Peterborough and Stamford Hospitals
NHS Foundation Trust

Annual Plan 2005/2006

Version 5: 7 June 2005

Chairman's Foreword

I am pleased to present this Annual Plan for Peterborough and Stamford Hospitals NHS Foundation Trust. This provides an overview of the past year and looks forward to our plans for the next year and beyond.

Our plans are built on messages from our governors and members to make sure we are reflecting what is important for our local population, our practical experience of payment by results and our determination to continue with strong partnership working across the local health economy for the benefit of the people of Stamford and Peterborough.

This is the first annual plan of this type that we have produced and I would value your constructive comments as these will help us make our future planning documents useful for you.

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1 Past Year Performance

1.1 Chief Executive's Statement

The Trust's first year as a foundation hospital was one of the most challenging ever. Our agenda included: a change in funding method to 'payment by results' and new legally binding contracts with commissioners; the modernisation of staff pay with the new consultant contract, and the agenda for change initiative; a change in governance structures including public membership, a new Board of Governors and changes in the composition of the Board of Directors; the selection of a preferred partner to build the new hospital and other facilities; a new Patient and Public Involvement Forum; tougher access and quality standards including 98% of patients being seen and treated through A&E in under 4 hours; a continuing increase in emergency admissions and A&E attendances for non-emergency problems; offering patients waiting more than six months for an operation the choice of an alternative hospital; complying with the European Working Time Directive for doctors by reducing their working hours and changing rota systems; the cessation of Department of Health central funding for PFI procurements which left the health system with a £1.8 million cost pressure; renegotiating the contractual basis of the Trust's relationship with the Ministry of Defence (the Trust is a Ministry of Defence Hospital Unit); the impact of the loss of a star based on the deficit in 2003-04, and a low rating of the Trust's capacity and capability due to the relatively low number of consultant appraisals in 2003-04 (76%), and progress towards European Working Time Directive (EWTD) compliance for doctors by 31 March 2004 (82%).

However the Trust continued to deliver its full range of services in accordance with its Terms of Authorisation and met all but one of the key access targets, achieving: outpatient 17 week wait; 9 month wait for an operation; 3 month wait for a cataract operation; 2 week wait for suspected cancers; no 12 hour trolley-wait breaches in A&E; and operations cancelled on the day at under 1% of the total. The Trust expected to meet all national key access targets and the A&E 4 hour target was met comfortably in the first nine months, but in the final quarter it averaged 94.7% as a result of reduced bed capacity due to Norwalk virus and an unprecedented level of emergency admissions. Since Easter 2005 we have averaged 98.9%.

The Trust maintained short waiting times and received a number of out-of-catchment patients exercising choice at 6 months. At 31 March 2005 no patient referred by a GP was waiting more than six months for an operation. Day case rates averaged 70% and will be increased in 2005/06. A number of wards were reconfigured to make better use of beds and staff, and to reduce expenditure. Theatre utilisation increased significantly through the year.

The home birth service was temporarily suspended for a three-month period due to staffing shortages, but the rest of the community midwife service was maintained throughout. The Trust again had one of the lowest MRSA rates in the country; in the last quarter of the year there were three cases of MRSA bacteremia.

The Trust continued its PFI procurement of a new hospital and other health facilities by selecting its preferred partner, Progress Health, in March 2005. The consortium is led by Multiplex and ABN-Amro. Financial close on the PFI deal is planned for March 2006 and building completion by end of 2009 with services transferring in 2010. The Trust completed replacements of its MRI scanner at the start of the year and its CT scanner at the end of the year. A number of projects have been suspended because of the Trust's poor financial position, but planning work continues on upgrades to the intensive care unit, the mortuary, and Stamford Hospital.

1.2 Financial Performance

The Trust's finances dominated the year and the Trust closed with a deficit of £7.7m. A potential deficit was identified early in the year and the Trust worked with Monitor, the Independent Regulator for Foundation Trusts, to improve financial reporting, and hence the understanding of the position. Two key risks were identified in the summer of 2004: firstly the possibility of over-performing, particularly on emergency activity, with the increased pressure on costs and capacity, and the possibility of the PCTs being unable to pay for it; and secondly the shift on the Trust's cost-base due to pay modernisation costs (consultant contract and agenda for change), EWTD, drugs, clinical negligence insurance and a high level of agency, bank and locum spend earlier in the year. Through payment by results the higher activity led to £5m more income than planned. But despite considerable effort to reduce in particular the locum, bank and agency costs, the overall cost base remained higher than plan, though in the second half of the year it showed more stability as a freeze on new posts and review of replacements took effect.

