Peterborough and Stamford Hospitals
NHS Foundation Trust

Annual Report and Accounts 2006/2007

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Annual Report

2006/2007

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This report is based on guidance issued by the Independent Regulator of NHS Foundation Trusts and was approved by the Board of Directors on 6 June 2007

Nik Patten
Chief Executive Officer

1. Chair's Statement

I am pleased to have the opportunity to make the opening statement for our annual report for 2006/07, our third as a NHS Foundation Trust. This year has seen a number of successes as we built on our financial recovery of the previous year and worked towards achieving our strategic objectives, and I am pleased and proud to be able to report on how well the Trust has performed.

As can be seen from the Chief Executive's statement and the supporting sections of the report, the Trust saw improvements in our services and support for our staff as evidenced in further improvements in the results from the independent national patient and staff surveys. The Trust also finished the year with a surplus of £2.5M compared to a planned surplus of just £0.2M. These successes have been achieved through service redesign, matching our services to our purchasers' expectations and through ensuring that with careful vacancy management and redeployment, redundancies have been kept to a minimum.

Work has also continued throughout the year on the management of our facilities – as I write there is an ongoing consultation on the innovative joint venture partnership to secure the future and development of Stamford and Rutland Hospital with local GPs, and there is the expectation that the final contracts and approvals will be secured so that we can begin to see the development of the new health facilities for Peterborough envisaged under the Greater Peterborough Health Investment Plan (GPHIP).

This year has also seen success in the delivery of our eight key strategic objectives. The Trust:

- is pursuing the patient choice agenda with clear targets for choose and book delivery;
- is continuing to develop our range of services for our local population with new services including a new Critical Care Unit and the first complete year of our local angiography services;
- has exceeded our financial targets;
- has made progress regarding plans for the long term future of the Peterborough estate through which our services are provided;
- has made progress regarding plans for the long term future of the Stamford and Rutland Hospital with community partners;
- has continued to develop productive relationships with the media and all of our stakeholders evidenced through good media coverage and national survey results;
- has continued to work in partnership playing our part in local strategic developments;
- has continued to work with our staff to ensure that we retain and maintain their commitment without which we would not be able to deliver services to the high standards that our patients expect, including excellent standards of hygiene and outstanding performance against infection control standards.

Whilst our performance has been exceptional, we are also addressing areas where we know improvements can be made. Work during the year to improve waiting list management highlighted problems with the management of our orthopaedic waiting list and an internal review (with support from external stakeholders including the Independent Regulator of NHS Foundation Trusts (Monitor) and Peterborough Primary Care Trust) has provided recommendations that we will implement during the coming year. This has been developed in tandem with our determination to ensure that patients affected by this issue are seen and treated as soon as possible.

The Trust's Governors worked with the Directors to formulate strategic objectives for this year which reflect views from membership priorities. Building on the success of achieving these, we will use the coming year to completely review our strategy and develop a new vision for the future that will embrace the new challenges within the NHS both locally and nationally.

This will ensure that our services meet patient and purchaser expectations, using the opportunities that our new facilities will afford us for developing the high standard of care that our community would like and deserves to receive.

We will also be managing our key risks through regular monthly reporting to the Board of Directors. The restoration of our reputation for waiting list management will be underpinned by a clear action plan based on the recommendations of the investigation review and the achievement of GPHIP. It will be supplemented by additional ad hoc reporting and partnership working across all stakeholders. The Board of Directors will also maintain a clear overview on financial performance and achievement of Primary Care Trust contracts – and any interventions that may be required – through the Board's Conformance Committee; and the Chief Executive will also maintain an overview of the Trust's capacity, to ensure progress across all these issues and the ongoing operational and strategic requirements of the Trust.

In summary, we have had a successful 2006/07 and we look forward to the opportunities of the year ahead, with the expected commencement of work on the Greater Peterborough Health Investment Plan, an overhaul of our strategy, further improvements on our services for our patients and continued financial success. My thanks go to all our staff, governors, volunteers, members and partners whose support and determination are fundamental to our continuing success.

Clive Morton

Chairman, Peterborough and Stamford Hospitals NHS Foundation Trust

2. Chief Executive's Statement

On behalf of the Board of Directors, I am delighted to present the Trust's annual report for the year ending 31 March 2007. The Trust progressed through the year with three different chief executives. Mr Chris Banks took up the role of Chief Executive of Cambridgeshire Primary Care Trust on 1 January 2007 and Mr Alan Turner filled the post of Interim Chief Executive until I started in post on 26 February 2007. I would like to take this opportunity to pay tribute to my two predecessors from whom I have inherited a Foundation Trust to be proud of, and the challenge to make it even better.

This has been a successful year for the Trust and progress has been made against all of our strategic objectives as highlighted by the Chairman. It is also a credit to the organisation that in discovering irregularities within orthopaedic waiting list management, these were highlighted to the appropriate external regulators (Monitor and the Healthcare Commission), investigated appropriately and progress made in an open and transparent manner. The learning from this issue will enable us to ensure that our systems and management become more robust, patient administration will become more transparent, our ability to manage capacity in a flexible way to meet patient requirements will increase and the likelihood of a recurrence of such an incident will be reduced as much as is possible.

2.1 Accountability and Involvement

We continue to work with our membership to gain their views on our priorities, their input into consultations (visiting times and the future management of Stamford), and to ensure that they are informed about current issues and services. The Board of Governors has been very supportive to the Board of Directors throughout the year and I look forward to further work during the coming year to review our strategic direction and objectives. This needs to be shaped with our governors, taking into account the views of the local membership and community, and the national and local priorities for development. We also work closely with our patients, with a board committee consisting of directors, governors, senior managers, patient group representatives and members of our Patient and Public Involvement Forum (PPIF), which co-ordinates our patient involvement activities. We have also developed and maintained good relationships with our local Overview and Scrutiny Committees run by local authorities.

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

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

2.2 Business Focus

We also continue to work closely with our local Primary Care Trusts (PCTs) and supported the successful campaign to maintain a local Peterborough PCT to ensure that a focus on the health requirements for the people of Peterborough and services to meet and improve these needs could continue. This working is also seen in the Trust's participation (led by the Chairman) in the local strategic partnership – the Greater Peterborough Partnership – and the work towards the successful implementation of the Greater Peterborough Health Investment Plan (GPHIP).

This close partnership working also ensures that the services we offer to our patients are scrutinised at a local level, and the year has seen the Trust respond to a number of developments whereby the PCT has looked at developing different models of service provision. This has seen responses to the provision of primary care based musculoskeletal services that are to move into the primary care setting in line with the GPHIP, and the successful retention of services for deep vein thrombosis which will be remodelled to provide increased community assessment and treatment.

To ensure that we have a clear understanding of the impact of such changes on our services, work has progressed, and will continue into the coming year, to understand the cost of providing services and the income we receive for their delivery. This is being undertaken with our clinical management teams alongside a review of our current operational and management structure so that we can ensure that patient services and their delivery are appropriately managed and supported. This work will be completed in the coming year.

2.3 Access, Targets, Standards and Services

The past year also saw good performance against both national and local targets and standards. This is supported by the ongoing development of a balanced scorecard which is used to monitor progress on a monthly basis throughout the year.

The Trust has met infection control targets for MRSA and clostridium difficile, seen a fall in the level of hospital acquired pressure sores and falls, and a reduction is staff sickness and absence rates. National waiting times for A&E attendees have continued to be met together with the waiting times for outpatients.

The progress towards national milestones for admitted patient care has been in line with our PCT funding levels and additional work is expected during 2007/08 to ensure ongoing progress towards the 18-week national maximum wait from referral to treatment. Unfortunately the year saw 328 reported breaches of the maximum waiting time for orthopaedic patients' admission to hospital at the end of March, which has been the subject of an internal investigation. These circumstances also led to the declaration of non-compliance with one of the core standards monitored by the Healthcare Commission as part of their annual healthcheck, as well as a change in our governance rating provided by Monitor from green to red. An action plan will be implemented to rectify this problem within the coming year.

The year also saw improvements in efficiency. The level of day case admissions increased to meet the Trust target of 75% for the year and the average length of stay for patients, both those admitted for routine operations and those admitted as emergencies, fell as the pathways for patient care - which includes different diagnostic and treatment interventions - was improved.

2.4 Workforce

Work has continued through the year to support staff through the changes being experienced in service delivery, the continuation of our savings plan and the imminent transfer of facilities staff into an interim services model to support the delivery of the GPHIP. This is supported by the Trust receiving good results in the national staff survey and a reduction in sickness absence levels.

2.5 Facilities

As detailed in section 3, the Trust has continued with our Private Finance Initiative (PFI) plans for a new hospital and other health facilities with Progress Health. The consortium is led by Multiplex and saw a change in the financial partner to Macquarie Bank during the year. Financial close on the PFI deal is planned for June 2007 with building completion in 2010. The project timeline has slipped from our original plans for a number of reasons including; the change in financial partner within the Progress Health Consortium, delays with local authority planning permission, and the decision by the Department of Health to undertake an additional review of all large PFI schemes.

The Trust is currently undertaking a consultation regarding the future management of Stamford and Rutland Hospital with a proposal that this is facilitated through a joint management venture with the local Stamford GPs.

The aim is to attract more services to be provided from the Stamford site and ensure that local services are developed to meet the needs of local people in line with Stamford GP and Lincolnshire PCT strategic aims.

2.6 Finance

As noted by the Chairman, the end of the year saw a financial surplus of £2.5M, compared to a deficit of £951,000 in 2005/06 and a £7.7M deficit in 2004/05. Our results have currently improved the Trust's financial risk rating, provided by Monitor from 3 to 4 out of 5.

2.7 Summary

Despite the areas identified for improvement, overall this has been a successful year for the Trust. Together with the service strategies developing in the surrounding local health economies, this will enable us to work with our governors, members and stakeholders to develop a clear plan for the future that will move our services from good to great throughout the next few years.

Nik Patten

Chief Executive Officer, Peterborough and Stamford Hospitals NHS Foundation Trust

3. Background Information

3.1 Establishment

The Peterborough and Stamford Hospitals NHS Foundation Trust ('the Trust') is a public benefit corporation formed pursuant to Section 6 of the Health and Social Care (Community Health and Standards) Act 2003. Monitor, the Independent Regulator of NHS Foundation Trusts, established the Trust under licence on 1 April 2004 as one of the first ten NHS organisations to achieve NHS Foundation Trust status. Prior to this date the organisation was an NHS Trust formed in April 1993.

3.2 Financial Information

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

Accounting policies for pensions and other retirement benefits are set out in note 1 to the accounts and details of senior employees' remuneration can be found in section 9 of this annual report.

The Trust's external auditors are appointed by the Board of Governors on a rolling annual basis on a recommendation from the Trust's Audit Committee. The external auditors are RSM Robson Rhodes LLP, their remuneration for 2006/07 was £92,000. No non-audit work was performed.

3.3 Future Developments

Greater Peterborough Health Investment Plan

As reported in the Chief Executive's statement the Trust is close to signing contracts for the Greater Peterborough Health Investment Plan (GPHIP) Private Finance Initiative project. The GPHIP project has been developed in partnership with Peterborough Primary Care Trust (PCT) and Cambridge and Peterborough Mental Health Partnership NHS Trust and is a good example of our close partnership working within the local health economy.

The scheme will provide an Integrated Care Centre (ICC) for the PCT on the District Hospital site, a 102 bed mental health unit (MHU) and a 612 bed acute hospital on the Edith Cavell site. The ICC and MHU are planned to open in 2009 and the new acute hospital in 2010. The scheme has gained approval from the Boards of Directors of all three participating Trusts and the East of England Strategic Health Authority; final approvals from the Department of Health and Treasury are expected imminently.

The GPHIP scheme is central to the Trust's long term plans and will allow both the development of new and improved models of patient care, and the provision of modern buildings and environments that our patients, visitors and staff deserve in the 21st century.

Stamford and Rutland Hospital Consultation

During the year the Trust, the Stamford GPs and Lincolnshire PCT have been working closely to ensure that Stamford and Rutland Hospital is best positioned to respond to the changes it faces as a result of the introduction of payment by results, patient choice and the government White Paper "Our health, our care, our say".

As a result of this close working the Trust is exploring sharing the management of Stamford and Rutland Hospital with local GPs as well as establishing a more formal means of ensuring the views of the local Stamford community are fully taken into account when making decisions on services provided at the hospital.

The Trust and the local GPs are confident that such an approach will ensure:

- a better understanding of local needs;
- improved co-operation between the GPs and the Hospital;
- the retention of the clinical benefits of a large Foundation Trust.

This will give the best chance of providing services that the local population will want to use and thus sustain services at Stamford and Rutland Hospital into the future.

