York Hospitals NHS
NHS Foundation Trust

Annual report and accounts 2008/09

York Hospitals NHS Foundation Trust

Presented to parliament pursuant to schedule 7, paragraph 25(4) of the National Health Service Act 2006

York Hospitals NHS Foundation Trust

Annual Report and Accounts 2008/09

STRATEGIC STATEMENT

The Trust's strategic direction has a number of key drivers which ensure we provide 21st century healthcare for the community.

The drivers are:

- To place the patient at the centre of what we do by ensuring our services are safe, clean, responsive and effective
- To be the provider of choice for the local population
- To transform how we work by working in partnership with other agencies across the health economy
- To develop services and environments that are fit for purpose
- To continue to improve our financial position to enable us to continue to deliver high quality patient care in a modern hospital environment.

The national agenda continues to advocate increased patient choice, better access times, safer, cleaner hospitals and improved patient satisfaction and outcomes. In this context these are the priorities for York Hospitals NHS Foundation Trust and we will work, with commissioner PCT support, to meet all targets and develop services appropriate for the local community. The Trust will continue to take part in and learn from national initiatives such as the safer patient initiative, choose and book, agenda for change, the productive ward, the rollout of patient-reported outcome measures and the next stage of the Darzi review.

The situation locally in North Yorkshire continues to be one of a financially challenged commissioner working to universally reduce spend and specifically to reduce admissions to hospital. This is an approach we have always supported and indeed have resized capacity in support of these plans. However, to date, acute admissions have not reduced significantly, so placing tremendous pressure on capacity and staffing.

STATEMENT OF THE CHAIRMAN AND CHIEF EXECUTIVE

Welcome to the annual report for York Hospitals NHS Foundation Trust for 2008/09.

Despite the financial climate and the challenge created by fluctuation in demand, the hospital continues to provide excellent patient care for the local population. We achieved an 'excellent' rating for both use of resources and quality of services, placing us among the top performing NHS organisations.

Our staff have been the reason behind our success, and we congratulate everyone for what we were able to achieve. It is also a credit to all our staff that, in spite of the pressures facing the hospital, all national service targets were met. Their input and that of volunteers is much appreciated by patients and colleagues.

Our Healthcare Commission staff survey results were encouraging, showing that, on the whole, staff feel 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. We aim to get an even higher response rate to the survey next year, as this is an important measure for us to use, and we will continue to work on developing the Trust as a supportive employer

creating work opportunities in a stimulating and caring environment.

The Trust has continued to focus on patient safety, and significant progress has been made, particularly on infection control. Due to the efforts and attention to detail of all our staff, we continue to enjoy some of the lowest healthcare-associated infection rates in the country. This is not just about hitting targets but also, importantly, about improving our patients' overall experience and confidence in us, and ensuring the best clinical practice for all patients all of the time. We are determined to continue to improve all aspects of patient safety and quality by measuring performance carefully and working with colleagues to ensure even better care for patients.

Whilst you will notice within the published accounts that the Trust has recorded a £5.6m deficit, this is due to a technical adjustment associated with the decommissioning of property within the hospital site. Our underlying performance for the year generated a surplus of £2.2m compared to a planned surplus of £1.2m. This position is reflected in an assessed financial risk rating of 4, placing the Trust in line with the plan submitted to Monitor and meaning that we have successfully completed our second year as a Foundation Trust.

Several capital projects were completed 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 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. 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.

We have enjoyed a number of 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 hope to build on this with an even bigger event this year.

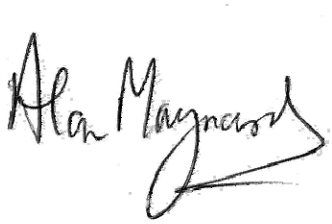
Since becoming a Foundation Trust in 2007 we have increasingly recognised the need to engage with our public, patient and staff membership. We are starting to see the positive impact our Members' Council is having on the Trust, and the influence our governors and wider membership can have on how we develop services. As York's largest employer, we acknowledge our place within, and our impact on, our local community, and we have begun to develop strong working relationships with other key local organisations so that we can work collaboratively to better serve the community we all represent.

While we have seen many successes, 2008/09 has also been a challenging year, particularly during the winter where we saw an unprecedented 20% increase in emergency admissions compared with the same period last year. This put pressure on our inpatient bed base, and in combination with Norovirus led to difficulties throughout the hospital, making patient flow and achievement of our targets all the more challenging.

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 continued staff focus being always on the patient and the welfare of them, their relatives and friends. Our patients expect high quality care and it is our mission to ensure that that is what they receive within the constrained resources we have at our disposal.



Alan Maynard
Chairman

Patrick Crowley
Chief Executive

DIRECTORS' REPORT

The directors of the Trust

The directors, appointed to membership of the Board of Directors, in post during the year from 1 April 2008 to 31 March 2009 were:

Professor Alan Maynard	Chairman
Mr Patrick Crowley	Chief Executive from June 2008 (Interim Chief Executive from November 2007)
Professor John Hutton	Senior Independent Director and Non-executive Director
Mrs Gillian Fleming	Non-executive Director
Mr Alan Rose	Non-executive Director
Mr Philip Ashton	Non-executive Director from 1 September 2008
Mr John Longworth	Non-executive Director from 1 September 2008 (resigned 31 January 2009)
Mrs Linda Palazzo	Non-executive Director
Mr Mike Proctor	Deputy Chief Executive and Chief Operating Officer
Mr Robert Chapman	Interim Director of Finance from November 2007 (until 19 January 2009)
Mr Andrew Bertram	Director of Finance from 19 January 2009
Mrs Alison Hughes	Director of Strategy and Facilities
Ms Elizabeth McManus	Chief Nurse
Ms Peta Hayward	Director of HR and Legal Services (appointed as an Associate to the Board of Directors)

Further details about the directors can be found on page 45 of this report.

The principal activities of the year

The principal purpose of the Trust is the provision of goods and services for the purpose of the health service in England.

Fair view of the Trust

The table below provides a high level summary of the Trust's financial results for 2008/09.

Summary Income and Expenditure	2008/9 Plan £million	2008/9 Actual £million	2008/9 Variance £million
Clinical income	185.1	190.0	4.9
Non-clinical income	29.2	30.0	0.8
Total income	214.3	220.0	5.7
Pay spend	-141.4	-139.8	1.6
Non-pay spend	-68.0	-74.3	-6.3
Total spend before dividend, interest and impairments	-209.4	-214.1	-4.7
Impairments	-3.0	-7.7	-4.7
Dividend and interest	-3.8	-3.7	0.1
Net surplus/deficit	-1.8	-5.6	-3.8
Financial risk rating	4	4	

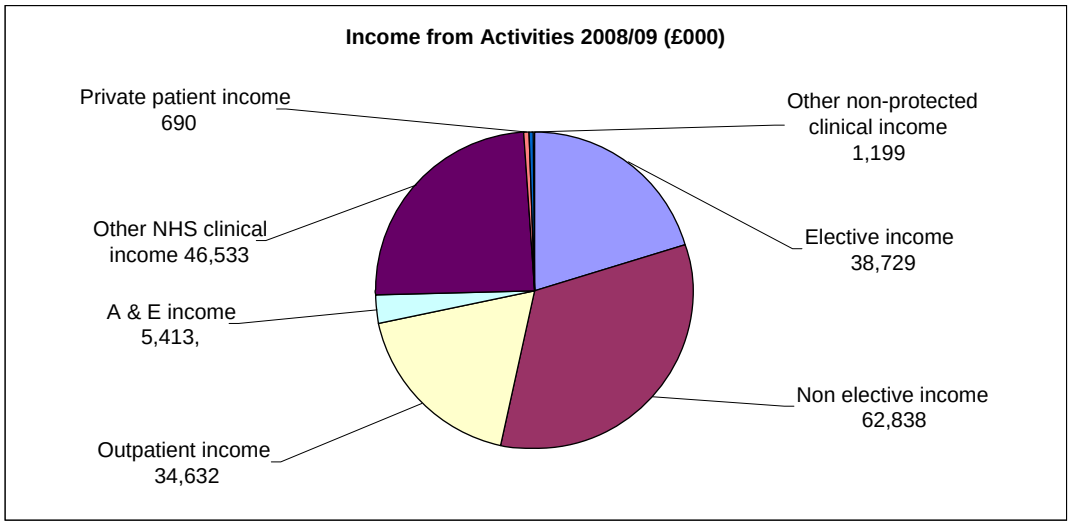
At the end of the financial year, the Trust reported a technical Income and expenditure deficit of £5.6m, compared with a planned deficit of £1.8m. This was after accounting for £7.8m impairment costs associated with the writing down of fixed assets mainly associated with the closure of staff accommodation at Bootham Park Court.

Excluding impairments, the Trust achieved an underlying surplus of £2.2m compared to a planned surplus of £1.2m.

Income from activities

Income from clinical activities totalled £190.0m, and comprised 86.4% of total income. It arose mainly from contracts with the North Yorkshire and York PCT and other local Primary Care Trusts (£188.2m), with the balance of £1.8 m from other patient related services, including private patients and road traffic accidents.

Total clinical income was £4.9m higher than planned levels, due to treating significantly more patients than originally planned.



Income generated from non-healthcare activities

Other income totalled £29.1m and comprised 13.2% of total income. It arose from funding for education and training, and for research and development, and from the provision of various non-clinical services to other organisations and individuals.

Cash

The Trust had a cash balance at the end of the year of £4.7m, which is consistent with its normal levels of cash holdings.

Borrowing limit

The Trust has a total borrowing limit of £44.1m, set by Monitor. This is the amount of money the Trust can borrow, based upon a detailed financial risk assessment. The Trust did not need to make use of its borrowing limit during 2008/09.

Monitor risk rating

The Trust achieved a risk rating of 4 in 2008/9, compared with 3 in the previous year. Financial risk is assessed on a scale of 1 (high risk) to 5 (low risk). A rating of 4 is low risk and under the Healthcare Commission's assessment framework represents excellent use of resources.

The risk rating calculations have been changed for 2009/10, and the Trust is forecasting a low risk score of at least 3 for 2009/10.

Capital investment activity

During 2008/09, the Trust invested £9.1m as part of the Trust's capital programme. This included:

- The major upgrade of a ward to provide a dedicated in-patient facility for oncology and haematology, with full air-conditioning and environmental controls
- The completion of the final phase of the major upgrade of the critical care unit
- Completion of the alterations funded by the Guardian Angels Appeal

- Adaptations to the new building purchased to house the occupational health department funded by the Department of Health under a national initiative to develop these services for local private sector businesses
- Completion of a new patients lounge facility in the main entrance area
- Continuation of the three-year programme to refurbish and re-equip the main theatre suite.

In addition the Trust bought significant amounts of new and replacement medical and IT equipment and plant through a combination of purchasing and lease finance.

During the year, the Trust's land and buildings were re-valued by the Valuation Office Agency, primarily on the basis of depreciated replacement cost, for a modern equivalent asset. As a result, fixed asset values reduced at the end of the year by £30.4m.

Planned capital investment

Capital investment plans for 2009/10 include:

- A major upgrade of the aseptic pharmacy facility
- Upgrade of the coronary care unit
- The provision of a bereavement suite to provide a centrally-located, supportive focal point for bereaved relatives belongings and receive advice
- The start of a phased programme of lift upgrades
- A programme of new and replacement x-ray equipment related to the breast screening expansion
- Further IT hardware and software developments.

Work is also expected to start on the construction of a multi-storey car park for patients and visitors, to be located at the front of York Hospital, funded by a loan from the Foundation Trust finance unit.

Land interests

There are no significant differences between the carrying amount and the market value of the Trust's land holdings.

Investments

The Trust made no investments through joint ventures or subsidiary companies, and no other financial investments were made. No financial assistance was given or received by the Trust.

Accounting policies

Accounting policies are consistent with those of the previous year. In 2009/10 the Trust will move to adopt International Financial Reporting Standards, and will revise its accounting policies accordingly.

Private patient income

Under the terms of authorisation, the proportion of private patient income to the total patient related income of the Foundation Trust should not exceed its 2002/3 proportion of 0.8%. Actual private patient income for 2008/9 totalled £0.7m and represented 0.4% of total patient-related income. The Trust is therefore compliant with this obligation.

Value for money

The Trust has a proven record of implementing cost improvement programmes aimed at improving efficiency. This has been achieved through a combination of central and directorate led initiatives. The amount achieved in 2008/09 in line with the plan was £4.5m.

Going concern

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

Political and charitable donations

No political or charitable donations were made during the year.

Accounting policies for pensions and other retirement benefits

Past and present employees are covered by the provisions of the NHS pension scheme. The scheme is accounted for as a defined contribution scheme. Further details are included in the accounting policies notes to the Trust's annual accounts.

Significant events since balance sheet date

There are no post balance sheet events likely to have a material impact on the financial statements for the year ended 31 March 2009.

Directors' statement

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

The development and performance of the Trust during the year

The headline for the year 2008/09 in terms of performance would have to read, 'Another successful year'. It is true that once again the organisation has met all its key access targets. However, the headline would mask some significant difficulties which have arisen because of the significant increase in demand experienced at the hospital, particularly in relation to emergency admissions and GP referrals. This can be illustrated in the following information:

Area	Number of Patients	Variation against plan
GP Referrals	60,126	+8%
Outpatient Attendances	95,217	+4%
In-patient Electives	8,930	+3%
Day Cases	28,343	+7%
In-patient Non-elective	46.922	+8%
Emergency Department	65,862	

In order to increase our capacity and deliver targets we have recruited consultants in the following specialities; gastroenterology, vascular, histopathology, radiology and stroke.

The Healthcare Commission's Annual Health Check revealed the organisation as 'Excellent' for both the use of resources and quality of services and the organisation was awarded an unconditional licence by the Care Quality Commission in April 2009.

During the year the hospital has increased its focus on specific issues of patient safety & quality. We continued to work closely with the Institute for Healthcare Improvement (IHI) and The Health Foundation and have now established ourselves as part of the National Patient Safety Campaign – Safety First!

Specific achievement areas are as follows:

Infection Control – we drove down infection rates for hospital acquired MRSA & Clostridium difficile through a number of clearly focused clinical and managerial interventions including; hand hygiene, dress code, local accountability & reporting systems from wards right through to Board and altered prescribing of antibiotics.
Critical Care – we have reduced ventilator and central line associated infections through implementing standardised packages of care (underpinned by international evidence) and audits of all practice.
Operating theatres – we have implemented safety check lists in all theatre areas within the trust reducing the likelihood of wrong site surgery and post operative infection rates.
Ward based care – we have reduced the number of crash calls in the hospital through implementing an early warning & escalation system for our sickest patients.
Medicines management – making simple changes in the prescription chart, which reminds prescribers and pharmacists to consider Venous Thromboembolism (VTE) prophylaxis has resulted in a significant increase in prescribing across the trust and a reduction in hospital acquired VTE associated mortality.

The results of the national patient survey, undertaken by patients who used our emergency department put us in the top 20% of hospitals throughout the country.

<u>Main trends and factors likely to affect the future development, performance and position of the business</u>

The organisation's primary operational focus during the next year is the efficient management of emergency admissions to the hospital. It is evident that growth in this area will continue and we have to establish patient flow systems that improve front-line

senior decision making and admission avoidance whenever it makes clinical sense to do so. The organisation can no longer simply respond to increased demand by putting up more and more beds.

During the period covered by this report the final phase of the refurbishment of Critical Care was completed, providing support facilities for staff and visitors. Three out of the original ten main operating theatres were completely refurbished. A new inpatient Oncology and Haematology ward, with full air conditioning, was opened on ward 31. Disappointingly our car parking partner was unable to secure funding to start the new car park as planned, however we have been able to use our Foundation Trust borrowing to secure our own funding, and this will form one of our major developments next year along with a new Aseptic Pharmacy, commencement of a much needed lift replacement programme and an additional MRI scanner.

Our workforce remain our most important and best asset. They always respond positively to change and the pressures of demands and continue to provide a high standard of care to our patients.

The majority of the Trust's income for clinical services is through contracts with PCTs. The North Yorkshire and York PCT is the Trust's main commissioner accounting for over 90% of the Trusts NHS clinical income during 2008/09. East Riding of Yorkshire PCT accounts for a further 8% with 2% coming from other PCTs. During 2008/09 activity with all PCTs was in excess of the contracted activity resulting in income being £6m above the plan for the year. The additional activity arose from the need to meet and maintain 18 week referral to treatment targets and extraordinary demand for non elective admissions throughout the year.

For the 2009/10 plan the Trust has assumed that the activity levels in 2008/09 will continue. In addition some growth is assumed in non elective Elderly Medicine and Paediatric based on recent trends along with elective growth in Vascular Surgery due to expansion of the service in Harrogate and Maxillo Facial Surgery elective and outpatient services to meet increased demand.

The demand for Lucentis to treat Age Related Macular degeneration continues to grow and income and expenditure for this is assumed in the plan.

PCTs have contracted for the 2008/09 outturn activity plus some growth in non elective demand, although this is lower than the Trust's assumptions. The North Yorkshire and York PCT contract also assumes significant growth in the use of expensive drugs including Lucentis.

2009/10 financial outlook and principal risks

For 2009/10 the national payment by results system continues to be applied in full within the NHS for elective and non-elective admitted patient care, outpatient services and accident and emergency services. The tariffs for 2009/10 are based on HRG version 4, which not only introduces some new tariffs but also results in additional risk for both commissioners and providers due to structural tariff changes. As part of the new tariff calculation for 2009/10 a sum equivalent to 0.5% has been withdrawn and this will be paid to providers on the provision of evidenced quality improvements (CQUIN).

A number of significant risks and assumptions to achieving the income and expenditure position summarised above are included in the plans, and these are set out below.

- Activity and income plans will be underpinned by payment by results principles. Income will be clearly linked to activity and there is a risk that if activity is below plan then income will be also be less than plan
- The Trust's activity plan and therefore income plan is based on directorate assessments of the forecast non-elective demand, and referrals into services generating additional activity necessary to sustain the cancer and 18 week access targets
- The expenditure plans assume that in-year overspending on operational budgets can be managed by directorates
- Further investment in NICE recommendations outside of the tariff is subject to securing specific agreement and income from commissioning PCTs. The plans assume that no unplanned investment will take place unless specific income is secured
- The plans assume a significant and challenging efficiency programme of 4.5% (£8.4m), which must be delivered
- The plans assume that £1.5m planned slippage of proposed developments is achieved
- The plan assumes full payment of the 0.5% for the CQUIN quality improvement scheme. Confirmation has been received that the SHA scheme will require delivery of all elements to secure payment. Failure of any one item will result in the full payment being withheld.

Charitable funds

The Board of Directors acts as corporate Trustee for the York Health Services General Charity which is a registered charity. All charitable fund expenditure is classed as granted from the charity. Items over £5,000 are capitalised and included in the Trust's fixed assets. The charity's annual report and accounts is published separately, and is available from the Trust on request.

Environmental issues

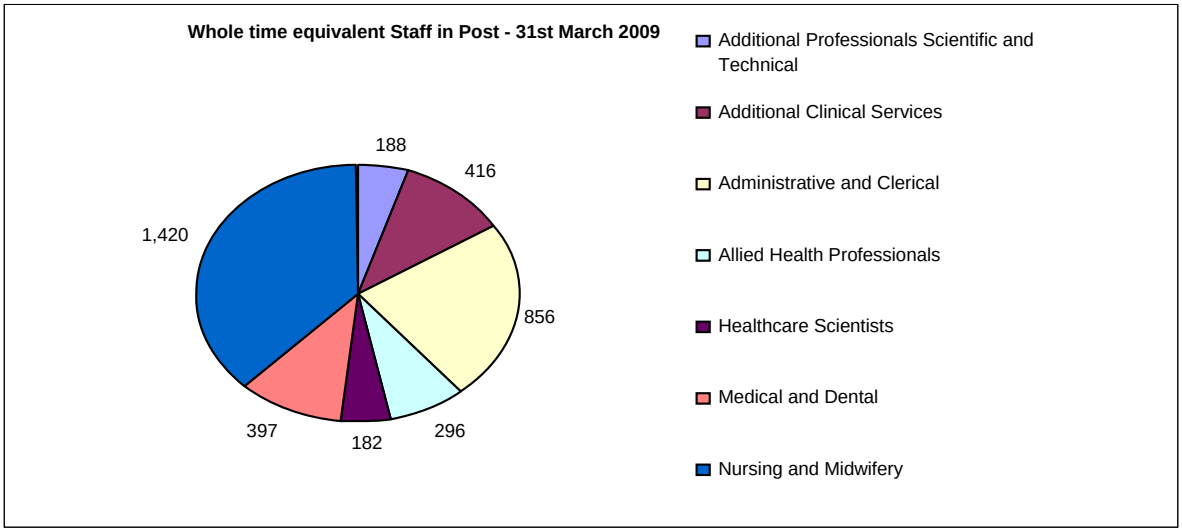
Sustainable development is about meeting society's needs today without compromising the ability of future generations to meet their needs – often referred to as good corporate citizenship.
The Trust is committed to being a good corporate citizen and as such has developed a number of plans to reduce its carbon footprint. Examples of the work being undertaken are:

- A sustainable travel plan incentivises staff to use alternative methods of coming to work in order to reduce single occupancy car journeys
- Our fleet of vehicles has recently been updated and this has significantly reduced carbon emissions
- Our procurement policy has been updated to help maximise the positive benefits and minimise the negative benefits on society, the economy and the environment throughout the full lifecycle of the product
- The Trust has started to procure goods as locally as possible to boost our local economy
- Our waste management strategy meets the new legislative requirements and the

Trust is recycling more and more waste. There are plans to go further with recycling in 2009/10. This not only has benefits for the environment but also reduces the costs of waste disposal

- The Trust is currently working on a carbon reduction strategy which will reduce the amount of energy we use that produces carbon dioxide
- When building new buildings, the Trust intends to follow the good practice guidance which is aimed at reducing the carbon footprint of the build.

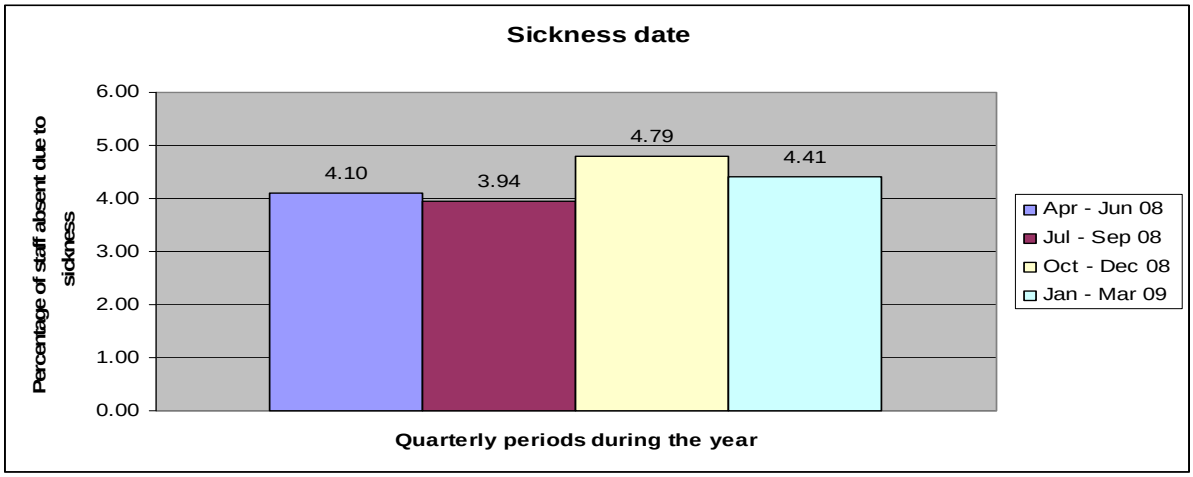
Our staff



Number of staff earning over £75000	Number of staff	
Annual Salary	**Medical Staff**	**Other staff**
£75,001-£100,000	29	7
£100,001-£125,000	71	1
£125,001-150,000	40	0
over £150,000	22	1
	162	**9**

Staff sickness

The quarterly sickness figures for the year are:



Indication of likely future developments

Our top priority going forward is to ensure that the hospital provides excellent care to all our patients. In order to achieve this we will continue to focus on a number of key themes. These are :

Improving patient and staff safety - We have made huge progress with infection control and our safer patients' initiative this year and a new patient safety strategy will be implemented during 2009.

Customer care - We want to improve our patients' whole experience and ensure that their interaction with the hospital is as good as the clinical care that they receive.

Planning for the future - In order to understand what demands and consequent capacity we need throughout the year we are undertaking a major review. This will ensure that we use our resources efficiently and can provide high quality services all year round.

Improving the environment through our capital programme spend - During 2009 we will build a new aseptic pharmacy to ensure that we have the right facilities to manufacture and dispense chemotherapy and other specialist drugs.

We are also replacing some major infrastructure e.g. lifts and automatic doors and upgrading theatre accommodation.

Developing the organisation - We recognise the need to develop, support and reward staff to ensure that that they have the right skills, behaviours and incentives to do a great job.

Actively engage our community - We want to build on the work already undertaken with our governors and members and ensure that the hospital is seen as a cornerstone of the community.

Significant activities in the field of research and development

The Trust makes a significant contribution to the organisation of NHS research in the region. It hosts the main office of the North and East Yorkshire Alliance Research and Development Unit, which provides research governance, management and support services for the acute Trusts in Harrogate, York and Scarborough, and for primary care in NHS North Yorkshire and York, NHS Hull and NHS East Riding of Yorkshire.

It also hosts the North and East Yorkshire and Northern Lincolnshire Comprehensive Local Research Network, which supports research within the National Institute for Health Research clinical research portfolio.