By January 2005 the outturn deficit was expected to be in the order of £4m-£5m but there were around £1.3m of year end adjustments for items disputed by the local primary care trusts, £0.6m of PFI fees unfunded, and asset write-offs and stock adjustments of £0.6m that took the total to £7.7m. In addition the Department of Health requires repayment of £969,000 for a deficit incurred in 2003/04 as a result of an accrual of back-pay in respect of the consultant contract. The Trust and its auditors do not believe it can legally make this payment and is planning to disclose this as a contingent liability in its accounts pending clarification.

It is of note that the Trust's 2003-04 reference cost was 82, compared with the national average of 100, and the tenth lowest in the country. Under the full tariff arrangements, which are based on national average costs, the Trust has the potential to earn up to £12 million extra revenue through Payment by Results. Because this is being phased in by the Department of Health there was an £9 million claw-back in 2004-05. Payment at full tariff would have covered the reported deficit.

1.3 Other Major Issues

The Board of Governors held four Board meetings in the year and established sub-committees for: non-executive director appointments and terms and remuneration; governance; members' communications and recruitment; and patient and public liaison. This last committee has been integrated with the Patient and Public Involvement Committee of the Board of Directors to form a joint committee that provides the full strategic overview of all such activities.

The Governors recruited three non-executive directors to the Board of Directors. They also established shadow partner arrangements with directors and senior managers to become more familiar with the workings of the Trust. Staff governors have conducted 'surgeries' for staff while public governors have attended public meetings where they have been asked to speak and they used these for recruiting new members. All governors participated in stands celebrating the first year of foundation trust status – aimed at awareness raising and recruitment – within the Trust's buildings.

Membership numbers remained fairly static following the initial membership drive for foundation trust status. Only limited efforts to increase membership were made in the year. A members' newsletter is distributed every 3 months, and we have conducted a major consultation of members on plans to reduce car-parking congestion.

The Trust has worked with the Patient and Public Involvement Forum on studies into hospital cleanliness, recruitment and retention, and nutrition. We held a hospital open day, which was attended by over 1200 people.

Implementation of the new consultant contract was completed by the 31 May 2004 with 96% of consultants taking it up. Appraisal is a key element of the contract and 100% consultant appraisal was achieved in 2004-05. Work on Agenda for Change is going well, but while the Trust has achieved targets for job matching, it wants to get the implementation right and consequently the work on assimilation and the knowledge and skills framework has been slower and the Trust is unlikely to meet the national target of 30 September for completion.

The national staff survey, conducted by Picker, was positive, and showed an improvement on the one undertaken two years previously. Overall permanent staff numbers on 31st March 2005 were 3,314, which was 50 less than the previous year end, and expenditure on temporary staff reduced by £1.9 million (equivalent to about 80 whole time equivalents). Sickness absence was 5.1% and staff turnover averaged 13.71%.

2 Business Plan and Governance

2.1 Strategic Overview

The overarching objective of the Trust for 2005-06 and 2006-07 is to get back into recurrent financial balance and then to generate surpluses. The current plan shows a forecast deficit of £2.9 million in 2005-06 with a break even position being achieved in 2006-07, but the Board is committed to exploring options that will get the current year position as close as possible to break even.

The Trust will also continue to deliver its mandatory services at least to the standards prescribed by "Better Standards for Health" and national targets, with the exception of the maximum wait for an operation, which will be 5 months (not 6 months) by 31st March 2006 subject to commissioners' ability to pay for it.

The Trust will fully implement the new contracts for non-medical staff under Agenda for Change by 31st December 2005 and not by 30th September 2005 as proposed by the Department of Health, because of insufficient management capacity to move quicker and it enables stronger union involvement and validation.

The Trust will complete the work on its Directory of Services and start receiving choice bookings from GPs in Lincolnshire from 1st October 2005, and from Peterborough from 1st January 2006.

The Trust, in conjunction with its partners, will reach commercial close and complete its full business case (FBC) for the new hospital by 31st December 2005 and financial close by 31st March 2006 subject to approval of the FBC and the deal by the approving bodies.

The Trust will increase its public membership from around 5,000 to at least 6,000 and will target its membership drive on parts of the community that appear to be under-represented at the moment.

The Trust will introduce its Priority 1 travel plans to reduce car-parking congestion, as adjusted to take into consideration the consultation of members, by 31st December 2005.

To summarise, during 2005-06 the Trust has to: substantially reduce its deficit; meet or exceed all the national standards; implement patient choice; work in competition with the NHS and private sectors; deal with changes in demand for emergency services and work with Primary Care partners to ensure appropriate facilities are available for patients and publicised appropriately; complete the deal on its new hospital; complete the pay modernisation programme; endeavour make its membership base more representative; and introduce schemes aimed at reducing car-parking congestion.

The risks to these objectives are noted in section 3.

