Peterborough and Stamford Hospitals
NHS Foundation Trust

Annual report

2004/2005

11 July 2005

Content

The annual report of Peterborough and Stamford Hospitals NHS Foundation Trust includes the following sections:

This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts

Chair's statement

We were delighted to hear on 31 March 2004 that our application to become one of the country's first NHS Foundation Trusts had been successful. It was reward for a huge amount of effort that had been put in during an unbelievably difficult application process, and more importantly, reward and recognition for the many good works done by staff and volunteers at the Trust's three hospitals every day of every year.

Now, a year on, we look back at what has proven to be our most challenging year ever. We started to focus on the job in hand from day one in the context of a new regime and ever changing systems within the NHS.

Foundation hospitals are public benefit organisations; that is, not for profit, public sector organisations, that work in a similar way to co-operatives or mutual companies. They are self-governing, reporting to a locally elected Board of Governors and regulated by Monitor, the independent regulator for foundation trusts. Whilst foundation trusts have a duty to remain solvent, this does not include reaching a break-even position at the end of each financial year. This year was only the second time since NHS trust status was awarded where break-even was not attained. When this likely position was identified we worked closely with Monitor to explain how we would control the situation. Against this background we have successfully achieved all our key performance targets and I would like to thank all our staff who worked so hard to reach new standards in patient care delivery.

As well as the Regulator we have had to develop new relationships with our members and our governors as well as redefine our existing relationships with local NHS organisations, the strategic health authority and the Department of Health. The links with governors and members have made us accountable to our communities in a different way and have given us valuable feedback on patient and carer views in addition to the traditional ways of involvement.

There have been a host of challenges and not least the Trust's financial position that has tested the Board, the management and our staff, as well as our relationships with our colleagues in our local primary care trusts. We continue to be challenged but we have two fundamental beliefs:

- We are here to provide the best possible service for our patients, a service that is safe, effective high quality and value for money; and

- We can do this best by working in partnership with patients and the public and with our NHS and other strategic partners.

We look forward to the challenges ahead in meeting, and where possible exceeding, performance targets which we will need to do against the background of patient choice, greater involvement of the private sector and with consideration to the financial constraints of our local primary care commissioners.

Our new status gives us new ways of working more inclusively with our community of public and patients. But it also gives us the freedom to act more independently of the NHS. We expect to take advantage of this freedom over time, but we will do so only with the wider public interest at heart, and we will continue to work closely with all our partners to improve and protect the NHS in Peterborough and Stamford.

Clive Morton

Chairman, Peterborough and Stamford Hospitals NHS Foundation Trust

Chief Executive's statement

Our first year as a foundation trust has been challenging and exciting. We are at the forefront of a new policy for the NHS that aims to make hospitals more accountable to their communities and more business orientated.

Accountability

We have fostered local ownership and accountability through the recruitment of a membership of over 5,000 members of public and 3,500 staff, the initial members of which elected 20 of the 26 members of the Board of Governors, with the other six governors representing key partners of the Trust. The Board of Directors of the Trust is now directly accountable to the Board of Governors which has overseen the appointment of three new non-Executive Directors into vacancies and has influenced the Trust's business plans. The Trust has used its more democratic base to consult its members about services and new travel options to solve one of its most pressing problems: car-parking.

As Chief Executive I am designated as the Accounting Officer under the Health and Social Care (Community Health and Standards) Act 2003. The relevant responsibilities of the Accounting Officer, including responsibility for the propriety and regularity of the public finances for which they are answerable, the keeping of proper accounts and compliance with the NHS Foundation Trust's terms of authorisation, are set out in the NHS Foundation Trust Accounting Officer Memorandum, published by Monitor. To the best of my knowledge and belief, I have discharged properly my responsibilities as Accounting Officer.

Business focus

As a business we are technically no longer accountable to the Secretary of State and freer to make our own decisions about investment in new services, estate and equipment. We have been pioneers of a new reimbursement system for hospitals, 'payment by results', which does away with funding through block allocations, and moves us towards payment at a nationally set tariff rate for each spell of care that we provide. The system is new and has suffered some teething problems, so its implementation into the wider NHS has been slowed down. Perhaps not surprisingly, while the foundation trust regime was heralded as reducing bureaucracy with less intervention from the state, at least as much intervention is now done 'indirectly' through directions from Monitor, the independent regulator for foundation trusts, and through Primary Care Trusts (PCTs)

We have a new legal status as a public benefit company, which requires us to contract with the rest of the NHS through legally binding contracts and not through service level agreements. This creates different dynamics with our local partners, the PCTs. In 2004-05 some of the PCTs did not contract with us for enough provision of emergency services, and measures they introduced to offer the public alternatives to emergency treatment in hospital were inadequate. Consequently we treated more patients than the PCTs had planned to pay for and unfortunately this has contributed to disputes about payment which are still to be resolved.

Access, targets, standards and services

The Trust has a good track record for access and in 2004-05 it continued to meet all the main waiting list targets and the challenging waiting time target for A&E where 98% of patients must be seen and treated or admitted to hospital within four hours. There was a slight drop in performance of this from January to March 2005 because of other pressures on the hospital but since Easter 2005 we have averaged nearly 99%. The home birth service was temporarily suspended for a three-month period due to staffing shortages, but the rest of the community midwife service was maintained throughout. We have worked hard to achieve good performance across an increasing range of targets and standards.

Patient focus and involvement

We have been more patient focused than ever, working through our own Patient and Public Involvement Committee, which is a committee of the Board of Directors and comprises directors, governors, senior managers, patient group representatives and members of the statutory Patients' Forum, which is an independent watchdog. Patient groups have been concerned about the centralisation of some specialist cancer services away from the Trust, and have been particularly interested in nutrition, disability access, the cleanliness of our hospitals and levels of MRSA. We had problems with our cleaning contractors earlier in the year but have worked with them to improve general levels of cleanliness and the Patients' Forum has been pleased with the progress though there is more to do. We continue to have one of the lowest rates of MRSA bacteraemia in the country.

Workforce

We have made significant progress in modernising the pay of our workforce having completed the introduction of the new consultant contract to over 96% of our consultants, and having started the implementation of 'Agenda for Change', which is modernising pay of the non-medical staff. We also had to ensure medical staffing rotas were fully compliant with the European Working Time Directive by 31 August 2004, and this was achieved. Unfortunately in our experience the cost of introducing all these changes has been significantly more than the original estimates made by the Department of Health, and there has been insufficient funding to cover them. Despite a reduction of 1.5% in total staff numbers over the year, and a reduction in our agency staffing costs by £2m (or 51.4%) our total staff costs still increased by 12.8%

Facilities

The Trust continued its private finance initiative (PFI) procurement of a new hospital and other health facilities by selecting its preferred partner, Progress Health, in March 2005. The consortium is led by Multiplex and ABN-Amro. Financial close on the PFI deal is planned for March 2006 and building completion by mid 2009 with services transferring later that year. Multiplex has recently issued a profit warning in respect of its contract to build Wembley Stadium, but it has reaffirmed its commitment to our project.

The Trust completed replacements of its MRI scanner at the start of the year and of its CT scanner at the end of the year. A number of projects have been suspended because of the Trust's poor financial position, but planning work continues on upgrades in various areas.

Finance

We identified a problem of overspending early in the year particularly on national pay awards, drugs and other clinical service costs and took a series of actions to reduce the rate of expenditure. Even so the Trust recorded an operating deficit of £7.7m for the year ended 31 March 2005 after treating approximately 4% more patients than the previous year.

This deficit was after charging stock and asset write-downs of £0.6m and a further £0.6m of unfunded costs of the new hospital project. This project had been funded by the Department of Health in 2003-04, and will be in 2005-06, but, it appears rather arbitrarily, was not funded in 2004-05. Fortunately our local PCTs contributed £1.2m towards the PFI fees or the deficit would have been correspondingly larger. Regrettably we have also made had to make provision of £1.3m for items which are in dispute with the PCTs.

Summary

In many respects this has been a good first year as a foundation trust. Although the financial position has been and remains a concern, we have successfully continued to improve and deliver the services mandated to us in our terms of authorisation; we have developed good local governance and accountability arrangements and we have a strong and effective Board of Governors that is already making a positive impact on the way the Trust is being run. We continue to look innovatively at our services and over the coming year we aim to bring the finances back under control through the provision of efficient services that provide value for money to the British taxpayer and safe and effective healthcare to our community.

