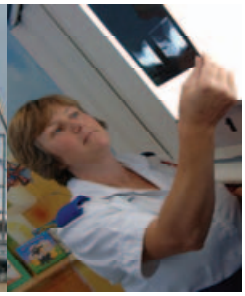
Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Annual Report and Accounts 2007/2008



Peterborough and Stamford Hospitals NHS Foundation Trust

Annual Report and Accounts 2007-08

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of the National Health Service Act 2006

Peterborough and Stamford Hospitals NHS
NHS Foundation Trust

Annual Report

2007/2008

Contents

This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors on 3 June 2008

Nik Patten
Chief Executive Officer

www.peterboroughandstamford.nhs.uk

1. Chair's Statement

I am writing this statement having been chairman of the Trust for 11 years up until my retirement on 31 March 2008. It is with pleasure and pride that I am able to report a year of significant improvement and achievement which will take the Trust forward into a strong future.

The year started with the completion of our review into the management and operational issues surrounding our orthopaedic waiting list breaches. Due to the hard work of our staff these issues have been tackled and all patients who had waited in excess of the national waiting time target were treated by the end of December. We have also seen reduced waiting times as we have worked to achieve the 18 week waiting time milestone. As of 31 March, 95% of patients who did not require admission were treated within 18 weeks (exceeding the national milestone of 90%); this compares to 79% of patients who required admission being treated within 18 weeks (missing the national milestone of 85%). Whilst it is disappointing not to meet the national milestone, the tremendous strides made in reducing our orthopaedic waiting list and the robust systems that are now in place will ensure our patients should have confidence in our ability to deliver the care they need and to achieve the full 18 week target in December 2008.

We have also seen improvements in lengths of stay, reduced MRSA and Clostridium difficile rates, and visibly improved cleaning throughout all of our buildings. This is against the background of our clinical staff working hard to accommodate an unexpected increase in demand for emergency admissions (12% above plan) and this achievement should not be overlooked.

Our financial performance has also been excellent. As shown in the detailed accounts, we have recorded an income and expenditure surplus of just over £7.4million, over £2million higher than planned; which means that we have the highest rating from Monitor (the Independent Regulator of NHS Foundation Trusts) for financial performance of 5.

A significant milestone for us has been the start of our building programme for the new acute hospital on our Edith Cavell site as part of the Greater Peterborough Health Investment Plan. Work commenced on all three building projects following the final contract exchange with Progress Health in July; the buildings are progressing at an impressive rate in accordance with the project plans, and we look forward to the opening of the new acute hospital at the end of 2010. We are also making progress with our plans to secure the future of the Stamford and Rutland Hospital in line with local GPs and the local community. 1 April 2008 saw a joint dedicated project manager appointed working to achieve a clear development plan for future services to our patients and the community.

The start of the building has also enabled us to look towards the future and the summer months saw the development of a new strategy and a vision for us to be *"a major healthcare provider in eastern England that is best for patients and great to work for."* This vision and our four main strategic aims were developed by our staff, board of directors, governors and stakeholders working together.

We have also seen significant organisational development with the creation of eight new Clinical Business Units, each led by a clinical lead and general manager. These organisational changes will also be complemented in the coming year by a board development plan, building on board evaluation work completed during 2007/08. This will provide the Board of Directors, Board of Governors and Clinical Business Unit leaders with clear roles, responsibilities and delegated decision making.

This development work together with our excellent performance provides an excellent basis on which the achievement of our own strategy can be built. In the future months we will see the launch of our own patient safety strategy, and we will be seeking to influence the development and implementation of the local response to the Lord Darzi review *Our NHS, Our Future*. This will ensure that whilst there are themes of centralising specialist care and providing care close to home where possible, we will continue to have thriving hospital and out-of-hospital services integrated to meet the needs of our patients and the local community.

There have also been changes to the Board of Governors and Board of Directors. Elections were held in August/September 2007, and we now have 9 new public and 3 new staff governors. Board of Directors changes mean that we have had two new non-executive directors and from 1 April 2008 a new Interim Chairman, Jonathan Radway, prior to the substantive appointment from 1 July 2008 of Nigel Hards who I am very pleased to welcome.

I would like to close my report by paying tribute to all of our staff, our volunteers, our directors and our governors for a year in which the organisation has shown tremendous resilience and the ability to meet patient care requirements and demanding performance targets. I wish my successor, Nigel Hards, every success for the future in an organisation that shows an outstanding ability to meet and embrace challenges and change – always with a view as to what is best for our patients.

Clive Morton

Chairman, Peterborough and Stamford Hospitals NHS Foundation Trust

As Interim Chairman for the period 1 April 2008 to 30 June 2008 and Deputy Chairman since 1 December 2007, I would like to take this opportunity to endorse Dr Morton's comments and thank him personally for all the hard work he has done for the Trust over the past 11 years. A period in which the Trust has grown with the development of the Ministry of Defence Hospital Unit, the inclusion of Stamford and Rutland Hospital, the achievement of Foundation Trust status and a new era of health provision from new buildings with the start of the build for our new hospital. On behalf of our staff, governors, directors, volunteers and many friends, I wish Clive all the best for the future.

Jonathan Radway

Interim Chairman, Peterborough and Stamford Hospitals NHS Foundation Trust

2. Directors' Report

2.1 Introduction

The current Trust was formed on 1 April 2004 succeeding the Peterborough Hospitals NHS Trust, which had been established on 1 April 1993. The Trust provides healthcare services from two main sites in Peterborough: the Peterborough District Hospital including 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, South Lincolnshire, East Northamptonshire, East Leicestershire and Rutland.

2.2 Performance

This year has seen some improvements in services for our patients. It has, however, also been a year of challenges in some key areas of performance.

The Trust has treated more emergency and elective patients this year than ever before. A rise in emergency referrals has been managed at the same time as additional activity to support the introduction of the 18 week targets. At the same time the length of stay for both emergency and elective patients has reduced. The Department of Sexual Health worked hard throughout the year to ensure that in March all patients had access to clinics within 48 hours.

Unfortunately, there have been four key areas where our performance has been less than satisfactory. Following an orthopaedic investigation, a large number of patients were found who had been waiting more than 26 weeks for their elective inpatient or day case treatment. This has meant that much of the year has been spent clearing this backlog of patients by treating patients both within the Trust and by using external providers.

The maximum number of 26 week inpatient breaches declared was 377 in May 2007. This reduced month on month until January 2008 when none were declared. This position has been maintained. Patient loyalty to the Trust has been surprising because large numbers of patients opted to continue their treatment at the Trust despite having to wait for significantly longer than they were expecting. Although performance in Orthopaedics has considerably improved and productivity has increased enormously, the underlying issues have meant that compliance with the 18 week referral to treatment target has been compromised across the Trust.

There have been some concerns regarding our management of cancer patients. The 62 day wait from referral to treatment target was not achieved in quarter three. Much work has been undertaken to improve performance and the patients' experience. This has involved clinicians and managers across the health economy working together to prioritise these patients. All cancer targets have been achieved in quarter four and for the year as a whole.

On 16 October 2007, five twelve-hour trolley waits were declared. This was at a time when the maximum four-hour A&E journey time target of 98% was consistently not achieved. There were a number of reasons for this poor performance including the high number of A&E attenders and emergency admissions, and the patient flows through the hospitals. Intensive work has been undertaken to improve the patients' journey. This has resulted in considerably improved performance from January 2008. Emergency patients are managed across the health economy, including via Peterborough PCT's Walk In Centre. End of year performance for the health economy is above the target of 98%.

In August 2007 it became clear that performance against the two week maximum wait to be seen in a rapid access chest pain clinic was not being achieved. Work was undertaken to improve performance which has been sustained at 100% since November 2007.

Despite all the difficulties described above, it is clear that clinicians and managers alike

have been committed to improving performance and ensuring the improvement is sustained.

March 2008 saw the implementation of the 18 week referral to treatment milestone. Whilst the Trust was compliant against the 90% milestone for non admitted patients to be seen and treated or discharged within 18 weeks, because of the long waits in orthopaedics described above, we did not achieve the 85% milestone for admitted patients. It is anticipated that compliance will be achieved for 2008/09. The Trust has been working closely with the Department of Health Intensive Support Team to manage the Orthopaedic 18 week issues and has been complimented on its validation processes and management of waiting lists.

A complete picture of performance is provided by the balanced scorecard used to monitor performance on a regular basis, with the complete version for the year reproduced on the following pages.

		Indicator	Gov/ Trust Target	Full Year Target	March 2008 Data	Full Year Data	Comments
Access	1	IP Waiting List - people waiting > 6 months	Gov	0	0	681	Orthopaedic investigation complete. Progress being tracked in conjunction with Monitor. 681 patients from Apr 07 to Mar 08 waited for more than six months.
	2	IP Waiting List - suspended as a % of total	Tru	6%	0.0%	Snapshot	At the beginning of the year (April 2007), 3.9 % of patients were suspended. This reduced to 0 in March 2008.
	3	Admitted pathways waiting times milestone for the 18 week referral-to-treatment target	Gov	85%	78.6%	79%	
	4	Inpatients - people waiting > 11 weeks (in month)	Gov		519	Snapshot	
	5	Inpatients - people waiting > 8 weeks (in month)	Gov		1060	Snapshot	Indicator measures in-month 8 weeks from Dec 2007.
	6	Outpatients - people waiting > 5 weeks (month end)	Gov		174	Snapshot	
	7	Outpatients - people waiting > 11 weeks (month end)	Gov		0	Snapshot	
	8	Outpatients - people waiting > 13 weeks (month end)	Gov	0	0	Snapshot	
	9	Non-admitted pathways waiting times milestone for the 18-week referral-to-treatment target	Gov	90%	94.8%	95%	
	10	12 Hour 'Trolley' Waits For Emergency Admission	Gov	0	0	5	In October 5 patients waitied for more than 12 hours for admission from A&E.
	11	Total Time In A&E 4 Hours Or Less:	Gov	98.0%	97.61%	97%	97.96% performance for previous rolling four-week period.
	11.1	Total Time In A&E 4 Hours Or Less - Health Economy		98.0%		99%	Monitor measures whole "Health Economy" which includes Rivergate Walk In Centre.
	12	All Cancers 2 Week Wait	Gov	100.0%	100%	100%	
	13	All cancers - 62 day wait from referral (new standard from Dec 2005)	Gov	95%	98.0%	96%	
	14	All cancers - 31 day wait from Decision-to-Admit (new standard from Dec 2005)	Gov	98%	99.0%	100%	
	15	Booking - New Outpatients	Gov	100%	100.00%	100%	
	16	Booking - Admissions	Gov	100%	100.00%	100%	
	17	Cancelled Operations	Gov	1.0%	0.59%	0.9%	
	17.1	% of Cancelled OPs admitted within 28 days	Gov	95.0%	100.00%	98.1%	
	18	Delayed Transfer Of Care - %	Tru	2.3%	2.38%	3.1%	
	19	Delayed Transfer Of Care - 4 Week Average Number of patients	Tru	12	13	16	Target of 12 is based on the average monthly DTs 2005/2006.
	20	Emergency readmission within 28 days	Tru	6.3%	8.7%	n/a	Currently sourced externally from Dr Foster analysis tool (figures from Nov 07 - latest available). Full year data not yet available.
	21	Emergency readmission within 28 days - Fractured Neck of Femur	Tru	15.9%	11.3%	n/a	Currently sourced externally from Dr Foster analysis tool (figures from Nov 07 - latest available). Full year data not yet available.
	22	Thrombolysis - 60 minute call to needle time	Gov	68%	91.0%	76.0%	Data from MINAP quarterly report.
	23	Waiting times for Rapid Access Chest Pain clinic (2wks)	Gov	98%	100.0%	84.6%	At the beginning of the year this target was not achieved. However, achievement has been consistent since November 2008.
	24	Access to DoSH clinics within 48hrs by 2008	Gov	100%	100%	86.7%	This target did not come into effect until March 2008.
	25	Outpatients DNA rates	Tru	6.5%	8.3%	8.4%	

		Indicator	Gov/ Trust Target	Full Year Target	March 2008 Data	End of Year Performance	Comments
Clinical	26	Complaints (response within 25 working days)	Tru	90%	98%	93.4%	National Target is 70% - Information collated quarterly.
	27	Infection Control - MRSA rates	Tru	10	0	6	Full Year Target is a 10% reduction on 2006/2007 infection rates.
	28	Infection Control - C-DIFF rates - Inpatients	Tru	195	12	194	All hospital acquired over-2's reported, measured against SHA 'trajectory'.
	29	Ethnic Group - % recorded (based on discharged inpatient episodes)	Tru	80%	85.1%	85.1%	Data calculated locally based on valid codes recorded for discharged inpatient episodes.
	30	Mortality (in-hospital deaths based on basket of diagnoses)	Tru	5.8%	5.3%	5.3%	Rolling 12 month value. Target based on nationally expected rates. Source: Dr Foster.
	31	Incidence of Hospital Acquired Pressure Sores	Tru	128	15	143	Target is 10% reduction on 2006/2007.
	32	Incidence of Drug Errors	Tru	441	2	379	
	33	Incidence of Falls	Tru	1182	31	889	
	34	Incidence of Staff Shortages	Tru	247	40	583	
Staff Focus	35	Sickness & Absence	Tru	4.5%	4.3%	4.36%	
	36	Turnover (Cumulative)	Tru	11.5%	13.4%	13.4%	
	37	Staff Productivity (No. of patient days per WTE)	Tru	7.4	9.0	8.6	
	38	Appraisals complete - JRD		100%	14.8%	82.0%	JRD essential for all staff to support AfC pay progression.
	39	Appraisals complete - Consultant (cumulative)		100%	87.9%	88%	Trust total of 116 out of a possible 132.
Efficiency	40	Non-Elective Spells (PbR) - Numbers (tolerance +/- 1.5%)	Tru	30,198	3,008	33723	
	41	Elective Spells (PbR) - Numbers (tolerance+/- 1.5%)	Tru	33,833	2,543	33050	
	42	Day Case admissions - % of elective work against 80% target	Tru	80%	75.9%	75.0%	
	43	Day Case admissions - % of elective work against Basket of Procedures	Tru	80%	71%	73.0%	
	44	Outpatient Total Attendances (PbR) - numbers (tolerance +/- 1.5%)	Tru	244,426	18,927	250893	
	45	GP Outpatient Referrals (tolerance +/- 1.5%)	Tru	68,419	4,833	60526	Referral levels are measured against actual referrals for 2006/2007.
	46	A&E - Attendances (tolerance +/- 1.5%)	Tru	69,757	5,892	68677	
	47	Average LOS - Emergency	Tru	4.8	4.2	4.6	
	48	Average LOS - Elective	Tru	2.9	2.8	2.8	
	49	% Bed occupancy - weekly snapshot (tolerance range 85%-90%)	Tru	90%	83.15%	83.2%	
	50	Theatre Utilisation: % Actual Time against Planned Time for lists undertaken	Tru	90%	91.87%	91.4%	
Financial Mgt	51	Financial Management	Tru	3	5	5	Monitor has formally confirmed rating as '5' for Q3.
	52	Revenue from Clinical & Non-Clinical	Tru	175.4m	15.6m	180.8m	
	53	EBITDA margin	Tru	8.76%	14.59%	10.5%	
	54	I & E surplus margin net of dividend	Tru	5.3%	-1.4%	4.1%	
	55	Days cash-in-hand	Tru	26.0	47.7	47.7	

= below or above target tolerance

= on target or within tolerance

2.3 Patient Care

Improving our healthcare quality

The Trust's main aim is to ensure that we provide excellent and safe patient care. This is supported through a number of different strands that come together for our patients through the application of standards and policies. The focus of patient care delivery is through a service unit structure, with each unit being headed by a general manager and lead clinician for each clinical management team.

These clinical units (Surgery, Medicine, Woman and Child, Clinical and Life Support) have their own clinical governance committees who focus on providing high quality healthcare to required national standards. This includes the delivery of standards expected from the Healthcare Commission in the national Annual Health Check and the Hygiene Code; patient safety and risk management requirements (including risk management standards from the NHS Litigation Authority); complaints management; compliance with national service standards and local networks for service delivery and development; and the implementation of guidance from the National Institute for Health and Clinical Excellence. An overview of these activities is maintained by the Trust's Healthcare Governance Committee.

The Trust's performance against Standards for Better Health, the national standards that form the basis of the Annual Health Check by the Healthcare Commission, gave our position for 2006/07 as excellent for the use of resources and fair for quality of care.

The assessment for 2007/08 is awaited and will be issued in October. Whilst it is hoped that the "fair" rating may show an improvement, this will be affected by ongoing orthopaedic waiting list breaches up to the end of December.

The Trust performance rating against quality of care fell from the previous 2005/06 rating of "good", the principal reason for this was the discovery of a number of irregularities in waiting times for orthopaedic services. This was reported as soon as it was uncovered during the last quarter of 2006/07 and was fully investigated with actions and progress reviewed by an internal panel and reports made to Monitor, the Independent Regulator of NHS Foundation Trusts. The report that was produced is available on the Trust's public internet website.

The Trust has recently received the results of the national patient survey, undertaken for the Healthcare Commission and against which all NHS providers are benchmarked. Patients answered questions across nine parts of their inpatient experience: admission to hospital, the hospital and the ward, doctors, nurses, care and treatment, pain management, operations and procedures, leaving hospital and overall experience. Of the 72 questions asked, the Trust scored in the intermediate 60 per cent of trusts in 58 questions and came in the best performing 20 per cent in eight questions. The Trust came in the bottom 20 per cent of trusts in six questions.

The Trusts came in the best performing 20 per cent of Trusts for the following:

- patients' perception of whether nurses washed their hands between touching patients;
- anaesthetists explaining procedures such as how he or she would put a patient to sleep or control their pain;
- post-operation explanations given to patients regarding how operation or procedures had gone;
- patients having somewhere to store their personal belongings on the ward;
- admission date not being changed by the hospital;
- patients not being bothered by noise at night;
- information given to patients regarding their condition in the Emergency department;
- explanation about medications to take home.

Areas for improvement include:

- patients' experience of having to use bathrooms or shower areas after members of the opposite sex;
- patient privacy when discussing their conditions or treatment;

- the length of time patients were on the waiting list for treatment.

The scores concerning the provision of bathroom facilities and patient privacy are restricted by the old building design at the District Hospital. The new hospital, which is due to open at the end of 2010, will have more than fifty per cent of the beds in single en-suite facilities with their own bathroom and toilet, and four-bedded bay areas with their own toilet and bathroom. This will address these privacy areas in the longer term. There are current changes including the trial of single sex accommodation in the separate arms of our wards, although this is restricted by the need to access disabled facilities.

The length of time waiting for treatment will have been affected by the orthopaedic waiting list breaches.

Patient Engagement

The patient and public involvement (PPI) agenda continues to be an important process whereby patients can be involved in the development of our services, using their experiences. The Trust has been involving patients in its workings for a number of years. The Trust has its own Patient and Public Involvement Committee which is currently being refocused to reflect the changing agenda within PPI. There is also a governor-led committee that focuses on public members' engagement as detailed in section 7.

The Trust has worked closely with the Patient and Public Involvement Forum (PPIF) established under the auspices of the Commission for Patient and Public Involvement in Health. The Forum is completely independent of the Trust and has played an integral part in evaluating services at the Trust. In the last year they have looked at the provision of areas including Accident and Emergency services, bereavement services and catering. Our working relationship with the Forum is good and we see them as a critical friend. The Forum will cease to exist from the end of March 2008 and will be replaced by a Local Involvement Network (LINk) under the auspices of the local authority. We are looking forward to working alongside the LINk who will have an overview of health and social care and who will work closely with the existing overview and scrutiny committee (for Peterborough this is the Health and Social Care Scrutiny Panel).

At a more local level the number of PPI initiatives in place within the Trust continues to grow.

There is a Readers Panel which looks at all of the leaflets available within the Trust making sure that they are user friendly and provide patients with the information they require. The Trust is now producing more information than ever for people who do not have English as a first language. Currently Polish and Portuguese are our most requested languages and the Trust now employs full time interpreters in both of these languages.

The Trust continues to have an annual Essence of Care Sharing Best Practice Day which celebrates the progress made to date with the Essence of Care Project. Members of the public assist with the presentations and participate in the project groups.

The Cancer Patient User Group continues to work hard with members of the public in developing the service as does the Maternity Services Liaison Committee. One of the areas which continues to benefit from public involvement is the Disability Involvement Forum. The group has been very active in looking at disability issues including reviewing impact assessments and helping to advise on issues related to the new hospital build.

The Patient Advice and Liaison Service (PALS) has a steering group that is chaired by a member of the public. This group looks at Trust-wide issues that are raised within PALS and has been integral in addressing some of the reoccurring problems that PALS have had to deal with. The group is also attended by the PCT PALS team which helps to enhance cross boundary working.

During 2007/08, the Trust received 329 complaints and 7090 accolades. The top five categories for complaints were to do with aspects of clinical care; attitude of staff; appointment delays or cancellations; admission, discharge and transfer arrangements; and communications. The Trust learns from the complaints received, and changes as a result include staff retraining; a joint smoke-free committee with the city council; changes in letters and leaflets to aid better communication; increased nurse

establishment and a review of junior doctor rotas for weekend cover.

The Trust also has a clear process for learning lessons and changing practice from adverse events. The emphasis of this adverse event and near miss reporting system is one of openness under a "no blame" culture with investigation and learning to ensure that the same event or near miss is not made again. This focuses on system and process errors to find the underlying cause of why something has happened, rather than what someone did wrong. All staff are however, expected to be accountable for their actions.

As part of the learning process the Trust has a quarterly report where claims, complaints, PALS interactions and adverse events and near misses are collated and reviewed looking for patterns and trends (CLAEP report).

Cleanliness

Infection control and cleanliness are important aspects of care for our patients and have been identified as priority areas by our Foundation Trust membership.

Responsibility for the cleanliness of clinical areas falls to ward managers and matrons. Matrons undertake regular audits of the environment and have well established and effective relationships with contracted cleaning services and help monitor the domestic contract. There has been no significant feedback through PALS or complaints services regarding hospital cleanliness, though some concerns raised about the use of hand gels and gloves have been fed back to the Infection Control Nurses. The Trust has commenced a process of intensive deep cleaning for its wards, including refurbishment, which has concentrated on our high risk areas such as our haematology and oncology ward, admissions, Medicine for the Elderly wards and isolation.

During March 2008 the Trust completed a series of self-assessment PEAT (Patient Environment and Action Team) inspections across its three main sites, Peterborough District Hospital, Edith Cavell Hospital and Stamford & Rutland Hospital. The assessment team members were made up of representatives from facilities, soft and hard facilities management services, hotel services, matrons, staff governors and patient representatives. The final scores for the assessment will not be available until August/September 2008, but action planning following on from the assessment visits is in place and will be monitored by the matrons.