The Trust is currently engaged in a process of public consultation on this approach while at the same time undertaking the necessary work to ensure such an approach will be financially sustainable.

The public consultation ends on the 22 June 2007 and the Trust intends feeding back to the local community during August 2007.

3.4 Service Developments

Service Improvement Team

The Trust's Service Improvement Team (SIT) works closely with operational teams to help support developments which benefit patient care across the organisation.

The team is responsible for analysing how the Trust can improve services for patients and make their hospital experience the best it can be. At the same time it looks at how to improve efficiency in the Trust and takes a lead on helping departments to implement changes.

In 2006, the team came first in the Top Team competition, organised by the Public Services Management Network in partnership with several other public sector organisations from across the UK. The team's winning submission was based on the challenges it has faced since it was launched, its achievements and its plans for the future.

The work of the team can be classified into three main areas; improvements to access to services for patients, improvements to the patient's journey, and developments to help the Trust achieve the 18-week target set for December 2008.

A. Access to Services

- *Choose and Book.* The Trust is in the final stages of implementing a directly bookable electronic referral process which allows patients to book into the appropriate service at the point at which they are referred by their GP. This takes away the uncertainty for patients and streamlines the current manual process. It means clinicians review patient referrals electronically and will in time reduce the administrative workload attached to the referral and booking process.
- *Audiology waiting times.* These are down from 103 weeks to 12 weeks due to implementing new ways of working.
- *RADWEB.* This is a web based GP radiology referral service, whereby the GP makes the referral on the web, and the following day the patient can phone for an appointment.
- *Glaucoma screening.* The Trust's glaucoma community screening programme has been short-listed for an Allergan Glaucoma Achievement Award. The scheme is part of a national chronic eye disease pilot and allows community optometrist practices to screen patients on their premises, saving many a visit to hospital. The team was also short-listed for a Health Service Journal award in 2006.

B. The Patient's Journey

- *Surgery.* The Pre-Operative Care Centre includes pre-assessment and pre-admission services for patients outside a ward environment. This scheme will be piloted by the ENT service in early summer.
- *Day Surgery.* The team has worked to increase day surgery rates throughout the Trust. 75 per cent of surgery carried out is now done so as day cases. This helps make the best use of capacity within the Trust and provides better access for patients.
- *Theatre improvement.* Work has been carried out to increase capacity and improve patient flow.
- *Predicted Date of Discharge.* Working with operational teams across the Trust, this scheme analyses the needs of the patient when they are admitted in order to plan their date of discharge from as early a time as possible. This enables clarification for the patient of their length of stay, and ensures that the patient journey happens to schedule. This policy is currently being implemented across the Trust.
- *Length of Stay.* Much work is ongoing to reduce the length of stay for patients across specialities by ensuring timely care and careful planning.
- *Stamford Venture Group.* A first draft pathway of care for knee pain has been developed with Consultants and GPs working together to bring care closer to patients.

- The Trust's administrative and clerical teams are currently being reviewed, with proposed structures being piloted in some specialties. These changes are to offer an improved service both to patients and staff. In addition, there will be centralisation of waiting list management and booking of elective patients.

C. 18-week Wait Target

- *E Track.* This is a system which collects data from outpatients' clinics to enable accurate assessment of where patients are on the 18 week wait pathway. This is currently being rolled out across clinics.
- *Electronic TCI.* An electronic version of the 'To Come In' card is being developed with Consultant involvement. This will support the booking process by streamlining the patient's movement between departments, and will help meet the 18 week wait target.

Other Service Developments

Other recent improvement work undertaken by the Trust outside the SIT's remit includes:

- A new Surgical Admissions Area has been introduced on 3X and in its first two months has already reduced the average length of stay.
- Bed Reconfiguration. Assisted by SIT work, this has meant reduction in capacity to better match patient requirements.
- A midwifery led birthing unit opened in January and promotes 'home from home' midwifery support during labour. It is available to women whose pregnancies have been assessed as low risk, and provides an alternative to the Trust's existing delivery options.
- A new £900,000 Intensive Care Unit was opened in April. It was designed to have more space for patients and medical equipment and an improved environment for patients, visitors and members of staff. Initially up to six patients can be cared for on the unit, but there are plans to expand the capacity to manage eight patients in the future.
- A new inpatient haematological cancer service developed in partnership with Hinchingbrooke Health Care NHS Trust.
- A new dermatology clinic (Clinic G) at Edith Cavell Hospital, offering a 'one stop shop' for patients. The clinic brought together three separate dermatology services (outpatients clinic, minor surgery and UV light treatment) that were previously offered from different parts of the District Hospital into one location. Clinic G is also used for plastic, breast and general surgery clinics.

Tendering for Health Care Services

As local Primary Care Trusts (PCTs), in line with the Government's White Paper "Our health, our care, our say", seek to move services out of a hospital setting and in to the community, the Trust finds itself having to reshape some of its services and bid against others to continue providing them.

Despite a significant amount of work, and close involvement with Peterborough PCT on shaping new solutions, this year was one of mixed results. While the Trust was successful in being selected as the provider of a community Deep Vein Thrombosis service (a nurse led service with a possible start date of October 2007) it was unsuccessful in winning the contract to provide a new musculoskeletal service. This service will now be provided through primary care services, rather than through the Trust, and whilst disappointing follows the model of delivery expected in GPHIP.

The effect of these contract decisions will be felt during the 2007/08 financial year.

3.5 Staffing

Learning and Development

The Trust strategy actively promotes learning and development that delivers benefits to patient care, supports service transformation and delivers value for money. All provision is aimed at promoting the core values of the National Health Service and seeks to establish our Trust as a model employer.

The implementation of the knowledge and skills framework (KSF) has formed the foundation of much of our practical development. Alongside establishing KSF outlines for staff groups, often against a backdrop of service pressures, the Trust has developed generic learning programmes that provide consistent and equitable access to learning across major staff groups.

These enable KSF outline targets to be achieved and provide support to operational managers by programming the major part of any individual's core learning whilst in post.

The Trust-wide effort to attain NHS Litigation Authority risk management standards has also had an impact within Learning and Development. A new induction policy has been approved and the induction packages reviewed across the Trust to align practice with policy. In doing so, the packages have been revamped again and now deliver an enhanced set of learning outcomes in a coherent and engaging format. We have also further reduced the time needed to complete and evaluations from staff are extremely positive. Part of this redevelopment includes a new 'Putting NHS Values into Practice' component, covering requirements under various aspects of equality legislation, while also promoting core values for patient care and public service.

The approach to mandatory training has also been reviewed with the aim of saving staff time whilst ensuring required standards are met. This has led to a very comprehensive training day covering essential updates, which has been evaluated very strongly indeed by clinical staff. We are also directly assessing the competence of most clinical staff for moving and handling procedures in the workplace, using a risk assessed, locally specific set of procedures developed with each clinical area. The work for NHS LA has also been extended with efforts to produce a Trust-wide training needs analysis, enabling the Trust to have a validated overview of all provision for the first time.

The Education, Learning and Development Group has been re-established and is now a forum embracing multi-disciplinary learning across the Trust. All developments go through this body, providing good governance links to the HR Committee and the Trust Executive. An immediate benefit has been improved integration of specific areas like practice development, risk management and policy implementation with the broad learning and development strategy.

Lastly, the annual celebration of achievements has grown into a significant event in the Trust calendar. Over 200 qualifications were awarded in November covering health and safety certification, advanced clinical skills, management awards, NVQs in a variety of areas and internal certificates such as link training. The continued commitment of staff to learning is extremely positive and the Trust is well on the way to achieving the goals established for 2010 in the Department of Health report 'Learning for Change in Healthcare'.

Involving Staff

The Trust continues to involve staff in key decisions which affect their working lives and the services they provide wherever possible. The staff briefings which were introduced in 2005 to support the Fit for the Future programme have become regular quarterly briefings. This provides all staff with the opportunity to receive first hand information from a member of the Trust Board and Executive team and gives a forum for staff to share their views and ask questions directly. The Chief Executive has also scheduled a series of quarterly briefings which will allow him to update staff on Trust news and performance, and to answer questions in an informal setting.

Regular weekly discussions between operational and human resources managers, Service Improvement Team members and union representatives have played an important part in ensuring the on-going delivery of the Fit for the Future programme, and have provided transparency and more effective communication.

The Agenda for Change project which involved the assimilation of over 3000 staff onto a new pay system continues to be a successful example of joint partnership working with trade union colleagues. The communication group established for facilities staff whose employment is affected by the Private Finance Initiative continues to thrive and be effective.

All staff have had the opportunity to participate in the review of the Trust's operational and management structure through presentations, workshops, discussion groups and web-site access, and many put forward their views.

Staff governors run surgeries at regular intervals throughout the year which are open to all staff should they wish to share views or concerns.

These ongoing involvement initiatives are underpinned by a routine monthly team briefing process which provides staff with information on Trust-wide indicators including national targets and financial performance. This is then supplemented by local information from their specific service area which outlines areas of particular focus, both congratulating staff on achievements and highlighting areas for further development.

Specialist newsletters are also widely used across the Trust for a variety of purposes. For example 'Team Brief' cascades Trust news and performance updates through the Trust, and operational information is given regularly to all staff through 'Factsheet'.

Equality and Diversity

The Trust has an established policy in place on equality and diversity which covers both service access and provision for patients and employment issues for staff.

Our commitment to equality means valuing individuals, recognising their differences and similarities and that any unique contribution can significantly benefit our organisation and the community. It is the policy of Peterborough and Stamford Hospitals NHS Foundation Trust to treat individuals fairly regardless of their gender, race, nationality, ethnic origin, marital status, disability, age, religious beliefs or sexual orientation.

One of the Trust's core values, as set out in its HR Strategy, is to respect people's dignity and treat them with fairness, consistency and honesty. This continues to be emphasised through induction and orientation for all new staff which adopts a values based approach and from 2006 includes a new session on 'Putting Values into Practice'.

We were particularly pleased to note that in the 2006 patient survey, responses by our patients to the question 'Did you feel you were treated with dignity and respect whilst you were in hospital?' were extremely positive and placed us in the top 20% of Trusts nationally.

The Trust has an established Race Equality Scheme and published its Disability Equality Scheme in December 2006. At its meeting in January 2007, the Trust Board reviewed its statutory equality duties in the light of recent guidance and anticipated legislative changes. The Board decided to adopt a Single Equality Scheme and agreed a new organisational framework to ensure the development and implementation of the scheme, including the establishment of a steering group chaired by a non-executive director. One of the key requirements of the scheme is for impact assessments to be undertaken on all existing Trust policies in respect of disability, race, gender and age issues and to date over 30 policies have been covered.

The Trust's Disability Equality Scheme has an action plan which is updated on a quarterly basis. One of its actions was to review our patient access audit and plans are in place to re-audit again later this year. As part of this audit, an electric scooter is now available for patients and/or visitors at Edith Cavell Hospital. We continue to work closely with our partners in Learning Disabilities to improve access and services to this special group of people.

3.6 Safety

The Trust continues to have a well established Health and Safety Committee which meets quarterly, and is chaired by a member of the Trust Executive. The committee membership consists of employee safety representatives and management representatives from across the Trust. It reviews work related accidents, adverse event and near miss reports, concerns raised by employee representatives, and any other factors that may affect the health, safety and welfare of staff, patients or visitors.

The positive safety culture is illustrated by the results of the 2006 staff attitude survey which identified that 77% of those questioned said they had received health and safety training in the last 12 months.

The Trust has a robust adverse event and near miss reporting and monitoring system to identify the potential for further safety improvements. The National Patient Safety Agency (NPSA) receives reports on all patient safety related adverse events and near misses; in the period 1 January – 30 September 2006 (the latest reports from the NPSA) the Trust continued to be in the in the best quartile of reporting NHS organisations, the majority of which were near misses or very low severity incidents. The 2006 staff attitude survey confirmed that 95% of staff questioned knew how to use the reporting system, it also identified that staff thought the system was fair and effective.

The Trust was in the top 20% of acute trusts surveyed.

The community wide consultation in 2005 on Travel Plans led to an action plan to improve access and car parking facilities for patients, visitors and staff, which has been implemented incrementally over the last two years as part of a three year programme. Work in partnership with Stagecoach and Peterborough City Council to provide subsidised travel for employees for both commuting and travelling between hospital sites continues and has been well accepted. There has been a significant increase in the purchase of subsidised 'Megarider' tickets and a marked decrease in car parking applications by staff. The patrolling of the hospital roads and car parks by Peterborough City Council has significantly reduced the problem of drivers parking on fire access roads.