2.2 Service Development Plans

2.2.1 Income from protected activities

After the high level of activity and revenue performance relative to contracted levels in 2004/05, we are anticipating a real terms reduction in activity and income levels in 2005/2006.

The broad approach we are taking in conjunction with our PCT partners is to start with the assumption that activity levels and case-mix in 2005/06 will be at least the same as the actual outturn in 2004/05.

INCOME

£M	**2004/05**	**2005/06**	**2006/07**	**2007/08**
Income from protected activities	119.3	124.8	137.1	150.1
Income from unprotected activities	5.4	6.2	6.5	6.8
Other operating income	18.6	20.0	20.0	21.1
Total income	143.3	151.0	163.6	178.0

Re-pricing of the actual activity levels takes into account the standard national tariff inflationary uplift of 5.3%, the estimated net overall reduction in revenue arising from the national tariff restructuring and the second year benefit of our transition to full standard national tariff prices.

Based on proposals received from the two Peterborough PCTs on 6 May 2005, we anticipate a further reduction in emergency, elective and outpatient activity equating to a real reduction in revenue of £2.5M. This has been incorporated into our revenue projections, but remains subject to further clarification and negotiation with our main PCT partners.

As we understand it, the two Peterborough PCTs are likely to get close to a break-even position in 2004/05, but only as a result of brokerage arrangements, leaving an underlying financial problem of £4M-£5M. The other major PCT with whom we have a contract, Lincolnshire South West, is similarly only likely to report break-even as a result of temporary fixes, leaving an underlying problem to be remedied in 2005/06.

Our revenue projections are therefore based on our best understanding of likely revised contracted activity levels for 2005/06, and then feature only modest real-terms growth of 2% in each of the following two years. This is based on an assumption about the minimum growth in activity arising as a result of local population changes, and delivering on shorter waiting times.

2.2.2 Income from unprotected activities

Other than inflationary uplifts in line with the standard national tariff, no significant changes are anticipated in these areas, with the exception of achieving a real terms increase of £0.5M in services provided outside normal contracts to PCTs. This increase, anticipated in 2005/06, and then maintained, is part of our plan for returning to break-even, and builds on the successful start made in this area in 2004/05 (when £0.3M was achieved).

2.2.3 Other operating income

We are expecting other operating income levels to be at least maintained in real terms in line with 2004/05 levels, with some modest improvement in income generation and trading activities as set out in our savings plans for 2005/06.

We have included in the plan for 2005/06 revenue support for the project costs relating to the Greater Peterborough Health Investment Plan of £1.6M, as recently confirmed to us by the Department of Health. Our planning assumption is to contain project costs within the central budget funding.

2.3 Operating Resources

Operating Expenditure

£M	2004/05	2005/06	2006/07	2007/08
Pay costs	99.8	102.4	108.0	116.1
Drug costs	6.9	8.0	8.4	9.2
Other operating costs	34.7	33.4	34.5	37.4
Total operating expenditure	141.4	143.8	150.9	162.7

2.3.1 Overview

Planned expenditure in 2005/2006 is based on the following:

- Continued control and stability in expenditure levels, as evidenced in the second half of 2004/05.
- Delivery of £2.8M of real cost savings, arising from the savings plan agreed in November 2004 and put in place to have an impact from April 2005 at the latest.
- Achievement of £0.6M of marginal cost reductions relating to the real terms reduction in activity and services proposed by the Peterborough PCTs.
- Achievement of at least £0.9M in savings through the work of the Service Improvement Team, with particular emphasis on reducing pay expenditure on non-clinical staff.
- The various inflationary uplifts and assumptions as set out in more detail below.

2.3.2 Inflationary uplifts and allowances

The inflationary uplifts and allowances applied in the expenditure projections for 2005/2006 are consistent with those used in earlier forecasts, and briefly are as follows:

- Pay inflation assumed at 3.225% on all pay and agency cost heads, in line with the national pay awards for 2005/06.
- The full year impact of pay modernisation under “Agenda for Change” is calculated at an average of 4% across all pay headings with the exception of medical staff and agency costs, based on the DH costing model.
- Non-pay inflation is assumed at 2.35% on all non-pay heads, except for the clinical negligence premium.
- The clinical negligence premium has been increased by 15% to reflect the actual premium advised by the NHS Litigation Authority. A discount of 10% has also been allowed, consistent with our continued achievement of level one accreditation.
- Prescribing costs are assumed to increase by 20% in total, comprising 8% for general increases and inflation, and 12% for the estimated impact of NICE guidance and requirements.

- An allowance has been made for the likely increase in operating costs arising from recent investment in capital equipment. This has been set at 5.6% on premises and fixed plant costs.