The Trust has an excellent record in the management of MRSA which has continued at low levels again through this year. Whilst maintaining figures for Clostridium difficile (C. diff), further work is progressing with the Trust's Infection Control Team in conjunction with clinicians to actively reduce the amount of infections. The figures for these infections are part of the routine balanced scorecard as can be seen in section 2.2. The recent deep cleaning in priority areas and further improvements in antibiotic prescribing and isolation arrangements in the coming year will also support this. The Trust has been supported and complimented in its progress by recent visits from both the local intensive support team from the Strategic Health Authority and from the Healthcare Commission.

There is also a detailed infection control annual work plan which is reported and managed through the Hospital Infection Control Committee. The Director of Nursing, as the Director of Infection Prevention and Control, provides regular reports to the Board of Directors and produces an annual infection control report, a copy of which is available on request.

Service Developments

The year has also seen a range of service developments in the year, improving patient care as follows.

- Single sex accommodation has been implemented at the District Hospital in Wards1Y, 2Z and 3Y.
- Capacity within the iron infusion clinic in Ward 2X has been increased to take account of increasing demand. This means patients can have treatment in Peterborough instead of having to travel to Leicester.
- A new state-of-the-art Intensive Care Unit (ICU) opened in April 2007. The £900,000 unit has been designed to have more

space for patients and medical equipment and an improved environment for patients, visitors and members of staff.

- The Trust was the first in the country to introduce the Kubtec Xpert Specimen Radiography Unit in June 2007 - a digital X-ray guided method of taking a core biopsy, making breast needle biopsies a quicker, more comfortable and less invasive experience for patients.
- A state-of-the-art computer system, that allows medical staff at all three Trust hospitals to view digital X-ray images and scans seconds after they are taken, was introduced in October 2007, meaning faster analysis and diagnosis. As well as handling conventional X-ray images, the system can deal with a wide range of specialties including radiotherapy, CT, MRI, nuclear medicine, angiography, fluoroscopy and ultrasound.
- Capital investment of £463,000 has been made in Stamford Hospital for the year ending 31 March 2008. This includes £375,000 spent on new and replacement medical equipment and £88,000 spent on buildings maintenance and refurbishment.
- A new Transitional Care Unit, based at Peterborough Maternity Unit, opened in April 2008. The Unit contains ten beds and been designed for mothers with babies who require some extra care after giving birth but who are not ill enough to be admitted to the Neonatal Unit. An additional eight midwives have been funded by the Trust, to provide specialist care and support.

Staff and Organisational Development

The Trust continues to deliver support to its staff through clear policy development and implementation. The year has seen the review and relaunch of the Trust's processes for raising issues of concern and the development of the Trust's Equality and Diversity Steering Group which comprises directors and governors to direct and oversee the implementation of clear equality schemes, processes and practice.

Staff development and training is key to ensuring our patients receive excellent patient care. A Trust-wide training needs analysis and review of mandatory training requirements lead to changes in the types of training being undertaken and how and when it was delivered. This had a particular focus on clinical nurse training and has improved the way in which we ensure that all new staff receive good induction training and that existing staff keep their skills up to date.

The requirement for all staff to have an annual appraisal continues to be given the highest priority and is closely monitored. The introduction of the Knowledge and Skills Framework (KSF) has provided staff with a clear pathway for personal development and career progression and is a key mechanism in the appraisal process in enabling staff and their managers to identify where additional development is required.

The Trust recently received the results from the 2007 national staff survey as required by the Healthcare Commission. The independent survey is carried out annually in all NHS trusts by the Healthcare Commission to gauge the views of staff on working for the NHS. The Trust scored average or better than average in 16 out of the 26 key areas assessed and was in the top 20 per cent of trusts in 9 of the 26 categories.

The areas in which the Trust scored very highly include:

- staff appraisals, personal development plans and learning and development;
- health and safety training;
- percentage of staff suffering work-related injury;
- effectiveness of procedures for reporting errors, near misses or incidents;
- staff perception of effective action taken by the Trust towards violence and harassment.

The Trust also performed well in questions relating to the number of staff using flexible working options, the percentage of staff working in a well-structured team environment, and the percentage suffering work related stress. However, the Trust scored below average in areas including the quality of work life balance, job satisfaction and work pressure felt by staff. The results of

the survey will be used to develop an action plan focussing on the lower scoring areas as part of the Trust's continuing commitment to being a good employer.

Following extensive consultation the Trust HAS implemented a new operational and management structure with the primary aim of increasing the involvement of medical and clinical staff in leading and developing their services. Key to this has been the development of a number of Clinical Business Units (CBUs) to replace current service unit arrangements. There are 8 of these units – emergency and critical care; surgery; musculoskeletal; medicine and long term conditions; cancer and specialist care; family and public health; clinical services, and clinical administration. These CBUs become operational from 1 April 2008.

CBUs will have the opportunity to apply to become autonomous units with greater financial freedoms and less central control over their operational management. With visionary and committed leadership CBUs have the potential to develop creative alliances and partnerships across the healthcare economy, and to deliver services that are increasingly responsive to patient needs.

The Trust has also undertaken a comprehensive board evaluation programme during the year to ensure that there are clear roles and responsibilities and that the board has the right balance of skills to deliver appropriate leadership and strategy. The initial evaluation report has been completed and is available on the Trust's public internet site. The next stage in this process is a board development programme. This will cover not only the Board of Directors and the Board of Governors, but also the Clinical Business Unit leaders to ensure that there is clarity on where decisions can be made and where accountability resides for performance.

In parallel with this work the Trust is also in the process of reviewing the current meetings structure. This is to ensure that recommendations from the board evaluation report are considered as well as the need to have a structure that supports decision making as close to patients as possible, whilst having due regard to good governance guidance and practice.

2.4 Stakeholder Relations

To facilitate the delivery of improved healthcare, a variety of partnerships and alliances are entered into by the Trust. These partnerships ultimately benefit patients and help further develop the services by involvement in local and national initiatives.

The Trust is part of the Clinical Governance Locality Forum which provides a unique opportunity for representatives from the Trust to meet with representatives from Peterborough; Northampton; Leicestershire County and Rutland; and Lincolnshire PCTs and Cambridgeshire and Peterborough Mental Health Partnership Trust to monitor quality issues across boundaries. As part of its remit the forum receives audits of common interest in order to gain insight into standards of care and patient management, and to recommend changes in practice, or process where improvements are deemed necessary.

This has included the recognition of issues concerning care of the dying across our local organisations which is being further investigated to ensure improvements for patients and their families.

Following a number of changes to membership the forum is in the process of reviewing terms of reference and developing new and existing relationships.

There are also a wide range of clinical networks aimed at improving the specialist care that our patients receive from a number of different organisations, including specialist tertiary care and GP services. The Trust is working to build on these networks to ensure clear reporting of issues to the Board to ensure that these link in to the Trust's strategy for improved healthcare. The Trust is also linked into our Local Strategic Partnership and has ensured that the development of our 2013 strategy is aligned with the local sustainable community strategy.

The Trust has various public health duties to fulfil in conjunction with our local partners. This includes a duty to meet our responsibility as a designated major incident receiving Trust and to effectively manage internal emergencies.

A "Healthy Weight in Peterborough" campaign was launched by the local health promotion team in February 2008; this is fully supported

by the Trust through representation from the Occupational Health team. The Occupational Health Team has introduced a number of initiatives to support staff that are overweight including weight assessment as part of pre employment screening, referral of staff to dieticians for advice as appropriate and health education advice and information being available to all staff via the Occupational Health department

The Trust has good relationships with the statutory Overview and Scrutiny Committees run by Local Authorities, and ensures that there is attendance at each meeting of the Peterborough Health and Adult Care Scrutiny Panel. As well as attendance at the meetings, the Trust works hard to ensure the panel is briefed on key issues. Areas of interest in the last year concerning the Trust's services have been progress on the new hospital and overall Greater Peterborough Health Investment Plan, recovery from the orthopaedic waiting list issue, car parking, patient transport services, Stamford Hospital proposals and the Annual Health Check declaration.

2.5 Financial Review

Overall position

The Trust recorded an income and expenditure surplus of £7.4million (or 4% of total income). This was significantly better than the plan for the year, which anticipated a surplus of just over £5.0million. This means the Trust has built on the achievement of a surplus of £2.5million in 2006/07, made good the deficits incurred in the first two years of operating as an NHS Foundation Trust, and is on the right trajectory going forward. The good performance in 2007/08 also indicates that the Trust is ahead on its plan to achieve surpluses equivalent to 2.5% of income going forward – to support investment in healthcare services and the development of a new hospital in Peterborough.

The Trust's finances continued to be a major topic on its agenda. The focus in 2007/08 was very much on sustaining progress made in achieving cost control and reduction, combined with delivering a major (18%) planned increase in elective activity and managing a substantial unplanned (9%) increase in emergency admissions.

Income earned on our main healthcare contracts with Primary Care Trusts (PCTs) was higher than originally planned. Additional income was earned for the significant increase in non-elective (emergency activity), outpatients and for other clinical services (such as chemotherapy and specialist drug treatments). Elective activity and therefore income fell a little short of the planned level – but was still significantly up (by 16%) on the previous year.

Other areas of income were a little higher than planned, with good performance on the contract with the Ministry of Defence, and increased income being generated in other areas.

Pay expenditure was lower than planned (by 3%). This was mainly due to vacancies in the scientific, technical and therapeutic staff group, and because the cost of covering the new arrangements for training medical staff (from August 2007) was lower than anticipated. In contrast, non-pay expenditure was higher than planned (by 10%), but driven by and covered by, the income being earned for the activity provided.

The Trust continued to make good progress on both delivering reductions in cost, improving the margin (the difference between income earned and the cost incurred) and improving efficiency as more elective and emergency activity was provided. In overall terms, income earned increased by 12% and operating expenses by 10%, resulting in the good overall financial performance.

The Trust secured a financial risk rating of "5" (the best possible) from Monitor (the Independent Regulator of NHS Foundation Trusts) for the financial position at the end of the third quarter, and anticipates retaining this score for the year overall.

The on-going focus on operational efficiency and cost control is set against a background of a range of risks and threats including:

- continued financial pressures facing the main PCTs with which we have contracts;
- the PCTs' strong desire to reduce emergency admissions, and to develop their own primary care services as an alternative to outpatient, diagnostic and minor surgery services provided by our Trust;

- the emerging strategy from the East of England Strategic Health Authority, in connection with Lord Darzi's review of the NHS, around the development of both more primary care services (such as urgent care centres) and increased centralisation of acute services in regional centres;
- the Government's efficiency savings target of 3% (as actioned in the standard national price tariff governing almost all of the services we provide), along with other detrimental changes to the national price tariff.

However, the Trust has agreed activity plans with all of the PCTs for 2008/09 which anticipate a sustaining of the levels of emergency activity, and maintenance of a high level of elective activity. The latter is needed in order to build on the improvements in waiting times achieved last year, and to ensure that no one waits more than 18-weeks (from GP referral to treatment) from December 2008. The Trust has been successful in the past in working with PCTs to organise service changes in a coherent and managed way, and there are opportunities for the Trust to both grow and develop important local clinical services (renal, angiography, stroke) and develop its own alternatives to hospital care.

Accounting policies

Monitor, the Independent Regulator of NHS Foundation Trusts, has directed that the financial statements of NHS Foundation Trusts must meet the accounting requirements of the NHS Foundation Trusts Financial Reporting Manual, as agreed with HM Treasury.

The accounting policies set out in the Financial Reporting Manual follow UK generally accepted accounting practice ('UK GAAP') and HM Treasury's Financial Reporting 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 2007/08 Financial Reporting Manual issued by Monitor. The accounting policies have been applied consistently in dealing with items considered material in relation to the Accounts.

The only area where the Trust has chosen to follow a different approach from that set out in the Financial Reporting Manual is in respect of partially-completed spells of care. The Trust has not adjusted its income figures for partially completed spells because this would be inconsistent with the way in which the healthcare contracts work, and the adjustment is not material to determining a fair and reasonable income figure.

The Trust is leading on the Greater Peterborough Health Investment Plan, which is a major project relating to the development of healthcare services in Peterborough. This will see the development of acute hospital services in Peterborough in a single new hospital on the Edith Cavell Hospital site, replacing the existing Peterborough District Hospital (including the Peterborough Maternity Unit) and the current Edith Cavell Hospital. The development of the new hospital is going ahead through the Government's Private Finance Initiative (PFI). The capital investment cost is estimated at £330million, and the new hospital is on track to be completed and in use by December 2010.

Progress Health is the name of the consortium responsible for building the new hospital, and associated facilities management (including buildings and engineering maintenance, some medical equipment management, and a range of other support services such as cleaning, catering and portering). The Trust achieved financial close on the contract with Progress Health on 29 June 2007, and actual building work started on 4 July 2007. Work has been progressing on time, and in accordance with the contractual requirements, since then.

The Trust continues to follow the advice of its financial advisors in connection with the PFI scheme, as confirmed by its External Auditors. This means that currently no asset or liability is recognised in the Trust's balance sheet, and no expenditure transactions have been recorded in connection with the PFI scheme, other than project-related costs borne by the Trust which have been accounted for as expenditure incurred in the year, in the normal way.

The application of International Financial Reporting Standards (IFRS) to the public sector is now likely to be required by HM Treasury for the 2009/10 financial year, with a restating of the 2008/09 Accounts, where appropriate, to enable prior-year comparisons to be made.

The application of International Financial Reporting Standards is likely to have a significant impact on accounting for PFI schemes, and all the associated disclosures in the accounts and strategic financial planning. However, this is not clear or certain at the present time, and the Trust awaits guidance from HM Treasury and Monitor on how International Financial Reporting Standards are to be applied.

After making enquiries, the Board of Directors has a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, the Board continues to adopt the 'going concern' basis in preparing the accounts.

The accounting policies are set out in full in the annual accounts as note 1 to the accounts with financial risk management at note 21 and the Trust's overall framework for risk management detailed in the Statement of Internal Control.

Income

Income from activities

Income earned from activities (providing healthcare services) was £160.7million. This is an increase of 12% on the previous year.

Private patient income

The Trust earned a little under £0.6million from providing services to private patients, which equates to 0.36% of income earned from activities. This accords with the "private patient cap" (limit on income) set out in Schedule 4 to the Trust's Terms of Authorisation from Monitor.

Other operating income

Income earned from other sources, including education, training and research and other trading activities was £20.6million.

Expenditure

Operating expenses

The total operating expenses of the Trust comprise £107.8million for pay costs and £62.8million in respect of non-pay costs. The Trust's total operating costs of £170.6million were 10% up on the previous year.

The operating expenses for 2007/08 also include £1.3million of expenditure on project costs and fees relating to the Greater Peterborough Health Investment Plan (GPHIP), which the Trust is managing for its local NHS partners.

The Trust made no donations to charitable or political organisations.

External audit fees

Expenditure incurred on external audit fees included £92,120 for statutory audit work.

In addition to the statutory audit work, the external auditors undertook a review of waiting list management, at the request of the Board of Directors. The fees for this work were £17,000.

The independent (external) auditor was Grant Thornton LLP (incorporating Robson Rhodes LLP), Byron House, Cambridge Business Park, Cowley Road Cambridge, CB4 0WZ.

Cash flow

Operating cash flow from activities was £22million.

The operating surplus generated £10.8million and, non-cash expenditure items (depreciation) generated a further £7.7million. The net change in the working capital position generated a further £3.5million of cash – debtors fell by £13.6million, and creditors and other items were reduced by £10.1million.

Interest earned on cash balances contributed another £1.1million of cash, with no payments having to be made in respect of interest charges.

Beyond this, the cash generated from activities was spent on payments to acquire fixed assets (£8.8million) and payment of the full dividend due to the Department of Health on Public Dividend Capital (£4.3million).

Receipts from the sale of fixed assets generated £1.1million. The Trust also received cash from the Department of Health in the form of Public Dividend Capital of £5.2million. This "cash injection" to the Trust is also represented by a corresponding increase in taxpayers' equity on the balance sheet. The cash injection included £4.9million to enable the Trust to purchase a number of properties on the Peterborough District Hospital site from the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust. A further £0.3million was also made available to finance capital investment in a number of initiatives relating to the treatment of glaucoma.

Taking into account all of the above, the net cash inflow into the Trust was just over £16.3million.

Relationships with trade creditors

The Trust has maintained good working relationships with its trade creditors (suppliers) over the past year. In total, the Trust paid over 46,000 invoices for goods and services. On average across all of last year, 87% of these invoices were settled within 30 days of registration in the Trust.

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

Prudential borrowing limit and debt

The Trust has a prudential borrowing limit, set by Monitor, of £41.5million. This comprises £29.5million for cumulative long-term borrowing, and £12million for an approved working capital facility.

The Trust did not plan to take on any long-term debt in 2007/08 and none was taken on.

The Trust has an approved working capital facility in the form of a committed money market facility of £12million with its bankers. This facility is available without any restrictive covenants or on-going fees. There was no requirement at all in 2007/08 to use this facility, and the Trust had all of its £12million working capital facility available at 31 March 2008.

Balance sheet

Total assets employed increased by £27.1million in the year to £155.3million at 31 March 2008.

The Trust's working capital position improved by £9million - moving from having net current assets of £4million at 31 March 2007 to having net current assets of £13million at 31 March 2008.

The net book value of fixed assets held increased by £17.5million. As required, the three-yearly interim valuation of the Trust's major fixed assets of land and buildings was carried out, with the District Valuer engaged to provide an independent and professional interim valuation. This valuation had a prospective valuation date of 31 March 2008, and resulted in an overall increased in asset values of £15.1million. On-going depreciation of fixed assets, along with disposals and impairments reduced fixed asset values by £8.8million in the year.

Investment in fixed assets was £11.2million, comprising £11million on purchased assets and £0.2million in respect of donated assets.

Of the £11million invested in purchased assets, £4.9million related to the acquisition of "The Gables" and neighbouring land and properties on the west side of the District Hospital site from The Cambridgeshire and Peterborough Mental Health Partnership NHS Trust. This was part of the programme of land and asset sales associated with the Greater Peterborough Health Investment Plan (GPHIP). This acquisition ensures that all land and property on the District Hospital site, other than that designated as needed for the long-term provision of healthcare, are consolidated into the ownership of the Trust. This will facilitate future redevelopment of the District Hospital site. The Trust received additional cash from the Department of Health as Public Dividend Capital to facilitate this purchase.

Some £6.1million was invested in a variety of schemes consistent with the overall strategy of focussing on the replacement of medical equipment, building and engineering work associated with maintaining compliance with statutory requirements and investments to support additional activity and services.

Key areas of capital investment included:

- upgrading our buildings and infrastructure - £0.9million;
- replacement and new medical equipment - £1.7million;
- installation of digital radiology equipment - £2.1million;
- new equipment for the diagnosis and treatment of glaucoma - £0.3million.

In their opinion, the directors do not feel that the market value of fixed assets is significantly different from that disclosed in the annual accounts.

Our on-going strategy, for 2008/09 and the medium-term, continues to focus on upgrading or replacing our fixed asset stock within internally-generated resources. The overall emphasis remains on investment to support our main healthcare activities (protected services). Investment in replacement equipment and various schemes to ensure statutory compliance is planned to be £7million in 2008/09.

Post balance sheet events

There are no post balance sheet events.

Charitable funds

The Trust's Board of Directors are also the Charity Trustees for the Peterborough and Stamford Hospitals NHS Foundation Trust Charitable Fund. This Charitable Fund is registered with the Charity Commission as number 1050601, and is managed by the Trust.

In the last financial year, this Charitable Fund made a contribution of £548,000 towards the operating expenses of the Trust (compared with £742,000 in the previous year). After allowing for administration charges of £30,000 this means that £518,000 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. This was made possible through donations from members of the public and other fund-raising activities from a number of local organisations, and the Board of Directors is grateful for this wonderful contribution to the services the Trust provides.

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 the Company Secretary.

Looking Ahead

The good performance in 2007/08 indicates that the Trust is on the right road to improve financial performance, and to achieve surpluses equivalent to at least 2.5% of income going forward to support investment in healthcare services and the development of a new hospital in Peterborough. It is essential that this improved financial performance is sustained.

The Board of Directors has identified the following as the key risks to maintaining good financial performance going forward:

Maintaining Cost Control and Delivering Planned Productivity Improvements

Having achieved a dramatic improvement in the Trust's financial performance, there is a risk of complacency, losing direction and regarding the matter as "closed" – against an on-going need to deliver productivity gains and continued national price tariff uncertainty.

This risk will be managed by a continued strong performance management process. The Board of Directors and senior management team are agreed on the overall strategy, and have spent time briefing staff throughout the organisation on the importance and purpose of the Trust's overall strategy and its supporting financial strategy. There will continue to be monitoring of progress by the Board of Directors and Conformance Committee, allied with more focus and direction within a larger number of smaller Clinical Business Units. Management of each Clinical Business Unit will comprise a Clinical Lead and General Manager. This management team will be accountable for financial performance and responsible for, and engaged with, service and productivity improvement.

Revised financial reporting and other monitoring mechanisms will continue to be developed, especially in respect of 'profit centre reporting' and to support financial management within the Clinical Business Units. The Finance Directorate will be

maintained at full establishment, with additional investment if necessary, to maintain financial controls, see the savings programme through and develop routine profit centre reporting with the Clinical Business Units. The Board of Directors will continue to engage external expertise and advice where it judges necessary, and will maintain a Service Improvement Team to work on key programmes to support organisational development, service improvement and productivity gains.

Operational and Tactical Planning

The Trust expects a 3% reduction in elective work in 2008/09 but needs to build on the productivity gains made in 2007/08 by planning and managing elective activity, month by month, more efficiently – to ensure waiting times targets are achieved, and to make the most productive use of normal operational capacity. At the same time, the Trust needs to plan for the ebb and flow of emergency activity – and be ready to respond to further increases and decreases. The Trust also needs to develop its operational and tactical planning capabilities.

There is a risk of failure in these areas, which could result in delay in achieving improvements in waiting times for patients, damaged reputation and contract disputes. There is an associated risk of not eliminating sufficiently quickly the significant additional costs incurred in 2007/08 in connection with providing additional capacity at short notice and sub-contracting orthopaedic work. There is an on-going risk of increasing capacity and costs inappropriately or ahead of additional activity and revenue coming through.

The mechanisms already described above in connection with maintaining cost control, and delivering planned productivity improvements, are also relevant to managing and mitigating the risk of failing plan effectively. There will also be a further development of the performance management process to focus on specialty and Clinical Business Unit performance, with special emphasis on performance against plans, forecasting and scenario planning.

Agreement of New Contracts with Primary Care Trusts

Primary Care Trusts (PCTs) have served notice on the Trust so that the current contracts governing the provision of healthcare services by the Trust to the PCTs (which have been in place since April 2004) end on 31 March 2009. This means that new contracts need to be formulated, negotiated and agreed for the 2009/10 financial year and beyond.

There is a risk to the Trust's cashflow for 2009/10 should contracts fail to be agreed. This would be a short-term issue, and would be mitigated by working capital management and short-term borrowing if necessary.