During 2008 there were 182 research projects active in the Trust, of which 74 were clinical trials of investigational medicinal products. Of the 182 projects 25% were commercially funded and 53% were funded by UK or foreign government funding streams, research councils or charitable bodies.

The Trust works closely with Hull York Medical School (HYMS) to promote growth of clinical research in the region and is developing clinical research facilities on the York

Hospital site in the form of the HYMS Experimental Medicine Unit. Funded by the National Institute for Health Research, this will provide expert facilities for conducting early-phase clinical trials and other forms of 'translational' research aimed at developing new treatments from basic scientific discovery.

External auditors

Grant Thornton UK LLP
No. 1 Whitehall Riverside,
Whitehall Road,
Leeds,
LS1 4BN

External auditors' remuneration

The total cost of audit services for the year was £55,000. This was for the statutory audit of accounts for the 12 months ended 31 March 2009.

Equality and diversity

The inclusivity scheme is the Trust's response to the general duties to promote race, disability and gender equality. It sets out the steps we would take to implement the specific duties of the legislation in order to promote equality. The scheme also recognises that although there is no duty to promote equality relating to a person's age, religion and sexual orientation, we would apply the equality principles to implementing the relative legislation and regulations. Achieving these aims is essential to delivering the Trust's key objectives - to improve patients' experience and to attract and retain the best staff. The inclusivity scheme will be updated in 2009.

The development and management of policies requires equality impact assessment to be undertaken as part of the development and review of all policies. All new policies undergo equality impact assessment before they are introduced.

Policies for disabled employees and equal opportunities

The Trust's Inclusivity scheme and its supporting policies are the cornerstone of its approach to equality of employment opportunity. We recognise our responsibility to provide (as far as is reasonably practicable) job security of all employees.

Our policies aim to ensure that no job applicant or employee receives less favourable treatment where it cannot be shown to be justifiable on the grounds of age, gender, sexual orientation, race, nationality or disability in relation to recruitment and selection, promotion, transfer, training, discipline and grievance and all terms and conditions of employment.

Policy applied for the continuing employment of disabled persons

As a foundation Trust, we recognise the important role we must play as an active and socially responsible member of the local community and that our patients, clients and staff represent the community we serve.

Policy applied for career development of disabled persons

We know that having a committed and motivated workforce depends on staff feeling that they are treated with fairness, respect and dignity and that they have equal opportunities for self-development. We want to ensure that our staff are not discriminated against, or harassed, on the grounds of their ethnic origin, physical or mental ability, gender, age, religious beliefs or sexual orientation. Equally, if this happens, we want staff to feel confident about using our policies to raise concerns and to have them addressed.

Providing information to employees

The Trust believes that having well informed and involved staff leads to well informed and involved patients, relatives and public. During the year staff have been consulted on issues that affect them in the way services are delivered and changes to practices that affect their working environment.

The Trust uses different methods of communicating with staff including:

- team brief – held on a monthly basis
- posters, leaflets, reports
- intranet – staff only website
- YorkTalk – quarterly newsletter

Action taken to encourage involvement of employees in the foundation Trust

The Trust has had a team brief system in place for a long time, this year the system was 'refreshed' to include more members of staff and provide more targeted information. The system requires senior managers to disseminate information in a cascade approach ensuring that key decisions taken by the Trust are reported to staff. The system also seeks feedback from staff on the issues covered in the Trust briefing.

The Chief Executive and directors encourage staff to send questions and comments to them. The Chief Executive and directors undertake to respond to any comments by staff within 24 hours.

Staff are encouraged to speak to their staff governors as another method of becoming involved in the Trust.

Information risks and data losses in 2008/09

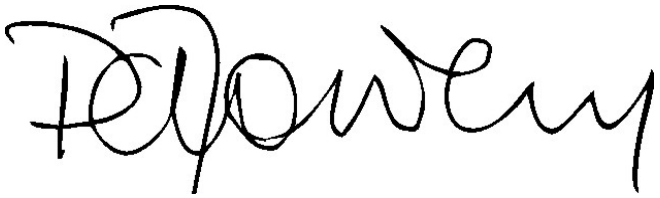
York Hospitals NHS Foundation Trust has a comprehensive Board-approved information governance policy in place and an established work programme to ensure compliance with the NHS Connecting for Health IG Toolkit standards. Its self-assessment score for the year 2008/09 is 86%, achieving a 'green' rating in all initiatives.

The Trust complies, at attainment level 2 or greater, with all the requirements of the current NHS Connecting for Health statement of compliance.

The Trust's internal auditors have verified that the self-assessment scores are accurate and supported by appropriate evidence of implemented risk control measures.

This year also saw the appointment of the Director of Finance as Senior Information Risk Owner (SIRO) for the Trust. The SIRO takes ownership of the Trust's information risk policy, acts as advocate for information risk on the Board, and provides written advice to the accounting officer on the content of our statement of internal control in regard to information risk.

No information security breaches occurred during the year, which were of a scale or severity to require a report to the Information Commissioner. However, there were two incidents in which personal information relating to Trust patients was, or could have been, unintentionally disclosed. The incidents are declared, in accordance with Department of Health guidance.



Patrick Crowley
Chief Executive
4 June 2009

BACKGROUND INFORMATION

Our history

The Foundation Trust provides acute hospital services for approximately 350,000 people living in and around York and also a range of specialist services over a wider catchment area of around 500,000 in North Yorkshire. The hospital's elderly department has community based units based at St Helen's, Nelson Court and White Cross Court in York. It also has satellite renal dialysis units based at Acorn Court, Easingwold and Harrogate and District NHS Foundation Trust. Sexual health services are provided at Monkgate Health Centre and school health services across York and Selby.

The Trust has a comprehensive range of acute services at the York Hospital site including a maternity unit, adult critical care unit, emergency department, and a coronary care unit.

In 1976, York District Hospital came in to being. The scale of the hospital, with 812 beds in thirty wards, was at the time, larger than anything ever seen in York. It replaced a total of nine hospitals: York County Hospital, York City Hospital, Military Hospital, Fulford Hospital, Acomb Hospital, Poppleton Gate, Deighton Grove, Fairfield Hospital and Yearsley Bridge Hospital. Princess Alexandra came to open it officially on 28 July 1977.

The new hospital as it was then, cost £10.5m to build and a further £2m to equip. It occupied 20 out of the 22 acres on the site and accommodated over 1,600 staff.

In 1981, a scheme commenced to house maternity services at the main site. A delivery suite and special care baby unit were built and existing wards were converted to ante natal and post natal wards and a new maternity entrance was created.

York Health Authority became a single district Trust in April 1992, known as York Health Services NHS Trust.

The development of the Selby and York Primary Care Trust had major implications on York Health Services NHS Trust, as it had provided secondary care and community services since 1992. Community and mental health services in Selby and York were taken over by the PCT and the function of York Health Services NHS Trust now centered on secondary acute care. In 2003 the main hospital changed from York District Hospital to York Hospital and we became York Hospitals NHS Trust.

Having achieved a 3 star performance rating in 2005, the Trust applied to become a NHS Foundation Trust in 2006. Monitor approved the application and York Hospitals NHS Foundation Trust began life on 1 April 2007. The attainment of this target was a great tribute to the hard work of staff throughout the organisation and is recognition that we are one of the top performing organisations in the country. Being a NHS Foundation Trust means we can manage our own budgets and are able to shape our services to reflect local needs and priorities whilst remaining fully committed to the core principles of the National Health Service.

Thank you to Kath Webb, Trust Archivist, for providing background information

OPERATING FRAMEWORK

Patient care and stakeholder relations

Information for patients and carers

Patient and public involvement (PPI) is an integral part of the Trust's work. The Trust listens and responds to patients to improve services. As a result of listening to patients, the Trust aims to:

- Improve access and reduce waiting
- Offer more information and choice
- Build closer relationships
- Provide safe, high-quality and co-ordinated care
- Provide a clean, comfortable and friendly environment
- Improve the patient experience

Areas in which patients were particularly positive about their experience were:

	Score %
• They had to wait less than 2 hours to be examined	87
• Overall their visit to the emergency department lasted less than 8 hours	89
• The emergency department was clean/very clean	96
• They did not feel bothered or threatened by other patients	92
• A member of staff fully explained the purpose of medication they were to take home	90
• Overall the rating of care was good/excellent	91

The national inpatient survey was completed in December 2008. It involved patients admitted to York Hospital in July 2008. The response rate was 54%. Interim results are generally very positive, although areas where patients report problems include:

	Score %
• not asked to give views on quality of care	84
• not enough opportunity for family to talk to a doctor	60
• nowhere to keep personal belongings safely	53

These and other issues raised are being addressed.

Local Involvement Networks (LINks)

The government replaced Patient and Public Involvement Forums (PPIF) with LINks in Local Government and Public Involvement legislation in 2008. The aims of LINks in the York area are to:

- Encourage and support more people to get involved in shaping local services
- Actively canvass every section of the community's views about what they think about their local care services
- Feedback to those who purchase and provide health and social care services what

people have said so that things can change for the better

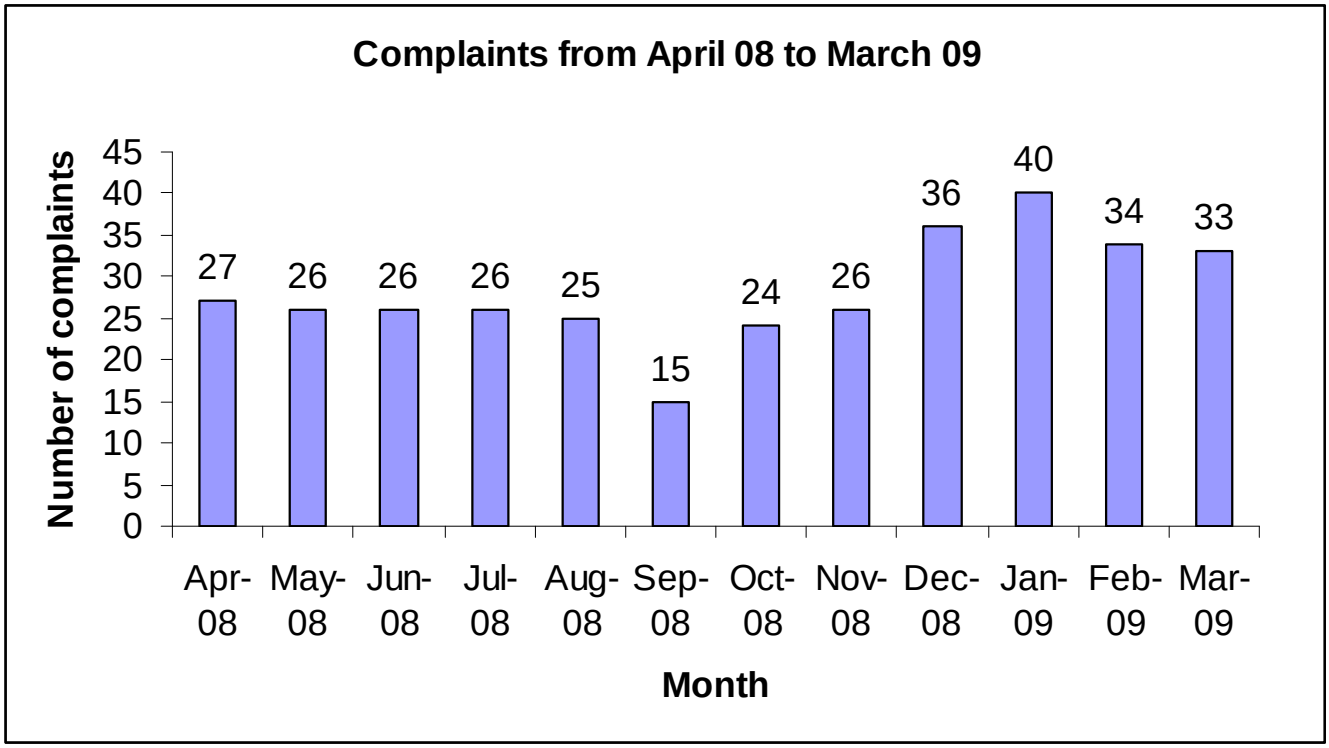
- The Trust will work closely with LINks to help them meet their aims and realise their work plans.

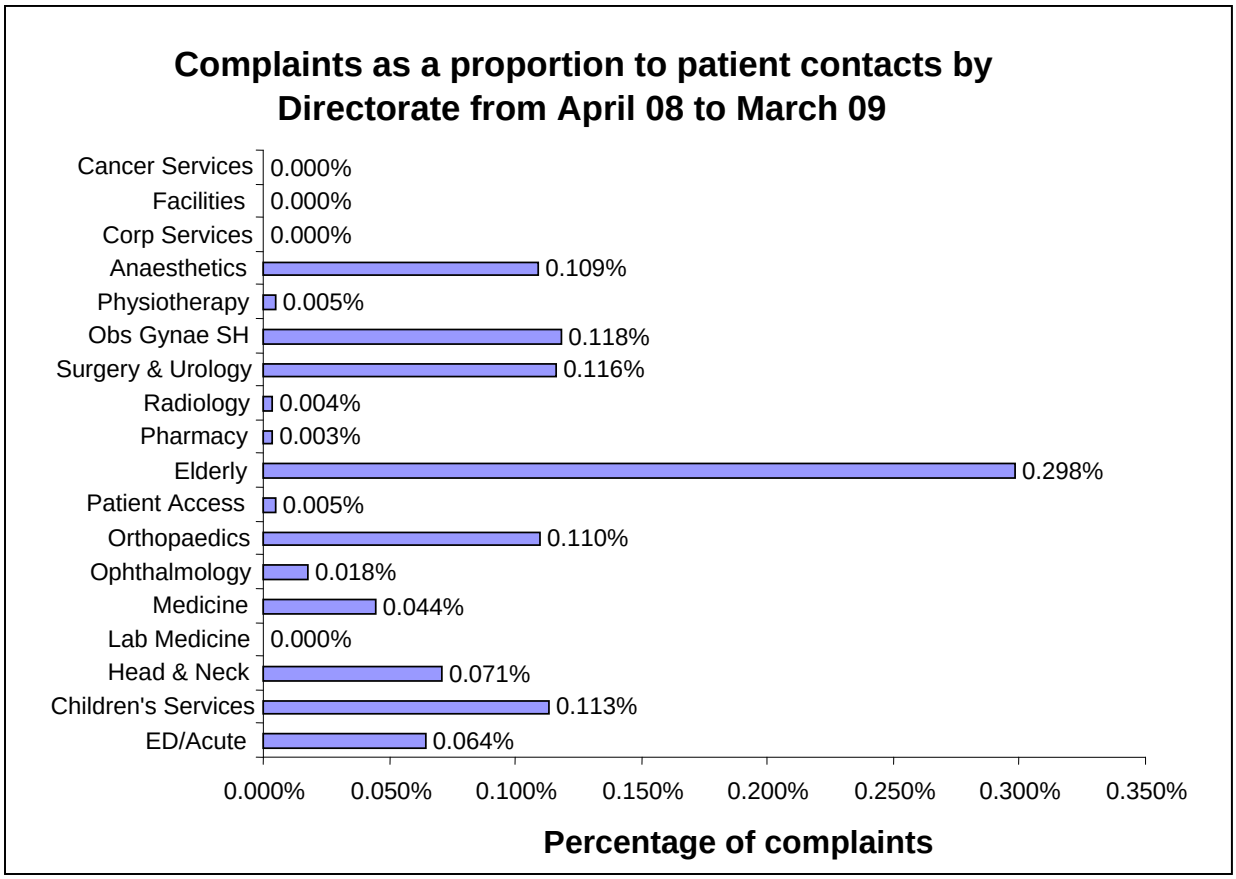
Learning from Listening

The Trust continues to work closely with York St John University to use its Learning from Listening DVD in training physiotherapists and occupational therapists. The DVD was a joint venture between the Trust and the University in which patients and carers were filmed talking about their experiences of York Hospital. The DVD is used extensively in staff training throughout the Trust and elements of it were used in collaboration with the NHS Institute for Innovation and Improvement to produce an e-learning module.

Information on handling complaints

338 formal complaints were received this year (260 last year) representing 0.02% of 1,437,530 patient contacts. In addition, 92 informal complaints were received (84 last year).





All formal complaints were acknowledged in writing within two working days and 265 (78%) were responded to within the local resolution deadline (75% last year).

29 (8%) remained dissatisfied after the Trust's response (11% last year).

Category of complaints received

The top five types of complaints using the Department of Health /Datix categories were: clinical care-medical/nursing/midwifery/other health professional (166), communication/information (43), staff attitude (40), appointment delay/cancellation outpatient (31), and admissions/discharge (19).

Complaints referred to the Healthcare Commission 2008/2009

Nine complaints in total were referred to the HCC.
Five complaints were not upheld, however two of these were referred back with suggestions for improvement. These were acted upon.
Three complaints were referred back for further local resolution and are now closed. One complaint was referred to the Health Service Ombudsman as the HCC was unable to complete the review before ceasing to handle the second stage of the complaint process.

A new NHS complaints procedure was introduced on 1 April 2009.

In reforming the NHS complaints process the Department of Health wants to see:

- Accountability at the most senior level of the organisation
- Responsiveness and ability to demonstrate improvements in response to complaints
- Information on complaints provided to commissioners who will use it to influence commissioning decisions
- A role in looking at responsiveness to complaints for the Care Quality Commission
- A process that is more accessible to complainants.

To meet the requirements of the new NHS complaints regulations, the Trust has introduced new complaints handling procedures. The Trust's NHS complaints policy and procedure will be updated and a new leaflet explaining the new procedure is available.

More information on the NHS Complaints Procedure is available from the Department of Health's website at: http://www.dh.gov.uk/en/ContactUs/ComplaintProcedures/index.htm

The Trust makes every effort to handle complaints:

- Directly and quickly
- With honesty and fairness
- With confidentiality

If a complaint is made to us about our services we will:

- Acknowledge the complaint verbally or in writing in three working days
- When acknowledging the complaint the Trust will:

    - Check we fully understand the issues raised
    - Offer to discuss how the complaint will be handled
    - Tell the complainant when the investigation will be completed and when they will be sent a full written response

- Offer to arrange a meeting to discuss the complaint with appropriate members of staff
- Investigate all the issues raised
- Tell the complainant if we need more time
- Identify any improvements we need to make in our services, tell the complainant the actions we are taking and when they will be completed

More information about making a complaint to the Trust about its services is available on the Trust's website at:
http://www.yorkhospitals.nhs.uk/index.php?id=38&ob=1

Positive Patient Feedback

This is collected and collated by the patient experience team from either the Chief Executive's office, or from wards and departments receiving the feedback directly. A total of 4,551 letters, cards and emails were received. The following comments are typical of those expressed by many patients:

Mr H was visiting York from Essex with his family when his mother became ill and he emailed the following:

"Mum has had more than her fair share of health problems over the years and it has been our experience that it is the odd exceptional person struggling against the system that gets things done, not so in York on Saturday. Every individual we engaged with was helpful, pleasant, clearly knew their job and did it well. Moreover the system delivered all that one could hope the NHS could provide.

We both much appreciate all that was done for mum and the people involved deserve our thanks. Mum was restored to her normal self and she enjoyed the party. I make critical assessments of people and systems for a living and it is certainly not normal to see such high standards. The NHS works in York and it works well!"

Corporate learning and development

Non-clinical learning

Statutory and mandatory training programme:

A number of improvements were made to the programme to make it more accessible. These included:

- The creation and promotion of a 'mandatory training week'
- Development of profiles to help learners identify which elements of the programme was required for their job role
- The provision of alternative methods of learning for core sessions.

This resulted in increased attendance and enabled the organisation to meet its 50% attendance target.

New programmes for 2008/09:

A number of pilot programmes were delivered:

- Two Institute of Leadership and Management accredited programmes were delivered. Following evaluation, further programmes of the ILM Management Assessment Proficiency Development Programme will be scheduled
- A healthcare assistants' training programme has been piloted and evaluated. Further cohorts are now being scheduled
- Six people have completed the Post Graduate Diploma in Workplace Coaching and Mentoring
- LQF360: 60 learners have used this tool to support their management learning and development.

The Trust has introduced some new systems during the year including:

The Oracle learning management system (which is part of the organisation's electronic staff record system) is now routinely being used to record all training co-ordinated by the team. The team are now actively involved in rolling out its use to other areas within the organisation.

The Trust's achievements in National Vocational Qualification (NVQ) are as follows:

Ten candidates have completed Level 2 NVQ in Care. Work continues to increase internal verification and assessment capacity.

Postgraduate medical education

In recent history, Trusts across the country have experienced difficulties in the recruitment of foundation doctors, York is no different. The position in May 2008 was that we had a full complement of 27 F2s offered employment with the Trust from August 2008. By the end of July 2008, ten had withdrawn, some for varying reasons such as being offered and accepting posts elsewhere. Rotations were reorganised to run on a complement of 25 rather than 27 posts with the loss of some GP posts temporarily. After five rounds of local recruitment five vacancies were filled but three posts remained vacant.

In 2008 the department experienced two quality assessment visits from the Foundation School director and the Yorkshire and Humber Deanery respectively. The reports, which took into account self assessments against practice and performance, were very good. They did highlight some action areas for both the Trust and the Deanery which the Trust has met. Update reports for the action plans were sent to the Deanery in November 2008 and March 2009. Two particular areas highlighted for action were greater liaison with the Royal College Tutors and the completion of a robust 'doctors in difficulty' policy. Medical Education Meetings have been re-formatted to give the tutors greater inclusion and an Education Review Board was established to provide a forum for the different education streams across the organisation. The 'doctors in difficulty' policy is in the final stages of completion.

In 2008 a total of 1,013 doctors were trained in a variety of general resuscitation and clinical skills. In addition there are the 33 generic skills training days and the weekly protected teaching for foundation doctors and GP vocational training scheme (VTS) half and full training days. The new prescribing and injectable medicines courses put on for foundation doctors have also evaluated very well.

August has become the main time for the annual junior doctor intake and this combined with increases in the numbers of foundation trainees has created a challenge in terms of staff and resources. 137 trainees from F1 to specialist registrar (SpR) were inducted in 2008. It became impossible to cover all the requirements for induction given these numbers and classroom space so the programme for the day was revised to create morning and afternoon mirror sessions. There is an impact on staff time as each contributor now has double the sessions to deliver and the day is very time sensitive because of movement across the site. In view of these challenges new software (training tracker) has been purchased so that the 'presented' elements of induction can be made available online. This is due to be piloted in May 2009 and launched by August 2009.

A bid was put into the Deanery for funding to cover refurbishment of the resuscitation skills lab, lecture theatre and centre classrooms and the establishment of a new clinical skills training area. This was approved in March 2009.

York Hospital health library and information service

The library relocated to York St John University in August 2008 and now operates as a distinct library within the Fountains Learning Centre. The library continues to support the needs of hospital staff. Trust staff have access to Trust computers and an improved learning environment.

Details of the holdings of the library were successfully transferred to a new online library catalogue. The catalogue can be accessed from any computer with an internet connection. Library users can search for titles, place holds or renew their books. The catalogue also displays the holdings of York St John University library and the public library.

A member of the library staff has completed a degree (BSc Econ Information and Library Studies).

During the previous 12 months there have been a number of changes to the electronic resources available for NHS staff. In April 2008 the hospital library staff were involved with supporting Trust staff with the transition from searching healthcare databases to a new interface developed in-house by the NHS National Library for Health. Library staff were also involved with selecting further electronic resources for staff working within the Yorkshire and Humber SHA region.

The Board of Directors have positively received the annual report and strategy. The report sets out targets for the service to achieve such as reviewing training and broadening the range of electronic resources. Many of the targets have already been fulfilled. A National Service Framework self-assessment exercise has been completed and the library user group has been established.

Clinical development team

During the first few months following the clinical development team's (CDT) formation it was found that the process for competence assessment appeared variable. This was confirmed when discussed with senior clinical staff and by checking incident reports.

With this in mind, CDT decided to modify the existing format to develop a robust, equitable and sustainable assessment process across all areas of the organisation. Several options were available, and with aims and objectives clearly identified, they concluded that an adapted objective structured clinical examination (OSCE) assessment incorporated into the existing process would meet the needs of the candidates, assessors and the organisation as a whole.

As part of a continuation of improvement of training and leadership of clinical staff the Trust introduced and facilitated a programme of specialist study days for clinical staff.

Following Trust-wide evaluations and questionnaires, and utilising the personal clinical experience of members within the team, the team has facilitated the setting up of study days called 'learning events 2009'. Linking with specialist clinicians throughout the Trust, the team arranged 17 topic sessions across eight clinical disciplines, with additional topics coming forward. To date the learning events have been very well subscribed and evaluated.

Resuscitation

The resuscitation services have developed a hospital major incident medical management and support training for designated staff with a role in the Trust's major incident policy. The Lead Resuscitation Officer Ian Wilson is a national instructor in this discipline.

Hull and York Medical School (HYMS)

The first cohort of newly qualified doctors graduated from the Hull York Medical School (HYMS) in summer 2008, an outcome that was widely applauded in the Yorkshire and Humber region and the culmination of six years of endeavour by HYMS and partner hospitals. HYMS at York Hospital played host to the Clinical Examinations (OSLERs) for half of this first cohort of final year students undertaking approximately 250 separate clinical examinations in the process.

A new patient recruitment campaign has begun and patient volunteering is now known as volunteer patient assisted teaching (VolPAT). A logo has been developed and information packs have been produced which include an information booklet highlighting what patients can expect if they attend a HYMS teaching session or an exam. The packs also include consent forms, data protection forms and contact details forms for the patients to complete and send in.