- Having worked through all of the above a contingency of £1M has been assumed and factored into the plan. This has been added to the calculated "miscellaneous" non-pay expenditure head (increasing the figure from £1.5M to £2.5M). Of this £1M contingency element, we are committed to investing up to £0.3M in expanding and developing our Service Improvement Team to modernise services and deliver savings. We are also committed to investing £0.13M in our Clinical Directorate to improve clinical governance arrangements for our services, and so that we secure accreditation of CNST level two in 2007 (20% premium discount), and level three in 2008 (30% premium discount).

2.4 Investment and Disposal Strategy

Investment in Fixed Assets

£M	2004/05	2005/06	2006/07	2007/08
Investment in maintenance assets	3.5	4.0	4.0	4.0

The emphasis in 2005/06 and beyond remains upgrading and replacing our current fixed asset stock within the internally generated financial resources available to the Trust. The Trust successfully delivered its reduced capital programme for 2004/05, and will need to maintain this level of strict control to support the overall working capital position.

The major areas of investment in 2005/06 will be:

- Investment in equipment replacement and various schemes relating to ensuring statutory compliance - £1.9M.

- Upgrade of Intensive Care Unit and Mortuary facilities to ensure compliance with Health and Safety Executive minimum requirements - £1.7M. Discussions are underway with the Health and Safety Executive to clarify their concerns and to establish the minimum investment needed.

- Upgrade of a current radiology interventional room to enable angiography services to be provided from January 2006 - £0.4M. In addition, almost all of the necessary equipment, with a value of £0.9M is being provided by the Big Lottery Fund.

In 2005/06, we will also be disposing of 5 non-protected residential properties in the west of Peterborough. These are all sold subject to contract, and will realise at least £0.5M. We will also explore further options to improve our cash position, and make more efficient use of our residential accommodation, including examining the potential to sell our Holdich Street flats.

Beyond 2005/06, the emphasis will be on maintenance of the asset base as we move towards the new hospital build in Peterborough in 2010.

2.5 Financing and Working Capital Strategy

The financial and working capital strategy has as its sole objective maintaining liquidity in the Trust as we move to an income and expenditure surplus from 2006/07.

Net Cash Position

£M	2004/05	2005/06	2006/07	2007/08
Net Cash	(2.6)	(5.6)	(1.4)	3.1

The main elements of the financing and working capital strategy are:

- No long-term borrowing to finance investments
- Capital expenditure financed within internally-generated resources, freeing up £2M per annum for supporting operating costs
- Some improvement in debtor turnover rates
- Maintenance of creditor payment performance
- Continued co-operation from the Peterborough PCTs and the Norfolk, Suffolk and Cambridgeshire Strategic Health Authority in making contract payments on time and also early to assist with any in-year cash pressures.

The Trust concluded the 2004/05 by drawing down £3M of its working capital facility in March 2004. The cash flow plan anticipates increases the drawing down to £6M by January 2006, then holding at that level through to November 2006. The plan is to conclude 2006/07 with a maximum draw down of £2M and move to positive overall cash balances early in 2007/08.

The Trust has a total working capital facility of £8M organised through the Department of Health. This is available without any covenants, restrictions or fees and carries a current interest charge of 4.99%. This expires in March 2006, and cannot be renewed. All outstanding borrowing will need to be repaid by 31 March 2006.

The Trust has negotiated and agreed with its bankers, Barclays, a new working capital facility comprising:

- An overdraft facility of £3M, guaranteed for one year, and
- A committed money market facility of £12M, guaranteed for two years

These facilities are similarly available without any restrictive covenants or on-going fees. The interest charges are set at 1% per annum above base rate for the overdraft facility, and 0.8% per annum above base rate for the committed money market facility.

3 Risk Analysis

This risk analysis is based on the review and development of the Trust's Board Assurance Framework, which incorporates views of the Board of Governors from their own SWOT analysis of the Trust as well as self-assessment of the various compliance requirements and assurance through internal and external audit. Risks themselves are scored according to a risk management framework with the most significant risks discussed in the commentary below.

3.1 Governance Risk

3.1.1 Proposed Risk Rating and Commentary

The Trust proposes a 'green' rating for governance risk. The Board of Directors has self-certified satisfactory compliance with the Terms of Authorisation using a framework that sets out the evidence to support this certification and an internal audit review that gave a rating of 'significant assurance' on foundation trust governance and reporting procedures.

3.1.2 Significant Risks

The most significant governance risks are stated below.

Management Capacity: There will be pressure on the management to deliver a large agenda for 2005-06 within the cost constraints imposed by the Trust's poor financial position. There is a corresponding lack of management capacity and money in the Trust's main commissioners. The Trust is partially mitigating this by additional investment in its Service Improvement Team to work alongside operational departments to improve efficiency and reduce costs. It also takes succession planning seriously and has recently appointed two associate medical directors in anticipation of the current medical director's retirement in the autumn.