There is a risk to the Trust's income and expenditure position in 2009/10, and going forward, where contracts are agreed, and where the kind of financial penalties set out in the Department of Health's "model" contract are agreed to be applicable and where contractual performance targets are not achieved. This can be mitigated by achievement of operational targets, and the agreement of a more balanced contract, including both rewards and penalties, and where there is clarity on the responsibilities of both parties.

3. Background Information

3.1 Establishment

The Peterborough and Stamford Hospitals NHS Foundation Trust ('the Trust') is a public benefit corporation formed pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003.

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. Prior to this date the organisation was an NHS Trust formed in April 1993.

It should be noted that the original enabling legislation has been superceeded by Part 2, Chapter 5 of the NHS Act 2006.

3.2 Financial Information

This annual report and accounts document provides detailed information on our financial and operational performance throughout the year. This paragraph provides particular information on our accounting policies and audit information that may be of specific interest.

Accounting policies for pensions and other retirement benefits are set out in note 5 to the accounts and details of senior employees' remuneration can be found in section 9 of this annual report.

The Trust's external auditors are appointed by the Board of Governors on a rolling annual basis on a recommendation from the Trust's Audit Committee. The current external auditors are Grant Thornton UK LLP. The Trust's previous auditors RSM Robson Rhodes LLP merged with Grant Thornton UK LLP on the 1 July 2007 and the current appointment transferred with a new letter of engagement. The remuneration for the whole of 2007/08 was £92,120.

In addition Grant Thornton UK LLP undertook waiting list review work during 2007 as part of the Trust's assurance work on waiting list management for a fee of £17,000. This was a separate contained piece of work to provide independent assurance on waiting list figures. Independence was safeguarded by separate teams being used for audit and non-audit services who, to strengthen the independence, were based out of different operating locations and departments.

The Trust's arrangements for countering fraud and corruption are overseen by the Audit Committee with an appointed Local Counter Fraud Specialist reporting directly. This work includes reactive work generated from queries raised through the Trust's policy on Fraud, Financial Irregularity and Corruption and concerns identified through the Trust's process for raising issues of concern. Pro-active work is guided by the National Fraud Initiative and the NHS Counter Fraud and Security Management Service.

3.3 Strategy

An important aspect of work during the summer of 2007 was a review of the Trust's strategy and vision. This work was undertaken with staff, governors and stakeholders.

The Trust's new vision is to be ***"a major healthcare provider in eastern England that is best for patients and great to work for"***, which is complemented by four strategic aims:

- to provide excellent patient care that is stream-lined, integrated, consistent and responsive;
- to extend our catchment population to sustain local clinical services;
- to determine our core services and how they are localised for patients;
- to develop the Foundation Trust as a major player in the City, contributing more to our social responsibilities.

The first of these aims includes a separate patient safety strategy, which is to be launched during spring 2008.

3.4 Future Estate Developments

The Peterborough and Stamford Hospitals NHS Foundation Trust, operates on three main sites, all of which are subject to current and future development.

The Peterborough District Hospital site consists of a number of separate buildings including the main hospital wards with A&E and children's services and a separate maternity unit. The Edith Cavell Hospital is situated 2 miles away and provides planned inpatient, day surgery and diagnostic services.

The Trust has entered into a PFI arrangement to have a single site acute hospital on the Edith Cavell site replacing the current facilities within Peterborough.

This agreement is unique in that it is in partnership with the Peterborough Primary Care Trust and Cambridgeshire and Peterborough Mental Health Partnership NHS Trust. A new City Care Centre is to be provided on the Peterborough District Hospital site for the Primary Care Trust, and a new Mental Health Unit is to be located on the Edith Cavell health campus site. The PFI project deal was agreed with Progress Health on 4 July 2007, with work starting on site almost immediately. The acute hospital will be opening in late December 2010.

Stamford and Rutland Community Hospital is based in Stamford. Following work with the Welland Practice Based Commissioning Group and the Lincolnshire PCT, a joint project manager has been appointed (starting 1 April 2008) to lead the development of an estate and service strategy which aims to secure the future of the hospital as a health campus providing hospital, primary care and social care services.

3.5 Environmental Issues

As the Trust operates from three distinct sites and is also involved in a major building project, the environmental impact of our operation is a key consideration to show that the Trust minimises its impact and promotes sustainability.

The Trust has a successful Travel Options initiative which encourages staff, patients and visitors to use alternative methods of transport rather than driving to the hospitals. This was launched in 2005 to alleviate pressure on parking at the Trust's Hospitals and includes a regular shuttle service and free travel on bus routes that run between the Trust's Peterborough sites; discounted mega-rider bus tickets for unlimited travel in and around Peterborough; the introduction of a daily staff car parking permit for those who do not need daily use of their car; and access to secure bicycle and motorcycle storage. In addition to these schemes, the Trust has also introduced visitor only parking zones and a "park and stride" scheme at the Edith Cavell Hospital for members of staff with extra spaces which are a five minute walk away, and have freed up extra spaces for patients and visitors closer to the hospital.

The Trust was awarded the Travel Plan Excellence Award which was presented to staff at a special ceremony in Cambridge on 22 November, and this is the third year running that an award has been received for the scheme.

To assist with the development of the new healthcare buildings, the Trust also has a well established "Hippo Times" which is distributed to staff and local resident organisations to provide a guide of the progress made for each phase of the construction programme and to communicate changes such as site access and parking arrangements.

The building scheme itself has taken advantage of new building requirements and technologies to ensure that the new facilities will be both energy and waste efficient, as well as meeting standards for single en-suite rooms.

The consideration of Trust operational policies regarding compliance with environmental controls is through the Health, Safety and Environment Committee. These actions are also supported by other considerations such as the purchasing of goods and services that assist the delivery of our healthcare services from local providers where possible.

3.6 Governance Arrangements

This Trust uses guidance from Monitor (the Independent Regulator of NHS Foundation Trusts) and best practice principles to guide governance arrangements. During 2007/08, the Trust has carried out a formal board evaluation undertaken by Whitehead Mann to review both the processes of the board and the skills and development requirements of individual board members. This review is available on the Trust's public internet site (www.peterboroughandstamford.nhs.uk).

This review forms the basis of a board development programme for 2008/09. As well as ensuring best practice for the Board of Directors and Board of Governors, this will encompass the effective running of the Trust's new clinical business unit structure whereby the five current clinical service units have been reshaped into eight clinical business units with joint clinical and general manager leadership. This reorganisation of our

services has been through a detailed operational and management review that has run throughout the year. The two unit structures for 2007/08 and 2008/09 are shown in the table below.

Operational Unit Structure

2007/08 Service Units	2008/09 Clinical Business Units
Medicine Surgery Woman & Child Clinical & Life Support Stamford Hospital	Emergency and Critical Care Medicine: Long Term Conditions Surgery Musculoskeletal Cancer and Specialist Services Family & Public Health Clinical Support Clinical Administration

The Trust has undertaken work to review compliance with both its Terms of Authorisation and the Code of Governance issued by Monitor (www.monitor-nhsft.gov.uk).

Compliance during the year with the Terms of Authorisation has been affected by orthopaedic waiting list breaches which has meant that condition 6(2), regarding compliance with national standards and targets, has been breached. This has seen the Trust given a red governance rating by Monitor throughout the year, whilst improvement work was undertaken to rectify this position. As the breaches have ceased and the Trust works towards achieving the 18 week admitted patient care target for 2008/09 it is expected that this rating will revert to amber and finally to green. A process for compliance with the Terms of Authorisation has also been supplemented by an internal audit review, and an action plan to strengthen systems will be implemented and achieved in 2008/09.

Compliance with the Code of Governance has also been reviewed by the Board of Directors and will be strengthened through a separate action plan and through the board development plan. The board development plan will include work to develop roles and responsibilities for the Trust's leadership structure (Board of Directors, Board of Governors, Clinical Business Unit leads) and confirm partnership development and management.

The Trust has been divergent from the Code of Governance in three areas.

Non-executive and Executive Director Balance (provision A.3.2)

Up to December 2007, the Trust had an equal balance between executive and non-executive directors. The PFI Project Director had overseen the successful completion of contract negotiations and the start of building works on the innovative Greater Peterborough Health Investment Plan. On his resignation the requirement for an executive director lead was reviewed and an associate project director appointed. The Board composition is now consistent with the Code of Governance guidance on greater non-executive director numbers.

Term of Office – Chief Executive (provision C.2.1)

In accordance with best human resources practice, the Chief Executive Officer and executive directors are not subject to a formal reappointment process. There is however a formal annual appraisal process to ensure that performance and development is considered and actions taken as required.

Term of Office – Non-Executive Directors (provision C.2.2)

Prior to the Code of Governance being issued, the Board of Governors had agreed on standard terms of four years for non-executive directors up to a maximum three terms. This is supported by an annual appraisal process, with a rigorous re-appointment process after four years and additional considerations after eight years.

3.7 Equality and Diversity

During 2007/8, under the leadership of the Equality and Diversity Steering Group, the Trust has undertaken an interim review of its published Race Equality Scheme, a formal review of the Disability Equality Scheme with the involvement of service users and has published a Gender Equality Scheme. Equality impact assessments on all Trust

functions and policies have also been undertaken.

The Trust Board made the decision to work towards the implementation of a Single Equality Scheme in the future and this will be the focus for continuing work in 2008/9 as well as the planned full review of the current Race Equality Scheme. As part of the Trust's is commitment to increasing the knowledge and skills of its senior managers in equality and diversity issues, training workshops for senior staff in equality impact assessment tools and techniques will be taking place in June and July 2008.

4. Operating and Financial Review

4.1 Introduction

This report provides a summary of the activities of the Trust for the year on behalf of the Board of Directors.

For 2007/08 the Board of Directors has the following officers:

- Chairman – Dr Clive Morton OBE
- Deputy Chairman and Senior Independent Director – Mr Geoff Clubbe (to 30 November 2007)
- Deputy Chairman – Mr Jonathan Radway (from 1 December 2007)
- Senior Independent Director – Ms Susan Grey (from 1 December 2007)
- Non-Executive Director – Mr Stuart Anderson (from 1 October 2007)
- Non-executive Director – Mr Andy Burroughs
- Non-Executive Director – Ms Susan Grey
- Non-Executive Director – Mr Raza Rahim
- Chief Executive Officer – Mr Nik Patten
- Director of Finance – Mr Christopher Hall
- Director of Nursing – Mrs Chris Wilkinson
- Medical Director – Mr John Randall
- Director of Operations – Mrs Paula Gorst
- Director of Human Resources – Mrs Christine Tolond
- PFI Project Director – Mr St Clair Armitage (to 7 December 2007)

As required by the Trust's terms of authorisation the principal activities for the year has been the provision of health services for the NHS of England.

This report is part of the Trust's Annual Report and Accounts for 2007/08 and as far as the Directors are aware, there is no relevant audit information of which the auditors are unaware and the directors have taken all of the steps that they ought to have taken as directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

The following sections outline patient care, performance, finances, staff engagement, governance and strategy activities for the year. This does not attempt to repeat the information contained in the rest of the report but to summarise the position of the Trust for the year.

4.2 Patient Care

The Trust's aim is to provide excellent patient care, and the year has seen a concentration on cleanliness and infection control. There has been an increase in the standards received through the domestic contract and deep cleaning has been performed in the Trust's high risk areas.

Infection control measures have been increased and scrutinised, and the Trust has been successful in maintaining a low number of MRSA cases throughout the year and containing Clostridium difficile. Further work will be undertaken in 2008/09 to reduce broad spectrum antibiotic prescribing and increase isolation facilities. These two actions are supported by the Intensive Support Team from the Strategic Health Authority (NHS East of England), and by the Healthcare Commission visit to review the Trust's compliance with the Hygiene Code.

Patient safety has been a key theme during the year and the Trust will be launching a patient safety strategy in May 2008 to ensure that this is seen and acted on as the Trust's top priority.

Staffing levels are always seen as a key issue for patient care and the Trust has continued to recruit nursing staff and will continue to do so in the coming year.

The development of services to meet the needs of our patients is supported by good patient, public and member engagement and this has grown throughout the year including additional activities with communities including participation in the Weeks of Action held in areas of greatest need by Peterborough City Council.

There is a clear vision of the future for patient care which involves localising care where possible but centralising where required, and

the Trust is keen to provide services that are integrated with primary care to ensure that patients receive the best care possible. Hospital care in Peterborough has a clear direction with new building facilities that are due to open at the end of 2010 which will ensure higher standards of privacy and dignity for our patients – one of the key areas of concern from the patients' survey.

Key risks to patient care are the development of new infections, which is mitigated by the work of the Trust's Infection Control Team and the potential need to respond to increases in patient demand, which is mitigated by close monitoring and work with the Trust's Primary Care Trust partners.

4.3 Performance

The Trust has seen mixed performance during the year with orthopaedic waiting list breaches dominating the first three quarters of 2007/08, as well as pressures in A&E care and breaches in cancer waiting times. However for A&E care and breaches in cancer waiting times the Trust has reached the required standards across the whole 12 months, and is currently achieving the required 18 week wait standards.

The Trust has reorganised its services into eight Clinical Business Units, with the aim to ensure delegated responsibility for patient care, performance and finance. It will be important that each Clinical Business Unit delivers on its responsibilities. This risk is being mitigated by involvement of the Clinical Business Unit leads in the board development programme and a process of conformance monitoring to hold each unit to account for its own performance.

4.4 Finances

The Trust has had a successful year concerning its financial performance. An income and expenditure surplus of £7.4million has been achieved for the year, better than the original plan of just over £5million.

This has been achieved and supported by a clear focus on finance as an underpinning requirement for investment and the development of patient care (for example good financial performance has meant the ability to invest in the deep cleaning programme).

Income earned on contracts with Primary Care Trusts were higher than originally planned and cost reductions were made which enabled the Trust to accommodate the increases in emergency patient care.

Whilst the year has been a successful one, the risks for the future include the need to achieve further savings, mitigated by clear plans for savings from all units and the adverse impact of changes in tariff and potential consequences of the impact of service changes from the local implementation of the Lord Darzi review. This is being mitigated by early involvement in the consultation process. The potential impact of new contracts with Primary Care Trusts is also being monitored carefully, and negotiations have commenced already for a new contract to be agreed for operation from 1 April 2009.

4.5 Staff Engagement

Staff involvement is a key process throughout the Trust.

There is individual staff engagement in the process of annual appraisals for all staff. This is complemented by a range of staff briefing arrangements. These include a monthly staff briefing process which enables information to cascade throughout the organisation and quarterly briefings on all sites by the Chief Executive as well as quarterly executive briefings carried out by the Directors.

There is also a developing programme of director visits to all areas of the Trust.

The Trust is also supported by strong partnership working with Trade Union representatives in operational and change management issues and through the Trust Joint Consultative Committee arrangements.

The Staff Governors for the Trust have also been active, having visited many departments and held drop-in sessions for staff. Additional work is required in this area and as part of the board development programme, it is envisaged that clear roles and responsibilities for staff governors regarding engagement with staff will be supported.

4.6 Governance

The Trust has seen a number of organisational changes during the year which are supported by governance arrangements. There has been an operational and management review which has seen the number of service units change from five to eight, with the aim of promoting key decision making closer to patients and clear responsibilities for performance within these units.

There has also been a board evaluation and there is to be a board development programme to support the development of the Board of Directors, Board of Governors and Clinical Business Unit leads.

The Trust needs to ensure the successful implementation of the board development programme and the Clinical Business Units. Additional resource is being provided in this area and an external company will be involved within the Trust to aid implementation and evaluate the processes. This will ensure that any issues can be identified and where required rectified as soon as possible.

Together with these changes the Trust will also be ensuring the successful delivery of the new hospital build and the overall Greater Peterborough Health Investment Plan. This is being monitored through a joint risk register and a Chief Executive Project Board. Progress with the development of Stamford Hospital is also a key issue for the coming year and is supported by the joint appointment with the Welland Practice Based Commissioners of a project manager to continue the development work.

4.7 Strategy

The Trust has worked during the year to review and agree a new strategy for the Trust. This has developed a new vision for the Trust to be *"a major healthcare provider in eastern England that is best for patients and great to work for."*

This strategy is supported by four key aims of excellent patient care; extending our catchment; understanding our core services so that we can localise care where possible; and being a major player in the city fulfilling our responsibilities.

There are two key risks to this strategy. Firstly this depends on patients continuing to choose their care from our services, and work will continue throughout the coming year on improving performance, building relationships with GPs and developing services to meet our patients' needs. The second risk to our strategy is the potential impact of the local implementation of the Lord Darzi review, and the Trust will engage early in this consultation to ensure that our services are flexible to respond to these requirements whilst being the services that patients want.

The rest of this report provides additional detail to the highlights outlined above.

5. Board of Governors

The Trust has both a Board of Governors and a Board of Directors.

The Board of Governors has the responsibility to appoint non-executive directors, approve the appointment of the Chief Executive Officer and also the Trust's external auditors. The process for non-executive director appointments and terms of service are detailed in section 6, with details on the attendance of governors serving on the committee, detailed within the table showing governor details.

The Board of Governors need to provide their views on the Trust's strategy to the Board of Directors – a role which has been of significance in this year with the development of the Trust's strategy – and play an important part in being a conduit of information to and from the Trust's membership.

The Directors ensure that they are updated with views from the Governors and the membership through a number of mechanisms. This includes attendance by the directors at the Board of Governors meetings; a joint board meeting (previously on annual basis, but which has now moved to a bi-annual event) between the directors and governors; involvement of the governors in staff briefing activities; and feedback from the membership through targeted questions regarding priorities or specific consultations throughout the year through the members newsletter. There has also been our first annual members meeting (17 April 2008) which will be used as a successful format for future engagement. There is also a Senior Independent Director that the governors can approach regarding any issues or concerns that they would like to be addressed.

The Board of Directors is responsible for the development and delivery of the Trust's strategy and the ongoing operational organisation of the Trust and its performance. The Board of Directors reserves decisions on items to itself for individual revenue commitments of £100,000 or more; contracts for periods of over one year; strategic objectives; acquisition and disposal of land; investment decisions; and major changes in services and forward planning as set out in the Board of Directors' standing orders. All other decisions are delegated to the Chief Executive Officer and Directors to direct as appropriate.

The composition of the Board of Governors is detailed below. The Board of Governors consists of 14 public governors, six staff governors and six partner governors.

Elections for public and staff governors to serve on the Board of Governors were held in August/September 2007 with the results being announced on the 7 September 2007. The Electoral Reform Ballot Services conducted the elections on behalf of the Trust using a single transferable vote system. This was the second set of elections since the formation of the Board of Governors in March 2004. There were 9 vacancies for public governors and 4 vacancies for staff governors. 10 candidates stood in the public governor elections and 5 candidates stood in the staff governor elections.

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

The year started with two existing vacancies for public governors. These were caused by resignations for personal reasons. There were successful elections for the public constituency with all the positions filled at the September elections. However since that date there has been one resignation prior to 31 March 2008 due to ill-health which has been filled by the runner-up in the public elections, and one resignation since the 31 March 2008 due to relocation outside the membership area.

One of our existing public governors, Mr Ken Wright, sadly passed away in September 2007, just before he was due to step down as a governor. His contribution was made over many years as a governor, volunteer and critical friend and always in a cheerful and supporting manner recognised by patients, staff, directors and governors alike.

The year started with two existing vacancies for staff governors. To attract candidates to these places in the elections, a staff governor development programme was initiated to introduce potential future candidates to the workings of the Board of Governors, the roles and responsibilities of governors, and rotation through attendance at governors meetings. This proved successful with all the positions filled at the September elections.

Partner governors have terms of office of three years. There has been one change during the year for the nominated representative of the two Friends organisations of both Peterborough and Stamford Hospitals. There has also been one resignation since the 31 March 2008 for the nominated representative of the volunteers who work across the Trust.

All public 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 on the Trust's internet website (www.peterboroughandstamford.nhs.uk). The details are also available from the office of the Company Secretary who can be contacted on 01733 874174.

Throughout the year 10 Governors have served on the Non-executive Director Remuneration and Terms of Service Committee, the workings of which are detailed in section 6. The elections held during the year account for the change in membership. From the 1 April to 30 September Mrs Broekhuizen, Mr Critchley, Mrs Dixon, Mr Morrison, Dr Moshy, Mrs Stafford with Mrs Stafford as chairman served on the committee; from the 1 October to 31 March Mr Alderton, Mrs Broekhuizen, Mr Beckwith, Mr Morrison, Dr Moshy, Rev Parkes, Mr Proudlock with Mr Morrison as chairman were members.

Governors also have a Governance Committee and a Members Recruitment and Communications Committee. Governors have also been involved in our Patient and Public Involvement Committee, in participating within the local community in Weeks of Action, utilising their own networks to give feedback on issues from our members and the public, and in giving individual talks and presentation on the Trust.

The following paragraphs give information on the individuals who have formed the Board of Governors for 2007/08.

Board of Governors 2007/08

Chairman

Dr Clive Morton OBE

Appointed to 31 March 2008, Dr Morton retired from the position of Chairman on 31 March 2008.

As Chairman of the Board of Directors, Dr Morton also chaired the Board of Governors. Dr Morton's details are listed in section 6.

Dr Morton attended 4 of 4 Board of Governors meetings he was eligible to attend in 2007/08.

Public Governors

Mr Robert Alderton

Term of office to September 2010

Mr Alderton stood for election in September 2007.

Mr Alderton has been a Foundation Trust public member for the past two years and has thirty years experience in NHS senior management.

Mr Alderton attended 2 of 2 Board of Governors and 1 of 2 Remuneration and Terms of Service Committee meetings meetings he was eligible to attend in 2007/08.

Mrs Margaret Anderson

Term of office to September 2010.

Mrs Anderson stood for election in September 2007.

Mrs Anderson is a Chartered Accountant, a member of the Women's Institute and has been Treasurer for the Lincolnshire South Federation of Women's Institutes for many years.

Mrs Anderson attended 2 of 2 Board of Governors meetings she was eligible to attend in 2007/08.

Mr Peter Beckwith

Term of office to September 2010.

Mr Beckwith stood for election in September 2007.

Mr Beckwith is a committee member of the Riverside Practice in March.

Mr Beckwith attended 2 of 2 Board of Governors and 1 of 2 Remuneration and Terms of Service Committee meetings meetings he was eligible to attend in 2007/08.

Mr Mark Bush

Term of office to September 2010

Mr Bush stood for election in September 2007.

Mr Bush is retired from full-time employment after 34 years as an officer in the Royal Navy and 11 years as a speech writer in London local government.

Mr Bush attended 2 of 2 Board of Governors meetings he was eligible to attend in 2007/08.

Mr Ken Craig

Term of office to September 2010.

Mr Craig stood for election in September 2007 and was re-elected as a Public Governor.

Mr Craig is a partner in one of Peterborough's leading accountancy firms, is a chartered tax adviser and heads the firm's specialist team, which advises medical practitioners.

Mr Craig attended 3 of 4 Board of Governors meetings he was eligible to attend in 2007/08.

Mr Mehboots Datoo

Term of office to 30 September 2010

Mr Datoo stood for election in September 2006, and whilst not being immediately elected took the position vacated by Gp Capt (now Air Cdre) Jenkins in November 2006; Mr Datoo also stood for election in September 2007, and took the position vacated by Mr Ian Scrutton. Mr Datoo is a prescribing adviser for Peterborough Primary Care Trust.