The management of verbal abuse and violence within the Trust continues to be a high priority, and personal safety training in conjunction with the Cambridgeshire Constabulary continues to be important. The results from the 2006 staff attitude survey acknowledged that the Trust continued to be in the best 20% of Trusts for low levels, having some of the lowest rates of verbal abuse and violence in the NHS nationally. The benefits of the tough stance taken by the Trust to zero tolerance of physical abuse to staff, is borne out by the 2006 staff attitude survey results. Once again the Trust was in the top 20% of trusts nationally. Staff perception is that the Trust takes such incidents very seriously and manages them well.

The Trust continues to review and tightly manage the levels of sickness absence through positive human resources management and the utilisation of the in-house occupational health service. Following on from the launch of the stress management policy in 2004 the Trust continues to manage stress as it would any other occupational health illness and was in the best 20% of trusts nationally for managing stress in the 2006 staff attitude survey. The management of sickness absence and stress is closely linked to good human resource practices such as training, flexible working, decreasing the long hours culture and allowing staff to work from home where possible. There are many excellent examples of staff who have changed their working hours by working flexibly, or reducing hours, to have a more structured work/life balance.

The occupational health service continues to work closely with our human resources specialists on redeployment of employees for reasons of health or disability. The Trust ethos is to assist, where possible, the redeployment and retraining of employees who cannot continue in their original role due to illness or disability.

3.7 Patient and Public Involvement

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

Members of the Patient and Public Involvement Forum have continued to work with Trust staff on hospital cleanliness and nutrition projects, including participation in audit and benchmarking activities. In relation to infection control and cleanliness issues the Patient and Public Involvement Forum continues to work with Trust staff on auditing hand hygiene and the environment, and raising the awareness of members of the public. A member of the PPI Forum has a place on the Hospital Infection Control Committee.

Other good work led by the Forum over the last year includes a well received report into the work of bereavement services, and a review of the services provided by PALS. The PALS Steering Group has been set up, chaired by a lay person, and is responsible for ensuring the services provided fit with the core standards set down by the Department of Health.

The Trust's governors and members are continuing to make a real difference to the development of our services and the redesign of public involvement activities.

There is governor and member input into improving the quality of care through Essence of Care Groups and the National Survey Group participation, and the provision of lay membership on the Formulary Committee, Maternity Liaison, Maternity Risk Management, Healthcare Governance and Patient and Public Involvement Committees. Each public governor is also aligned to an area of the Trust to gain experience of the particular area and to provide a public perspective to the particular director or general manager of that area.

A group chaired by a member of the public meets six monthly to review findings from the National Patient Survey Programme. This group has driven changes in a number of working practices following analysis of the results of the various surveys. For example:

- enabling young patients to choose between the paediatric ward or adult wards for in patient care,
- reviewing noise issues for patients at night, including staff footwear and rubbish bin closing mechanisms.

The Trust has a Readers' Panel whose primary job is to look at patient information leaflets and to comment on their grammar, style and overall reader friendliness. Staff are encouraged when reviewing their information sheets to send them through to the Readers' Panel for comment and then to revise them in line with the feedback received. The Panel has reviewed between 50 and 60 leaflets during the year including leaflets for Medical Services, Surgery, and Woman and Child.

In providing our services we are extremely well supported by both the Friends organisations and by our volunteers. The Friends of Peterborough Hospitals and the Friends of Stamford Hospital have donated money throughout the year to purchase equipment and improve amenities. The Trust has a strong base of volunteers who provide a much valued service. In the last year, a volunteer has been recruited who has cerebral palsy who comes along, with his carers, to participate in the meet and greet service at Edith Cavell Hospital. The Trust has approximately 250 volunteers who are actively volunteering in all areas, providing support to our substantive staff but, most importantly, providing a service to all of the Trust users.

Working closely with Voluntary Services, the Chaplaincy Department uses 92 volunteers in a variety of roles, including Chaplaincy ward visitors, Chapel escort, musicians, flower arrangers and calligraphers.

An audit of attendees' response to the babies and children's remembrance service in July 2006 overwhelmingly approved the holding of such a religious service, its content and of the active involvement of staff from the Accident and Emergency Department, Maternity Unit, Amazon Ward and Bereavement Services. This was endorsed again by the audit of the January 2007 service.

3.8 Code of Governance

The Trust Board of Directors and Board of Governors have jointly reviewed the NHS Foundation Trust Code of governance issued by Monitor, and welcome this guidance as an aid to ensuring good governance. Of the 141 separate items in the code, the Trust is compliant with the large majority (97 per cent) of items. However, the code has enabled the Trust to identify areas where further work is required to meet the recommendations and explain those areas where Trust practice differs.

There are four areas of divergence from the code, and these are detailed below.

- Board of Directors configuration (provision A.3.2) - The code recommends that half of the Board of Directors, excluding the chair, to be independent non-executive directors. The Trust currently has equal numbers of executive and non-executive directors. There are two reasons for this. One of the existing executive directors posts concerns the development of the Greater Peterborough Health Investment Plan Private Finance Initiative (PFI) project and therefore the remit and nature of this post may change as the PFI scheme progresses. The size of the Board of Directors is also considered to be an important factor. An additional non-executive director would increase the Board to 15 members, a

point at which it is considered that its functioning may become unwieldy.

- Non-Executive chair of nominations committee (provision C.1.3) – The code requires the chairman or an independent non-executive director to chair the nominations committee(s) that consider executive and non-executive director appointments. The Trust operates with two nomination committees, one for executive directors and one for non-executive directors. The nominations committee for executive director appointments is chaired by the Trust chairman. However the nominations committee for non-executive director appointments is chaired by a governor who is deputy chairman of the Board of Governors on all matters relating to non-executive director appointments. This process has worked extremely well and has seen the Trust progress with good quality non-executive director recruitment, revision to non-executive director appraisal processes and key debates concerning remuneration. As the Board of Governors is responsible for non-executive recruitment the Trust considers that this arrangement properly reflects this duty and intends to continue with this arrangement.
- Reappointment of executive directors (provision C.2.1) – The code requires that executive directors should be subject to reappointment at intervals of no more than five years. In line with current employment law and practices, executive directors are appointed on a permanent basis. Performance and objectives are reviewed formally at least on an annual basis, and as for all other Trust employees, there are agreed mechanisms for performance management and appraisal. A reappointment process is therefore not considered appropriate.
- Reappointment of non-executive directors (provision C.2.2) – The code requires non-executive directors to be appointed for terms of no more than three years. The Board of Governors took the decision to appoint non-executive directors for terms of no more than four years to allow for continuity and experience. However performance and objectives are reviewed formally at least annually and there are agreed mechanisms for performance management and appraisal which ensures rigorous annual review.

As the Trust has been a Foundation Trust for three years, work will commence on reviewing the Trust's constitution and standing orders. This will include the Trust values, code of conduct and clear statements on roles for the Chair, Chief Executive, Board of Directors and Board of Governors. Work is also progressing on reviewing our patient and public involvement agenda, which will include formal development of processes and documentation regarding stakeholder relations, and developing our compliance in this area.

4. Operating Review

4.1 Introduction

The current Trust was formed on 1 April 2004 succeeding the Peterborough Hospitals NHS Trust, which had been established on 1 April 1993. The Trust provides healthcare services from three main sites in Peterborough: the Peterborough District Hospital, the Peterborough Maternity Unit, and the Edith Cavell Hospital; and in Stamford at the Stamford and Rutland Hospital. We organise and manage a wide range of mainly hospital-based healthcare services for people in Peterborough and the surrounding area of North Cambridgeshire, South Lincolnshire, East Northamptonshire, East Leicestershire and Rutland.

4.2 Guiding Principles and Goals

The Trust is here to provide the best possible healthcare for our community, and to help people to have healthier lives. The Board of Directors and Board of Governors have discussed objectives and these have been developed into a set of strategic objectives as follows that have been in place throughout the year, to:

- be the healthcare provider of choice for the community of Greater Peterborough and the surrounding area;
- provide a comprehensive range of elective, emergency and diagnostic services suitable for a medium sized district general hospital at least to national standards;
- generate a surplus of at least 2% annual turnover every year to invest in our services;
- invest in hospital estate in Peterborough to ensure facilities are fit for purpose;
- invest in Stamford and Rutland Hospital to create a vibrant health campus in Stamford through development of NHS services, public/private partnerships and sub-lets to complementary service organisations;
- 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;
- 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;
- be a model employer with a reputation as a great place to work in order to attract and retain excellent staff.

The delivery of these objectives is through the work of our Trust Executive, which has the remit for operational implementation being composed of all the Executive Directors together with senior operational staff.

4.3 Performance

The Chief Executive's statement summarises the main service and performance achievements and associated issues for 2006/07 as well as the financial position for the end of the year.

The year has seen some key achievements in our services for patients. This includes continued good performance regarding infection control, reduced length of stay. There have also been challenges in the year concerning the higher rate of outpatient, A&E and emergency referrals and restrictions placed on elective activity due to PCT affordability issues. These financial restrictions were lifted after the new year to which the Trust responded with higher levels of planned inpatient and day case activity.

Risks had been identified for this year concerning the legal contractual framework, financial recovery, continued patient and staff satisfaction and the need to address the patient choice agenda. These risks have been managed throughout the year, evidenced by strong financial performance, positive results from the national patient and staff surveys and increased levels of referrals from GPs whose patients choose to use their

local hospital. These issues need to be managed throughout the coming year.

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

		Indicator	Gov/ Trust Target	Full Year Target	End of year performance	Comments
Access	1	IP Waiting List - people waiting > 6 months	Gov	0	**328**	This is snapshot data. Breaches identified after audit of Orthopaedic waiting list. Ongoing investigation between Trust, SHA and Monitor.
	2	IP Waiting List - suspended as a % of total	Trust	6%	**4.5%**	Snapshot data
	3	IP Waiting List - Total numbers of people waiting	Trust	na	**6190**	This is snapshot data. The waiting list size is at it's highest level since February **2003,** reflecting PCT access management restrictions
	4	Outpatients - people waiting > 13 weeks	Gov	0	**0**	Snapshot data
	5	12 Hour 'Trolley' Waits For Emergency Admission	Gov	0	**0**	
	6	Total Time In A&E 4 Hours Or Less:	Gov	98.0%	**98.53%**	
	7	All Cancers 2 Week Wait	Gov	100.0%	**100%**	
	8	All cancers - 62 day wait from referral (new standard from Dec 2005)	Gov	95%	**98%**	
	9	All cancers - 31 day wait from Decision-to-Admit (new standard from Dec 2005)	Gov	98%	**98%**	Standard = At least 98% of cancer patients (including those not urgently referred by their GP) are to be treated within 31 days of the decision to treat
	10	Booking - New Outpatients	Gov	100%	**100%**	
	11	Booking - Admissions	Gov	100%	**99.79%**	Snapshot data
	12	Cancelled Operations	Gov	1.0%	**0.81%**	The cumulative position is in line with the national standard of 1%.
	13	Delayed Transfer Of Care - %	Trust	2.3%	**2.95%**	
	14	Delayed Transfer Of Care - 4 Week Average Number of patients	Trust	12	**14**	Target of 12 is based on the average monthly DTs 2005/2006.
	15	Emergency readmission within 28 days	Trust	6.3%	**6.7%**	Data to end of December. Data is calculated from local data and definitions that match National Clinical Indicators (eg Maternity & Oncology episodes are excluded). Readmission data obtained using Dr Foster is based on different criteria.
	16	Emergency readmission within 28 days - Fractured Neck of Femur	Trust	15.9%	**15.7%**	Data to end of December. Measure is sensitive due to low numbers involved. Data is calculated from local data and definitions that match National Clinical Indicators (eg Maternity & Oncology episodes are excluded). Readmission data obtained using Dr Foster is based on different criteria.
	17	Outpatients DNA rates	Trust	6.5%	**8.5%**	
Clinical	18	Complaints (response within 25 working days)	Trust	90%	**84%**	National Target is 70% - Information collated quarterly. Complaints received in Q4 up by 50% on same period last year.
	19	Infection Control - MRSA rates	Trust	10	**11**	
	20	Infection Control - C-DIFF rates	Trust	230	**205**	Full Year Target is a 10% reduction on 2005/2006 infection rates.
	21	Ethnic Group - data collection completeness	Trust	80%	**80%**	Snapshot data. Data to end of September. Data now sourced from Dr Foster
	22	Mortality (in-hospital deaths based on basket of diagnoses)	Trust	5.8%	**5.7%**	Snapshot data. Data to end of February. Rolling 12 month value. Target based on nationally expected rates.
	23	Incidence of Hospital Acquired Pressure Sores	Trust	168	**142**	Target is 10% reduction on 2005/2006. Data is 1 month behind due to data completeness issues.
	24	Incidence of Drug Errors	Trust	439	**490**	Target is 10% reduction on 2005/2006. Data is 1 month behind due to data completeness issues.
	25	Incidence of Falls	Trust	1543	**1313**	Target is 10% reduction on 2005/2006. Data is 1 month behind due to data completeness issues.