Reputation: As one of the first foundation trusts we are under close scrutiny by the media. When the financial results for the first year are published this is likely to increase. Good reputation management is essential to ensure that patients have confidence in the services provided and staff are confident in the management of the Trust. This is being mitigated by: a review of the communications strategy for the Trust; investment to increase pro-active media coverage; continuing close partnership working with the PCTs, the Trust's Patient and Public Involvement Forum, and local Overview and Scrutiny Committees; and developing relationships with local media editorial teams and new MPs.

These risks are being managed and neither is thought to endanger compliance with the Trust's terms of authorisation.

3.2 Mandatory Services Risk

3.2.1 Proposed Risk Rating and Commentary

The Trust proposes a 'green' rating for mandatory services risk. The Board of Directors has self-certified satisfactory compliance with the Terms of Authorisation which covers mandatory services.

In addition the Trust's performance last year shows delivery of contract volumes and achievement of key national access targets. A short-term drop below the A&E 4-hour wait standard in the last quarter, and the temporary suspension of home births in the autumn, were both highlighted to Monitor and resolved promptly, and the local

Primary Care Trusts have supported us in understanding the issues and helping the management action taken.

3.2.2 Significant risks

The most significant risks to mandatory services are:

Partner investment: Our Primary Care Trust partners face severe financial constraints and are reducing their overall investment in the Trust. We will need to work very closely with them to deliver our mandatory services within a smaller budget in real terms.

Patient Choice: The Trust is used by the local Strategic health Authority as one of the few providers with capacity to offer choice at six months and some additional contracts have been secured. However there are two private providers in Peterborough: the Fitzwilliam Hospital (run by Capio); and the independent Specialist Orthopaedic and Spine Hospital. Later in the year Hinchingbrooke Hospital NHS Trust in Huntingdon, 20 miles south of Peterborough, is opening a new treatment centre that appears to have surplus capacity. We therefore face significant competition for elective care, particularly with orthopaedics. To mitigate the risk market intelligence is being collected on these providers' marketing activities and referrals from primary care trusts, as well as watching for any drop in referrals to the Trust. Our strategy of maintaining waiting lists at or below six months reduces the risk of patients choosing to go elsewhere. We have also re-organised our management of orthopaedic services to make them more responsive to our customers.

Business Continuity: The business continuity plans in the event of service disruption through the loss of IT infrastructure, MoD deployments or the loss of buildings has been highlighted as a risk through the Trust's risk management process and through internal audit. They need updating and fallback systems put in place, supported by appropriate insurance arrangements.

These risks are being managed and are not thought to significantly endanger compliance with the Trust's terms of authorisation.

3.3 Financial Risk

3.2.1 Financial risk rating and commentary

The risk rating metrics indicate that the Trust will attain a "2" rating for 2005/06, consistent with the rating applicable in 2004/05.

3.2.2 Significant risks

Achievement of our financial strategy would mean achievement of a "2" rating in 2006/07 and then a "3" rating in 2007/08.

The most significant risks to improving the financial risk rating are:

Cost control and cost reduction: In order to achieve an improved income and expenditure position in 2005/06, and then to move towards the achievement of surpluses, the Trust must deliver significant cost reductions. These relate to delivery on existing cost savings and income generation plans, coupled with achieving further cost reductions in response to the real terms reduction in activity being proposed by our major commissioners in 2005/06.

This risk is being managed through a strong performance management process, including direct monitoring of progress by a Committee of the Board of Directors,

along with revised financial reporting and other mechanisms. In addition, the Trust conducted a diagnostic review of its services and cost base in February using external consultants, and as a result is investing in a refreshed and expanded Service Improvement Team to focus on key areas for service modernisation and delivery of substantial cost reductions identified in the review.

Working capital / liquidity: The Trust's working capital position will remain under pressure in 2005/06 as the Trust still anticipates trading at an income and expenditure deficit (albeit reduced from the previous year). The ongoing income and expenditure position remains the main driver of working capital, and lack of progress on improving trading performance remains the major threat.

The Trust demonstrated successful management of its working capital position in 2004/05, and the working capital strategy in this document sets out the actions being taken to maintain control in this area. In addition, the Trust has agreed a new working capital facility with its bankers, which in total amounts to £15M. This will provide significant additional headroom as we move forward over the next three years.

3.4 Risk of any other non-Compliance with Terms of Authorisation

There are four other significant risks:

Delay in implementation of Agenda for Change: The delay in completing Agenda for Change (A4C) assimilation was noted earlier. The Trust believes this is in line with the progress of other trusts. However, the Trust's A4C Project lead is leaving the Trust. A replacement is being sought but there is a risk the project will lose momentum though the close partnership working with union representatives is helping to mitigate this.