Mr Datoo attended 0 of 1 Board of Governors meetings he was eligible to attend in 2007/08.

Mr George Dickens

Term of office to 30 September 2009.

Mr Dickens stood for election in September 2006.

George has spent 40 years working for The Salvation Army, working mainly in financial administration which included being secretary/manager of their multi-million pound pension funds

Mr Dickens attended 4 of 4 Board of Governors meetings he was eligible to attend in 2007/08.

Mr Dorian East

Term of office to September 2010

Mr East stood for election in September 2007.

Mr East is a member of the Cambridgeshire Clinical Priorities Forum and the Trust's Public and Patient Involvement Committee.

Mr East attended 2 of 2 Board of Governors meetings he was eligible to attend in 2007/08.

Mr Brian Hackman

Term of office to September 2010

Mr Hackman stood for election in September 2007.

Mr Hackman worked for Peterborough and Stamford Hospitals from 1972 as a consultant obstetrician and gynaecologist. He has also been County Commander for St John Ambulance in Cambridgeshire for 12 years, as well as a member of the St John Council in London and a trustee of the charity.

Mr Hackman attended 2 of 2 Board of Governors meetings he was eligible to attend in 2007/08.

Mrs Susan Mahmoud

Term of office to 30 September 2009.

Mrs Mahmoud was successfully re-elected in September 2006. Mrs Mahmoud is Chairman of Macmillan Cancer Support Peterborough and a Chairman of the Friends of Peterborough Hospitals.

Mrs Mahmoud attended 2 of 4 Board of Governors meetings she was eligible to attend in 2007/08.

Mr Peter Morrison

Term of office to 30 September 2009. Mr Morrison was also elected as Vice Chairman of the Board of Governors at the meeting held on 17 January 2008.

Mr Morrison stood for election in September 2006.

Mr Morrison has recently retired from 36 years in industry, 32 of which were spent in Peterborough working for Perkins and has expertise in senior financial management including strategic and business planning, risk management and audit.

Mr Morrison attended 3 of 4 Board of Governors meetings and 3 of 3 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Mr Bill Proudlock

Term of office to September 2010

Mr Proudlock stood for election in September 2007.

Mr Proudlock was a non-executive director of Lincolnshire Hospitals for five years and is also a former director of Glaxo Wellcome UK. He is currently chairman of the Pharmaceutical Industry National Training Organisation.

Mr Proudlock attended 2 of 2 Board of Governors meetings and 1 of 2 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Ms Maria Stafford

Term of office to 30 September 2009.

Having retired from a successful business career Ms Stafford was successfully re-elected in September 2006. Ms Stafford is a member of Council and Audit Committee of Sheffield University and non-executive director of Opportunity Peterborough.

Mrs Stafford attended 3 of 4 Board of Governors meetings and 2 of 3 Remuneration and Terms of Service Committee meetings she was eligible to attend in 2007/08.

Mrs Sandra Woodhouse

Term of office to 30 September 2009.

Mrs Woodhouse stood for election in September 2006.

Mrs Woodhouse was active as a volunteer in the community as an assessor of nursing, residential and children's homes in Lincolnshire, and is at present treasurer to Stamford Town Scouts.

Mrs Woodhouse attended 4 of 4 Board of Governors meetings she was eligible to attend in 2007/08.

Mrs Moira Beattie OBE

Mrs Beattie stood down as a public governor on 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.

Mrs Beattie attended 1 of 2 Board of Governors meetings she was eligible to attend in 2007/08.

Mr Arthur Critchley

Mr Critchley stood down as a public governor on 30 September 2007

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

Mr Critchley attended 2 of 2 Board of Governors meetings and 1 of 1 Remuneration and Terms of Service Committee meetings that he was eligible to attend in 2007/08.

Mrs Sarah Dixon Mrs Dixon stood down as a public governor on 30 September 2007 Mrs Dixon was formerly Head Teacher of Peterborough High School. Mrs Dixon attended 2 of 2 Board of Governors meetings and 1 of 1 Remuneration and Terms of Service Committee meetings she was eligible to attend in 2007/08.
Dr Dennis Guttmann Dr Guttmann stood down as a public governor on 30 September 2007 Dr Guttmann was previously a Consultant Physician at the Trust. Dr Guttmann attended 1 of 2 Board of Governors meetings he was eligible to attend in 2007/08.
Mr Ian Scrutton Whilst elected with a term of office to 30 September 2010, Mr Scrutton had to step down due to personal circumstances on 30 October 2007.
Mr Ken Wright Term of office to 30 September 2007 Mr Wright was formerly chairman of the Bretton doctors and Patients Association. While Mr Wright's term of office was to 30 September 2007, he sadly passed away on 27 September 2007. Mr Wright attended 2 of 2 Board of Governors meetings he was eligible to attend in 2007/08.

Staff Governors

Ms Angela Broekhuizen, Associate Director - Projects Term of office to 30 September 2009. Ms Broekhuizen stood for election in September 2006. Ms Broekhuizen attended 3 of 4 Board of Governors and 3 of 3 Remuneration and Terms of Service Committee meetings meetings she was eligible to attend in 2007/08.
Mrs Sue Friend, Project Manager – Stamford Hospital Term of office to 30 September 2009. Mrs Friend stood for election in September 2006 and is also vice-chair of governors for Deeping School. Mrs Friend attended 3 of 4 Board of Governors meetings she was eligible to attend in 2007/08.
Dr Roger Moshy, Consultant Radiologist Term of office to 30 September 2010 Dr Moshy is Chairman of the Association of Early Pregnancy Units, and Director and member of the council of the British Medical Ultrasound Society. Dr Moshy attended 3 of 4 Board of Governors and 2 of 3 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Rev David Parkes, Head of Chaplaincy Services Term of office to 30 September 2010. Rev. Parkes is a trustee of “The Well” counselling service. Rev Parkes attended 2 of 2 Board of Governors meetings and 1 of 2 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.
Mrs Isobel Bird Term of office to 30 September 2010. Mrs Bird attended 2 of 2 Board of Governors meetings she was eligible to attend in 2007/08.
Mr Edward Payne Term of office to 30 September 2010. Mr Payne attended 2 of 2 Board of Governors meetings he was eligible to attend in 2007/08.
Mr N A (Dan) Anandan, Associate Specialist Mr Anandan stood down as a staff governor on 30 September 2007. Mr Anandan attended 2 of 2 Board of Governors meetings he was eligible to attend in 2007/08.

Partner Governors

Mr Kevan Arbon, representing the Friends organisations of the Trust Nomination expires 5 December 2010. Mr Arbon was nominated to succeed Mr Lilliman as a representative of the Friends organisations. Mr Arbon is a Trustee and Vice Chairman of the Friends of Peterborough Hospitals. Mr Arbon attended 1 of 1 Board of Governors meetings he was eligible to attend in 2007/08.
Mrs Angela Bailey, Chief Executive, Peterborough Primary Care Trust Nomination expires on 31 October 2008. Mrs Bailey is also a governor of Papworth Hospital and Director of Gladstone Connect. Mrs Bailey attended 3 of 4 Board of Governors meetings she was eligible to attend in 2007/08.
Air Cdre Paul Evans, Director of Healthcare, Defence Medical Services Department representing the Ministry of Defence Nomination expires on 31 March 2010. Air Cdre Evans is responsible for the commissioning of healthcare for service personnel from other NHS Trusts and occasionally the private sector. He also co-ordinates rehabilitation and mental health services for the armed forces. Air Cdre Evans attended 2 of 4 Board of Governors meetings he was eligible to attend in 2007/08.
Mrs Heather Hanlon representing the Volunteers of the Trust Nomination expires on 31 March 2010. Mrs Hanlon is volunteer co-ordinator at Stamford Hospital and a registered doula providing care and support for mothers both during and after the birth of their babies. Mrs Hanlon attended 2 of 4 Board of Governors meetings she was eligible to attend in 2007/08.

Cllr Diane Lamb, Cabinet Member for Health and Adult Social Care, Peterborough City Council

Nomination expires on 22 May 2009.

Councillor Lamb is vice-chairman of the licensing committee, chair of the licensing act 2003 committee and a member of the employment committee.

Councillor Lamb attended 1 of 4 Board of Governors meetings she was eligible to attend in 2007/08.

Mrs Ellen Smith, Managing Director Provider Services, Lincolnshire Primary Care Trust

Nomination expires 21 December 2009.

Mrs Smith attended 2 of 4 Board of Governors meetings she was eligible to attend in 2007/08.

Mr Michael Lilliman, representing the Friends organisations of the Trust

Mr Lilliman resigned from the Board of Governors on 11 October 2007, prior to the expiry of his nomination on 13 January 2008.

Mr Lilliman attended 3 of 3 Board of Governors meetings he was eligible to attend in 2007/08.

6. Board of Directors

The composition of the Board of Directors is detailed below. As at the 31 March 2008 the Board consisted of seven non-executive (including the chairman) and six executive directors (including the chief executive). This altered upon the retirement of the current chairman on the 31 March, when the current Deputy Chairman became Interim Chairman from the 1 April until the appointment of a new chairman who will take up post on 1 July 2008.

The balance of numbers and appropriate skills required for effective working and leadership is monitored by the Board itself and through the processes for director nomination discussed below. This work has been further complemented during the year by a board evaluation process which has confirmed the skills of the members of the Board of Directors. This report is available on the Trust's public internet site. Actions identified in the report are to be taken forward during 2008/09 by a board development programme. This will confirm and enhance the processes by which the Trust complies with Monitor's Code of Governance, the NHS Foundation Trust equivalent of the Combined Code for the private sector.

The details in the tables below cover the length of service, meeting attendance (including statutory committees) and interests for all directors, including the Chairman, non-executive directors, Chief Executive Officer and executive directors. All non-executive directors are considered to be independent, providing impartial scrutiny at the Board of Directors on decisions and developments. There have been no changes to the interests of the Chairman during the year.

Non-Executive Director Nomination and Remuneration

The appointment of non-executive directors is undertaken by the Board of Governors. This work is carried out by the Non-executive Director Appointments and Terms of Service Committee of the Board of Governors and is chaired by the Vice Chairman (Governor) who presides at Board of Governors meetings on all matters concerning non-executive directors. This committee is composed solely of governors and operates with support and advice from the Trust Chairman, Chief Executive, Director of Human Resources and Company Secretary. The work and recommendations from the committee are ratified by the full Board of Governors. The committee covers both remuneration and nomination functions for non-executive directors as envisaged in the Code of Governance, but in some respects deviates from the code's recommendations as discussed in section 3.

As well as being involved in non-executive director and chairman recruitment activities, the committee met three times during the year with membership and attendance as shown in section 5. In addition a number of meetings were held in regard to the activities surrounding the recruitment of the non-executive directors to replace Mr Hindle and Mr Clubbe and the recruitment of a chairman to replace Dr Morton.

As well as a recruitment process for the replacement of Mr Clubbe, the fulfilment of responsibilities as Deputy Chairman, Chairman of the Audit Committee and Senior Independent Director, were considered. These were allocated amongst existing non-executive directors for a period of one year only. Mr Radway was appointed Deputy Chairman, Mr Rahim was appointed Chair of Audit Committee and Mrs Grey assumed the post of Senior Independent Director.

Appointments for non-executive directors are currently made for a four year term for a maximum of three terms. There is an annual review of performance as noted below and re-appointment is subject to further review. Appointment for a third period would necessitate further review.

The Chairman appraises the non-executive directors, and is in turn appraised by the Vice Chairman (Governor). This appraisal process includes a 360^{o} feedback mechanism completed anonymously for feedback to the recipients from amongst governor and other nominated colleagues together with feedback from the non-executive directors on the Chairman who meet at least annually in the absence of the Chair. Results of non-

executive director appraisals are 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 Vice Chairman (Governor) 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 this committee.

Non-Executive Director Nomination and Remuneration

The non-executive directors, led by the Chairman, have the responsibility for the appointment and terms of service of the executive directors as described below. There have been no executive director appointments in the 2007/08 year.

Board of Directors committees

The tables below give information on all the individuals who have formed the Board of Directors for 2007/08 including attendance at board meetings and the statutory committees (Audit and Remuneration and Terms of Service) of the Board.

The Board has discharged its functions through five committees as detailed below. For 2008/09 these committees will change to take into account recommendations from the board evaluation report and good governance principles.

Remuneration and Terms of Service Committee

The non-executive directors undertake the appointment of the executive directors. Remuneration for the executive directors is undertaken through the Remuneration and Terms of Service Committee of the Board of Directors. This comprises all the non-executive directors. The committee is advised by the Chief Executive and Director of Human Resources who are absent when discussions over their own remuneration or terms of service take place.

This group also maintain an overview regarding succession planning and recruitment for executive directors and therefore acts as the remuneration and nomination functions for executive directors as envisaged in the Code of Governance. 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 Remuneration and Terms of Service Committee are included in the annual accounts and in section 9 of this annual report. The Trust also maintains a register of directors' interests. This is available to view on the Trust's public website with details also available from the office of the Company Secretary who can be contacted on 01733 874174.

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 was chaired by Mr Clubbe, the Deputy Chairman of the Board, with Mr Rahim and Mr Radway as members up to the end of November 2007. From 1 December 2007 Mr Rahim took chair of the committee with Mr Radway and Mr Anderson as members. The committee includes internal and external audit representatives with the Chief Executive, Finance Director and Company Secretary in attendance. The Chief Executive and Finance Director are asked to leave the meeting prior to the end to enable the committee to raise any issues of concern. Attendance is noted in the tables below.

The appointment of the Trust's external auditors is undertaken by the Board of Governors with advice from the Audit Committee. The Trust's external auditors for the 2007/08 year are Robson Rhodes LLP up to 1 July 2007, when they merged with Grant Thornton UK LLP, who continued as external auditors with a new letter of engagement. A tender exercise for the appointment of external auditors is currently being undertaken. A statement regarding the external auditors reporting responsibilities can be found on the following page.

Statement from Grant Thornton UK LLP, external auditors for the Trust

Under the Independent Regulator of Foundation Trusts ("Monitor's") code of audit practice we are responsible for undertaking an audit and reporting whether, in our opinion, the Trust's financial statements represent a true and fair view of the financial position at the balance sheet date. We are also required to reach a formal conclusion on whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

International Standards on Auditing (UK and Ireland) require us to report to those charged with governance, which in the case of the Trust is the Audit Committee, certain matters before giving an opinion on the financial statements, as well as our opinion on whether or not the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.
The principal purposes of communication to those charged with governance are to:

- reach a mutual understanding of the scope of the audit and the respective responsibilities of the auditor and those charged with governance;
- share information to assist both the auditor and those charged with governance with fulfilling their respective responsibilities;
- provide to those charged with governance constructive observations arising from the audit process.

Conformance Committee

This committee considers the financial performance of the Trust and compliance against national performance standards. The committee was chaired by Mr Clubbe, the Deputy Chairman of the Trust with Mr Radway and Mr Rahim as non-executive members together with the Chief Executive, Finance Director and Director of Operations. Since the 1 December 2007 the committee has been chaired by Mr Radway with Mr Anderson as a non-executive member. The committee ensures a systematic focus on the operational performance of each service unit and directorate of the Trust. Other senior managers of the Trust are also in attendance for consideration of their particular service unit or directorate and to assist with specific items such as service tenders. The committee meets monthly.

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 of complaints and other related items. Up to the end of June the committee was chaired by Ms Grey with Mr Burroughs as a non-executive members. Since July Mrs Stark has chaired the meeting with Ms Grey and Mr Burroughs as non-executive members. The Chief Executive, Medical Director, Director of Nursing, Director of Operations, Finance Director and Director of Human Resources are all members of the committee. Other senior managers of the Trust are also in attendance. The committee meets bi-monthly.

Patient and Public Involvement Committee

This committee considers both strategy and high-level initiatives to ensure appropriate patient and public involvement and co-ordinates the many streams of patient and public involvement activity across the Trust. The committee is chaired by Ms Grey with the Director of Nursing and Chief Executive also being members of the committee together with four governors. Other senior managers and lay representatives are also part of the committee, which meets quarterly, but which is currently undergoing revision to its terms of reference.

Board of Directors 2007/08

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. Dr Morton retired on 31 March 2008 having served the Trust for over 11 years.

Dr Morton is has had a range of successful company director positions with over 20 years of achievement. He is an independent adviser and coach on World Class Strategy and Board Development, and leads The Morton Partnership, which specialises in organisational transformation, consulting to boards in the private, public and not-for-profit sectors.

Dr Morton is Chairman of Dermasalve Sciences PLC, Chairman of Sabien Technology Limited, Deputy Chairman of Opportunity Peterborough and Deputy Chairman of D1 Oils, an international bio-diesel producer. He is an associate professor at Middlesex University and a former Vice President of the Institute of Personnel and Development.

Dr Morton is also a successful author. His first book *Becoming World Class* was voted MCA's Best Management Book of the Year in 1994. *Beyond World Class*, concerning economic and social sustainability, was published and acclaimed in 1998. His latest book, *By the Skin of Our Teeth*, on business sustainability, was published in 2003.

Dr Morton attended 12 of 12 Board of Directors and 1 of 1 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Non-Executive Director/Deputy Chairman – Mr Jonathan Radway

Appointment start date 30 August 2005: Appointment end date 29 August 2009

The Board of Governors appointed Mr Radway to a non-executive director vacancy effective from the date shown above. Mr Radway has been Deputy Chairman since the 1 December. Since Dr Morton retired as Trust Chairman on 31 March 2008, Mr Radway has also been Interim Chairman.

Mr Radway is a non-practising barrister and is self-employed as a management consultant currently undertaking work for the Reuniting Europe Programme for the Foreign Office. Previous appointments include being Performance Director for Her Majesty's Courts Service and Justices' Chief Executive for Hertfordshire Magistrates' Courts Service. Employed by the Ministry of Justice he has been a Deputy District Judge (MC) since 1999.

Mr Radway has attended 12 of 12 Board of Directors, 3 of 4 Audit Committee, and 1 of 1 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Non-Executive Director – Mr Stuart Anderson

Appointment start date 01 October 2007: Appointment end date 30 November 2011.

Mr Anderson was appointed to a non-executive director vacancy by the Board of Governors to fully take up the position with a two month overlap period with Mr Clubbe from 1 October 2007. He was therefore not eligible to vote at meetings in October and November.

Mr Anderson is a retired Finance Director from Warmington, who has held a number of director level positions at both Transco and British Gas. More recently he has run his own consultancy specialising in the gas industry, and until April 2006 was an investor and part-time Group Finance Director for Lanara Group Ltd.

Mr Anderson has attended 6 of 6 Board of Directors, 2 of 2 Audit Committees, and 1 of 1 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Non-Executive Director – Mr Andrew Burroughs

Appointment start date 24 April 2006: Appointment end date 23 April 2010.

The Board of Governors appointed Mr Burroughs to a non-executive director vacancy effective from the date shown above.

Mr Burroughs is a self-employed management consultant (Burroughs Lynam Ltd), specialising in the IT and technology sector. His previous roles have included a ten-year spell at Microsoft in a variety of sales and marketing positions, most recently in that part of the business selling to the education sector in Europe, the Middle East and Africa.

Mr Burroughs has attended 10 of 12 Board of Directors and 1 of 1 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

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 above. Ms Grey is the current Senior Independent Director.

Ms Grey has 26 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. Ms grey's mother was a member of the Trust's Patient and Public Involvement Forum.

Ms Grey has attended 11 of 12 Board of Directors and 1 of 1 Remuneration and Terms of Service Committee meetings she was eligible to attend in 2007/08.

Non-Executive Director – Mr Razahusein Rahim

Appointment start date 1 April 2004: Appointment end date 31March 2009

Mr Rahim was a non-executive director of the previous NHS trust, a position he has held since November 2000. Mr Rahim was appointed by the Board of Governors as Chairman of the Audit Committee for a year following Mr Clubbe's retirement.

Mr Rahim is a Fellow of The Institute of Chartered Accountants in England & Wales, and is self-employed running his own accountancy firm. He served as a school governor between 1989 and 2004 for two different schools in Peterborough. Mr Rahim's firm acts for tenants of the Trust who run the Jack in the Box Nursery which is situated on the Peterborough District Hospital site.

Mr Rahim has attended 10 of 12 Board of Directors, 4 of 4 Audit Committee and 1 of 1 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Non-Executive Director – Mrs Caroline Stark

Appointment start date 11 May 2007: Appointment end date 10 May 2011.

Mrs Caroline Stark was appointed as a non-executive director to fill the vacancy left by Mr Hindle and started in post on 11 May 2007.

Mrs Stark's career has included management and directorship roles for organisations as diverse as Customs and Excise and English Nature, where she was Director of Resources until her retirement in September 2006.

Mrs Stark has attended 9 of10 Board of Directors and 1 of 1 Remuneration and Terms of Service Committee meetings she was eligible to attend in 2007/08.

Deputy Chairman – Mr Geoffrey Clubbe (to 30 November 2007)

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 was appointed as Senior Independent Director in March 2007 and retired at the end of his term of office on 30 November 2007.

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.

Mr Clubbe has attended 8 of 8 Board of Directors, 3 of 4 Audit Committee, and 1 of 1 Remuneration and Terms of Service Committee meetings he was eligible to attend in 2007/08.

Executive Directors

Chief Executive – Mr Nik Patten

Mr Patten was appointed as Chief Executive taking up his appointment in February 2007. Mr Patten was previously Director of Planning and Performance Improvement and Interim Deputy Chief Executive at Leeds Teaching Hospitals NHS Trust. He has 20 years' experience in the NHS and has held senior positions at South Tees Hospitals NHS Trust, the NHS Modernisation Agency of the Department of Health, George Eliot NHS Trust and Manor Hospital. Mr Patten is a nominated partner governor for the aspirant Cambridgeshire and Peterborough Mental Health Partnership NHS Foundation Trust.

Mr Patten has attended 12 of 12 Board of Directors meetings for which he was eligible to attend in 2007/08.

Director of Operations – Mrs Paula Gorst

Mrs Gorst was appointed Director of Operations, coming into post in April 2006. She had previously been Associate Director Service Improvement of the Trust and held a senior post at the NHS Modernisation Agency. Mrs Gorst has a clinical background and worked as a nurse for 17 years in paediatrics and critical care.

Mrs Gorst has attended 9 of 12 Board of Directors meetings she was eligible to attend in 2007/08.

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. Mr Hall's wife is a senior internal auditor for the Cambridgeshire Health Internal Audit Service, but performs no audit work for the Trust. Mr Hall's stepson's partner is also an employee of the Trust.

Mr Hall has attended 10 of 12 Board of Directors meetings he was eligible to attend in 2007/08.