Chris Banks

Chief Executive Officer, Peterborough and Stamford Hospitals NHS Foundation Trust

Operating review

Introduction

The Peterborough and Stamford Hospitals NHS Foundation Trust ('the Trust') is a public benefit corporation. Monitor, the Independent Regulator of NHS Foundation Trusts, established the Trust under licence on 1 April 2004 as one of the first ten NHS organisations to achieve NHS Foundation Trust status.

The Trust succeeded the Peterborough Hospitals NHS Trust, which had been established on 1 April 1993. The Trust provides healthcare services from three main sites in Peterborough: the Peterborough District Hospital, the Peterborough Maternity Unit, and the Edith Cavell Hospital; and in Stamford at the Stamford and Rutland Hospital. We organise and manage a wide range of mainly hospital-based healthcare services for people in Peterborough and the surrounding area of North Cambridgeshire and South Lincolnshire.

Guiding principles and goals

The Trust is here to provide the best possible healthcare for our community, and to help people to have healthier lives.

We aim to be a centre of excellence of clinical, organisational, managerial and workforce practices. We will benchmark our performance against an inclusive and meaningful range of measures, and will regard the average performance of the benchmark group as our minimum acceptable standard.

We aim to be the hospital of choice for our community in Greater Peterborough and Stamford, and increasingly the hospital of choice for people living further away.

We aim to be financially viable to ensure that we can provide as a minimum the mandatory services prescribed in our Terms of Authorisation (set by Monitor, the Independent Regulator) and we will be entrepreneurial in order to do so.

We will act ethically to ensure that our services are provided according to what is best for patients, rather than best for individual organisations.

Operating review

The Chief Executive's statement summarises the main service and performance achievements and associated issues for our first year as an NHS Foundation Trust.

Performance on contracts and levels of activity

Most of our work relates to contracts we have with Primary Care Trusts (PCTs). We also have a contract to provide services to the Ministry of Defence, and undertake a small amount of private patient activity. The PCT contracts set out service and performance level requirements for patients under the National Health Service. Last year, the Trust undertook the following levels of activity on our contracts with PCTs:

Non-elective (emergency) spells	31,734
Elective (planned) spells	29,361
Outpatients new attendances	74,570
Accident and Emergency attendances	68,189

Emergency activity

Non-elective or emergency spells of care were 1,456 or 4.8% above contract and earned additional revenue of £2.9m. This excess over contract levels was consistent with the original estimates prepared by the Trust as part of the negotiations with PCTs for 2004/05.

In the Accident and Emergency (A&E) department, the total number of people seen exceeded the contract level agreed with North Peterborough PCT by 3,189 or 4.9%, for which the Trust received no additional revenue. For 2005/06, A&E activity will be financed on a case-by-case basis through the standard national tariff arrangements.

For the first nine months of the year, the Trust achieved the progressively tougher waiting time targets for seeing and treating or admitting Accident and Emergency patients within four hours. In the third quarter, we met the national requirement of 97%. From the week beginning 27 December 2004, the national requirement was 98%. The Trust's average achievement for the final quarter of the year was 95.6%, due to reduced bed capacity because of an outbreak of the Norwalk virus and an unprecedented level of emergency admissions. Since Easter 2005, we have consistently exceeded 98%.

Elective activity

Elective inpatient and day case activity exceeded contracted levels by 1,034 spells or 3.7%. The number of new outpatient attendances increased and exceeded contracted levels by 1,874 or 2.6% by the end of the year. This additional activity earned the Trust an extra £1.8m.

The waiting times targets for elective admissions and outpatient appointments were achieved. No one had to wait more than nine months for an operation all year, and at 31st March 2005, no one was waiting more than six months for admission. No one waited more than 17 weeks for their first outpatient appointment, and there were reductions in the number of people waiting more than 13 weeks for an appointment despite an increase in referrals to the Trust by GPs. No one had to wait more than two weeks following referral by a GP for suspected cancer.

Patient care and involvement, and clinical governance

The focus of patient care delivery is through a service unit structure, with each unit (Surgery, Medicine, Clinical & Life Support, Woman & Child, and Stamford Hospital) being headed by a general manager and a senior lead clinician. These units work together to provide a seamless integrated service for patients.

The Board of Governors has been in place for a year and according to a self-assessment exercise completed in April 2005, members feel they are starting to make a difference to patients, staff and the running of the Trust. A key development has been to integrate governors into strategic planning processes where they can represent the views of constituents and ensure the Trust continues to act according to the purpose of the NHS.

A development in progress, brought about by a staff governor on behalf of some staff members at Stamford Hospital, is the refurbishment of a room at Stamford Hospital with computer equipment. This will provide access to online library services and means that staff working at Stamford can update their practice regularly to the benefit of patients in their care.

We have strengthened infrastructure for clinical governance during the past year by further developing service unit clinical governance committees. Terms of reference of committees have been revised to ensure there are systems in place to implement recommendations coming out of national confidential enquiries and feedback from the Healthcare Commission.

Service unit clinical governance committees also agree topics for local clinical audit and ensure audits are presented and action plans are agreed and monitored. Service units prioritise audit to ensure national audit requirements are met, local areas of concern are investigated, and the Clinical Negligence Scheme for Trusts standards can be accommodated and re-audit can take place. The Trust's healthcare governance committee monitors clinical audit across the Trust and requests audits where there are concerns about the quality of clinical care.

The Trust's national confidential enquiry into patient outcome and death (NCEPOD) committee meets quarterly and receives any new reports. Relevant clinicians are invited to respond to findings from them and to alert the committee to any major concerns in meeting recommendations for best practice. Arrangements are also in place to monitor all deaths and adverse patient outcomes occurring in hospital and to identify and investigate trends in mortality and morbidity.

The recently formed trust standards steering group has responsibility to ensure the Trust is compliant with the core standards described in new Standards for Better Health. The group, chaired by the Director of Nursing will in addition facilitate compliance with developmental standards that are the framework for the Trust's clinical governance development plan. Progress with National Service Frameworks and targets located in cancer networks are also fed into the standards steering group.

In April 2005 the Trust signed a flexible contract with Dr. Foster, the organisation that works alongside the Department of Health to provide specific information to the general public, on some aspects of NHS Trusts' performance. Trusts that contract with Dr Foster receive additional information that allows benchmarking of some clinical activity across specialties and between selected trusts. Clinicians are being encouraged to interrogate the data provided by Dr Foster to compare outcomes and identify any areas for concern.

Patient and public involvement is a key area for the Trust to ensure that the views of the local community forums are taken into account when delivering and designing services. There is a joint committee of both the Board of Directors and Board of Governors to steer the work and good local relations have been established with our local independent Patient and Public Involvement Forum and the local authority Health Overview and Scrutiny Committee.

Members of the Patient and Public Involvement Forum joined the activities in the Trust on Think Clean Day (28 February) and participated in auditing the patient's environment across the majority of clinical areas. This demonstrated partnership between clinical, hotel service, cleaning contract staff and members of the public in reviewing cleanliness standards and formulating an action plan where areas required further development.

The local Overview and Scrutiny Committee has also completed a review of delayed transfers of care across the local health system which acknowledges good practice and was also consulted on the Foundation Trust application and is being kept up-to-date with the process for achieving a single site hospital in Peterborough together with developments in mental health and integrated care which form the Greater Peterborough Health Investment Plan.

Internally the Trust has an established model of reviewing service delivery and implementing change where indicated. The service improvement team (incorporating the former transformation team) leads developments and co-ordinates the many groups of staff involved in service improvement. Developments are reported to the Board of Directors through the year, for example in 2004-05:

- Glaucoma community screening and monitoring
- Introduction of diabetes care technician role
- Introduction of postnatal classes and baby massage
- Introduction of palliative care consultant
- Nurse led asymptomatic clinics in genitor-urinary medicine
- GP electronic access to radiology results

A group chaired by a member of the public meets bi-monthly to review findings from the national patient survey programme. This group has driven changes in a number of working practices following analysis of the results of the various surveys. For example:

- The checking procedure for Oromorph has been changed to make it easier and quicker for staff to respond to requests for analgesia.

- A number of concerns were raised regarding the delay in receiving medication and information of side effects at discharge. This was addressed through the staff in the departure lounge taking responsibility for provision and information. This was also addressed through the one-stop dispensing project.
- Snack boxes are available on all sites as are fridges containing food for 24-hour access for patients.
- Information has been distributed to all trust users on how much money is allocated for food on a daily basis for patients and how it is spent, including choice of menu and drinks.
- Customer care courses were reviewed and comments made by patients through the survey are fed into the group so that staff can learn about how they come across to the patients and reflect on good and bad practice.