Organisational development (OD)

Organisational development is about improving organisational performance through working with the human dimension to create a continually reflexive and learning organisation that has the capacity in its workforce to respond to the ongoing demands that are put upon it. This year has been a busy one for the OD team, working across the hospital and with a variety of staffing groups.

The main piece of work has been, and continues to be, working on the theatres development project in conjunction with the quality and safety team (previously known as the improvement team). This has involved acting as a 'Trusted party' and assisting communication throughout the department, providing learning and development opportunities, and acting as workstream leaders for elements of the project.

The OD team has been involved with a variety of programmes run in the organisation this year (including the directorate managers' and clinical directors' programmes) as well as designed and delivered numerous bespoke workshops for a variety of teams.

They have also worked in other capacities: as observers involved in recruitment processes, as trainers for foundation programme for junior doctors, as facilitators for a number of cohorts of action learning sets, and as coaches in one-to-one developmental coaching.

This year the team has also been working with individuals and teams using the Myers Briggs indicator – a development tool for understanding personality – interweaving it into workshops, using it to help individuals understand more about themselves as well as others and the team as a whole.

For the future, they are looking forward to working with more clinical and non-clinical teams and individuals in their development, to support them and the organisation, achieve their/its objectives.

Improvement facilitator

This year saw the introduction of a new post: 'improvement facilitator' to the team, a shared post with the improvement team.

The role includes secondment to teach improvement skills to the undergraduate programme for physiotherapists and occupational therapists at York St John University.

The post holder also has an organisational development component to the role and works in partnership with the organisational development facilitator.

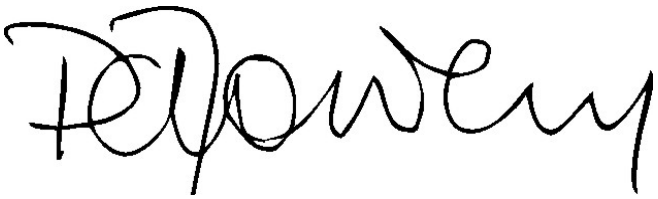
The post holder has worked in partnership with the improvement team in a number of service improvement projects and delivery of improvement training to various clinical and non-clinical teams within the organisation, including supporting staff as students on the admin foundation programme at York College and doctors in training in HYMS on their quality improvement projects.

The post holder has worked closely with the Institute for Improvement in supporting a joint initiative ‘Learning from Listening’ with York Hospital and York St John University.

QUALITY REPORT 2008-09

'As Chief Executive I am committed to giving patient quality and safety the highest priority and this quality report builds on the positive outcomes in the reduction of measurable harm, already proven through the Safer Patient Initiative (SPI) here in York. Patients and their views are critical to us and we should understand better what they consider important in terms of *their* care. Our business is about serving and caring for patients and *every* member of staff supports delivery of that care and represents the organisation irrespective of grade or profession.
The hard work and commitment of everybody in the Trust and our collective determination to deliver services to the highest standard possible has lead to real improvements in care. Excellence in care for our patients is the essence of health care delivery in York Hospitals NHS Foundation Trust and I will continue to make it my mission, with your support, to continue to improve our services over time and deliver the vital contribution we make to the community as a whole.

This quality report is about committing to action to improve both the reliability of our care for all our patients and the way in which we deliver it'.



Patrick Crowley
Chief Executive

Current view of Trust's position and status for quality

The Trust has made significant progress in reducing our infection rates for MRSA and Clostridium Difficile, and Monitor have recognised our significant improvement on infection control.

For the Healthcare Commission (HCC) annual health check 2007/08 we have been assessed as 'excellent' for both use of resources and quality of services. This places us amongst the best performing hospitals in the country.

The Healthcare Commission congratulate us on our performance in the A&E survey results, and in the patient experience results in general.

Our overall hospital standardised mortality rate (HSMR) is lower than the average.
We recognise that there are challenges ahead and that our stroke mortality rates are significantly higher than the national average and know that our stroke strategy will address many of the issues contributing to that mortality rate. We also recognise that we need to improve in some aspects of positive patient identification in order to improve patient safety.

Overview of organisational effectiveness initiatives

The Trust has a number of ongoing initiatives to improve organisational effectiveness around both quality and safety. Some examples are:

- We were a pilot site for the Safer Patient Initiative (SPI). By focussing on small tests of change to make significant improvements we have been able to demonstrate reduction in harm to our patients. For example, wards are using safety briefings at the start of each shift to highlight areas of concern about patients and also communicate key safety messages to staff. We are committed to continuing the work of the SPI.

- We are launching our quality and safety strategy early in 2009, overseen by a Patient Quality and Safety Board. The aim is to make patient care safe, effective and personal. The three high level drivers in the strategy are: safety, evidenced based practice and patient experience and this will be achieved through measurement, building capability and capacity, improving communication, leadership and culture. Our high level aims are:

    - to reduce our HSMR from 90 to 80 by January 2010

    - to reduce our adverse events/harm rate from 76 to 40 by January 2010.

  The high level aims will be monitored by the Board of Directors every month.

- The Trust agreed our organisational strategy. It has been developed to encapsulate the approach the organisation wishes to take in affecting the culture and environment in which staff operate and practice. This development of this culture will support respectful and transparent communication, an environment to enable innovation and challenge and behaviours which foster respect and value for staff. This will in turn, we believe, improve the quality of care our patients receive.

Prioritising the quality initiatives

Following Board consultation on our analysis, we confirmed our top five quality priorities to be:

Priority 1: to reduce our stroke mortality rate by 5% in the next year

Priority 2: to further reduce our MRSA and Clostridium Difficile rate

Priority 3: increase the percentage of patients who would recommend the Trust to a friend/relative to 95% in the next year

Priority 4: to reduce our crash calls by a further 10% in the next year

Priority 5: to improve the number of eligible patients receiving venous thromboembolism (VTE) prophylaxis to 95%

We assessed each quality initiative in terms of:

1. **Impact** on improving quality though considering the likely reduction in variation, improvement in patient safety, outcomes and experience

2. **Feasibility,** as a reflection of the ease of implementation, resources required and likely completion or delivery

3. Also factored in were areas of concern or action from inspection reports.

Selected priorities and proposed initiatives

The priorities, as stated above, are described in more detail on the following pages:

Priority 1:
Reducing our stroke mortality rate

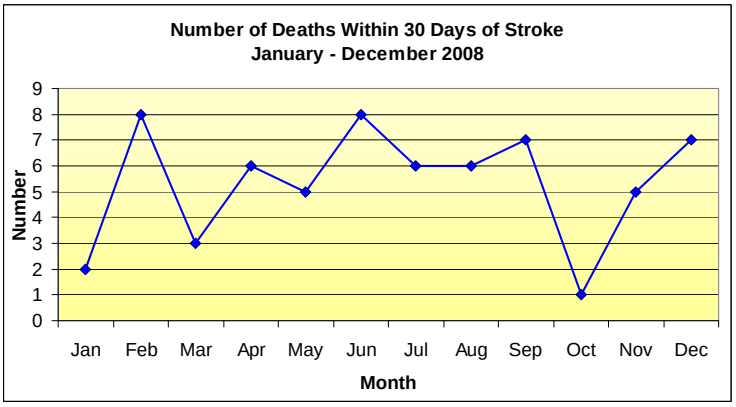
Description of issue and rationale for prioritising

Our stroke rate mortality rate amounts to 30% of patients admitted with stroke. As well as being a key metric for the DH, improving this rate will have significant impact on our overall hospital mortality rate. Our developing stroke strategy will enable us to deliver our initiative.

Aim / Goal

To reduce our stroke mortality rate by 5% in 2009-10.

Current status



Identified areas for improvement

Access to appropriate / specialist treatment especially within the first 24 hours of admission

Management of the care pathway from admission to post-discharge

Current initiatives 08/09

Development of integrated care pathway for stroke
Thrombolysis service 9am-5pm Monday to Friday

3rd stroke consultant

T.I.A service 3 days a week

New initiatives to be implemented in 2009-10

1. Direct admissions to the acute stroke unit
2. 7 day thrombolysis service 24 hours
3. 7 day Transient Ischaemic Attack (T.I.A) service
4. Early supported discharge team
5. Program manager for strategy

Board sponsor
Alison Hughes, Director of Facilities and Strategy

Implementation lead
Dr. John Coyle

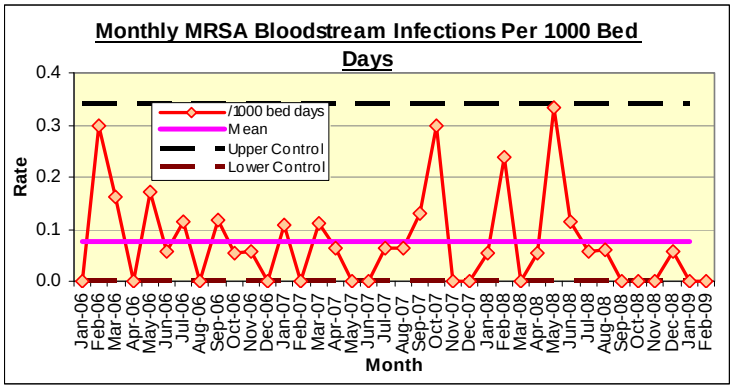
Program manager
To be appointed

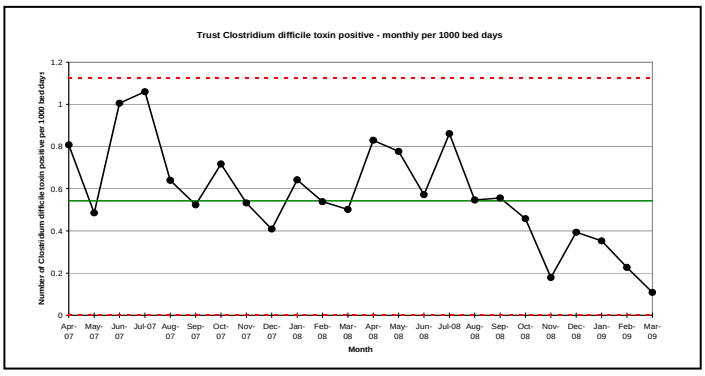
Priority 2:
To further reduce our MRSA & Clostridium Difficile rate

Description of issue and rationale for prioritising
We have made significant and excellent progress in reducing our MRSA and C.difficile rates over the last year. We believe we can reduce this further, in line with national priorities.

Aim / Goal
To at least maintain at least the current threshold of 6 post 48 hour MRSA Bacteraemia cases & not exceed C.difficile target rate in the next year.

Current status





Identified areas for improvement
Consistency of compliance with 'bare below the elbows' and hand hygiene with all staff groups.
Consistency of MRSA screening for pre-op patients

Current initiatives 08/09
Infection Prevention and Control Mandatory Training for all Trust staff.
Infection Prevention and Control Assurance Framework, integral to the Corporate Governance Framework.
Implementation and monitoring of the National Standards for Cleanliness 2007.
Implementation of Infection Prevention and Control Performance dashboards for all directorates from December 2008 with escalation when necessary of risks and action plans.
Implementation of Narrow Spectrum antimicrobial prescribing formularies in Elderly Care, Medical and Surgical Directorates via the Antimicrobial Stewardship Team.
Root Cause Analysis for all MRSA Bacteraemia and *C.difficile* cases.
Enhanced environmental disinfection when cases of *C.difficile* occur.
Implementation of MRSA operational screening guidance for elective cases.

New initiatives to be implemented in 2009-10

1. Implementation of Saving Lives and High Impact Interventions – target – 100% compliance.
2. Enhanced MRSA screening in Critical Care and Pre-Op Assessment, admissions from other Health Care facilities.
3. Continuous assessment of implementation and compliance with the Hygiene Code.
4. Weekly Hand Hygiene and Bare Below the Elbows Observational compliance audits – aiming for and sustaining 100% compliance across all staff groups.

Board sponsor
Elizabeth McManus, Chief Nurse
Program manager
Vicki Parkin

Implementation lead
Dr. Neil Todd, Consultant Microbiologist

Priority 3:

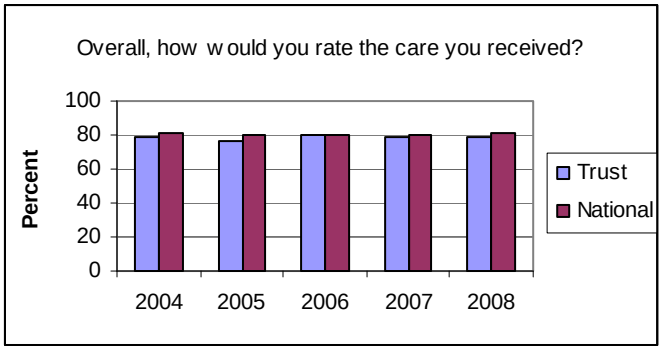
Increase the percentage of patient recommendations

Description of issue and rationale for prioritising
We will continue to respond to patient feedback to improve the patient experience so that patients are inclined to recommend the Trust to relatives / friends. Although the Trust performs well through our national in-patient surveys we intend to gather this feedback more frequently and on more patients.

Aim / Goal
Increase the percentage of patients who would recommend the Trust to a friend / relative to 95% in the next year (national survey results)

Current status

Results from previous national inpatient surveys



Notes: National is threshold for best 20% of Trusts.
'Would you recommend this hospital to your family / friends' - Yes, definitely + yes, probably from Picker report. HCC does not address this question in its report, therefore, there is no national figure.
'Overall, how would you rate the care you received' - The figures for 2008 are expected week commencing 4 May 2009.

Identified areas for improvement (based on last years results)
Not enough information on how to complain
No where to keep personal belongings
Could not always find a staff member to discuss concerns with
Not enough opportunity for family to talk to doctor
Inconsistent use of volunteers

Current initiatives 08/09
In-patient survey action group
Purchased new standpoint equipment for more timely patient feedback
Development of nursing care quality metrics
Approved dignity action plan

New initiatives to be implemented in 2009-10

1. Recruitment of a project manager to scope the potential to improve the numbers and remit of our volunteer workforce
2. Implementation of stand point rolling program
3. Implementation of new complaints procedure, including additional staff to support Patient Advice and Liaison Service (PALS) and Patient and Public Involvement (PPI)
4. Excellence in care training to be included in statutory and mandatory training
5. Establishment of governors patient focus groups
6. Governors workplan to include gathering real time patient feedback

Board sponsor
Gillian Fleming, Non-Executive Director
Implementation lead
Elizabeth McManus, Chief Nurse
Program manager
Marilyn Thirlway, Head of Patient Experience

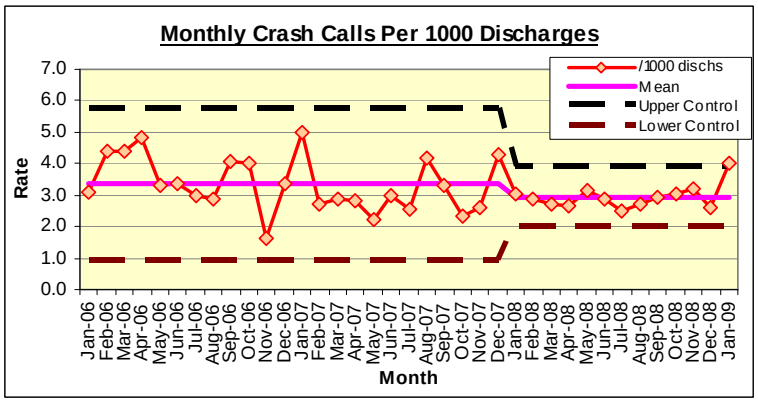
Priority 4:

<u>To further reduce our crash call rate</u>

Description of issue and rationale for prioritising
Through the work of the Safer Patient Initiative (SPI) we have demonstrated a reduction of 27% in our crash call rate. This has been by focussing on the identification and treatment of the deteriorating patient. We believe we can further reduce this rate and improve our overall mortality rate.

Aim / Goal
To reduce our crash call rate by a further 10% in the next year

Current status



Identified areas for improvement
Poor quality of patient observations.
Inconsistent knowledge of Patient at Risk (PAR) score and management of the deteriorating patient.
Critical care outreach team (CCOT) not staffed to full establishment.

Current initiatives 08/09
Further roll out of reliable patient observations and routine use of PAR score.
Recruitment of end of life care pathway coordinator.
Development of an escalation policy for medical patients.

New initiatives to be implemented in 2009-10

1. Increase percentage of reliable observations to 95% across all wards.
2. Review of Critical Care Outreach Team (CCOT) service and recruitment to full establishment.
3. Review of care of the dying pathway, improved training and roll out to all clinical areas.
4. Escalation policy development for all clinical areas.
5. Crash call analysis of all crash calls.

Board sponsor
Dr. Ian Woods, Medical Director

Implementation lead
Michelle Carrington, Assistant Chief Nurse (Quality & Safety)

Program manager
Critical Care Outreach Team

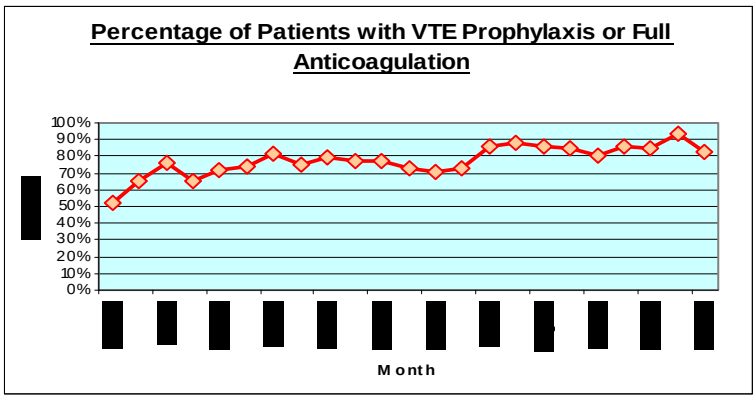
Priority 5:

To further improve the number of eligible patients receiving venous thromboembolism (VTE) prophylaxis

Description of issue and rationale for prioritising
Through the work of the Safer Patient Initiative (SPI) we have demonstrated a 50% reduction in our occurrence of VTE. We believe we can further improve compliance with VTE prophylaxis prescribing and improve our overall mortality rate.

Aim / Goal
For 95% of eligible patients to have VTE prophylaxis prescribing within 24 hours of admission.

Current status



Identified areas for improvement
No standardised risk assessment for admissions.
No policy for VTE prophylaxis.
None compliance with NICE guidance on VTE prophylaxis

Current initiatives 08/09
Redesign of the drug chart to incorporate a prompt for VTE prophylaxis.
Development of departmental guidelines for VTE prophylaxis.
Small tests of change to improve compliance.

New initiatives to be implemented in 2009-10

1. Capture data on readmissions rates with VTE / Pulmonary Embolism (PE)

2. Establishment of a VTE Committee to develop Trust policy, risk assessment tool and patient information.

Board sponsor
Dr. Ian Woods, Medical Director

Implementation lead
Dr. Donald Richardson, consultant physician

Program manager
Lynn Ridley, senior pharmacist

Response to LINks and to feedback from members and governors

A recent report from a LINks representative highlighted that patients are concerned over delays in their discharges, such as waiting for medication. We will be undertaking a point prevalence study of all patients on one day during the month of May. This data will advise the Acute Board which areas of patient flow to prioritise. We will consider the appropriate initiatives to deal with these concerns and continue to ask the necessary questions to identify the care processes which require improvement. Governors are also establishing a patient focus group and together we have developed a workplan based on their interest and willingness to be more involved in gathering timely feedback on patient experiences.

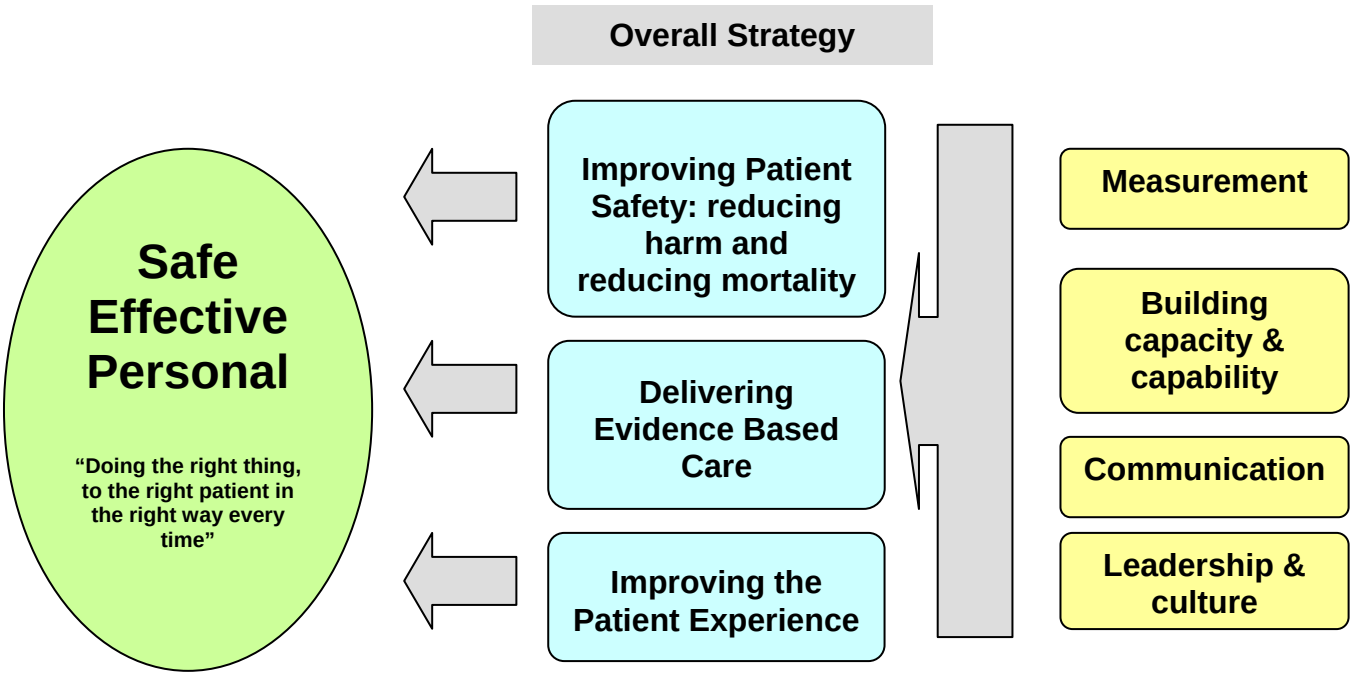
Quality Overview

Performance of Trust against selected measures

We have chosen to measure our performance against the following metrics:

Safety measures		
1.	Patients with MRSA infection/10,000 bed days	**As detailed in our Quality & Safety Strategy and in line with national targets**
2.	Patients with C.difficile infection/1,000 bed days	**As detailed in our Quality & Safety Strategy and in line with national targets**
3.	Harm events that occur within the Trust	**As detailed in our Quality & Safety Strategy**
Clinical outcome measures		
4.	Stroke mortality rates	**In line with new CQUIN framework, NICE guidance and our Stroke Strategy**
5.	Occurrence of VTE	**As detailed in our Quality & Safety Strategy and in line with CQUIN framework**
6.	Crash call rates	**As detailed in our Quality & Safety Strategy**
Patient experience measures		
7.	% of patients that would recommend hospital to relative/friend	**As detailed in our Quality & Safety Strategy and in line with national surveys**
8.	% of patients who felt they were treated with dignity and respect	**As detailed in our Quality & Safety Strategy and in line with national surveys**
9.	% of patients rating the overall care they received	**As detailed in our Quality & Safety Strategy and in line with national surveys**

Our Quality & Safety Strategy includes more drivers and outcome and process measures than can be detailed here. In addition to the above we will continue to monitor performance on additional measures through the Board of Directors via our dashboard.



National targets and regulatory requirements	2008-2009	2007-2008	Target
• The Trust has fully met the HCC core standards, and national targets.	Achieved	Achieved	except C20A
• Clostridium difficile year on year reduction	Achieved	Achieved	121
• MRSA – maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level	Achieved	Achieved	16
• Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments	Achieved	Achieved	to be determined
• Maximum waiting time of 62 days from all referrals to treatment for all cancers	Achieved	Achieved	to be determined
• 18-week maximum wait from point of referral to treatment (admitted patients)	Achieved	Achieved	90%
• 18-week maximum wait from point of referral to treatment (non-admitted patients)	Achieved	Achieved	95%
• Maximum waiting time of four hours in A&E from arrival to admission, transfer or discharge	Achieved	Achieved	98%
• Maximum waiting time of 31 days from diagnosis to treatment for all cancers	Achieved	Achieved	tbc
• Maximum waiting time of 62 days from urgent referral to treatment for all cancers	Achieved	Achieved	tbc
• People suffering heart attack to receive thrombolysis within 60 minutes of call (where this is the preferred local treatment for heart attack)	Achieved	Achieved	68%
• Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals	Achieved	Achieved	100%

Notes on regulatory requirements and national targets

The Trust has made huge progress over the last year and experienced significant improvements in key quality measures. During 2008/9 we complied with all of the Core Standards for Health with the exception of standard C20A, where an improvement plan is in place. We achieved all national targets despite a significant increase in GP referrals and non-elective activity.

The Trust's governance rating from Monitor is excellent as of the fourth quarter this year.

BOARD OF DIRECTORS

Board of Directors – April 2008 to March 2009

An effective Board of Directors should lead every NHS Foundation Trust as the Board is collectively responsible for the exercise of the powers and performance of the organisation.

The Board of Directors has a strategic focus – developing, monitoring and delivering plans. The Board members have collective responsibility for all aspects of the performance of the Trust including financial, performance, clinical and service quality including patient safety, management and governance.