		Indicator	Gov/ Trust Target	Full Year Target	End of year performance	Comments
	26	Incidence of Staff Shortages	Trust	250	**274**	Target is 10% reduction on 2005/2006. Data is 1 month behind due to data completeness issues.
Staff Focus	27	Sickness & Absence	Trust	4.5%	**4.5%**	
	28	Turnover	Trust	11.5%	**12.3%**	
	29	Staff Productivity (No. of patient days per WTE)	Trust	7.4	**8.9**	
	30	Total staff costs per wte pa (tolerance +/- 1.5%)	Trust	33,542	**35,407**	Both wtes and pay expenditure significantly lower than planned; productivity higher than planned (see indicator 29 above)
	31	Appraisals complete - JRD	Trust	100%	**82%**	JRD essential for all staff to support AfC pay progression
	32	Appraisals complete - Consultant	Trust	100%	**85%**	Total of 109 out of a possible 128
Efficiency	33	Non-Elective Spells (PbR) - Numbers (tolerance +/- 1.5%)	Trust	31,311	**30,684**	Year to Date position is -2.0% against the plan
	34	Elective Spells (PbR) - Numbers (tolerance+/- 1.5%)	Trust	30,283	**28,539**	Year to Date position is -5.8% against the plan
	35	Day Case admissions - % of elective work against 75% target	Trust	75%	**75%**	
	36	Day Case admissions - % of elective work against Basket of Procedures	Trust	75%	**73%**	
	37	Outpatient Total Attendances (PbR) - numbers (tolerance +/- 1.5%)	Trust	242,056	**251,504**	Year to Date position is 3.9% against the plan. Currently reviewing follow-up rates
	38	GP Outpatient Referrals (tolerance +/- 1.5%)	Trust	57,610	**58,855**	Year to Date position is 2.2% against the plan
	39	A&E - Attendances (tolerance +/- 1.5%)	Trust	67,831	**69,779**	Year to Date position is 2.9% against the plan
	40	Average LOS - Emergency	Trust	5.5	**4.8**	
	41	Average LOS - Elective	Trust	3.1	**3.1**	
	42	% Bed occupancy - weekly snapshot (tolerance range 85%-90%)	Trust	90%	**82%**	Snapshot data
	43	Theatre Utilisation: Unused lists %	Trust		**7%**	
	44	Theatre Utilisation: Used lists %	Trust		**93%**	
Financial Mgt	45	Financial Management	Trust	3	**4**	
	46	Revenue from Clinical & Non-Clinical	Trust	158.1m	**162.1m**	
	47	EBIDTA margin	Trust	6.40%	**7.81%**	
	48	I & E surplus margin net of dividend	Trust	2.9%	**4.2%**	
	49	Days cash-in-hand	Trust	10.0	**41.1**	Snapshot data

Snapshot Data : Indicates that the value is taken at a given point in time

For the future we are looking to build on the achievements against our current strategic objectives, the strong local partnership working, and the direction of national and local strategy to review our strategy and develop a vision for the future. This will encompass the achievement of the Greater Peterborough Health Investment Plan, the delivery of patient choice and the consolidation of local services for local people available at the right time, to the right standard and in the right place. This includes our intention to extend our catchment and our services to a wider population.

To ensure we fulfil our responsibilities as a public benefit corporation the Trust is pursuing the development of good corporate citizenship using a self-assessment model developed by the NHS. Following the completion of the self-assessment process, which added to the good practices that we already follow, the Trust has undertaken the development of a cohesive suite of policies to support sustainable development and benefit local social, economic and environmental conditions.

One of the most successful has been our travel options policy which encourages the use of alternative transport and won a second county award for sustainable transport schemes this year - the only organisation in Peterborough to do so.

In January, the Trust successfully implemented a smoke-free policy. This included establishing a 15m no smoking zone around each of the Trust's hospitals, removing smoking shelters from Peterborough hospital sites, supporting members of staff trying to quit through free advice and nicotine patches, and supporting and advising patients trying to quit.

The Trust is committed to working with the Carbon Trust and involving staff in campaigns and energy audits. This year, energy awareness sessions were set up with the Carbon Trust where staff were given information on how they could help the Trust meet its government set carbon dioxide emission reduction targets, as well as measures they could achieve at home to reduce their own emissions. The Facilities department Intranet site includes information from the Carbon Trust on saving energy and is used to illustrate the Trust's environmental policy.

Staff newsletter 'Factsheet' is also used as a method of communicating hints and tips on saving energy and being more environmentally aware.

New tighter regulations on waste disposal and the emphasis on segregating more waste to recycle means the Trust has had to change its methods and attitudes regarding disposal of our rubbish. Due to the vast and varied amount of waste produced in our hospital environments, the Trust has convened a Waste Management Group consisting of the main leads responsible for the various waste streams leaving the Trust. The group has already established changes in the colour of sharps bins to clearly differentiate the correct bin for different types of rubbish.

One of the group's focus areas is the need to segregate waste. Clinical waste costs approximately ten times more in disposal costs than domestic waste, so the group is aiming to educate staff about the importance of disposing of different types of waste in the correct way.

When reviewing purchasing decisions, the Trust considers the use of local suppliers as a criteria to ensure that, where economically sound and effective, contracts for goods and services can be placed locally.

Finally in developing the Greater Peterborough Health Investment Plan (GPHIP) PFI scheme all the associated specifications and contracts have ensured that environmental standards are met.

To be sure of robust performance, the Trust has a system of risk management and governance which ensures a process for highlighting and managing risk and ensuring high standards in clinical care for patients and high standards of corporate performance. To make sure that governance arrangements are robust, the Trust Board of Directors continually reviews its structure when replacing executive and non-executive directors (the latter in conjunction with the Board of Governors), having due regard to the mix of skills required. Performance reporting to the Boards also has a sharp focus on operational delivery as well as a more strategically focused Board of Directors meeting.

Risks that have been identified and are being addressed include the need to address waiting list management, achieve GPHIP, ensure progress on financial and contract management and ensure capacity to meet a wide and challenging agenda. There is also the need to ensure the ongoing robustness of local partnership working whilst having clearly defined legal contractual obligations where a robust approach to contracting discussions is required; to ensure that the Trust develops its reputation through patient satisfaction; and to ensure that our services are attractive to patients under the government patient choice agenda. Further information on the management processes for identifying, assessing and managing risks are contained in the Statement on Internal Control in the Annual Accounts.

Further details on plans for the coming year and their risk management are also available in the Trust's Annual Plan 2007/2008, which is available on the Trust's website or direct from the Trust's Company Secretary.

4.4 Patient Care

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

A number of developments in patient care at the Trust have progressed throughout the year. A new dermatology clinic at Edith Cavell Hospital opened in July 2006, bringing together three separate dermatology services (Outpatients clinic, minor surgery and UV light treatment) that were previously offered from different parts of the District Hospital. The clinic is also used for plastic, breast and general surgery clinics. Mothers-to-be were given a new delivery option at Peterborough Maternity Unit in January 2007 with the launch of a Midwife-Led Unit offering the choice of 'home from home' midwifery support during labour to women requiring minimal intervention during the birth of their child. The Trust also opened a new state-of-the-art Intensive Care Unit (ICU) on the first floor at Peterborough District Hospital in April 2007. The £900,000 purpose-built unit was designed to have more space for patients and medical equipment and an improved environment for patients, visitors and members of staff. Up to six patients can be cared for on the unit, but there are plans to expand the capacity to manage eight patients in the future.

Service Unit Healthcare Governance Committees form the infrastructure for integrated governance within the Trust and report to the Healthcare Governance Committee. The function of these committees is reviewed by the Healthcare Governance Committee to ensure appropriate clinical governance activities. For example, systems to implement recommendations coming out of national confidential enquiries and feedback from the Healthcare Commission have been reviewed.

Service Unit Healthcare Governance Committees also agree topics for local clinical audit and ensure audits are presented and action plans are agreed and monitored. Clinicians have protected time for clinical governance activities and clinical audits are presented at most sessions. Service units prioritise audit to ensure national audit requirements are met, including the implementation of NICE (National Institute for Health and Clinical Excellence) guidance. Local areas of concern are investigated, and the Clinical Negligence Scheme for Trusts standards can be accommodated and re-audit can take place. The Trust's Healthcare Governance Committee monitors clinical audit across the Trust and requests audits where there are concerns about the quality of clinical care.

Quality concerns can be cross boundary and need to be addressed with partners in the community. For this reason the Clinical Governance Locality Forum has been re-established to bring together GP, mental health and social care colleagues. Jointly chaired by the Medical Director of the Trust and the Medical Director of the Peterborough Primary Care Trust (PCT), this forum addresses issues of combined quality interests and makes recommendations for changes in practice where improvements are needed. Three elements of care that have been considered by this group during the year have been infection prevention and control, investigations (particularly blood tests) and communication with patients.

Progress with NICE guidance is one area of particular joint concern for the PCTs and the Trust and a separate NICE Implementation Group has been established by the PCTs to monitor developments in this area. The Trust has representatives on this group and works with the PCTs to identify and manage any barriers to the implementation of mandatory guidance alongside maintaining an overview of compliance with recommended best practice.

The Trust's National Confidential Enquiry into Patient Outcome and Death (TCEPOD) Committee meets quarterly and receives any new reports. The committee reviews data on all deaths in hospital and uses data from Dr Foster to highlight areas for review where mortality rates appear to be higher when compared with figures from other organisations.

Relevant clinicians are invited to respond to findings from TCEPOD and to alert the committee to any major concerns in meeting recommendations for best practice. Members of the Clinical Management Board have reviewed all current recommendations from national reports and provided an overview to the TCEPOD on progress against implementation.

The Trust Annual Health Check group has responsibility to ensure the Trust is compliant with the core standards described in Standards for Better Health. The group, chaired by the Director of Nursing, also reviewed progress with the shadow developmental standards that are the framework for the Trust's clinical governance development plan. Progress with National Service Frameworks and all other elements of the Annual Health Check are also co-ordinated by the group, which in turn reports to the Trust Executive and the Healthcare Governance Committee. The cancer peer review report shows that the Trust is achieving a high level of compliance against the national standards in this area of care.

The Trust has continued its contract with Dr. Foster, the organisation that works alongside the Department of Health to provide specific information to the general public on some aspects of NHS Trusts' performance. Reports are received regularly by the Healthcare Governance Committee and the Clinical Management Board for review of benchmarked data. Clinicians are encouraged to interrogate the data provided by Dr. Foster to compare outcomes and identify any areas for concern. This work has led to an improvement in clinical coding within the Trust.

The Trust continues to work closely with the local Overview and Scrutiny Committee which has been kept informed of changes due to our *Fit for the Future* financial recovery plan, been involved in the development of our travel options initiative and also been kept up-to-date with the progress of the local Private Finance Initiative scheme. They have also been very supportive in the Annual Health Check process.

The Service Improvement Team, as detailed in section 3.4, leads developments and co-ordinates the many groups of staff involved in service improvement. Developments are reported to the Board of Directors through the year. The main streams of work undertaken during 2006/07 were:

- work to streamline the patient's journey through the Trust;
- improve access to services;
- prepare to meet the 18-week wait target set for December 2008;
- improve administrative and clerical processes.

The Trust cares for a large number of patients who do not speak English as their first language. Interpretation and translation services are key to these patients' care and experience. The Trust has been working closely with the current provider of these services to ensure availability, quality and cost effectiveness of interpretation, moving appropriate elements of this demand to telephonic provision with good effect. A full time translator for Portuguese patients was employed given the demand for this language and this has been evaluated positively.

A new group was convened to replace the patterns and trends meeting during the year, which reviews reports from the PALS, Complaints, Risk Management, Legal Services and Clinical Standards departments. Through this meeting action is taken to address concerns, and identify trends in risk management and lessons to be learnt across the Trust.

The Trust was involved as a pilot site for the development of the NHS Litigation Authority Risk Management Standards, and was accredited at Level 1 across general services in December 2006. The Maternity Unit was accredited at Level 2 in January 2007.

Other developments in the year include the development and piloting of the 'Care of the dying pathway', which is to be rolled out across the Trust. Continued audit of health care records shows standards are improving and further work to improve the structure of records for clinical use is underway. A research project has been initiated to investigate the processes of nursing care and some of the influences on the nursing workload, including prioritisation in patient care delivery. The Essence of Care project groups continue to undertake benchmarking and quality development work, and a new group has been convened to progress the

newly published Health Promotion benchmark.

