Homerton University Hospital NHS
NHS Foundation Trust

Annual plan

2006/7

Contents

Section one

Past year performance

1.1 Chief Executive's summary of the year

In summarising the year's events I would like to start with reference to the major clinical information system (Electronic Patient Record) development, which commenced here in 2004/5 and continued into 2005/6. I do this to both highlight the tangible benefits that are now being reaped from this and acknowledge the impact of its implementation on the running of the Trust.

We now have a highly integrated and sophisticated IT system in place, which many in the NHS seek to emulate. The benefits for patient, clinician and manager are increasingly apparent. Clinical information on patients can be retrieved in real time, from any point in the hospital. An externally run evaluation revealed patients had noticed improvements to scheduling and sequencing of their appointments. Increasingly high quality information is available to managers on which to base decisions.

We did however experience disruption to activity reporting in the first half of the year as a result of the EPR implementation. This created a business risk and deflected management attention from other activities. It is therefore of note that we maintained and, in areas, exceeded our position on service quality and performance. For example, the new cancer targets have been handled effectively and hospital acquired infection rates remain amongst the lowest in the country. These are things that matter hugely to patients.

We are however for the first time ever, reporting a financial deficit, albeit at a level of less than 0.5% of income. Although this cannot automatically be put down to factors associated with EPR implementation, the reality is that this may be the case.

It is of course right that we invested time and resource in the EPR programme; it is an important part of our future. This did not however happen at the expense of all other developments. Refurbishment to patient areas took place; a major extension to our academic facilities opens soon; and enabling works to allow for the development of clinical facilities in the year ahead were undertaken. The detailed work in support of the case to develop a new perinatal centre on site was completed, and we are now in a position to commence this important build and service development.

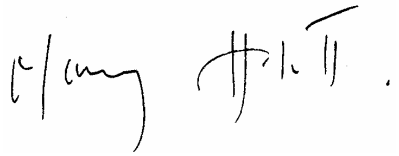
We also reviewed our strategic development plan, recognising that the health service world was changing fast. The impact of new capacity elsewhere in the system had to be considered, as did changes in policy direction and to the economic environment. In the event, the fluctuations to the national price tariff were greater than anticipated. The work we commenced in 2005/6 on efficiency and productivity gains is now being rapidly accelerated and will be critical to us retaining financial stability in the year ahead and achieving a surplus the year after.

This work needs to be undertaken in a highly structured manner and is being organised as a pan-Trust programme with dedicated resource assigned to it. It will be the absolute focus of our work in the year ahead.

I would like at this point to pay tribute to our Council of Governors who helped steer us through 2005/6, and who face next year's challenges with us. None of us are expecting an easy year but the refinement made to our governance structure this year equip us to handle these.

2005/6 saw two other significant milestones in the life of Homerton Hospital. Being just 3kms from the main site of the London 2012 Olympic and Paralympic Games, Homerton has been designated as the main hospital for the Games. Such will be the clinical facilities at the Olympic Park that the Games are not predicted to impact heavily on the hospital; however, the investment associated with them, particularly in public transport, will bring major benefits to the hospital.

Finally I pay tribute to our long-serving Chairman, Andy Windross, who has announced his intention to stand down in the coming year. Andy has been with the Trust since its inception in 1994. We cannot thank him enough for all he has done for us.



Nancy Hallett
Chief Executive

1.2 Summary financial performance 2005/6

1.2.1 Introduction

The Trust posted a pre-audit deficit of £709,000 for the financial year ended 31 March 2005/6, giving a margin of 6.1% against a planned margin of 7.4%. Overall, NHS clinical income was 2.5% higher than plan.

1.2.2 Income

The first six months of the year saw continuing issues with data quality, resulting from the implementation of the Electronic Patient Record (EPR) system. The Trust successfully negotiated block contracts with the majority of PCTs in order to mitigate against income loss, for the first two quarters. By October 2005, data quality had significantly improved and the Trust returned to full Payment by Results. Lack of robust data for the 12 month period Oct 2004 – Oct 2005 has been extremely challenging for the management of the Trust, and measurement of performance targets required investment in manual paper-based systems. Continuous improvement in data quality will be a key theme for the Trust over the coming year.

