategy have been developed using identified priorities formed by national and local data and international and national evidence.

The Strategy will be embedded and evidenced by measurement within directorates alongside their existing performance and risk management measures. Achievement of the aims will be supported by specialists and staff will be trained in the methodology, tools and techniques and measurement. Increasing capability will begin to change the quality and safety culture and allow for sustainability.

A communication plan will be developed alongside the Strategy in order to ensure that staff and patients hear and understand key quality and safety messages (e.g. SUI recommendations) and patient safety success stories in order to spread learning and improve and develop public confidence.

2.2.3 Key actions

The main management initiatives this year are to

- implement the Quality and Safety Strategy how will we maintain effect? Diminishing returns is the great risk
- improve the management of acute patients within the hospital and in partnership with others through the health economy overall.
- deliver all new and existing targets and quality measures,
- ensure that the Staff Health and Wellbeing Strategy is implemented.
- prepare for pandemic
- further develop our approach to sustainability
- finalise the estates strategy 2009-2015

2.2.4 Service development plans

The key features of the Trust's service development plans for 2009/10 focus on the growth and improvement of existing services.

The Trust has, or is in the process of developing the following services after consultation and in agreement with its main commissioners in response to local and national needs. Each fits with the Trust's strategy of becoming the provider of choice for specialist services to the wider North Yorkshire community.

(a) Lucentis

This service development commenced as a new service to the Trust during 2008/09, and is planned to reach full operation during 2009/10. Additional income of £1.84m is estimated in 2009/10.

(b) North Yorkshire Diabetic Retinopathy screening service

This service development commenced as a new service to the Trust during 2008/09, and is planned to reach full operation during 2009/10. Additional income of £0.39m is estimated in 2009/10.

(c) Expansion of the North Yorkshire Breast screening service

The Trust is the existing provider of this service to the North Yorkshire area, and will be expanding the service to accommodate the new national target extending the screening age range from 50-70 years to 47-73 years. The expanded service is not planned to go live until January 2011, although in preparation the main investment during 2009/10 will be in respect of project management costs and the leasing of equipment.

(d) Provision of Chlamydia services to Harrogate and Scarborough community

The Trust provides the service to the York community, but will now extend the service to cover the Harrogate and Scarborough communities for an initial period of 2 years. In addition to seeing patients on a drop-in basis, the service will also include promotional work. The service will include additional income on a block contract basis of £0.32m.

The Trust in agreement with its main commissioners developed during 2008/09 a clinical alliance with Harrogate for the provision of vascular services. Outpatient services are provided at Harrogate (who retain the income), and inpatient services at York. Additional income of £0.49m is estimated in 2009/10.

In terms of growth of existing services, the main changes over the 2008/09 plan are assessed as:

- General Medicine – +£1.50m from growth in day cases and outpatients
- Elderly Medicine – +£0.75m from growth in non-elective and outpatients
- General Surgery – +£0.86m from growth in elective, day cases, non-elective, and outpatients
- Ophthalmology – +£0.50m from growth in elective and outpatient activity
- Trauma & Orthopaedics – +£2.12m from growth in elective, day cases, non-elective, and outpatients

2.2.5 Summary of key service developments

The table below summarises the activity and financial impact of the Trust's service developments. Given that some of the

developments commenced during 2008/09 and were included in the 2008/09 plan, the figures represent the marginal change on the 2008/09 plan.

Initiative	Activity included in 2009/10 plan over 2008/09 plan	Financial & activity implications in annual plan 2009/10 (£m)	
		Capital	Net Revenue
Lucentis	225 1st Ops 2000 FU Ops	0.00	0.46
North Yorkshire Retinopathy	15000 patients on register	0.00	0.15
Chlamydia	n/a	0.00	0.03
Vascular Clinical Alliance	339 spells	0.00	0.11
North Yorkshire Breast Screening	n/a	0.00	0.00

During 2009/10, the focus for the expansion of the North Yorkshire Breast Screening service is around preparatory work including the leasing of equipment pending 'go live' in January 2011. The additional costs of this work will be met in full by commissioners resulting in a nil revenue impact on the Trust.

2.3 Summary of financial forecasts

2.3.1 How the plan was built

The financial forecasts supporting this Annual Plan have been a process of gradual development since November 2008. They are the product of extensive discussions and consultation with key stakeholders both internally and externally to the Trust.

The process adopted by the Trust has involved a significant bottom up approach involving detailed debate with individual Directorates. They have each undertaken a detailed assessment of demand for their services; of their capacity to deliver activity, and in the development of efficiency improvement plans. The consolidation of the activity plans have been used in discussions with the Trust's main commissioners, and form the basis of the Trust's planned activity going forward.

Using the NHS operating framework for 2009/10, an assessment has been made against each element to determine any material gaps in the Trust's ability to deliver and where gaps have been identified provisions have been built into the financial forecasts to support service development.

Given the worsening economic outlook a top down overall assessment of the affordability of the plan has been undertaken at regular intervals. The Trust's Executive Board, Board of Directors and Members' Council have received regular updates on progress in developing the plan, and have had the opportunity to discuss its overall implications and direction.

2.3.2 The impact of IFRS

Going forward, no significant accounting adjustments are anticipated, following the planned implementation of International Financial Reporting Standards with effect from 1 April 2009. The restatement of 2008/9 results under IFRS, however, will reduce the 2008/9 exceptional impairment loss from £7.8m to £3.8m.

2.3.3 Key financial assumptions

The Trust's long term financial strategy is to continue to improve our financial position to enable us to continue to deliver high quality patient care in a modern hospital environment. This will be achieved over the next 3 years by:

- Delivering small surpluses (excluding exceptional costs) in each of the 3 years covered by this plan with a Financial Risk Rating of 3 being maintained over the 3 years.

- To maintain our relative cost position against tariff and other NHS providers through continuous achievement of cost reductions, benchmarking services against other Foundation Trusts and ensuring that service growth delivers a contribution to indirect and overhead costs.

- The further development of service line reporting and patient level costing through the acquisition of a system to provide clinicians and managers with the information required to make informed decisions underpinned by the autonomy, accountability and skills to deliver improved quality and

- To generate financial contribution by growing services across the county and region where we have specialist expertise and capacity.

(a) Income & Expenditure

The Trust's income and expenditure plans covering the next three years are summarised below. The sections that follow detail the assumptions that underlie this summary.