Following a presentation by the National Patient Safety Agency (NPSA) at the Healthcare Governance Annual General Meeting a project group was initiated and has developed competencies in tracheostomy care. The Trust also has representation on the NPSA national working party considering this element of care. This group has also picked up on issues and concerns raised by the local Support Group for patients who have undergone laryngectomy surgery.

The Trust has robust infection prevention and control measures in place as part of the fight against infections such as MRSA and Clostridium Difficile. Members of the Infection Control Team work closely with other clinical, non-clinical and cleaning staff to reduce the risk of infections, and visitors to the Trust are asked to follow the 'Clean Your Hands' guidance and use alcohol gel to clean their hands when they are entering or leaving a ward. Cases of MRSA bacteraemia for 2006/07 totalled 11, making the Trust one of the highest performing trusts for infection control in the country. In the same period, the number of cases of hospital acquired C. difficile in patients aged 65 or over recorded by the Trust was 205.

Staff attending the Trust induction are given a presentation on complaint handling and further training is provided at locally organised updates. Leaflets are available on all wards for patients regarding the process of making complaints and how to go about it.

Quarterly complaints reports are published for each service unit and are distributed to the relevant staff and meetings. The total number of complaints received in 2006/2007 was 318, of which 81% were responded to within 25 working days. The total number of accolades recorded was 8,456 for the same time period. The Trust strives to achieve local resolution of complaints and members of staff met with relatives regarding 27 complaints during the year.

Eight concerns were raised with the Healthcare Commission, one of which required further action and seven were closed. Three cases were referred to the Ombudsman for investigation, two of which required further action.

The most common categories of complaints for the year were:

- standards of care;
- clinical practice – treatment;
- clinical practice – diagnosis.

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

- increase in the number of staff to patients on wards;
- withdrawal of a specific piece of equipment used for an operative technique;
- specific training for ward staff designed and supplied by the Practice Development Team;
- changes to the checking of tablets in pharmacy prior to discharge;
- changes to the way the Orthopaedic waiting lists are managed;
- the Service Improvement Team are working with Therapy Services to streamline the system for referral and treatment;
- senior medical staff providing extra training to junior doctors regarding result reporting;
- new leaflets for overseas visitors;

4.5 Stakeholder Relations

There is strong collaborative working across the local health economy. Partnership working is one of the organisation's strengths and there is significant collaboration, input and decision making that transcends organisational boundaries. Projects, for example exploring employment pathways for refugees, take place with input from health and social care and educational providers in the city.

The Chairman is the Deputy Chairman of Opportunity Peterborough, the city's urban regeneration committee, and represents the Trust at a senior level on a number of external forums regarding developments in Peterborough including the Greater Peterborough Partnership - the area's local strategic partnership - where he is a member of the board, and the Environmental Capital Partnership.

The Trust is organised and run with the direct input of Ministry of Defence staff that play an essential and vital part in service delivery. The MoD staff are fully integrated alongside Trust staff in the clinical areas in which they work. Both Ministry of Defence and ISS Mediclean staff attend the Trust induction and orientation sessions as part of their training and development programme.

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

Multidisciplinary working across primary care is commonplace, for example in terms of the development of services to HMP Peterborough, discharge planning, National Service Frameworks and other service developments. Also, regular meetings take place between NHS Professionals and the Peterborough Primary Care Trust (PCT) regarding the provision of temporary staff for the PCTs, service delivery and enhancement.

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

4.6 Financial Review

Overall position

The Trust recorded an income and expenditure surplus of just over £2.5M (or 1.5% of total income). This was significantly better than the plan for the year, which anticipated a surplus of just over £0.2M. This puts the Trust on the right track for making good its past deficits (£7.7M in 2004/2005 and £0.9M in 2005/2006). The good performance in 2006/2007 also indicates that the Trust is ahead on its plan to achieve surpluses equivalent to 2.5% of income going forward – to support investment in healthcare services and the development of a new hospital in Peterborough.

The Trust's finances continued to be a major topic on its agenda. The focus in 2006/2007 was very much on sustaining progress made in achieving cost control and reduction in the previous year, and delivering on the first phase of savings planned in the Trust's Fit for the Future programme. This programme delivered £3M of savings in 2006/2007, with a second phase of similar savings being implemented in 2007/2008. These cost reductions have to be achieved by modernising services and changing the way they are provided – while at the same time ensuring services to patients are not compromised, and activity and revenue are secured.

Income earned on our main healthcare contracts was higher than originally planned. Additional income was earned for elective inpatient and outpatient care, and for the range of other clinical services provided (such as chemotherapy, audiology and specialist drug treatments).

However other areas of income were lower than planned. Significantly, funding for training and education was some £0.6M down on plan because of cuts in funding imposed by the East of England Strategic Health Authority half-way through the year in order to support overspending elsewhere in the region.

Pay expenditure was slightly lower than planned (by under 1%), with non-pay expenditure being higher than planned (but driven by, and covered by, the income being earned on contracts).

The focus on operating efficiency and cost control is set against a background of substantial financial pressures facing the main Primary Care Trusts (PCTs) with which we have contracts. In addition, the PCTs' on-going strategy of looking to reduce emergency admissions into our hospitals and to develop primary care services as an alternative to outpatient care in our Trust represents another considerable threat.

However, in contrast, there is the potential for the Trust to secure significant additional revenue in 2007/2008 and 2008/2009 as PCTs look to achieve substantial increases in elective (planned) activity in order to ensure no one waits more than 18 weeks (from GP referral to treatment) from December 2008.

Accounting policies

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

The accounting policies set out in the *Financial Reporting Manual* follow UK generally accepted accounting practice ('UK GAAP') and HM Treasury's *Financial Reporting Manual* to the extent that they are meaningful and appropriate to the NHS.

The Trust's Annual Accounts and associated financial statements have been prepared in accordance with the 2006/2007 *Financial Reporting Manual* issued by Monitor. The accounting policies have been applied consistently in dealing with items considered material in relation to the Accounts.

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

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

The accounting policies are set out in full in the annual accounts.

Income

Income from activities

Income earned from activities (providing healthcare services) was £147.5M. This is an increase of 3.9% on the previous year.

This was then adjusted down by £3.9M, under the Department of Health's transition arrangements for the implementation of the new "Payment by Results" funding system for the NHS. Income earned by providing services to PCTs is recorded at the full national tariff price.

The total income earned included an additional £15.4M, being the difference between local historic costs/funding and national average costs/funding under the standard national price tariff. However, under the rules set by the Department of Health, 25% of this additional income (£3.9M) had to be paid back to the Department of Health in 2006/07.

Having adjusted for the funding withdrawn by the Department of Health, income earned from activities was £143.6M. Had the Trust received the full funding under the standard national tariff in 2006/07, the Trust would have recorded an income and expenditure surplus of £6.3M.

In 2007/2008 the transitional arrangements finally come to an end, meaning that the Trust will be fully funded through the national tariff, with no funding withdrawn by the Department of Health. This will benefit the Trust, but is more than offset by other changes to the national tariff, resulting in overall increases in tariff prices of 2.5% compared with the Department of Health's own assessment of inflation and NHS cost pressures for the year of 5%.

Private patient income

The Trust earned £0.5M from providing services to private patients, which equates to 0.35% of income earned from activities. This accords with the "private patient cap" (limit on income) set out in the Trust's Terms of Authorisation.

Other operating income

Income earned from other sources, including education, training and research and other trading activities was £18.2M. This is in line with the results reported for 2005/2006.

Expenditure

Operating expenses

The total operating expenses of the Trust comprise £102M for pay costs and £53.2M in respect of non-pay costs. The Trust's total operating costs of £155.2M were 3.3% up on the previous year.

The operating expenses for the year also include a provision of £0.7M for the estimated cost of known or likely redundancies associated with the next phase of restructuring arising from the *Fit For The Future* savings programme.

We also felt it necessary to increase our provision for credit notes and bad debts by just over £2.3M. This mainly relates to providing for credit notes that may have to be issued for invoices for healthcare activities which are in dispute. This is because we are concerned that some of our commissioning PCTs will fail to pay the Trust for services we have provided to their patients.

In some instances, specific concerns or queries have been raised by PCTs in respect of the activity identified on the contracts and the prices charged. There is also some increased uncertainty in this area because of the need to estimate the value of some activity undertaken in March 2007, and attribute this to Primary Care Trusts, in order to achieve the 30 April 2007 deadline for submitting the Annual Accounts for external audit.

However, the main area of dispute is with the Leicestershire and Rutland PCT which continues to dispute invoices issued in 2005/2006 and 2006/2007 for some elective inpatient, day case and outpatient activity on the basis that the activity exceeded expectations or that the Trust saw and treated patients "too quickly". In addition, this PCT has also raised other queries in the course of 2006/2007 citing various conditions and performance requirements which this Trust contends have never been agreed between the two parties.

The Trust will strive to resolve these outstanding matters, having recourse to mediation and arbitration (the process set out in the terms and conditions of the healthcare contracts) if necessary.

The operating expenses for 2006/2007 also include £1.4M of expenditure on project costs and fees relating to the Greater Peterborough Health Investment Plan (GPHIP), which the Trust is managing for its local NHS partners.

The Trust made no donations to charitable or political organisations.

Other than the disclosure in paragraph 3.3 there are no other significant post balance sheet events.

External audit fees

Expenditure incurred on external audit fees comprised £92,000 for statutory audit work. No non-audit fees were paid to the external auditors in 2006/07. The independent (external) auditor was Robson Rhodes LLP, Daedalus House, Station Road, Cambridge CB1 2RE.

Cash flow

Operating cash flow from activities was £14.7M.

The operating surplus generated £6.6M and, non-cash expenditure items (depreciation) generated a further £6M. The net change in the working capital position generated a further £2.1M of cash – debtors grew by £8.8M, and creditors and other items increased by £10.9M.

Interest earned on cash balances contributed another £0.3M of cash, with no payments having to be made in respect of interest charges.

Beyond this, the cash generated from activities was spent on payments to acquire fixed assets (£6.3M) and payment of the full dividend due to the Department of Health on Public Dividend Capital (£4.3M).

The Trust also received just over £4.2M from the sale of fixed assets. Almost all of this amount related to the sale of land at the Edith Cavell Hospital site to the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust, and land and a building on part of the District Hospital site to the Peterborough PCT as part of the GPHIP. This is a major project relating to the development of healthcare services in Peterborough, through the Government's Private Finance Initiative (PFI). More detail on this is set out in Note 18 in the Annual Accounts.

The Trust also received cash from the Department of Health in the form of Public Dividend Capital of £0.9M.

This 'cash injection' to the Trust is also represented by a corresponding increase in taxpayers' equity on the balance sheet. The cash injection of £0.9M was the total amount due to be invested by the Department of Health in a number of capital investment schemes (the largest of which relates to information technology through Connecting for Health, the National Programme for Information Technology and Picture Archiving Computerised Systems – PACS) less the amount of cash received from the Trust partners in the GPHIP (as covered above).

Taking into account all of the above, the net cash inflow into the Trust was just over £9.5M.

Relationships with trade creditors

The Trust has maintained good working relationships with its trade creditors (suppliers) over the past year. In total, the Trust paid almost 51,000 invoices for goods and services. On average across all of last year, 92% of these invoices were settled within 30 days of registration in the Trust.

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

Prudential borrowing limit and debt

The Trust has a prudential borrowing limit, set by Monitor, of £37.5M. This comprises £25.5M for cumulative long-term borrowing, and £12M for an approved working capital facility.

The Trust did not plan to take on any long-term debt in 2006/2007 and none was taken on.

The Trust has an approved working capital facility in the form of a committed money market facility of £12M with its bankers. This facility is available without any restrictive covenants or on-going fees. There was no requirement at all in 2006/2007 to use this facility, and the Trust had all of its £12M working capital facility available at 31 March 2007.

Balance sheet

Net assets employed increased by £3.1M in the year to £128.2M at 31 March 2007. This was primarily the result of an improvement in the Trust's working capital position which moved from having net current liabilities of (£4.4M) at 31 March 2006 to having net current assets of £4M at 31 March 2007. The net book value of fixed assets held fell by £5.3M. There were no changes to the value of fixed assets held because of revaluations. The reduced value reflects the impact of on-going depreciation of the assets held along with sale or disposal of assets in the year, mitigated by investment in purchased assets.

Investment in fixed assets was £6.7M, comprising £6.6M on purchased assets and £0.1M in respect of donated assets. Of the £6.6M invested in purchased assets, £1.3M related to the acquisition of the St John's office building on the District Hospital site from Peterborough PCT. This was part of the programme of land and asset sales required as the Trust prepared to move ahead with the GPHIP. The Trust received additional cash from the Department of Health as Public Dividend Capital to facilitate this purchase.

