Peterborough and Stamford Hospitals
NHS Foundation Trust

Annual Plan 2006/2007

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 second 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

This report refers to the financial year ended 31st March 2006 but it is worth reflecting how the year started.

The Trust had ended the previous financial year with a £7.7m deficit. The Trust had been under-funded for the cost of the consultant contract and Agenda for Change, the pay modernisation package for all other staff. The Department of Health had also arbitrarily withdrawn nearly £2m of funding for the cost of the new hospital project. The impact of these and other structural changes in funding arrangements hit the Trust earlier than much of the NHS because as a first wave foundation trust we were working with the new financial regime a year early.

The restriction on funds had also caused the Trust to struggle with the access target of 98% of patients being seen, treated, admitted or discharged from the Accident and Emergency Department within 4 hours.

Both these factors contributed to the Trust again achieving two rather than three stars when they were announced in July 2005, and both dominated the Trust's focus and attention over the last year.

Following a report by independent advisers in February 2005, the Trust re-launched the Service Improvement Team and appointed an Associate Director to lead it. The team was expanded over the next three months and worked on improving clinical practice to reduce lengths of stay. The advisers had proposed that if lengths of stay were uniformly reduced across the Trust to the 60th percentile best performance of a similar group of hospitals then at least 100 beds could be taken out of commission. They also suggested that improvements to theatre utilisation and administration would yield further savings.

The improvements in clinical practice released beds and enabled patients in A&E to be admitted more quickly. The Trust promptly bettered the 98% access target, and maintained it for the whole of 2005-06.

In the summer of 2005, the Trust reconfigured its wards and closed 106 beds. Regrettably there was very limited notice or consultation as the Trust needed to make the savings urgently in order to stay within its borrowing limits. This prompted public concerns, particularly in Stamford where one of two wards was closed at Stamford Hospital, which fanned fears the whole hospital might close. A campaign to save the hospital led to three protest marches. In Peterborough there were two marches against bed closures.

As a result of the ward reconfigurations 75 posts were removed, but by redeploying staff into vacancies and posts being filled by temporary workers there was only one redundancy.

Over the early winter the Trust continued to manage well on the reduced bed capacity, and theatre utilisation improved through an increase in the amount of surgery done as day cases and greater throughput of major operations.

Nevertheless the financial trajectory indicated costs were still not falling fast enough to match anticipated revenues and the Trust commissioned further work to develop a £6m savings plan over two years (2006/7 and 2007/8) with a reduction of about 185 jobs. Formal consultation of unions and staff representatives commenced in February 2006, and the plan is now being enacted. Whilst there will probably be further bed reductions because the Primary Care Trusts (PCTs) are reducing their investment in our hospitals, we are also making significant changes to our administrative and management arrangements.

The final position for the year ended 31st March 2006 was a deficit of £950,000 after providing £1.7 million for work done but disputed by PCTs.

Finance was not the only item on the Trust's agenda. In May 2005 we developed a new form of knee surgery at Stamford Hospital using a 'magic wand'. In June we commenced a new glaucoma screening service. We introduced a new bladder scanner in August and we opened an angiography suite in November funded by the national lottery. On the wards we introduced 'protected mealtimes' in September, and in November we had displayed the results of our 'Art in Hospital' project when local photographers donated outstanding photographs of local scenes to decorate the corridors.

During the summer we launched our Travel Options programme to encourage people to consider alternatives to using their cars to get to hospital so as to relieve pressure on our car parks for those who have no alternatives. Although not universally popular, this had been fully consulted on and it has had quite an impact, not least for safety because there has been a huge reduction in the number of cars parked illegally on yellow lines on hospital sites. The scheme won a county award for sustainable transport schemes.

In October the Trust was named as one of the top 100 employers by the Nursing Times for 2005, the only NHS organisation in East Anglia to be in the list.

Despite the financial problems all key targets were met and many exceeded. The Trust already had one of the lowest MRSA rates in the country so it was particularly pleasing to see a further reduction in the number of MRSA bacteraemia cases. The Trust delivered its mandatory services at least to the standards prescribed by "Better Standards for Health" with the exception of one area: training records for medical devices, where it was not totally compliant during the year, but achieved full compliance by the year end, 31st March 2006.

Although no one would pretend it was the Trust's 'best year yet', we have achieved a major turnaround from the situation that we started with, and there has been some excellent work to improve the standards and quality of our services.

1.2 Financial Performance

The table below sets out the ***provisional*** financial results for the Trust for the year ended 31 March 2006.

The annual accounts for the year are not yet completed, having been submitted for external audit scrutiny on 5 May 2006. Following external audit review, the Board of Directors will be requested to consider any further amendments and will then approve the annual accounts at a meeting in June.

The annual accounts will then be submitted by Monitor, the Independent Regulator for NHS Foundation Trusts, to Parliament in late July 2006. Once this has happened, the Board of Directors will be able to publish the accounts.

Income and Expenditure – Provisional Results For The Year

£ Millions	Plan	Actual	Variance Better/(Worse)
INCOME			
Protected income (PCT contracts)	131.8	137.3	5.5
Funding withdrawn by Dept of Health	(6.8)	(6.8)	-
Unprotected income	6.0	4.5	(1.5)
Other operating income	20.0	19.6	(0.4)
Total Income	**151.0**	**154.6**	**3.6**
EXPENDITURE			
Pay costs	102.4	100.9	1.5
Non-pay costs	41.4	45.0	(3.6)
Depreciation, dividends and other costs	10.2	9.7	0.5
Total Expenditure	**154.0**	**155.6**	**(2.6)**
Retained Surplus / (Deficit)	**(3.0)**	**(1.0)**	**2.0**

[Sources: Plan – Annual Plan, approved May 2005; Actuals – year-to-date provisional results]

The Trust achieved a deficit of £1.0M in 2005/2006, significantly better than plan, and demonstrating sufficient progress on the planned route towards break-even and then financial surpluses. The main focus throughout last year was on maintaining tight control on expenditure and realising £5M of clear cost reductions.

1.3 Other Major Issues

There were a number of changes to the Trust Board of Directors. Mr Alan Turner, Medical Director and Mr Bill Stevenson, Director of Operations, retired during the year, and Dr Sarah Raper, non-executive director resigned following a promotion. In their places Mr John Randall was appointed as Medical Director and Mrs Paula Gorst was appointed in May 2006 as Director of Operations. Mr Jonathan Radway joined the board as a non-executive director following the departure in 2004-05 of Mr Keith Pearson. The Chairman, Dr Clive Morton OBE, and Mr Geoff Clubbe and Mr Raza Rahim, both non-executive directors, were re-appointed by the Board of Governors on expiry of their previous terms of office. Mr Andrew Burroughs has been appointed non-executive director since the year-end to replace Dr Raper.