Partnership Working: The poor financial position of the local NHS organisations is causing understandable tensions amongst partners. The Trust believes that good relationships must be maintained and has organised some team-building meetings with its partners.

Greater Peterborough Health Investment Plan: The key future development for the Trust is the delivery of a single site acute hospital in Peterborough as part of a wider PFI scheme with our local partners. Disruption or delay to the scheme would cause both a loss of morale and a potential impact on service development and modernisation as one of the key drivers for change would be lost. A significant investment is being maintained in the scheme to ensure it is delivered to time and at an affordable budget. During the year the Trust will formally re-assess the affordability of the scheme. If it were to prove unaffordable the Trust would need to undertake a major review of its estate strategy.

Car-park congestion: Car parking congestion is creating safety issues as well as inconveniencing patients who wish to access our services. There are therefore both safety and commercial risks if it is not addressed. The recent consultation which attracted over 1,000 responses supports ensuring sufficient income to pay for the travel choice initiatives though people are then reluctant to pay more charges. The Trust is currently assessing the responses and reconsidering its traffic congestion strategy in the light of them. If it pursues the charge increase this should increase income, and while there is a risk it will not necessarily reduce congestion and it is likely to alienate some staff and public, it should ensure the congestion reduction measures are affordable. The Board will need to strike the right balance.

These risks are being managed and are not thought to significantly endanger compliance with the Trust's terms of authorisation.

4 Declarations and Self-Certification

4.1 Board Statements

The Board of Directors considered the requirements of declarations and self-certification at its meeting on the 3 May 2005 and, having due regard to the assurance it received on the management of risks noted above, is able to certify agreement and compliance with the following statements.

4.1.1 Risk and performance management

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

All recommendations to the Board from the audit committee are implemented in a timely and robust manner and to the satisfaction of the committee.

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

A Statement of Internal Control ("SIC") is in place, and the NHS Foundation Trust is compliant with the risk management and assurance framework requirements that support the SIC pursuant to the most up-to-date guidance from HM Treasury.

The Board is satisfied that plans are in place to ensure that all core national healthcare targets and standards are met going forwards.

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

4.1.2 Board roles, structures and capacity

The Board maintains its register of interests, and can specifically confirm that there are no material conflicts of interest in the Board as defined in the Terms of Authorisation.

The Board is satisfied that all Directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

The selection process and training programs in place ensure that the NEDs have appropriate experience and skills.

The management team have the capability and experience necessary to deliver the annual plan.

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

4.1.3 Compliance with Authorisation

The Board will ensure that the NHS Foundation Trust remains at all times compliant with the Authorisation and relevant legislation.

The Board has considered all likely future risks to compliance with the Terms of Authorisation they face going forwards, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks.

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

4.2 Membership Report

4.2.1 Membership Numbers

The Trust's membership for 2004-05 and the planned membership for 2005-06 are as follows:

Membership Numbers

	Last Year 2004/05	**This Year (estimated) 2005/06**
Public constituency		
At year start (April 1)	1,055	5,036
New members*	4,200	2,220
Members leaving*	200	250
At year end (March 31)	5,036	7,500
Staff constituency		
At year start (April 1)	3,978	3,649
New members*	350	350
Members leaving*	679	350
At year end (March 31)	3,649	3,650
Total at 31 March	8,685	11,150

* numbers are estimates only as full electronic membership database management was instituted part way through the year

The increase in public membership over the year was due to two exercises. Firstly the public membership which was low at the beginning of the period was increased through routine leaflet distributions, leaflets included in outpatient appointment letters and most significantly by a randomised mailing undertaken on behalf of the Trust by Computershare using electoral register information. This generated in excess of 2,500 public members. Public membership is also validated by separate processes to track both deaths and those leaving the area. These "gone-away members" account for 66 leavers.

All staff members are automatically opted-in to membership with an opportunity to opt-out if they wish. The in-year reduction in membership was due to staff registered with NHS Professionals, which is managed locally by the Trust, but not working on the Trust's sites, opting out of membership. Changes in staff membership are mirrored by changes to staff leavers and joiners.

4.2.2 Membership Constituencies

The Trust has two membership constituencies – one public and one staff.

The Trust's wider patient and public engagement initiatives encompass not only our governors and our membership, but also specific patient involvement groups (e.g.

disability advisory group, cancer patient information group) and wider consultation as appropriate (including the Trust's statutory Patient and Public Involvement Forum, local Overview and Scrutiny Committees, interaction with the local strategic partnership' local health partners and the media).

The Trust has a diverse membership population. An initial analysis of public members plus their distribution compared with census details is shown below.