Medical Director – Mr John Randall

Mr Randall was appointed Medical Director, coming into post on 1 October 2005. He is a consultant in obstetrics and gynaecology and specialises in reproductive medicine. Mr Randall has a private practice at the Fitzwilliam Hospital and has a non-pecuniary interest in Care Nottingham concerning reproductive medicine and IVF. Mr Randall was previously an associate medical director of the Trust, and together with Mrs Wilkinson, he forms part of the Clinical Directorate of the Trust.

Mr Randall has attended 9 of 12 Board of Directors meetings he was eligible to attend in 2007/08.

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.

Mrs Tolond has attended 11 of 12 Board of Directors meetings she was eligible to attend in 2007/08.

Director of Nursing – Mrs Christine Wilkinson

Mrs Wilkinson was Director of Nursing of the previous NHS trust. Together with Mr Randall she leads the clinical directorate of the Trust. Mrs Wilkinson is also the Director for Infection Prevention and Control. Mrs Wilkinson's estranged husband is an officer of the Royal College of Nursing.

Mrs Wilkinson has attended 11 of 12 Board of Directors meetings she was eligible to attend in 2007/08.

Project Director – Mr St Clair Armitage (to 7 December 2007)

Mr Armitage was appointed Project Director of the NHS Foundation Trust on 12 May 2004. He has experience in the private sector with Catalyst Healthcare of bidding for, and delivery of, Private Finance Initiative projects in the healthcare sector. He previously served in the Royal Navy.

Mr Armitage left his position on 7 December 2007, to take up a position leading a PFI project in Canada.

Mr Armitage attended 8 of 9 Board of Directors meetings he was eligible to attend in 2007/08.

7. Membership

Background

The Trust has had the same form of membership constituencies since authorisation in 2004; a single public membership and single staff membership. Neither of the constituencies are divided by geographical areas and the staff constituency is not sub-divided into particular staff groupings.

The Trust provides district general hospital services to its local communities and does not have a separate patient constituency but does ensure that public membership opportunities are offered and advertised among patients.

All individuals employed by the Trust for 12 months or more are eligible for membership. Members of staff are opted in upon commencement of employment and given the choice to opt out of membership in writing. Staff numbers include Trust employees who are part of the Flexible Working Service.

Anyone aged 16 and above who lives in the Trust's membership catchment area is eligible to become a public member. The catchment is based upon local authority electoral wards. The details of the Trust's catchment can be found in the Trust's constitution which is available on the Trust's public internet site (www.peterboroughandstamford.nhs.uk). The details are also available from the office of the Company Secretary who can be contacted via 01733 874174.

During the year, the Trust considered its eligibility criteria and whilst keeping it the same, it will be reviewing them to ensure it has an appropriate technique to capture the views of a wide-range of members of the public including and especially, younger people.

Trust members are expected to adhere to the principles of NHS Foundation Trust status and the Greater Peterborough Health Investment Plan. The Trust also expects members to be committed to honesty and integrity and the Trust's policy of treating everybody equally regardless of age, race, religion, sexual orientation or disability.

In year activity

The Trust achieved a small membership increase by 31 March 2008. Although the Trust is committed to increasing and retaining membership year in year, the Trust's continuing primary aim for its membership is to engage more frequently and more effectively particularly with harder to reach groups in its catchment area. Thus, the Trust was actively involved in several membership engagement activities throughout the year.

The Trust became a participating partner of the multi-agency Weeks of Action campaign in Peterborough. The campaign is led by the police and the local authority which see areas of social deprivation targeted for a week of activities, events and engagement with local communities. Trust governors volunteered and used the Weeks of Action to promote the Trust, its services, its plans and the benefits of membership.

To respond to the growing number of patients and communities that have English as a second language the Trust started to produce membership materials in foreign languages with a view to expanding the range of material on an on-going basis.

The governor elections that took place in September were very well attended in terms of nominations and polling and the Trust was able to appoint 14 new public and staff governors. The new group of staff governors were elected were very proactive in engaging with members of staff following their appointment.

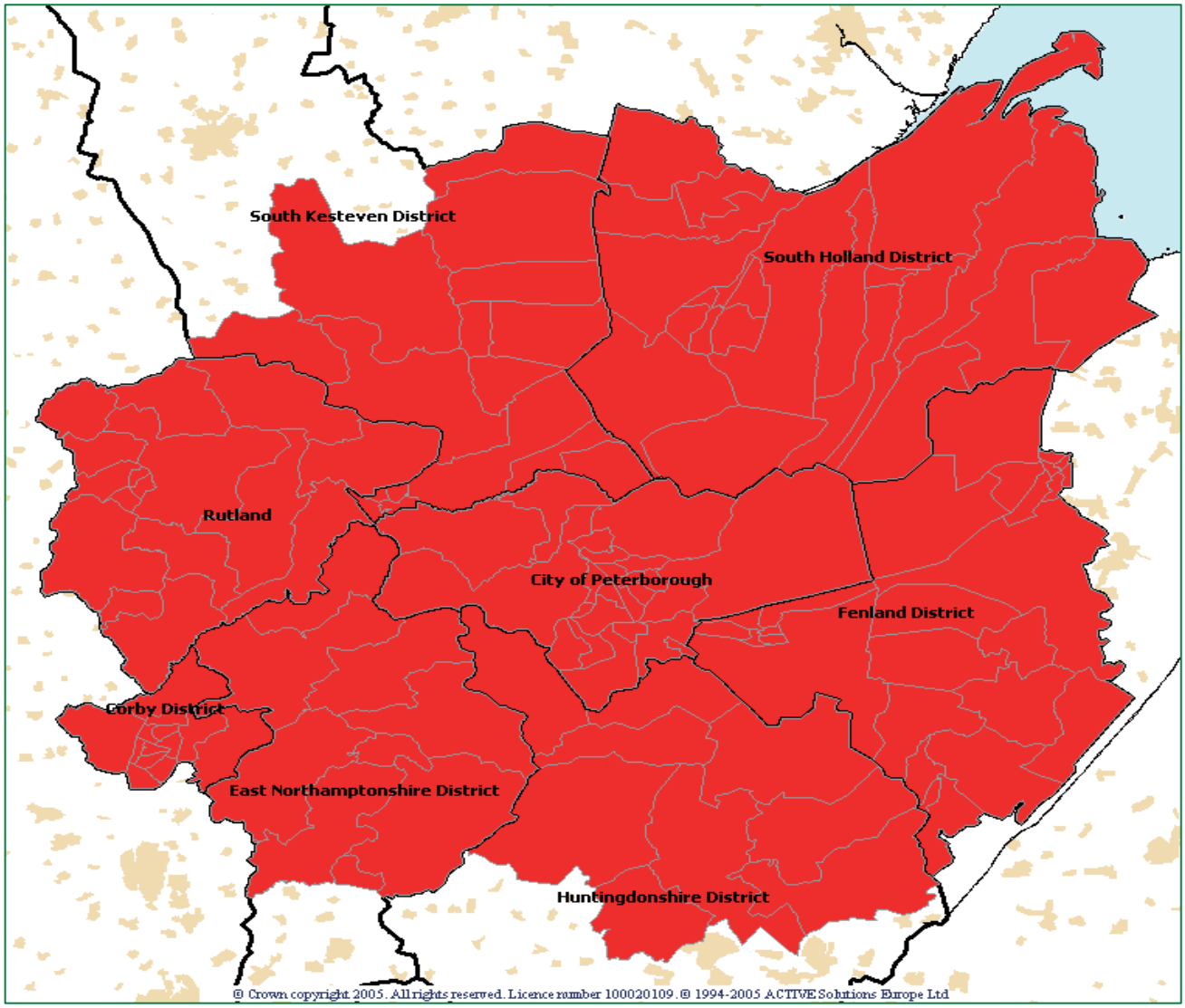
Membership numbers for 2007/08 are shown in the table below.

	1 April 2007	31 March 2008
Public Membership	5,196	5,326
Staff Membership	3,134	3,114
Total	8,330	8,440

To ensure the delivery of the Trust's membership strategy, and that the Foundation Trust members receive the appropriate level of support and service they require, a tender was developed in year that will be awarded during 2008/09. The tender represents the Trust's desire to engage with its membership more intelligently and proactively and to provide a higher level of service to its members.

Members are required to use the Trust's standard procedures if they have any concerns or complaints regarding services that they or a friend or relative has received. The Trust's patient Advice and Liaison Service can be contacted on 01733 875847. However, members also have a dedicated membership line for non-patient care issues – 01733 343221 – and can contact members of the Board of Governors or Board of Directors c/o Company Secretary, Edith Cavell Hospital, Bretton Gate, Peterborough, PE3 9GZ.

Public membership area map



8. Public Interest Disclosures

There is a range of information that will be of interest to members of the public (such as equality processes, financial practice and policies) which are included throughout this report rather than being repeated here. However as the Trust's orthopaedic performance and actions taken to resolve the position and secure future performance are of specific interest these are detailed below.

In January 2007, the Trust became aware of issues with its elective (non-emergency) orthopaedic treatment waiting list. It became apparent that a number of patients had waited, or were going to wait, longer than the government-set maximum target of six months. An investigation was launched immediately.

All of the patients involved were contacted and a public helpline set up. The Trust has worked continuously with its partner primary care trusts to book all of the patients in for their surgery at the earliest opportunity and all breaches were cleared by the end of December. Additional procedures including an access governance programme, to ensure that any concerns on patient data handling can be addressed, waiting list audits and a re-launch of the Trust's policy on raising issues of concern have all been put in place.

The waiting list investigation and board evaluation report are on the Trust's public internet site (www.peterboroughandstamford.nhs.uk). The next stage in the Trust's development is a board development programme which is to run until December 2008 and will cover not only the Board of Directors, but the Board of Governors and the leaders of the Trust's new Clinical Business Units.

9. Remuneration Report

The table below shows the remuneration report for the Trust's Executive and Non-Executive Directors.
Remuneration for the Executive Directors is agreed by the Remuneration and Terms of Service Committee of the Trust's Board of Directors. All the Non-Executive Directors are members of this Committee and attendance is shown in the Non-Executive Director tables in section 6 of this report. This Committee also has advice from the Director of Human Resources and Chief Executive as well as access to external comparisons to ensure appropriate benchmarking.

Remuneration for the Non-Executive Directors is agreed by the Board of Governors on advice from the Non-Executive Directors Appointments and Terms of Service Committee. This Committee consists of Governors as outlined in section 5 of this report. The Committee has advice from the Chairman, Director of Human Resources, Chief Executive and Company Secretary and has access to external comparisons to ensure appropriate benchmarking.

The processes are consistent with good practice as outlined in Monitor's Code of Governance.

Nik Patten

Chief Executive

Remuneration Details
(section 4.3 Annual Accounts 2007/2008)

Name and Title		Remuneration		Pension Rights as at Age 60		Increase Arising in 2007/08 whilst employed by Peterborough & Stamford NHS Foundation Trust		Cash Equivalent Transfer Value as at 31/03/07	Cash Equivalent Transfer Value as at 31/03/08	Real Increase in CETV as funded by Peteborough & Stamford NHS Foundation Trust during 2007/08
		Salary £000	Other £000	Accrued £	Lump Sum £	Accrued £	Lump Sum £	£	£	£
2007/08		(bands of £5000)								
Stuart Anderson	Non-executive Director (commenced 01/10/07)	5-10	Nil			Non executive directors do not have a pensionable position				
St Clair Armitage	Project Director (left 25/12/07)	75-80	Nil	5289	15867	1006	3019	68886	89771	13414
Andy Burroughs	Non-executive Director	10-15	Nil			Non executive directors do not have a pensionable position				
Geoffrey Clubbe	Non-executive Director (left 30/11/07)	5-10	Nil			Non executive directors do not have a pensionable position				
Paula Gorst	Operations Director	90-95	Nil	33408	100225	5481	16444	368625	468322	63336
Susan Grey	Non-executive Director	10-15	Nil			Non executive directors do not have a pensionable position				
Christopher Hall	Finance Director	100-105	Nil	29517	88551	4039	12116	311115	381691	43959
Clive Morton	Chairman (left 31/03/08)	35-40	Nil			Non executive directors do not have a pensionable position				
Nicholas Patten	Chief Executive Officer	140-145		57190	171569	4172	12517	799136	910241	63788
Jonathan Radway	Non-executive Director	10-15	Buk			Non executive directors do not have a pensionable position				
Raza Rahim	Non-executive Director	10-15	Nil			Non executive directors do not have a pensionable position				
John Randall	Medical Director	10-15	70-15	40202	120607	8110	24331	487727	644904	101488
Caroline Stark	Non-executive Director (commenced 11/05/07)	10-15	Nil			Non executive directors do not have a pensionable position				
Christine Tolond	Director of Human Resources	85-90	Nil	33254	99762	1045	3135	551937	584488	13127
Christine Wilkinson	Director of Nursing	85-90	Nil	26068	78204	1957	5870	334073	379598	26021

10 Statement of Accounting Officer's Responsibilities

Statement of the Chief Executive's Responsibilities as the Accounting Officer for Peterborough and Stamford Hospitals NHS Foundation Trust

The National Health Service Act 2006 designates the Chief Executive of an NHS Foundation Trust as the Accounting Officer.

The relevant responsibilities of the Accounting Officer, including their 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 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

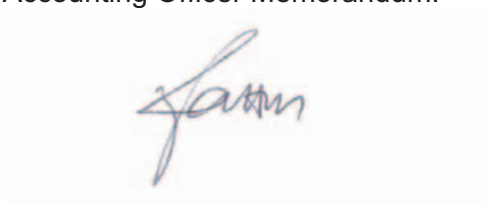
Under the National Health Service Act 2006, Monitor has directed Peterborough and Stamford Hospitals NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of Peterborough & Stamford Hospitals NHS Foundation Trust and of its income and expenditure, balance sheet, total recognised gains and losses and cashflows 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 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 taking reasonable steps for the prevention and detection of fraud and other irregularities.

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



N Patten, Chief Executive

Statement of Directors' Responsibilities in Respect of the Accounts

The directors are required under the National Health Service Act 2006, and as directed by Monitor, the Independent Regulator for NHS Foundation Trusts, to prepare Accounts for each financial year.

Monitor, with the approval of HM Treasury, directs that these Accounts shall show, and give a true and fair view of the NHS Foundation Trust's gains and losses, cash flow and financial state at the end of the financial year. Monitor further directs that the Accounts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these Accounts, the directors are required to:

- apply on a consistent basis, for all items considered material in relation to the Accounts, accounting policies contained in the NHS Foundation Trust Financial Reporting Manual issued by Monitor;

- make judgements and estimates which are reasonable and prudent; and ensure the application of all relevant accounting standards, and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the Accounts.

The directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for the published accounts.

The directors are also responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief, they have complied with the above requirement in preparing the Accounts.

By Order Of The Board Of Directors

N Patten, Chief Executive
Date: 3 June 2008

C A Hall, Finance Director
Date: 3 June 2008

11. Statement on Internal Control

Scope of responsibility

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

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 only, therefore, 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 policies, aims and objectives of the Peterborough and Stamford Hospitals NHS Foundation Trust. The process involves the evaluation of the likelihood of these risks being realised, and their impact, should they be realised, and to manage these risks efficiently, effectively and economically. The system of internal control has been in place at the Peterborough and Stamford Hospitals NHS Foundation Trust for the year ended 31 March 2008, and up to the date of the approval of the annual report and accounts.

Capacity to handle risk

The Medical Director is operationally responsible for leading the risk management process, supported by the Governance and Risk Management Department. Three key posts are identified regarding the management of risk. These are the Assistant Director - Clinical Standards; the Assistant Director - Risk and Occupational Health; and the Litigation Services Manager. They are supported by the Patient Services Department, and Patient Advice Liaison Service (PALS), which provide information from formal and informal complaints. Together these posts are responsible for:

- communicating and co-ordinating the process of risk management throughout the Trust;
- supporting the development of Directorate and Service Unit risk/governance groups to identify and manage risk at local level;
- acting as a central reference point for all risk management issues;
- co-ordinating the management of all risk activities throughout the Trust;
- educating and stimulating Trust staff to take an active role in the identification and reduction of risk, and in particular,- training and supporting risk representatives and risk officers;
- co-ordinating the Trust's implementation of controls assurance;
- ensuring full and prompt reporting of all actual and near-miss incidents, and ensuring the necessary action is taken;
- investigating incidents where appropriate and facilitating or undertaking root cause analysis for more serious incidents to ensure that lessons are learned and changes implemented;
- liaising with statutory and other official bodies, for example the Health and Safety Executive, the NHS Litigation Authority and the Coroner;
- managing claims (clinical negligence, employer's and public liability, property losses) quickly, economically and effectively so as to minimise the financial and other potential negative consequences (for example, distress to the claimant, negative publicity and so on);
- ensuring the Trust has appropriate and adequate insurance arrangements for clinical negligence, employer's and public liability, property and other third party and professional liabilities;
- acting as a central source of information on risk issues and distributing this information as necessary; and
- ensuring that the Trust has policies, procedures and plans in place to manage

risk, that reflect the latest guidance, comply with statutory requirements and are audited formally where reasonably practicable.

Guidance and training are provided to staff through induction, annual refresher and specific risk management training; wider management training; MHRA and NHS Estates Hazard/Safety Notices; the 'Risky Times' bulletin; policies and procedures; information on the Trust's intranet; feedback from audits, inspections and incidents; the Healthcare Governance annual general meeting. Included within all of this is the sharing of good practice and learning from incidents.

The risk and control framework

The Trust has in place a committee of the Board of Directors known as the Healthcare Governance Committee to oversee all aspects of risk and clinical governance. The committee met every two months in 2007/08. The committee is chaired by a Non-Executive Director, with appropriate membership from the Board of Directors and other senior clinical and managerial staff. The committee has responsibility for:

- developing, maintaining and reporting on the Trust's Risk Strategy;
- ensuring the adequacy of systems for quality assurance, managing risk and the control environment in all areas not covered by the Audit Committee;
- providing a committee structure that supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and reported to the Board;
- taking steps to ensure that the Trust meets all relevant statutory and regulatory obligations;
- approving the development plans for improvement in clinical quality and effectiveness;
- advising the Board on quality and risk considerations relevant to the agreement of strategic objectives and investment priorities;
- ensuring that integrated performance reports to the Board include an adequate range of risk indicators and that these form part of the Trust's systems for performance management;
- monitoring the Board Assurance Framework and escalating significant issues arising from it to the Board of Directors, where not covered by the Audit Committee;
- receiving regular high level reports from appropriate groups in order to form an overview of all dimensions of clinical service quality;
- addressing any serious and sustained failure to meet minimum clinical standards where this cannot be resolved through line management or professional self-regulation;
- ensuring the adequacy of arrangements for professional self-regulation, in so far as they are locally determined;
- reviewing guidance from NICE and the Healthcare Commission and the response of the Trust; and
- promoting effective liaison between the Trust and providers of clinical education and research.

The Trust has a well-documented Risk Management Strategy and Policy.

The Trust also has in place a committee of the Board of Directors known as the Conformance Committee, to oversee all aspects of conformance and performance. This committee is chaired by a Non-Executive Director, with appropriate membership from the Board of Directors and senior management staff. This committee has responsibility for:

- reviewing the Trust's annual and long-term business plans and budgets, and confirming that the Trust Executive team has produced them in line with the Board's strategic objectives, and has identified the resources required, and the source of those resources, to deliver the plans;
- receiving the income and expenditure, trading update, balance sheet, cash flow, balanced scorecard and service unit and directorate conformance reports on a monthly basis, ensuring that the Trust is conforming with its terms of authorisation and other regulatory requirements;
- receiving human resources and health and safety information on a quarterly basis to ensure that the Trust is conforming with national targets and statutory duties;
- reviewing and considering for approval by the Board of Directors business cases for

services or capital investment with a value in excess of £100,000 (i.e. where the value exceeds the limit of authority delegated by the Board to the Chief Executive);
- reviewing all proposed new major contracts (in excess of £100,000 or lasting more than a year) and making recommendations to the Board on their approval or otherwise;
- considering all matters of a corporate governance nature that could have an impact on the Trust and making recommendations to the Board of Directors and / or the Audit Committee; and
- ensuring that the Trust fulfils all the internal and external conformance requirements (does what it has to do) to enable it to focus on what it wants to do to meet local priorities.

The Board of Directors sets the strategic direction of the Trust, working with the Board of Governors and liaising with members, and monitors progress. During last year, the Board of Directors has worked with the Board of Governors to review the existing strategy, and set a new strategy for the organisation through to 2013. The review and development work included a number of workshops involving members, stakeholders, staff and governors, facilitated by expert advisors.

The Trust works closely with the Peterborough Primary Care Trust and the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, especially through the Project Board directing the Greater Peterborough Health Investment Plan.

The Trust engages with Monitor, the Independent Regulator for NHS Foundation Trusts, and other local organisations, including the East of England Strategic Health Authority, and local Overview and Scrutiny Committees, through regular planned meetings and performance reviews, and ad-hoc meetings as necessary.

Sound working relationships with these other key organisations enables information to be shared and provides opportunities for joint-working to identify, understand and resolve issues that might impact on the services we provide. The Trust has continued to work closely with Monitor on a number of issues. These have included the Trust's annual plan, confirming progress on financial performance, and remedial action to deal with a significant failure in respect of waiting times in the orthopaedics specialty. The Trust has also worked with Monitor to carry out independent reviews of the Trust's governance and Board of Directors arrangements.

The Trust's strategy for managing its risks is to:
- adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the Trust's risk management policy;
- manage risk as part of normal line management responsibilities and provide funding to address risk issues, based on a moderated risk assessment, as part of the normal business planning process;
- undertake risk assessments on existing, new and proposed activities to ensure that significant risks are identified, assessments are made of their potential frequency and severity, control measures are implemented, risks are always minimised and risks are recorded on the Trust's risk registers;
- use the risk registers to inform the Trust's business planning and investment decision-making so that informed decisions are made in the full knowledge of the level of risk;
- record the results of risk assessments in the Trust' risk registers and use them to ensure that any decision to accept risk is taken at the appropriate level in the Trust;
- use internal and external audit and other independent and regulatory and assessment bodies to provide assurance that risk is being managed appropriately; and
- the Trust will integrate the risk registers into a combined document.

Within each clinical Service unit there is a governance group, and in the non-clinical units a risk group, whose role is to ensure that:
- risks within the unit are identified through a process of risk assessment, prioritised,

minimised and, where possible, eliminated;
- the importance of managing risks is communicated to all staff within the unit;
- the Healthcare Governance Committee is made aware of any unacceptable risks that cannot be managed within the service unit; and
- data from incidents, claims and complaints are reviewed to identify and trends or areas for retrospective action.

Managers are responsible for ensuring effective risk management within their own area. A large number of staff have been trained across the Trust to undertake risk assessment in their own areas of work and to report these to their managers.

All staff are expected to: provide safe clinical practice in diagnosis and treatment; report incidents and near misses; be familiar with the Trust's Risk Management Strategy and departmental risk issues; comply with Trust policies and procedures and take reasonable care of their own safety and the safety of others.