Trust information leaflets have been updated in a number of areas to reflect comments from surveys e.g. a new leaflet on when to resume normal activities following discharge.

The Trust has a readers' panel whose primary job is to look at patient information leaflets and to comment on their grammar, style and overall reader friendliness. Staff are encouraged when reviewing their information sheets to send them through the readers' panel for comment and then to revise them in line with the comments made.

All leaflets can be translated into different languages and we are currently looking at getting the most popular leaflets translated into Portuguese, currently the Trust's most requested language.

The Trust's complaints policy and procedure was revised to incorporate the requirements of the new regulations. Staff attending trust induction are given a presentation on complaint handling and further training is provided at locally organised updates. Leaflets are available on all wards for patients regarding the process of making complaints and how to go about it.

Quarterly reports are published for each service unit and are circulated to all members of the Board of Directors. The results of these reports are discussed at a patterns and trends meeting which includes representatives from the patient advice and liaison service, risk management and clinical standards. Through this meeting action is taken to address concerns. The quarterly complaints report is also fed into the Trust's clinical management board, healthcare governance committee, nursing and midwifery advisory group and each service unit clinical management team meeting.

The total number of complaints received in 2004/2005 was 329, of which 93.6% were responded to within 20 days. The Trust strives to achieve local resolution and members of staff met with relatives regarding 20 complaints during the year.

During the year four concerns were raised with the Convenor and more recently the Healthcare Commission. One was closed with no further action required and three remain pending. One complaint was referred to the Ombudsman for investigation and following initial review it was decided that there would be no ombudsman's office investigation.

The most common five categories of complaints for the year were:

- All aspects of clinical treatment (148)
- Outpatient appointments, delay/cancellation (56)
- Attitude of staff (38)
- Written/verbal communication/information to patients (22)
- Admissions, discharge and transfer arrangements (21)

The Trust seeks to learn from the experiences of patients and visitors expressed through complaints. The following is a list of examples of changes made in response to them:

- Changes to appointment letters for endoscopies to stop confusion about timescales for procedures
- Toilets changed and re-designed to provide separate facilities for men and women

- Changes in patient booklets to depict clearer information for better understanding
- Changes made with how midwives attend to mothers pre and post-natally to improve service
- More staff employed in the ophthalmic department to provide more clinics and reduce waiting times
- Policy developed on the transfer of deceased patients from wards to the chapel of rest
- Several medical wards have improved communication by the use and introduction of a communications book
- Training provided by clinical educators and practice development nurses to staff about the importance of correct discharge

Communications

The Trust has a small professional communications team supporting internal and external corporate communications; media enquiries; promotions and events management; and foundation trust membership.

The Trust has an established team briefing process, which follows the monthly trust executive meeting, when information is collated and cascaded to all staff through the line management. All areas have staff briefing meetings to cascade the team brief information and staff can ask questions and share views. Recent examples of this include a consultation on travel options to reduce parking congestion and one on the national NHS pension scheme review. Local team briefs within our service units and directorates provide local relevant information to all staff and support the trust-wide team brief.

The Trust produces a staff and visitor magazine, 'Pulse', five times a year. The magazine is well established having been produced for approximately eight years. It has recently undergone a revamp.

Specialist newsletters are also widely used across the Trust for a variety of purposes. For example the 'clinical brief' cascades information and policies from the Clinical Management Board meeting; we also give regular operational information to all staff through 'Factsheet'.

On becoming a foundation trust we introduced a members' newsletter, 'Your Trust News' which is issued quarterly to all public members (currently 5036) and is available to all staff members.

The Trust has three website versions: an internal intranet; an NHS-only extranet; and the Internet. The intranet holds trust-wide and departmental information such as policies and procedures and department information. The Trust's extranet site, which all NHS staff can access, holds information on our clinical services, teams, guidelines and procedures. The Trust's Internet site holds information about our services, directions to our hospitals, news, our Freedom of Information publication scheme, and a section dedicated to members. Development of the Trust's Internet with information targeted at patients to help them choose Peterborough and Stamford Hospitals as their preferred location for care will be a key area of activity for the coming year.

Feedback mechanisms in the Trust include discussion boards, consultation documents and web pages. More information on staff involvement communications can be found later in this annual report.

The Trust has a suite of communications standards, which support NHS identity standards and guidelines, and are aimed at promoting clear and understandable information both internally and externally including patients. These are communicated and available to all staff.

Learning and development

Over the past 18 months the Trust has made concerted efforts to pursue an ambitious learning and development strategy that delivers the national agenda, enhances patient care and service delivery while also providing individual staff with structured programmes of learning.

A key component of our strategy has been based around the challenges of implementing the knowledge and skills framework (KSF) for all staff groups. The KSF is an integral part of Agenda for Change. We are building a knowledge and skills framework that meets individual staff group requirements e.g. radiographers, ward clerks, nursing staff and medical secretaries. Learning programmes are established and agreed with individual staff as part of their initial development review, which occurs after three months in post and subsequently at their annual appraisal. In this way the foundations of lifelong learning are reinforced and staff can understand their learning plan, the link to career progression and associated learning activities.

To support this process, our induction package has been redeveloped around KSF core dimensions and aims to deliver a foundation level of competence for all staff. The programme has a strong values-based approach. The principle has been extended to local induction, with plans to provide staff with self-directed learning packages that drive their local induction learning. This is to promote principles of ownership where possible with staff encouraged to seek information they need to know about their own work area. This is also reviewed during the first development review to highlight and address any gaps in understanding.

In addition to existing leadership and management development programmes which include the RCN clinical leadership programme, leadership at the point of care and a wide range of short courses, we are currently developing a standard package which will provide a foundation for all managers within the Trust which is also KSF based.

All the KSF based programmes are designed to ensure that our staff can attain and develop the target skills level appropriate to their role with confidence and assurance. We also support our staff with their individual training requirements, and this year has seen a number of staff, clinical and non-clinical gain NVQ and degree-level qualifications.

Friends and Volunteers

In providing our services we are extremely well supported by both the Friends organisations and by our volunteers. The Friends of Peterborough Hospitals and the Friends of Stamford Hospital have donated money throughout the year to purchase equipment and improve amenities.

Our volunteers support the Trust in our day-to-day operations escorting patients and visitors to wards and clinics, providing a mobile library service and acting as an information point.

Financial review

Overall position

The Trust recorded a deficit on its income and expenditure account of £7.7m for the year ended 31 March 2005.

The potential deficit was identified early in the year, and the Trust worked closely with Monitor to improve financial reporting, and hence the understanding of the position. Two main problems were identified in the summer of 2004:

- The possibility of over performing on contracts, particularly on emergency activity. This would increase pressure on costs and capacity, and raised a possibility that PCTs would be unable to pay for the activity.
- The shift on the Trust's cost base due to national pay modernisation costs (the new consultant contract and Agenda for Change for other staff groups), compliance with the European Working Time Directive, drugs, clinical negligence and a high level of agency, bank and locum spend in the first part of the year.

Through the increased levels of activity on contracts, income was almost £5m higher than planned and contracted for. However, the cost base remained significantly higher than planned, despite considerable effort to reduce locum, agency and bank-staff costs.

The second half of the year showed more stability to the cost base, as a freeze on new posts, review of replacement posts and a revised cost improvement programme took effect.

By January 2005, the outturn deficit was expected to be £4.5m - £5m. However, there was around £1.3m of year-end adjustments for items disputed by our local Primary Care Trusts, £0.6m of unfunded project costs on our Greater Peterborough Health Investment Plan, and asset write-offs and stock adjustments of £0.6m that took the total deficit for the year to £7.7m.

Accounting policies

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the NHS Foundation Trusts Manual For Accounts, which has been agreed with HM Treasury. The accounting policies contained in the Manual For Accounts follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Resource Accounting Manual to the extent that they are meaningful and appropriate to the NHS.

The Trust's Annual Accounts and associated financial statements have been prepared in accordance with the 2004/05 NHS Foundation Trusts Manual For Accounts issued by Monitor. The accounting policies have been applied consistently in dealing with items considered material in relation to the Accounts.

Income

Income from activities

Under the new 'payment by results' funding system for the NHS income earned from most services to PCTs is at the full national tariff price, which is currently based on the national average cost of a patient spell. The Trust has a historically low cost base relative to the national average cost (18% lower according to the latest reference costs published for 2003-04).