Membership by Electoral Ward

Ward	Population	Members	Percent Membership
Empingham	2400	9	0.4%
Fleet	1830	8	0.4%
Spalding Castle	1813	7	0.4%
Spalding St Paul's	3248	14	0.4%
Toller	1758	7	0.4%
Cottesmore	2277	12	0.5%
Pinchbeck	4220	23	0.5%
Sawtry	5323	27	0.5%
The Saints	1764	9	0.5%
Whaplode	2013	10	0.5%
Spalding Monks House	3464	21	0.6%
Surfleet	1814	11	0.6%
Dryden	1456	10	0.7%
Spalding St John's	3669	24	0.7%
Spalding St Mary's	3026	22	0.7%
Weston and Moulton	4701	31	0.7%
Parson Drove and Wisbech St Mary	3259	25	0.8%
Spalding Wygate	3676	29	0.8%
Elm	3240	29	0.9%
Lyveden	1483	13	0.9%
Stanground	9191	81	0.9%
Whittlesey Central	1961	18	0.9%
East	6582	69	1.0%
Deeping St Nicholas	1062	12	1.1%
Dogsthorpe	6645	70	1.1%
Manea	1254	14	1.1%
Benwick and Doddington	4805	60	1.2%
Holbeach St Johns	1409	17	1.2%
Orton Longueville	7732	96	1.2%
Ketton	2067	26	1.3%
March North	5062	67	1.3%
North Bretton	7281	96	1.3%
Whittlesey East	1953	26	1.3%
Whittlesey West	1976	26	1.3%
Crowland	2928	42	1.4%
Fletton	6408	92	1.4%
North	4074	57	1.4%
Barnwell	1555	23	1.5%
Exton	1475	22	1.5%
Northborough	2149	33	1.5%
Park	6503	99	1.5%
Wimblington	1347	20	1.5%
Market and West Deeping	5070	80	1.6%
St George's	3208	52	1.6%

Ward	Population	Members	Percent Membership
Walton	4286	68	1.6%
Werrington North	6006	97	1.6%
Yaxley and Farcet	7101	113	1.6%
Aveland	1634	28	1.7%
Eye and Thorney	4293	73	1.7%
March West	4997	87	1.7%
Stilton	2387	41	1.7%
Whittlesey Kingsmoor	1320	22	1.7%
Central	6393	117	1.8%
Fineshade	1353	25	1.8%
March East	5382	97	1.8%
Newborough	1864	34	1.8%
Paston	6147	110	1.8%
Ramsey	6295	111	1.8%
Ryhall and Casterton	2171	41	1.9%
South	2791	53	1.9%
Stamford St John's	4927	92	1.9%
Deeping St James	5527	111	2.0%
Ringstone	2132	45	2.1%
Truesdale	3524	76	2.2%
All Saints	3794	86	2.3%
Hillsides	1615	37	2.3%
Orton Waterville	6413	147	2.3%
Ravensthorpe	5078	117	2.3%
Bourne East	4997	119	2.4%
St Mary's	3809	91	2.4%
Werrington South	5586	136	2.4%
Elton	2187	55	2.5%
Whittlesey Basenhally	1307	33	2.5%
Barrowden, Edith Weston and Luffenham	1455	41	2.8%
Thurlby	1645	46	2.8%
Bourne West	4638	137	3.0%
West	6877	204	3.0%
King's Forest	1502	46	3.1%
Morkery	1842	58	3.1%
Oundle	4100	128	3.1%
Barnack	2094	66	3.2%
Prebendal	1379	44	3.2%
Glen Eden	1755	66	3.8%
Lower Nene	1542	67	4.3%
Glinton and Wittering	4860	221	4.5%
South Bretton	2427	123	5.1%
Total	301563	5048	1.7%

Members by Age

Age Group	Population	Members	Percent Membership
16 – 24	37489	42	0.1%
25 – 34	52374	89	0.2%
35 – 59	132133	800	0.6%
60 – 75	51573	922	1.8%
75	27994	496	1.8%
Unknown		2699	-

Grand Total	301563	5048	1.7%

Members by Ethnic Group

Ethnic Group	Population	Members	Percent Membership
Unknown		2686	-
Chinese	762	1	0.1%
White & Black Caribbean	524	1	0.2%
Other Black	250	1	0.4%
Other Ethnic Group	559	2	0.4%
White & Asian	460	2	0.4%
Black African	533	3	0.6%
Black Caribbean	1197	7	0.6%
Other White inc Italian	6905	40	0.6%
Asian/pakistani	4313	29	0.7%
Irish	2885	20	0.7%
Other Asian	890	6	0.7%
British	279179	2219	0.8%
Asian Indian	2564	24	0.9%
Other Mixed	542	7	1.3%
Total	301563	5048	1.7%