Income & Expenditure	2009/10	2010/11	2011/12
	£m	£m	£m
Income	229.77	239.40	247.05
Expenditure	-219.01	-227.31	-234.29
EBITDA	**10.76**	**12.09**	**12.76**
Impairment	-0.50	-0.50	-0.50
Net Interest	0.04	-0.13	-0.12
Profit/(Loss on Disposal	0.00	0.00	0.00
Depreciation	-5.74	-6.14	-6.54
PDC Dividend	-3.70	-4.40	-4.60
Surplus/ (Deficit)	**0.86**	**0.92**	**1.00**

(b) Income

Projected income is summarised in the table below, and is based upon the assumptions that follow.

Income Projections	Plan 2008/09	Actual 2008/09	Current Plan 2009/10	Current Plan 2010/11	Current Plan 2011/12
	£m	£m	£m	£m	£m
NHS Acute Activity					
Elective	36.88	38.73	39.73	41.77	43.39
Non-Elective	61.30	62.85	66.20	69.60	72.31
Outpatients	32.83	34.63	33.90	35.64	37.02
Other Services	46.20	46.53	56.30	58.74	60.38
A&E	5.03	5.41	5.00	5.10	5.15
Total	**182.24**	**188.15**	**201.13**	**210.85**	**218.25**
Non Mandatory/ Non-protected	2.00	1.89	1.66	1.69	1.71
Other Operating Income	24.82	30.01	26.98	26.86	27.09
Total Income	**209.06**	**220.05**	**229.77**	**239.40**	**247.05**

- Net Tariff inflation increases of 1.7%, 1.45%, and 0.5% over the next three years respectively based on national guidance. The non-tariff increase is assumed to be the same.
- Quality improvement payments are received equivalent to 0.5% in each year.
- Non-tariff income growth is assumed only where schemes are agreed or close to agreement and occurs mainly in the first year of the plan
- No significant changes in case mix are assumed.
- Growth in specific new services, and transfers from other providers in agreement with commissioners.
- Limited growth in activity in 2009/10 to sustain 18 week and other targets and meet anticipated growth in demand for outpatients. No activity growth is assumed in 2009/10 for non elective activity. Minimal activity growth is assumed in 2010/11 and 2011/12, as illustrated in the following table.

Clinical Activity Forecasts '000s Cases	Plan 2008/09	Actual 2008/09	Current Plan		
			2009/10	2010/11	2011/12
Elective	34.7	36.7	37.5	37.3	38.2
Non-Elective	32.2	34.7	34.7	36.0	37.1
Outpatients	297.9	302.6	317.5	319.5	325.5
A&E	64.1	68.2	68.6	69.6	70.6
	428.9	**442.2**	**458.3**	**462.4**	**471.4**

The North Yorkshire and York PCT have contracted with the Trust for 2009/10 at the assessed 2008/09 outturn levels plus an overall growth level of approximately 1.5% in financial terms across the entire contract.

For 2009/10 the Trust has agreed in principle to sign up to the new NHS Standard Contract with some minor amendments. The contract will expire on the 1st April 2011. The contract continues to include financial penalties for failure to meet 18 week targets and Clostridium Difficile reduction targets which are a significant financial risk if targets are not met, although the assessed risk of this is low. No additional new penalties have been included in the contract.

(c) Operating Expenditure

Operating expenditure is summarised in the table below, and is based upon the assumptions that follow.

Operating Expenditure	Plan 2008/09	Actual 2008/09	Current Plan		
			2009/10	2010/11	2011/12
	£m	£m	£m	£m	£m
Pay	136.24	139.79	150.81	156.81	161.62
Drugs	18.65	18.23	20.33	21.44	22.50
Clinical Supplies & Services	18.97	19.40	20.22	21.03	21.65
Other Costs	23.16	30.55	27.65	28.03	28.52
	197.02	**207.97**	**219.01**	**227.31**	**234.29**

- The Trust incurs around 69% of its operating costs on pay. The most significant increase in operating costs arises from pay awards to staff. Based on national guidance pay award inflation in 2009/10 is expected to average 2.3% across all staff groups, with average rises of 2% assumed in both 2010/11 and 2011/12.
- Other pay pressures are expected to arise from national initiatives particularly through the continued progression of staff up incremental scales resulting from Agenda for Change and the Consultant Contract which alone are expected to cost £1.7m in 2009/10.
- Staff numbers are assumed to grow by 6% in 2009/10 over 2008/09 as a result of the specific developments described earlier, and general growth in response to anticipated demand, other quality initiatives, and as some posts held vacant during 2008/09 are filled. More modest increases of between 1% and 2% are assumed in later years.
- Non pay inflation is assumed to be contained within 2% per annum over the three years. The significant increases in energy and provision costs experienced during 2008/09 are not expected to be repeated during the period of this plan and will be contained in the 2% stated above. One exception to this is in respect of a notified significant increase in NHS Litigation Authority premiums expected to cost the Trust £1m and which has been provided for separately.
- The Trust will incur £2.5m costs on the use of private providers and through out of hours working at premium rates in meeting planed activity.

- No major cost arising from NICE recommendations are assumed.
- An overall efficiency and cost improvement target of £8.4m (3.8%) is set for 2009/10 of which £6.0m (2.7%) relates to cost improvement. It is assumed that this target is achieved. Overall cost improvement targets in later years are assumed at 3.4%.
- A Fixed Asset impairment of £0.5m in each of the three years.

In order to ensure compliance with targets and national core standards including addressing the quality initiatives described in section 2.2.2, the Trust is planning to increase its resources through investment in additional consultant posts and other supporting infrastructure:

Recruited	To be recruited
• 5th Gastroenterologist • 3rd Upper GI Surgeon • 4th Breast Surgeon • 4th Maxillo-Facial Surgeon • 2 Acute Physicians • 2 Medicine for the Elderly Consultants • ED Consultant	• 4th Neurologist • 6th Gastroenterologist • 5th Cardiologist • 7th Histopathologist • Further ED Consultant

- The plan includes a general provision in 2009/10 of £1m (with additional provision in later years) to meet a range of predominantly quality issues identified as of high priority by the Trust, primarily improving infection control, improving Stroke services, improving the number of midwives, improving ward nursing ratios, addressing general estate issues, and the acquisition of a service line reporting system. The Board of Directors will determine the deployment of provision during 2009/10 in the context of financial performance to date, and the relative priority of the competing issues.

The financial impact of the service developments discussed under section 2.2.4 are included within the financial plan.

2.3.4 Phasing

The phasing in year 1 of this plan (2009/10) is based upon the following rationale.

(a) Income – Clinical income is phased based on the number of both calendar and working days in each quarter, adjusted for bank holidays and clinical staff annual leave over the summer period. The resulting overall phasing is broadly in line with the actual income phasing received during 2009/10.