In 2004-05 the Trust earned gross income from patient activities of £133m, which included £11.2m that was the difference between the Trust's historic costs and national average costs under the standard national price tariff. The Department of Health has transitional arrangements for the implementation of 'payment by results' such that 75% of the additional income (£8.4m) was clawed back by the Department of Health in 2004/05.

Thus the net income earned from activities was £124.6m. Had the Trust received the full funding under the standard national tariff in 2004/05 it would have recorded an income and expenditure surplus of £0.7m.

In 2005/06, the transitional arrangements require 50% of the additional income to be paid back to the Department of Health. This will benefit the Trust, but is offset by changes to the national tariff especially a significant reduction in the price set for short-stay emergency spells.

Private patient income

The Trust earned £0.8m from providing services to private patients, which equates to 0.6% of income earned from activities. This accords with the 'private patient cap' (limit on income) set out in the Trust's Terms of Authorisation.

Other operating income

Income earned from other sources, including education, training and research and other trading activities was £17.2m. This included £1.2m of funding provided by North Peterborough PCT as a contribution towards the project costs and fees relating to the Greater Peterborough Health Investment Plan.

Expenditure

Operating expenses

The total operating expenses of the Trust comprise £98.6m for pay costs and £47.3m for non-pay costs.

Pay expenditure includes a provision of £1.4m for the estimated payments due in 2005/06 in respect of the arrears of pay due to staff under Agenda for Change for the period 1 October 2004 to 31 March 2005. Agenda for Change is a programme of pay modernisation, agreed at national level by the Department of Health, for all staff groups in the NHS other than medical staff and senior managers. The provision is based on the assumption that overall pay costs will increase on average by 4% in a full year, for all relevant staff groups.

We have also increased our provision for credit notes and bad debts to include a provision of £1.3m relating to credit notes that may have to be issued for invoices for healthcare activities which are in dispute.

The operating expenses for 2004/05 also include £1.8m of expenditure on project costs and fees relating to the Greater Peterborough Health Investment Plan, which the Trust is managing for its local NHS partners.

Contingent liability

The Peterborough Hospitals NHS Trust recorded a deficit of £969,000 in its Accounts for the year ended 31 March 2004. The Peterborough and Stamford Hospitals NHS Foundation Trust was asked by the Department of Health to repay this deficit in 2004/2005.

This matter has been considered by the Board of Directors on a number of occasions, and the directors believed that the Trust managed its deficit last year through its own working capital, and without recourse to any third party. The Board of Directors was therefore unsure of any basis for having to repay any such deficit in the following year.

This matter is therefore disclosed in the Accounts for the year ended 31 March 2005 as a contingent liability, pending resolution with the Department of Health. Advice issued by the Department of Health on 27 June 2005 states that the deficit of £969,000 will not have to be repaid. Formal confirmation of this is awaited.

External audit fees

Expenditure incurred on external audit fees comprised £89,000 for statutory and on-going work and £41,000 for statutory ad-hoc work. The independent auditor (external auditor) was Robson Rhodes LLP, Daedalus House, Station Road, Cambridge CB1 2RE.

Cash flow

Operating cash flow from activities was almost £2.9m. Although the operating deficit was £4m, non-cash expenditure items (depreciation) generated £5.9m and the overall improvement in the working capital position generated another £1m.

The operating cash flow was boosted by a modest amount of interest earned by the Trust in year on its cash balances held (£0.2m). Cash was then spent on making payments in respect of fixed assets (£4.3m) and payment of the full dividend due to be paid to the Department of Health on Public Dividend Capital (£3.6m).

Before further financing, and taking into account all of the above, the net cash outflow in the Trust was £4.8m. This was partly financed by a cash allocation by the Department of Health of £1.8m in the form of additional Public Dividend Capital. This represented the return to the Trust of cash brokered (loaned) by the Trust to the Department of Health in 2003/04 in respect of the timing of capital creditor payments.

The rest of the net cash outflow (£3m) was financed by the Trust drawing down £3m of its working capital facility at the Department of Health. This is due for repayment by 31 December 2006.

Relationships with trade creditors

The Trust has maintained good working relationships with its trade creditors (suppliers) over the past year. On average across all of last year, 89.3% of trade creditor invoices were settled within 30 days of registration in the Trust. For the period between April and February, typically over 90% of trade creditor invoices were being settled within 30 days.

We are pleased to report that no in interest had to be paid under the Late Payment of Commercial Debts (Interest) Act 1998.

Prudential borrowing limit and debt

The Trust was set a prudential borrowing limit by Monitor of £11.5m. This included an approved working capital facility with the Department of Health of £8m. The Trust actually had £5m of the approved working capital facility remaining at 31 March 2005 after drawing down £3m to support operating costs.

The working capital facility at the Department of Health is available to the Trust until 31 March 2006. The Trust has secured a new working capital facility with its bankers comprising an overdraft facility of £3m, guaranteed for one year, and a committed money market facility of £12m, guaranteed for two years. These facilities are available without any restrictive covenants or on-going fees. The Board of Directors formally approved the new arrangements on 31 May 2005.

The Trust did not plan to take on any other interest-bearing debt in 2004/05 and none was taken on. The Board has no plans to take on any other interest-bearing debt in 2005/06.

Balance sheet

Net assets employed increased by £22.7m in the year to £122m at 31 March 2005. This increase comprised a gain of £28.7m as a result of fixed asset revaluations offset by other reductions in net assets held.

Investment in fixed assets was £3.8m, with particular emphasis on replacement medical equipment and building and engineering work associated with maintaining compliance with statutory requirements.

Charitable funds

The Trust's Board of Directors are also the Charity Trustees for the Peterborough and Stamford Hospitals NHS Foundation Trust Charitable Fund, registered charity number 1050601, which the Trust manages.

In the last financial year, the Peterborough and Stamford Hospitals NHS Foundation Trust Charitable Fund made a contribution of £623,000 towards the operating expenses of the Trust. After allowing for administration charges of £22,000, this means that £601,000 was made available to support enhancements to our healthcare services, along with improved amenities for patients and staff in a wide variety of wards and departments.

More details are included in the Annual Accounts for the Peterborough and Stamford Hospitals NHS Foundation Trust Charitable Fund, which will be published separately and will be available from Jane Pigg, Company Secretary.

Board of Directors

The composition of the Board of Directors is detailed below. As at the 31 March 2005 the Board consists of seven non-executive and seven executive directors. This was increased from six non-executive and six executive directors at the start of the year following the appointment of a Project Director to lead the implementation of the Greater Peterborough Health Investment Plan and the agreement of the Board of Directors to an additional non-executive director to maintain a balance between executive and non-executive directors.

For NHS Foundation Trusts the appointment of non-executive directors is undertaken by the Board of Governors which also approves the appointment of the Chief Executive. At the time of the formation of the Foundation Trust on the 1 April 2004, the Board of Governors approved the appointments of all the existing non-executive directors up to the end of their existing terms of office or for a full year (whichever was the longest). Appointment start dates for pre-existing non-executive directors are therefore all stated as 1 April 2004. The Board of Governors also approved the appointment of the existing Chief Executive.

During the year, the Board of Governors has formed a non-executive director appointments and terms of service committee to advise the governors. This committee is chaired by a governor acting as a deputy chairman who presides at Board of Governors meetings on all matters concerning non-executive directors. With advice from the committee, the Board of Governors has agreed a standard term of office of four years for non-executive directors up to a maximum of three terms of office (12 years in total).

The Chairman appraises the non-executive directors, and is in turn appraised by the Deputy Chair of the Board of Governors. Results of appraisal are to be reported to the Board of Governors through the non-executive director appointments and terms of service committee.

The Board of Governors has the responsibility for appointing or removing the Chairman and non-executive directors. A recommendation on any such action would be made by the governor deputy chairman on behalf of the non-executive director appointments and terms of service committee and any such action would need to be approved by the full Board of Governors. The Board of Governors agrees remuneration for non-executive directors with advice from the non-executive director appointments and terms of service committee of the Board of Governors, which is composed solely of governors with support and advice from the Trust Chairman and Director of Human Resources.

The non-executive directors undertake the appointment of the executive directors.

Remuneration for the executive directors is agreed by the remuneration and terms of service committee of the Board of Directors, which comprises the non-executive directors. The remit of the committee covers approval of directors' remuneration only although a view is maintained of other senior posts.

Remuneration details for the directors as determined by the terms and remuneration committee are included in the annual accounts. The Trust also maintains a register of directors' interests. This is available to view from the main Peterborough public library or from the cash offices situated in each of the Trust's main hospitals (Peterborough District Hospital, Stamford Hospital, Edith Cavell Hospital). The details are also available from the office of the Company Secretary who can be contacted on 01733 874174. Arrangements are being made for the publication of this information on the Trust's website during 2005/06. The following paragraphs give information on the individuals who have formed the Board of Directors for 2004/05 and on the committees of the Board.