The public membership area is defined by electoral ward boundaries as determined by the Boundary Committee for England. There have been some electoral boundary changes in the Peterborough and Fenland areas. These changes have not significantly altered the shape of the catchment area, the main changes being:

- South Ward (Peterborough Unitary Authority) – to Orton with Hampton
- South Bretton Ward (Peterborough Unitary Authority) – to Bretton South
- North Bretton Ward (Peterborough Unitary Authority) – to Bretton North
- Yaxley Ward and Farcet Ward (Peterborough Unitary Authority) – to Yaxley and Farcet
- Glinton Ward and Wittering Ward (Peterborough Unitary Authority) – to Glinton and Wittering
- Ryhall Ward and Casterton Ward (Rutland Unitary Authority) - to Ryhall and Casterton
- Benwick and Doddington Ward, Whittlesey Central Ward, Whittlesey East Ward, Whitllesey South Ward and Whittlesey West Ward (Fenland District Council) - to St Marys Ward, Latterly Ward, Benwick Ward, Doddington Ward, St Andrews Ward.

Although these changes do not materially affect the Trust's catchment, work is underway to update it to take account of the changes and to consider any catchment expansion. This is discussed below.

4.2.3 Future Membership

The Trust has a Board of Governors' Committee that monitors membership communication and recruitment. To support the work of the group a full membership strategy is being developed to cover not just recruitment but the methods of communication that can be used for engaging members, receiving their views and feeding back to them.

There are three key pieces of work for the coming year detailed below.

(1) Membership catchment review

The Trust's public catchment has been set according to our patient catchment area (where there is an average rate of at least one in ten contacts per ward with the hospital in a year). A review of our catchment area is to be undertaken to ensure that any growth in a patient catchment area is matched by a corresponding increase in membership for that area. This work is being done by an external company with the results expected in June.

To ensure stability we plan to review the catchment once every two years.

(2) Membership representativeness

The tables in annex 4 show the representativeness of the Trust's membership when matched to the census population of the catchment area. There are a significant number of members who have withheld details. To help complete the missing data members have been specifically mailed to ask for missing details. This was done when the Trust asked for e-mail addresses to provide a facility for e-mail rather than paper communications for those members who prefer to receive information electronically. This exercise generated 751 public members who registered to receive their information in this way, and a total of 2394 updates to individual pieces of information.

For the sake of simplicity where details are withheld these are currently assumed to be representative of the membership.

The methods to be used for addressing representation are:

Population numbers – A targeted mailing will be carried out to under-represented areas (see annex 4(a)) including any new wards that may be added in the exercise noted in (1) above. This is planned for September 2005.

Ethnicity – An approach is to be made to community leaders of under-represented groups (see annex 4(b)) in conjunction with the Trust's overall work with "hard to reach" groups. This will include working with the local Commission for Racial Equality.

Age – Work is to commence with the Local Education Authority to engage with young people through schools. Initial contact work is underway. Leaflets for recruitment will also be targeted at local gyms and health clubs.

(3) Membership growth

Looking at the current membership numbers the following are the plans for membership growth. This concentrates solely on public membership numbers as staff are all invited to be members and there is currently a low opt-out level.

Planned Public Membership Growth

Date 31 March	2005	2006	2007	2008	2009
Public Membership Target	5,036	7,500	10,000	12,500	15,000

Given the success of the previous direct mailing, this is being considered again across the catchment area, but it will also be targeted at those wards and postcode areas that are underrepresented in the membership as noted above on (2)(a).

Other groups are also being targeted for their interest including individual local councillors and General Practitioners.

4.2.3 Election of Governors

The Trust has held one election for governors the close of the ballot was on 24 March 2004. It was managed on behalf of the Trust by Electoral Reform Ballot Services who certified the process. The Board of Directors is therefore able to certify that the elections undertaken were in accordance with the election rules in the constitution.

Since these elections new model rules have been issued by the Department of Health. These simplify the process and have been discussed and ratified by the Board of Governors. The Trust will be writing to the Regulator requesting that these rules be incorporated into the constitution.

4.2.4 Membership Management

The Trust successfully tendered for membership management services. This contract was awarded to Hercules Direct Marketing, the set-up of which commenced on the 1 November 2004. This service includes a telephone helpline for members.

Consideration is also being given to the potential for associate members who may not quality for full membership but may be interested in receiving details concerning our services. This includes those under 16 and those who live just outside the catchment area but may have relatives or friends who are users of our services. Such membership will also be an indication of the potential to grow our membership area in the future. Associate members would obviously not be able to vote.

5 Financial Projections

Please see attached templates (Annual Plan Template monthly version 1.12)