(b) Operating expenditure – pay, representing the largest element of operating expenditure is largely based on a monthly profile, although this is refined to reflect the likely commencement of expenditure associated with planned developments and the anticipated use of agency and other forms of premium rate working. Non-pay expenditure associated directly with clinical activity is profiled to match the planned profile of activity referred to above, whereas expenditure not directly linked to activity is assumed to be incurred on an even profile during the year unless clear seasonal variations are anticipated e.g. heating costs, which have more bias during the winter months. Planned developments that impact on non pay are profiled based on when they are expected to go live, and in the context of the anticipated characteristics of the expenditure.

(c) Cost improvements – comprise many different initiatives, and have been profiled on an individual initiative basis.

(d) Investments, financing and working capital - Spending on investments is assumed to occur evenly throughout the year, other than the multi storey car park where construction starts in the second half of the year, and loan financing is drawn down in line with planned spend. Working capital levels are expected to remain constant throughout the year.

2.3.5 Investment and disposal plan

Foundation Trust status has provided us with more capital financing options through retaining depreciation and cash

surpluses, and opportunities for external borrowing. Our strategy over the next three years is to spend retained depreciation, and the planned income and expenditure surplus. In addition, we have successfully applied for a loan of £6.9m from the Foundation Trust Finance Unit to fund a new on–site multi storey car park. This was originally planned to be developed through third party finance. The funding will be repaid over 15 years, financed from the additional net car park fees generated.

No Private Finance Initiative schemes are planned, and there are no plans to dispose of protected assets.

The summary Capital Programme is set out below. The majority of the Trust's equipment is leased and is excluded from this programme.

Capital Expenditure Plans	Plan 2008/09	Actual 2008/09	Current Plan 2009/10	Current Plan 2010/11	Current Plan 2011/12
	£m	£m	£m	£m	£m
Multi Storey Car Park	0.0	0.0	3.5	3.4	0.0
Pharmacy aseptics	0.1	0.1	2.7	0.0	0.0
Lift upgrades	0.0	0.0	0.5	1.1	0.0
IT programme	1.0	0.9	1.0	1.0	1.0
Additional MRI facility	0.0	0.0	0.6	0.0	0.0
Ward upgrades	4.3	4.5	0.0	0.0	0.0
Other minor projects	1.8	3.6	2.6	5.3	6.4
	7.2	**9.1**	**10.9**	**10.8**	**7.4**
Financed from:					
Surpluses	7.2	9.1	7.4	7.4	7.4
Disposals	0.0	0.0	0.0	0.0	0.0
Loans	0.0	0.0	3.5	3.4	0.0
	7.2	**9.1**	**10.9**	**10.8**	**7.4**

Investment (including new contracts) and Disposals	Plan 2008/09	Actual 2008/09	Current Plan 2009/10	Current Plan 2010/11	Current Plan 2011/12
	£m	£m	£m	£m	£m
Investment in Property, Plant & Equip (non-maintenance)	0.0	0.0	3.5	3.4	0.0
Investment in Property, Plant & Equipment (maintenance)	7.2	9.1	7.4	7.4	7.4

Asset Disposals- none planned

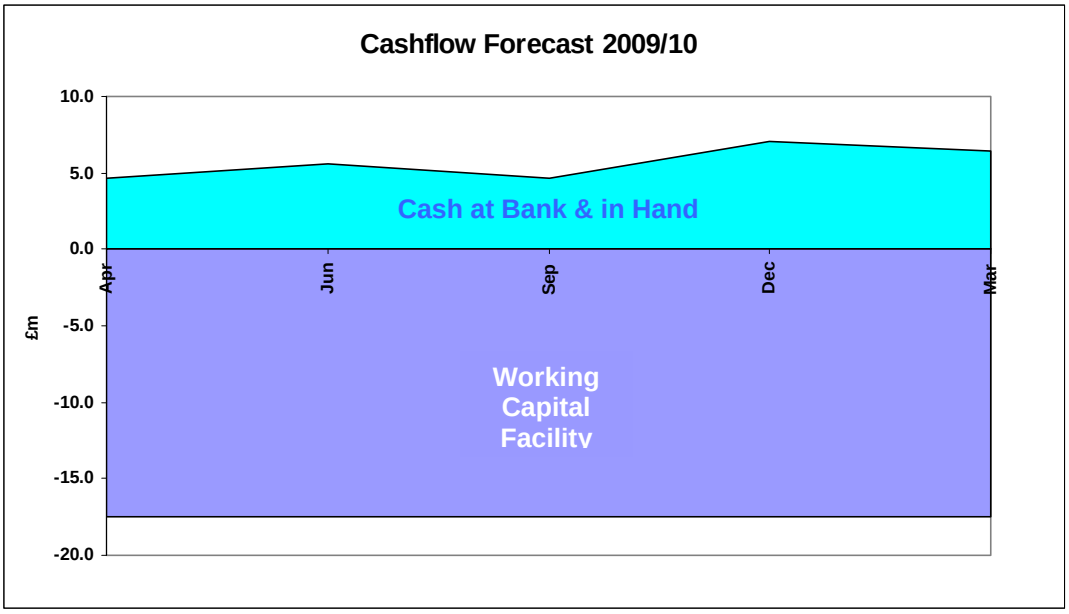
Protected asset declassifications- none planned

2.3.6 Loans and working capital

We have successfully applied for a loan of £6.9m from the Foundation Trust Finance Unit to fund a new on–site multi-storey car park, repayable over 15 years.

The Trust's working capital facility was renewed for a further 18 months in March 2009, and increased to £17.5m. There are no plans to use the facility.

Forecast cash levels for 2009/10, are shown in the table below, and are considered sufficient. No significant liquidity problems are expected to occur in 2009/10, 2010/11 or 2011/12.



2.3.7 Cost improvement plans (CIPs)

The underlying theme of the cost improvement and overarching efficiency agenda in 2009/10 is supporting innovative behaviour. The magnitude of the savings agenda going forward will be significant, with clinician and manager engagement essential to ongoing delivery. Our approach therefore aims to provide incentives to efficiency enabling work; as well as the delivery of current cash savings.

The efficiency and cost saving programme for 2009/10 is £8.38m. This comprises planned contributions from new income

of £2.42m and a cost improvement programme of £5.96m. The table below summarises the income plans currently in place.

Efficiency Plan - Income	Plan 2009/10
	£m
Business case contribution	1.00
Improved capture of clinical income	1.19
Other activities	0.23
	2.42

For 2009/10 the cost improvement target, £5.96m has been devolved to Directorates with the aim of embedding the delivery of cost improvement into core management business. There are three categories for delivery:

(a) Contribution - To include net contributions from new business cases and other non clinical activities

(b) Workforce - To include skill mix reviews, reduced use of temporary staffing, management of vacancies and post reductions.