The Board of Governors suffered the sad loss of two public governors who died whilst in office - Councillor John Horrell and Mr John Dawson. The year has also seen the resignation of two governors, Mrs Rosemary McCulloch (public governor) for personal reasons and Mrs Jane Porter (staff governor) who moved to a position with the University of Leicester Hospitals NHS Trust. Two changes in partner governors also occurred with Councillor Graham Murphy assuming the role of partner governor representing Peterborough City Council as the cabinet member for Health and Adult Social Care (replacing Councillor John Holdich) and Mrs Angela Barr who assumed the role of partner governor for the Greater Peterborough Primary Care Partnership as Acting Chief Executive (replacing Mr Chris Town).

In accordance with its terms of authorisation the Trust has continued to work with the 'Connecting for Health' team to implement the national programme for IT. Progress by the Department of Health has been frustratingly slow, and their systems to support the 'Choose and Book' service have been very poor and so far, not fit for purpose.

The Trust had virtually finished implementing the Agenda for Change programme by the end of the year. The only significant group not to have been processed by the year-end was senior mangers and their changes have now been made.

2 Business Plan and Governance

2.1 Strategic Overview

But for the PCTs not having enough money to pay for the services arising from the referrals they had sent us, the Trust would have been in surplus in 2005/2006. At the time of writing the PCTs have identified, and the Trust has agreed, the amount of activity it will need to undertake in 2006/2007 but the PCTs have already signalled that they cannot afford to pay for it all. They have tasked the Trust with identifying procedures that should take a lower priority in order to save the PCTs money. However as the PCTs will require significantly more activity to be done in the following year in order to get waiting lists down to 18 weeks (and should have the funds to pay for it), it would be nonsensical for the Trust to lay staff off in one year only to have to recruit again the next year. The Trust is therefore seeking a fair settlement in the current year. Assuming this is eventually forthcoming, and the Trust delivers its current savings plans, it should make a small surplus in 2006/2007.

PCT finances are complicated by the reorganisation of PCTs. We have been part of the campaign for a Peterborough PCT and are pleased with the outcome of the local lobbying resulting in this achievement. However, the PCT's finances continue to look very precarious because of crippling deficits in south Cambridgeshire which the Peterborough PCT will be expected to support.

The Choose and Book system and patient choice are both threats and opportunities. In order to gain best advantage from this new system the Trust has appointed a Head of Business Development to seek new business and maximise income and hence make best use of our capacity. The Trust sees opportunities to expand its catchment to the north, west and east as other providers are in considerable financial difficulty and struggling to provide services. We are actively engaged in discussions with GP practice-based commissioning groups in these areas and have started to develop outreach clinics in community hospitals up to an hours drive from Peterborough. To our south Hinchingbrooke Hospital has recently opened a new diagnostic and treatment centre. This represents a potential threat but the Trust is in discussion with Hinchingbrooke about ways to work cooperatively to minimise the potential loss to either Trust.

The Trust also plans to conclude the contract for its new hospital with Progress Health, a consortium comprising ABN-Amro and Multiplex by September 2006. This will see the hospital opening in 2010. The commercial negotiations are well advanced and the Trust Board of Directors has agreed that the financial projections are affordable. The Government in the form of the Department of Health's Private Finance Unit, HM Treasury and the Independent Regulator for NHS Foundation Trusts must now consider the plans for approval. The Government is reviewing all major PFI schemes but at the time of writing it is unclear how these bodies are going to conduct the review or the parameters by which they are going to assess whether they will approve a scheme.

The Trust will deliver its mandatory services at least to the standards prescribed by "Better Standards for Health" and national targets subject to commissioners' ability to pay for it.

The Board of Directors and Board of Governors discussed objectives at a joint meeting and these have been developed by the Trust Executive and Board of Directors into a new set of strategic objectives.

To ensure that the Trust becomes and remains fit for the future our objectives, and broad performance indicators (in italics) are to:

- Be the healthcare provider of choice for the community of Greater Peterborough and the surrounding area; *we will undertake patient surveys and market research to monitor this.*

- Provide a comprehensive range of elective, emergency and diagnostic services suitable for a medium sized district general hospital at least to national standards; *we will maintain all our current services or will consult on any anticipate d changes.*

- Generate a surplus of at least 2% annual turnover every year to invest in our services from 2007/08; *we will monitor performance against this current annual plan*

- Invest in hospital estate in Peterborough to ensure facilities are fit for purpose; *we compare the results of our annual estate survey with previous years and with national benchmarks to demonstrate improvement.*

- Invest in Stamford Hospital to create a vibrant health campus in Stamford through development of NHS services, public/private partnerships and sub-lets to complementary service organisations; *we will establish a local hospital advisory committee to monitor this activity.*

- Project a positive image of the Trust and its individual services through pro-active communication and consultation with: Foundation Trust members, public, patients, staff, commissioners and stakeholders; *we will survey our members and stakeholders to give us feedback on our image in the community.*

- Continually improve services and reputation, and promote customer loyalty through a model that fully involves patients and primary care colleagues; we will maintain our service improvement team; *we will produce a project plan and timetable for our 'total patient involvement' project and monitor progress against that.*

- Be a model employer with a reputation as a great place to work in order to attract and retain excellent staff. *we will undertake an annual staff survey to check staff opinions and attitudes, and we will demonstrate an improvement in sickness absence statistics and a lowering of underlying staff turnover rates*

The main financial projections are set out in the accompanying appendix 2.

The income and expenditure projections are summarised as follow:

INCOME AND EXPENDITURE PROJECTIONS

£M	Actual 2005/06		Plan 2006/07	Plan 2007/08	Plan 2008/09
Earnings before interest, tax, depreciation and amortisation (EBITDA)	8.7		10.2	15.4	16.1
EBITDA Margin	5.61%		6.43%	9.15%	9.23%
Surplus/(Deficit) for the year	**(1.0)**		**0.2**	**5.1**	**5.6**
Bottom Line Margin (Target 2%)	**(0.7%)**		**0.17%**	**3.44%**	**3.66%**
Cumulative retained surplus(deficit)	(7.1)		(6.9)	(1.8)	3.8

2.2 Service Development Plans

Our current activity and revenue projections are set out in the main table below, and analysed in more detail in the subsequent sections.

INCOME

£M	Plan 2005/06	Actual 2005/06		Plan 2006/07	Plan 2007/08	Plan 2008/09
Income from protected activities	125.0	130.5		134.7	143.8	149.2
Income from unprotected activities	6.1	4.5		5.1	5.2	5.4
Other operating income	20.0	19.6		18.4	19.1	19.7
Total income	**151.1**	**154.6**		**158.2**	**168.1**	**174.3**

2.2.1 Income from protected activities

Clinical Income

£M	Plan 2005/06	Actual 2005/06		Plan 2006/07	Plan 2007/08	Plan 2008/09
Elective	29.0	30.9		29.5	30.7	31.9
Non-Elective	55.8	54.7		56.9	59.2	61.5
Outpatients	24.9	27.3		26.7	27.7	28.8
Accident and Emergency	4.9	5.4		5.5	5.7	5.9
DoH Clawback	(6.8)	(6.8)		(3.8)	0	0
Sub-Total	**107.8**	**111.5**		**114.8**	**123.3**	**128.1**
Other services	17.2	19.0		19.9	20.5	21.1
Total income from protected activities	**125.0**	**130.5**		**134.7**	**143.8**	**149.2**