The Board of Directors consists of a Chairman, Deputy Chairman/Senior Independent Director, Chief Executive, non-executive directors and executive directors. Its role includes:

- Providing active leadership of the Trust within a framework of prudent and effective controls which enables risk to be assessed and managed

- Ensuring compliance by the Trust with its terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations

- Setting the Trust's strategic aims, taking into consideration the views of the Members' Council, ensuring that the necessary financial and human resources are in place for the NHS Foundation Trust to meet its objectives and review management performance

- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, Monitor, the Care Quality Commission, and other relevant NHS bodies

- Ensuring that the Trust exercises its functions effectively, efficiently and economically

- Setting the Trust's values and standards of conduct and ensuring that its obligations to its members, patients and other stakeholders are understood and met

- All directors must take decisions objectively in the interests of the Trust

- All directors have joint responsibility for every decision of the Board of Directors regardless of their individual skills or status

- The concept of the unitary Board refers to the fact that within the Board of Directors the non-executive directors and the executive directors share the same liability. All directors have responsibility to challenge constructively the decisions of the Board and improve proposals on strategy

- Setting targets, monitoring performance and ensuring the resources are used in the most appropriate way

- As part of their role as members of a unitary Board, non-executive directors have a particular duty to ensure such challenge is made. Non-executive directors should scrutinise

the performance of the management in meeting agreed goals and objectives and monitor the reporting of performance. They should 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. They are responsible for determining appropriate levels of remuneration of executive directors and have a prime role in appointing, and where necessary removing, executive directors, and in succession planning.

- Being accountable for provided funds and how those public funds are used

- Having specific duties relating to audit, remuneration, clinical governance, charitable funds and risk assurance

- Working in partnership with the Members' Council.

Directors' biographies

Under section 17 and 19 of Schedule 7 of the National Health Service Act 2006, the Chairman, Chief Executive, executive and non-executive directors were appointed to the Board of Directors as follows:

Chairman - Alan Maynard
Initially appointed in 1997
Reappointed January 2008 until April 2010

Alan Maynard chairs both the Board of Directors and the Members' Council. Alan has spent his career deeply involved in the theory and practice of the funding and delivery of health care.

He has been Chair of York Hospital since 1997 and involved in NHS management in York since 1983. His specialist interests in the hospital are general surgery and urology, clinical support services and systems and network services.

He also works at the University of York where he was Founding Director of the Centre for Health Economics (1983-95) and is currently Professor of Health Economics in the Department of Health Sciences and the Hull-York Medical School.

Alan is a member of the Board of Compass, a charity that provides treatment services for drug users in Yorkshire, the Humber area, the Midlands and London.

Alan has special linkages with general surgery and urology, ophthalmology, head and neck and IT services.

Non-executive Director – Philip Ashton
Initially appointed September 2008 to September 2011

Born in Yorkshire and a graduate of Oxford University, Philip worked primarily in London before returning to the York area in 2003. During his years at PricewaterhouseCoopers he specialised in technical aspects of the audit practice, developing audit techniques and technology, particularly internal control and risk management. Philip was also involved in training and development, an area which continues to be of great interest to him.

He was a founder member of the Auditing Practices Board, and more recently was a representative of the auditing profession on the International Auditing and Assurance Standards Board.

Currently he is also a Governor on the Board of the Archbishop Sentamu Academy in Hull, and is a member of the York Minster Finance Committee.

Philip is Chair of the Audit Committee and a member of the Remuneration Committee.

Philip has special linkages with estates and the diagnostic areas of pathology, pharmacy and radiography.

Non-executive Director – Gillian Fleming
Initially appointed December 2004
Reappointed December 2008 to December 2011

Gillian has been a member of the Board since January 2005. She has wide experience in disputes resolution and has worked for Citizens Advice, with trade unions and within the local government sphere for the Ombudsman. She is an accredited mediator and works independently undertaking investigation and conciliation assignments. Gillian is also involved with the regulation of healthcare professions and other tribunals.

Gillian has special linkages with children and women's health.

Vice Chairman/ Senior Independent Director – John Hutton
Initially appointed December 2004
Reappointed December 2008 to December 2011

A non-executive director and vice chair since January 2005, John's special interest at the Trust is in medicine for the elderly. His training is in economics, and his career has included periods in universities, local government and the private sector. He is now Professor of Health Economics at the University of York and is also a non-executive director of Medipex, the NHS Innovation Hub for Yorkshire and Humberside.

John has a special linkage with elderly.

Non-executive Director – John Longworth
Initially appointed September 2008 to September 2011
Resigned from the Trust January 2009

John started his commercial life in marketing and strategy at the Cooperative Group where he became Deputy Secretary of the Group. He has advised Government on reputation matters ranging from the De-regulation Task Force through to the Health and Safety Commission and has frequently attended UK Parliamentary and European Committees for the giving of evidence.

Until his recent retirement John was Executive Main Board Director with Asda /Wal*Mart (Europe), leading Corporate Reputation Strategy and Execution. Before that he was a member of the Operating Board of Tesco Stores Ltd where he had global accountability for developing brand reputation and for product development, risk and compliance.

John resigned from the Trust as a Non-executive director on 31 January 2009 to take up a role at

another Trust.

Non-executive Director – Cai Mallet
Initially appointed 1 June 2004 to 30 April 2008
Resigned from the Trust April 2009

Cai trained as a chartered accountant with Price Waterhouse and continued to work with that business for nine years, latterly as a Financial Management Consultant. Since then she has worked with business, charities and community groups in Yorkshire. Her interest in health services developed through her membership and Chairmanship of a Community Health Council, her work in education with children with special needs and her use of health services as a patient and parent. Within the Trust, Cai took an interest in children's services and head and neck services.

Cai resigned from the Trust in April 2008 to take up a role in another Trust.

Non-executive Director – Linda Palazzo
Initially appointed 1 May 2006 to 31 April 2010

Linda has previously been employed in senior management positions in finance and has been involved in various community groups and campaigns with significant experience in charitable fund raising. Linda is Chairman of the Charitable Funds Committee. She was previously a Non-executive director and Chair of a Health Authority in London prior to moving to Yorkshire five years ago.

Linda has special linkage to emergency medicine, orthopedics, anesthetics and theatres.

Non-executive Director – Alan Rose
Initially appointed 1 March 2006 to 28 February 2010

Alan has been a non-executive at the Trust for two years and has over 25 years' experience in private sector business management and consulting, mainly in the energy sector, with Shell and Booz Allen Hamilton. His focus has been on marketing, strategy, partnering and business development.

At the Trust, Alan has a special linkage to the Medicine and Cancer Services Directorates and a focus on Strategy Development

Chief Executive – Patrick Crowley

Patrick has worked with the Trust since 1991 in a variety of finance and performance management roles, and was appointed to the role of Director of Finance and Performance in 2001. He became Interim Chief Executive in November 2007, following the resignation of Jim Easton. He previously worked for the Ministry of Defense financial management development unit in Bath and in private sector industry.

Patrick was appointed to the post of Chief Executive in June 2008.

Director of Finance – Andrew Bertram

Andrew Bertram joined the Trust as Director of Finance in January 2009. He joined the Trust from Harrogate and District NHS Foundation Trust where he held the position of Deputy Finance

Director for four years. Prior to working at Harrogate he previously held a number of roles at York, first joining in 1991 as a finance trainee as part of the NHS graduate management training scheme. On qualifying as an accountant, he undertook numerous finance manager roles at York before becoming Directorate Manager for Medicine and subsequently joining the senior finance team.

Andrew has responsibility for finance and purchasing.

Acting Director of Finance – Robert Chapman

Robert has been with York Hospitals NHS Foundation Trust in various roles within the Finance Directorate since 1986. He has 28 years experience in Finance in the NHS, all of which has been in the acute hospital sector. Robert is a member of the Chartered Institute of Management Accountants. Robert had responsibility for both finance and purchasing. Robert retired in January 2009 and Andrew Bertram took up his appointment as the Director of Finance in January 2009.

Director of HR and Legal Services – Peta Hayward

Peta Hayward has been with York Hospitals NHS Foundation Trust as Director of Human Resources since 2003. She joined the Trust after working at Birmingham Heartlands and Solihull NHS Trust (Teaching) for seven years, and has over 15 years' experience in human resources (HR) in the acute sector of the NHS. Her experience within HR is broad, covering a wide range of specialist and generalist issues with a particular interest in employment law matters supported by a diploma in employment law and personnel practice. Peta has an honours degree in mathematics and economics and is a member of the Chartered Institute of Personnel and Development.

Director of Strategy and Facilities – Alison Hughes

Alison has been working in the NHS for over 20 years. She began her career in 1985, qualifying as a chartered physiotherapist at Guy's Hospital. A number of clinical posts followed in various acute hospitals and teaching hospitals across the country.

In 1993, Alison moved into health service management and studied for an MBA at Manchester Business School which she gained with distinction in 1996. She subsequently worked as a general manager across a number of specialties gaining wide-ranging operational experience in both small rural district general hospitals and a large tertiary centre. She was appointed to the role of Director of Strategy and Planning at York in January 2005, and during 2007 extended her role to include facilities.

Chief Nurse – Elizabeth McManus

"Libby" has worked for the NHS for 24 years, mainly in acute hospitals but also with the NHS Modernisation Agency for the two years prior to her appointment as a Director at York in Spring 2003. As a registered nurse she worked in cardiothoracic surgery and intensive care units before pursuing a managerial role in hospitals.

Safety and quality for patients is at the core of her role as Chief Nurse.

She holds professional responsibility for standards of nursing and midwifery care for patients at the hospital and provides advice to the Board on professional issues.

She is the director responsible for infection prevention and control (DIPC).

Chief Operating Officer/Deputy Chief Executive – Mike Proctor

Mike has 32 years' experience in the NHS, 18 as a clinical nurse and a nurse educator and the last 14 years have been spent at York in senior management positions. He has been a director at the Trust since 1998.

Mike's current role includes responsibility for the day-to-day operational management of the organisation and he is the Trust board director with responsibility for performance management and communications.

Medical Director – Ian Woods

Ian was appointed Medical Director to the Trust in January 2006. He has been a consultant at the Trust since 1988, specialising in anaesthesia and until 2000 in critical care services. Originally from Lancashire, he trained in medicine at Manchester and prior to his arrival in York worked in several locations including Australia. Ian now combines his duties as Medical Director with a continued clinical input into anaesthesia, while maintaining an interest in his specialist area of peri-operative care.

Prior to becoming Medical Director, Ian spent time on secondment to the National Patient Safety Agency.

Attendance at Board and sub-committee meeting

The table below details the attendance of Board members at the Board of Directors' meeting during the year and Board sub-Committees

	Board of Directors	**Governance Committee**	**Remuneration Committee**	**Charitable Funds Committee**	**Strategy Committee**	**Audit Committee**	**Resource Management Committee**
Alan Maynard	Attended all meetings	Attended all meetings except Nov 08	Attended all meetings	N/A	N/A	N/A	Attended all meetings except July 08
Philip Ashton	Attended all meetings from Sept 08 except Nov 08	N/A	Attended all meeting from Sept 08	N/A	N/A	Attended all meetings from Sept 08	N/A
Gillian Fleming	Attended all meetings	Attended all meetings	Attended all meetings	Became a member of the Committee March 09 and attended the meeting	N/A	N/A	Attended all meetings except July 08
John Hutton	Attended all meetings	N/A	Attended all meetings	N\A	N/A	Attended all meetings	Attended all meetings
John Longworth	Attended all meetings from Sept 08 until 16 Dec 08	N/A	Attended all meetings from September 08	N/A	N/A	N/A	N/A

	Board of Directors	Governance Committee	Remuneration Committee	Charitable Funds Committee	Strategy Committee	Audit Committee	Resource Management Committee
Cai Mallett	Resigned from the Trust at the end of April 08. No meetings attended	N/A	Resigned from the Trust at the end of April 08. No meetings attended	Resigned from the Trust at the end of April 08. No meetings attended	N/A	Resigned from the Trust at the end of April 08. No meetings attended	N/A
Linda Palazzo	Attended all meetings	Attended all meetings except Nov 08	Attended all meetings	Attended all meetings	Attended all meetings except July 08 and March 09	Attended all meetings except Sept 08	N/A
Alan Rose	Attended all meetings	Attended all meetings except Nov 08	Attended all meetings	N/A	Attended all meetings	N/A	N/A
Patrick Crowley	Attended all meetings	Attended all meetings except May and July 08	Attended meetings as required	N/A	Attended all meetings	N/A	N/A

	Board of Directors	Governance Committee	Remuneration Committee	Charitable Funds Committee	Strategy Committee	Audit Committee	Resource Management Committee
Andrew Bertram	Attended all meetings from Jan 09	N/A	N/A	Attended all meetings from Jan 09	Attended all meetings from Jan 09	Attended all meetings from Jan 09	Attended all meetings from Jan 09
Robert Chapman	Attended all until Jan 09	N/A	N/A	Attended all meetings until Jan 09	Attended all meetings except May 08 and Sept 08. Attended the Committee until Jan 09	Attended all meetings except Sept 08	Attended all meetings until Jan 09
Peta Hayward	Attended all meetings	Attended all meetings from July 08	Attended meetings as required	Attended all meetings except March 09	N/A	N/A	Attended all meetings
Mike Proctor	Attended all except June 08 and November 08	N/A	N/A	Attended all meeting except April 2008. Was no longer a member from July 2008	N/A	N/A	Attended all meetings except May 08, Nov 08 and Jan 09

	Board of Directors	Governance Committee	Remuneration Committee	Charitable Funds Committee	Strategy Committee	Audit Committee	Resource Management Committee
Alison Hughes	Attended all except July 08	Attended all meetings	N/A	N/A	Attended all meetings	N/A	Attended all meetings except March 08, May 08, Sept 08, Nov 08 and Jan 09
Elizabeth McManus	Attended all except June 08 and March 09	Attended all meetings except Sept 08	N/A	N/A	N/A	N/A	Attended all meetings except July 08
Ian Woods	Attended all meetings	Attended all meetings except Sept 08	N/A	N/A	Attended all meetings except May 08, July 08 and Sept 08	N/A	N/A

Register of directors' interests

The Trust holds a register listing any interest declared by members of the Board of Directors. They must disclose details of company directorship or other positions held, particularly if they involve companies or organisations likely to do business or possibly seeking to do business with the Trust. The public can access the register at www.york.nhs.uk or by making a request in writing to:

The Foundation Trust Secretary
York Hospitals NHS Foundation Trust
Wigginton Road
York
YO31 8HE
or by e-mailing enquires@york.nhs.uk

As at 31 March 2009, the Board of Directors had declared these interests:

Public limited companies (PLCs) with the exception of those of dormant companies

Alan Maynard
Director (unpaid) - Dr Foster Ethics Committee Ltd

John Hutton
Non-executive Director - MEDIPEX Ltd
Executive Director - York Health Economics Consortium
Visiting Scientist and Shareholder—UBC Health Care Analytics Group

Ownership, part ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS:

Gillian Fleming
Director - An Independent View ltd

Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS:

The directors did not make any declarations under this section.

A position of authority in a charity or voluntary organisation in the field of health and social care:

Alan Maynard
Patrick Crowley
Mike Proctor
Alison Hughes
Elizabeth McManus
Linda Palazzo
Gillian Fleming
John Hutton

John Longworth (as from September 2008 , he resigned from the Trust January 2009)
Cai Mallett (resigned from the Trust April 2008)
Philip Ashton (as from September 2008)
Andrew Bertram (as from January 2009)
Robert Chapman (Acting Director until January 2009)
All Directors listed act as Trustees for the York Hospital NHS Foundation Trust which is the corporate Trustee of the York Health Service Trust General Charity.

Any connecting with a voluntary of other organisation contracting for NHS services or commissioning NHS services:

Alan Maynard

- Director of York Health Policy Group -Department of Health Sciences University of York
- Expert witness for National Institute for Clinical Excellence in a legal action
- Member— DoH, PbR External Advisory Group
- Specialist Adviser **-** Select Committee on Health, House of Commons

John Hutton
Honorary Chairman - Patient, Industry and Professionals Forum

Gillian Fleming
Lay Partner with Health Professions Council
Lay Conciliator for Hull and East Yorkshire PCTs
Lay Member of the Investigating Committee for the Royal Pharmaceutical Society

Patrick Crowley
Trustee (and Hon. Treasurer) - York Peptic Ulcer Research Trust

Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation Trust including but not limited to lenders or banks:

The Directors did not make any declaration under this section.

Board sub-Committees

The Board of Directors has delegated decision-making authority to the Governance Committee, the Resource Management Committee, the Strategy and Planning Committee, Charitable Funds Committee and Remuneration Committee. These Committees are required to provide the Board with written minutes of their proceedings.

Audit Committee

The membership of the Audit Committee during 2008/09 consisted of:

Cai Mallet – Non-executive Director (Chair of the Committee) until April 2008
John Hutton – Non-executive Director. Professor Hutton acted as Interim Chairman of the Committee until November 08 following the departure of Cai Mallet.
Linda Palazzo – Non-executive Director

Philip Ashton – Non-executive Director. Appointed as Chairman of the Audit Committee after his appointment in September 08.

The Committee receives reports from internal and external auditors and undertakes detailed examination of financial and value for money reports on behalf of the Board of Directors.

The Committee's terms of reference are as follows:

- Monitor the integrity of the financial performance of the Trust and any formal announcement relating to the Trust's financial performance
- Monitor governance and internal control
- Monitor the effectiveness of the internal audit function
- Review and monitor external audit's independence and objectivity and effectiveness of the audit process.
- Develop and implement policy on the employment of the external auditors to supply non-audit services
- Review of standing orders, financial instructions and scheme of delegation
- Review of schedule of losses and compensation
- Review of annual fraud report
- Provide assurance to the Board of Directors on a regular basis
- Report annually to the Board of Directors on its work in support of the statement on internal control.

The Committee has met seven times during the year. Each meeting considers the business that will enable the Committee to provide the assurance to the Board of Directors that, systems and processes in operation within the Trust, are functioning effectively.

The list of activities below show some of the work the Committee has undertaken during the year:

- Considered 22 internal audit reports and reviewed the recommendation associated with the reports
- Reviewed the progress against the work programme for internal and external audit and the counter fraud service
- Considered the annual accounts and associated documents and provided assurance to the Board of Directors
- Considered and approved various ad hoc reports about the governance of the Trust.
- Maintained close links with the Governance Committee
- Addressed various consultation documents released by Monitor
- Reviewed quarterly reports from Monitor.

<u>Governance Committee</u>

The membership of the Governance Committee during 2008/09 consisted of:

Gillian Fleming –	Non-executive Director (Chair of the Committee)
Alan Maynard –	Chairman of the Trust
Linda Palazzo –	Non-executive Director

Alan Rose –	Non-executive Director
Patrick Crowley –	Chief Executive
Ian Woods –	Medical Director
Peta Hayward –	Director of HR and Legal Services from July 2008
Alison Hughes –	Director of Strategy and Facilities
Elizabeth McManus –	Chief Nurse
Elaine Miller –	Head of Risk and Legal Services
Anna Pridmore –	Foundation Trust Secretary from August 2008

The Committee received reports from a number of sub-committees including:

Clinical Risk
Non Clinical Risk
Clinical Standards Committee
York and Selby Research and Development Committee
Patient Experience Committee
Nursing Board
Health and Safety Committee

The Committee's terms of reference are as follows:

- Provide assurance that the organisation is managing the principal risks to achieving its objectives
- Advising the Board on risk management and governance
- Consider, prioritise and report the most significant current issues identified to the Board of Directors
- Receive and review assurance from internal management and performance reports
- Receive and review the corporate risk register
- Receive and consider recommendations following the publication of external reports.

The Committee has during the year:

- Reviewed the Corporate Risk Register and led the re-development of the corporate risk register
- Reviewed and overseen the results and action plan of the inpatient survey report and maternity services
- Considered a report on the outcome of PROMS (patient reported outcome measures)
- Commissioned internal audit to undertake a review of the process for NHSLA standards
- Reviewed and tested the assurance provided by regular reports from the Governance Committee's sub-committees.

<u>Resource Management Committee</u>

The Resource Management Committee was established to support the Trust's improving efficiency agenda. The Committee sits bi-monthly and the membership during 2008/09 was as follows:

Professor John Hutton –	Non-executive Director (Chair)
Professor Alan Maynard –	Chairman of the Trust
Mrs Gillian Fleming –	Non-executive Director

The Committee monitored the progress against the corporate savings plan and provide support to a range of associated work streams.

Efficiency projects supported by the Resource Management Committee in 2008/09 include re-negotiating service level agreements, the nurse-centred productive ward project and a range of pharmacy modernisation initiatives.

In 2008/09, savings of £4.58m were delivered against a target of £4.57m, representing a significant achievement of a challenging plan.

Strategy Committee

The membership of the Strategy and Planning Committee during 2008/09 consisted of:

Alan Rose –	Non-executive Director (chair)
Robert Chapman/Andrew Bertram –	Director of Finance
Patrick Crowley –	Chief Executive
Alison Hughes –	Director of Strategy and Facilities
Linda Palazzo -	Non-executive Director
Ian Woods –	Medical Director

The Strategy and Planning Committee's purpose is to enable the development of strategy and strategic actions in support of the Trust's goals and objectives. It will assist the Trust Board to focus appropriate time and resources on specific components of strategy.

Principal duties are to ensure:

- The strategic direction of the Trust is reviewed on an annual basis and that detailed market/environmental analysis is undertaken to support this work
- Preparation of appropriate information to enable the Board of Directors to consider the strategic direction and identify priorities
- Issues of strategic importance to the Trust and the wider health economy are properly worked through and get appropriate consideration and involvement of the Board
- Agreed processes are followed to enable Board of Directors' approval of new strategies
- Appropriate members of the Board of Directors, Executive Board, governors and appropriate others are involved in strategy development
- The Board of Directors is kept briefed as to what stage strategies are at, and that a work plan is developed each year
- The expertise of the Committee is used to aid scenario planning and unblock complex issues.

The Committee has, during the year:

- Supported the development of a clinical services strategy (to be completed Q2 09)
- Reviewed the site development strategy that has led to the formation of a Programme Board (Space 21), to oversee the development of a significant new build
- Engaged with the development of strategies related to workforce, eastern geography and the Clifton independent treatment centre
- Driven the evolution of an improved process for dedicated strategy discussion time at Board of Directors – which it is envisaged will replace the role of the existing Strategy and Planning Committee.

Charitable Funds Committee

The membership of the charitable funds Committee during 2008/09 consisted of:

Linda Palazzo –	Non-executive Director (Chair of the Committee since May 2008)
Cai Mallet –	Non-executive Director (former Chair of the Committee) until April 2008
Gillian Fleming –	Non-executive Director, joined the Committee in February 2009
Robert Chapman/Andrew Bertram –	Director of Finance
Mike Proctor –	Chief Operating Officer/Deputy Chief Executive until July 2008
Mandy McGale –	Head of Patient Flow from July 2008 following the retirement from the Committee of Mike Proctor
Peta Hayward –	Director of HR and legal services from July 2008

Representatives of the Members' Council also attend the meeting.

On behalf of the Charity Trustee, the Committee has during the year:

- Begun the development of a fundraising strategy
- Approved specific expenditure projects
- Appointed Brewin Dolphin as Investment Managers
- Supported the development of plans for future use of charitable funds
- Reviewed the use of charitable funds
- Monitored charitable funds investment performance
- Updated the investment policy and scheme of delegation.

Remuneration Committee

The Remuneration Committee determines the remuneration of the Chief Executive and executive directors.

The membership of the Committee during 2008/09 was as follows:

Alan Maynard –	Chairman of the Trust
John Hutton –	Non-executive Director, Vice Chairman and Senior Independent Director
Philip Ashton –	Non-executive Director and Chairman of the audit Committee
Gillian Fleming –	Non-executive Director
Linda Palazzo –	Non-executive Director
Alan Rose –	Non-executive Director
John Longworth –	Non-executive Director (now resigned)
Cai Mallet –	Non-executive Director (now resigned)

The Committee met four times during the year to consider the remuneration of the executive directors, appointment of the Director of Finance and consideration of the executive directors' portfolios.

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 11 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 fulfil their responsibility for determining appropriate levels of remuneration of executive 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 Healthcare 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 BoD has reviewed its values and standards to ensure they meet 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 Trust's 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 newsletter 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. A detailed report on the activities of the Audit Committee is at page 56.

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 Chief Executive 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 five-year contracts and took into account that executive directors hold substantive contracts and are not subject to reappointment at five 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 re-appointment.

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 five-year contracts and took into account that executive directors hold substantive contracts and are not subject to re-appointment at five 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.

Resolution of disputes between the Members' Council and the Board of Directors

The code of governance requires the Trust to hold a clear statement explaining how disagreements between the Members' Council and the Board of Directors would be resolved.

The Board of Directors promotes effective communications between the Members' Council and the Board of Directors.

The Chairman of the Trust also acts as Chairman of the Members' Council. The Chairman's position is unique and allows him to have an understanding of a particular issue expressed by the Members' Council. Where a dispute between the Members' Council and the Board of Directors occurs, in the first instance the Chairman of the Trust would endeavour to resolve the dispute.

Should the Chairman not be willing or able to resolve the dispute, the senior independent director and the Vice-Chairman of the Members' Council would jointly attempt to resolve the dispute.

In the event that the senior independent director and the Vice-Chairman of the Members' Council not be able to resolve the dispute, the Board of Directors, pursuant to section 15(2) of Schedule 7 of the 2006 Act, will decide the disputed matter.

Board balance, completeness and appropriateness

As at year ending 31 March 2009 the Board of Directors for York Hospitals NHS Foundation Trust comprised five executive directors, five independent Non-executive Directors and an independent Non-executive Chairman.

Alan Maynard was re-appointed Chairman of the Trust by the Members' Council at a public meeting held on 8 January 2008.