(c) Improving resource utilisation - To include projects in theatres, outpatients and ongoing reviews of medical supplies, drugs and laboratory tests.

The schedule below represents a summary of Directorate cost improvement initiatives

Cost Improvement Plan 2009-12	Plan 2008/09	Actual 2008/09	Current Plan 2009/10	2010/11	2011/12
	£m	£m	£m	£m	£m
Target	3.95	3.95	5.96	7.67	7.96
Improved resource utilisation:					
Drugs	0.37	0.33	0.26	0.25	0.25
Medical supplies & equipment	0.38	0.38	0.44	0.30	0.30
Patient pathway	0.06	0.01	0.69	0.75	0.75
Other	0.99	1.03	0.77	0.50	0.50
	1.80	**1.75**	**2.16**	**1.80**	**1.80**
Contribution					
Business cases	0.02	0.15	0.73	0.50	0.50
Other actvities	0.67	0.76	0.99	3.00	3.00
	0.69	**0.91**	**1.72**	**3.50**	**3.50**
Workforce					
Increased vacancy factor	0.08	0.09	0.55	0.57	0.86
Reduced posts	0.82	0.63	0.62	1.00	1.00
Salary deduction scheme	0.05	0.07	0.07	0.10	0.10
Skill mix review	0.27	0.31	0.53	0.50	0.50
Reduce temporary staffing	0.24	0.19	0.31	0.20	0.20
	1.46	**1.29**	**2.08**	**2.37**	**2.66**
Total	**3.95**	**3.95**	**5.96**	**7.67**	**7.96**
Variance against target	0.00	0.00	0.00	0.00	0.00
Recurrent	3.03	2.28	4.76	6.80	6.80
non-recurrent	0.92	1.67	1.20	0.87	1.16
	3.95	**3.95**	**5.96**	**7.67**	**7.96**
% of cost base	2.0%	1.9%	2.7%	3.4%	3.4%

The size of the savings programme presents a risk to the organisation and considerable management time has been devoted to this year's plan. To reflect this, the Trust's Internal Audit has recently awarded a "Significant" assurance rating on the Trust's approach to the delivery of cost savings. A new Efficiency Committee, chaired by the Chief Executive, has also been established to provide director level monitoring and support to this agenda.

Plans for later years, 2010/11 and 2011/12 will continue to be developed and refined throughout the year.

2.3.8 Risk rating

The impact of the revenue and capital plans on the compliance regime has been forecast and is calculated to provide a provisionally calculated ongoing financial risk rating of 3. The Trust is planning to borrow £6.9m over the next two years to finance a multi storey car park.

SECTION 3: RISK ANALYSIS

3.1 Governance risk

3.1.1 Governance commentary

The Board of Directors is assured that it is compliant with the compliance framework in 2008/09. During quarter 4 the Board of Directors identified that that it could not declare full compliance with core standard for better health C20A *'Healthcare services are provided in environments which promote effective care and optimise health outcomes by being a safe and secure environment which protects patients. Staff, visitors and their property, and the physical assets of the organisation'.* As part of a full review of governance arrangements, health and safety management systems were rigorously and comprehensively tested across the organisation. At various levels it became clear that the systems in place could be improved upon to ensure robust assurance to the Board.

a) Legality of constitution

The Trust was authorised on 1 April 2007. The Trust has reviewed the constitution during 2008/09 and will be seeking Monitor's approval for the changes during June-July 2009. The review of the constitution included due diligence checks against changes in legislation, review of guidance and review of Monitor's model constitution.

The review of the constitution was undertaken in consultation with the Members' Council and Board of Directors. A subcommittee of the Members' Council provided oversight of the review. The amended constitution has been considered by the Members' Council and the Board of Directors prior to submission to Monitor.

b) Growing the membership

See section 5

c) Board roles and structures

The Board of Directors and the members are collectively responsible for the performance of the organisation

The Board of Directors has a strategic focus – developing, monitoring and delivering plans. It is responsible for the development of strategy plans and for ensuring the delivery of those plans in line with national targets and the need to ensure patient safety and high quality patient care.

Code of Governance

Monitor published the Code of Governance at the end of October 2006. The Code was released on a 'comply or explain' basis. The Trust reviewed its governance arrangements in light of the code and makes the following statement.

Directors

The Trust is headed by a Board of Directors (BoD) that ensures it exercises its functions effectively, efficiently and economically. The Board is a unitary board consisting of a Non-executive Chairman, six Non-executive Directors and six Executive Directors. The BoD provides active leadership within a framework of prudent and effective controls and ensures it is compliant with its terms of authorisation. The BoD meets a minimum of eleven times a year so that it can regularly discharge its duties.

The Non-executive Directors scrutinise the performance of the management, monitor the reporting of performance, and satisfy themselves as to the integrity of financial, clinical and other information and that financial and clinical quality controls and systems of risk management are robust and defensible. The Non-executive Directors determine appropriate levels of remuneration of Executive Directors, one Director and two Associate Directors.

Annually the BoD reviews the strategic aims after consultation with the Members' Council (MC) and takes responsibility for the quality and safety of the healthcare services, education, training and research. Day to day responsibility is devolved to the

Executive Directors and their teams. The BoD is committed to applying the principles and standards of clinical governance set out by the Department of Health and the Care Quality Commission. As part of the planning exercise the BoD reviews its membership and undertakes succession planning on an annual basis.

The BoD and MC hold joint meetings at least once a year to discuss the development of strategy.

The Board of Directors has reviewed its values and standards to ensure they met the obligations the trust has to its patients, members, staff and other stakeholders.

The appointment of the Chairman and Non-executive Directors is detailed in the Trusts annual report. Each year the Chairman and Non-executive Directors receive an appraisal which is reviewed by the MC.

A clear statement outlining the division of responsibility between the Chairman and the Chief Executive has been approved by the BoD.

Governors

The Trust has a Members' Council (MC) which is responsible for representing the interests of the members of the Trust, partner and voluntary organisations within the local health economy. The MC holds the BoD to account for the performance of the Trust including ensuring the BoD acts within its Terms of Authorisation. Governors' feedback information about the Trust to members through a regular news letter and information placed on the Trust's website.

MC consists of elected and appointed governors. More than half the governors are public governors elected by community members of the Trust. Elections take place once every three years.

Information, development and evaluation

The information received by the BoD and MC is timely, appropriate and in a form that is suitable for members of the board and council to discharge their duty.

The Trust runs a programme of development throughout the year for Governors and Non-executive Directors. All Governors and Non-executive Directors are given the opportunity to attend a number of training sessions during the year.

The MC has agreed the process for the evaluation of the chairman and non-executive directors and the process for appointment or re-appointment of the Non-executive Directors.