Contract negotiations are well underway with all our main PCT commissioners at the present time but are not yet concluded. The main issues under consideration include:

- PCT commissioning intentions which anticipate:

    - Continued, but more modest reduction, in emergency activity.
    - Continued transfer of some outpatient activity and other activity to primary care settings.
    - Some additional investment in some surgical specialties to ensure waiting times can be maintained – but offset by reductions in other surgical specialties.
    - Continued commissioning from the private sector to fulfil the national patient choice agenda.
- Disagreement over the actual value of the elective and outpatient activity undertaken by the Trust last year.
- Issues around PCT allocations and finances, linked with the new standard tariff, and especially in the context of major financial deficits across Norfolk, Suffolk and Cambridgeshire Strategic Health Authority and Trent Strategic Health Authority.
- Issues around the affordability of required activity levels to sustain waiting times performance in 2006/2007, let alone make progress on getting towards the 18-week total waiting time target for 2008. Having agreed activity levels with the Peterborough PCTs on 12 April 2006, the PCTs are concerned that these activity levels are not affordable.
- The impact of 'patient choice' on activity levels and waiting times.
- Financing, through our contracts, the so-called 'excluded drugs' in chemotherapy/oncology, rheumatology and AIDS/HIV+ retro-virals. These are all areas where actual spending exceeded contracted levels last year, and we can expect increased spending to continue as demand for these services grow locally.

The approach taken to forecasting revenue from clinical services at this stage is based on the following:

1. The start point is the actual activity undertaken in 2005/2006, re-priced under the new national tariff to 2006/2007 prices. This generates a price increase of 1.5% on average on tariff-based services. A similar increase for inflation of 1.5% has also been applied to non-tariff based services. This increases revenue by £2.1M.

2. The valuation of emergency activity has been adjusted in line with Department of Health technical guidance issued in March 2006. This requires the gap between emergency activity and a predetermined threshold (2004/2005 actual outturn plus 3.2%) to be valued at 50% of tariff prices. As actual emergency activity has fallen below this threshold, the pricing adjustment compensates the Trust at an estimated £1.3M. This approach and the technical guidance has been queried by the Peterborough PCTs with the Department of Health.

3. A real terms reduction of £2.8M has been effected, in the light of disagreement about the actual level of activity undertaken last year, and partly in anticipation of further reductions in activity being possible. No real terms growth has been factored in to non-mandatory services with the exception of just under £0.6M in respect of 'excluded drugs'. This assumed increase in funding would be sufficient to cover the actual cost of spending in this area

in 2005/2006. This is judged to be a prudent approach at the present time.

4. The Department of Health 'claw-back' reduces again in 2006/2007 and based on current figures has the effect of increasing revenue by £3M (as shown in the table above). This means that the Trust is allowed to keep 75% of the benefit of earning revenue based on national tariff prices (partly derived from national averages) compared with earning revenue based on our own unit costs.

Our revenue projections are therefore based on our current understanding of likely revised contracted activity levels for 2006/2007, and then feature only modest real-terms growth of 0.9% 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, linked with some transfer of activity to the primary care sector.

In addition, in 2007/2008, assuming no fundamental policy changes, after four years the Trust will finally move to retain 100% of the benefit from moving to national prices. This is expected to improve the revenue position by another £3.8M.

2.2.2 Income from unprotected activities

Other than inflationary uplifts in line with that advised by the Department of Health of 4%, no significant changes are anticipated in these areas.

This means we intend to maintain activity and revenue levels in line with the actual outturn achieved last year, primarily on our activity contract with the Ministry of Defence (£3.0M) and ad-hoc arrangements, driven by 'patient choice' with more distant PCTs (£0.5M). The latter item is at some risk – but our planning assumption is based on what we have actually achieved in the last two years.

2.2.3 Other operating income

We are expecting other operating income levels in most areas to be at least maintained in real terms in line with 2005/2006 levels, with some modest improvement in income generation and trading activities as set out in our *Fit For The Future* plans.

The Trust received £2.2M from the NHS Bank in 2005/2006 as central funding to support the project costs of the Greater Peterborough Health Investment Plan (GP HIP). Discussion is underway with the NHS Bank and Department of Health on securing transitional funding in 2006/2007 ahead of the first phases of the scheme going ahead. What happens here is largely dependent on decisions being made on the whole GP HIP scheme, progress through the approvals process (still to be determined) and financial and contractual completion. At this stage, the only income included is £0.4M being that part of the income received last year and deferred to 2006/2007.

2.3 Operating Resources

Operating Expenditure

£M	Plan 2005/06	Actual 2005/06		Plan 2006/07	Plan 2007/08	Plan 2008/09
Pay costs	102.0	100.9		103.1	106.3	109.9
Drug costs	8.0	8.3		9.8	10.1	10.5
Other operating costs	33.6	36.7		35.1	36.4	37.8
Total operating expenditure	**143.6**	**145.9**		**148.0**	**152.8**	**158.2**

2.3.1 Overview

Planned expenditure in 2006/2007 is based on the following:

- Continued control and stability in expenditure levels, as evidenced throughout last year.
- Delivery of £3.0M of real cost savings through phase one of our *Fit For The Future* savings programme, agreed in November 2005, and being implemented.
- 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 2006/2007 are consistent with those used in earlier forecasts, and briefly are as follows:

- Pay inflation assumed at 2.5% on all pay and agency cost heads, in line with the national pay awards for 2006/2007.

- The full year impact of pay modernisation under “Agenda for Change” works out at an average of 2.8% across all pay headings with the exception of medical staff and agency costs.

- Non-pay inflation assumed at 2.0% on all non-pay heads, except for prescribing and the clinical negligence premium.

- The clinical negligence premium has been reduced by 10% 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 24% in total, comprising 12% for general increases and inflation, and 12% for the estimated impact of NICE guidance and requirements.

In addition to all of the above, a contingency of £1M has been factored into the plan.

From 2007/2008 onwards, costs have been assumed to increase by 4.7% for inflation and similar pressures (compared with a tariff and revenue uplift assumption of 3%). Cash releasing savings have been assumed to cover this gap – in 2007/2008 through the second phase of *Fit For The Future* (2% or

£3M) and in the following year through further savings/income generation (equivalent to 1.7% or £2.6M)

2.3.3 Cash Releasing Savings – 'Fit For The Future'

The Board of Directors approved a two-year savings programme in November 2005, based on a detailed assessment of opportunities to modernise services and deliver real cost reductions at the same time. The savings programme was launched under the badge *Fit For The Future* in January 2006 and is being implemented at the present time.

In summary, the savings programme is planned to deliver a minimum of £6M over the next two years – 'stretch targets' are being set beyond this to maintain a focus on further opportunities for savings.