Some £5.4M was invested in a variety of schemes consistent with the overall strategy of focussing on the replacement of medical equipment and building and engineering work associated with maintaining compliance with statutory requirements. Two major schemes came to completion in the course of the year – the upgrading of the central sterile supplies department (expenditure in the year: £0.7M) and the upgrading of the intensive care unit at the District Hospital (expenditure in the year: £1M). A further £0.7M was invested in information technology as part of an on-going commitment to participate in the Department of Health's National Programme for Information Technology.

At the same time, £5.5M of assets were disposed of in the course of the year. Almost all of this related to land and buildings sold right at the end of the financial year as part of clearing the way for the GPHIP. A portion of land at the Edith Cavell Hospital site was sold to the Cambridgeshire and Peterborough Mental Health Partnership NHS Trust to enable that organisation to register ownership of land planned to be used for the new mental health unit. In a similar way, land and buildings associated with the former Fenland Wing on the District Hospital site were sold to the Peterborough PCT. This enabled that organisation to register ownership of the land planned to be used for the new Integrated Care Centre.

The sale of these land and building assets went ahead in accordance with the Trust's Terms of Authorisation, and legal provision exists for these assets to be transferred back to the Trust, at NHS book value, should the GPHIP not proceed.

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

Our on-going strategy, for 2007/2008 and the medium-term, continues to focus on upgrading or replacing our fixed asset stock within internally-generated resources. The overall emphasis remains on investment to support our main healthcare activities (protected services). Investment in replacement equipment and various schemes to ensure statutory compliance is planned to be £4M in 2007/2008.

Over and above this, there is expected to be further investment of almost £3M in new information technology (linked to the Department of Health's National Programme for Information Technology and the Connecting For Health programme) and digital image capture, storage and retrieval (in Radiology and throughout the Trust). This investment will be financed through cash received from the Department of Health as Public Dividend Capital.

Beyond 2007/2008, the emphasis will be on maintaining our asset base as we move towards the new single hospital in Peterborough opening in 2010/2011. Should this scheme not proceed, then the investment and disposal strategy, and associated financing and working capital strategy, will need to be revised significantly to reflect a need for substantial additional investment in the existing buildings in Peterborough.

Post balance sheet events

The Trust is leading on the GPHIP which is a major project relating to the development of healthcare services in Peterborough. The major element of this envisages the development of acute hospital services in Peterborough on the Edith Cavell Hospital site through the Government's Private Finance Initiative (PFI). The capital investment cost is estimated at £330M. The Trust appointed a preferred bidder, Progress Health, in March 2005. The scheme is subject to review and approval by the East of England Strategic Health Authority, the Department of Health and HM Treasury's Private Finance Unit. The Full Business Case for the scheme was approved by the East of England Strategic Health Authority in February 2007. The Trust plans to secure the remaining approvals in early June 2007, and to achieve financial close on the contract later on in June 2007. This would enable the new hospital on the Edith Cavell site to open late in 2009/2010.

There are no other post balance sheet events.

Charitable funds

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

In the last financial year, this Charitable Fund made a contribution of £742,000 towards the operating expenses of the Trust (compared with £678,000 in the previous year). After allowing for administration charges of £30,000 this means that £712,000 was made available to support enhancements to our healthcare services, along with improved amenities for patients and staff in a wide variety of wards and departments. This was made possible through donations from members of the public and other fund-raising activities from a number of local organisations, and the Board of Directors is grateful for this wonderful contribution to the services the Trust provides.

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

Looking Ahead

The good performance in 2006/2007 indicates that the Trust is on the right road to improve financial performance, and to achieve surpluses equivalent to at least 2.5% of income going forward to support investment in healthcare services and the development of a new hospital in Peterborough.

It is essential that this improved financial performance is sustained. Two significant financial risks going forward have been identified by the Board of Directors.

Maintaining Cost Control and Delivering Planned Savings

Having achieved a dramatic improvement in the Trust's financial performance, there is a risk of complacency, losing focus and direction, and regarding the issue as 'closed'.

This risk will be managed through a continued strong performance management process. The Board of Directors and Trust Executive are agreed on the overall strategy, and have spent time briefing staff throughout the organisation on the importance and purpose of the Trust's overall strategy and its supporting financial strategy. There will continue to be monitoring of progress by the Board of Directors, Conformance Committee and Trust Executive team.

Revised financial reporting and other monitoring mechanisms have been bedded in and will continue to be developed, especially in respect of 'profit centre reporting'. The Finance Directorate will be maintained at full establishment, with additional investment if necessary, to maintain financial controls, see the savings programme through and develop 'profit centre reporting'. The Trust's Service Improvement Team remains fundamental to focussing on key areas for service modernisation and delivery of substantial cost reductions, and supporting and ensuring the achievement of these cost reductions.

Delivery of Increased Elective Activity

The Trust plans to achieve an 18% increase in activity and revenue in 2007/08. There is a risk of failing to achieve this increase, resulting in a delay in achieving improvements in waiting times for patients, damaged reputation and contract disputes. There is an associated risk of increasing capacity and costs ahead of additional activity and revenue being earned.

The mechanisms already described above in connection with maintaining cost control, and delivering planned savings, are also relevant to managing and mitigating the risk of failing to achieve the increased elective activity. There will also be further development of the performance management process to focus on specialty and service unit performance, and especially information governance and performance against activity and waiting times trajectories.

5. Board of Governors

The Trust has both a Board of Governors and a Board of Directors. The Board of Governors has the responsibility to appoint non-executive directors, approve the appointment of the Chief Executive Officer and also the trust's external auditors. The Governors need to provide their views on the Trust's strategy to the Directors – a role which will be of great significance in the coming year as our strategy is reviewed – and play an important part in being a conduit of information to and from the Trust's membership. The directors ensure that they are updated with views from the governors and the membership through attendance of the directors at the Board of Governors meetings, a formal meeting at least on an annual basis between the directors and governors, involvement of the governors in staff briefing activities, and feedback from the membership through targeted questions regarding priorities or specific consultations throughout the year through the mechanism of the members newsletter. There is also a senior independent director that the governors can approach regarding any issues or concerns that they would like to be addressed. The Board of Directors is responsible for the development and delivery of the Trust's strategy and the ongoing operational organisation of the Trust and its performance. The Board of Directors reserves decisions on items above an annual revenue of £100,000, strategic objectives, acquisition and disposal of land, investment decisions, and major changes in services and forward planning to itself as set out in the Board of Directors' standing orders. All other decisions are delegated to the Chief Executive Officer and Directors to direct as appropriate.

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

Elections for public and staff governors to serve on the Board of Governors were held in August/September 2006 with the results being announced on the 15 September 2006. The Electoral Reform Ballot Services conducted the elections on behalf of the Trust using a single transferable vote system. This was the first set of elections since the formation of the Board of Governors in March 2004 and only half of the positions were due for re-election.

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

The year started with two existing vacancies for public governors, one caused by the resignation of a governor for personal reasons and one for a governor who passed away. There were successful elections for the public constituency with all the positions filled at the September elections. However since that date there have been two resignations, one of which has been filled by the runner-up in the public elections, with one vacancy remaining.

The year started with one vacancy for a staff governor. Despite the elections in September, there were not enough nominations for the staff constituency and therefore no formal elections took place for the staff constituency and two vacancies currently remain. To address this gap the Trust has been running a staff governor development programme to introduce interested future candidates to the workings of the Board of Governors, the roles and responsibilities of governors, and rotation through attendance at governors meetings.

Partner governors have terms of office of three years. There have been two changes during the year, and confirmation of partner governors who have served a three year term is now being sought.

All governors can be elected or appointed up to a maximum of nine years. Governors receive no remuneration but are reimbursed for any expenses incurred. The Trust also maintains a register of governors' interests. This is available to view from the cash offices situated in each of the Trust's main hospitals (Peterborough District Hospital, Stamford Hospital, Edith Cavell Hospital). The details are also available from the office of the Company Secretary who can be contacted on 01733 874174.

Governors also serve on the Non-executive Director Remuneration and Terms of Service Committee as detailed in section 6, a Governance Committee (Dr Moshy, Mr

Anandan, Mrs Mahmoud, Mrs Stafford, Mr Morrison, Ms Broekhuizen, Mr Lilliman) and a Members Recruitment and Communications Committee (Mr Craig, Mrs Beattie, Dr Guttmann, Mrs Hanlon, Mr Wright, Mrs Friend, Mr Dickens).

The following paragraphs give information on the individuals who have formed the Board of Governors for 2006/07:

Members of the Board of Governors in post as at 31 March 2007

Chairman

Dr Clive Morton OBE

Appointed to 31 March 2008

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

Dr Morton attended 3 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Mr Clubbe, Deputy Chair of the Board of Directors took the chair of the meeting Dr Morton was unable to attend.

Public Governors

Mrs Moira Beattie OBE

Term of office to 30 September 2007

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

Mrs Beattie attended 4 of 4 Board of Governors meetings she was eligible to attend in 2006/07.

Mr Kenneth Craig

Term of office to 30 September 2007

Mr Craig is a partner in a local accountancy firm.

Mr Craig attended 4 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Mr Arthur Critchley

Term of office to 30 September 2007

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

Mr Critchley attended 3 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Mr Mehboots Datoo

Term of office to 30 September 2007

Mr Datoo stood for election in September 2006, and whilst not being immediately elected took the position vacated by Gp Capt (now Air Cdre) Jenkins.

Mr Datoo attended 1 of 1 Board of Governors meetings he was eligible to attend in 2006/07.

Mr George Dickens

Term of office to 30 September 2009

Mr Dickens stood for election in September 2006.

Mr Dickens attended 2 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

Mrs Sarah Dixon

Term of office to 30 September 2007

Mrs Dixon is Head Teacher of Peterborough High School.

Mrs Dixon attended 4 of 4 Board of Governors meetings she was eligible to attend in 2006/07.

Dr Dennis Guttmann

Term of office to 30 September 2007

Dr Guttmann was previously a Consultant Physician at the Trust.

Dr Guttmann attended 3 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Mrs Rubina Hussain, MBE

Term of office to 30 September 2009

Mrs Rubina Hussain stood for election in September 2006.

Mrs Hussain attended 0 of 2 Board of Governors meetings she was eligible to attend in 2006/07, and resigned at the end of the financial year.

Mrs Susan Mahmoud

Term of office to 30 September 2009

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

Mrs Mahmoud attended 4 of 4 Board of Governors meetings she was eligible to attend in 2006/07.

Mr Peter Morrison

Term of office to 30 September 2009

Mr Morrison stood for election in September 2006.

Mr Morrison attended 2 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

Ms Maria Stafford

Term of office to 30 September 2009

Having retired from a successful business career Ms Stafford was successfully re-elected in September 2006. Ms Stafford is a member of Council of Sheffield University, and a member of the Audit Committee of the Department for Constitutional Affairs at Westminster. Ms Stafford was also formerly Chairman of Glasgow Caledonian University.

Mrs Stafford attended 4 of 4 Board of Governors meetings she was eligible to attend in 2006/07.

Mrs Sandra Woodhouse

Term of office to 30 September 2009

Mrs Woodhouse stood for election in September 2006.

Mrs Woodhouse attended 1 of 2 Board of Governors meetings she was eligible to attend in 2006/07.

Mr Ken Wright

Term of office to 30 September 2007

Mr Wright is chairman of the Bretton Doctors and Patients Association.

Mr Wright attended 4 of 4 Board of Governors meetings he was eligible to attend in 2006/07**.**

Staff Governors

Mr N A (Dan) Anandan, Associate Specialist

Term of office to 30 September 2007

Mr Anandan attended 4 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Ms Angela Broekhuizen, Assistant Project Director

Term of office to 30 September 2009.

Ms Broekhuizen stood for election in September 2006.

Ms Broekuizen attended 1 of 2 Board of Governors meetings she was eligible to attend in 2006/07.

Mrs Sue Friend, Head of Contracts

Term of office to 30 September 2009.

Mrs Friend stood for election in September 2006.

Mrs Friend attended 2 of 2 Board of Governors meetings she was eligible to attend in 2006/07.

Dr Roger Moshy, Consultant Radiologist

Term of office to 30 September 2007

Dr Moshy is past Chairman of the Association of Early Pregnancy Units (a non-trading company) and Director and member of the council of the British Medical Ultrasound Society.

Dr Moshy attended 4 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Partner Governors

Mrs Angela Bailey, Chief Executive, Peterborough Primary Care Trust

Nomination expires on 31 October 2008.

Mrs Bailey is also a governor of Papworth Hospital and Director of Gladstone Connect.