The Chief Executive evaluates the performance of the Executive Directors on an annual basis and the outcome is reported to the Chairman.

Directors' remuneration

The Remuneration Committee meets as a minimum on an annual basis to review the remuneration of the Executive Directors. The MC Remuneration Committee meets on an annual basis to review the remuneration of the Chairman and Non-executive Directors.

Accountability and audit

The BoD has an established Audit Committee that meets on a quarterly basis as a minimum.

Relations and stakeholders

The BoD has ensured that there is satisfactory dialogue with its stakeholders during the year.

The Trust is able to comply with the code in all areas except the following:

Requirements	Explanation
C.2.1 Approval by the board of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairman and non-executive directors. Re-appointment by the non-executive directors followed by re-approval by the board of governors thereafter should be made at intervals of no more than five years. All other executive directors should be appointed by a committee of the chief executive, the chairman and non-executive directors and subject to re-appointment at intervals of no more than five years	The CE and executive directors have their performance reviewed on an annual basis by the remuneration committee as part of the annual evaluation appraisal system. The remuneration committee considered the issue of 5-year contracts and took into account that executive directors hold substantive contracts and are not subject to reappointment at 5 year periods for the following reasons: a) Executive directors are subject to regular review of performance and existing procedures allow for appointment to be terminated if the performance is not satisfactory without the need for formal re appointment. b) The scope for refreshing the board exists as executive director posts turnover. The board has the option of restructuring the executive directors' responsibilities through organisation change in accordance with local HR policies and procedures. c) Fixed term appointment will create a short-term focus on the part of the executive directors, which in turn will create divergence between managerial and clinical perspective and could be detrimental to the engagement of clinicians, which is vital to the success of any FT.
C2.2 Non-executive directors may serve longer than nine years (e.g. three three-year terms), subject to annual re-election. Serving more than nine years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).	To ensure compliance with the constitution no non-executive director should have more than two re appointments or serve more than three terms for a maximum of three years each because of the need to maintain independence and refresh the skill set of the non-executive director. We do not intend to extend appointment beyond nine years on the basis of annual reappointment.
Main Principle All directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The board of directors should ensure planned and progressive refreshing of the board of directors.	The CE and executive directors have their performance reviewed on an annual basis by the remuneration committee as part of the annual evaluation appraisal system. The remuneration committee considered the issue of 5-year contracts and took into account that executive directors hold substantive contracts and are not subject to reappointment at 5 year periods for the following reasons: a) Executive directors are subject to regular review of performance and existing procedures allow for appointment to be terminated if the performance is not satisfactory without the need for formal re appointment. b) The scope for refreshing the board exists as executive director posts turnover. The board has the option of restructuring the executive directors' responsibilities through organisation change in accordance with local HR policies and procedures. c) Fixed term appointment will create a short-term focus on the part of the executive directors, which in turn will create divergence between managerial and clinical perspective and could be detrimental to the engagement of clinicians, which is vital to the success of any FT.

E1.1
Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should follow the following provisions:

(i) The remuneration committee should consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public. Upper limits should be set and disclosed.

(ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria, which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators.

(iii) In general, only basic salary should be pensionable.

The remuneration committee considered the introduction of performance related and pay element to the executive remuneration. It was agreed it should not be introduced because it could substantially undermine the ability to achieve targets and standards. This is because the commitment of all staff to achieve targets and standards has been gained on the basis of the benefits for the organisation and patient services. This commitment will be at risk if PRP for executive directors is introduced.

The process of review of performance of executive directors provides a more than adequate approach for dealing with under performance with the possibility of terminating the employment if unsatisfactory performance persists.

d) Service performance (targets and national core standards)

The Trust has met the Monitor's Compliance Framework during 2008/09. The Trust did have some significant issues to address during the year, specifically related to MRSA and A&E performance. Action plans were developed and have been fully implemented.

The Trusts performance against the Healthcare Commission's existing and new national targets for the same period is good; all standards except C20A directly attributable to the Trust have been achieved. During quarter 4 the Board of Directors identified that that it could not declare full compliance with core standard for better health C20A As part of a full review of governance arrangements, health and safety management systems were rigorously and comprehensively tested across the organisation. At various levels it became clear that the systems in place could be improved upon to ensure robust assurance to the Board.
.

The Board of Directors is confident that it is receiving accurate information as to the current and expected levels of performance against healthcare targets and national core standards and that

the reports used forecasting and extrapolation of historical trends to help predict future performance.

The Board of Directors requires internal audit and other independent advisors to provide assurance to the Board through the sub committee structure of the Board.

e) Clinical quality

The Board of Directors is confident that systems are in place that ensures continued improvements in quality and safety are implemented across the organisation. The Board of Directors has assessed it compliance with the Healthcare Commission's core standards for 2008/09 and there are indications that the Trust is compliant in most areas. However, there is evidence that the standard C20A was not complied with throughout the year.

Last year the Trust was measured against NHSLA standards and achieved level 1. The Trust has developed an action plan to work towards achieving level 2.

The Trust has been awarded a full licence by the Care Quality Commission for 2009/10.

The Trust has an agreed Quality & Safety Strategy with clear objectives of reducing harm and overall Hospital Standardised Mortality Rates (HSMR). The Quality Accounts for 2009/10 reflect these priorities which have been informed through local and national work.

High level measures of harm will be reported to the Board on a monthly basis and more detailed reports on a quarterly basis. The approach taken to benchmarking, audit and validation of the accounts has been carefully considered to ensure that the measures are specific, provide greater assurance that the data used is accurate so ensuring improved public accountability and engaging boards in the quality improvement agenda.

The Board of Directors is confident that the systems are in place to improve quality, meet healthcare targets, national core standards and comply with all relevant legislation. The Board of Directors understands the relevant risks that exist and that mitigation is put in place where ever possible.

f) Effective risk and performance management

Effective risk and performance management is continually monitored within the Trust. The Trust uses a number of methods to assure itself of the risk and performance management of the trust; including:

- The Governance Committee has met regularly during the year to review the corporate risk register. The Trust has reviewed its governance arrangements and introduced a Risk Committee to specifically review and manage risks within the organisation.
- Monthly and quarterly reports produced by the Directors providing detail on the financial, clinical and performance management of the Trust.
- Quarterly Corporate Risk Register reported to Board.
- The work that internal and external audit undertaken during the financial year to support the Trust in understanding the risk and performance management.
- The Trust holds monthly performance management meetings with the Directorates.
- The Trust's monitoring and reviews its performance against the Healthcare Commission standards and its self-certification.

g) Co operation with NHS bodies and local authorities

There are external arrangements in place for working with partner organisations. Those operating at Chief Executive level are as follows:

- Yorkshire & Humberside Chief Executive Forum
- Health Scrutiny Committees
- Monthly Chief Executive Forum
- North Yorkshire Community Review
- Hull and York Medical School (HYMS) North Yorkshire Local Steering Group
- Healthy City Board
- Foundation Trust Network (FTN) Chairs and Chief Executives meeting

There are similar arrangements in place for working with partner organisations that operated at Director level for finance, business and service planning, clinical governance and risk management and HR.