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

The framework for obtaining assurance on the management of risk at the Trust includes:
- identifying and managing risks, in particular those that affect the achievement of the Trust's principle objectives, or following assessment and implementation of all practical control measures remain as significant risks;
- the use of the risk register to prioritise and manage risk so that appropriate investment decisions can be made;
- commissioning specific internal and external audit reports and opinions;
- compliance with Healthcare Commission requirements and inspection visits;
- accreditation levels achieved with the Clinical Negligence Scheme for Trusts and the Risk Pooling Scheme for Trusts;
- progress towards and achievement of risk-related targets, completion of annual risk audits; and
- compliance with the requirements of Monitor, the Health and Safety Executive and other independent regulatory bodies.

On major projects, such as the Greater Peterborough Health Investment Plan for the redevelopment of health facilities, the public have been directly involved in the evaluation criteria for the project. Members of the public are reminded about managing their own risks through warning signs and notices as appropriate on the Trust's premises, and through their participation as patients in the consent process.

Information governance assurance review of person identifiable data transfers

The Board put in place arrangements for obtaining assurance on the security of bulk transfers of person identifiable data. Bulk transfer data has been defined by the Department of Health as comprising more than 50 records transferring from one medium to another, or from one system or geographical location to another. Work undertaken in the Trust was considered by the Board in January and February 2008. The Board confirmed that no high risk bulk transfers of patient data had been identified, and that the necessary measures and mechanisms are in place, and have been reconfirmed to all staff, to safeguard the transfer of patient data and to minimise the risk of loss or error.

The review work identified a number of other areas, judged to be low risk, but where action had been or would be taken to reduce the risk of loss or error further. Such areas had not been highlighted by the Department of Health or Monitor, but the Board felt it would be good practice and good governance to make further improvements where possible and appropriate. These areas were set out in the form of an action plan.

The Board of Directors confirmed to Monitor that it "had reviewed the systems and

procedures for securing personal data, including patient data in transit, and confirms that it is satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998, with the possible exception of the specific matters highlighted on the attached review summary and action plan".

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

As Accounting Officer, I have responsibility for reviewing the economy, efficiency and effective use of resources. This is done in a number of ways:

- Regular review of financial performance by the Board of Directors, Audit Committee and Conformance Committee;
- Reports by internal and external audit on the use of the Trust's resources;
- Participation in benchmarking studies undertaken by the Audit Commission, the Healthcare Commission and other external bodies;
- Use of benchmarking and other comparative data to provide assurance and inform and guide improvement in financial and clinical performance;
- Engagement of independent advisors to review and evaluate specific patient services and areas of the Trust's business. Examples for 2007/08 include reviews of theatre management and organisation, medical manpower, nurse rostering, medical equipment and renal services.
- The Trust's service improvement team supports a number of key projects, agreed by the Board of Directors, which are designed to reduced costs whilst improving clinical and operational efficiency;
- Listening and responding to matters raised by staff, members, Governors and patients.

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of its effectiveness is informed by the work of the internal auditors and the executive managers within the 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, the Audit Committee, the Healthcare Governance Committee and a process to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:
- the opinion of the Chief Internal Auditor;
- the Board Assurance Framework;
- the regular accreditation visits from the NHS Litigation Authority in respect of the Clinical Negligence Scheme for Trusts and the Risk Pooling Scheme for Trusts. For both schemes, the level one accreditation was retained for all areas, but for maternity services the significantly higher level two accreditation was retained.
- the reports on governance and Board of Directors' arrangements prepared by independent advisors.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by the following:
- The Board of Directors, which has responsibility for setting the overall direction, agreeing the Trust's principal objectives, assessing and managing strategic risks to the development of those objectives and monitoring progress;
- The work of the Audit Committee, Conformance Committee and Healthcare Governance Committee;
- The programme of work undertaken by internal audit.
- Reports on governance and Board of Directors' arrangements.

There has been continued focus on improving the financial position of the Trust, as evidenced by:
- The formulation of a robust financial plan for 2007/08 and forward projections;
- The formulation and delivery on the Fit For The Future savings programme, with the first phase of cost reductions achieved in

2006/07 and the second phase achieved in 2007/08;
- Close monitoring of financial performance and delivery on savings plans through the Trust executive team, Conformance Committee, Audit Committee and Board of Directors;
- Maintaining cash flow and liquidity and confirming a working capital facility with our bankers, approved by Monitor, and judged by the Board to provide sufficient headroom going forward;
- The achievement of a financial risk rating of '4' (better than average), with a further improvement to a financial risk rating of '5' (best possible score) under Monitor's compliance framework in the year;
- The conclusion, by the Healthcare Commission, in the summer of 2007 that the Trust's use of resources was 'excellent'.

The Healthcare Commission also concluded, as part of its work in the summer of 2007 on the Trust's 'Annual Health Check', that the quality of the Trust's clinical services was 'fair'. Linked with this, Monitor continued to award the Trust a red risk rating for governance throughout 2007/08, driven by the failure to achieve a maximum inpatient waiting time of six months in orthopaedics, and by Monitor's broader concerns in respect of the Trust's governance and Board of Directors' arrangements. These matters were also reported to the Healthcare Commission with the Trust declaring non-compliance on core standard C18.

The Trust has worked closely with Monitor on these matters, ensuring that no patients were waiting longer than six months for inpatient treatment in January 2008.

The Trust has focused on the development of improved arrangements relating to information governance and data quality, including the following key actions:
- Delivery on the action plan arising from the recommendations from the investigation into waiting list management in Orthopaedics;
- Further external review work by the Trust's external auditors and by specialist advisors from the Department of Health;
- Internal Audit reviews to test systems and mechanisms to provide assurance to the Board on the accuracy and completeness of data recording and the accuracy of information being presented to the Board;
- Participation in the national programme of work led by the Audit Commission to provide assurance on the clinical coding of activity, and compliance with the Department of Health's "payment by results" arrangements;
- Incorporation of rolling verification programme for waiting list data and other key performance indicators into the Internal Audit plan for 2008/09.

Given the recovery from the orthopaedic waiting list issue, the main risk identified is to ensure that the Board of Directors has assurance on the performance and management information systems on which the reporting of service delivery is based. Systems have been revised and audit used to verify waiting list reporting; there are also processes for access and information governance to provide separate assurance.

As part of the organisational development referred to above, the Board of Directors will need to be assured that the revised Conformance Committee process provides scrutiny and assurance on service delivery. The Conformance Committee will be able to review the work undertaken on the forecasting and modelling for the achievement of performance targets. These arrangements will enable the directors to be assured on forecasting of future activity and performance, and enable the governors, Monitor and other external stakeholders to have confidence in the reported achievements.

An external consultancy, Whitehead Mann, carried out an independent review of governance and Board of Directors' arrangements in January and February 2008, interviewing all directors, attending Board and committee meetings and reviewing Board documentation. A list of action points has been produced by Whitehead Mann, covering how the Trust can improve its governance arrangements and Board effectiveness. The full report is available through the Trust's website (www.peterboroughandstamford.nhs.uk - under publications and called "Board Evaluation Report) or from the Company Secretary. The Board of Directors is taking

the appropriate action, and has appointed Whitehead Mann to facilitate and support a further phase of governance and Board development.

Nik Patten, Chief Executive Officer,
June 2008.

Peterborough and Stamford Hospitals
NHS Foundation Trust

AUDITED ANNUAL ACCOUNTS

FOR THE

FINANCIAL YEAR

ENDED 31 MARCH 2008

STATEMENT OF THE CHIEF EXECUTIVE'S RESPONSIBILITIES AS THE ACCOUNTING OFFICER FOR PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

The *National Health Service Act 2006* designates the Chief Executive of an NHS Foundation Trust as the Accounting Officer.

The relevant responsibilities of the Accounting Officer, including their 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 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the *National Health Service Act 2006*, Monitor has directed Peterborough and Stamford 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 Peterborough & Stamford Hospitals NHS Foundation Trust and of its income and expenditure, balance sheet, total recognised gains and losses and cashflows 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 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 taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

N Patten, Chief Executive
3 June 2008

STATEMENT OF DIRECTORS' RESPONSIBILITIES IN RESPECT OF THE ACCOUNTS

The directors are required under the *National Health Service Act 2006*, and as directed by Monitor, the Independent Regulator for NHS Foundation Trusts, to prepare Accounts for each financial year.

Monitor, with the approval of HM Treasury, directs that these Accounts shall show, and give a true and fair view of the NHS Foundation Trust's gains and losses, cash flow and financial state at the end of the financial year. Monitor further directs that the Accounts shall meet the accounting requirements of the NHS Foundation Trust Financial Reporting Manual that is in force for the relevant financial year, which shall be agreed with HM Treasury.

In preparing these Accounts, the directors are required to:

- apply on a consistent basis, for all items considered material in relation to the Accounts, accounting policies contained in the NHS Foundation Trust Financial Reporting Manual issued by Monitor;
- make judgements and estimates which are reasonable and prudent; and
- ensure the application of all relevant accounting standards, and adherence to UK generally accepted accounting practice for companies, to the extent that they are meaningful and appropriate to the NHS, subject to any material departures being disclosed and explained in the Accounts.

The directors are responsible for keeping proper accounting records which disclose, with reasonable accuracy, at any time the financial position of the Trust. This is to ensure proper financial procedures are followed, and that accounting records are maintained in a form suited to the requirements of effective management, as well as in the form prescribed for the published accounts.

The directors are also responsible for safeguarding all the assets of the Trust, including taking reasonable steps for the prevention and detection of fraud and other irregularities.

The directors confirm to the best of their knowledge and belief, they have complied with the above requirement in preparing the Accounts.

By Order Of The Board Of Directors

N Patten, Chief Executive
3 June 2008

C A Hall, Finance Director
3 June 2008

STATEMENT ON INTERNAL CONTROL

Scope of responsibility

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

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 only, therefore, 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 policies, aims and objectives of the Peterborough and Stamford Hospitals NHS Foundation Trust. The process involves the evaluation of the likelihood of these risks being realised, and their impact, should they be realised, and to manage these risks efficiently, effectively and economically. The system of internal control has been in place at the Peterborough and Stamford Hospitals NHS Foundation Trust for the year ended 31 March 2008, and up to the date of the approval of the annual report and accounts.

Capacity to handle risk

The Medical Director is operationally responsible for leading the risk management process, supported by the Governance and Risk Management Department. Three key posts are identified regarding the management of risk. These are the Assistant Director - Clinical Standards; the Assistant Director - Risk and Occupational Health; and the Litigation Services Manager. They are supported by the Patient Services Department, and Patient Advice Liaison Service (PALS), which provide information from formal and informal complaints. Together these posts are responsible for:

- communicating and co-ordinating the process of risk management throughout the Trust;
- supporting the development of Directorate and Service Unit risk/governance groups to identify and manage risk at local level;
- acting as a central reference point for all risk management issues;
- co-ordinating the management of all risk activities throughout the Trust;
- educating and stimulating Trust staff to take an active role in the identification and reduction of risk, and in particular,- training and supporting risk representatives and risk officers;
- co-ordinating the Trust's implementation of controls assurance;
- ensuring full and prompt reporting of all actual and near-miss incidents, and ensuring the necessary action is taken.

STATEMENT ON INTERNAL CONTROL

Capacity to handle risk (continued)

- investigating incidents where appropriate and facilitating or undertaking root cause analysis for more serious incidents to ensure that lessons are learned and changes implemented;
- liaising with statutory and other official bodies, for example the Health and Safety Executive, the NHS Litigation Authority and the Coroner;
- managing claims (clinical negligence, employer's and public liability, property losses) quickly, economically and effectively so as to minimise the financial and other potential negative consequences (for example, distress to the claimant, negative publicity and so on);
- ensuring the Trust has appropriate and adequate insurance arrangements for clinical negligence, employer's and public liability, property and other third party and professional liabilities;
- acting as a central source of information on risk issues and distributing this information as necessary; and
- ensuring that the Trust has policies, procedures and plans in place to manage risk, that reflect the latest guidance, comply with statutory requirements and are audited formally where reasonably practicable.

Guidance and training are provided to staff through induction, annual refresher and specific risk management training; wider management training; MHRA and NHS Estates Hazard/Safety Notices; the 'Risky Times' bulletin; policies and procedures; information on the Trust's intranet; feedback from audits, inspections and incidents; the Healthcare Governance annual general meeting. Included within all of this is the sharing of good practice and learning from incidents.

The risk and control framework

The Trust has in place a committee of the Board of Directors known as the Healthcare Governance Committee to oversee all aspects of risk and clinical governance. The committee met every two months in 2007/08. The committee is chaired by a Non-Executive Director, with appropriate membership from the Board of Directors and other senior clinical and managerial staff. The committee has responsibility for:

- developing, maintaining and reporting on the Trust's Risk Strategy;
- ensuring the adequacy of systems for quality assurance, managing risk and the control environment in all areas not covered by the Audit Committee;
- providing a committee structure that supports the risk management accountability arrangements within the organisation and ensures that all significant risks are properly considered and reported to the Board;
- taking steps to ensure that the Trust meets all relevant statutory and regulatory obligations;
- approving the development plans for improvement in clinical quality and effectiveness;
- advising the Board on quality and risk considerations relevant to the agreement of strategic objectives and investment priorities;

STATEMENT ON INTERNAL CONTROL

The risk and control framework (continued)

- ensuring that integrated performance reports to the Board include an adequate range of risk indicators and that these form part of the Trust's systems for performance management;
- monitoring the Board Assurance Framework and escalating significant issues arising from it to the Board of Directors, where not covered by the Audit Committee;
- receiving regular high level reports from appropriate groups in order to form an overview of all dimensions of clinical service quality;
- addressing any serious and sustained failure to meet minimum clinical standards where this cannot be resolved through line management or professional self-regulation;
- ensuring the adequacy of arrangements for professional self-regulation, in so far as they are locally determined;
- reviewing guidance from NICE and the Healthcare Commission and the response of the Trust; and
- promoting effective liaison between the Trust and providers of clinical education and research.

The Trust has a well-documented Risk Management Strategy and Policy.

The Trust also has in place a committee of the Board of Directors known as the Conformance Committee, to oversee all aspects of conformance and performance. This committee is chaired by a Non-Executive Director, with appropriate membership from the Board of Directors and senior management staff. This committee has responsibility for:

- reviewing the Trust's annual and long-term business plans and budgets, and confirming that the Trust Executive team has produced them in line with the Board's strategic objectives, and has identified the resources required, and the source of those resources, to deliver the plans;
- receiving the income and expenditure, trading update, balance sheet, cash flow, balanced scorecard and service unit and directorate conformance reports on a monthly basis, ensuring that the Trust is conforming with its terms of authorisation and other regulatory requirements;
- receiving human resources and health and safety information on a quarterly basis to ensure that the Trust is conforming with national targets and statutory duties;
- reviewing and considering for approval by the Board of Directors business cases for services or capital investment with a value in excess of £100,000 (ie. where the value exceeds the limit of authority delegated by the Board to the Chief Executive);
- reviewing all proposed new major contracts (in excess of £100,000 or lasting more than a year) and making recommendations to the Board on their approval or otherwise;
- considering all matters of a corporate governance nature that could have an impact on the Trust and making recommendations to the Board of Directors and / or the Audit Committee; and
- ensuring that the Trust fulfils all the internal and external conformance requirements (does what it has to do) to enable it to focus on what it wants to do to meet local priorities.

STATEMENT ON INTERNAL CONTROL

The risk and control framework (continued)

The Board of Directors sets the strategic direction of the Trust, working with the Board of Governors and liaising with members, and monitors progress. During last year, the Board of Directors has worked with the Board of Governors to review the existing strategy, and set up a new strategy for the organisation through to 2013. The review and development work included a number of workshops involving members, stakeholders, staff and governors, facilitated by expert advisors.

The Trust works closely with the Peterborough Primary Care Trust and the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, especially through the Project Board directing the Greater Peterborough Health Investment Plan.

The Trust engages with Monitor, the Independent Regulator for NHS Foundation Trusts, and other local organisations, including the East of England Strategic Health Authority, and local Overview and Scrutiny Committees, through regular planned meetings and performance reviews, and ad-hoc meetings as necessary.

Sound working relationships with these other key organisations enables information to be shared and provides opportunities for joint-working to identify, understand and resolve issues that might impact on the services we provide. The Trust has continued to work closely with Monitor on a number of issues. These have included the Trust's annual plan, confirming progress on financial performance, and remedial action to deal with a significant failure in respect of waiting times in the orthopaedics specialty. The Trust has also worked with Monitor to carry out independent reviews of the Trust's governance and Board of Directors arrangements.

The Trust's strategy for managing its risks is to:

- adopt an integrated approach to risk management, whether the risk relates to clinical, organisational, health and safety or financial risk, through the processes and structures detailed in the Trust's risk management policy;
- manage risk as part of normal line management responsibilities and provide funding to address risk issues, based on a moderated risk assessment, as part of the normal business planning process;
- undertake risk assessments on existing, new and proposed activities to ensure that significant risks are identified, assessments are made of their potential frequency and severity, control measures are implemented, risks are always minimised and risks are recorded on the Trust's risk registers;
- use the risk registers to inform the Trust's business planning and investment decision-making so that informed decisions are made in the full knowledge of the level of risk;
- record the results of risk assessments in the Trust' risk registers and use them to ensure that any decision to accept risk is taken at the appropriate level in the Trust;
- use internal and external audit and other independent and regulatory and assessment bodies to provide assurance that risk is being managed appropriately; and
- the Trust will integrate the risk registers into a combined document.

STATEMENT ON INTERNAL CONTROL

The risk and control framework (continued)

Within each clinical Service unit there is a governance group, and in the non-clinical units a risk group, whose role is to ensure that:

- risks within the unit are identified through a process of risk assessment, prioritised, minimised and, where possible, eliminated;
- the importance of managing risks is communicated to all staff within the unit;
- the Healthcare Governance Committee is made aware of any unacceptable risks that cannot be managed within the service unit; and
- data from incidents, claims and complaints are reviewed to identify and trends or areas for retrospective action.

Managers are responsible for ensuring effective risk management within their own area. A large number of staff have been trained across the Trust to undertake risk assessment in their own areas of work and to report these to their managers.

All staff are expected to: provide safe clinical practice in diagnosis and treatment; report incidents and near misses; be familiar with the Trust's Risk Management Strategy and departmental risk issues; comply with Trust policies and procedures and take reasonable care of their own safety and the safety of others.

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

The framework for obtaining assurance on the management of risk at the Trust includes:

- identifying and managing risks, in particular those that affect the achievement of the Trust's principle objectives, or following assessment and implementation of all practical control measures remain as significant risks;
- the use of the risk register to prioritise and manage risk so that appropriate investment decisions can be made;
- commissioning specific internal and external audit reports and opinions;
- compliance with Healthcare Commission requirements and inspection visits;
- accreditation levels achieved with the Clinical Negligence Scheme for Trusts and the Risk Pooling Scheme for Trusts;
- progress towards and achievement of risk-related targets, completion of annual risk audits; and
- compliance with the requirements of Monitor, the Health and Safety Executive and other independent regulatory bodies.

On major projects, such as the Greater Peterborough Health Investment Plan for the redevelopment of health facilities, the public have been directly involved in the evaluation criteria for the project. Members of the public are reminded about managing their own risks through warning signs and notices as appropriate on the Trust's premises, and through their participation as patients in the consent process.

STATEMENT ON INTERNAL CONTROL

Information governance assurance review of person identifiable data transfers

The Board put in place arrangements for obtaining assurance on the security of bulk transfers of person identifiable data. Bulk transfer data has been defined by the Department of Health as comprising more than 50 records transferring from one medium to another, or from one system or geographical location to another. Work undertaken in the Trust was considered by the Board in January and February 2008. The Board confirmed that no high risk bulk transfers of patient data had been identified, and that the necessary measures and mechanisms are in place, and have been reconfirmed to all staff, to safeguard the transfer of patient data and to minimise the risk of loss or error.

The review work identified a number of other areas, judged to be low risk, but where action had been or would be taken to reduce the risk of loss or error further. Such areas had not been highlighted by the Department of Health or Monitor, but the Board felt it would be good practice and good governance to make further improvements where possible and appropriate. These areas were set out in the form of an action plan.

The Board of Directors confirmed to Monitor that it "had reviewed the systems and procedures for securing personal data, including patient data in transit, and confirms that it is satisfied that these have been and remain compliant with relevant information governance guidance and the Data Protection Act 1998, with the possible exception of the specific matters highlighted on the attached review summary and action plan"

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

As Accounting Officer, I have responsibility for reviewing the economy, efficiency and effective use of resources. This is done in a number of ways:

- Regular review of financial performance by the Board of Directors, Audit Committee and Conformance Committee;
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- Participation in benchmarking studies undertaken by the Audit Commission, the Healthcare Commission and other external bodies;
- Use of benchmarking and other comparative data to provide assurance and inform and guide improvement in financial and clinical performance;
- Engagement of independent advisors to review and evaluate specific patient services and areas of the Trust's business. Examples for 2007/08 include reviews of theatre management and organisation, medical manpower, nurse rostering, medical equipment and renal services.
- The Trust's service improvement team supports a number of key projects, agreed by the Board of Directors, which are designed to reduced costs whilst improving clinical and operational efficiency;
- Listening and responding to matters raised by staff, members, Governors and patients.

STATEMENT ON INTERNAL CONTROL

Review of effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of its effectiveness is informed by the work of the internal auditors and the executive managers within the 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, the Audit Committee, the Healthcare Governance Committee and a process to address weaknesses and ensure continuous improvement of the system is in place.

My review is also informed by:
- the opinion of the Chief Internal Auditor;
- the Board Assurance Framework;
- the regular accreditation visits from the NHS Litigation Authority in respect of the Clinical Negligence Scheme for Trusts and the Risk Pooling Scheme for Trusts. For both schemes, the level one accreditation was retained for all areas, but for maternity services the significantly higher level two accreditation was retained.
- the reports on governance and Board of Directors' arrangements prepared by independent advisors.

The process that has been applied in maintaining and reviewing the effectiveness of the system of internal control has been supported by the following:
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- The work of the Audit Committee, Conformance Committee and Healthcare Governance Committee;
- The programme of work undertaken by internal audit.
- Reports on governance and Board of Directors' arrangements.

There has been continued focus on improving the financial position of the Trust, as evidenced by:

STATEMENT ON INTERNAL CONTROL

- The formulation of a robust financial plan for 2007/08 and forward projections;
- The formulation and delivery on the Fit For The Future savings programme, with the first phase of cost reductions achieved in 2006/07 and the second phase achieved in 2007/08;
- Close monitoring of financial performance and delivery on savings plans through the Trust executive team, Conformance Committee, Audit Committee and Board of Directors;
- Maintaining cash flow and liquidity and confirming a working capital facility with our bankers, approved by Monitor, and judged by the Board to provide sufficient headroom going forward;
- The achievement of a financial risk rating of '4' (better than average), with a further improvement to a financial risk rating of '5' (best possible score) under Monitor's compliance framework in the year;
- The conclusion, by the Healthcare Commission, in the summer of 2007 that the Trust's use of resources was 'excellent'.