John Hutton has served on the Board of Directors since December 2004. Professor Hutton was appointed Vice Chairman and Senior Independent Non-executive Director in April 2007. Mr Hutton was reappointed by the Members' Council at the December 2008 meeting as a Non-executive Director for a further three years.

Gillian Fleming has served on the Board of Directors since December 2004. Mrs Fleming was reappointed by the Members' Council at the December 2008 meeting as a Non-executive Director for a further three years.

Mr Philip Ashton and Mr John Longworth joined the Board of Directors on 24 September 2008 following the resignation of Ms Cai Mallet as a Non-executive Director in April 2008. Mr Longworth resigned as Non-executive Director at the end of January 2009 to take up a role at another Trust in London. The Board appointed Mr Andrew Bertram as Director of Finance during the year. He replaces Mr Patrick Crowley who was appointed as Chief Executive.

The remainder of the composition of the Board of Directors has not changed during the financial year 2008/09.

The Trust appointed the Director of Finance as the Senior Information Risk Owner (SIRO) for the Trust. The SIRO takes ownership of the Trust's information risk policy, acts as advocate for information risk on the Board, and provides written advice to the Accounting Officer on the content of our statement of internal control in regard to information risk.

The Chairman has conducted a thorough review of each Non-executive Director to assess

their independence and contribution to the Board of Directors and confirmed that they all are effective independent Non-executive Directors. A programme of appraisals has been introduced during the financial year 2008/09 and all Non-executive directors have undergone an annual appraisal as part of the review.

The Board of Directors maintains a register of interests as required by the constitution and Schedule 7 section 20 (1) National Health Service Act 2006.

The Board of Directors requires all non-executive directors to be independent in their judgement. The structure of the board and integrity of the individual directors ensures that no one individual or group dominates the decision-making process.

Each member of the Board of Directors upholds the standards in public life and displays selflessness, integrity, objectivity, accountability, openness, honesty and leadership.

The Board, in relation to the appointment of executive and Non-executive Directors, does not have a standing nominations Committee but convenes an ad hoc nominations committee, in accordance with the constitution, as and when required.

Biographies for the Board of Directors can be found on pages 48-50 of the annual report and accounts 2008/09.

Statement of the division of responsibility between the Chairman and the Chief Executive

The Chairman

The Chairman is accountable for the Board of Directors and the Members' Council.

The Chairman is responsible for ensuring that the Board of Directors operates as a unitary board and effectively develops and determines the Trust's strategy and overall objectives.

The Chairman is responsible for ensuring that the development of the business and the protection of the reputation of the Trust is maintained.

The Chairman is responsible for leadership of the Board of Directors and the Members' Council, ensuring their effectiveness on all aspects of their role and setting their agenda.

The Chairman is responsible for ensuring that the Board of Directors and the Members' Council receive accurate, timely and clear information that is appropriate for their respective duties. He is responsible for ensuring effective prioritised meetings are held where actions are followed up and reported to the Members' Council or Board of Directors as appropriate.

The Chairman ensures effective communication with patients, members, clients, staff and other stakeholders occurs.

The Chairman also facilitates the effective contribution of all executive and non-executive directors and ensures that constructive relations exist between the executive and the non-executive directors, and between the Board of Directors and the Members' Council.

The Chairman is not responsible for the executive and operational management of the Trust's business.

The Chief Executive

The Chief Executive reports to the Chairman and the Board of Directors.

The Chief Executive is the accountable officer for the Trust and in this regard is accountable to Parliament for the proper management of the public funds available to the Trust. He is responsible for the propriety and regularity of public finances within the Trust and for keeping proper accounts. He is responsible for prudent and economical administration, the avoidance of waste and extravagance and efficient and effective use of all the resources in his charge.

The Chief Executive has responsibility for the overall organisation, management and staffing of the Trust.

The Chief Executive is responsible for executive and operational management of the Trust's business, consistent with the strategy and business objectives agreed by the Board of Directors. All members of the executive team report either directly or indirectly to him.

The Chief Executive is responsible, working with the executive team, for researching, proposing and developing the Trust's strategy and overall business objectives, which is done in consultation with the Chairman.

The Chief Executive is responsible with the executive team for implementing the decisions of the Board of Directors and its Committees.

In delivering the Trust's strategic and business objectives the Chief Executive is responsible for the maintenance and protection of the reputation of the Trust.

The operation of the Board of Directors and Members' Council including high-level statement of decisions taken by each

The Board of Directors and the Members' Council recognise the importance of the operational relationship of the two forums. The Board of Directors seeks the opinion of the Members' Council on strategic issues affecting the Trust.

The scheme of delegation details the decisions that are taken by the Board of Directors.

MEMBERS' COUNCIL

Every NHS Foundation Trust is required to have a body of elected governors. York Hospital NHS Foundation Trust has a Members' Council (MC), which is responsible for representing the interests of NHS Foundation Trust members, patients and carers, staff members and partner organisations in the local health economy.

As a public benefit corporation the Trust is accountable to the local people and staff who have registered for membership and to those elected to seats on the MC.

The MC roles and responsibilities are outlined in law and detailed in the Trust's constitution.

During the financial year ending 31 March 2009 the MC met six times to discuss and comment on a number of aspects of the functioning of the Trust.

The MC's prime role is to represent the local community and other stakeholders in the stewardship of the Trust. It has a right to be consulted on the Trust's strategies and plans and any matter of significance affecting the Trust or the services it provides.

The MC is specifically responsible for the:

- Appointment and removal of the Chairman and other non-executive directors
- Approval of the appointment of the Chief Executive
- Appointment and removal of the external auditors.

The MC will consider and receive:

- The annual accounts, auditors' report and annual report
- Views from staff and community members on matters of significance affecting the Trust or the services it provides.

The governors elected and appointed to the Council, act in the best interest of the NHS Foundation Trust and adhere to the values and code of conduct of the Trust.

The MC holds the Board of Directors to account for the performance of the Trust.

The MC has regularly received details of significant projects and strategies. Comments from the MC are included in any decision-making discussion held at the Board of Directors.

<u>Elections</u>

The Trust holds elections every three years. The 'returning officer' role is undertaken by the Electoral Reform Services (ERS) – this ensures independence and impartiality.

On the occasion of a vacant seat following the resignation of an existing governor, the Trust's constitution allows the Trust to appoint from the runner up candidates. During 2008/09 the Trust has appointed a number of governors this way.

The next full election of the Members' Council will be held at the beginning of 2010.

Governors sit for a maximum of three years before they are required to stand in a further

election. Some governors have resigned during the year and the Trust's constitution allows for the person with the next highest votes to stand as a replacement governor for the balance of the term.

Elections will be held in the following areas:

- York City
- Selby
- Hambleton
- Patient/carer constituency

Partner organisations will consider the membership of their representatives on the Council at the end of the three year term on 31 March 2010.

Promoting elections

The Trust will continue to work to promote elections as they fall due to encourage greater interest and turnout. It will:

- Work with Electoral Reform Services (the Trust's independent scrutineers) to adopt fair electoral that encourage participation of all active members

- Maintain guidelines for running elections, including policies on canvassing, election expenses and election material

- Work with local media and other organisations (such as local councils) to feature elections and the public governor role in newspaper, magazine and radio media

- Organise election briefing opportunities for members who are potential governor candidates

- Ensure all members are fully informed about elections and the opportunity to become a governor.

The Council

The MC works with the BoD in an advisory capacity, bringing the views of staff and local people forward, and helping to shape the Trust's future. Their role includes:

- Representing the interests and views of local people
- Regularly feeding back information about the Trust, its visions and its performance to the community they represent
- Selecting and appointing non-executive directors and the Chairman of the Trust
- Appointing the Trust's auditors
- Attending meetings of the MC
- Receiving an annual report from the Board of Directors
- Monitoring performance against the Trust's service development strategy and other targets
- Advising the Board of Directors on their strategic plans
- Making sure the strategic direction of the Trust is consistent with its terms of authorisation as agreed by Monitor

- Being consulted on any changes to the Trust's constitution
- Agreeing the Chairman's and non-executive directors' remuneration
- Providing representatives to serve on specific groups and committees
- Working in partnership with the Board of Directors
- Informing Monitor if the Trust is at risk of breaching its terms of authorisation, if the concerns cannot be resolved within the Trust.

The MC at York Hospitals NHS Foundation Trust currently has 32 governors:

Public governors - seventeen elected
Staff governors – five elected
Partner governors - eight appointed

- Three from the local Primary Care Trust
- Three from the local authorities
- Two from local universities
- Two from the patients' forum, self-help forum or local voluntary groups.

Following the 2006 elections there have been some changes to the membership of the MC. These are shown below.

Governors – public governors including patient/carer governors

There are four constituencies represented by seventeen elected public and patient/carer governors: there was a change in public governor representation in the Hambleton, Selby and the patient/carer constituency during the year.

Governor	Elections held	Appointed from	Term	Term of office ends/ ended
City of York constituency				
Paul Baines	2006	April 1 2007	Three years	March 31 2010
Winifred Blackburn	2006	April 1 2007	Three years	March 31 2010
Linda Hatton	2006	April 1 2007	Three years	March 31 2010
Stephen Lewis	2006	April 1 2007	Three years	March 31 2010
Helen Mackman	2006	April 1 2007	Three years	March 31 2010
James Porteous	2006	April 1 2007	Three years	March 31 2010
Stefan Ruff	2006	April 1 2007	Three years	March 31 2010
Bob Towner	2006	April 1 2007	Three years	March 31 2010

Hambleton constituency

Jane Dalton	2006	October 1 2008	Balance of the three years	March 31 2010
Ann Harrison	2006	April 1 2007	Three years	March 31 2010*
Pam Turpin	2006	April 1 2007	Three years	March 31 2010

* Retired/resigned during the year – the candidate at the election with the next highest number of votes was appointed as in line with the constitution.

Selby constituency

Bob Curran	2006	October 1 2008	Balance of the three years	March 31 2010*
Patrick McGowan	2006	July 1 2008	Balance of the three years	March 31 2010
Nevil Parkinson	2006	April 1 2007	Balance of the three years	March 31 2010

*Retired during the year – the candidate at the election with the next highest number of votes was appointed as in line with the constitution.

Patient/carer constituency

Jane Farquharson	2006	April 1 2007	Three years	March 31 2010
Jennifer Moreton	2006	October 9 2008	Balance of the three years	March 31 2010
Geoffrey Rennie	2006	April 1 2007	Three years	March 31 2010
Brian Thompson	2006	April 1 2007	Three years	March 31 2010
David Vassey	2006	April 1 2007	Three years	March 31 2010*

* Retired/resigned during the year – the candidate with the next highest number of votes was appointed as in line with the constitution.

Governors – staff governors

There are four staff classes in the staff constituency. One new staff governor joined the MC during the year.

Governor	Elections held	Appointed from	Term	Term of office ends/ended
Consultant				
Lee Bond	2006	April 1 2007	Three years	March 31 2010
Nursing				
Lynne Atkinson	2006	April 1 2007	Three years	March 31 2010*
Kate Harper	2006	January 6 2009	Balance of the three years	March 31 2010
Anne Penny	2006	April 1 2007	Three years	March 31 2010

* Retired/resigned during the year – the candidate at the election with the next highest number of votes was appointed as in line with the constitution.

Clinical professional				
Martin Skelton	2006	April 1 2007	Three years	March 31 2010
Non-clinical				
Mandy McGale	2006	April 1 2007	Three years	March 31 2010

Governors – partner governors

Primary Care Trust (PCT)				
Gill Cashmore	2006	April 1 2007	Three years	March 31 2010
Michael Sweet	2006	April 1 2007	Three years	March 31 2010
Vacant				
Local Authority governors				
Elizabeth Casling	2006	April 1 2007	Three years	March 31

Alexander Fraser	2006	April 1 2007	Three years	2010 March 31 2010
Madeleine Kirk	2006	April 1 2007	Three years	March 31 2010
Caroline Patmore	2006	April 1 2007	Three years	March 31 2010
Sian Wiseman	2006	April 1 2007	Three years	March 31 2010

Education governors (appointed by the University of York)

Ian Greer	2006	April 1 2007	Three years	March 31 2010

Attendance at the Members' Council meeting during the year April 2008 to March 2009

A record is kept of the attendance at council of governor meetings. Below is the table showing, which governors have attended during the year.

	23 April 08	23 June 08	9 July 08	15 Sept 08 (AGM)	8 Oct 08	10 Nov 08	6 Jan 09	11 March 09	Total
Lynne Atkinson	Apol	Apol	✔	✔	Apol	✔	Resigned Nov 08		**3**
Paul Baines	✔	✔	✔	✔	✔	✔	✔	✔	**8**
Winifred Blackburn	Apol	✔	✔	✔	✔	✔	✔	✔	**7**
Lee Bond	✔	✔	✔	✔	✔	✔	Apol	✔	**7**
Gill Cashmore	Apol	✔	Apol	Apol	Apol	✔	Apol	Apol	**2**
Elizabeth Casling	Apol	Apol	Apol	Apol	Apol	Apol	Apol	✔	**1**
Bob Curran	Appointed October 1 2008				✔	Apol	Resigned Nov 08		**1**
Jane Dalton	Appointed October 1 2008				✔	✔	✔	✔	**4**
Alexander Fraser	✔	✔	✔	✔	✔	✔	✔	✔	**8**
Jane Farquharson	Apol	✔	✔	✔	✔	✔	✔	✔	**7**
Ian Greer	Apol	✔	Apol	Apol	Apol	Apol	Apol	Apol	**1**
Kate Harper	Appointed January 6 2009						Apol	Apol	**0**
Ann Harrison	✔	✔	Resigned July 2008						**2**
Linda Hatton	✔	Apol	✔	✔	✔	Apol	✔	✔	**6**
Madeleine Kirk	Apol	✔	Apol	Apol	Apol	Apol	✔	✔	**3**
Stephen Lewis	✔	Apol	Apol	✔	✔	Apol	Apol	✔	**4**

	23 April 08	23 June 08	9 July 08	15 Sept 08 (AGM)	8 Oct 08	10 Nov 08	6 Jan 09	11 March 09	Total
Helen Mackman	✔	✔	✔	✔	✔	✔	✔	✔	**8**
Mandy McGale	Apol	✔	✔	✔	✔	✔	Apol	✔	**6**
Patrick McGowan	Appointed October 1 2008				✔	Apol	Apol	Apol	**1**
Mike Moran	Apol	✔	✔	✔	Apol	✔	✔	✔	**6**
Jennifer Moreton	Appointed October 9 2008					Apol	✔	✔	**2**
Nevil Parkinson	✔	✔	Apol	✔	Apol	✔	✔	✔	**6**
Caroline Patmore	✔	✔	✔	✔	✔	Apol	✔	✔	**7**
Anne Penny	✔	✔	✔	✔	✔	Apol	✔	✔	**7**
James Porteous	Apol	✔	✔	✔	✔	Apol	✔	✔	**6**
Geoffrey Rennie	✔	✔	✔	✔	✔	✔	✔	✔	**8**
Stefan Ruff	✔	✔	✔	✔	Apol	✔	✔	✔	**8**
Martin Skelton	Apol	✔	✔	✔	Apol	✔	✔	✔	**6**
Michael Sweet	✔	✔	✔	✔	Apol	✔	✔	✔	**8**
Brian Thompson	Apol	✔	✔	✔	Apol	✔	✔	Apol	**6**
Bob Towner	✔	Apol	Apol	✔	Apol	✔	✔	✔	**5**
Pam Turpin	Apol	✔	Apol	✔	Apol	✔	✔	Apol	**4**
David Vassey	✔	Apol	✔	Resigned July 2008					**2**
Sîan Wiseman	✔	✔	✔	Apol	✔	✔	✔	✔	**7**

Register of governors' interests

The Trust holds a register listing any interests declared by members of the MC. Governors must disclose details of company directorships or other positions held, particularly if they involve companies or organisations likely to do business, or possibly seeking to do business with the Foundation Trust. The public can access the register at: www.yorkhospitals.nhs.uk or by making a request in writing to:

The Foundation Trust Secretary
York Hospitals NHS Foundation Trust
Wigginton Road
York
YO31 8HE

or by e-mailing: enquiries@york.nhs.uk

The Members' Council declared the following interests:

1. Directorships including non-executive directorships held in private companies or public limited companies (PLCs) with the exception of those of dormant companies:

Ian Greer
Director – Daisy Appeal
Madeleine Kirk
Trustee – York Theatre Trust
Mike Moran
Trustee – MyknowledgeEmap York
James Porteous
Trustee – Notions Business and Marketing Consultants
Brian Thompson
Trustee – Thompson's of Helmsley Ltd

2. Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS:

Mike Moran
Trustee – MyknowledgeEmap York

3. Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS:

There were no declarations under this section

4. A position of authority in a charity or voluntary organisation in the field of health and social care:

Gill Cashmore
Chief Officer – Selby District AVS
Jan Farquharson
Chief Executive – Age Concern, Knaresborough
Alexander Fraser
Appointee – City of York Council, non-voting participating observer on York CVS Trustees.
Ian Greer
Medical Advisor – ITP Association
Medical Advisor – APEC (Action on Pre-eclampsia)
Mike Moran
Chairman – York CVS
Nevil Parkinson
Director – West Riding Masonic Charities Ltd

James Porteous
Chairman – Governor at Applefield School
Chairman – Hob Moor Oaks School
President – Leeds and North Yorkshire Region British Polio Fellowship
Bob Towner
Vice Chairman – York Older Peoples Assembly
Pam Turpin
Member – York Pain Management Support Group

5. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:

Gill Cashmore
Chief Officer – Selby District AVS
Jane Farquharson
Chief Executive – Age Concern, Knaresborough
Alexander Fraser
Appointee – City of York Council, non-voting participating observer on York CVS Trustees
Jennifer Moreton
Systematic Reviewer – Mother and Infant Unit, MIRU Health Sciences University of York
Caroline Patmore
Councillor – North Yorkshire County Council
Michael Sweet
Non- executive Director – North Yorkshire and York PCT
Bob Towner
Vice Chairman – York Older Peoples Assembly
Pam Turpin
Project worker – OVE ARUP

6. **Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation Trust including but not limited to, lenders or banks:**

Jane Dalton
Researcher – Health and Social Care, University of York
Ian Greer
Dean – HYMS
Jennifer Moreton
Systematic Reviewer – Mother and Infant Unit, MIRU Health Sciences University of York
Caroline Patmore
Councillor – North Yorkshire County Council
Michael Sweet
Beneficiary – The Pension Fund – Tibbett & Britten Group

<u>Governor expenses</u>

Governors are not remunerated, but are entitled to claim expenses for costs incurred while undertaking duties for the Trust as a governor, (i.e. travel expenses to attend the MC meeting). The total amount of expenses claim during the year from 1 April 2008 to 31

March 2009 by governors was £3481.31.

Related party transactions

Under Financial Reporting 8 “Related Party Transactions”, the Trust is required to disclose, in the annual accounts, any material transactions between the NHS Foundation Trust and members of the MC or parties related to them.

There were no such transactions for the period 1 April 2008 to 31 March 2009.

Membership of the sub-Committees

The Committees listed below also play a key role in the running of the Members’ Council. The Members’ Council has delegated authority to a number of sub-committees to address specific responsibilities of the Members’ Council. These are:

Remuneration Committee

The Committee meets on an ad hoc basis to consider the remuneration of the Chairman and non-executive directors. During 2008/09 the Committee agreed the increase in the Chairman and non-executive directors pay to reflect the additional demand of foundation Trust status. The Committee has not met since that agreement to review non-executive director pay.

The Committee has a membership of four governors and is supported by the Chief Executive and Director of HR as appropriate.

The Committee will meet during 2009/10 to review non-executive pay.

Nominations Committee

The Committee met during the year to address the appointment and appraisal of the non-executive directors. The Committee has a membership of five governors and the Chairman of the Trust.

The Committee has considered the appraisal of the non-executive directors and made recommendations to the Members’ Council for the re-appointment of two non-executive directors.

Membership Engagement Committee

This Committee was established in November 2008 and was originally known as the Membership Communication Working Group which held its first meeting in October 2007. It is a sub-Committee of the Members’ Council and therefore acts on behalf of the Members’ Council. It is supported by the Membership Development Manager.

The Committee strives to achieve a membership that is representative of each constituency and to this end we have one governor representative each for the public of Selby and Hambleton, two for the public of the City of York, one for patients and carers, one nominated governor and one staff governor.

The role of the Committee is to review, monitor and support the development of plans for membership recruitment, engagement and involvement. Although the Committee may make recommendations for approval to the Members' Council, it does not itself have decision-making powers.

In carrying out this role, the Committee contributes to the establishment of membership development and membership communication strategies, reviews and analyses the Trust's membership, recommending an annual work programme for governors to support membership recruitment, retention and development. It also engages with local forums and groups to actively promote membership and the work of the governors, encouraging two-way communication and involvement.

As a result of the review of the terms of reference this year, the Committee has become more focused with a greater clarity of purpose. It has been recognised that the Foundation Trust's *YorkTalk* newsletter is the singular most effective communication with the membership and the Committee meets the Trust's Communications Service Manager to put forward ideas and suggestions for governor contributions to the newsletter.

MEMBERSHIP

Foundation Trust membership

The Trust has two constituencies – staff and community. It does not host a patient constituency.

Community membership (2008 – 2009) - eligibility

The Trust's available public constituency is defined as 'those people (aged 16 and over) living in specific wards of local authorities within the North Yorkshire and York Primary Care Trust area'.

During 2008/09, residents of the following local government administrative areas were eligible for membership of the NHS Foundation Trust (see map below):

PCT area map

York (all wards)

Selby (all wards)

Hambleton (the wards of Easingwold, Helperby, Huby and Sutton, Shipton, Stillington and Tollerton)

Co-terminosity:

In the region, the PCT has co-terminosity with several local authority boundaries:

- **York City Council**
- **Selby District Council**
- **Hambleton District Council**
- **North Yorkshire County Council**

Around 95% of the patients treated at York Hospitals NHS Foundation Trust as inpatients, day cases and outpatients live in these areas.

Total public/patient/carer membership size and movements during 2008/09

	Last year	**Estimated for next year**
At year start (1 April)	13,961	13,245
New members	158	1,100
Members leaving	874	500
At year-end (31 March)	13,245	13,845

Total staff membership size and movement during 2008/09

	Last year	**Estimated for next year**
At year start (1 April 2008)	4,240	4,448
New members	1052	250
Members leaving	844	50
At year-end (31 March 2009)	4,448	4,648

Below are summary tables providing further analysis of the tables above

Public membership breakdown at 31 March 2009.

Catchment area	Total number of members	Number eligible for membership (aged 16 & over) in catchment *	Number of members as a % of eligible population
City of York	7722	149,334	5.17%
Hambleton	703	11,371	6.18%
Selby	2097	60,525	3.46%
Total	**10,522**	**221,232**	**4.76%**

Age representation at 31 March 2009

In common with most Foundation Trusts over 95% of our membership is in the age range of 22 +. Analysis of our membership raw data shows that we are over represented by people aged 55 to 80 compared to the eligible population. This applies in all three catchment areas.

Equally, less than 1% of our members are in the age range 16 to 21, indicating significant under representation within the eligible population.

Eligible population by age in each constituency at 31 March 2009

Age	City of York	Hambleton	Selby	Total public membership
0 -16	0	0	3	3
17 - 21	53	5	16	74
22+	7281	687	2038	10,006
Unknown	388	11	40	439
Total	**7,722**	**703**	**2,097**	**10,522**

Age representation at 31 March 2009

Age	Number of members	Representing % of current public membership
0 -16	3	0.03%
17 - 21	74	0.70%
22 +	10,006	95.10%
Unknown	439	4.17%
Total	**10,522**	**100%**

Eligible population by age in each catchment area at 31 March 2009

Age Range	City of York	Hambleton	Selby
0 -16	2,108	162	1004
17 - 21	14,676	679	3,797
22 +	132,484	10,526	55,699
Total eligible population	**149,334**	**11,371**	**60,525**

Gender report at 31 March 2009

The Trust has a reasonably balanced male/female representation as the following tables show.

Public membership by gender at 31 March 2009

Gender	City of York	Hambleton	Selby	Total public membership
Male	3,368	302	930	4,600
Female	4,021	386	1,147	5,554
Unknown	333	15	20	368
Total	**7,722**	**703**	**2,097**	**10,522**

Gender breakdown by percentage at 31 March 2009

Gender	Total membership	Gender percentage
Male	4,600	43.72%
Female	5,554	52.78%
Not stated	368	3.50%
Total	**10,522**	**100%**

Ethnicity report at 31 March 2009

BME groups form less than 2% of our eligible population. All the BME groups are under represented in our registered membership.

Ethnicity- membership breakdown at 31 March 2009

Ethnicity	City of York	Hambleton	Selby	Total
White	2,079	201	535	2,815
Asian	6	0	3	9
Black	2	0	1	3
Mixed	8	1	0	9
Other	0	1	0	1
Unknown	5627	500	1,558	7,685
Total	**7722**	**703**	**2097**	**10,522**

Ethnicity of catchment population against membership shown as a percentage

Ethnicity	Catchment	Membership
White	98.43	26.75%
Asian	0.83%	0.09%
Black	0.16%	0.03%
Mixed	0.41%	0.09%
Other	0.17%	0.01%
Unknown	0.00%	73.04%

Socio-economic report of membership at 31 March 2009

We have analysed our 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) gradings.

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.

NRS Grouping	Number of members	Potential membership (ACORN statistics)
ABC1	8,314	112,570
C2	1,448	35,520
D	359	34,175
E	386	31,560
Unclassified	15	0

Membership strategy

Engaging our membership

Since the appointment of the Membership Development Manager in July 2008 a number of recruitment and membership engagement activities have taken place which has resulted in

the recruitment of new members and the development of several long term projects and strategies. The Membership Manager works closely with the Members' Council's sub-committee, the Membership Engagement Committee, to decide an annual engagement plan and membership strategy.