Mrs Bailey attended 2 of 4 Board of Governors meetings she was eligible to attend in 2006/07

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

Nomination expires 31 March 2007

Air Cdre Evans is responsible for the commissioning of healthcare for service personnel from other NHS Trusts and occasionally the private sector. He also co-ordinates rehabilitation and mental health services for the armed forces.

Air Cdre Evans attended 3 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

Mrs Heather Hanlon representing the Volunteers of the Trust

Nomination expires 31 March 2007

Mrs Hanlon is volunteer co-ordinator at Stamford Hospital and is now a registered doula providing care and support for mothers both during and after the birth of their babies.

Mrs Hanlon attended 2 of 4 Board of Governors meetings she was eligible to attend in 2006/07.

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

Nomination from 23 May 2006 expires 22 May 2009

Councillor Lamb replaced Councillor Murphy on taking responsibility for health and social care.

Councillor Lamb has attended 2 of 3 Board of Governors meetings she was eligible to attend in 2006/07.

Mr Michael Lilliman, representing the Friends organisations of the Trust

Nomination from 14 January 2005 expires 13 January 2008

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

Mr Lilliman attended 4 of 4 Board of Governors meetings he was eligible to attend in 2006/07.

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

Nomination from 22 December 2006, expires 21 December 2009.

Mrs Smith attended 1 of 1 Board of Governors meetings she was eligible to attend in 2006/07.

Adviser

Mrs Geeta Pankhania, adviser on health and ethnicity issues.

Appointed on 12 April 2006, nomination expires 11 April 2009, but resigned with effect from 9 May 2007.

Mrs Pankhania is Public Health Specialist (Ethnicity and Health) for Peterborough Primary Care Trust and is a committee member on Pulse Healthy Living Centre in Bretton.

Mrs Pankhania has attended 1 of 3 Board of Governors meetings she was eligible to attend in 2006/07.

Members of the Board of Governors who served during 2006/07 but left post prior to 31 March 2007

Public Governors

Mr John Dawson

Term of office to 30 September 2006.

Whilst Mr Dawson's term of office was to 30 September 2006, he sadly passed away on 4 May 2006.

Mr Dawson was unable to attend the one meeting he was eligible to attend in 2006/07.

Air Cdre Michael Jenkins OBE

Term of office to 30 September 2007, but resigned with effect from 16 November 2006.

Air Cdre Jenkins attended 1 of 3 Board of Governors meetings he was eligible to attend in 2006/07.

Mr Alan Shippey

Term of office to 30 September 2009, but resigned with effect from 16 January

Mr Shippey attended 0 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

Mr Keith Smith

Term of office to 30 September 2006

Mr Smith did not stand for re-election. He is the East Anglia Representative on the National Executive of the NHS Retirement Fellowship and was Chairman of the Peterborough Branch of the Fellowship until 25 April 2007. He was also the Membership Secretary of the Peterborough Senior Citizens' Forum until 13 March 2007.

Mr Smith attended 2 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

Mr Bob Woolley

Term of office to 30 September 2006

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

Mr Woolley attended 2 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

Staff Governors

Mr Robert Donlevy, Clinical Audit Facilitator

Term of office to 30 September 2006

Mr Donlevy did not stand for re-election.

Mr Donlevy attended 1 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

Mrs Liz Phillips, Assistant General Manager Medical Inpatients

Term of office to 30 September 2006.

Mrs Phillips did not stand for re-election.

Mrs Phillips attended 2 of 2 Board of Governors meetings she was eligible to attend in 2006/07.

Miss Katrina Wilson, Neurology Development Manager (now Multiple Sclerosis Nurse Specialist)

Term of office to 30 September 2006.

Miss Wilson did not stand for re-election.

Miss Wilson attended 2 of 2 Board of Governors meetings she was eligible to attend in 2006/07.

Partner Governors

Cllr Graham Murphy, Cabinet Member for Health and Adult Social Care, Peterborough City Council Nomination from 25 May 2005 to 22 May 2006 Councillor Murphy's nomination expired when cabinet responsibility for health and social care was re-assigned following annual council. Councillor Murphy attended 0 of 1 Board of Governors meetings he was eligible to attend in 2006/07
Mr Martin Whittle, Director of Quality, Lincolnshire South West teaching Primary Care Trust Nomination expires 31 March 2007, but Mr Whittle resigned in October 2006 on being appointed as Director of Corporate Strategy for Derbyshire Primary Care Trust. Mr Whittle attended 1 of 2 Board of Governors meetings he was eligible to attend in 2006/07.

6. Board of Directors

The composition of the Board of Directors is detailed below. As at the 31 March 2007 the Board consists of six non-executive (plus one vacancy) and seven executive directors. The balance of numbers and appropriate skills required for effective working and leadership is monitored by the Board itself and through the processes for director nomination discussed below. These processes have confirmed the appropriateness of the current composition of the Board of Directors. Details of the individuals holding positions of Chairman, non-executive directors, Chief Executive and executive directors throughout the year are detailed in the tables below.

Non-Executive Director Nomination and Remuneration

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

As well as being involved in non-executive director recruitment activities, the committee met twice during the year as shown below with Mrs Phillips and Wg Cdr Jenkins being replaced by Ms Broekhuizen and Mr Morrison.

11 July 2006 – attendance Ms Stafford (chairman), Mr Critchley, Mrs Dixon, Dr Moshy, Mrs Phillips; apologies from Wg Cdr Jenkins

14 December 2006 – attendance Ms Stafford (chairman), Ms Broekhuizen, Mr Critchley, Mrs Dixon; apologies from Dr Moshy and Mr Morrison

In addition a number of meetings were held in regard to the activities surrounding the recruitment of the non-executive director to replace Mr Hindle.

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

A joint committee of the Board of Directors and Board of Governors met to discuss compliance with the Code of Governance. This recommended the appointment of Mr Clubbe, as Chair of Audit Committee, to serve as Senior Independent Director. This was ratified by the Board of Directors in February and the Board of Governors in April.

The Chairman appraises the non-executive directors, and is in turn appraised by the Deputy Chairman (Governor). This appraisal process includes a 360^{o} feedback mechanism completed anonymously for feedback to the recipients. Results of appraisals are reported to the Board of Governors through the Non-executive Director Appointments and Terms of Service Committee. All the current non-executive directors are considered to be independent.

The Board of Governors has the responsibility for appointing or removing the chairman and non-executive directors. A recommendation on any such action would be made by the Deputy Chairman (Governor) on behalf of the Non-executive Director Appointments and Terms of Service Committee and any such action would need to be approved by the full Board of Governors. The Board of Governors agrees remuneration for non-executive directors with advice from this committee.

Executive Director Nomination and Remuneration

The non-executive directors undertake the appointment of the executive directors. Remuneration for the executive directors is agreed by the Remuneration and Terms of Service Committee of the Board of Directors, which comprises all the non-executive directors. This group also maintain an overview regarding succession planning and recruitment for executive directors and therefore acts as the remuneration and nomination functions for executive directors as envisaged in the Code of Governance. The remit of the committee covers approval of directors' remuneration only, although a view is maintained of other senior posts.

There has been one significant appointment during the year, the appointment of the Chief Executive Officer. This was undertaken with the support of Odgers, an external executive recruitment agency with a two day interview process towards the end of December. This first day of the interview process involved informal discussion groups with executive and non-executive directors, governors and senior managers prior to a presentation to a wide group of staff including senior clinicians. The second day consisted of the formal interview panel consisting of the chairman, non-executive directors and an external assessor.

Remuneration details for the directors as determined by the Remuneration and Terms of Service Committee are included in the annual accounts and in section 9 of this annual report. The Trust also maintains a register of directors' interests. This is available to view on the Trust's public website with details also available from the office of the Company Secretary who can be contacted on 01733 874174. The following paragraphs give information on the individuals who have formed the Board of Directors for 2006/07 and the committees of the Board.

Non-executive Directors

Chairman – Dr Clive Morton OBE

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

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

Dr Clive Morton OBE is an experienced and successful company director with over 20 years of achievement in public and private organisations. He has been Director of Personnel/Human Resources for Komatsu UK, Northern Electric, Rolls Royce Industrial Power Group and Anglian Water Services. He was also Director of Business Development for Anglian Water International. He is an independent adviser and coach on World Class Strategy and Board Development, and leads The Morton Partnership, which specialises in organisational transformation, consulting to boards in the private, public and not-for-profit sectors.

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

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

Dr Morton has attended 11 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Deputy Chairman – Mr Geoffrey Clubbe

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

Mr Clubbe was the Deputy Chairman of the previous NHS trust and has served as a non-executive director since 1994. The Board of Governors approved the re-appointment of Mr Clubbe on the 1 July 2005 to extend his term by two additional years. Mr Clubbe was appointed as Senior Independent Director in March 2007.

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

Mr Clubbe has attended 12 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Non-Executive Director – Mr Razahusein Rahim

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

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

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

Mr Rahim has attended 10 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Non-Executive Director – Mr Martin Hindle

Appointment start date 1 April 2004: Appointment end date 31 December 2006

Mr Hindle was a non-executive director of the previous NHS trust, a position he held since December 2002. The Board of Governors approved Mr Hindle's reappointment from 1 December 2006 to 30 November 2010, but Mr Hindle resigned effective from 31 December 2006 to take up the appointment of Chairman to University Hospitals of Leicester NHS Trust.

Mr Hindle was formerly Chief Executive of Cable and Wireless Nautec where he was responsible for business networks for the global shipping industry. Mr Hindle retains shares in Cable and Wireless. He has a long and successful career at board level in the pharmaceutical industry. He is a non-executive director of the National Institute of Biological Standards and a director of the Leicestershire and Rutland Probation Service. He is also a Member of the Royal Pharmaceutical Society.

Mr Hindle attended 9 of 9 Board of Directors meetings he was eligible to attend in 2006/07.

Non-Executive Director – Ms Susan Grey

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

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

Ms Grey has 26 years of international healthcare experience having worked in health and social care in the UK and abroad and in the public, private and voluntary sectors. She was formerly Director of Strategy and Modernisation at Bedfordshire and Luton Community NHS Trust and has previously worked for Bedfordshire Health Authority. Ms Grey is also a board member of the Bedfordshire Pilgrims Housing Association based in Bedford and undertakes consultancy work for health and social care organisations.

Ms Grey has attended 10 of 12 Board of Directors meetings she was eligible to attend in 2006/07

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Non-Executive Director – Mr Jonathan Radway

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

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

Mr Radway is a legal professional and is self-employed as a management consultant currently undertaking work for the Judicial Appointments Commission and the Reuniting Europe Programme for the Foreign Office. Previous appointments include being Performance Director for Her Majesty's Courts Service and Justices' Chief Executive for Hertfordshire Magistrates' Courts Service. He has been a Deputy District Judge (MC) since 1999.

Mr Radway has attended 10 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Non-Executive Director – Mr Andrew Burroughs

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

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

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

Mr Burroughs has attended 10 of 11 Board of Directors he was eligible to attend in 2006/07.

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

Executive Directors

Chief Executive – Mr Christopher Banks (to 31 December 2006)

Mr Banks was Chief Executive of the previous NHS trust. He was appointed Chief Executive in July 2002, having filled previous roles in the Trust as Project Director and Finance Director. Mr Banks is a qualified Chartered Accountant and also a director of Bluestone Creative Ltd based at Lynch Wood, Peterborough. Mr Banks left the Trust at the end of December 2006 to take up the appointment of Chief Executive of Cambridgeshire Primary Care Trust.

Mr Banks attended 8 of 9 Board of Directors meetings he was eligible to attend in 2006/07.

Interim Chief Executive – Mr Alan Turner (from 1 January 2007 to 25 February 2007)

Mr Turner was appointed Interim Chief Executive prior to Mr Patten taking up his appointment. Mr Turner was previously the Medical Director of the Trust having retired in September 2005 and is self-employed providing support to various healthcare organisations including the Healthcare Commission and the General Medical Council, Mr Turner is also a Lecturer at the Keele University Clinical Leadership Unit.

Mr Turner attended 2 of 2 Board of Directors meetings he was eligible to attend in 2006/07.

Chief Executive – Mr Nik Patten (from 26 February 2007)

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

Mr Patten has attended 1 of 1 Board of Directors meetings for which he was eligible to attend in 2006/07 (as well as attending one meeting prior to taking up post.)

Finance Director – Mr Christopher Hall

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

Mr Hall has attended 11 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Director of Nursing – Mrs Christine Wilkinson

Mrs Wilkinson was Director of Nursing of the previous NHS trust. Together with Mr Randall she leads the clinical directorate of the Trust. Mrs Wilkinson is also the Director for Infection Prevention and Control.

Mrs Wilkinson has attended 12 of 12 Board of Directors meetings she was eligible to attend in 2006/07.