The main savings reductions comprise:

- The closure of another medical ward - £0.9M
- The closure of another surgical ward - £0.8M

(linked to reductions in inpatient activity, and increased day surgery for surgical patients)

- Reduction in administrative staffing costs - £0.9M

(linked with centralised patient booking arrangements and increased investment in information technology)

- Improved pharmaceuticals and general procurement - £0.8M
- Reduction in insurance premiums - £0.5M

2.4 Investment and Disposal Strategy

Investment in Fixed Assets

£M	Plan 2005/06	Actual 2005/06		Plan 2006/07	Plan 2007/08	Plan 2008/09
Investment in maintenance assets	4.0	3.5		4.0	4.0	4.0

Actual investment in fixed assets was finally 0.5M lower than planned because of slippage on our scheme to re-locate and upgrade the Intensive Care Unit at Peterborough District Hospital. However, the Trust successfully delivered on its revised programme for 2005/2006, and will need to maintain this level of strict control to support the overall working capital position.

The emphasis in 2006/2007 and beyond remains upgrading and replacing our current fixed asset stock within the internally generated financial resources available to the Trust.

The major areas of investment in 2006/2007 will be:

- Investment in equipment replacement and various schemes relating to ensuring statutory compliance - £2.4M

- Upgrade of the Intensive Care Unit at the Peterborough District Hospital – £1.2M
- Investment in Information Technology (IT) linked to the NHS programme for IT (Connecting For Health) and to enable a number of our Fit For The Future cost reductions schemes to be achieved - £0.4M

Beyond 2006/2007, the emphasis will be on maintenance of the asset base as we move towards the new hospital build in Peterborough in 2010. Should this scheme not proceed, then the investment and disposal strategy, and associated financing and working capital strategy, will need to be revised to reflect additional investment in the existing hospital buildings in Peterborough.

2.5 Financing and Working Capital Strategy

Net Cash Position

£M	2004/05	2005/06	2006/07	2007/08	2008/09
Net Cash	(2.6)	0.5	0.3	3.4	7.4

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 2006/2007.

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
- Improvement in debtor turnover rates
- Maintenance of trade creditor payment performance

The Trust negotiated and agreed with its bankers, Barclays, a new working capital facility. This came into effect in December 2005, and comprises a committed money market facility of £12M.

These facilities are available without any covenants, restrictions or fees. The interest charges are set at 0.8% above base rate.

The Trust concluded the 2005/2006 financial year by repaying the £3M drawn down from the committed money market facility with Barclays. This leaves the whole working capital facility of £12M available to support any in-year working capital pressures, and as a hedge against not achieving in line with the income and expenditure plan.

3 Risk Analysis

This risk analysis is based on the review and development of the Trust's Board Assurance Framework and 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 Commentary

The five elements of governance are noted below together with the approach that the Trust is using to ensure compliance.

Legality of constitution: The Trust's original constitution was developed with external legal advice and is kept under review by the Governance Committee of the Board of Governors, who explore in detail any national requirements and local developments that need reflecting to ensure that the constitution remains up-to-date. In the past year changes have been made to reflect the revised Department of Health election rules and to update the public membership boundaries to ensure that these reflect changes in ward boundaries. Further developments are expected in the coming year to ensure the appropriate reflection of partner organisations following PCT reconfigurations. We are considering a full review of the constitution during 2006/2007 using legal advice to ensure continued compliance.

Representative membership: The membership report at section 5 provides details of the actions that have been taken regarding membership development including increased community engagement, advice concerning local ethnic minority groups and the identification of geographic areas of under-representation which are to be tackled.

Appropriate board roles and structures: The Trust has reviewed its structure for the Board of Directors during the year, taking the opportunities of retirements amongst its executive directors and vacancies amongst non-executive directors to review skills and capabilities. Given the clear need for maintaining strong leadership the vacancies caused by the retirement of the Medical Director and Director of Operations have been filled and the Trust senior management team has also been supplemented by a Head of Business Development who commenced in post in May 2006. Vacancies arising from the resignation of non-executive directors have led to the skill mix complementary to the executive directors being reviewed and non-executives with legal, marketing and business backgrounds being recruited.

Effective risk and performance management: The Trust has worked throughout the year to put in place effective performance management arrangements to ensure the delivery of an effective savings plan. The lessons from this exercise have been reviewed and board-level performance management arrangements changed to ensure a sharp focus on operational delivery as well as a more strategically focused Board of Directors meeting. The Trust has also been reporting a single non-compliance with one of the standards for better health concerning medical devices. An action plan has successfully been put in place for this to be addressed and compliance has been achieved by 31 March 2006.

Co-operation with NHS bodies and local authorities: The Trust has a long history of partnership working which is evidenced in the Greater Peterborough Health Investment Plan. The Trust is committed to working in partnership with representation on the Local Strategic Partnership (Greater Peterborough Partnership) and has established good working relationships with the local Overview and Scrutiny Committees. An advisory committee for the future development of Stamford Hospital has been established which will ensure that links with local Stamford partners are developed and strengthened. These working relationships are also balanced with a robust approach to commissioning and contracting discussions as the Trust needs to safeguard its effective provision of, and payment for, services.

The Trust would therefore expect a 'green' rating for governance in the coming year.

3.1.2 Significant Risks

The most significant governance risks are stated below.

Reputation: As mentioned in the previous year's plan, reputation management is a key area to be addressed. Whilst the Trust's financial position has improved, plans for recovery include the loss of jobs at the Trust including redundancy. 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. Work is ongoing to develop closer working relationships with the media who are key to the portrayal of the Trust, and the past year has seen an increase in pro-active positive media coverage.

Partnership working: There are inevitable tensions to working in co-operation with NHS bodies due to the need for clear contracting terms regarding payment for work undertaken, and developing a clear understanding with PCT commissioners that the levels of patient care within contracts match patient demand and the requirements to meet national targets. At the same time there needs to be good partnership working and understanding between local organisations to ensure that the plans for the Greater Peterborough Health Investment Plan and the development of the Stamford hospital campus proceed with partnership support. The maintenance of this balance is addressed on an ongoing basis with strong chief executive relationships and participation in local partnership events.

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 Commentary

The Trust has worked throughout the year to ensure that the national targets for services are achieved and maintained, and progress made towards future targets.

Mandatory services: Plans for the continued development of our services and delivery to national targets are part of our ongoing contacting discussions with Primary Care Trusts. Emergency planning preparedness has progressed well and the Trust plan is listed on the Department of Health website as best practice. The impact of the white paper on community health and care services – "Our health, our care, our say" – has been considered and confirms the direction already foreseen through the development of the

Greater Peterborough Health Investment Plan where the move of appropriate services out of an acute hospital setting such as diabetes care is already planned, and prudent assumptions for growth have been made.

Protected assets: There has been no change to the Trust's protected assets. Changes will come on stream with the progression of the delivery of the Greater Peterborough Health Investment Plan, for which part of the District Hospital site was originally classed as unprotected.

The Trust would therefore expect a 'green' rating for mandatory services risk.

3.2.2 Significant risks

The most significant risks to mandatory services are:

Partner investment: Our Primary Care Trust partners continue to face severe financial pressures 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; as mentioned regarding the risk to partnership working we need to be clear that this investment does not mitigate our ability to provide services to national standards.