Non-executive directors

Chairman – Dr Clive Morton OBE

Appointment start date 1 April 2004 - Appointment end date 31 March 2008

Dr Morton was the chairman of the previous NHS trust having held this position since 1996. The Board of Governors approved his re-appointment as the Chairman on the 1 April 2005 to give a four-year term since the establishment of the Foundation Trust.

Dr Morton is a civil engineering graduate with a PhD in industrial relations and has worked as a Director of Human Resources at Anglian Water, Director of Wimpey Offshore and Wimpey Engineering, Komatsu, Northern Electric, Rolls Royce. Dr Morton runs his own consultancy business, The Morton Partnership. Previously Chairman of Gateshead Hospitals NHS Trust and also served as the first Chairman of the Postgraduate Medical Education and Training Board. He has recently been appointed as Deputy Chair of the Peterborough Urban Regeneration Company. He is also an Associate Professor at the Middlesex University and Director of Board Performance Ltd based in London and non-executive director of D1 Oils, a bio diesel producer.

Deputy Chairman – Mr Geoffrey Clubbe

Appointment start date 1 April 2004: Appointment end date 30 November 2007

Mr Clubbe was the Deputy Chairman of the previous NHS trust and has served as a non-executive director since 1994. The Board of Governors approved the re-appointment of Mr Clubbe on the 1 July 2005 to extend his term by two additional years.

Mr Clubbe worked for Royal Insurance for almost 40 years before retiring and is an active member of the community. Mr Clubbe is also a director of The Baptist Insurance Company plc based in Gloucester, and a director and chairman of Christian Endeavour Holiday Centres Ltd.

Non-Executive Director – Mr Razahusein Rahim

Appointment start date 1 April 2004: Appointment end date 31 March 2008

Mr Rahim a non-executive director of the previous NHS trust a position he has held since November 2000. The Board of Governors approved the re-appointment of Mr Rahim on the 1 April 2005 to give a four-year term since the establishment of the Foundation Trust.

Mr Rahim is a qualified chartered accountant running his own accountancy firm and is active in the local muslim community as well as being a part-time lecturer at Peterborough Regional College. He served as a school governor between 1989 and 2004 for two different schools in Peterborough.

Non-Executive Director – Mr Martin Hindle

Appointment start date 1 April 2004: Appointment end date 30 November 2006

Mr Hindle was a non-executive director of the previous NHS trust. Mr Hindle is currently a locum community pharmacist and was formerly chief executive of Cable and Wireless Nautec where he was responsible for business networks for the global shipping industry. Mr Hindle retains shares in Cable & Wireless. He has a long and successful career at board level in the pharmaceutical industry and is a non-executive director for the National Blood Authority and the National Institute of Biological Standards. Mr Hindle is also a director of the Leicestershire and Rutland Probation Service.

Non-Executive Director – Miss Christine Emmett

Appointment start date 1 April 2004: Appointment end date 31 August 2004

Miss Emmett was a non-executive director of the previous NHS trust, serving in this role since 1997 and resigned from the Board during the year.

Miss Emmett is a partner in a management and specialist business consultancy, Bee Services,

and has had successful careers in both public and private sectors. Miss Emmett was commercial director of the vendor unit of British Rail until 1996 and is an associate of Alpha Consulting and an associate of Interfleet Technology.

Non-Executive Director – Mrs Gloria Milne

Appointment start date 1 April 2004: Appointment end date 31 March 2005

Mrs Milne was a non-executive director of the previous NHS trust having served in this role since 1997 and was unable to continue in post due to living outside the membership catchment area.

Mrs Milne was the chief executive of the Greater Peterborough Investment Agency which was successful in encouraging growth and investment in Peterborough and is a non-executive director of Deaf Blind UK. Mrs Milne started her career as a nurse.

Non-Executive Director – Ms Susan Grey

Appointment start date 24 January 2005: Appointment end date 31 December 2008

Ms Grey was appointed to a non-executive director vacancy by the Board of Governors effective from the date shown.

Ms Grey has 25 years of international healthcare experience having worked in health and social care in the UK and abroad and in the public, private and voluntary sectors. She was formerly director of strategy and modernisation at Bedfordshire and Luton Community NHS Trust and has previously worked for Bedfordshire Health Authority. Ms Grey is also a board member of the Bedfordshire Pilgrims Housing Association based in Bedford and undertakes consultancy work for health and social care organisations.

Non-Executive Director – Dr Sarah Raper

Appointment start date 21 February 2005: Appointment end date 31 December 2008

The Board of Governors appointed Dr Raper to a non-executive director vacancy effective from the date shown.

Dr Raper is a qualified doctor who has experience in the commercial property sector as well as having worked on regeneration in Liverpool and Corby. Dr Raper undertook her doctor training at King's College London and Bromley Hospital Kent. Following a career change she is currently commercial director for Catalyst Corby, leading on the regeneration and growth of Corby. Previously Dr Raper was acting joint chief executive of Speke Garston an award-winning regeneration initiative for Liverpool.

Non-Executive Director – Mr Keith Pearson

Appointment start date 24 January 2005: Appointment end date 25 March 2005

Mr Pearson was appointment to a non-executive director vacancy by the

Board of Governors effective from the date shown. Due to his successful appointment to the position of Chairman of the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority Mr Pearson resigned effective from the appointment end date shown.

Mr Pearson has a wealth of private sector experience in financial services. He served five and half years as a non-executive director and chair for South Somerset NHS Primary Care Trust. He has also served as a lay member and chair on community projects for Somerset's County and District Councils and Yeovil Town Council, is a magistrate and serves on the Peterborough bench.

NB: There was an overlap in the appointments to allow for a smooth transition of the departure of Mrs Milne. During this period there were no votes on decisions made by the Board.

Executive directors

Chief Executive – Mr Christopher Banks

Mr Banks was Chief Executive of the previous NHS trust. He was appointed Chief Executive in July 2002, having filled previous roles in the Trust as Project Director and Finance Director. Mr Banks is a qualified Chartered Accountant and also a director of Bluestone New Media Ltd based in Northborough, Peterborough.

Finance Director – Mr Christopher Hall

Mr Hall was Finance Director of the previous NHS trust. He is a chartered public finance accountant and acts as principal financial advisor to the Trust Board.

Medical Director – Mr Alan Turner

Mr Turner was Medical Director of the previous NHS trust. He is a consultant urologist at the Trust and also has a private practice at the Fitzwilliam Hospital. Mr Turner is a lead assessor and trainer for the General Medical Council Performance Procedures and is a Lecturer at the Keele University Clinical Leadership Unit. Together with Mrs Wilkinson he is responsible for clinical governance within the Trust and they jointly lead the Trust's Clinical Directorate.

Director of Nursing – Mrs Christine Wilkinson

Mrs Wilkinson was Director of Nursing of the previous NHS trust. Together with Mr Turner she leads the clinical directorate of the Trust. Mrs Wilkinson is the Director for Infection Prevention and Control. She is also a member of the editorial board for the British Journal of Nursing.

Director of Human Resources – Mrs Christine Tolond

Mrs Tolond was Director of Human Resources of the previous NHS trust and has a wealth of human resources experience in the public and private sector, previously working at Leicester Hospitals.

Director of Operations – Mr William Stevenson

Mr Stevenson was Director of Organisational Development/Acting Director of Operations of the previous NHS trust.

Project Director – Mr StClair Armitage

Mr Armitage was appointed Project Director of the NHS Foundation Trust on 12 May 2005. He has experience in the private sector of delivery of private finance initiative projects and previously served in the Royal Navy.

Board of Directors committees

The Board functions through five committees as follows:

Terms and Remuneration Committee

This committee considers the remuneration and terms of service of executive directors, is chaired by Dr Morton, the Chairman of the Board with all non-executive directors being members. The committee is advised by the Chief Executive and Director of Human Resources who are asked to be absent when discussions over their own remuneration or terms of service take place.

Audit Committee

This committee examines the audit requirements and audit reports from external and internal audit ensuring that actions are taken on the agreed recommendations of audits. The committee is chaired by Mr Clubbe, the Deputy Chairman of the Board with Mr Rahim and Mrs Milne as

members for 2004/05. The committee includes internal and external audit representatives with the Chief Executive and Director of Finance in attendance.