Quarter 4 saw activity rise significantly over plan in non-elective admissions. Elective activity was lower than contract for the period. Activity in GP Direct Access services, and in particular in pathology services was significantly higher than planned. This activity has traditionally been paid for on a block contract basis, with prices being set historically lower than cost. There is not yet a mandatory price tariff for these services, so the Trust has had to negotiate a local Payment by Results type arrangement for 2006/7 with its major PCT in order to ensure that income covers costs.

Non-patient income (so-called “Category C income”) was in line with plan, with a small reduction seen in levy income. Private patient income was slightly below plan and within the private patient cap of 0.2% of turnover.

1.2.3 Expenditure

There were a number of areas where costs were significantly above plan. These included drug and blood product costs, the costs of implementing Agenda for Change, and the costs of implementing the EPR. Furthermore, the costs of out-sourced pathology tests rose significantly and the Trust has had to take action to manage the demand for these tests.

At the end of the first quarter, the management team successfully took action to reduce costs by implementing a recovery plan to take a further 1% of cost out. Against a planned reduction of £3.9m, cost reductions of £4.9m were actually achieved. This success forms the context for 2006/7, which will be a more challenging year financially as a result of late changes to the price tariff.

Summary of financial performance against plan

Plan 2005/06		Actual pre-audit 2005/06
	£m	
	Income	
117.6	NHS clinical income	120.5
(1.1)	PBR Clawback/relief	(1.1)
0.3	Private patient income	0.2
14.4	Non-patient income	14.0
131.3	**Total income**	**133.7**
	Expenses	
(86.6)	Pay costs	(87.1)
(6.1)	Drug costs	(6.7) *
(28.7)	Other costs	(31.6)
(121.5)	**Total costs**	**(125.4)**
9.8	**EBITDA**	**8.3**
(0.0)	Profit/loss on asset disposal	(0.0)
(5.6)	Depreciation	(5.4)
(3.6)	PDC dividend	(3.6)
(0.1)	Interest	0.1
0.0	Corporation tax	0.0
0.5	**Net surplus (pre exceptionals)**	**(0.7)**
(0.4)	Exceptional items	0.0
0.1	**Net surplus (post exceptionals)**	**(0.7)**
Plan		**Actual**

* Actual drug costs for 2005/6 include £400k relating to medical gases and blood products.

1.2.4 Performance against key targets

Performance against key national targets was maintained in line with expectations. The Trust reported compliance with the Healthcare Commission's Core Standards for Better Health (Annual Health Check).

1.2.5 Liquidity

Improving liquidity is one of the Trust's major financial issues. Upon licence as a Foundation Trust, the Trust carried a net current liability of £7.8m, and this position has continued with the March 2005/6 balance sheet showing higher levels of debtors and creditors than planned. The Trust has historically carried a relatively high debtor position, and this was made worse in 2005/6 by PCT challenges to the Trust's billing data, resulting in a high number of disputed payments. Despite improved credit control arrangements, the

year-end NHS debtor position was £5.7m. Improving upon this position in 2006/7 will be critical in managing the working capital position.

Actual capital expenditure in year was £0.5m less than planned, and for 2006/7 the planned spend will be £5m, a reduction of £7m. This will allow the Trust to improve the cash position and to concentrate on cost control, in effect making the coming year one of consolidation rather than development.

1.3 Other major issues

In 2006, the sad death of Irving Mellor, non-executive director to the Trust, was announced. Irving was an exceptional person who contributed to the life and work of this hospital to a level way beyond that required by his role.

The Trust is currently re-appointing to this vacant post and to an additional non-executive post, which is in the process of being formally constituted to allow the non-executive representation on the Board to better match that of the executive representation.

The resignation of our Chairman, Andy Windross, is referred to in the Chief Executive's report attached to this plan. The re-appointment process has commenced.

The NHS Local Counter Fraud Service had reason to undertake an investigation on the hospital site last year. The findings of this report have led to further internal investigations, which are not yet complete. There has been no impact on clinical service provision.

This is the first year ever in the history of Homerton that we have reported a year-end deficit, albeit small. Our annual plan for this year is designed to place the Trust in a position of surplus by the end of 2007/8, with a deficit planned for this year.

Section two

Future business plans

2.1 Strategic overview

2.1.1 Introduction

Homerton is located in the London Borough of Hackney and provides hospital services for the local community and those of neighbouring boroughs, and in some circumstances further afield. The hospital is a major base for pre and post-registration teaching of health care professionals and undertakes research in a number of defined areas.