Patient Choice and marketing: Whilst there has been little evidence of the impact of patient choice, the Trust's Head of Business Development will develop a marketing strategy which will aim to maintain and increase patient flows to the Trust. This will ensure that gaps caused by any withdrawal of local funding into alternative providers can be secured from elsewhere, and that services can effectively be protected. There has been as yet, no discernable impact of private sector competition, however this situation is being monitored to ensure early warning of any change can be highlighted and action taken.

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

3.3 Financial Risk

3.3.1 Commentary

Achievement of our financial strategy is likely to mean achievement of a risk rating of '3' (normal or average) in 2006/2007 and 2007/2008, moving to a '4' (better then average) in the following two years.

3.3.2 Significant risks

The most significant risks to the financial risk rating are:

Cost control and cost reduction: In order to achieve an improved income and expenditure position in 2005/2006, and then to move towards the achievement of surpluses, the Trust must continue to deliver on its *Fit For The Future* savings programme. This is a major programme of savings reductions, amounting to £6M on top of the £5M achieved last year.

This risk is being managed through a strong performance management process, including direct monitoring of progress by the Trust Executive team, a Committee of the Board of Directors and the full Board of Directors itself.

Revised financial reporting and other monitoring mechanisms are bedded in, and the Trust has invested in a refreshed and expanded Service Improvement Team which is focussing on key areas for service modernisation and delivery of substantial cost reductions.

Working capital / liquidity: The Trust's working capital position will remain under pressure in 2006/2007 as the Trust anticipates trading at just above break-even. 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 2005/2006, and the working capital strategy set out in this document sets out the actions being taken to maintain control in this area. In addition, the Trust has negotiated and agreed a working capital facility with its bankers, which in total amounts to £12M. This provides significant additional headroom as we move forward over the next three years.

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

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

There is one significant risk:

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 because 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. Whist the Board of Directors has confirmed the schemes' affordability; the outcome of the governmental review of all PFI schemes is awaited. Delay will stretch the Trust's ability to finance the project. If the scheme does not proceed due to this review the Trust will need to undertake a major review of its estate strategy.

This risk is being managed and is not thought to significantly endanger compliance with the Trust's terms of authorisation at this stage.

4 Declarations and Self-Certification

Board Statements

The Board of Directors considered the requirements of declarations and self-certification at its meeting on the 4 April 2006 and, having due regard to the assurance it received, is able to certify agreement and compliance with the Board statements for:

- risk and performance management
- board roles, structures and capacity self-certification
- compliance with the terms of authorisation

The full templates are attached as appendix 1.

5 Membership Report

5.1 Membership Numbers

The Trust's planned and actual membership numbers for 2005-06 and the planned membership for 2006-07 are as follows:

Membership Numbers

	Last Year (Plan) 2005/06	**Last Year (Actual) 2005/06**	**Next Year (estimated) 2006/07**
Public constituency			
At year start (April 1)	5,036	5,006	5,073
New members	2,220	405	2,765
Members leaving	250	338	338
At year end (March 31)	7,500	5,073	6,500
Minimum number of members required under Schedule 1	100	100	100
Staff constituency			
At year start (April 1)	3,649	3,686	3,450
New members	350	228	230
Members leaving	350	464*	330
At year end (March 31)	3,650	3450	3350
Minimum number of members required under Schedule 1	50	50	50
* of these staff member leavers, 218 converted to public membership			

As can be seen from the figures in the table, membership numbers have remained relatively static. Plans for increasing membership numbers were halted as part of the Trust's savings plan for 2005/2006, and work has concentrated on maintaining numbers and considering methods of effective communication. This has included using the membership as a reference group to comment on our travel options plan (mentioned in section 1) and to provide feedback on visiting time arrangements, and also through working in partnership with the Trust's Patient and Public Involvement Forum allowing them access to the membership to ask for their assistance in assessing our Patients Advice and Liaison Services.

5.2 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 and the media). There is therefore no separate patient constituency.

5.2.1 Public Constituency

The public constituency is defined by a membership catchment area. The Trust has a diverse membership population with a full breakdown of numbers as at the 20 March 2006 shown below.

Members by Age

Age Group	Population*	Members	Percent Membership
16 – 24	53,431	42	0.1%
25 – 34	74,127	98	0.1%
35 – 59	190,235	818	0.4%
60 – 75	75,827	969	1.3%
75	40,610	491	1.2%
Unknown		2,635	-
Grand Total	434,230	5,048	1.2%

* 2001 Census Output Area Statistics (CAS Table 01)

Members by Ethnic Group

Ethnic Group	Population*	Members	Percent Membership
Chinese	1,035	1	0.1%
Other Black	416	1	0.2%
Other Ethnic Group	753	2	0.3%
White & Black Caribbean	694	2	0.3%
Other White inc Italian	9,748	38	0.4%
Black African	704	3	0.4%
Irish	4,607	21	0.5%
White & Asian	631	3	0.5%
British	405,403	2,279	0.6%
Black Caribbean	1,344	8	0.6%
Asian Pakistani	4,361	27	0.6%
Other Asian	962	7	0.7%
Asian Indian	3,079	8	0.8%
Other Mixed	744	8	1.1%
Not Stated		2,628	-
Total	434,481	5,053	1.2%