The Healthcare Commission also concluded, as part of its work in the summer of 2007 on the Trust's 'Annual Health Check', that the quality of the Trust's clinical services was 'fair'. Linked with this, Monitor continued to award the Trust a red risk rating for governance throughout 2007/08, driven by the failure to achieve a maximum inpatient waiting time of six months in orthopaedics, and by Monitor's broader concerns in respect of the Trust's governance and Board of Directors' arrangements. These matters were also reported to the Healthcare Commission with the Trust declaring non-compliance on core standard C18.

The Trust has worked closely with Monitor on these matters, ensuring that no patients were waiting longer than six months for inpatient treatment in January 2008.

The Trust has focused on the development of improved arrangements relating to information governance and data quality, including the following key actions:
- Delivery on the action plan arising from the recommendations from the investigation into waiting list management in Orthopaedics;
- Further external review work by the Trust's external auditors and by specialist advisors from the Department of Health;

STATEMENT ON INTERNAL CONTROL

Review of effectiveness (continued)

- Internal Audit reviews to test systems and mechanisms to provide assurance to the Board on the accuracy and completeness of data recording and the accuracy of information being presented to the Board;
- Participation in the national programme of work led by the Audit Commission to provide assurance on the clinical coding of activity, and compliance with the Department of Health's "payment by results" arrangements;
- Incorporation of rolling verification programme for waiting list data and other key performance indicators into the Internal Audit plan for 2008/09;

Given the recovery from the orthopaedic waiting list issue, the main risk identified is to ensure that the Board of Directors has assurance on the performance and management information systems on which the reporting of service delivery is based. Systems have been revised and audit used to verify waiting list reporting; there are also processes for access and information governance to provide separate assurance.

As part of the organisational development referred to above, the Board of Directors will need to be assured that the revised Conformance Committee process provides scrutiny and assurance on service delivery. The Conformance Committee will be able to review the work undertaken on the forecasting and modelling for the achievement of performance targets. These arrangements will enable the directors to be assured on forecasting of future activity and performance, and enable the governors, Monitor and other external stakeholders to have confidence in the reported achievements.

An external consultancy, Whitehead Mann, carried out an independent review of governance and Board of Directors' arrangements in January and February 2008, interviewing all directors, attending Board and committee meetings and reviewing Board documentation. A list of action points has been produced by Whitehead Mann, covering how the Trust can improve its governance arrangements and Board effectiveness. The full report is available through the Trust's website (www.peterboroughandstamford.nhs.uk - under publications and called "Board Evaluation Report) or from the Company Secretary. The Board of Directors is taking the appropriate action, and has appointed Whitehead Mann to facilitate and support a further phase of governance and Board development.

Nik Patten, Chief Executive
3 June 2008

INDEPENDENT AUDITORS' REPORT TO THE BOARD OF GOVERNORS OF THE PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

We have audited the financial statements of Peterborough and Stamford Hospitals NHS Foundation Trust for the year ended 31 March 2008. 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 2007/08.

This report is made solely to the Board of Governors of the Peterborough and Stamford 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 to you whether in our opinion the information given in the Director's 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 are aware 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 audited financial statements. 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. 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. 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 the Peterborough and Stamford Hospitals NHS Foundation Trust as at 31 March 2008 and of its income and expenditure for the year ended;
-the financial statements have been properly prepared in accordance with paragraph 25 of Schedule 7 of the National Health Service Act 2006 and the NHS Foundation Trust Financial Reporting Manual 2007/08 issued by Monitor; and
- the information given in the Director's 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.

Auditors' 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 NHS 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, Peterborough and Stamford 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 2008.

Certificate

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

Grant Thornton UK LLP

11 June 2008

Grant Thornton UK LLP
Byron House
Cambridge Business Park
Cowley Road
Cambridge
CB4 0WZ

FOREWORD TO THE ACCOUNTS

PETERBOROUGH AND STAMFORD HOSPITALS NHS FOUNDATION TRUST

These accounts, for the year ended 31 March 2008, have been prepared by the Board of Directors of the Peterborough and Stamford Hospitals NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the *National Health Service Act 2006,* and in accordance with directions made by Monitor, the Independent Regulator of NHS Foundation Trusts.

N Patten, Chief Executive
3 June 2008

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 March 2008

	NOTE	2007/08 £000	2006/07 £000
Income from activities:	2	**160,767**	143,593
Other operating income	3	**20,640**	18,194
Operating expenses	4-5	**(170,619)**	(155,207)
OPERATING SURPLUS (CONTINUING ACTIVITIES)		**10,788**	6,580
Loss on disposal of fixed assets	6	**(118)**	(118)
SURPLUS BEFORE INTEREST		**10,670**	6,462
Interest receivable		**1,078**	303
Other financing charges	7	**(18)**	0
Interest payable		**0**	0
SURPLUS FOR THE FINANCIAL YEAR		**11,730**	6,765
Public Dividend Capital dividends payable	8	**(4,308)**	(4,309)
RETAINED SURPLUS FOR THE YEAR		**7,422**	2,456

Please note: all operations are continuing activities.

BALANCE SHEET AS AT 31 March 2008

	NOTE	31 March 2008 £000	31 March 2007 £000
FIXED ASSETS			
Tangible assets	9	**144,162**	126,581
		144,162	126,581
CURRENT ASSETS			
Stocks and work in progress	10	**2,460**	2,419
Debtors	11	**6,645**	21,444
Cash at bank and in hand	16.3	**26,218**	9,971
		35,323	33,834
CREDITORS: Amounts falling due within one year	12	**(22,364)**	(29,840)
NET CURRENT ASSETS		**12,959**	3,994
TOTAL ASSETS LESS CURRENT LIABILITIES		**157,121**	130,575
CREDITORS: Amounts falling due after more than one year	12	**(135)**	(138)
PROVISIONS FOR LIABILITIES AND CHARGES	14	**(1,674)**	(2,210)
TOTAL ASSETS EMPLOYED		**155,312**	128,227
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		**75,764**	70,540
Revaluation reserve	15	**70,588**	56,354
Donated Asset reserve	15	**3,499**	3,368
Income and expenditure reserve	15	**5,461**	(2,035)
TOTAL TAXPAYERS' EQUITY		**155,312**	128,227

N Patten, Chief Executive
3 June 2008

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 March 2008

	2007/08	2006/07
	£000	£000
Surplus for the financial year before dividend payments	**11,730**	6,765
Fixed asset impairment loss	**(471)**	0
Unrealised surplus on fixed asset revaluations	**15,068**	0
Increases in the donated asset reserve due to receipt of donated assets	**244**	119
Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets	**(402)**	(386)
Total recognised gains for the financial year	**26,169**	6,498

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 March 2008

	NOTE	2007/08 £000	2006/07 £000
OPERATING ACTIVITIES			
Net cash inflow from operating activities	16.1	**21,962**	14,740
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE			
Interest received		**1,078**	293
Other financing charges		**(18)**	0
Net cash inflow from returns on investments and servicing of finance		**1,060**	293
CAPITAL EXPENDITURE			
Payments to acquire tangible fixed assets		**(8,840)**	(6,344)
Receipts from the sale of fixed assets		**1,149**	4,221
Net cash outflow from capital expenditure		**(7,691)**	(2,123)
DIVIDENDS PAID		**(4,308)**	(4,309)
Net cash inflow before financing		**11,023**	8,601
FINANCING			
Public Dividend Capital received		**5,224**	906
Net cash inflow from financing		**5,224**	906
Increase in cash		**16,247**	9,507

1 ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundation Trusts shall meet the accounting requirements of the *NHS Foundation Trusts Financial Reporting Manual* which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the *2007/08 NHS Foundation Trusts 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 modified to account for the revaluation of tangible fixed assets at their value to the business by reference to their current costs. 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.

Acquisitions and discontinued operations

Activities are considered to be 'discontinued' where they meet all of the following conditions

a. The sale (this may be at nil consideration for activities transferred to another public sector body) or termination is completed either in the period or before the earlier of three months after the commencement of the subsequent period and the date on which the financial statements are approved.

b. If a termination, the former activities have ceased permanently.

c. The sale or termination has a material effect on the nature and focus of the reporting NHS Foundation Trust's operations and represents a material reduction in its operating facilities resulting either from its withdrawal from a particular activity or from a material reduction in income in the NHS Foundation Trust's continuing operations.

d. The assets, liabilities, results of operations and activities are clearly distinguishable, physically, operationally and for financial reporting purposes.

Operations not satisfying all these conditions are classified as continuing. Activities are considered to be 'acquired' whether or not they are acquired from outside the public sector.

Income Recognition

Income is accounted for applying the accruals convention. The main source of income for the Trust is under contracts from commissioners in respect of healthcare services. Income is recognised in the period in which services are provided. Consistent with the terms and conditions of the Trust's legally-binding contracts for the provision of healthcare services, income is recognised on the basis of completed items of service, including spells of inpatient care, in the period. The Trust has not included partially completed spells because this would be inconsistent with the way contracts work and not material to determining a fair and reasonable income figure. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income earned through providing services to commissioners (Primary Care Trusts) is recorded at full price under the Department of Health's "Payment By Results" system. In 2006/07, this income included £15,380,000 of additional income, being the difference between local costs/funding and national average costs/funding. Under the rules set down in 2006/07 by the Department of Health, 25% of this income benefit had to be paid back to the Department of Health. In 2007/08, the Trust was finally able to retain all of the additional income earned from moving to the "Payment By Results" system, after four years of transitional arrangements.

Expenditure

Expenditure is accounted for applying the accruals convention.

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 have 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 (for leased assets, fair value) 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.

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.

Professional valuations are carried out by the District Valuers of the Inland Revenue Government Department. The valuations are carried out in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health and HM Treasury. The last full asset valuations were undertaken in 2004 as at the prospective valuation date of 1 April 2005. The only exception to this is in respect of the Day Surgery Unit based at Edith Cavell Hospital where an independent valuation was sought in 2006 following disagreement with the District Valuer's valuation. The value included within the accounts reflects gross replacement cost (after indexation) for this asset. In the directors' view, this is the most appropriate method of valuation for this asset. The full revaluation undertaken at that date was accounted for on 31 March 2005.

The firm engaged to undertake the independent valuation on the Day Surgery Unit at Edith Cavell Hospital was Northcroft Construction Consultants.

As required, the three yearly interim valuation has been carried out, with the District Valuer engaged by the Trust to provide an independent and professional interim valuation during 2007. This valuation has a prospective valuation date of 31 March 2008, and this is reflected and described in the relevant notes to these accounts. Again there was disagreement with the valuation for the Day Surgery Unit at Edith Cavell Hospital as well as the property at 60/62 Thorpe Road which the District Valuer believed was about to be demolished, which is not now the case. The value included within the accounts for these two assets reflects gross replacement cost. In the directors' view, this is the most appropriate method of valuation for these assets.

The valuations are carried out primarily on the basis of Depreciated Replacement Cost for specialised operational property and Existing Use Value for non-specialised operational property. 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.

Additional alternative Open Market Value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Assets in the course of construction are valued at cost and are valued by professional valuers as part of the 5 or 3-yearly valuation or when 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 or reverts to the trust, respectively.

Buildings, installations and fittings are depreciated on their current value over the estimated remaining life of the asset as advised by the District Valuer.

Equipment is depreciated on current cost evenly over the estimated life. The estimated life of equipment assets is between 3 to 15 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

Stocks are valued at the lower of cost and net realisable value.

Cash, bank and overdrafts

Cash, bank and overdraft balances are recorded at the current values of these balances in the Trust's cash book. These balances exclude monies held in the 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, 'finance income' and 'finance costs - interest expense' in the periods to which they relate. Bank charges are recorded as operating expenditure in the periods to which they relate.

Provisions

The 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. Should the effect of the time value of money be judged to be so significant that it would materially misstate the accounts, the estimated risk-adjusted cash flows would be discounted using the Treasury's discount rate of 2.2% in real terms.

Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the NHS Foundation Trust pays an annual contribution to the NHSLA, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the NHS Foundation Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the NHS Foundation Trust is disclosed at note 14.

Non-clinical risk pooling

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

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 Secretary of State, in England and Wales. As a consequence it is not possible for the NHS Foundation Trust to identify its share of the underlying scheme liabilities. Therefore, the Scheme is accounted for as if it was a defined contribution scheme: the cost of the Scheme is equal to the contributions payable to the Scheme for the accounting period.

Employers pension cost contributions are charged to operating expenses as and when they become due. Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the actuary. This valuation took place as at 31 March 2004 and has yet to be finalised. The Scheme is subject to a full valuation for FRS17 purposes every four years. At the last valuation on which contribution rates were rebased (31 March 1999 as the 31 March 2003 valuation has not yet been published as the revaluation is to be aligned with the full valuation and will take place in 2008,) employer contribution rates from 2003-04 were set at 14% of pensionable pay. The total employer contribution payable in 2007/08 was £9,870,000 (2006/07, £9,459,000.) Employees pay contributions of 6% (manual staff 5%) of their pensionable pay. The latest assessment of the liabilities of the Scheme is contained in the Scheme Actuary report, which forms part of the annual NHS Pension Scheme (England & 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.

The conclusion from the 1999 valuation was that the Scheme continues to operate on a sound financial basis and the notional surplus of the Scheme was £1.1 billion.

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th of the best of the last 3 years pensionable pay for each year of service. A lump sum normally equivalent to 3 years pension is payable on retirement. Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. On death, a pension of 50% of the member's pension is normally payable to the surviving spouse.

Early payment of a pension, with enhancement, is available to members of the Scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year pensionable pay for death in service, and up to five times their annual pension for death after retirement, less pension already paid, subject to a maximum amount equal to twice the member's final years pensionable pay less their retirement lump sum for those who die after retirement, is payable.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the income and expenditure account at the time the Trust commits itself to the retirement, regardless of the method of payment.

The Scheme provides the opportunity to members to increase their benefits through money purchase Additional Voluntary Contributions (AVCs) provided by an approved panel of life companies. Under the arrangement employees can make contributions to enhance their pension benefits. The benefits payable relate directly to the value of the investments made.

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.

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.

Third Party Assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the 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's Financial Reporting Manual.

Leases

All leases are classified 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. It has its origins in the assessment of the excess of assets over liabilities - net assets - at the point when an NHS Trust was first established. This Trust took on, at its inception as an NHS Foundation Trust or public benefit corporation on 1 April 2004, the public dividend capital vested in the preceding NHS Trust at 31 March 2003.

A charge, reflecting the forecast cost of capital used by an NHS Foundation Trust, is paid over to the Department of Health as a public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the forecast average relevant net assets of an 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 Payment General. Average relevant net assets are calculated as a simple mean of the opening and closing relevant net assets.

Contingent assets and liabilities

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the Trust's control) are not recognised as assets, but are disclosed in note 19 where an inflow of economic benefits is probable.

Contingent liabilities are provided for where a transfer of economic benefits is probable. Otherwise, they are not recognised, but are also disclosed in note 19 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 Trust'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.

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.

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

Derecognition

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

Financial liabilities are derecognised when the obligation is discharged, cancelled or expires.

Classification and measurement

The Trust's financial assets are all within 'loans and receivables'.

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. They are included in current assets. The Trust's receivables comprise: cash at bank and in hand, NHS debtors, accrued income and other debtors.

Loans and receivables are recognised initially at fair value, net of transaction 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.

The Trust's financial liabilities are all within 'other financial liabilities'.

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 assessed whether any financial assets were impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cashflows of the asset.

The Trust considers all outstanding debtor accounts passed their due date resulting in an impairment assessment being made of those not likely to result in settlement following implementation of and adherence to the Trust's credit control process. Amongst other action, this could involve the use of debt collection agencies and/or pursuing debts via court proceedings if the Trust feels these are approporiate avenues.

2. INCOME FROM ACTIVITIES

2.1 Income from activities comprise

	2007/08	2006/07
	£000	£000
Elective Care	**38,067**	31,776
Non elective Care	**57,937**	54,963
Outpatient Care	**28,114**	27,537
Other types of activity and services	**26,318**	22,810
Accident and Emergency department services	**5,486**	5,400
	155,922	142,486
Funding Withdrawn By Department of Health #	**0**	(3,853)
	155,922	138,633
Other non-protected clinical income	**3,475**	3,549
Private Patients	**583**	497
Overseas Patients (non-reciprocal)	**67**	60
Compensation Recovery Unit (NHS Injury Benefit Scheme)**	**720**	854
	160,767	143,593

There was no funding withdrawn from the Trust by the Department of Health in 2007/08 (£3,853,000 in 2006/07) as result of moving from local, historic costs to full funding under the national standard average price tariff. Income earned through providing services to PCTs is recorded at full price under the "Payment By Results" system. In 2006/07, this income included £15,414,000 of additional income, being the difference between local costs/funding and national average costs/funding.

Under the rules set down by the Department of Health, 25% of this income benefit had to be paid back in 2006/07. This adjustment is known in the NHS as the "Payment by Results Clawback" and represented an explicit element of underfunding of the Trust. In 2007/08, the rules set down by the Department of Health permitted all income earned by the Trust to be retained by the Trust.

** Income assessed as due from the Compensation Recovery Unit is subject to a provision for doubtful debts of 7.8% to reflect expected rates of actual collection.

2.2 Income from protected and non-protected services

	2007/08	2006/07
	£000	£000
Protected services	**155,922**	138,714
Non-protected services	**4,845**	4,879
	160,767	143,593

2.3 Private Patient Income Cap	**2007/08**	Base Year
	£000	£000
Private patient income	**583**	573
Total patient related income	**160,767**	97,779
Proportion (as percentage)	**0.36 %**	0.59 %

The Trust's Terms of Authorisation contain a private patient income cap (limit) of 0.6% of income earned from activities. This cap was based on the actual results of 2002/03 where the Trust earned £573,000 from private patient income as a percentage of a total patient related activities income of £97,779,000 (as stated in section 44 of the National Health Service Act 2006). The private patient income cap has not been breached.

3. OTHER OPERATING INCOME

	2007/08	2006/07
	£000	£000
Patient transport services	**33**	41
Research and development	**176**	71
Education, training and research	**6,552**	6,034
Charitable and other contributions to expenditure	**548**	742
Transfers from the donated asset reserve	**402**	386
Non-patient care services to other bodies	**83**	175
Service Level Agreement with Cambridgeshire and Peterborough Mental Health Partnership NHS Trust	**1,997**	2,046
Other income	**10,849**	8,699
	20,640	18,194

4. OPERATING EXPENSES

4.1 Operating expenses comprise:

	2007/08	2006/07
	£000	£000
Directors' costs	**736**	850
Staff costs	**107,032**	101,193
Drug costs	**10,033**	9,056
Supplies and services		
- clinical	**20,022**	17,793
- general	**6,548**	4,912
Establishment	**6,339**	3,553
Transport	**212**	323
Premises	**7,908**	5,960
Increase in provision for credit notes and bad debts#	**796**	2,340
Depreciation and amortisation	**6,418**	6,048
Fixed asset impairments and reversals	**1,699**	42
Audit services:		
Statutory audit and on-going	**92**	92
Further assurance services	**17**	0
Clinical negligence	**2,040**	2,327
Other	**727**	718
	170,619	155,207

The increased provision mainly relates to the need to make some provision for possible credit notes that may have to be issued for invoices for healthcare activities in dispute.

4.2 Operating leases

4.2/1 Operating expenses include:

	2007/08	2006/07
	£000	£000
Hire of plant and machinery	**286**	290

4.2/2 Annual commitments under non - cancellable operating leases are:

Other leases

	2007/08	2006/07
	£000	£000
Operating leases which expire:		
Within 1 year	**4**	12
Between 1 and 5 years	**264**	263
After 5 years	**0**	0
	268	275

4.3 Salary and pension entitlements of the Board of Directors

Name and Title

		Remuneration		Pension Rights as at Age 60		Increase Arising in 2007/08 whilst employed by Peterborough & Stamford NHS Foundation Trust		Cash Equivalent Transfer Value as at 31/03/07	Cash Equivalent Transfer Value as at 31/03/08	Real Increase in CETV as funded by Peteborough & Stamford NHS Foundation Trust during 2007/08
		Salary £000	Other £000	Accrued £	Lump Sum £	Accrued £	Lump Sum £	£	£	£
2007/08		**(bands of £5,000)**								
Stuart Anderson	Non-executive Director (commenced 01/10/07)	5-10	Nil	Non executive directors do not have a pensionable position						
St Clair Armitage	Project Director (left 25/12/07)	75-80	Nil	5,289	15,867	1,006	3,019	68,886	89,771	13,414
Andy Burroughs	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
Geoffrey Clubbe	Non-executive Director (left 30/11/07)	5-10	Nil	Non executive directors do not have a pensionable position						
Paula Gorst	Operations Director	90-95	Nil	33,408	100,225	5,481	16,444	368,625	468,322	63,336
Susan Grey	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
Christopher Hall	Finance Director	100-105	Nil	29,517	88,551	4,039	12,116	311,115	381,691	43,959
Clive Morton	Chairman (left 31/03/08)	35-40	Nil	Non executive directors do not have a pensionable position						
Nicholas Patten	Chief Executive Officer	140-145		57,190	171,569	4,172	12,517	799,136	910,241	63,788
Jonathan Radway	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
Raza Rahim	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
John Randall	Medical Director	10-15	70-75	40,202	120,607	8,110	24,331	487,727	644,904	101,488
Caroline Stark	Non-executive Director (commenced 11/05/07)	10-15	Nil	Non executive directors do not have a pensionable position						
Christine Tolond	Director of Human Resources	85-90	Nil	33,254	99,762	1,045	3,135	551,937	584,488	13,127
Christine Wilkinson	Director of Nursing	85-90	Nil	26,068	78,204	1,957	5,870	334,073	379,598	26,021

4.3 Salary and pension entitlements of senior managers continued

Senior employees are defined as "those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust". The people listed overleaf make up the Trust's Board of Directors. None of the individuals detailed have received any other payments in respect of attraction, severance or any other benefits-in-kind.

5. STAFF COSTS AND NUMBERS

5.1 Staff costs

	2007/08	2006/07
	£000	£000
Salaries and wages	**88,871**	84,575
Social Security Costs	**6,772**	6,528
Employer contributions to NHSPA #	**9,870**	9,459
Other pension costs	**83**	61
Agency, contract and seconded-in staff	**2,056**	1,301
	107,652	101,924

The NHSPA is the NHS Pensions Agency

5.2 Average number of persons employed

	Total	Permanently Employed Staff (including Bank staff)	Agency and Contract Staff	
	Number	Number	Number	2006/07 Number
Medical and dental	**305**	294	11	313
Clinical administration staff	**364**	364	0	356
Administration and estates	**194**	187	7	212
Healthcare assistants & other support staff	**464**	456	8	495
Nursing, midwifery & health visiting staff	**929**	921	8	887
Nursing, midwifery & health visiting learners	**3**	3	0	4
Scientific, therapeutic and technical staff	**420**	411	9	400
Other	**93**	93	0	120
Total	**2,772**	**2,729**	**43**	2,787

The above numbers include staff directly employed by Peterborough and Stamford Hospitals NHS Foundation Trust, plus an estimate for an aggregate number for staff employed through agency arrangements. The numbers exclude Ministry of Defence personnel working at the Trust, and covered through the contract between the Ministry of Defence and the Trust.