Conformance Committee

This committee considers the financial performance of the Trust and compliance against national standards. The committee is chaired by Mr Clubbe, the Deputy Chairman of the Trust with Dr Morton, Mrs Milne, Miss Emmett, Mr Hindle, Mr Rahim all being members of the committee along with all the executive directors. Other senior managers of the Trust are also in attendance.

Healthcare Governance Committee

This committee considers the Trust's performance against clinical and corporate governance requirements, receiving updates from the Trust's clinical operational units, on risk management issues, infection control, clinical audit results, reports from the clinical management board, details on complaints and other related items. Mrs Milne chaired the committee for 2004/05 with non-executive members being Mr Clubbe as deputy chairman up to 24 March and Miss Emmett. The Chief Executive, Medical Director, Director of Nursing, Director of Finance and Director of Human Resources are all members of the committee. Other senior managers of the Trust are also in attendance. Mr Hindle is chairing this committee for 2005/06 with Dr Raper and Ms Grey as a non-executive members.

Patient and Public Involvement Committee

This committee considers the strategy and high-level initiatives to ensure appropriate patient and public involvement. During the year the committee also widened its remit to cover patient and public involvement aspects from the Board of Governors. Mrs Milne chaired the committee for 2004/05 with the Director of Nursing and Chief Executive also being members of the committee. Other senior managers, lay representatives and governors are also part of the committee. Ms Grey chairs this committee for 2005/06 with Dr Raper as a non-executive member.

Board of Governors

The composition of the Board of Governors is detailed below. The Board of Governors consists of 14 public governors, six staff governors, six partner governors and currently one co-opted adviser.

Elections for public and staff governors to serve on the Board of Governors were held in March 2004 with the results being announced on the 25 March 2004. The Electoral Reform Ballot Services conducted the elections on behalf of the Trust using a single transferable vote system. Partner governors were nominated by the agreed partner organisations for the Foundation Trust.

There are no sub-divisions of either the public or staff constituency.

Half of the public governors (seven) gaining most votes have terms of office for 3½ years, the remaining (seven) have terms of office for 2½ years. Half of the staff governors (three) gaining most votes have terms of office for 3½ years, the remaining (three) have terms of office for 2½ years. Routine elections are to be held so that results can be announced at the annual public meeting of the Foundation Trust and that attendance can be one of the last duties for any outgoing governors.

All the public and staff governor vacancies were filled by the initial election. There were no resignations or vacancies for 2004/05.

Partner governors have terms of office of three years. Whilst all partner governors were appointed, there have been two changes during the year, which are detailed below.

All governors can be elected or appointed up to a maximum of nine years. Governors receive no remuneration but are reimbursed for any expenses incurred. The Trust also maintains a register of governors' interests. This is available to view from the main Peterborough public library or from the cash offices situated in each of the Trust's main hospitals (Peterborough District Hospital, Stamford Hospital, Edith Cavell Hospital). The details are also available from the office of the Company Secretary who can be contacted on 01733 874174. Arrangements are being made for the publication of this information on the Trust's website during 2005/06. The following paragraphs give information on the individuals who have formed the Board of Governors for 2004/05

Chairman

Dr Clive Morton OBE

Appointed to 31 March 2008

As Chairman of the Board of Directors, Dr Morton also chairs the Board of Governors. Dr Morton's details are listed in the previous section.

Public governors

Mrs Moira Beattie OBE

Term of office to 30 September 2007

Mrs Beattie is a member of the Macmillan Appeals Committee and a member of the local Primary Care Trust Patient and Public Involvement Forum.

Mr Arthur Critchley

Term of office to 30 September 2007

Mr Critchley is a director and shareholder of Barnes Kavelle Ltd, Bradford.

Dr Dennis Guttmann

Term of office to 30 September 2007

Gp Capt Michael Jenkins OBE

Term of office to 30 September 2007

Mrs Sarah Dixon

Term of office to 30 September 2007

Mrs Dixon is Head Teacher of Peterborough High School for Girls.

Mr Kenneth Craig

Term of office to 30 September 2007

Mr Ken Wright

Term of office to 30 September 2007

Mr Wright is Chairman of the Health and Adult Care Sub-Committee of the Peterborough Senior Citizens' Forum.

Mr Keith Smith

Term of office to 30 September 2006

Mr Smith is the East Anglia Representative on the National Executive of the NHS Retirement Fellowship and Chairman of the Peterborough Branch of the Fellowship. He is also the Membership Secretary of the Peterborough Senior Citizens' Forum.

Mrs Rosemary McCulloch

Term of office to 30 September 2006

Ms Maria Stafford

Term of office to 30 September 2006

Ms Stafford is a non-executive director for National Savings and Investments, Chairman of Glasgow Caledonian University, a governor of the Peterborough Regional College, and a non-executive director of the Peterborough Urban Regeneration Company.

Mrs Susan Mahmoud

Term of office to 30 September 2006

Mrs Mahmoud is Chairman of Macmillan Cancer Relief Peterborough, Chairman of the Friends of Peterborough Hospitals, a trustee of the Peterborough Council of Voluntary Services and was previously a member of the local Primary Care Trust Patient and Public Involvement Forum.

Mr John Dawson

Term of office to 30 September 2006

Mr John Horrell CBE TD DL

Term of office to 30 September 2006

Councillor Horrell is a director of Horrell Farmers Ltd. He is a city councillor and was elected Mayor of Peterborough in May 2005. He is a Vice President and past Chairman of the East of England Agricultural Society.

Mr Bob Woolley

Term of office to 30 September 2006

Mr Woolley is Chairman of the Park Road Baptist Housing Association Florence House

Retirement Home

Staff governors

Dr Roger Moshy, Consultant Radiologist

Term of office to 30 September 2007

Dr Moshy is Chairman of the Association of Early Pregnancy Units

Mr N A (Dan) Anandan, Associate Specialist at Stamford Hospital

Term of office to 30 September 2007

Mrs Jane Porter, Deputy General Manager of Woman and Child Services and Head of Midwifery

Term of office to 30 September 2007

Mrs Porter resigned her post effective from 3 June 2005 to take up a new post at Leicester Royal Infirmary.

Mrs Elizabeth Phillips, Assistant General Manager Medical Inpatients

Term of office to 30 September 2006

Miss Katrina Wilson, Stroke Unit Project Nurse until June 2005 and now Neurology Development Manager

Term of office to 30 September 2006

Mr Robert Donlevy, Clinical Audit Facilitator

Term of office to 30 September 2006

Partner governors

Mr Chris Town, Chief Executive, Greater Peterborough Primary Care Partnership

Nomination expires 31 March 2007

Mr Town is a director of Gladstone Connect.

Mr Martin Whittle, Director of Quality, Lincolnshire South West teaching Primary Care Trust

Nomination expires 31 March 2007

Councillor Mike Burton, Cabinet Member for Health and Social Care, Peterborough City Council

Nomination from 1 April 2004 to 10 June 2004

Councillor Burton's nomination expired when cabinet responsibility for health and social care was re-assigned following local elections.

Cllr John Holdich OBE, Cabinet Member for Health and Social Care, Peterborough City Council

Nomination from 30 June 2004 to 24 May 2005

Councillor Holdich's nomination expired when cabinet responsibility for health and social care was re-assigned following annual council.

Mrs Judy Puar representing the Friends organisations of the Trust

Nomination from 1 April 2004 to 18 December 2004

Mrs Puar was nominated by the Friends organisations but resigned at the end of December 2004.

Mr Michael Lilliman, representing the Friends organisations of the Trust

Nomination from 14 January 2005 expires 13 January 2008

Mr Lilliman succeeded Mrs Puar as the partner governor representing the friends organisations

Mr Lilliman is secretary/treasurer of the Peterborough Ecclesiastical and Ancient Parish Trusts of Hetley, Langton, Corby and Sambrook.

Mrs Heather Hanlon representing the Volunteers of the Trust

Nomination expires 31 March 2007

Air Commodore Paul Evans, Director of Healthcare, Defence Medical Services Department representing the Ministry of Defence

Nomination expires 31 March 2007

Adviser

Mr Greg Lee, adviser with young persons remit, competition winner, Kings School in Peterborough.

Membership

The Trust has adopted the simplest form of membership constituencies and has a single public membership and a single staff membership constituency, neither of which are sub-divided into geographical areas or particular staff groupings. As a district general hospital providing services to its local community, a decision was made not to have a separate patient constituency but to ensure that public membership is advertised amongst patients.