The overarching strategic aims for Homerton remain as set out in our Service Development Strategy issued at the time of our authorisation as a Foundation Trust in April 2004. These being, to be '**the hospital for Hackney**'; to provide a defined range of **specialist services** for north east London and beyond; to be a **thriving and sustainable** organisation; to continuously **improve on performance**; to have **high quality systems and processes** based in excellent technology; and to have the **infrastructure** of services and academic resources and buildings to meet the needs of the local population and contribute to the development of the wider NHS.

In 2005/6 the Trust undertook a review of its service development strategy; a significant component of this was done in conjunction with our host PCT and facilitated by an external organisation. It was agreed that the overall strategic direction of the Trust should be maintained. Our activity and performance projections are in line with this strategic review.

In considering the direction of the Trust over the forthcoming three years we recognise the following key strategic drivers to be of particular relevance, posing both opportunities and threats. This assessment follows on from that outlined in the 2005/6 Annual Plan.

2.1.2 Practice based commissioning

The Trust is now operating within a contract that is built up from a practice based commissioning (PBC) base. Our host PCT has developed structures which both actively support the GPs in developing PBC and, perhaps more significantly, improve their demand management capability. This includes looking to establish additional community based services designed to reduce hospital admissions and referrals. Although our main contract continues to be managed through the PCT, there will inevitably, and indeed rightly, be an increased level of scrutiny from the GP commissioners.

PBC provides a potential threat to the Trust, as successful demand management leads to reductions in referrals to hospital clinicians. However, it also provides opportunities to create stronger links with primary care services to provide a more satisfactory pathway of care for the patient. Consequently we have revised our previous growth associations downwards, to take into account potential developments.

2.1.3 Payment by results and changes to the national tariff

The revised national tariff is clearly going to be challenging for all trusts, particularly those like Homerton with a high emergency work-load. In addition, revisions of the structure of the tariff to accommodate revised clinical groupings from 2008/9 (HRG Version 4.0), and the review of the market forces factor combine to give further instability to the Trust's income base. Tariff "unbundling" to reflect more accurately the patient pathway will provide both an opportunity for the Trust to provide services out of hospital (in line with the White Paper "Our Health, Our Care, Our Say"), and a potential threat as alternative providers enter the community and primary care market.

2.1.4 Demand and capacity management

An increase in primary and community based services, procurement of independent sector provision and developments at other local hospital could give rise to excess capacity within the locality. The anticipated population growth in east London will however increase demand. It is essential that the Trust responds early to changes in the demand resulting from these factors, maximising opportunities where growth is possible.

2.1.5 Choose and Book and extended choice

As electronic 'booking' from the GP's office progresses, the Trust must place itself in a position to maximise the opportunities of this. This is not only through the development of the technical IT requirements, but also through the promotion of the Trust's services to referring clinicians. The Trust needs to maximise the opportunities afforded by Choose and Book by maintaining, and further developing its reputation as a high quality hospital, with services that can be rapidly accessed.

2.2 Service development plan

2.2.1 Introduction and corporate objectives

The Trust enters 2006/7 with the most significant and challenging cost improvement programme it has ever experienced. This has to be the focus of work in the year ahead. This, however, cannot happen at the expense of all else. Service quality and performance must be maintained. We have an absolute duty of care to the patient and public we serve and they, and those who commission on their behalf, have the right to exercise choice about where care is received.

Our corporate objectives for 2006/7 are:

1. **Financial stability**: to maintain financial stability to allow us the opportunity to invest in our future.
2. **Access to services**: to continue to reduce the time patients wait to be seen and treated, in order that we remain and grow as the 'hospital of choice' for patients and GPs.

3 **Healthcare commission standards**: to provide high quality and safe services in a clean environment by skilled staff, which again encourages the people of Hackney and beyond to choose to be a patient at Homerton.

In addition the Trust must in 2006/7 continue its development programme to ensure we have facilities and services which equip us for the future.

2.2.2 Financial recovery and managing performance

2.2.2.i Financial recovery

A major, highly-structured **financial recovery programme (FRP)** has been established in the Trust, comprising a range of defined and managed projects designed to reduce or contain costs. The programme is lead by an executive director and dedicated senior personnel are being assigned to work on it.

Preliminary work on this commenced in 2005/6 and action is now being accelerated to reflect the changes to our financial situation subsequent to this year's tariff settlement.