The Membership Manager, supported on occasions by governors, has attended a variety of public and community events e.g. City of York Ward Committees (18 in number), the Older People's Assembly AGM, sixth form group at Tadcaster Grammar School, City of York Residents Forum, International Womens' Day event, York and 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.

We have begun a project with Tadcaster Grammar School 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 YorkTalk 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 four to six issues a year to maintain its relevance.

We have held four lunchtime YorkTalk presentations aimed at members to raise their awareness in a range of hospital based issues e.g. stroke medicine, respiratory medicine, infection control and cardiology services. Uptake by public members to these events has been disappointing with attendance mainly by governors and staff members. We will be reviewing the promotion and publicity of these events within the community.

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.

During the year we wrote to 300 members who expressed interest in bereavement services inviting them to an event held on 20 May 2009. At the event members were invited to view the plans and meet the team that have planned the suite.

We 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.

We are planning a further event in July for 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.

In May 2009, the Trust attended a Town Meeting in Helmsley where they met residents and discussed membership of the Trust. The Trust will be attending similar events organised by Selby District Council and Hambleton District Council over the next few months and will notify members and the public of the dates as they become available.

During 2008/09 we attended all of the City of York Ward Committees, once to present our objectives and to recruit further members from the general public. We 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.

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

We plan to provide an area on the Trust's intranet (Horizon) to provide 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.

We will 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.

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 (six times per year) 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 employment. This project must be concluded by October 2009 at the latest to allow the elections for staff governors to be held at the end of the year/early 2010.

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 (including contracted out staff) are aware of staff membership, what it means for them and to encourage them not to decline membership
- To strive towards a composition of public membership to reflect diversity – geographically spread across our catchment area and reflecting age, gender, ethnicity and socio-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
- Socio-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.

<u>Elections 2009/10</u>

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

PUBLIC INTEREST DISCLOSURES

Throughout the year, staff and community members have been consulted about issues that affect them in the way services are delivered or that mean changes to practices that affect how staff work.

Communication with staff has remained a high priority, staff at the Trust can access a variety of communication material including;

- YorkTalk quarterly membership paper – with authorisation of Foundation Trust status, the Trust launched YorkTalk, which is distributed to all community and staff members
- Intranet
- Team brief

As an NHS Foundation Trust, the Trust consults with both staff and community members on a regular basis through the various committees outlined in the report. Some examples of consultation and development of services involving staff and patients are given below.

Guardian Angels appeal

The Guardian Angels appeal involved a large number of people from the local community in a series of fund raising events to raise money to develop two rooms with the best facilities for paediatric high dependency care. The appeal raised over £300,000 and there were numerous press articles raising awareness of some of the life threatening problems that can affect children and how they are treated. The opening event in October 2008 was attended by over 50 patients who had previously been on our ward and had subsequently been involved in the appeal. The rooms have been developed to a very high standard to provide superb assessment, monitoring and treatment facilities and were built with the support of The Press (York). A further interesting element of this was the consultation regarding the best artwork pictures to be designed for the rooms which children would enjoy looking at as they recovered from illness. Children were involved in the choice of picture and the overall result is a calm, child-friendly environment which hides some of the technical equipment needed.

The teenage room was developed as a space for older children and teenagers to have as their own relaxation area on the ward - away from treatment and assessment areas. A small project team of teenagers from some of the children's clinics and local schools worked together with ward staff to prepare a specification of what furniture, colour scheme, lighting and entertainment equipment would be best for the room. The resulting project was successful in bidding for funding from a City of York group (that included some teenagers) and the Trust also added some financial support. The room will be completed next year and will provide an excellent area for teenagers to relax in whilst in hospital with medical and surgical problems.

Quality and practice development team

The quality and practice development team (QDP) is now part of the bigger quality and safety team (which includes, QPD, patient experience team and improvement and

effectiveness teams). During the last year QPD have been concentrating on the development of our monthly nursing quality indicators. By auditing nursing practice each month we are beginning to demonstrate the contribution nursing makes to patient care, able to measure the impact and action plan for improvements. Subjects have covered documentation, nutrition, privacy and dignity and communication. Patient feedback is sought each time the indicators are measured. National nursing indicators are due shortly and the team are pivotal to the development and embedding of these into the organisation.

As part of the assurance sought by the QPD team in implementing the tools and questionnaires used with the patients, a group of staff are consulted and the process tested to ensure the quality, robustness and accuracy.

Developing the standards around medicines management has also been a priority for QPD including improvements in the management of controlled drugs and improved security of medicines delivered to wards and departments. A training package for statutory and mandatory training will allow from April 09, an opportunity to train all clinical and non-clinical staff in the key areas of medicines safety and allow them to hear key changes to practice and legislation in this format for the first time.

This is developed through a nursing and midwifery medicines management group which includes representation from multi-disciplinary groups.

The introduction of the local dignity action plan has been led by QPD in line with the national dignity campaign and includes practical improvements such as; clips for patient bed curtains to ensure they are not opened without due reason and raising awareness of dignity issues amongst staff.

QPD continue to play a large role in the standardisation of equipment to improve safety and reduce costs e.g. changing over to a new anti-embolic stocking for patients and intravenous infusion equipment, following national safety alerts.

QPD also continue to support staff to improve their documentation e.g. pathways and nursing assessments. QPD, through the Nursing Policy Board, have developed and introduced policies on safe use of bedrails, patients' property and the chaperone policy.

Patient safety

The Safer Patient Initiative uses small tests of change often involving patients, nurses and doctors to introduce improvements and evaluate their effectiveness before rolling out across the organisation.

We recognise that despite the efforts and hard work of our staff, a number of patients are unintentionally harmed whilst in our care every day e.g. hospital acquired infections, adverse drug events and delays in treatment. It is also recognised that most harm occurs not as a result of staff doing the wrong thing but as a result of failures in the system and processes that staff work within.

Over the last two years the organisation has been part of a safer patient initiative which aimed to reduce the level of unintentional harm.

The Safer Patient Initiative is about making changes to the way we work making sure the right things happen at the right time. By applying the learning we gained from the initiative it has enabled us to examine the way in which we work and by making a number of changes we have begun to improve the safety and experience for the patient.

The Trust has identified through a number of work stream specific improvements across the Trust. Some examples of those improvements are:

- Weekly leadership walk rounds where directors visit clinical areas to talk to staff about their patient safety concerns
- Ensuring patient safety is included in all relevant agenda
- The introduction of pre-operative safety briefings and stop points which create an open team culture and improve communication, so reducing the potential for adverse events in theatre
- Routine use of patient at risk (PAR) scoring has increased the standard of patient observations, as a result of high quality observations there has been an increase in the reliability in identifying deteriorating patients
- Standardised warfarin protocols
- Introduction of the central line care bundle has reduced central line infections.

In order for us to achieve and sustain the level of reliability of these processes, we have built in continuous measurement and the mechanism to monitor performance on a regular basis so that we will be able to identify any decline in compliance and to make the necessary adjustments.

The Trust has demonstrated its ongoing commitment to patient safety and has developed a patient safety strategy which outlines what the aims and outcomes relating to patient safety and quality are for the next two years. The strategy will provide organisational focus and enable staff to see their role and responsibility in achieving the aims. The Trust has also signed up to the national patient safety campaign and as a result, was asked to share our learning with other organisations who are starting to look at some of the same issues.

<u>Patient Advice and Liaison Service (PALS)</u>

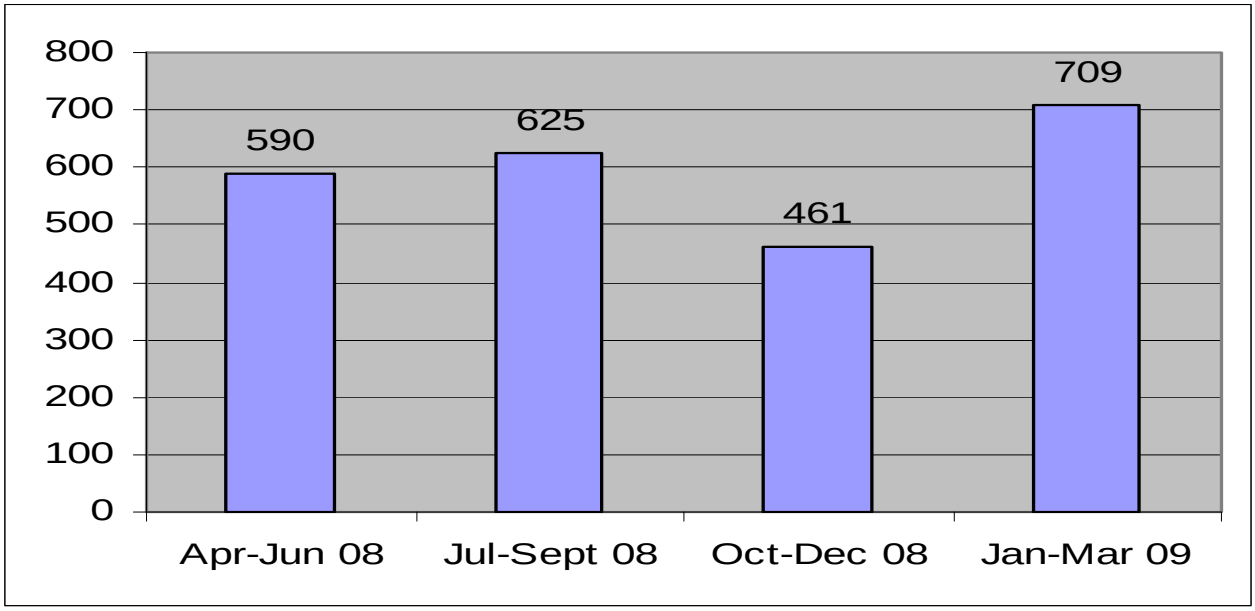
The service:

- Is a single point of contact for any hospital related enquiry
- Deals with patient concerns and can offer a speedy, on the spot resolution to issues
- Acts as a gateway to other statutory and community services
- Acts as a listening ear and monitors patient concerns
- Provides information about York hospital issues and the wider NHS
- Is a free and confidential service
- Supports staff at all levels to consider the patient perspective
- Provides data to directorates on emerging themes and trends and takes direct action where necessary to improve patient experience
- Is involved in voicing patient issues in a range of meetings and initiatives
- Can advise on the complaints process.

Activity

A large proportion of the cases dealt with by PALS are resolved immediately or within 24 hours, ensuring that the patient and their relatives or carers receive a high standard of service. However, the service also works hard to ensure that issues do not recur in the future for other patients by working with directorates to effect service improvement.

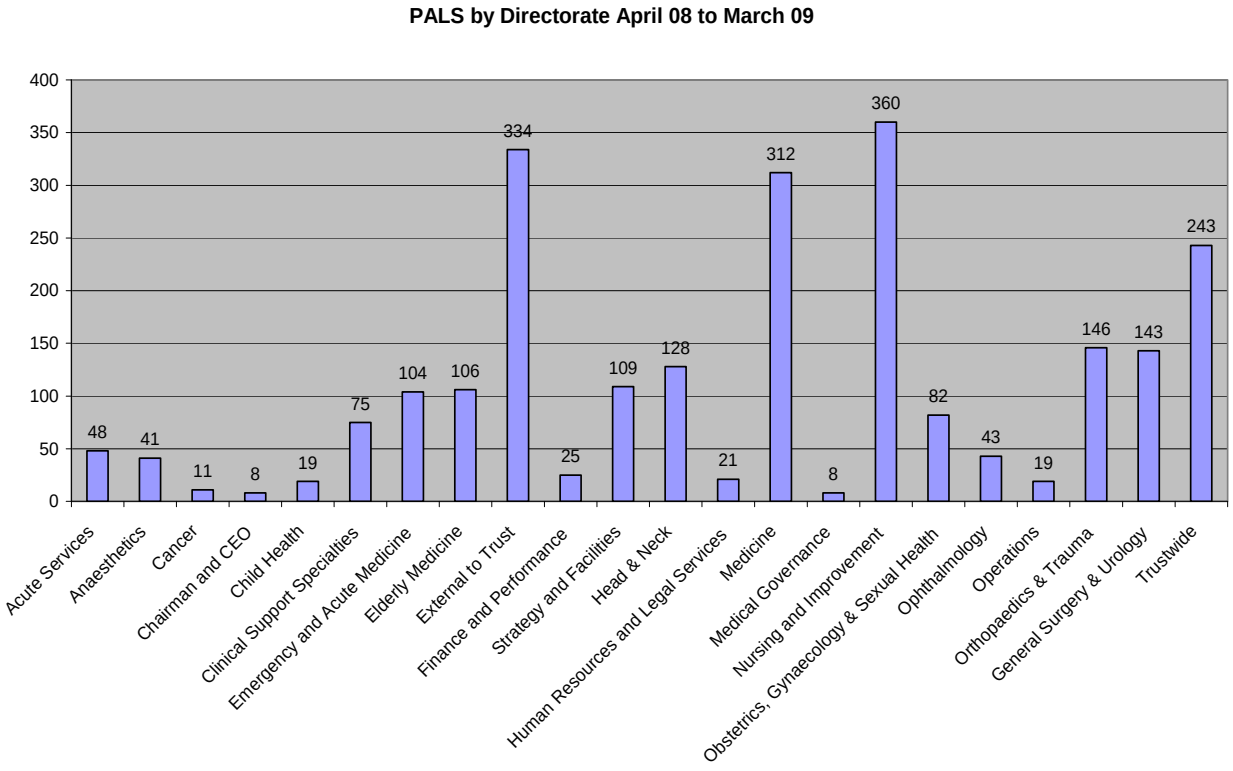
The graph below details activity for the period April 2008 to March 2009:



The table below shows a breakdown by subject of the cases PALS dealt with during this period:

Subject (primary)	Apr-Jun 08	Jul-Sept 08	Oct-Dec 08	Jan-Mar 09	Grand total
Admissions, discharge, transfer arrangements	23	9	18	33	83
Aids / appliances / equipment	10	15	1	4	30
Appointments, delay/cancellation (inpatient)	16	14	10	22	62
Appointments, delay/cancellation (outpatient)	59	48	49	87	243
Staff attitude	21	20	16	17	74
Any aspect of clinical care/treatment	97	84	82	99	362
Communication issues	44	49	31	46	170
Compliment / thanks	26	51	27	42	146
Environment / premises / estates	12	7	7	8	34
Failure to follow agreed procedure	0	2	6	2	10
Foreign language	6	10	1	13	30
Hotel services (including cleanliness, food)	10	11	6	4	31
Requests for information and advice	139	182	108	191	620
Other	6	4	3	4	17
Car parking	19	17	10	14	60
Privacy & Dignity	0	4	2	2	8
Property and expenses	28	16	29	31	104
Personal records / Medical records	18	14	7	25	64
Signer	13	15	11	10	49
Support (eg benefits, social care, vol agencies)	20	25	21	21	87
Patient transport	22	26	15	34	97
Welfare benefits	1	2	1	0	4
Totals:	**590**	**625**	**461**	**709**	**2385**

The graph below shows the overall PALS activity within directorates during this period.



Service user involvement groups

Several service user involvement groups continue to operate within the Trust, including:

- Child Hearing Services Working Group (CHSWG)
- Maternity Services Liaison Committee (MSLC)
- Older Peoples' Liaison Group (OPLG)
- York and District Cancer Partnership (YDCP)

All the groups provide valued opportunities for the exchange of feedback and information between service users and the Trust, which improve patient experience.

Patient surveys within the Trust

In 2008 the Trust acquired new survey equipment consisting of 3 free-standing and 2 hand-held touch screen survey devices. One of the free-standing machines has been purchased by the maternity department for use in maternity only. Areas where the devices have been used to obtain patient feedback since they were put into service in December 2008 include:

- Audiology
- Head and neck
- Cardiology
- General medicine

- Discharge lounge
- Ophthalmology (repeat survey)
- Hydrotherapy clinic.

The previous survey equipment was used to obtain patient feedback prior to December 2008 in the following areas:

- Endoscopy
- Dermatology
- Irritable Bowel Syndrome (IBS) Clinic
- Cancer care
- Ophthalmology
- Antenatal clinic
- Maternity service.

When a survey is completed, action plans are generated to improve patient experience. Examples of actions completed this year are:

- Patients reported that staff in dermatology did not always greet them on arrival in the department. In order to address this, the department altered the times the reception staff are available to ensure that someone is always there to greet patients.

- In one area, more than half of the respondents felt there could be more toys and entertainment facilities in the department. Since receiving this feedback the department now have a named paediatric link who, with the play therapist, has reviewed the provision of toys in the department. They are now swapping toys at regular intervals and changing the way the toys are displayed.

- The results of the IBS survey were discussed in Autumn 2008 at the monthly gastroenterology multidisciplinary meeting and results were also disseminated to the line manager. All of the consultant gastroenterologists understood the purpose and outcomes of the survey and were invited to verbally respond. It was agreed by all parties that the outcomes of the survey were extremely encouraging and positive.

- The discharge lounge had a suggestion from a patient who would like to see a computer available within the lounge. This option is being considered as part of the ongoing development for the lounge and funding is being considered to provide this facility for patients.

Health and Safety

The Trust believes that good health and safety systems are a fundamental requirement for any organisation. It believes that good health and safety systems are required to help support a safe environment for staff, visitors and patients.

The Trust had a visit from the Health and Safety Executive during the year to undertake a review of the Health and Safety standards including stress and manual handling.

The Chief Executive has overall responsibility for health and safety; however the nominated director for health and safety throughout 2008/09 was the Director for HR and Legal Services.

The Board of Directors receive annual training on health and safety and staff are required to undergo update training annually as part of the mandatory training. New employees receive training as part of their induction training to the Trust.

Counter fraud and corruption

The Foundation Trust's counter fraud arrangements are in compliance with the Secretary of State's directions on countering fraud and the requirements specified in the NHS Counter Fraud and Corruption Policy. These arrangements are underpinned by the appointment of accredited Local Counter Fraud Specialists and the introduction of a Trust-wide countering fraud and corruption policy. An annual plan identifying the actions to be undertaken to create an anti-fraud culture, deter, prevent, detect and, where not prevented, investigate suspicions of fraud is produced and approved by the Trust's Audit committee.

REMUNERATION REPORT

The Remuneration Committee

There are two Remuneration Committees. One is made up of a group of Governors to determine the appropriate remuneration for Non-executive Directors, including the Chair.

The second has delegated authority from the Board of Directors to make decisions in respect of salary and conditions of service for the Executive Directors and two Associate Directors of the Trust, and is made up of the Non-executive Directors of the Trust.

During the financial year 2008/09 the Committee met on four occasions (May, July, November and March). This is more than usual due in part to some reconfiguration of roles following the appointment of the substantive Chief Executive, and due to the appointment of a new Director of Finance.

Remuneration of the Chairman and Non-executive Directors

During 2007/08 the remuneration of the Chairman and the Non-executive Directors was considered by the Governors' Remuneration Committee.

Remuneration of the Chief Executive and Executive Directors

The membership of the Committee is the Non-executive Director cohort including the Chairman.

Remuneration policy

With the exception of the Chief Executive, executive directors and medical staff, all employees of the Trust, including senior managers, are remunerated in accordance with the national NHS pay structure, *Agenda for Change.* It is the Trust's policy that this will continue to be the case for the foreseeable future. The remuneration of the Chief Executive and five other executive directors is determined by the Board of Directors' Remuneration Committee.

The Chief Executive and the four whole-time executive directors (Director Of Finance, Chief Nurse, Director of Strategy and Facilities and Deputy Chief Executive) are paid a flat rate salary within the range determined by the Remuneration Committee. The part-time Executive Director (Medical Director) is paid a flat rate within the range determined by the Remuneration Committee, which is separate from his salary as a medical practitioner. The Remuneration Committee also considers the remuneration of one Director (the Director of HR and Legal Services) who does not hold executive status and two Associate Directors.

In reviewing remuneration, the Committee has regard for the Trust's overall performance, the delivery of the agreed corporate objectives for the year, the pattern of executive remuneration among Foundation Trusts and the wider NHS, and the individual director's level of experience and development in the role.

There is no performance-related element, but the performance of the executive directors is assessed at regular intervals and unsatisfactory performance may provide ground for termination of contract.

Salaries and pension entitlements of senior managers

a) Salaries

	2008/09			2007/8		
Name and title	Director salary (bands of £5000)	Remuneration for other duties (bands of £5000)	Benefits in kind £000	Director salary (band of £5000)	Remuneration for other duties (band of £5000)	Benefits in kind £000
Executive directors						
Mr P Crowley Chief Executive	150-155		4.0	60-65		1.5
Mr P Crowley Director of Finance				60-65		2
Mr A Bertram Director of Finance	15-20		0.9			
Mr R Chapman Interim Director of Finance	80-85	5-10	0	40-45	30-35	0.1
Mr M Proctor Deputy Chief Executive	105-110		5.0	95-100		5.2
Mrs A Hughes Director of Strategy and Facilities	95-100		5.4	80-85		2.8
Ms E McManus Chief Nurse	20-25	70-75	1.9		80-85	3.8
Dr I Woods Medical Director	135-140	55-60	1.9	125-130	55-60	3.8
Non-executive directors						
Professor A Maynard Chairman	40-45			40-45		
Professor J Hutton Non-executive Director and Vice Chairman	10-15			10-15		
Mr P Ashton Non-executive Director	5-10			N/A		

Name and title	2008/09 Director salary (bands of £5000)	2008/09 Remuneration for other duties (bands of £5000)	2008/09 Benefits in kind £000	2007/8 Director salary (band of £5000)	2007/8 Remuneration for other duties (band of £5000)	2007/8 Benefits in kind £000
Mrs G Fleming Non-executive Director	10-15			10-15		
Mrs L Palazzo Non-executive Director	10-15			10-15		
Mrs C Mallett Non-executive Director	5-10			10-15		
Mr J Longworth Non-executive Director	1-5					
Mr A Rose Non-executive Director	10-15			10-15		

Patrick Crowley was promoted from Interim Chief Executive to Chief Executive in 2008
Robert Chapman was acting Director of Finance from November 2007 to January 2009
Andrew Bertram was appointed as Director of Finance in January 2009
John Longworth was a Non-executive Director from September 2008 to January 2009
Philip Ashton was appointed as Non-executive Director in September 2008
Cai Mallett resigned as Non-executive Director in April 2008

Benefits in kind shown in 2008/09 relate to provision of a lease car and other travel expenses.

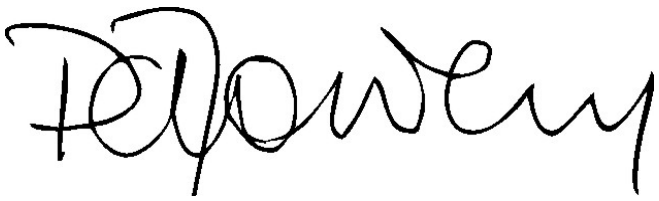
b) Pensions

Name	**Real increase in pension and lump sum at age 60** **Bands of £2500**	**Total accrued pension and lump sum at age 60 at 31 March 2009** **Bands of £2500**	**Cash Equivalent Transfer Value at31 March 2008** **£000**	**Cash Equivalent Transfer Value at 31 March 2009** **£000**	**Real Increase in Cash Equivalent Transfer Value** **£000**
Mr P Crowley, Chief Executive	7.5 -10	137.5-140	489	694	135
Mr A Bertram, Director of Finance	0-2.5	65-67.5	146	222	10
Mr R Chapman, Acting Director of Finance	0	120-122.5	504	0	0
M Proctor, Deputy Chief Executive	17.5-20	172.5-175	600	890	192
Mrs A Hughes, Director of Strategy and Estates	15-17.5	112.5-115	316	470	102
Ms E McManus, Chief Nurse	12.5-15	95-97.5	240	354	75
Dr I Woods, Medical Director	5-7.5	175-177.5	619	901	187

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

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

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



Patrick Crowley
Chief Executive
4 June 2009

Annual Accounts 2008/09

York Hospital NHS Foundation Trust

Index	**Page**

Statement of the Chief Executive's responsibilities as the accounting officer of York Hospitals NHS Foundation Trust

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

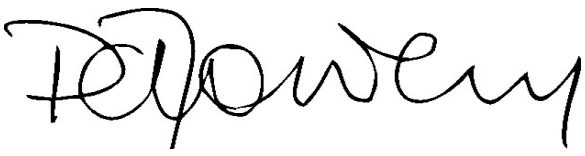
Under the National Health Service Act 2006, Monitor has directed the York Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair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

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS foundation trust Financial Reporting Manual and in particular to:

- Observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- Make judgements and estimates on a reasonable basis;
- State whether applicable accounting standards as set out in the NHS foundation trust Financial Reporting Manual have been followed, and disclose and explain any material departures in the financial statements; and
- Prepare the financial statements on a going concern basis.

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

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

Signed: 

Chief Executive Date: 04 June 2009

York Hospitals NHS
NHS Foundation Trust

STATEMENT OF INTERNAL CONTROL

1 Scope of responsibility

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

1.2 There are arrangements in place for sharing views and working with other 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
- Yorkshire Cancer Network
- National Programme for Information Technology (NPfIT) Information Management &Technology (IM&T) Programme Board
- Hull and York Medical School (HYMS) North Yorkshire Local Steering Group
- Healthy City Board
- Foundation Trust Network (FTN) Chairs and Chief Executives meeting
- York St John University and York College

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

1.3 **Risk Management**

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.