Patient representation to the Trust can also be made through a number of direct patient involvement groups including a disability advisory group, a cancer involvement group, the maternity liaison services committee and through local patient surveys aimed at improving patient care.

Membership numbers at the beginning and end of 2004/05 are shown in the table below.

	1 April 2004	31 March 2005
Staff members	3,978	3,649
Public members	1,055	5,036
Total	5,033	8,685

Any individual employed by the Trust for more than six months is eligible for membership and all eligible staff members were automatically opted in and given the opportunity to opt-out if required. The Trust provides staff bank services, through its management of NHS Professionals, to a range of other organisations and the drop in staff members is mainly due to those staff who do not work at the Trust's sites opting out of membership and to a drop in bank staff usage. All new staff are opted in to membership and written to with the opportunity to opt-out if preferred.

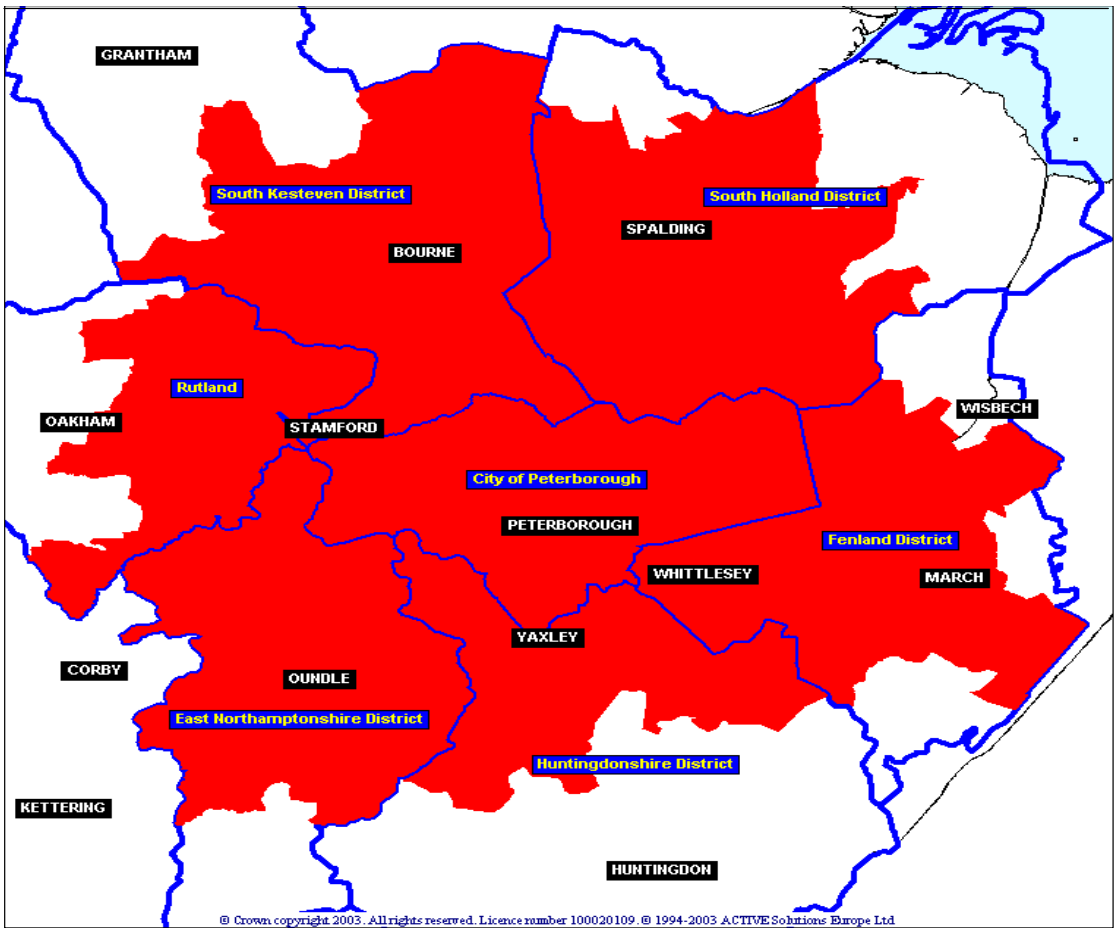
Any person aged 16 or over living in the Trust's membership catchment is eligible to become a member. This catchment is based on electoral wards. This is detailed in the Trust's constitution which is available to view from the main Peterborough public library or from the cash offices situated in each of the Trust's main hospitals (Peterborough District Hospital, Stamford Hospital, Edith Cavell Hospital). The details are also available from the office of the Company Secretary who can be contacted on 01733 874174. Arrangements are being made for the publication of this information on the Trust's website during 2005/06. The catchment area is represented in the map below. Work is ongoing to update the area for recent changes in ward configurations.

The Trust expects members to be committed to the principles of NHS Foundation Trust status, the Greater Peterborough Health Investment Plan, honesty and integrity and racial and religious tolerance.

Work is proceeding in conjunction with the Board of Governors members communication and recruitment committee on increasing public membership including addressing any shortfalls in representation. This will initially be done by targeting wards with lower than average representation and through work with community groups to address any minority groups that are under-represented according to available census data.

Significant growth has been achieved in the public membership during the year. The Trust's aim is to increase public membership to 7,500 by the end of next year (31 March 2006).

Public membership area map



Public interest disclosures

Disability

The Trust has a very active disability advisory group which includes a wide range of external members including patients and members of voluntary organisations. This group focuses on issues regarding service provision and access as well as some employment issues. The group is chaired by the service unit general manager for clinical life support services, and reports to the public and patient involvement committee and the diversity and equality steering group.

An audit of accessibility of the Trust's services and buildings was undertaken in 2004 to assess our progress in relation to our requirements under the Disability Discrimination Act. An action plan was produced and progress is monitored by the disability advisory group. Furthermore, this group continues to play an essential role in the development of the new health buildings as part of the Greater Peterborough Health Investment Plan, for example they have considered issues such as the proportion of disabled parking spaces (which is likely to be 10% compared to 6% average for other organisations), supported a pelican crossing; reviewed disabled toilet, shower, and bathroom facilities; assessed access to the hospital including ward access, signage and the overall organisation of wards, types of call bells, beds and facilities. The group members visited the national centre for deafblind (Deafblind UK) in Peterborough as part of their training, in order to support their involvement in the development of the plans. In addition, some members have attended the disability awareness workshop run for staff and access audit training in order to further develop their awareness and expertise.

The disability advisory group also discusses trends in patient complaints and concerns in order to determine whether any wider action needs to be taken across the trust in order to prevent future repetition.

The revised induction and orientation sessions have been developed to reflect a ‘values based’ approach. The importance of valuing diversity is highlighted. In particular, the orientation includes a session co-run by a disabled patient in order to emphasis the importance of treating people with respect and dignity from a service as well as employment perspective and the value that this brings to service delivery.

The staff appraisal system, joint review and development, provides a formal opportunity for a discussion as part of an individual’s ongoing review and development. In particular, our responsibilities under the Disability Discrimination Act are covered in recruitment and selection workshops and induction and orientation. The Trust operates the double tick symbol and training on the requirements of this is included in the recruitment and selection workshops.

There are examples of disabled staff who have been supported within the Trust. A number of staff at different levels, in different departments have been successfully rehabilitated back to work or re-deployed as appropriate and we have recently launched a redeployment register in order to capture redeployment needs and track progress.

The 2004 staff survey results will be considered by the equality and diversity steering committee in order to assess trends and identify actions.

Equal opportunities

The Trust has an established policy in place on equality and diversity which covers both employment issues for staff and service access and provision for patients. One of the Trust's core values set out in its HR strategy ‘Our Plan for Staff’ is to respect people's dignity and treat them with fairness, consistency and honesty. This continues to be emphasised through induction and orientation.

Induction and orientation for staff has been fully revised in order to adopt a values based approach, which recognises contribution, values staff and treats people fairly and with dignity. The adoption of a values based approach has provided an excellent platform to discuss equality and diversity

within the workplace and as a service provider. This has been very positively received by staff, including those with many years experience in the health service elsewhere. Orientation includes a session co-run by a disabled patient in order to emphasis the importance of treating people with respect and dignity from a service as well as employment perspective and the impact of this on service delivery. Staff are also made aware of Language Line and other resources available to support them when working with a diversity of colleagues, patients and visitors. For examples, as part of the national Clean Your Hands campaign the 'clean your hands day' poster was translated into many languages in order to engage all staff, patients and visitors.