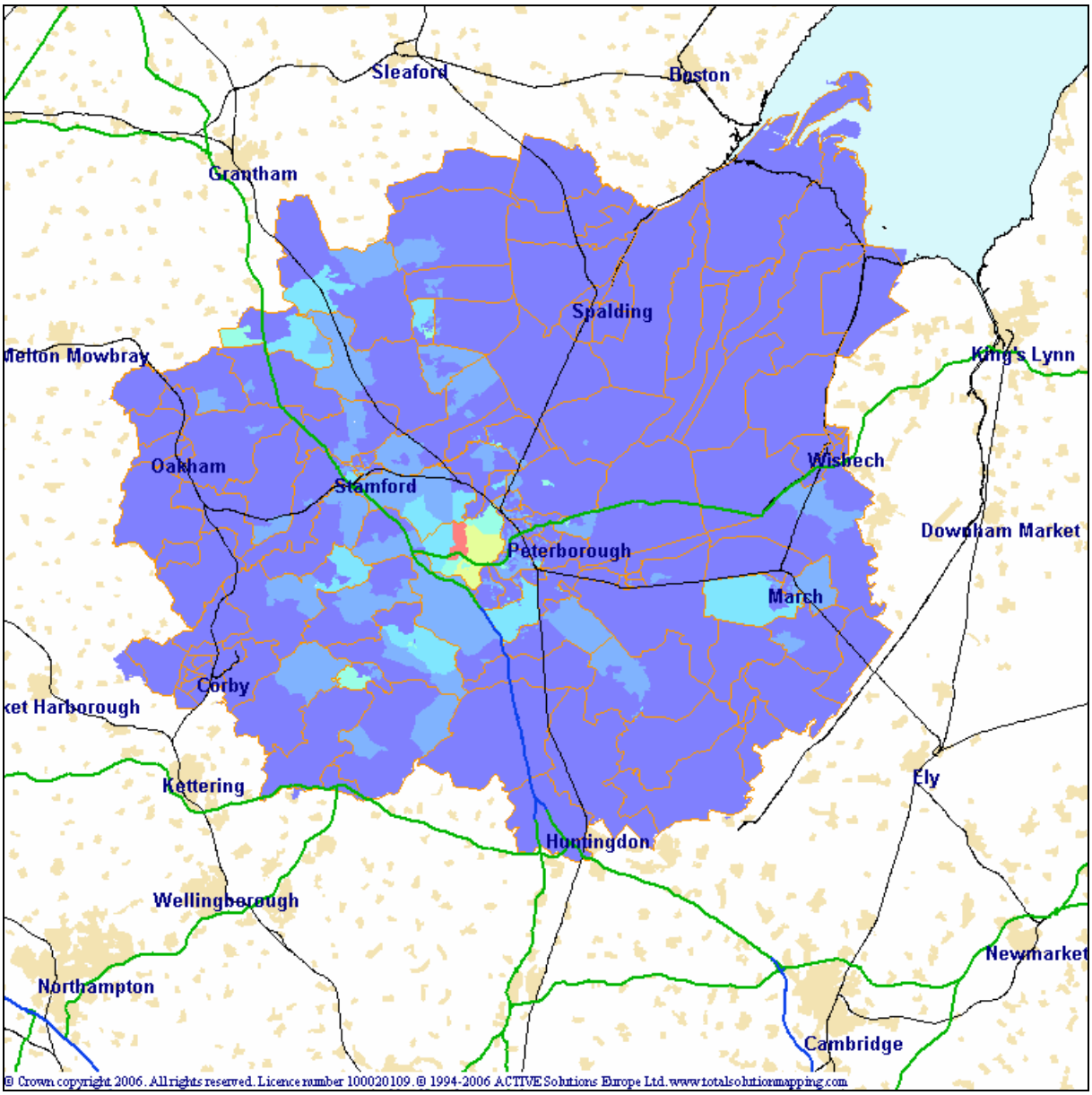
*2001 Census Output Area Statistics (CAS Theme Table 3)

The membership catchment area is defined by electoral ward boundaries and due to changes in these areas, the membership catchment was recommended for revision by the Board of Governors in July 2005, when the opportunity was taken to align the areas with local authority boundaries for

Rutland, South Holland, Fenland and Corby. This change was formally incorporated into the Trust's constitution in November 2005 on approval from Monitor. The result of this change served to increase the Trust's eligible membership catchment by over 100,000 and is a consistent approach with the Trust's aim to attract patients from a wider area under the Government's choice agenda.

The geographical spread of the Trust's population is shown in the map below.

Membership by Geographical Area



Membership per population per Census Output Area:

Key	Lower	to	Upper
	0.0	to	2.09
	2.1	to	4.19
	4.2	to	6.29
	6.3	to	8.39
	8.4	to	10.49
	10.5	to	12.59
	12.6	to	14.69
	14.7	and	Over

These analyses highlight areas of work that need to be tackled in the forthcoming years to address representational issues whilst building the catchment population numbers. These areas are discussed in 5.2 below.

5.2.2 Staff Constituency

The staff constituency is based on an opt-out arrangement for staff. All staff eligible for membership (i.e. permanent members of staff, or staff with temporary contracts of 6 months or more in duration) are written to on joining to confirm their membership and given the opportunity to opt out. The level of opt-outs remains very small.

It can be seen that the numbers for the staff constituency have fallen; this is due to the overall reduction in staff numbers due to the impact of the Trust's savings plan.

5.3 Future Membership

The Trust has a Board of Governors' Committee that monitors membership communication and recruitment. To support the work of the Board of Governors an engagement programme has been developed of different approaches to the local community.

There are four challenges for the coming years as noted below.

(1) Geographical coverage - As can be seen by the map above, the Trust is under-represented in the Eastern areas of the catchment. A plan of action is being compiled to target these areas and increase representation.

(2) Membership ethnic diversity – The ethnic group table above shows the diversity of the population as compared to the census population. However these figures mask the growth in the diversity of the population due to immigration. In particular there has been considerable growth in the Portuguese population. Plans are being developed for additional activities with minority groups through the recent co-option of a governor with experience of liaison with black and minority ethnic communities.

(3) Membership age group representation – The age group analysis above also shows under-representation in the 35-59 year age group. Plans need to be put in place to address this shortfall and the potential to target employers is being considered.

(4) Raising awareness – There is also work to do on raising the general public awareness of foundation trust membership and a plan of work is being considered involving a media campaign.

These activities will also be focused around the elections to be held for the Board of Governors in September 2006 and September 2007.

5.4 Election of Governors

There have been no elections held during the 2005/2006 year. The next elections are planned for September 2006 and will be in accordance with the election rules contained within the constitution, which are the new model rules issued by the Department of Health.

6 Financial Projections

Please see attached templates in appendix 2.

7. Supporting Schedules

The supporting schedules outlining revised schedule 2 (mandatory services) and schedule 3 (education and training) are attached at appendix 3 and appendix 4 respectively.

Appendix 1

Declarations and self-certification

Board Statements (1 of 3)

Risk and Performance Management

The Board of Directors is required to confirm that:

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

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

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

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

☑ The Board is satisfied that plans are in place to ensure that all relevant core national healthcare targets and standards (Please see Appendix B of the Compliance Framework) are met going forwards

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

Commentary in absence of full self certification

Signature  Signature 

…… ……

Mr Chris Banks *Dr Clive Morton*

In capacity as Chief Executive & Accounting Officer In capacity as Chairman

Signed on behalf of the board of directors, and having regard to the views of the governors.

Board Statements (2 of 3)

Board roles, structures and capacity

The Board of Directors is required to confirm that:

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

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

☑ The selection process and training 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

Commentary in absence of full self certification

Signature 

……..

Mr Chris Banks

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In capacity as Chief Executive & Accounting Officer

Signature 

……

Dr Clive Morton

In capacity as Chairman

Signed on behalf of the board of directors, and having regard to the views of the governors.

Board Statements (3 of 3)

Compliance with the Authorisation

The Board of Directors is required to confirm that:

☑ 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

Commentary in absence of full self certification

Signature 

……

Mr Chris Banks

In capacity as Chief Executive & Accounting Officer

Signature 

……

Dr Clive Morton

In capacity as Chairman

Signed on behalf of the board of directors, and having regard to the views of the governors.