The Trust has during the year undertaken a review of the committee structures and governance arrangements in the organisation and has spent some time developing a more appropriate structure to ensure valid and relevant assurance is received by the Board on a regular basis. The implementation of the new structures will be undertaken during 2009/10.

1.4

Currently, the Board is supported by five committees (each chaired by a Non-Executive Director) that ensures effective monitoring and accountability arrangements for the system of internal control. These, and their principal responsibilities, are set out below:

<u>Audit Committee</u>

- Consideration of financial risk management.
- Soundness of overall system of internal control.

<u>Governance Committee</u>

- Consideration of risks and governance.
- Providing assurance to the Board about the key risks.

<u>Remuneration Committee</u>

- Review of the Executive Directors' Remuneration package.

<u>Resource Management Committee</u>

- Consideration of risk relating to cost improvement savings.
- Providing assurance to the Board about CIP savings and use of resources

<u>Strategy Committee</u>

- Consideration of risks relating to strategy development.

The minutes and other key documents of these committees are submitted to the Board of Directors, and the five committees ensure effective communication between them through sharing of minutes and papers.

2

The purpose of the system of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- Identify and prioritise the risks to the achievement of the policies, aims and objectives of York Hospitals NHS Foundation Trust.

- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in York Hospitals NHS Foundation Trust for the year ended 31 March 2009 and up to the date of approval of the annual report and accounts.

3

Capacity to handle risk

The Chief Executive has overall responsibility for the management of risk. Other members of the Executive Team exercise lead responsibility for the specific types of risk as follows:

• Clinical risk	Medical Director
• Financial risk	Director of Finance
• Non-Clinical and organisational risk	Director of HR and Legal Services
• Environmental risk	Director of Strategy and Facilities Chief Operating Officer

Executive Directors ensure that appropriate arrangements and systems are in place to achieve:

- Identification and assessment of risks and hazards;

- Compliance with internal polices and procedures, and statutory and external requirements;

- Integration of functional risk management systems and development of the assurance framework.

These responsibilities are managed operationally by managers supporting the Executive Directors.

The Trust has a Risk Management policy and procedure document, which is reviewed annually and endorsed by the Board. The policy is regularly reviewed during the year to ensure that it is fully embedded into the day-to-day management of the organisation and conforms to best management standards within the organisation. It also sets out the Trust's approach to the identification, assessment, scoring, treatment and monitoring of risk.

Staff are equipped to manage risk at strategic and operational levels. Programmes include:

- Formal in-house training for staff as a whole in dealing with specific everyday risks, e.g. fire safety, health and safety, moving and handling, infection control, security.

- Training and induction in incident investigation, including documentation, root cause analysis, serious untoward incidents and steps to prevent or minimise recurrence and reporting requirements.

- Developing shared understanding of broader financial, non-clinical, organisational and clinical risks through collegiate clinical, professional and managerial groups (such as Clinical Risk Group, Executive Board and Nursing Board) and sharing good practice with other peer foundation trusts through appropriate forums such as the Foundation Trust Network.

4

The risk and control framework

The Risk Management Policy and Procedure document:

- Defines the objectives of risk management and the process and structure by which it is undertaken;
- Sets out the lead responsibilities and the organisational arrangements as to how these are discharged;
- Sets out the key policies, procedures and protocols governing risk management;
- Identifies the link between directorate and corporate risk management.

The risk evaluation and treatment model is based on a grading matrix of severity and probability. This produces a risk score to enable the risk to be prioritised against other risks. The score, in turn, is linked to a matrix of the cost and responsibility of risk treatment so that either the risk is addressed locally by the directorate within its resources or it feeds into the Corporate Risk Register.

The Board of Directors reviews the Assurance Framework, which monitors the most serious risks facing the Trust in the achievement of its principal objectives and the sources of assurance currently available, both internal and external; the classification of principal risk which identifies the lead responsibilities within the Trust, how the risks are being mitigated; and any gaps in sources of assurance and the actions and timescales for addressing gaps.

During 2008/09 the Audit Committee and Board of Directors has received reports from various sources containing assurances. The Governance Committee is supported by two operational committees, one considering issues of clinical risk, the other non-clinical risk, which regularly review risks on the corporate risk register. The Assurance Framework has been redesigned during the year, and is now regularly updated and presented to the Audit Committee and Board of Directors on a quarterly basis.

The Trust has a fully updated Corporate Risk Register.

Risks are identified by the Directorates and recorded in their risk registers. Risks are also identified as a result of an AIRs or incident forms and are entered onto the DATIX database along with the directorate risk registers. The Directorates review their risks using a trained risk reviewer linked to the area and the central support team with the Risk Register Committee and the directorate Clinical Governance Committee is now reviewing the registers on a regular basis.

The Executive Team consider the draft Corporate Risk Register and the high level issues that require consideration for escalation to the Corporate Risk Register. The Corporate Directorates review and agree the Corporate Risk Register prior to presentation at the Governance Committee.

All staff have a responsibility to identify risk and report it to their line manager. The managers with responsibility for risk management:

- Ensure the effective identification and treatment of risks in relation to NHSLA standards and

- Develop whole system solutions to risks that that have the greatest potential to prevent disruption of patient care.

A number of forums exist that allow communication with stakeholder, the forums provide a mechanism for risk identified by stakeholders that affects the Trust to be discussed and where appropriate action plans can be developed to resolve any issues.

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

Members Council

The Council has a formal role as a stakeholder body for the wider community in the governance of the Trust.

- Regular newsletter
- Minutes of the Members' Council including joint meetings with the Board of Directors.

Staff

- Raising Concern Policy
- Regular newsletter
- Staff meetings and team briefings
- Staff surveys

Public and service users

- Patient surveys
- PALs service
- Patient forum
- Meetings with the Friends of York Hospitals and self-help groups
- LinKs

Other organisations

- Other health and social care communities
- Clinical and professional network groups in North Yorkshire

Changes to the Board during the year

During 2008/09 the Board of Directors membership was considered. The Board of Directors in consultation with the Members' Council agreed to increase the number of Non-Executive Directors by one; subsequently the Board of Directors agreed to increase the Executive Membership of the Board and appointed the Chief Nurse as an Executive Director.

Compliance with NHS pension scheme regulations

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

Information governance assurance programme

The Trust has a strong information governance (IG) focus, and has consistently performed well against the Information Governance Toolkit standards. Patient data confidentiality remains a high priority, with regular internal audit reviews and an annual report to the Board of Directors on these issues by the Caldicott Guardian.

The Chief Executive has overall responsibility for all aspects of information management, including security and governance, and is accountable to the Board of Directors.

The Medical Director is the Trust's Caldicott Guardian.

The Deputy Director of Corporate Performance and Compliance has operational responsibility for information management, and acts as the Trust's Data Protection Officer.

Information Governance risks are managed in accordance with Trust risk management standards, and, where appropriate, recorded on directorate risk registers.

All staff are governed by a code of confidentiality, and access to data held on IT systems is restricted to authorised users. Information governance training is incorporated as appropriate in all IT training sessions, and the corporate induction process has a dedicated IG session.

No information security breaches occurred during the year, which were of a scale or severity to require a report to the Information Commissioner. However, there were two incidents in which personal information relating to trust patients was, or could have been, unintentionally disclosed. The incidents were declared in accordance with Department of Health guidance.

The Trust complies and has attained level 2 or greater, with the majority of all the requirements of the current NHS Connecting for Health Statement of Compliance. Where this has not been attained plans are in place to ensure improvements are made

In accordance with the Information Governance Assurance Programme, the Trust completed actions required by the Department of Health by 31 March 2009

This year also saw the appointment of the Director of Finance as Senior Information Risk Owner (SIRO) for the Trust. The SIRO is responsible for the implementation of the Trust's information risk policy, acts as advocate for information risk on the Board, and provides written advice to the Accounting Officer on the content of our Statement of Internal Control in regard to information risk.

Compliance with equality, diversity and human rights legislation

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

Disclosure of standards for better health –Core standards declaration within the SIC

The Trust is compliant with all core standards for better health except for standard 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 organization. At various levels it became clear that the systems in place could be improved upon to ensure robust assurance to the Board and it was not appropriate to declare compliance with standard C20A at the close of Quarter 4.

5

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

During the year the Board of Directors have received regular reports informing of the economy, efficiency and effectiveness of the use of resources. The reports provide detail on the financial, clinical and performance of the Trust during the previous period and highlight any areas where there are concerns.

The Resource Management Committee, as a formal sub-committee of the Board of Directors review the Trust's use of resources including assessment of previously approved business cases and the productivity of the organisation. The Resource Committee is chaired by the Trust Vice Chairman and is attended by other executive and non-executive directors.

Internal Audit have reviewed the systems and processes in place during the year and published reports detailing the required actions within specific areas to ensure economy, efficiency and effectiveness of the use of resources is maintained, the outcome of these reports are graded according to the level of remaining risks within the area.

The Board of Directors has also received assurances on the use of resources from agencies outside the trust including Monitor. Monitor requires the Board of Directors to self assess on a quarterly basis. Monitor scores the assessment on a traffic light system.

The Trust further obtains assurance of its systems and processes and tests its benchmarking by membership of the Foundation Trust network where other Foundation Trusts share good practice.

6

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors and the executive managers within the NHS foundation trust who have responsibility for the development and maintenance of the internal control framework, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board of Directors, Audit Committee, Governance Committee, Clinical Risk Group and Non-Clinical Risk Group. Each of the groups has a key and distinct role and is linked to the others to ensure a comprehensive system of risk identification, risk management and of internal control. A plan to address weaknesses and ensure continuous improvement of the system is in place.

My opinion is also informed by:

- Maintained accreditation of the trust granted in June 2008 for NHSLA at level one for general standards;
- Maintained accreditation granted in March 2008 at level one of the CNST maternity standards;
- Achieving Practice Plus accreditation for IWL (March 2006);
- Healthcare commission performance rating (October 2008);
- External Audit interim report;
- Head of internal audit opinion;
- Licence received from Care Quality Commission
- Confirmation that the Trust has declared full compliance with the Healthcare Commission standards for better health declaration for 2007/08.
- Confirmation by Monitor through quarterly monitoring that the Trust is compliant with Monitor's regime with a financial risk scoring of at least 4 for Q1,Q2 and Q4 and a financial risk scoring of 3 in Q3. The Trust declared a mandatory services scoring of green throughout the year. The governance score was green for Q1 and Q3 and Q4. The governance score for Q2 was amber.
- Overall the SHA is confident that students\trainees receive teaching / training in a supportive environment.

At the end of the 3rd quarter an income and expenditure surplus of £1.57m was reported against a planned income and expenditure surplus for the period of £1.35m. The Trust had a cash balance of £4.9m at the end of the 3rd quarter against a plan of £8.5m.

In respect of the 3rd quarter performance only, an income and expenditure surplus of £0.18m was reported against a planned income and expenditure surplus for the period of £1.05m. The Trust declared a financial risk rating of 3.

At its meeting on 28 January 2009 the Board discussed the reduction from a previous (and planned) rating of 4, noting current liquidity, EBITDA and I&E surplus margin impact. It remained a clear objective of the Board to deliver a risk rating of 4 for the 2008/09 financial year and further implementation plans were put in place to achieve it.

At Q2 the Trust declared that it had reported 76 hospital acquired C-diff infections against an annual trajectory of 122. For the quarter, this represented 34 reported cases against a trajectory of 33.

The Trust developed a detailed action plan to address the number of hospital acquired infections.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the committees identified at 1.4 above, by the Board's monitoring of corporate and directorate performance, by the publication of audit reports in line with their work programme by internal audit during the year and, by the evidence of the assessment of the Trust and the capacity and capability of the Board by Monitor in relation to its financial management, governance arrangements and risk management systems by the Board's self-certification to Monitor.

As part of the Healthcare Commission's programme of inspections, the Trust received an inspection from the Healthcare Commission on 9th and 10th December 2008 to check that the Trust was following four duties of the hygiene code. The duties reviewed were duty 2, 4, 8, and 10j. The inspection concluded that the Trust was compliant with duties 8 and 10j and identified breaches in duties 2 and 4. An action plan with timescales was developed to address the areas of breach. The Trust has continued to update the Board of Directors and the Healthcare Commission of the progress of the action plan.

During 2008/09 work has continued on a number of developments to strengthen the internal control framework.

- Work has been carried out to develop the internal approach to risk, governance and control which links and supports the Trust's capacity to meet both Monitor's compliance framework and the Healthcare Commission's Assessment for improvement framework.

The Trust has during the year undertaken a review of the committee structures and governance arrangements in the organisation and has spent some time developing a more effective structure to ensure valid and relevant assurance is received by the Board on a regular basis. The implementation of the new structures will be undertaken during 2009/10.

.....
Patrick Crowley

4 June 2009

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF GOVERNORS OF YORK HOSPITALS NHS FOUNDATION TRUST

We have audited the financial statements of York Hospitals NHS Foundation Trust for the year ending 31 March 2009. These comprise the Income and Expenditure Account, Balance Sheet, Statement of Total Recognised Gains and Losses, the Cash Flow Statement and the related notes. These financial statements have been prepared in accordance with directions issued by Monitor through the NHS Foundation Trust Financial Reporting Manual 2008-09.

This report is made solely to the Board of Governors of York Hospitals NHS Foundation Trust, as a body, in accordance with paragraph 24(5) of Schedule 7 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Board of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's governors as a body, for our audit work, for this report, or for the opinions we have formed.

Respective responsibilities of directors and auditors

The directors' responsibilities for preparing the Annual report and the accounts in accordance with applicable law, direction from Monitor, the Independent Regulator for NHS Foundation Trusts, and United Kingdom Accounting Standards are set out in the Statement of Directors' Responsibilities.

The directors are responsible for the maintenance and integrity of the corporate and financial information on the Trust's website. Legislation in the United Kingdom governing the preparation and dissemination of the financial statements and other information included in annual reports may differ from legislation in other jurisdictions.

Our responsibility is to audit the accounts in accordance with relevant legal and regulatory requirements, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (UK and Ireland).

We report to you our opinion as to whether the accounts give a true and fair view and are properly prepared in accordance with paragraph 25(2) of Schedule 7 of the National Health Service Act 2006, and in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. We also report whether the part of the remuneration report to be audited has been properly prepared in accordance with the accounting policies directed by Monitor as being relevant to NHS Foundation Trusts. We also report to you whether in our opinion the information given in the Directors' Report is consistent with the financial statements.

We review the directors' Statement on Internal Control. We report if the Statement is misleading or inconsistent with other information we are aware of from our audit of the financial statements. We are not required to consider, nor have we considered, whether the directors' Statement on Internal Control covers all risks and controls. We are also not required to form an opinion on the effectiveness of the Trust's corporate governance procedures or its risk and control procedures. Our review was not performed for any purpose connected with any specific transaction and should not be relied upon for any such purpose.

We read other information contained in the Annual Report, and consider whether it is consistent with the audited financial statements. This other information comprises the foreword, the unaudited part of the Remuneration Report, the Chairman's Statement and the remaining elements of the Operating and Financial Review. We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with the financial statements. Our responsibilities do not extend to any other information.

Basis of audit opinion

We conducted our audit in accordance with paragraph 1 of Schedule 10 the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor, which requires compliance with International Standards on Auditing (UK and Ireland) issued by the Auditing Practices Board.

An audit includes examination, on a test basis, of evidence relevant to the amounts and disclosures in the financial statements and the part of the remuneration report to be audited. It also includes an assessment of the significant estimates and judgements made by the directors in the preparation of the financial statements, and of whether the accounting policies are appropriate to the Trust's circumstances, consistently applied and adequately disclosed.

We planned and performed our audit so as to obtain all the information and explanations which we considered necessary in order to provide us with sufficient evidence to give reasonable assurance that:

- the financial statements are free from material misstatement, whether caused by fraud or other irregularity or error; and
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared.

In forming our opinion we also evaluated the overall adequacy of the presentation of information in the financial statements.

Opinion

In our opinion:

- the financial statements give a true and fair view of the state of affairs of York Hospitals NHS Foundation Trust as at 31 March 2009 and of its income and expenditure for the year ended;
- the financial statements and the part of the Remuneration Report to be audited have been properly prepared in accordance with paragraph 25 of Section 7 of the National Health Service Act 2006 and the NHS Foundation Financial Reporting Manual 2008-09 issued by Monitor; and
- the information given in the Directors' Report is consistent with the financial statements.

Conclusion on arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust's Responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

Auditor's Responsibilities

We are required under Schedule 10 1(d) of the National Health Service Act 2006 to be satisfied that proper arrangements have been made by the Trust for securing economy, efficiency and effectiveness in its use of resources. The Audit Code for NHS Foundation Trusts issued by Monitor, the Independent Regulator for Foundation Trusts, requires us to report to you our conclusion in relation to proper arrangements. We report if significant matters have come to our attention which prevent us from concluding that the Trust has made such proper arrangements. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Conclusion

We have undertaken our audit in accordance with the Audit Code for NHS Foundation Trusts and we are satisfied that in all significant respects, York Hospitals NHS Foundation Trust has made proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2009.

Certificate

We certify that we have completed the audit of the accounts in accordance with requirements of paragraph 4 of Schedule 10 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

Signature: ……..

Sarah Howard Senior Statutory Auditor

For and on behalf of Grant Thornton UK LLP, Registered Auditor, Chartered Accountants
No 1 Whitehall Riverside, Whitehall Road, Leeds, LS1 4BN

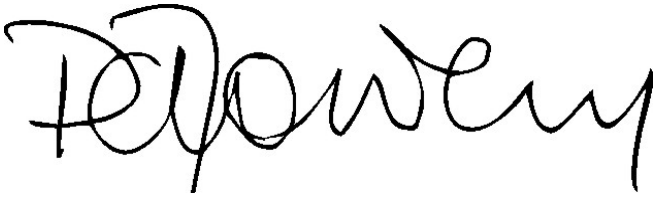
Date: 4 June 2009

FOREWORD TO THE ACCOUNTS

YORK HOSPITALS NHS FOUNDATION TRUST

These accounts for the year ended 31 March 2009 have been prepared by York Hospitals NHS Foundation Trust under paragraphs 24 and 25 of schedule 7 of the Health and Social Care (Community Health and Standards) Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

York Hospitals NHS Foundation Trust Annual Report and Accounts are presented to Parliament pursuant to Schedule 8, paragraph 11(3) of the Health and Social Care (Community Health and Standards) Act 2006.

Signed 

Patrick Crowley – Chief Executive

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDING 31 MARCH 2009

	Notes	2008/09 £000	2007/08 £000
Income from activities	**3**	**190,034**	174,131
Other operating income	**5**	**30,016**	24,908
Operating expenses	**6**	**(214,072)**	(193,961)
OPERATING SURPLUS BEFORE IMPAIRMENTS		**5,978**	5,078
Fixed asset impairments		**(7,788)**	(70)
OPERATING (DEFICIT)/SURPLUS		**(1,810)**	5,008
Loss on disposal of fixed assets	**9**	**(37)**	(26)
(DEFICIT)/SURPLUS BEFORE INTEREST		**(1,847)**	4,982
Interest receivable		**501**	553
Other finance costs - unwinding of discount	**17**	**(18)**	(18)
(DEFICIT)/SURPLUS FOR THE FINANCIAL YEAR		**(1,364)**	5,517
PDC dividends payable		**(4,224)**	(3,962)
RETAINED (DEFICIT)/SURPLUS FOR THE YEAR		**(5,588)**	1,555

The notes on pages 21 to 42 form part of these accounts.

All income and expenditure is derived from continuing operations.

The impairment loss of £7.8m is due to an exceptional technical adjustment mainly associated with the decommissioning of property on the hospital site, which requires the entire reduction in value of the property to be taken to the Income and Expenditure account. Associated with this property is a corresponding credit balance built up from historical price increases in the revaluation reserve of £4.0m. This balance has been taken to the Income and Expenditure Reserve as a reserve movement

The underlying performance for the year generated a surplus of £2.2m compared to a planned surplus of £1.2m.

BALANCE SHEET AS AT 31 MARCH 2009

	Notes	31 March 2009 £000	31 March 2008 £000
FIXED ASSETS:			
Intangible assets	**11**	**358**	448
Tangible assets	**12**	**105,325**	135,872
TOTAL FIXED ASSETS		**105,683**	136,320
CURRENT ASSETS:			
Stocks and work in progress	**13**	**3,137**	3,229
Debtors	**14**	**15,832**	10,574
Cash at bank and in hand	**19.3**	**4,681**	22,143
TOTAL CURRENT ASSETS		**23,650**	35,946
CREDITORS: Amounts falling due within one year	**15**	**(17,872)**	(28,306)
NET CURRENT ASSETS		**5,778**	7,640
TOTAL ASSETS LESS CURRENT LIABILITIES		**111,461**	143,960
CREDITORS: Amounts falling due after more than one year	**15**	**(150)**	(215)
PROVISIONS FOR LIABILITIES AND CHARGES	**17**	**(1,204)**	(1,421)
TOTAL ASSETS EMPLOYED		**110,107**	142,324
FINANCED BY			
TAXPAYER'S EQUITY			
Public Dividend Capital	**23**	**64,811**	64,811
Revaluation reserve	**18**	**28,758**	59,771
Donated asset reserve	**18**	**465**	403
Income and expenditure reserve	**18**	**16,073**	17,339
TOTAL TAXPAYERS' EQUITY		**110,107**	142,324

The financial statements on pages 17 to 42 were approved by the Trust Board on 4 June 2009 and signed on its behalf by:

Signed:  (Chief Executive) Date: 4 June 2009

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2009

	2008/09	2007/08
	£000	£000
(Deficit)/surplus for the financial year before dividend payments	**(1,364)**	5,517
Unrealised (deficit)/surplus on fixed asset revaluations	**(26,691)**	18,222
Increase in the donated asset reserve due to receipt of donated assets	**168**	179
Reduction in the donated asset reserve due to depreciation	**(106)**	(91)
TOTAL RECOGNISED GAINS AND LOSSES IN THE FINANCIAL YEAR	**(27,993)**	23,827

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2009

	Notes	2008/09 £000	2007/08 £000
OPERATING ACTIVITIES			
NET CASH (OUTFLOW)/INFLOW FROM OPERATING ACTIVITIES	**19.1**	**(4,570)**	30,159
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:			
Interest received		**501**	553
NET CASH INFLOW FROM RETURNS ON INVESTMENTS AND SERVICING OF FINANCE		**501**	553
CAPITAL EXPENDITURE:			
Payments to acquire tangible fixed assets		**(9,087)**	(8,762)
Receipts from sale of tangible fixed assets		**12**	1,077
Payments to acquire intangible fixed assets		**(94)**	(41)
NET CASH OUTFLOW FROM CAPITAL EXPENDITURE		**(9,169)**	(7,726)
DIVIDENDS PAID		**(4,224)**	(3,962)
NET CASH (OUTFLOW)/INFLOW BEFORE FINANCING		**(17,462)**	19,024
FINANCING:			
New public dividend capital received		**0**	2,665
NET CASH INFLOW/(OUTFLOW) FROM FINANCING		**0**	2,665
(DECREASE)/INCREASE IN CASH		**(17,462)**	21,689

NOTES TO THE ACCOUNTS

Accounting policies and other information

Monitor has directed that the financial statements of NHS foundation trusts shall meet the accounting requirements of the *NHS Foundation Trust Financial Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *2008/9 NHS Foundation Trust Financial Reporting Manual* issued by Monitor. The accounting policies contained in that manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

These accounts have been prepared under the historical cost convention. NHS foundation trusts, in compliance with HM Treasury's *Financial Reporting Manual*, are not required to comply with the FRS 3 requirements to report "earnings per share" or historical profits and losses.

Income recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is under contracts with commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Expenditure

Expenditure is accounted for applying the accruals convention.

Intangible fixed assets

Intangible assets are capitalised when they are capable of being used in a trust's activities for more than one year; they can be valued; and they have a cost of at least £5,000.

Intangible fixed assets held for operational use are valued at historical cost and are amortised over the estimated life of the asset on a straight line basis. The carrying value of intangible assets is reviewed for impairment at the end of the first full year following acquisition and in other periods if events or changes in circumstances indicate the carrying value may not be recoverable.

Purchased computer software licences are capitalised as intangible fixed assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful economic lives.

Tangible fixed assets

Capitalisation

Tangible assets are capitalised if they are capable of being used for a period which exceeds one year and they:

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

Valuation

Tangible fixed assets are stated at the lower of replacement cost and recoverable amount. On initial recognition they are measured at cost including any costs, such as installation, directly attributable to bringing them into working condition. The carrying values of tangible fixed assets are reviewed for impairment in periods if events or changes in circumstances indicate the carrying value may not be recoverable. The costs arising from financing the construction of the fixed asset are not capitalised but are charged to the income and expenditure account in the year to which they relate.

All land and buildings are restated to current value using professional valuations in accordance with FRS 15 every five years. A three yearly interim valuation is also carried out. Valuations are carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) *Appraisal and Valuation Manual*.

The valuations are carried out primarily on the basis of depreciated replacement cost, for a modern equivalent asset. The value of land for existing use purposes is assessed at existing use value. For non-operational properties including surplus land, the valuations are carried out at open market value.

The last asset valuations were undertaken by the District Valuer in 2009 as at the prospective valuation date of 1 April 2009. The revaluation undertaken at that date was accounted for on 31 March 2009. This valuation was carried out to bring the asset values onto the modern equivalent asset basis.

Assets in the course of construction are valued at cost and are included as part of the valuation exercise once they are brought into use.

Operational equipment is valued at net current replacement cost. Equipment surplus to requirements is valued at net recoverable amount.

Depreciation, amortisation and impairments

Tangible fixed assets are depreciated at rates calculated to write them down to estimated residual value on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land, and assets surplus to requirements.