Risks identified by stakeholders that affect the Trust are discussed in a number of forums at different levels. These forums will develop action plans to address the risks.

Examples of the forums and methods of communication with stakeholders are as follows:

- Members' Council meetings
- Staff meetings such as Joint Consultative Committee
- Ward meetings

h) Significant risks

The Board of Directors is responsible for the management of key risks; these are managed through:

Local directorate risk registers
A corporate risk register
An Assurance Framework

The Governance Committee receives details of the key risks through regular meetings. The Governance Committee is a sub committee of the Board of Directors. The Governance Committee is chaired by a Non-Executive Director, and membership includes the Chairman of the Trust as well as other non-executive and executive members of the Board.

The Executive Director Team also considers high level issues and is responsible for the development of the Corporate Risk Register.

The Board of Directors also addresses the risks reported in the quarterly self-assessment document for submission to Monitor. This arrangement ensures the Board of Directors understands the strategic risks to the Trust in the context of the Trust's strategic direction.

Proposed governance risk rating

The trust proposes a governance risk rating of green, reflecting the submission in section 3 of complete and satisfactory self-certification on risk

3.1.2 Significant risks

Details of the governance risks considered by the Trust to be most significant are provided in the table at 3.5.

3.1.3 HCAI targets

Target		Q1	Q2	Q3	Q4	Total
MRSA	2008/09 target	1	4	4	3	12
	2008/09 actual	5	0	0	1	6
	2009/10 target	2	3	4	3	12
Clostridium Difficile	2008/09 target	26	33	35	28	122
	2008/09 actual	42	34	18	14	108
	2009/10 target	26	26	33	32	117

3.2 Mandatory services risk

3.2.1 Mandatory services

There are no foreseeable changes that threaten the delivery of the mandatory services provided by the trust at this time, nor are there any issues of accreditation that threaten viability of a service in 2009/10. Discussions are taking place with the local GP provider consortium on some peripheral services moving into a community GP setting and the intention is that this will be done in partnership with both the GPs and the North Yorkshire and York PCT. The main impact of this would be to reduce outpatient activity in the York Hospital, releasing capacity for higher priority work with this being reprovided locally and involving clinician expertise and oversight provided by the Trust.

3.2.2 Significant risks

The Trust considers there are no significant risks related to the delivery of mandatory services.

The Trust's self-assessment of the mandatory services rating is considered to be green.

3.3 Financial risk

3.3.1 Commentary on financial risk rating

The achievement of the financial plan for 2009/10 results in a provisional calculated Financial Risk Rating of 3. The liquidity ratio rating at 4 compared to 5 in 2008/09 reflects a combination of the national change in the metrics by Monitor, and a lower planned average cash position being maintained by the Trust during 2009/10 than in the previous year. The income and expenditure surplus margin rating at 2 presents the most significant challenge for the Trust in improving the overall rating as an overall improvement of some £0.73m in the income and expenditure position is required to improve this rating to a 3, although achieving this would still leave an overall financial risk rating of 3. Given the overall pressures and risks being faced during 2009/10 and beyond further improvement to income and expenditure position is considered very challenging, although this will be reviewed as the year progresses.

Financial Risk Metrics	2009/10	2010/11	2011/12
EBITDA margin	2	3	3
EBITDA, % achieved	5	5	5
Return on Assets	3	3	3
Income and Expenditure surplus	2	2	2
Liquidity ratio	4	4	4
Weighted average	**3**	**3**	**3**
Over-riding rules rating	**3**	**3**	**3**

EBITDA is Earnings before Interest, Tax, Depreciation and Amortisation.

3.3.2 Significant financial risks

The table below highlights the most significant financial risks facing the Trust over the next 3 years and actions to be taken to control and mitigate the impact of these.

Scenario	Financial Impact £m	Overall Risk Rating
Base Case	n/a	3
Activity significantly below plan resulting in income plan not being achieved - £3m less variable cost	2.4	2
Trust over trades for which income is not forthcoming	1.0	3
Trust's overall efficiency target is not achieved	1.5	3
Trust incurs financial penalties for failure to meet C. Difficile infection control target	1.6	3
Trust incurs financial penalties for failure to meet 18 week target	1.6	3
Failure to deliver CQUIN requirements	1.0	3

3.3.3 Risk of any other non-compliance with the terms of authorisation

The Trust considers there are no significant risks related to the terms of authorisation as a Foundation Trust.

3.4 Presentation of risk

Type of risk	Risk	Magnitude	Likelihood	Mitigation action	Residual risk
Finance	Activity significantly below plan resulting in income plan not being achieved	£3m	Low	Remove variable costs in short term and semi-fixed costs in longer term. Delay investments. Service review where necessary. Additional CIPs in year.	Low
Finance	Trust over trades for which payment from commissioners is not forthcoming	£1m	Low	Strict monitoring of activity to contract. Maintain continuous dialogue with commissioners. Delay investments. Service review where necessary. Additional CIPs in year.	Low
Finance	Trust's overall cost improvement target is not achieved	£1.5m	Medium	Strong performance management of CIPs. Delay investments. Defer developments.	Low
Finance/ Governance	Trust incurs financial penalties for failure to control C, Difficile infection control target	£1.6m High	Low	High level and Trust-wide focus on Infection Control. Defer investments. Defer	Low

				developments. Additional CIPs in year.	
Finance	Trust incurs financial penalties for failure to meet 18 week target	£1.6m	Low	High level and Trust-wide focus on managing 18 weeks. Defer investments. Defer developments. Additional CIPs in year.	Low
Finance/ Governance	Failure to deliver CQUIN requirements	£1.0m Medium	Low	High level and Trust-wide focus on managing CQUIN requirements. Defer investments. Defer developments. Additional CIPs in year.	Low
Governance	Failure to achieve MRSA trajectory	High	Medium	Significant changes in practice process and performance management introduced and as a result Trust is able to provide more robust assurance of outcome	Low
Authorisation	The risk of the Trust not complying with the terms of authorisation and not undertaking satisfactory self-certification.	High	Low	Detailed consideration given to all self certification with robust systems and evidence in place to support statements. Board	Low

				considers certification and compliance with Terms of Authorisation on a quarterly and annual basis	
Governance	Risk of not achieving full compliance with the requirements of C20a Standard for Better Health	High	Medium	Significant work being undertaken to ensure compliance with the standard. Enhancement of all health and safety systems being developed to improve reporting and assurance	Low

SECTION 4: DECLARATIONS AND SELF-CERTIFICATION

4.1 Self- certification and Board statement

Clinical quality

The board of directors is required to confirm the following:

☒ The board is satisfied that, to the best of its knowledge and using its own processes (supported by Care Quality Commission information and including any further metrics it chooses to adopt), its NHS foundation trust has and will keep in place effective arrangements for the purpose of monitoring and continually improving the quality of healthcare provided to its patients.