The focus of the work is on efficiency and productivity and the FRP seeks not just to address the financial imperative but also to enhance service provision for patients. In addition, it must be taken forward with reference to the overall direction of travel for the Trust.

It is anticipated that the programme will run over two years, allowing us to achieve stability in year one and a surplus in year two.

Further information is provided on this in section 2.3.

2.2.2.ii Managing and improving performance

In planning for 2006/7, the Trust has due regard for the changing regulatory environment and has taken into account the requirements of Monitor and the Healthcare Commission. The point has been made earlier that in addressing the all important financial issues facing the Trust that we must not lose sight of service quality or performance.

In terms of specific initiatives in 2006/7, the following will be the focus:

Homerton as the 'hospital of choice': short wait times are a key determinant to GPs and patients exercising their choice to use Homerton over other providers. Whilst the Trust has had to delay its plans to make Homerton a 'two-week wait hospital' (ie all patients to be seen within two weeks of referral), the philosophy is one we adhere, and in progressing plans with our commissioners, to

achieve the 18 week wait targets we will continue to seek opportunities to improve access to the hospital's services.

Data quality: the implementation of EPR did adversely impact on our data quality, and restoring data quality was a major focus of our work last year. The system code upgrade, scheduled for July of this year, will stabilise and embed our system further, increasing its reliability and functionality. The code upgrade is however a major technical exercise and additional measures may have to be taken during the implementation period to ensure quality levels are maintained.

2.2.3 Development schemes

The Trust will progress with the following service developments in 2006/7:

Perinatal centre: the Trust has been designated by the Specialist Commissioning Network as a perinatal centre for north east London. The business case to develop the neonatal and maternity service provision gained approval from the Board of Directors in April 2006. The new facilities will begin in 2006/7, providing increased capacity by 2007/8. This development will be largely funded from a loan agreed by the Department of Health financing facility.

Endoscopy service: the increasing demand for diagnostic and interventional endoscopy services suggests that the current facilities will no longer be adequate to meet the relevant access targets. This potential capacity gap will be exacerbated by the introduction of colon cancer screening anticipated in September 2006. A detailed business case has been developed to determine physical and workforce capacity required to support that demand.

Fertility unit: following the publication of the NICE Guidance on NHS funded fertility treatment, the Trust's established fertility unit has secured contracts with PCTs within the sector for the provision of fertility services. Previously, very few PCTs in this area contracted on a routine basis for this, so this will provide us with an increase of income and a reduced income risk. A business case is being prepared to ensure that the unit can respond effectively to this increase in demand, and it is planned for the unit to be fully redeveloped.

Centre for Laparoscopic Surgery – obesity service: the Trust has developed a laparoscopic surgical centre, supported by the most modern equipment, enabling trained clinicians to operate using the latest laparoscopic surgical techniques. This surgical approach minimises post-operative recovery and supports the efficient use of beds within the Trust. This centre currently provides an obesity surgical service. This will be enhanced in 2006/7 to provide a full obesity service.

EPR and information systems developments: the EPR system has now been in live operation at the Trust for 18 months and whilst there are still a number of outstanding issues, a recent benefits realisation exercise showed an increasing acceptance of the system as an essential tool for managing the patient journey within the hospital. The Trust is widely regarded as a pace setter in the use of technology to manage our hospital activity.

As stated above, a major system's code upgrade is planned for this year that will significantly improve the reliability and functionality of the system. Importantly, it allows for full Choose and Book connectivity, something we currently do not have.

Homerton contracts directly with Cerner Corporation for EPR services. Cerner is a service provider for the national 'Connecting for Health' programme and in 2006/7 discussions will be taken forward about migration to the national contract.

2.2.4 Summary of service developments

	Additional activity			Additional revenue £000		
	2006/7	**2007/8**	**2008/9**	**2006/7**	**2007/8**	**2008/9**
Perinatal Centre						
Neonatal bed days	0	0	768	0	0	768
Obstetric admissions with delivery	0	197	317	0	335	539
Obstetric admissions without delivery	0	86	165	0	60	116
Fertility						
IVF cycles	50	100	150	125	250	375
Endoscopy						
Colonoscopies	0	147	147	0	49.5	49.5

2.3 Operating resources required to deliver services

2.3.1 Introduction

Clearly the Trust has a challenging year ahead financially, in constructing an effective response to the reducing acute price tariff, and potential changes in patient flows. The directors have constructed a robust recovery programme which, based on the experience gained in 2005/6 of successful delivery of cost improvements, is believed to be deliverable over a two-year period and will allow the hospital to keep pace with the changing NHS system. Our plans are designed to improve the financial risk rating and to ensure compliance with the Prudential Borrowing Code. For 2006/7 the target cost improvement is 5% and this gives a target deficit of just over £1m.