Financial projections

	2005/06	2006/07	2007/08	2008/09
	£'000s	£'000s	£'000s	£'000s
PLANNED INCOME AND EXPENDITURE				
Income from activities (protected)	130,496	134,672	143,764	149,213
Income from activities (unprotected)	4,531	5,074	5,226	5,383
Other operating income	19,593	18,361	19,127	19,650
Operating expenses - pay	(100,887)	(103,674)	(106,906)	(110,591)
Operating expenses - non-pay	(45,052)	(44,281)	(45,838)	(47,586)
EBITDA	8,681	10,152	15,373	16,070
Operating expenses - depreciation	(5,599)	(5,672)	(6,330)	(6,523)
OPERATING SURPLUS/(DEFICIT)	**3,082**	**4,480**	**9,043**	**9,547**
Exceptional gain/(loss)	0	0	0	0
Profit/(loss) on disposal of fixed assets	50	0	0	0
SURPLUS/(DEFICIT) BEFORE INTEREST	**3,132**	**4,480**	**9,043**	**9,547**
Interest receivable	192	138	338	538
Interest payable	(153)	(69)	0	0
Other finance costs	(16)	0	0	0
SURPLUS/(DEFICIT) FOR THE YEAR	**3,155**	**4,549**	**9,381**	**10,085**
Other dividends	0	0	0	0
PDC dividends payable	(4,106)	(4,309)	(4,261)	(4,440)
RETAINED SURPLUS/(DEFICIT) FOR THE YEAR	**(951)**	**240**	**5,120**	**5,645**
EBITDA MARGIN	***5.61%***	***6.42%***	***9.14%***	***9.22%***
BOTTOM LINE MARGIN	***(0.70%)***	***0.17%***	***3.44%***	***3.65%***
BALANCE SHEET				
FIXED ASSETS				
Intangible assets	0	0	0	0
Tangible assets	131,434	130,017	128,887	127,564
CURRENT ASSETS				
Stocks and work in progress	2,574	2,574	2,574	2,569
Trade debtors and prepayments	11,499	10,581	10,330	8,000
Cash at bank and in hand	464	1,228	2,954	7,422
TOTAL CURRENT ASSETS	**14,537**	**14,383**	**15,858**	**17,991**
CREDITORS				
Bank overdraft/Drawdown credit facility	0	0	0	0
Amounts falling due within 1 year	(18,943)	(17,120)	(12,607)	(8,000)
NET CURRENT ASSETS/(LIABILITIES)	**(4,406)**	**(2,736)**	**3,250**	**9,991**
TOTAL ASSETS LESS CURRENT LIABILITIES	**127,028**	**127,281**	**132,137**	**137,555**
CREDITORS				
Amounts falling due after 1 year	(86)	(86)	(86)	(86)
PROVISION FOR LIABILITIES AND CHARGES	(1,812)	(1,812)	(1,812)	(1,812)
TOTAL ASSETS EMPLOYED	**125,130**	**125,383**	**130,239**	**135,657**
TAXPAYERS' EQUITY				
Public dividend capital	69,633	69,633	69,633	69,633
Revaluation reserve	59,041	59,041	59,041	59,041
Donated asset reserve	3,636	3,649	3,385	3,158
Government grant reserve	0	0	0	0
Other reserves	0	0	0	0
Income and expenditure reserve	(7,180)	(6,940)	(1,820)	3,825
TOTAL TAXPAYERS' EQUITY	**125,130**	**125,383**	**130,239**	**135,657**

Financial projections

	2005/06	2006/07	2007/08	2008/09
	£'000s	£'000s	£'000s	£'000s
SOURCES AND APPLICATIONS OF FUNDS				
OPERATING ACTIVITIES				
Operating surplus	3,082	4,480	9,043	9,547
Depreciation and amortisation	5,599	5,672	6,330	6,523
Transfer from the donated asset reserve	(227)	(242)	(464)	(427)
(Increase)/decrease in stock	(108)	0	0	5
(Increase)/decrease in debtors	(3,511)	918	251	2,330
Increase/(decrease) in creditors	5,693	(1,823)	(4,512)	(4,607)
Increase/(decrease) in long-term creditors/provisions	(593)	0	0	0
NET CASH INFLOW(OUTFLOW) FROM OPERATING ACTIVITIES	9,935	9,005	10,648	13,370
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE				
Interest Received / Paid	23	69	338	538
FUNDS FROM OTHER SOURCES				
Proceeds from sale of fixed assets	632	0	0	0
CAPITAL EXPENDITURE				
Capital expenditure	(3,470)	(4,000)	(5,000)	(5,000)
DIVIDENDS PAID	(4,106)	(4,309)	(4,261)	(4,440)
NET CASH INFLOW (OUTFLOW) BEFORE FINANCING	3,014	764	1,725	4,468
FINANCING				
PDC Received	25	0	0	0
Movement in overdraft/drawdown credit facility	(3,000)	0	0	0
INCREASE/(DECREASE) IN CASH	39	764	1,725	4,468
PRUDENTIAL BORROWING RATIOS				
FREE CASH FLOW				
Operating surplus	3,082	4,480	9,043	9,547
Depreciation and amortisation	5,599	5,672	6,330	6,523
Transfer from the donated asset reserve	(227)	(242)	(464)	(427)
Earnings before interest, tax, depreciation and amortisation	**8,454**	**9,910**	**14,909**	**15,643**
DEBT SERVICE COVER RATIO	2.07	2.34	3.80	4.01
DEBT / NET REVENUE	3.02%	3.03%	2.63%	2.52%
INTEREST COVER RATIO	2.07	2.34	3.80	4.01

Schedule 2 for mandatory services

Schedule 2
Mandatory Goods and Services **Location 1** **Note 1**

Specialty		Emergency in-patients	Elective in-patients	Total of Emergency & Elective	Day Cases	Out patients	Other (1)	Other (2)
Code	Specialty	SPELLS	SPELLS	SPELLS	SPELLS	currency (note 1)	currency (note 1)	currency (note 1)
100	General Surgery	3141	4619	7760	0	20971	12	0
101	Urology	870	4679	5549	0	9875	5	0
110	Trauma & Orthopaedics	1804	3659	5463	0	34808	3	0
120	Ear, Nose & Throat (ENT)	326	1359	1685	0	14670	1	0
130	Ophthalmology	47	2409	2456	0	33926	0	0
140	Oral Surgery	119	2069	2188	0	7923	0	0
141	Restorative Dentistry	0	0	0	0	0	0	0
142	Paediatric Dentistry	0	0	0	0	0	0	0
143	Orthodontics	0	0	0	0	4599	0	0
145	Oral & Maxillo Facial Surgery	0	0	0	0	0	0	0
146	Edontics	0	0	0	0	0	0	0
147	Peridontics	0	0	0	0	0	0	0
148	Prosthodontics	0	0	0	0	0	0	0
149	Surgical dentistry	0	0	0	0	0	0	0
150	Neurosurgery	0	0	0	0	0	0	0
160	Plastic Surgery	0	616	616	0	3183	0	0
170	Cardiothoracic Surgery	0	0	0	0	0	0	0
171	Paediatric Surgery	0	0	0	0	223	0	0
180	Accident & Emergency (A&E)	1690	0	1690	0	0	41	0
190	Anaesthetics	3	2006	2009	0	4505	0	0
192	Critical Care Medicine	0	0	0	0	0	0	0
199	Non-UK Provider; specialty function not known, treatment mainly surgical	0	0	0	0	0	0	0
300	General Medicine	7236	3650	10886	0	20813	67	0
301	Gastroenterology	0	0	0	0	0	0	0
302	Endocrinology	0	0	0	0	66	0	0
303	Clinical Haematology	190	557	747	0	7249	454	0
304	Clinical Physiology	0	0	0	0	0	0	0
305	Clinical Pharmacology	0	0	0	0	0	0	0
310	Audiological Medicine	0	0	0	0	0	0	0
311	Clinical Genetics	0	0	0	0	0	0	0
312	Clinical Cyto/Molecular Genetics	0	0	0	0	0	0	0
313	Clinical Immunology & Allergy	0	0	0	0	0	0	0
314	Rehabilitation	0	0	0	0	0	0	0
315	Palliative Medicine	0	0	0	0	0	0	0
320	Cardiology	623	683	1306	0	8482	5	0
321	Paediatric Cardiology	0	0	0	0	54	0	0
330	Dermatology	0	67	67	0	11030	0	0
340	Thoracic Medicine	0	0	0	0	129	0	0
350	Infectious Diseases	0	0	0	0	0	0	0
352	Tropical Medicine	0	0	0	0	0	0	0
360	Genito-urinary Medicine	0	0	0	0	0	0	0
361	Nephrology	0	0	0	0	0	0	0
370	Medical Oncology	303	160	463	0	9361	814	0