☒ The board will self-certify annually that, to the best of its knowledge and using its own processes, it is satisfied that plans in place are sufficient to ensure ongoing compliance with the Care Quality Commission's registration requirements.

Service performance

☒ The board is satisfied that plans in place are sufficient to ensure ongoing compliance with all existing targets (after the application of thresholds) and national core standards and with all known targets going forwards;

Other Risk management processes

☒ Issues and concerns raised by external audit and external assessment groups (including reports for NHS Litigation Authority assessments) have been addressed and resolved. Where any issues or concerns are outstanding, the board is confident that there are appropriate action plans in place to address the issues in a timely manner;

☒ All recommendations to the board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the body concerned;

☒ The necessary planning, performance management and risk management processes are in place to deliver the annual plan;

☒ A Statement of Internal Control ("SIC") is in place, and the NHS foundation trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up to date guidance from HM Treasury (see http://www.hm-treasury.gov.uk); and

☒ The trust has achieved a minimum of Level 2 performance against the requirements of their Information Governance Statement of Compliance (IGSoC) in the Department of Health's Information Governance Toolkit

☒ All key risks to compliance with its Authorisation have been identified and addressed.

Compliance with the Terms of Authorisation

☒ The board will ensure that the NHS foundation trust remains at all times compliant with its Authorisation and relevant legislation at all times;

☒ The board has considered all likely future risks to compliance with its Authorisation, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks; and

☒ The board has considered appropriate evidence to review these risks and has put in place action plans to address them where required to ensure continued compliance with its Authorisation.

Board roles, structure and capacity

☒ The board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the board;

☒ The board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting

strategy, monitoring and managing performance, and ensuring management capacity and capability;

☒ The selection process and training programmes in place ensure that the non-executive directors have appropriate experience and skills;

☒ The management team has the capability and experience necessary to deliver the annual plan; and

☒ The management structure in place is adequate to deliver the annual plan objectives for the next three years.

Patrick Crowley
Chief Executive
May 2009

Professor Alan Maynard
Chairman
May 2009

SECTION 5: MEMBERSHIP

5.1 Membership

5.1.1 Public membership – size and membership

Public constituency	Last year	Next year (estimates)
At 1 April	11,084	10,522
New members	139	1,000
Members leaving	701	500
At March 31	10,522	11,022

The table above shows the public membership total and movement for the year 2008/09

At the start of the year our total membership was 18,201. During the year 2008/09 we lost 970 members (due to deaths and relocations) but recruited 165 new members. The total membership at 31 March 2009 was 17,396 giving an overall loss of 805 members. Despite this loss it remains one of the largest public membership of any NHS foundation Trust nationally.

Age report

The table above shows the age profile of the public membership during 2008/09.

Public constituency	Last year	Eligible membership
Age (years):		
0-16	3	3,274
17-21	74	19,152
22+	10,006	198,711
Unknown	439	

Gender report

Gender		
Male	4,600	106,014
Female	5,556	115,218
Unknown	366	0

The table above shows the gender profile of the public membership during 2008/09

Ethnicity report

Public constituency	Number of members	Eligible membership
White	2,815	217,750
Mixed	9	913
Asian or Asian British	9	1,842
Black or Black British	3	349
Other	1,996	378
Unknown	5,690	

The table above shows the ethnicity mix of the public membership during 2008/09.

PCT area map

The public constituencies cover the following areas:

City of York (all wards)
Selby and District Council (all wards)
Hambleton District Council (the wards of Easingwold, Helperby, Huby & Sutton, Shipton, Stillington and Tollerton).

In addition to the central catchment population York, Hambleton and Selby, increasing numbers of patients are referred from

other areas, mainly to the east of York but also right across North Yorkshire. In this context, there is an additional population base of c50, 000 from the market towns and surrounding rural areas of Pickering, Malton, Helmsley and Pocklington.

These additional flows are as a result of referrals to treat more complex conditions as the hub of clinical alliances with other Trusts (Harrogate and Scarborough) and the development of North Yorkshire wide services (e.g. Lucentis, Breast Screening).

In order to provide membership opportunities to this growing number of patients from outside the main residential qualification geographical area, there is a qualification to membership for those who have been patients since April 2001, or their close family/carer/guardian.

5.1.2 Staff membership – size and membership

The staff constituency comprises:

- Permanent members of staff
- Temporary members of staff who have been employed in any capacity
  on a series of short term contracts for 12 months or more
- People who work within the Trust but are not directly employed.

For directly employed staff, membership runs on an opt-out basis i.e. all qualifying staff are automatically members unless they seek to opt out.

The staff constituency is broken down into four groups:

- Medical
- Nursing and midwifery
- Allied health professionals, pharmacists, scientists
- Non- clinical

By sub-dividing the staff constituency in this way, representation from each major staff grouping is possible, and therefore a balanced contribution from staff members is achievable.

Staff constituency	Last year	Next year (estimates)
At 1 April	4,240	4,448
New members	1052	250
Members leaving	844	50
At March 31	4,448	4,648

5.1.3 Patient/carer membership –size and membership

The patient/carer constituency consists of members of the public who have used our services, or who act as a carer for a patient that has used our services, and live outside the Trust's catchment area

Size and membership

Patient/carer constituency	Last year	Next year (estimates)
At 1 April	2,877	2,723
New members	19	100
Members leaving	173	50
At March 31	2,723	2,773

Age report

Patient Constituency	Number of memebers	Eligible members
Age:		
0-16	0	0
17-21	15	15
22+	2,682	2,682
Unknown	26	

5.1.4 Socio-economic grouping

The Trust analysed the membership using the ACORN consumer classifications. ACORN is a geo-demographic tool used to identify and understand the UK population and the demand for products and services. It is often used to make informed decisions on where direct marketing campaigns will be

most effective. ACORN classifies all 2 million UK postcodes which have been described using over 125 demographic statistics and 287 lifestyle variables.

The Trust's external membership management company Computershare provided the socio-economic profile in the table below which was mapped from ACORN to National Readership Survey (NRS) grading.