	Actual	Plan		
	2005/06	**2006/07**	**2007/08**	**2008/09**
Income	133.7	133.5	138.4	143.1
Operating costs	(125.4)	(125.0)	(126.7)	(129.8)
EBITDA	**8.3**	**8.5**	**11.7**	**13.3**
Depreciation	(5.4)	(5.9)	(6.4)	(6.6)
Net interest	0.1	0.0	(0.4)	(0.4)
Other	(3.7)	(3.7)	(3.9)	(4.2)
Net surplus	**(0.7)**	**(1.1)**	**1.1**	**2.0**
CIP target	4.9	6.7	5.0	4.6
CIP as a % of turnover	3.7	5.0	3.6	3.2

2.3.2 Income

The 2006/7 price tariff saw a number of late changes that will make the year financially challenging for the Trust. In particular, the reduction in emergency tariff has had a disproportionate impact on our income position. With 2006/7 contract activity set at 2005/6 outturn levels (with some reduction for PCT demand management initiatives factored in), the Trust has over 95% of contract income secured for the year. For 2007/8 and 2008/9, a 2.5% tariff efficiency component has been assumed, giving overall tariff inflation of 2.5% and 2.2% respectively. The impact of the service developments described in section 2.3 has been included. Apart from the service developments described elsewhere, patient activity is assumed to be stable in the medium term, with the impact of a rising population being offset by changes brought about by practice based commissioning, out-of-hospital care initiatives and patient choice.

Overall in 2006/7, the Trust is assuming a 1.2% price increase in tariff, based upon our particular case-mix, with an increase in costs of 6.5%.

Total operating expenses (£m)

	2005/6 plan projections				2006/7 projections		
	2005/6	**2006/7**	**2007/8**	**2005/6 actual**	**2006/7**	**2007/8**	**2008/9**
Pay costs	86.6	91.3	100.3	87.1	85.3	86.2	88.6
Drug costs	6.1	6.1	6.9	6.7	6.9	7.5	8.2
Other operating costs	28.7	28.7	29.9	31.6	32.8	32.9	33.1
Total	**121.5**	**126.1**	**137.7**	**125.4**	**125.0**	**126.7**	**129.8**

2.3.3 Expenditure

2005/6 saw a number of costs rising above plan. These included the costs of pay modernisation, in particular the implementation of Agenda for Change; the costs of implementing the Electronic Patient Record; and the continued investment in A&E services in order to meet the four hour target. These investments were highlighted in the 2005/6 plan as necessary for the long term future of the Trust.

In addition, an unplanned cost was incurred in pathology services sourced from a neighbouring Trust, where the overall cost of virology, immunology and histopathology services were over £400k more than plan, largely as a result of increased pricing. This has led to a £1million cost pressure for 2006/7. Closer management of access to pathology and other diagnostic tests will form a key part of the financial plan for the coming period.

In April 2005, the Board approved a business case for investment in a Picture Archive and Communication System (PACS), but implementation was delayed due to a number of outstanding contractual issues with the main supplier and Connecting for Health. The development of PACS will now be considered in 2006/7 alongside our future relationship with Connecting for Health.

May 2005 saw the successful implementation of a new Oracle-based financial system. 2006/7 will see the roll-out of the electronic procurement system and the Trust will drive changes to business processes, in order to achieve further cost reductions.

If costs ran at 2005/6 levels, the Trust would face a £6.9m net deficit. Therefore a financial recovery plan has been put in place to reduce costs by £6m in 2006/7. The plan is in two phases, with £4m being identified in Phase 1 and £2m in Phase 2. Further cost improvements will be identified for implementation in the latter part of the year and into 2007/8 so that the Trust returns to I&E surplus. Current phasing of the plans shows the monthly run rate returning to balance in August 2006.