5.3 Employee benefits

The Trust had no expenditure in relation to employee benefits.

5.4 Retirements due to ill-health

During 2007/08 there were 5 early retirements from the Trust agreed on the grounds of ill-health (5 in 2006/07). The estimated additional pension liabilities of these ill-health retirements will be £324,214 (£207,195 for 2006/076). These retirements represented 1.44 per 1,000 active scheme members (1.27 per 1,000 for 2006/07). This information has been supplied by, and the cost of these ill-health retirements will be borne by, the NHS Pensions Agency.

6. LOSS ON DISPOSAL OF FIXED ASSETS

Loss on the disposal of fixed assets is made up as follows:

	2007/08	Protected	Unprotected	2006/07
	£000	£000	£000	£000
Loss on disposal of land and buildings	**0**	0	0	(9)
Loss on disposal of plant and equipment	**(118)**	0	(118)	(109)
	(118)	0	(118)	(118)

Under its Terms of Authorisation, the Trust is not permitted to sell any protected fixed asset as such assets are required for the provision of main healthcare activities (known as protected services). The Trust conformed with this requirement.

7. INTEREST PAYABLE

No interest was payable in 2007/08 as was also the case in 2005/06, and no interest had to be paid under the *Late Payment of Commercial Debts (Interest) Act 1998* for 2007/08 again which was also the case in 2006/07.

8. PUBLIC DIVIDEND CAPITAL DIVIDEND

The dividend paid to the Government in 2007/08 was £4,308,000 (£4,309,000 in 2006/07). This was based on a forecast rate of 3.5% on estimated average relevant net assets in 2007/08. The actual dividend rate is the dividend paid, £4,308,000, expressed as a percentage of the simple mean of the opening and closing net assets for the year. The actual dividend rate worked out at 3.58% (3.65% for 2006/07). The very small difference between the actual rate and the forecast rate is not material.

9. TANGIBLE FIXED ASSETS

9.1 Tangible fixed assets at the balance sheet date comprise the following elements:

	Land	Buildings excluding dwellings	Dwellings	Assets under construction and payments on account	Plant & Machinery	Transport Equipment	Information Technology	Furniture & fittings	Total	2006/07
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2007	29,565	106,394	5,681	5,862	25,186	112	4,088	1,646	**178,534**	180,483
Additions - purchased	782	4,593	0	3,826	1,515	0	260	0	**10,976**	6,606
Additions - donated	0	0	0	0	209	0	6	30	**245**	119
Impairments	0	(2,042)	(443)	0	0	0	0	0	(2,485)	(116)
Reclassification	0	4,163	0	(4,461)	298	0	0	0	0	0
Revaluation	13,012	883	1,173	0	0	0	0	0	15,068	0
Disposals	0	0	0	0	(865)	(15)	(366)	(16)	(1,262)	(8,558)
At 31 March 2008	**43,359**	**113,991**	**6,411**	**5,227**	**26,343**	**97**	**3,988**	**1,660**	**201,076**	178,534
Accumulated depreciation at 1 April 2007	0	32,163	1,087		15,316	112	2,755	520	**51,953**	49,049
Provided during the year	0	3,131	145		2,552	0	547	43	**6,418**	6,048
Impairments	0	(308)	(7)		0	0	0	0	**(315)**	(74)
Revaluation	0	0	0		0	0	0	0	**0**	0
Disposals	0	0	0		(778)	(15)	(333)	(16)	(1,142)	(3,070)
Accumulated depreciation at 31 March 2008	**0**	**34,986**	**1,225**		**17,090**	**97**	**2,969**	**547**	**56,914**	51,953
Net book value										
- Purchased at 1 April 2007	29,565	72,230	4,594	5,862	8,504	0	1,333	1,126	**123,214**	127,799
- Donated at 1 April 2007	0	2,001	0	0	1,366	0	0	0	**3,367**	3,635
Total at 1 April 2007	**29,565**	**74,231**	**4,594**	**5,862**	**9,870**	**0**	**1,333**	**1,126**	**126,581**	131,434
- Purchased at 31 March 2008	43,359	76,768	5,186	5,227	8,860	0	1,013	250	**140,663**	123,214
- Donated at 31 March 2008	0	2,237	0	0	393	0	6	863	**3,499**	3,367
Total at 31 March 2008	**43,359**	**79,005**	**5,186**	**5,227**	**9,253**	**0**	**1,019**	**1,113**	**144,162**	126,581

9.2 Analysis of tangible fixed assets:

Net book value										
- Protected assets at 31 March 2008	40,258	78,670	0	0	0	0	0	0	**118,928**	100,820
- Unprotected assets at 31 March 2008	3,101	335	5,186	5,227	9,253	0	1,019	1,113	**25,234**	25,761
Total at 31 March 2008	**43,359**	**79,005**	**5,186**	**5,227**	**9,253**	**0**	**1,019**	**1,113**	**144,162**	126,581

9.3 Valuation of land and buildings:

The revaluation of land and building assets undertaken by the District Valuer and approved by the Board generated an increase in assets held of over £15M, which has been carried to reserves. Details of this interim valuation is included in the Accounting Policies on pages 2 and 3.

All land, buildings and dwellings owned are freehold.

10. STOCKS AND WORK IN PROGRESS

	31 March 2008	31 March 2007
	£000	£000
Raw materials and consumables	**2,460**	2,419

11.1 DEBTORS

	31 March 2008	31 March 2007
	£000	£000
Amounts falling due within one year:		
Government Department debtors	**4,286**	21,463
Provision for irrecoverable debts	**(2,774)**	(3,105)
Other prepayments and accrued income	**1,872**	1,546
Other debtors	**2,629**	1,050
	6,013	20,954
Amounts falling due after more than one year:		
Other debtors	**632**	490
	632	490
	6,645	21,444

11.2 Reconciliation of the provision for bad debts:

	2007/08	2006/07
	£000	£000
At 1 April 2007	**(3,105)**	**(2,253)**
New provision raised in year	**(1,008)**	**(2,369)**
Debtors written off during the year as uncollectable	**1,199**	**1,517**
Unused amounts reversed	**140**	**0**
At 31 March 2008	**(2,774)**	**(3,105)**

Peterborough & Stamford Hospitals NHS Foundation Trust does not impair all outstanding debts, even if they are past their due date. These debtors undergo a detailed review resulting in an impairment assessment being made of those not likely to result in settlement following implementation of and adherence to the Trust's credit control process. This could involve the use of debt collection agencies and/or pursuing debts via court proceedings if the Trust feels these are approporiate avenues to enable it to recover legitimate and enforcable monies due to it thereby enabling reinvestment into the provision of healthcare.

11.3 Analysis of impaired debtors:

	31 March 2008	31 March 2007
	£000	£000
Ageing of impaired debtors:		
Up to three months	**681**	1,306
In three to six months	**571**	36
Over six months	**1,522**	1,763
Total	**2,774**	3,105
Ageing of non-impaired debtors past their due date:		
Up to three months	**477**	660
In three to six months	**948**	952
Over six months	**777**	2,320
Total	**2,202**	3,932

12. CREDITORS

	31 March 2008	31 March 2007
	£000	£000
Amounts falling due within one year:		
Revolving working capital facility	**0**	0
Payments received on account	**301**	123
Government Department credito	**5,890**	18,052
Other tax and social security cos	**2,629**	2,281
Capital creditors	**2,534**	412
Non - Government trade creditor	**7,569**	8,353
Accruals and deferred income	**3,441**	619
	22,364	29,840
Amounts falling due after more than one year:		
Other	**135**	138
	22,499	29,978

Government Department creditors include;
- £1,233,000 outstanding pensions contributions at 31 March 2008 (£1,180,000 as at 31 March 2007.)

The Trust did not hold any assets under finance leases or hire purchase contracts at the balance sheet date.

13 PRUDENTIAL BORROWING LIMIT

The Trust has a total Prudential Borrowing Limit, set by Monitor, of £41.5M (£37.5M in 2006/07). This comprises £29.5M (£25.5M in 2006/07) for cumulative long term borrowing and £12M (£12M in 2006/07) for an approved working capital facility. The Trust paid £18,000 for the arrangement of this facility with it's commercial bankers. The Trust actually had all of the approved working capital facility remaining at 31 March 2008, having not drawn down anything to support operating costs.

Peterborough & Stamford Hospitals NHS Foundation Trust is required to comply and remain within the Prudential Borrowing Limit. This is made up of two elements:

- the maximum cumulative amount of long-term borrowing. This is set by reference to the five ratio tests set out in Monitor's *Prudential Borrowing Code*. The financial risk rating set under Monitor's *Compliance Framework* determines one of the ratios and therefore can impact on the long term borrowing limit.
- the amount of any working capital facility approved by Monitor.

13.1 Debt Cover Ratios

	2007/08		2006/07	
	Actual	**Planned**	Actual	Planned
Minimum dividend cover	**4.39**	**3.60**	2.90	2.40
Minimum interest cover	**0.00**	**0.00**	0.00	0.00
Minimum debt service cover	**0.00**	**0.00**	0.00	0.00
Minimum debt service to revenue	**0.00**	**0.00**	0.00	0.00
Maximum debt capital cover	**0.00**	**0.00**	0.00	0.00

Apart from the minimum dividend cover ratio, all other ratios are nil because the Trust did not plan to take on any interest-bearing debt in 2007/08, and no long-term debt was taken on.

The actual minimum dividend cover was higher than planned because earnings before interest, taxation, depreciation and amortisation were greater than planned.

14. PROVISIONS FOR LIABILITIES AND CHARGES

	Pensions relating to other staff	**Legal claims**	**Other**	**Total**	2006/07
	£000	**£000**	**£000**	**£000**	£000
At 1 April 2007	343	646	1,221	**2,210**	1,811
Arising during the year	0	70	97	**167**	1,168
Utilised during the year	0	(3)	(628)	**(631)**	(685)
Reversed unused	(31)	0	(41)	**(72)**	(84)
At 31 March 2008	312	713	649	**1,674**	2,210
Expected timing of cashflows:					
Within 1 year	44	184	649	**877**	1,436
1 - 5 years	165	97	0	**262**	322
Over 5 years	103	432	0	**535**	452
	312	713	649	**1,674**	2,210

Aside from the provisions recorded in the Trust's Accounts, £13,724,000 is included as a provision in the Accounts of the NHS Litigation Authority at 31 March 2008 in respect of clinical negligence liabilities of the Trust (£9,160,000 at 31 March 2007).

The total 'other' provision of £649,000 as at 31 March 2008 (£1,221,000 as at 31st March 2007), is intended to cover the estimated payments expected to become due in 2008/09 in respect of various current Human Resources issues (including outstanding Agenda for Change assimilations and potential redundancies as the Trust has recently implemented a revised organisation structure with effect from 1 April 2008).

15. MOVEMENTS ON TAXPAYERS' EQUITY AND RESERVES

15.1 Taxpayers' Equity

	31 March 2008	31 March 2007
	£000	£000
Taxpayers' equity at 1 April 2007	**128,227**	125,132
Surplus for the financial year	**11,730**	6,765
Public dividend capital dividends	**(4,308)**	(4,309)
Gains from revaluation of fixed assets	**14,779**	0
Fixed asset impairments	**(471)**	0
New public dividend capital received	**5,224**	906
Transfers from donated asset reserve	**131**	(267)
Taxpayers' equity at 31 March 2008	**155,312**	128,227

15.2 Reserves

	Revaluation reserve	**Donated Asset reserve**	**Income and Expenditure reserve**	**Total**	2006/07
	£000	**£000**	**£000**	**£000**	£000
At 1 April 2007	**56,354**	**3,368**	**(2,035)**	**57,687**	55,498
Transfer from the income and expenditure account	**0**	**0**	**7,422**	**7,422**	2,456
Fixed asset impairments	**(471)**	**0**	**0**	**(471)**	0
Surplus on other revaluations/indexation of fixed assets	**14,779**	**289**	**0**	**15,068**	0
Receipt of donated assets	**0**	**244**	**0**	**244**	119
Transfers to the Income and Expenditure Account for depreciation, impairment, and disposal of donated assets	**0**	**(402)**	**0**	**(402)**	(386)
Other transfers between reserves	**(74)**	**0**	**74**	**0**	0
At 31 March 2008	**70,588**	**3,499**	**5,461**	**79,548**	57,687

16. NOTES TO THE CASHFLOW STATEMENT

16. 1 Reconciliation of operating surplus to net cash flow from operating activities:

	2007/08	2006/07
	£000	£000
Total operating surplus	**10,788**	6,580
Depreciation and amortisation charge	**6,418**	6,048
Fixed asset impairment	**1,699**	42
Transfer from donated asset reserve	**(402)**	(386)
(Increase)/decrease in stocks	**(41)**	156
Decrease/(increase) in debtors	**13,620**	(8,780)
(Decrease)/increase in creditors	**(9,585)**	10,681
(Decrease)/increase in provisions	**(535)**	399
Net cash inflow from operating activities	**21,962**	14,740

16.2 Reconciliation of net cash flow to movement in net funds

	2007/08	2006/07
	£000	£000
Increase in cash in the period	**16,247**	9,507
Net funds at 1 April 2007	**9,971**	464
Net funds at 31 March 2008	**26,218**	9,971

16.3 Analysis of changes in net funds

	At 31 March 2008	Cash changes in year	At 1 April 2007
	£000	£000	£000
Cash held at Office of the Paymaster General (OPG)	**26,107**	16,186	9,921
Commercial cash at bank and in hand	**111**	61	50
	26,218	16,247	9,971

16.4 Reconciliation of net cashflow to movement in net debt

	2007/08	2006/07
	£000	£000
Increase in cash in the period	**16,247**	9,507
Cash inflow from new debt	**(5,224)**	(906)
Change in net debt resulting from cash flows	**11,023**	8,601
Net debt as at 1 April 2007*	**(60,569)**	(69,170)
Net debt as at 31 March 2008 **	**(49,546)**	(60,569)

* Net debt at 1 April 2007 comprises Public Dividend Capital of £70,540, 000 less cash at bank of £9,971,000

** Net debt at 1 April 2008 comprises Public Dividend Capital of £75,764,000 less cash at bank of £26,218,000

17. CAPITAL COMMITMENTS

Commitments under capital expenditure contracts at the balance sheet date were £291,000 (£460,000 in 2006/07).

18. POST BALANCE SHEET EVENTS

There were no post balance sheet events.

19. CONTINGENT ASSETS AND LIABILITIES

There were no contingent liabilities at the balance sheet date.

20. RELATED PARTY TRANSACTIONS

Peterborough and Stamford Hospitals NHS Foundation Trust is a body corporate established by order of the Secretary of State for Health.

The Department of Health is regarded as a related party. During the year the 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, namely:

Peterborough Primary Care Trust
Lincolnshire Primary Care Trust
Cambridgeshire Primary Care Trust
Northamptonshire Primary Care Trust
Leicester City Primary Care Trust
Leicestershire County & Rutland Primary Care Trust
Norfolk Primary Care Trust
East of England Ambulance NHS Trust
NHS Blood & Transplant Agency
NHS Supply Chain
NHS Litigation Authority
NHS Business Services Authority
Prescription Pricing Authority
Cambridge University Hospitals NHS FT
East of England Strategic Health Authority
Hinchingbrooke Healthcare NHS Trust
Cambridgeshire & Peterborough Mental Health Partnership NHS Trust
Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust (OBMH)

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 with the Ministry of Defence in respect of collaborative working as a Ministry of Defence Hospital Unit (MDHU). The total patient treatment value of this contract for 2007/08 was £3,761,000 (£3,918,000 for 2006/07). Under separate arrangements the Trust employed Ministry of Defence staff for £2,505,000 (£2,136,000 for 2006/07).

During the year none of the members of the Board of Directors, Board of Governors, members of the senior management staff or parties related to them, has undertaken any material transactions with the Trust with the exception of those transactions set out below:

One of the Trust's governors is also a governor at Papworth Hospitals NHS Foundation Trust with whom Peterborough & Stamford Hospitals NHS Foundation Trust commissioned and made services and supplies from/to during 2007/08, resulting in receipts totalling £55,000.00 and payments totalling £52,000.00. Peterborough & Stamford Hospitals NHS Foundation Trust can confirm that she has not been involved in the negotiation or award of contracts between the Trust and Papworth Hospitals NHS Foundation Trust

The Trust's Board of Directors are also the Charity Trustees for Peterborough and Stamford Hospitals NHS Foundation Trust Charitable Fund, registered charity number 1050601, which the Trust manages. During 2007/08, £548,000 (£742,000 during 2006/07) was taken to both the Trust's income and expenditure figures, (see notes 2 to 5 respectively), as this effectively represents a grant from the charitable funds to the Trust.

21. FINANCIAL INSTRUMENTS

FRS 25,26 and 29 give guidance on financial instruments. These reporting standards 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. Financial instruments play a much more limited role in creating or changing risk than would be typical of the listed companies to which these FRS mainly apply. The Trust has powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Peterborough & Stamford Hospitals NHS Foundation Trust mitigates financial risks by investing surplus cash in short term deposit investment accounts, in accordance with the Trust's Standing Financial Instructions and in line within Monitor guidance on managing working capital.

21.1 Financial risk

The following statements made for 2007/08 are consistent with those applied in previous years.

Credit risk

Due to the continuing service provider relationship that the Trust has with local Primary Care Trusts and the way those Primary Care Trusts are financed, the Trust is not exposed to the same degree of credit risk faced by some business entities. Those items in dispute or under query have been assessed and a provision for imparment made, if deemed appropriate.

The bulk of the Trust's cash balances were held with H.M.Paymaster General at the Bank of England, thereby not being subject to any credit risk.

Liquidity risk

The Trust's net operating costs are incurred mainly in respect of delivering on legally binding long-term contracts with NHS Primary Care Trusts (PCTs). The PCTs themselves are financed from resources voted annually by Parliament. As noted above, this means the Trust is not exposed to quite the same level of liquidity risk as some other business entities. The Trust had in place a guaranteed working capital facility of £12M with its commercial bankers.

Interest-rate and currency (market) risk

0% (0% for 2006/07) of the Trust's financial assets and 100% (100% for 2006/07) of its financial liabilities carry nil rate of interest. The Trust is not, therefore, exposed to any interest-rate risk.

All of the Trust's gross financial assets (£32,108,000.00 as at 31 March 2008) and gross financial liabilities (£22,198,000.00 as at 31 March 2008), were denominated in sterling. The Trust is not, therefore, exposed to currency rate fluctuations.

21.2 Financial assets and liabilities by category

Set out below is a comparison, by category, of the Trust's financial assets and liabilities as at 31 March 2008 and 31 March 2007.

	2007/08	2006/07
	£000	£000
Assets as per balance sheet		
NHS Debtors (net of provision for irrecoverable debts)	**2,182**	18,950
Accrued income	**1,749**	818
Other debtors	**1,959**	948
Cash at bank and in hand	**26,218**	9,971
Total at 31 March 2008	**32,108**	30,687
Liabilities as per balance sheet		
NHS Creditors	**(5,890)**	(18,052)
Other creditors	**(12,867)**	(11,184)
Accruals	**(3,441)**	(619)
Total at 31 March 2008	**(22,198)**	(29,855)

21.3 Fair values

As permitted by FRS29, as the Trust's financial assets and liabilities are primarily short-term trade receivables and payables, the fair value (carrying amounts) equals the book value.

21.4 Maturity of financial liabilities

	2007/08	2006/07
	£000	£000
Less than one year	**22,063**	29,717
In more than one year but not more than two years	**13**	12
In more than two years but not more than five years	**53**	52
In more than five years	**69**	74
Total	**22,198**	29,855

22. THIRD PARTY ASSETS

The Trust held £810.29 cash at bank and in hand as at 31 March 2008 (£1,649.72 as at 31 March 2007) which related to monies held by the Peterborough and Stamford Hospitals NHS Foundation Trust on behalf of patients. This has been excluded from the cash at bank and in hand figure reported in the accounts.

23. LOSSES AND SPECIAL PAYMENTS

Payments under this category are made on a cash rather than an accruals basis.

The Trust made 145 payments under this category during 2007/08, amounting to £53,000 (216 during 2006/07 totalling £95,000). Within this total were 11 personal injury payments totalling £43,000 (12 payments totalling £40,000 for 2006/07) and 9 ex-gratia payments for loss of personal effects by patients which amounted to £2,000 (17 payment totalling £2,000 for 2006/07). Also included in the overall totals were the write-off of 123 debtor accounts which came to £5,000 (184 totalling £49,000 for 2006/07).

24. GREATER PETERBOROUGH HEALTH INVESTMENT PLAN

The Trust is leading on the Greater Peterborough Health Investment Plan, which is a major project relating to the development of healthcare services in Peterborough. This will see the development of acute hospital services in Peterborough in a single new hospital on the Edith Cavell Hospital site, replacing the existing Peterborough District Hospital (including the Peterborough Maternity Unit) and the current Edith Cavell Hospital. The development of the new hospital is going ahead through the Government's Private Finance Initiative (PFI). The capital investment cost is estimated at £330M, and the new hospital is on track to be completed and in use by December 2010.

Progress Health is the name of the consortium responsible for building the new hospital, and associated facilities management (including buildings and engineering maintenance, some medical equipment management, and a range of other support services such as cleaning, catering and portering). The Trust achieved financial close on the contract with Progress Health on 29th June 2007, and actual building work started on 4th July 2007. Work has been progressing on time, and in accordance with the contractual requirements, since then.

These Accounts have been prepared according to the relevant accounting standards, and the requirements of Monitor and HM Treasury, as applicable at the present time in respect of accounting for PFI schemes. The Trust continues to follow the advice of its financial advisors in connection with the PFI scheme, as confirmed by its External Auditors. This means that currently no asset nor liability is recognised in the Trust's balance sheet, and no expenditure transactions have been recorded in connection with the PFI scheme, other than project-related costs borne by the Trust which have been accounted for as expenditure incurred in the year, in the normal way.

The application of International Financial Reporting Standards (IFRS) to the public sector is now likely to be required by HM Treasury for the 2009/2010 financial year, with a restating of the 2008/2009 Accounts, where appropriate, to enable prior-year comparisons to be made. The application of International Financial Reporting Standards is likely to have a significant impact on accounting for PFI schemes, and all the associated disclosures relating to the Accounts. However, this is not clear or certain at the present time, and the Trust awaits guidance from HM Treasury and Monitor on how International Financial Reporting Standards are to be applied.

As noted above, the healthcare facilities on the Peterborough District Hospital site are planned to be replaced in the new hospital on the Edith Cavell Hospital site in December 2010. The land, building and engineering asset values for the facilities on the Peterborough District Hospital site are reported in the Trust's balance sheet at the District Valuer's assessment of their revised values for continuing healthcare operational use, effective 31 March 2008. This approach to valuation of the assets will continue for at least the 2008/2009 financial year, and will be maintained until there is greater certainty about the timing of when assets will be taken out of use and the future use and development of the District Hospital site.