Staff grievances, disciplinaries and long term sickness cases are monitored and reviewed regularly (including an ethnicity breakdown) at Trust Board and service unit meetings to assess trends and take necessary action. The new recruitment and selection handbook reflects the importance of treating people fairly and the recruitment and selection workshops mainstream the importance of equality of opportunity and diversity through the course, whilst exploring examples and situations. The course has been compulsory for all panel chairs from April 2005 and will be compulsory for the majority of panel members by April next year and all panel members by April 2007. Diversity awareness training days are available and attended by staff and feedback has been excellent.

The refurbished Chapel was re-launched last year as a multi-faith facility with adjustments to enable non Christian faiths to access this more readily.

Another trust value, highlighted in the HR strategy 'Our Plan for Staff', is 'to work together as a team supporting and encouraging all members'. The Trust encourages individuals to recognise the importance of effective multi-disciplinary team work, valuing the skills and experience that people bring irrespective of their professional background. It is notable that there is a great deal of multi-disciplinary working focused on the delivery of patient services, which is happening across the Trust and local healthcare economy.

An important principle for the Trust is the mainstreaming of diversity and equality and the issue of transference of learning across employment and service delivery and access. This is one of the drivers to strengthen the diversity and equality steering group.

Health and safety and occupational health

The Trust has a well established Health and Safety Committee, chaired by the General Manager for Facilities, supported by the Assistant Director Risk and Occupational Health, Health and Safety Advisor, Moving and Handling Specialist Advisor, Site Services Manager who leads on fire, other operational managers and a network of staff side safety representatives. There is a robust reporting and monitoring system in place which demonstrates a reduction in violent incidents involving staff and increases in reporting and investigating incidents. The security forum, which includes our local Police officer meets regularly, reviews and monitors security related adverse events. In 2004/05 the Trust has upgraded the existing health and safety policy folder to a trust-wide risk management manual which incorporates policies, procedures, generic risk assessments and other guidance.

Car parking, as in most NHS acute hospitals, is a major problem and significant frustration which can spill over into verbal abuse and aggression towards staff. The Trust has taken this issue very seriously and is determined to put solutions in place to reduce the frustration created by car parking through the travel options consultation.

The reporting of violent or verbal abuse related incidents is now captured as part of the single adverse event and near miss reporting system. There is a comprehensive ongoing programme of education, information and training covering risk and health and safety issues throughout the Trust. This incorporates comprehensive induction sessions for new starters and a variety of training courses for existing staff. The results of the staff opinion survey reveal that staff are well aware of when and how to report adverse events and are confident that follow up action will be taken. We continue to demonstrate sound performance in this area with a firm policy on follow ups to visitors (or patients) that are verbally abusive or aggressive towards staff. As part of the essence of care project, looking at clinical service delivery, work is underway to identify and review ways in which violent or abusive behaviour from patients may be managed. Many of these patients may not be

able to help their behaviour due to the medication they are receiving or their clinical condition but, the Trust recognises that this type of behaviour is unacceptable and distressing to staff.

The Trust has recently reviewed the sickness absence policy with a view to continuous improvement. The approach to manage sickness absence is focused through line managers by having a trust standard that assists managers to identify ways in which they can reduce sickness absence.

Counselling services are advertised through the induction programme and through a variety of other communications systems. Over 79 per cent of staff in the 2004/05 staff opinion survey admitted that they knew how to access counselling services.

The staff opinion survey demonstrated that staff were fully aware (98.4 per cent positive response) of the occupational health services available and knew how to access them. During 2004/05 the Trust launched its first stress management policy and work is underway with at least one clinical area to undertake a stress assessment. The occupational health service is committed to the personal development of its staff to further improve the quality and range of services provided. The Trust has the benefit of a part-time occupational health physician and access through a service level agreement to an occupational health consultant.

The Trust has specific and separate guidance on redeployment for reasons of health or disability and reference is also incorporated within the sickness absence processes. The Trust believes very strongly that staff who cannot continue in their original role due to illness or disability are provided with further opportunity to re-train and develop in a more suitable role. There are some excellent examples of rehabilitation and redeployment across the Trust which we explore in partnership with staff side representatives. We support trial periods for staff to explore alternative roles and have a strong culture around phased returns and introductions.

The Trust supports a number of initiatives to help manage workloads and minimise the long hours culture including time management training, strategy days allowing staff to work from home in an uninterrupted fashion where appropriate and the newly introduced stress management policy. The challenge is to achieve this against a backdrop of major national implementations, performance targets and initiatives. There are good examples of staff that have changed their working hours by working flexibly or reducing hours to have a more structured work/life balance.

Staff involvement

Partnership working

A health-system-wide modernisation board is in place with strong collaborative working across the local health economy. Partnership working is one of the organisation's strengths and there is significant collaboration, input and decision making that transcends organisational boundaries. The Trust is organised and run with the direct input of Ministry of Defence staff that play an essential and vital part in service delivery. These staff are fully integrated alongside trust staff in the clinical areas in which they work. Ministry of Defence staff and ISS Mediclean staff attend the trust induction and orientation sessions, as part of their training and development programme.

The Greater Peterborough Health Investment Plan (GPHIP) and Stamford Hospital Investment Partnership (SHIP) and travel choice plans are all being developed in conjunction with the local health communities. The Peterborough Health System Future Healthcare Workforce Group, which includes representatives from acute, primary care and social care sectors, and is chaired by the Director of HR, is established and working effectively to support the Greater Peterborough Health Investment Plan and provides leadership on workforce modernisation. Projects for example exploring employment pathways for refugees take place with input from health and social care and educational providers in the city. The chairman is a member of the city's urban regeneration committee and the Trust is represented at a senior level on a number of external forums regarding developments in Peterborough.

There have been several opportunities for all staff to attend open days to input into the design of the new facilities in the Greater Peterborough Health Investment Plan and identify new ways of working, in addition to the more specific design meetings that have occurred with staff and

management input. Feedback from bidders is that the high level of involvement of staff affected is unprecedented nationally. The communication group established in facilities, for staff whose employment is affected by the private finance initiative scheme is a good example of effective staff involvement. In 2003/04 there was greater involvement in the workforce component of the local delivery plan which feeds into workforce modernisation.

Board of Governors

As an NHS Foundation Trust, there is a Board of Governors including public, partner and staff governors who were democratically elected and actively participate in the running of the organisation, including the appointment process for non-executive directors.

Multi-disciplinary and multi-agency working

There are many examples of multi-disciplinary and multi-agency meetings, which take place to enhance service delivery e.g. discharge planning which takes place with the full involvement of a wide range of stakeholders including registered and unregistered nurses, therapists, pharmacists, social services, and primary care.

Multidisciplinary working across primary care is commonplace, for example in terms of the development of services to the new prison, discharge planning, National Service Frameworks and other service developments. Also, regular meetings take place between NHS Professionals and primary care partnership regarding the provision of temporary staff for the partnership, service delivery and enhancement.

Getting involved

In early 2005 the Trust has undertaken a travel options consultation with staff and public foundation members, partner organisations and volunteers. The outcomes have been analysed and are being prioritised to implement ways in which car parking frustrations can be reduced.

The Agenda for Change project team have run many seminars and training sessions in order to ensure that staff and managers understand Agenda for Change and have the information they need to implement this within the Trust, in addition to providing the opportunity for them to raise issues of concern or confusion which can be addressed or taken forward. All staff have been invited to participate in the implementation process, with applications from staff resulting in a cross section of job evaluators and matchers, including recently retired staff.

Regular surveys and questionnaires, trials, open days and sessions are used to involve and engage staff, providing an opportunity for staff and staff representatives to discuss issues. There are induction and orientation sessions for all new staff, including temporary staff, which have been recently revised. Comments and suggestions arising out of these sessions are circulated to appropriate senior managers and directors within the organisation.

Staff have the opportunity to share ideas and views formally and informally within their service units and views which are not represented directly by the staff themselves are fed back by managers appropriately. Also, the staff governors run surgeries which are open to all staff should they wish to share concerns or views.

All staff received a copy of ‘Our Plan for Staff’, which they had the opportunity to contribute to, and personal copies of a number of Agenda for Change publications, in order to ensure that they would have every opportunity to receive information available and understand how this affected them.

The Trust Board sought feedback from staff regarding ‘Our Plan for Staff’ document and a range of service unit staff were involved in the development of the local level versions of these, which have been disseminated to staff.

In addition to other channels of communication in the trust, quarterly meetings are held with the junior doctors to enable them to raise any concerns that they may have about accommodation, training or rotas. The Medical Director and the clinical tutor chair these meetings.