In terms of being representative of our eligible populations the Trust is over represented in the wealthy achievers, retired home owners, urban prosperity and comfortably off groups while being under represented in the moderate means and hard pressed groups.

The table below defines our membership breakdown in socio-economic groupings and details the possible pool of members the Trust could access.

It should be noted that following the analysis of our figures there is a discrepancy of socio-economic groupings. The profiling techniques demonstrate that there is a 7,400 person discrepancy in the potential membership against a total eligible population of 221,232. The eligible population estimates are obtained from the Office of National Statistics. They provide the data in a number of different tables which allows the analysis to be undertaken in different ways. The socio–economic data is based on people 16 years and over and no statistics exist for those below the age of 16.

Socio-economic groups	Number of members	Eligible members
ABC1	8,314	112,570
C2	1,448	35,520
D	359	34,175
E	386	31,560
Unclassified	15	0

5.1.5 Analysis of election turnout

The Trust will continue to work to promote its elections and to encourage greater interest and turnout. The current governor terms of office end on March 31 2010, therefore the nomination and election process will begin at the end of 2009.

5.2 Membership commentary - current position

- The Trust and governors have attended a variety of public and community events e.g. City of York Ward Committees the Older People's Assembly AGM, Sixth Form group at Tadcaster Grammar School, City of York Residents Forum, International Womens' Day event, York & District Cancer Partnership Group meeting as well as having a membership recruitment stand on several occasions in the main entrance of York Hospital and during the Open Event and AGM in 2008.

- A new project with Tadcaster Grammar School (TGS) was started this year as a pilot for youth engagement in our catchment area. We now have a formal partnership agreement with TGS and an action plan for the forthcoming year outlining the projects and activities the young people will be involved in at the hospital. This has already led to an increase in number of 16 to 18 year olds as members. This work will be spread to other local secondary schools and further education centres as part of a formal and funded youth engagement strategy.

- The main focus of the year has been to develop and improve communication with members. The York Talk newsletter is now produced in-house and regularly features articles written by Governors about their involvement in the Trust. The membership engagement committee is the forum for discussing the content of each edition. The newsletter has remained at four pages but the frequency has been increased from 4 to 6 issues a year to maintain its relevance.

- The Trust has held four lunchtime YorkTalk presentations aimed at members to raise their awareness in a range of hospital based issues e.g. Stroke Medicine, Respiratory

- In December 2008, we attached a survey form to the YorkTalk newsletter and asked the patient and public members to complete and return it indicating their specific interests in hospital services. We will be using this information throughout the coming year as a means of involving our members in the work of the hospital.

  The Trust has recently written to the 300 members who expressed interest in bereavement services inviting them to an event 20 May to view the plans and meet the team planning the new Bereavement Suite.

  The Trust will be writing to all members who are resident in a specific post code area of York to invite them to a public debate on health issues in June which is being organised as part of a local church centenary celebration.

  The Trust is planning a further membership event in July with the York & District Cancer Partnership Group and will be inviting the 700 members interested in cancer services to come in to discuss their involvement in developing services.

- The Trust will be attending a town meeting in Helmsley to meet with residents and discuss membership of the Trust. We will be attending similar events organised by Selby District Council and Hambleton District Council when notified of the dates.

  During 2008/09 the Trust attended all of the City of York Ward Committees to present the Trust's objectives and recruit further members from the general public. The Trust will continue this strategy throughout 09/10 in order to update the public on our plans and will particularly target recruitment activity in those wards with a higher percentage of the lower socio- economic groups.

- The Trust plans to develop a membership discount scheme during 2009 to give members access to discounts in local shops and services currently enjoyed by Trust staff.

- Wednesday 30 September 2009 is the date of the next open day and the Trust's AGM will take place during this event.

- The Trust is planning to provide an area on the Trust's intranet (Horizon) as a communication means between staff members and staff governors. We are also exploring ideas on how to effectively improve communications between public/patient/carer members and their governors using the Trust's website.

- The Trust will continue to attend as many prominent local events as possible when resources and governor availability allow in order to promote membership of the Trust and the Trust's key position within the local community. We will tap into local markets, community publications and social networks to promote membership within communities and to engage with our members.

5.3 Membership management

- The Trust will continue to manage its membership effectively. For public and patient/carer membership, the Trust will continue to buy an ongoing service from its current external supplier. This enables membership growth to be specifically targeted in line with ACORN profiling and census information to ensure the current membership remains representative. Cleansing and review exercises will be undertaken with each membership communication to ensure that as far as possible inappropriate contacts are not made.

- It is planned to transfer the staff membership database from our current external supplier to link it with the Trust's electronic staff record (ESR) to provide a more efficient and cost effective system of recording staff leavers and joiners. It will allow the staff the choice of transferring to public membership (if eligible) when they leave Trust

5.3.1 Developing a representative membership

The prime source for recruiting members is and will remain those people who have an existing relationship with York Hospitals. This could be past and present patients or carers, staff or those who are potential future users of our services as residents of our catchment area.

The Trust continues to believe that membership should be voluntary – to show definite, willing and interested participation. Our membership recruitment objectives are:

- To ensure all current and future staff working for the Trust that are eligible for membership are aware of staff membership, what it means for them.
- To strive towards a composition of public membership to reflect diversity – geographically spread across our catchment area and reflecting age, gender, ethnicity and social-economic groups.
- To keep accurate and informative databases of members to meet regulatory requirements and to provide a useful tool for membership development and engagement.
- To recognise and use members as a valuable resource
- To define the right and responsibilities of membership to strengthen the partnership between the Trust and its members.
- To provide targeted and appropriate communications that offer timely, consistent and regular messages about membership
- To set up a feedback system so all constituencies of members have suitable channels to feedback ideas and concerns, raise issues with Governors, ask questions and find out more information.

Public membership: - The focus for this year will be to gain growth (planned 1000 additional members - 10%) in key areas. Using the analysis tables available we will undertake a number of recruitment drives targeted at specific pockets of the population. These are:-

- Ages 16 to 22
- Ages 23 to 50
- Ethnic minority groups
- Specific council /ward postcode areas in all three constituencies
- Social economic groups D

Patient membership: - The focus for this year will be to gain some growth (planned 100+ members - 5%) through a targeted campaign using letters with patient meal trays and inpatient/outpatient appointments aimed specifically at the age group 23 to 50.

Staff membership: - The focus for this year will be the transfer of staff membership data to the ESR and a re-launch of staff membership across the Trust. This is expected to result in an increased membership (planned at least 250 additional members - 6%). In addition new starters in the Trust will be provided with welcome packs at corporate induction sessions.