Assets in the course of construction are not depreciated until the asset is brought into use.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as assessed by the NHS foundation trust's professional valuers.

The standard economic lives of building and engineering assets are as follows:

Buildings	80 years
Engineering and fixed plant	35 years

Equipment is depreciated at current cost evenly over the estimated life.

The useful economic lives of equipment assets are as follows:

Medical equipment and engineering plant and equipment	5 to 15 years
Transport	3 to 7 years
Mainframe information technology installations	5 to 8 years
Furniture and Fittings	5 to 10 years
Office and information technology equipment	3 to 5 years
Set up costs in new buildings	10 years

Fixed asset impairments resulting from losses of economic benefits are charged to the income and expenditure account. All other impairments are taken to the revaluation reserve and reported in the statement of total recognised gains and losses to the extent that there is a balance on the revaluation reserve in respect of the particular asset.

Donated fixed assets

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

Stocks and work-in-progress

Stocks and work-in-progress are valued at the lower of cost and net realisable value. This is considered to be a reasonable approximation to current cost due to the high turnover of stocks. Work-in-progress comprises goods and services in intermediate stages of production partially completed contracts for patient services are not accounted for as work-in-progress, but rather as debtors

Cash, bank and overdrafts

Cash and bank balances are recorded at the current values of these balances in the NHS foundation trust's cash book. These balances exclude monies held in the NHS foundation trust's bank account belonging to patients (see "third party assets" below). Account balances are only set off where a formal agreement has been made with the bank to do so. In all other cases overdrafts are disclosed within creditors. Interest earned on bank accounts and interest charged on overdrafts is recorded as, respectively, "interest receivable" and "interest payable" in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the NHS foundation trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of the HM Treasury *Financial Reporting Manual*.

Provisions

The NHS foundation trust provides for legal or constructive obligations that are of uncertain timing or amount at the balance sheet date on the basis of the best estimate of the expenditure required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using HM Treasury's discount rate of 2.2% in real terms.

Contingencies

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are disclosed in a note unless the probability of a transfer of economic benefits is remote. Contingent liabilities are defined as:

- Possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or

- Present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS foundation trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS foundation trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS foundation trust is disclosed at note 17.

Non-clinical risk pooling

The NHS foundation trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the NHS Litigation Authority and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying Scheme assets and liabilities. Therefore, the Scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the Scheme is taken as equal to the contributions payable to the Scheme for the accounting period.

The Scheme is normally subject to a full actuarial investigation every four years. The main purpose of which is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such investigation, on the conclusions of which scheme contributions rates are currently based, had an effective date of 31 March 2004 and covered the period from 1 April1999 to that date. Between the full actuarial valuations, the Government Actuary provides an annual update of the scheme liabilities for FRS17 purposes.

The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the NHS Pension Scheme (England and Wales) Resource Account, published annually. These accounts can be viewed on the Business Service Authority - Pensions Division website at www.nhspa.gov.uk. Copies can also be obtained from The Stationery Office.

Employer contributions comprise 14% of pensionable pay. On advice from the actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities. Employees pay contributions according to a tiered scale from 5% up to 8.5% of their pensionable pay.

Value Added Tax

Most of the activities of the NHS foundation trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

Corporation Tax

The NHS foundation trust has determined that it does not carry out any trading activities that would give rise to a corporation tax liability.

Foreign exchange

Transactions that are denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. Resulting exchange gains and losses are taken to the income and expenditure account.

Leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the NHS foundation trust, the asset is recorded as a tangible fixed asset and a debt is recorded to the lessor of the minimum lease payments discounted by the interest rate implicit in the lease.

The asset and liability are recognised at the inception of the lease, and are de-recognised when the liability is discharged, cancelled or expires.

The interest element of the finance lease payment is charged to the income and expenditure account over the period of the lease at a constant rate in relation to the balance outstanding. Other leases are regarded as operating leases and the rentals are charged to the income and expenditure account on a straight-line basis over the term of the lease.

Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the original NHS trust.

A charge, reflecting the forecast cost of capital utilised by the NHS foundation trust, is paid over as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the NHS foundation trust. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Office of the Paymaster General. Average relevant net assets are calculated as a simple mean of opening and closing relevant net assets.

Financial instruments and financial liabilities

Recognition

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

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Classification and Measurement

Financial assets are categorised as 'Fair Value through Income and Expenditure', Loans and receivables or 'Available-for-sale financial assets'.
Financial liabilities are classified as 'Fair value through Income and Expenditure' or as 'Other Financial liabilities'.

Financial assets and financial liabilities at 'Fair Value through Income and Expenditure'

Financial assets and financial liabilities at 'fair value through income and expenditure' are financial assets or financial liabilities held for trading. A financial asset or financial liability is classified in this category if acquired principally for the purpose of selling in the short-term. Derivatives are also categorised as held for trading unless they are designated as hedges. Derivatives which are embedded in other contracts but which are not 'closely-related' to those contracts are separated-out from those contracts and measured in this category. Assets and liabilities in this category are classified as current assets and current liabilities.

These financial assets and financial liabilities are recognised initially at fair value, with transaction costs expensed in the income and expenditure account. Subsequent movements in the fair value are recognised as gains or losses in the income and expenditure account.

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

The Trust's loans and receivables comprise: current investments, cash at bank and in hand, NHS debtors, accrued income and other debtors.
Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset. Interest on loans and receivables is calculated using the effective interest method and credited to the income and expenditure account.

Other financial liabilities
All other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability. They are included in current liabilities except for amounts payable more than 12 months after the balance sheet date, which are classified as long-term liabilities. Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to the income and expenditure account.

Impairment of financial assets
At the balance sheet date, the Trust assesses whether any financial assets, other than those held at 'fair value through income and expenditure' is impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the income and expenditure account and the carrying amount of the asset is reduced directly except in the case of debtors which are reduced through the use of a bad debt provision. The bad debt provision account is used when there is significant doubt as to the recoverability of the debt. Where there is evidence to show that the debt will not be recovered, the carrying value is written down directly.

Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way each individual case is handled.

Losses and Special Payments are charged to the relevant functional headings in the income and expenditure account on an accruals basis, including losses which would have been made good through insurance cover had NHS Trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure). However, note 10 is compiled directly from the losses and compensations register which is prepared on a cash basis.

EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government granted current asset investments, valued at open market value. As the Trust makes emissions a provision is recognised, with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The current asset investment, provision and government grant reserve are valued at current market value at the balance sheet date.

2. Segmental Analysis

All income and activities are for the provision of health and health related services in the UK.

3.1 Income from activities	**2008/09**	2007/08
	£000	£000
Elective income	**38,729**	35,294
Non elective income	**62,838**	60,483
Outpatient income	**34,632**	31,719
A & E income	**5,413**	4,893
Other NHS clinical income	**46,533**	41,406
PBR clawback	**0**	(1,390)
Private patient income	**690**	794
Other non-protected clinical income	**1,199**	932
TOTAL	**190,034**	174,131

Some element of the Trust's income for 2008/9 is still subject to further negotiation over the coming months, which is entirely in line with the national clinical income settlement timetable. The position has been reviewed carefully, and the income included in the accounts reflects the amount we expect to receive.

3.2 Income from activities arising from mandatory services

The NHS Foundation Trust had £189,344,000 (2007/08 - £173,337,000) of income from activities arising from mandatory services and £690,000 (2007/08 - £794,000) arising from non-mandatory services in 2008/09.

4 Private patient income	**2008/09**	**2007/08**	**Base year**
	£000	**£000**	**£000**
Private patient income	**690**	794	900
Total patient related income	**190,034**	174,131	113,162
Proportion (as percentage)	**0.4%**	**0.5%**	**0.8%**

Section 15 of the 2003 Act requires that the proportion of private patient income to the total patient related income of NHS Foundation Trusts should not exceed its proportion whilst the body was an NHS Trust using 2002/03 as the base year.

5. Other operating income	**2008/09**	2007/08
	£000	£000
Research and development	**4,186**	1,055
Education and training	**8,542**	7,299
Charitable and other contributions to expenditure	**47**	46
Transfers from the donated asset reserve in respect of depreciation, impairment and disposal of donated assets	**106**	91
Non-patient care services to other bodies	**13,136**	12,809
Other	**3,999**	3,608
TOTAL	**30,016**	24,908

6. Operating Expenses

6.1 Operating expenses	**2008/09**	2007/08
	£000	£000
Services from NHS Foundation Trusts	**247**	28
Services from NHS Trusts	**2,247**	2,837
Services from other NHS Bodies	**1,439**	1,572
Purchase of healthcare from non NHS bodies	**3,190**	47
Executive directors costs	**1,051**	1,012
Non-executive directors costs	**118**	113
Staff costs	**138,622**	127,427
Drug costs	**15,446**	12,678
Supplies and services - clinical (excluding drug costs)	**22,184**	21,443
Supplies and services - general	**3,922**	3,574
Establishment	**4,073**	3,419
Research and development	**2,428**	316
Transport	**805**	637
Premises	**7,906**	6,922
Increase in bad debt provision	**67**	734
Depreciation and amortisation	**6,103**	6,534
Audit fees	**55**	65
Clinical negligence	**2,169**	2,287
Other	**2,000**	2,316
	214,072	193,961

6.2 Operating lease rentals	2008/09 £000	2007/08 £000
Hire of plant and machinery	**2,317**	1,872
Other operating lease rentals	**438**	369
	2,755	2,241

6.3 Operating lease commitments	2008/09 Land and Buildings £000	2008/09 Other £000	2007/08 Land and Buildings £000	2007/08 Other £000
Annual commitments on leases expiring:				
- within one year	**122**	**225**	32	158
- between one and five years	**83**	**1,623**	213	1,405
- after five years	**312**	**404**	112	417
	517	**2,252**	357	1,980

7. Staff costs and numbers

7.1 Staff costs	2008/09 £000	2007/08 £000
Salaries and wages	**114,060**	107,182
Social security costs	**8,677**	7,935
Employers contributions to NHSPA	**13,090**	12,146
Agency/contract staff	**3,846**	1,176
	139,673	128,439

7.2 Average number of persons employed (whole time equivalent)	2008/09 Number	2007/08 Number
Medical and dental	**397**	390
Administration and estates	**856**	777
Healthcare assistants and other support staff	**416**	416
Nursing, midwifery and health visiting staff	**1,416**	1,326
Nursing, midwifery and health visiting learners	**4**	4
Scientific, therapeutic and technical staff	**666**	590
Social care staff	**0**	0
Bank and agency staff	**0**	0
	3,755	3,503

7.3 Retirements due to ill-health

This note discloses the number and additional pension costs for individual who retired early on ill-health grounds during the year. During 2008/09 there were 6 early retirements (2007/08 – 8) from the NHS Foundation Trust on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £276,000 (2007/08 - £597,000). These retirements represented 1.46 per 1000 active scheme members. This information has been supplied by NHS Pensions and the cost of these ill-health retirements will be borne by the NHS Business Services Authority -Pensions Division.

8. Better Payment Practice Code - measure of compliance

	2008/09	
	Number	**£000**
Total Non-NHS trade invoices paid in the year	**61,009**	**72,940**
Total Non NHS trade invoices paid within target	**44,445**	**57,330**
Percentage of Non-NHS trade invoices paid within target	**73%**	**79%**
Total NHS trade invoices paid in the year	**2,898**	**25,297**
Total NHS trade invoices paid within target	**1,895**	**17,475**
Percentage of NHS trade invoices paid within target	**65%**	**69%**

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later. The Trust operates its Better Payment Policy with a five day allowance for goods to be dispatched and received in the Trust.

9. Profit/(loss) on disposal of fixed assets

	2008/09	2007/08
	£000	£000
Profit on disposal of other tangible fixed assets	**8**	46
Loss on disposal of other tangible fixed assets	**(45)**	(72)
	(37)	(26)

10. Losses and special payments

	2008/09		2007/08	
	Number	**Value**	Number	Value
		£000		£000
Losses	**80**	**50**	169	223
Special Payments	**78**	**93**	68	46
	158	**143**	237	269

11. Intangible fixed assets	Software licences	**Total**
	£000	**£000**
Gross cost at 1 April 2008	1,000	**1,000**
Additions - purchased	94	**94**
Gross cost at 31 March 2009	1,094	**1,094**
Amortisation at 1 April 2008	552	**552**
Provided during the year	184	**184**
Amortisation at 31 March 2009	736	**736**
Net book value		
Purchased at 1 April 2008	436	**436**
Donated at 1 April 2008	12	**12**
	448	**448**
Purchased at 31 March 2009	358	**358**
Donated at 31 March 2009	0	**0**
	358	**358**

12. Tangible Fixed Assets

12.1 Tangible fixed assets at the balance sheet date comprise the following elements	Land	Buildings excluding dwellings	Dwellings	Assets under Construction	Plant & Machinery	Transport Equipment	Information Technology	Furniture & Fittings	**Total**
	£000	£000	£000	£000	£000	£000	£000	£000	**£000**
Cost or valuation at 1 April 2008	26,060	91,689	6,576	4,714	19,990	525	5,509	17	**155,080**
Additions - purchased	0	7,156	0	1,126	1,284	0	163	0	**9,729**
Additions - donated	0	132	0	0	37	0	0	0	**169**
Impairments	0	(1,484)	(6,304)	0	0	0	0	0	**(7,788)**
Reclassifications	400	3,484	0	(4,190)	144	0	162	0	**0**
Other revaluations	(17,450)	(12,732)	(179)	0	0	0	0	0	**(30,361)**
Disposals	0	0	0	0	(418)	(140)	0	0	**(558)**
Cost or valuation at 31 March 2009	**9,010**	**88,245**	**93**	**1,650**	**21,037**	**385**	**5,834**	**17**	**126,271**
Depreciation at 1 April 2008	0	440	7	0	14,709	424	3,617	11	**19,208**
Provided during the year	0	3,548	163	0	1,386	33	787	2	**5,919**
Other revaluations	0	(3,500)	(170)	0	0	0	0	0	**(3,670)**
Disposals	0	0	0	0	(372)	(139)	0	0	**(511)**
Depreciation at 31 March 2009	**0**	**488**	**0**		**15,723**	**318**	**4,404**	**13**	**20,946**
Net book value									
Purchased at 1 April 2008	26,060	91,224	6,569	4,714	4,920	101	1,886	5	**135,479**
Donated at 1 April 2008	0	25	0	0	361	0	6	1	**393**
	26,060	**91,249**	**6,569**	**4,714**	**5,281**	**101**	**1,892**	**6**	**135,872**
Purchased at 31 March 2009	9,010	87,466	93	1,650	5,010	67	1,425	4	**104,725**
Donated at 31 March 2009	0	291	0	0	304	0	5	0	**600**
	9,010	**87,757**	**93**	**1,650**	**5,314**	**67**	**1,430**	**4**	**105,325**
12.2 Analysis of tangible fixed assets									
Net book value									
Protected assets at 31 March 2009	6,200	83,834	0	0	0	0	0	0	**90,034**
Unprotected assets at 31 March 2009	2,810	3,923	93	1,650	5,314	67	1,430	4	**15,291**
	9,010	**87,757**	**93**	**1,650**	**5,314**	**67**	**1,430**	**4**	**105,325**

12.3 Tangible Fixed Assets (continued)

The total at 31 March 2009 included land valued at £2,000,000 open market value. There were no, buildings or dwellings valued at open market value.

There were no assets held under Finance Leases or Hire Purchase contracts at the balance sheet date.

13. Stocks and work in progress	**31-Mar-09**	31-Mar-08
	£000	£000
Raw materials and consumables	**3,137**	3,229
	3,137	3,229

14.1 Debtors	**31-Mar-09**	31-Mar-08
	£000	£000
Amounts falling due within one year:		
NHS Debtors	**14,174**	8,221
Provision for impaired debtors	**(2,860)**	(1,356)
Prepayments	**1,093**	741
Accrued income	**457**	748
Other debtors	**2,256**	1,729
	15,120	10,083
Amounts due after more than one year:		
Other debtors	**712**	491
	15,832	10,574

14.2 Provision for impairment of debtors	**2008/09**	2007/08
	£000	£000
At 1 April 2008	**1,356**	376
Increase in provision	**1,995**	1,356
Amounts utilised	**(216)**	0
Unused amounts reversed	**(275)**	(376)
At 31 March 2009	**2,860**	1,356

14.3 Analysis of impaired debtors	31-Mar-09	31-Mar-08
Ageing of impaired debtors	**£000**	£000
Up to three months	**1,900**	1,165
In three to six months	**494**	0
Over six months	**466**	191
	2,860	1,356

Ageing of non-impaired debtors past their due date	£000	£000
Up to three months	**7,490**	2,076
In three to six months	**2,083**	547
Over six months	**0**	1,049
	9,573	3,672

15. Creditors	31 Mar 2009 £000	31 Mar 2008 £000
Amounts falling due within one year:		
Payments received on account	**113**	11,745
NHS creditors	**3,609**	3,001
Other tax and social security costs	**2,910**	2,717
Capital Creditors	**1,063**	421
Other Creditors	**5,652**	5,029
Accruals	**4,154**	3,984
Deferred income	**371**	1,409
	17,872	**28,306**
Amounts falling due after more than one year:		
Other	**150**	215
	18,022	**28,521**

Other creditors include £1,701,000 (2007/08 - £1,537,000) outstanding pensions contributions as at 31 March 2009.

16. Prudential Borrowing Limit

The Trust is required to comply with, and remain within, a total borrowing limit. This is made up of two elements.

- the maximum cumulative amount of long term borrowing. This is set by reference to the five ratio tests set out in Monitor's Prudential Borrowing Code.
- the amount of any working capital facility approved by Monitor

The Trust had a prudential borrowing limit of £44,500,000 in 2008/09. No borrowing has been undertaken this period

The Trust had a £17,500,000 approved working capital facility in place although this was unused during the year. The renewal date of this facility is September 2010.

The Trust did not utilise any borrowing this year therefore only the minimum dividend cover ratio is applicable

Financial ratio	Actual 2008/09	Approved 2008/09	Actual 2007/08	Approved 2007/08
Maximum debt/capital	N/A	N/A	N/A	N/A
Minimum dividend cover	2.98	2.96	3.05	2.70
Minimum interest cover	N/A	N/A	N/A	N/A
Minimum debt service cover	N/A	N/A	N/A	N/A
Minimum debt service to revenue	N/A	N/A	N/A	N/A

17. Provisions for liabilities and charges

	Pensions relating to other staff £000	Other £000	**Total £000**
At 1 April 2008	819	602	**1,421**
Arising during the year	17	0	**17**
Utilised during the year	(56)	(196)	**(252)**
Unwinding of discount	18	0	**18**
At 31 March 2009	798	406	**1,204**
Expected timing of cashflows:			
Within one year	54	109	**163**
Between one and five years	204	297	**501**
After five years	540	0	**540**
	798	406	**1,204**

£6,313,000 (2007/08 - £4,920,000) is included in the provisions of the NHS Litigation Authority at 31 March 2009 in respect of clinical negligence liabilities of York Hospitals NHS Foundation Trust. Other provisions relates to agenda for change and other pay claims against the Foundation Trust.

18. Movements on reserves

	Revaluation Reserve	Donated asset reserve	Income and expenditure reserve	**Total**
	£000	£000	£000	**£000**
At 1 April 2008	59,771	403	17,339	**77,513**
Transfer from the income and expenditure account	0	0	(5,588)	**(5,588)**
Deficit on revaluations of fixed assets	(26,691)	0	0	**(26,691)**
Transfer of realised profits to the income and expenditure reserve	(4,322)	0	4,322	**0**
Receipt of donated assets	0	168	0	**168**
Transfers to the income and expenditure account for depreciation	0	(106)	0	**(106)**
At 31 March 2009	28,758	465	16,073	**45,296**

19. Notes to the cash flow Statement

19.1 Reconciliation of operating (deficit)/surplus to net cash (outflow)/inflow from operating activities

	2008/09	2007/08
	£000	£000
Total operating (deficit)/surplus	**(1,810)**	5,008
Depreciation and amortisation	**6,103**	6,534
Fixed asset impairments	**7,788**	70
Transfer from the donated asset reserve	**(106)**	(91)
Decrease in stocks	**92**	131
Increase in debtors	**(5,260)**	(776)
(Decrease)/Increase in creditors	**(11,142)**	18,942
(Decrease)/Increase in provisions	**(235)**	341
Net cash (outflow)/inflow from operating activities	**(4,570)**	30,159

19.2 Reconciliation of net cash flow to movement in net funds

	2008/09	2007/08
	£000	£000
(Decrease)/Increase in cash in the year	**(17,462)**	21,689
Change in net funds resulting from cash flows	**(17,462)**	21,689
Net funds at 1 April 2008	**22,143**	454
Net funds at 31 March 2009	**4,681**	22,143

19.3 Analysis of changes in net funds

	At 1 April 2008	**Cash changes in year**	**At 31 March 2009**
	£000	**£000**	**£000**
Cash at commercial banks and in hand	42	15	**57**
Cash at OPG (Office of Paymaster General)	22,101	(17,477)	**4,624**
	22,143	(17,462)	**4,681**

20. Capital Commitments

Commitments under capital expenditure contracts at 31 March 2009 were £491,000 (31 March 2008 - £2,729,000)

21. Contingent Liabilities

The NHS Foundation Trust has identified the possibility of a number of claims for equal pay occurring. At this stage no estimate can be made for any potential settlement costs which may arise however £297,000 of claims already identified have been included in the amounts provided for in note 17.

22. Movement in taxpayers' equity	**2008/09**	2007/08
	£000	£000
Taxpayers' equity at 1 April 2008	**142,324**	119,794
Surplus/(deficit) for the financial year	**(1,364)**	5,517
Public dividend capital dividends	**(4,224)**	(3,962)
Surplus/(deficit) from revaluations of fixed assets and current asset investments	**(26,691)**	18,187
New public dividend capital received	**0**	2,665
Additions to donated asset reserve	**62**	123
Taxpayers' equity at 31 March 2009	**110,107**	142,324

23. Movements in public dividend capital	**2008/09**	2007/08
	£000	£000
Public dividend capital at 1 April 2008	**64,811**	62,146
New public dividend capital received	**0**	2,665
Public dividend capital at 31 March 2009	**64,811**	64,811

24. Related Party Transactions

York Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health

During the year none of the Board Members, members of the Board of Governors or members of the key management staff or parties related to them has undertaken any material transactions with York Hospitals NHS Foundation Trust

The Department of Health is regarded as a related party. During the year York Hospitals NHS Foundation Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are listed below:

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been in the course of the latter's business as government agencies.

The Trust has also received revenue and capital payments from a number of charitable funds, certain of the Trustees for which are also members of the NHS Trust Board.

	Income	Expenditure
	£000	£000
Department of Health	13,718	
East Riding of Yorkshire PCT	12,328	
Harrogate & District Foundation Trust	1,315	1,839
HM Revenue & Customs		27,319
Hull & East Yorkshire Hospitals NHS Trust		922
Leeds PCT	2,154	
Leeds Teaching Hospital NHS Trust		2,027
NHS Blood and Transplant Authority		1,467
NHS Litigation Authority		2,310
NHS Pension Scheme		13,090
NHS Professionals		2,115
NHS Supply Chain		5,162
North Yorkshire & York PCT	172,909	1,429
SHA Yorkshire & The Humber	8,213	
Yorkshire Ambulance Service		1,231
	209,801	58,911

25. Financial Instruments

FRS 25, 26 and 29 regarding Financial Instruments, require disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the NHS Foundation Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which FRS 25, 26 and 29 mainly apply.

Liquidity Risk

The NHS Foundation Trust's net operating costs are incurred under annual service agreements with local Primary Care Trusts, which are financed from resources voted annually by Parliament. York Hospitals NHS Foundation Trust is not, therefore, exposed to significant liquidity risks.

Interest Rate Risk

The Trust's financial assets and financial liabilities carry nil or fixed rates of interest. York Hospitals NHS Foundation Trust is not, therefore, exposed to significant interest-rate risk.

Credit Risk

The Foundation Trust receives the majority of its income from Primary Care Trusts and Statutory Bodies, the credit risk is therefore negligible.

Foreign Currency Risk

The Foundation Trust carries out a minimal amount of foreign currency trading therefore the foreign currency risk is negligible.

Financial Assets	**Floating rate**
Currency	**£000**
At 31 March 2009	
Denominated in Sterling	19,420
In other currencies restated in Sterling	0
Gross financial assets	**19,420**

Financial Liabilities	**Floating rate**
Currency	**£000**
At 31 March 2009	
Denominated in Sterling	15,682
In other currencies restated in Sterling	0
Gross financial liabilities	**15,682**

25.1 Financial assets by category	**Loans and receivables**	Loans and receivables
	31-Mar-09	31-Mar-08
	£000	£000
Assets as per balance sheet		
NHS Debtors	**14,174**	8,221
Provision for irrecoverable debts	**(2,860)**	(1,356)
Accrued income	**457**	748
Other debtors	**2,968**	2,220
Cash at bank and in hand	**4,681**	22,143
	19,420	31,976

25.2 Financial liabilities by category	**Other financial liabilities 31-Mar-09 £000**	Other financial liabilities 31-Mar-08 £000
Liabilities as per balance sheet		
NHS creditors	**3,609**	3,001
Other creditors	**5,652**	5,029
Accruals	**4,154**	3,984
Capital creditors	**1,063**	421
Provisions under contract	**406**	602
	14,884	13,037

25.3 Fair Values

York Hospitals NHS Foundation Trust has carried all financial assets and financial liabilities at fair value for the year 2008/09

26. Third Party Assets

The Trust held £4,000 cash at bank and in hand at 31 March 2009 (31 March 2008 - £3,000) which relates to monies held by the NHS Foundation Trust on behalf of patients.