Financial recovery programme (£'m)

	2005/6 plan	2005/6 actual		2006/7	2007/8	2008/9
Last year CIP	3.9	4.9				
Phase 1 identified projects						
Service modernisation				1.6	0.5	
Service management				2.4		
Phase 2 identified projects						
Clinical service rationalisation				0.9	0.3	
Clinical resource management and other				1.2	0.5	
Directorate savings identified				0.6		
Phase 3 targets					3.71	4.6
Total target	**3.9**	**4.9**		**6.7**	**5.01**	**4.6**

Specific projects related to improved service delivery and productivity are critical to the delivery of a sustainable financial position. Therefore, the Trust has established a formal financial recovery team with appropriate resources to support the delivery of that plan. Phases 1 and 2 of the programme are currently being implemented and detailed project plans will receive external validation from a third party to ensure delivery.

Detailed projects include:

- closure of at least one 28-bed ward supported by sustained work around reducing length of stay
- optimal utilisation of theatres to achieve a sustained improvement in day surgery rates
- outpatient productivity review
- maternity productivity review to achieve length of stay reduction
- clinical and corporate services rationalisation to achieve increased workforce productivity
- a range of management initiatives aimed at controlling pay and non-pay costs more effectively
- a range of income optimisation projects aimed at maximising revenues
- ongoing clinical service financial contribution analysis to assess income recovery in relation to costs.

2.4 Investment and disposal strategy

2.4.1 Introduction

Within the tight financial constraints of 2006/7 it is proposed to limit the capital programme to the following areas:

2.4.2 Investment in property - construction

Perinatal centre: as a result of the reconfiguration of neonatal care across London, and Homerton designation as one of the perinatal centres for north-east London, the Trust is to redevelop current facilities to improve maternity service facilities and provide an enlarged neonatal unit. The adopted scheme involves part refurbishment of existing accommodation and part new build at a cost in the order of £8.7m exec vat. The detailed design is due to be completed in November 2006 with a start on site proposed in spring 2007. It is anticipated that the works phase will be in the order of 12 months.

Front entrance and police office: as a result of a partnership programmed with the Metropolitan Police and Hackney Council to reduce crime and fear of crime, the Trust in collaboration with the Metropolitan Police is to build a new police office at the front of the site that could accommodate up to 24 officers. In addition, as the front entrance creates the first and last impression of the hospital, it must be safe, easy to access, provide clear navigation and way finding, and provide a positive image of the hospital. To address these issues we are to reconfigure vehicular and pedestrian access points and routes through the front of the site, improve parking and create a large pedestrian forecourt. Works are due to start in July 2006 and completed by January 2007, at a cost to the Trust in the order of £500,000, with outstanding costs being met by the Metropolitan Police.

Power supply upgrade: to cope with the increasing energy demands, a new power supply is being procured and laid within the site. At the current time there is no spare capacity to feed new developments or equipment use intensification. The new supply will allow for the planned development over the next five years and will also give 30% spare capacity. At the same time, a new standby generator is being installed, which will be 'networked' to the other generators across the site to minimise risk in the event of mains supply failure. The estimated cost of this work is £600,000 and will take six months to complete.

2.4.3 Disposal

As part of the Financial Recovery Programme, the Trust will review its major assets against operational and financing requirements. This may result in limited disposal or re-financing.

2.4.4 Maintenance

To reflect the need to reduce capital and revenue budget expenditure, the investment in routine and planned maintenance is being reduced. The intention is to focus on legislative compliance and essential work. Ultimately this will impact on the level of backlog maintenance, which will have to be addressed in future years. However as a result of prudent investment in earlier years, the estate structure, fabric and services are generally in good shape and the level of significant maintenance can be limited without significant impact.

During 2006/7, the Trust will review its fixed asset base to ensure that the optimum financing strategy is pursued. This may result in a request to Monitor to release assets where non-mandatory (non clinical) services are being provided e.g. office space for non clinical staff.

Investment and disposal strategy

	Plan 2005/6	**Actual 2005/6**		**2006/7**	**2007/8**	**2008/9**
	£m	**£m**		**Current plan (£m)**		
Investment in fixed assets (non maintenance)	6.0	5.0		3.6	6.4	6.8
Investment in fixed assets (maintenance)	0.2	0.1		0.6	0.2	0.2
Investment in other assets	3.4	2.7		1.3	1.7	1.1
Total	**9.6**	**7.8**		**5.5**	**8.3**	**8.1**

2.4.5 Compliance with the Prudential Borrowing Code

The table on page 19 shows that with an assured financial risk rating of 3, the Trust's borrowing will be within the Prudential Borrowing Code (PBC). The risk to this position is if the I&E margin is reduced to –3%, equivalent to a deficit of £4m. The management team believes that the actions taken to reduce costs would make this scenario extremely unlikely and the Trust will not breach the PBC.