Schedule 2 for mandatory services

Schedule 2
Mandatory Goods and Services **Location 1** **Note 1**

Specialty		Emergency in-patients	Elective in-patients	Total of Emergency & Elective	Day Cases	Out patients	Other (1)	Other (2)
Code	Specialty	SPELLS	SPELLS	SPELLS	SPELLS	currency (note 1)	currency (note 1)	currency (note 1)
371	Nuclear Medicine	0	0	0	0	0	0	0
400	Neurology	0	0	0	0	0	0	0
401	Clinical Neuro-physiology	0	0	0	0	0	0	0
410	Rheumatology	0	14	14	0	9771	223	0
420	Paediatrics	4617	187	4804	0	10687	79	0
421	Paediatric Neurology	0	0	0	0	0	0	0
430	Geriatric Medicine	2887	46	2933	0	3096	33	0
450	Dental Medicine Specialties	0	0	0	0	0	0	0
460	Medical Ophthalmology	0	0	0	0	0	0	0
501	Obstetrics	5241	1	5242	0	12193	2	0
502	Gynaecology	692	1762	2454	0	14434	0	0
560	Midwife episode	1522	0	1522	0	0	0	0
601	General Dental Practice	0	0	0	0	0	0	0
700	Learning Disability (previously MH)	0	0	0	0	0	0	0
700	Mental handicap	0	0	0	0	0	0	0
710	Adult Mental Illness	0	0	0	0	0	0	0
711	Child & Adolescent Psychiatry	0	0	0	0	0	0	0
712	Forensic Psychiatry	0	0	0	0	0	0	0
713	Psychotherapy	0	0	0	0	0	0	0
715	Old Age Psychiatry	0	0	0	0	0	0	0
800	Clinical Oncology (previously Radiotherapy)	0	0	0	0	0	0	0
810	Radiology	0	0	0	0	0	0	37667
820	General Pathology	0	0	0	0	0	0	0
821	Blood Transfusion	0	0	0	0	0	0	0
822	Chemical Pathology	0	0	0	0	0	0	123527
823	Haematology	0	0	0	0	0	0	86730
824	Histopathology	0	0	0	0	0	0	2407
830	Immunopathology	0	0	0	0	0	0	0
831	Medical Microbiology	0	0	0	0	0	0	77342
900	Community Medicine	0	0	0	0	0	1	0
901	Occupational Medicine	0	0	0	0	0	0	0
902	Community Health Services Dental	0	0	0	0	0	0	0
950	Nursing episode	0	0	0	0	0	0	0
TOTAL		31311	28543	59854	0	242048	1740	327673

Critical Care services

Specialty	Total	Currency
Neonatal Intensive Care Unit (NICU)	0	(note 1)
Radiatric Intensive Care Unit (PICU)	0	(note 1)
Special Care Baby Unit (SCBU)	0	(note 1)
Intensive Care Unit (ITU)	1574	(note 1)
High Dependency Unit (HDU)	0	(note 1)
Coronary Care Unit (CCU)	0	(note 1)

Schedule 3 for education and training

WORKSHEET 1

Mandatory Education and Training Services

Commissioning body	Educational body	Contract Length	Expiry date of contract	Student group	Type of training	Number of Students	Contract Value
		(Years)					(£000s)
(note 1)	(note 2)	(note 3)	(note 4)	(note 5)	(note 6)	(note 7)	(note 8)
Eastern Deanery[2]	Eastern Deanery	1 year	31.03.07	Training Grade Doctors	Postgraduate medical & dental education	118	213
Eastern Deanery	Eastern Deanery	1 year	31.03.07	Training Grade Doctors	Salary for training grade doctors	118	3,311
Eastern Deanery	Eastern Deanery	1 year	31.03.07	GDP VTS	General dental vocational training [3]	12	18
Eastern Deanery	Eastern Deanery	1 year	31.03.07	GDP CPD	General dental contin. profess.develop	varies	14
Eastern Deanery	Eastern Deanery	1 year	31.03.07	GP VTS	General practice vocational training [4]	30	8
Leics, Northants, Rutland WDC	Leicester University	1 year	31.03.07	Medical Students	Undergraduate medical education	23 fte [5]	291
NSC WDC	Cambridge University	1 year	31.03.07	Medical Students	Undergraduate medical education	13fte	266
University of Sheffield	Sheffield University	1 year	31.03.07	Dental Students	Undergraduate dental education	0.3 fte	2
GKT Dental Institute	GKT, London	1 year	31.03.07	Dental Students	Undergraduate dental education	0.25fte	2
NS&CWDC	Homerton	5 years	31.07.07	Nurses	EN-RGN	13	133
NS&CWDC	Homerton	5 years	31.07.07	Nurses	HCA's	56	523
NS&CWDC	Homerton	5 years	31.07.07	Midwives	Midwifery	15	184
NS&CWDC	University of Westminster	5 years	31.07.07	Pathology	Mortuary Tech	1	9
NS&CWDC	Homerton	5 years	31.07.07	Theatres	ODP	5	48
NS&CWDC	Internal NVQ programme	5 years	31.07.07	Pharmacy	Pharmacy Techs	7	77
NS&CWDC	Sheffield University	5 years	31.07.07	Therapies	PT Helper	4	43
NS&CWDC	UEA	5 years	31.07.07	Pharmacy	Pharmacy pre reg	3	34
NS&CWDC	University of Westminster	5 years	31.07.07	Pathology	MLSO	16	173
Peterborough and Stamford Hospitals NHS FT							

Notes	This sheet is for mandatory services.Therefore the applicant should include only services for third parties where a contract has been signed (or is understood to be going to be signed) with the relevant commissioners or other third parties.
1	Specify commissioning body or third party e.g. WDC.
2	Specify accrediting educational body, e.g. university
3	Specify contract length in years
4	Specify expiry date of contract
5	Specify student group for which the education/training is to be provided, e.g. medical students
6	Specify type of training
7	Specify student number
8	Specify per annum contract value in £1000s