Director of Human Resources – Mrs Christine Tolond

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

Mrs Tolond has attended 11 of 12 Board of Directors meetings she was eligible to attend in 2006/07.

Director of Operations – Mrs Paula Gorst (from 24 April 2006)

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

Mrs Gorst has attended 9 of 11 Board of Directors meetings she was eligible to attend in 2006/07.

Project Director – Mr StClair Armitage

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

Mr Armitage has attended 12 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Medical Director – Mr John Randall

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

Mr Randall has attended 11 of 12 Board of Directors meetings he was eligible to attend in 2006/07.

Board of Directors committees

The Board functions through five committees as follows:

Remuneration and Terms of Service Committee

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

The committee met on the 1 August 2006 to consider remuneration requirements. All non-executive directors were present with the exception of Ms Grey. The non-executive directors also met separately to discuss the Chief Executive recruitment requirements.

Audit Committee

This committee examines the audit requirements and audit reports from external and internal audit ensuring that actions are taken on the agreed recommendations of audits. The committee is chaired by Mr Clubbe, the Deputy Chairman of the Board, with Mr Rahim and Mr Radway as members for 2006/07. The committee includes internal and external audit representatives with the Chief Executive, Finance Director and Company Secretary in attendance. The Chief Executive and Finance Director are asked to leave the meeting prior to the end to enable the committee to raise any issues of concern.

The committee met on 3 May 2006, 28 June 2006, 1 November 2006 and 24 January 2007. Mr Clubbe attended all four meetings, Mr Radway and Mr Rahim attended three meetings with apologies for the 28 June and 24 January respectively.

A statement from the Trust's external auditors regarding their reporting responsibilities can be found below:

Statement from Robson Rhodes LLP, external auditors for the Trust.

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

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

The principal purposes of communication to those charged with governance are to:

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

Conformance Committee

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

Healthcare Governance Committee

This committee considers the Trust's performance against clinical and corporate governance requirements, receiving updates from the Trust's clinical operational units on risk management issues, infection control, clinical audit results, reports from the clinical management board, details of complaints and other related items. Up to the end of December the committee was chaired by Mr Hindle, with Mr Burroughs and Ms Grey as non-executive members. Since January Ms Grey has chaired the meeting. The Chief Executive, Medical Director, Director of Nursing, Director of Operations, Finance Director and Director of Human Resources are all members of the committee. Other senior managers of the Trust are also in attendance. The committee meets bi-monthly.

Patient and Public Involvement Committee

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

7. Membership

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

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

Membership numbers at the beginning and end of 2006/07 are shown in the table below.

	1 April 2006	31 March 2007
Staff members	3,450	3,522
Public members	5,073	5,321
Total	8,523	8,843

Any individual employed by the Trust for 12 months or more is eligible for membership and all staff are opted in to membership and written to with the opportunity to opt-out if preferred. Staff numbers include those employed by the Trust in the local NHS Professionals service.

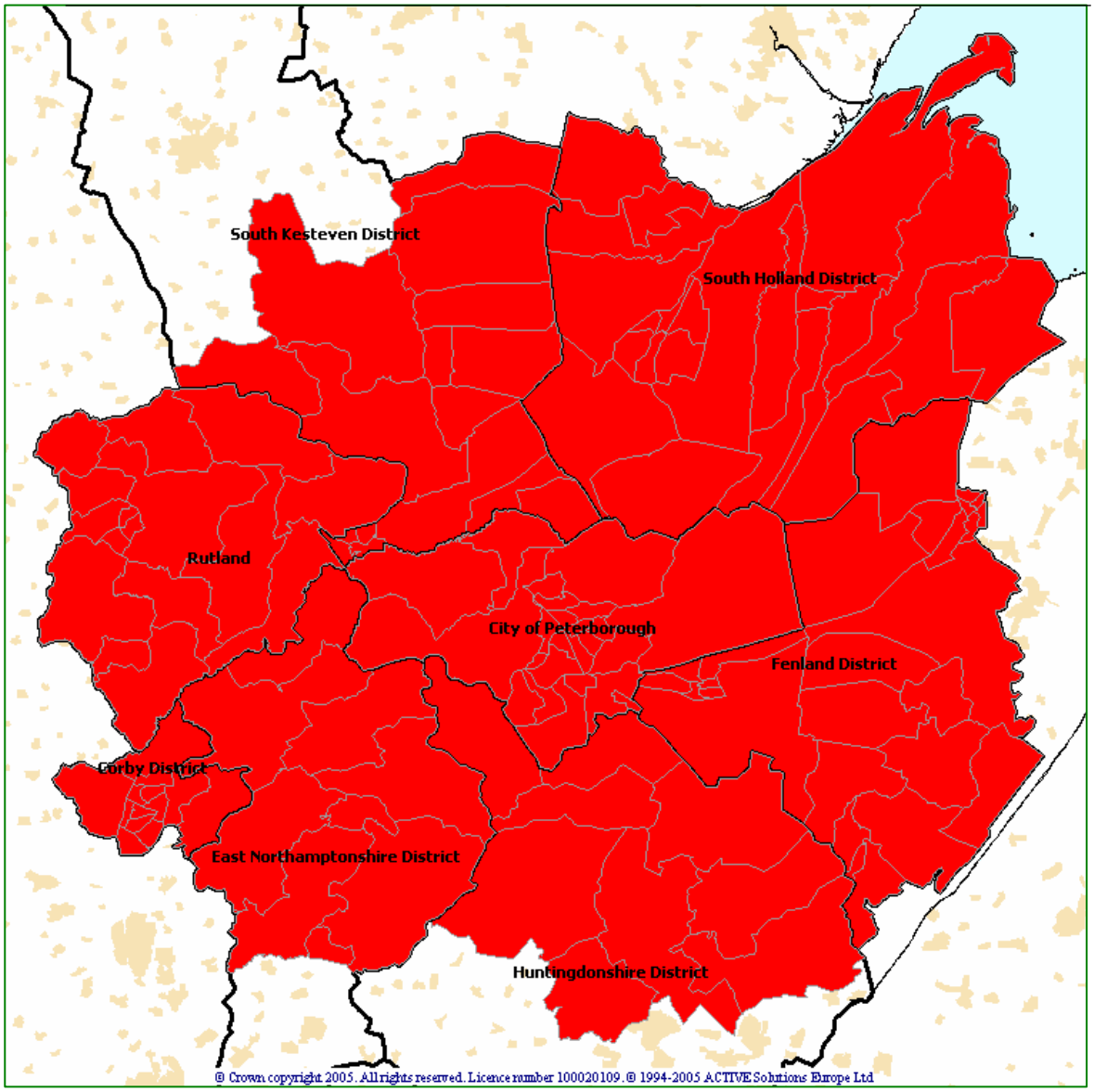
Any person aged 16 or over living in the Trust's membership catchment is eligible to become a member. This catchment is based on electoral wards. This is detailed in the Trust's constitution which is available to view from the cash offices situated in each of the Trust's main hospitals (Peterborough District Hospital, Stamford Hospital, Edith Cavell Hospital). The details are also available from the office of the Company Secretary who can be contacted on 01733 874174. The catchment area is represented in the map below and was updated in October 2005 to take account of changes in ward configurations.

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

A target was set to increase public membership to 6,500 at 31 March 2007 and activity has been undertaken to target the eastern part of the Trust's membership catchment for recruitment. This generated 152 new members. Activity is also ongoing to ensure promotional activities include the opportunity for members of the public to become members, this includes advertising in the local council newsletter and the ability to attract members through consultation exercises. To the end of March 38 new members had been generated from the consultation concerning management arrangements at Stamford Hospital. For the following year activity is planned to attract under-represented age groups. An awareness campaign and recruitment exercise is planned for the media to run in tandem with preparations for the governors' elections to be held in August/September 2007.

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

Public membership area map



8. Public Interest Disclosures

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

All of the patients involved were contacted and a public helpline set up. To date, 645 patients have been affected by this situation. At the end of April the Trust reported that 370 patients had breached the six month target – the rest have been treated already.

Since January, the Trust worked continuously with its partner primary care trusts to book all of the patients in for their surgery at the earliest opportunity. The Trust is confident that by the end of August normal service will be resumed with no patient waiting longer than six months.

The investigation is now complete and copies of the report and the associated action plan have been sent to Monitor, the Foundation Trust regulator, and partner primary care trusts. All have supported the way in which the investigation was carried out and have been kept up to date on progress.

The internal investigation team reported to an investigation panel, led by a legally qualified Non-executive Director (NED), which included other NEDs, the Chief Internal Auditor and an external audit member. The terms of reference for the investigation team and panel were agreed in advance with Monitor and the lead Primary Care Trust.

9. Remuneration Report

The details of senior managers remuneration is detailed in page 9 of the Annual Accounts and is replicated below. This covers the Trust's non-executive and executive directors whose experience is outlined in section 6 of this Annual Report. The terms of office are also outlined in section 6 of this annual report; executive directors do not hold fixed term appointments.

Remuneration – Executive Directors

The remuneration committee for determining the pay of executive directors is the Terms and Remuneration Committee. This is chaired by the Chairman of the Trust with all non-executive directors being members. Further details are included in section 6.

In order to make decisions on remuneration, the committee is informed by the Chief Executive concerning performance and by the Director of Human Resources concerning comparisons of similar posts obtained through an independent external agency. The Chief Executive and Director of Human Resources are required to leave when their own posts are being discussed.

Remuneration – Non-Executive Directors

The Board of Governors is responsible for determining the remuneration of non-executive directors. In order to maintain an overview of appointments, performance and remuneration, the Board of Governors has established a Non-Executive Directors Remunerations and Terms of Service Committee as discussed in section 6. Recommendations are made to the full Board of Governors for approval.

Remuneration increases agreed for this year were based on the NHS standard uplift. The previous year's level was established following an independent review commissioned by the Foundation Trust Network.

Chief Executive's Declaration

I can confirm that this report accurately represents the arrangements for remuneration for the Trust's senior management.

Nik Patten
Chief Executive Officer

Remuneration Details

Name and Title		Remuneration		Pension Rights as at Age 60		Increase Arising in 2006/07 whilst employed by Peterborough & Stamford NHS Foundation Trust		Cash Equivalent Transfer Value as at 31/03/06	Cash Equivalent Transfer Value as at 31/03/07	Real Increase in CETV as funded by Peterborough & Stamford NHS Foundation Trust during 2006/07
		Salary £000	Other £000	Accrued £	Lump Sum £	Accrued £	Lump Sum £	£	£	£
2006/07		**(bands of £5,000)**								
St Clair Armitage	Project Director	100-105	## Nil	4,178	12,535	1,356	4,068	44,226	68,886	16,488
Christopher Banks	Chief Executive Officer (left 31/12/06)	95-100	Nil	14,933	44,798	1,057	3,170	199,544	232,746	14,879
Andy Burroughs	Non-executive Director (started 01/04/06)	10-15	Nil	Non executive directors do not have a pensionable position						
Geoffrey Clubbe	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
Paula Gorst	Operations Director (started 24/04/06)	70-75	Nil	27,246	81,738	270	808	355,361	368,625	2,873
Susan Grey	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
Christopher Hall	Finance Director	85-90	Nil	24,857	74,571	2,149	6,447	268,531	311,115	25,110
Martin Hindle	Non-executive Director (left 31/12/06)	5-10	Nil	Non executive directors do not have a pensionable position						
Clive Morton	Chairman	35-40	Nil	Non executive directors do not have a pensionable position						
Nicholas Patten	Chief Executive Officer (started 26/02/07)	10-15		51,724	155,172	460	1,380	683,261	799,136	6,442
Jonathan Radway	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
Raza Rahim	Non-executive Director	10-15	Nil	Non executive directors do not have a pensionable position						
John Randall	Medical Director	70-75		Authority to disclose withheld						
Christine Tolond	Director of Human Resources	80-85	Nil	Authority to disclose withheld						
Alan Turner	Interim Chief Executive Officer (01/01/07-27/02/07)	15-20	Nil	As this was a temporary arrangement, it was not pensionable						
Christine Wilkinson	Director of Nursing	80-85	Nil	23,523	70,570	2,143	6,429	286,811	334,073	28,064

St Clair Armitage has been allowed the use of a maisonette owned by the Trust at no charge.

Further information on the Trust can be obtained from

The Trust's website at www.peterboroughandstamford.nhs.uk

The Trust's Information Governance Manager

Information Governance Manager
Information Services
Memorial Wing
Peterborough District Hospital
Thorpe Road
Peterborough
PE3 6DA

The Trust's Company Secretary

Company Secretary
Edith Cavell Hospital
Bretton Gate
Bretton
Peterborough
PE3 9GZ

All media enquiries should be made through the Communications Office on 01733 874110