Even if the financial rating was 2, and the debt/capital limit was 10%, the Trust would still be within this limit with current investment plans.

PBC ratios			Compliant?		Rule
Maximum debt/capital ratio		3%	Yes		<15%
Minimum dividend cover		2.3	Yes		>1
Minimum interest cover		44.6	Yes		>3
Minimum debt service cover		44.6	Yes		>2
Maximum debt service to revenue		0.1%	Yes		<3%
PBC metrics			**Compliant**		

2.5 Financing and working capital strategy

The Trust's working capital position has historically been challenging, with a net current liability upon authorisation of £7.8m. This increased in 2005/6 to £8.7m. In addition, the Trust has a retained I&E deficit of £1.09m. The Trust had an £11m working capital facility in 2005/6, and although the use of that facility was usually well below £2m, our liquidity metric as assessed by Monitor was low, due to the historic position of the Trust. In 2005/6, tighter management of the creditor and cash positions meant that the Trust earned interest of £110,000 against a plan of £30,000.

The strategy in 2006/7 must therefore address both the accumulated deficit and the working capital issue. There are a number of strands to this strategy:

- draw down part of the Department of Health financing facility long-term loan, to finance long-term revenue generating investments (principally the perinatal centre)
- a reduced capital programme, mainly financed from internally generated resources. An estimated £2m will be freed up in terms of cash resources to support the working capital position
- stricter control of the debtors position, with a continued focus on PCT and other NHS debt
- implementation of a credit card facility to reduce non-NHS debt
- agreement from the main PCTs to make contract payments on the 1st of the month
- closer management of creditor payments, with a commitment to maintain the current creditor payment performance
- an increased working capital facility to £15m, which has been agreed with our commercial bankers Nat West, subject to an increased approval from Monitor. This is a committed facility, which is renewable on an annual basis. The Board of Directors has applied to Monitor for an increase in this facility.

2.6 Summary of key assumptions

Inflationary assumptions have been derived from those used in the North East London Sector Foundation Trust diagnostic work, and have been validated by the local Strategic Health Authority as part of that work. Assumptions around cost reduction have been derived from the Trust's financial recovery programme and include the following high level indicators:

Income

Inflation assumptions	**2005/6 actual**		**2006/7**	**2007/8**	**2008/9**
Average clinical income	4%		2.7%	2.7%	2.2%
Non-clinical income	3%		2.7%	2.7%	2.2%
R&D and education and training income	2.5%		2.5%	2.5%	2.4%
Other income	2.5%		2.5%	2.5%	2.4%

Pay costs

	2005/6 actual		**2006/7**	**2007/8**	**2008/9**
Salary inflation	2.4%		1.9%	1.9%	1.9%

Headcount	**2005/6 actual**		**2006/7**	**2007/8**	**2008/9**
Clinical	1744		1701	1669	1674
Non-clinical	325		308	297	293
Total	**2069**		**2009**	**1966**	**1967**
Agency costs (£m)	6.16		5.54	4.98	4.73

Section three

Risk analysis

3.1 Governance risk

3.1.1 Commentary on governance risk

Governance risks have been assessed under the five elements defined in the Compliance Framework. These are: legality of the Constitution; growing a representative membership; effective risk and performance management; appropriate Board roles and structures and co-operation with NHS bodies and local authorities.

The Constitution was formally reviewed in 2005/6 by the Council of Governors and Board members. Proposed constitutional amendments will be put to the members for approval at the Annual Members' Meeting in September. The governors and the Board have recommended changes to the composition of the Board of Directors to reflect best practice in corporate governance and the proposed Monitor code, and in particular an increase in the number of non-executive directors (NEDs).

In 2006/7 the Trust will need to appoint two new NEDs and a new Chair to lead the Board and the Council of Governors. The Trust has an effective, well-tested process in place to recruit the new NEDs. The process for appointing to the Chair will be in line with this. Clearly however this is a critical post and securing the 'right' person for Homerton will be a particular concern in the year ahead.

Overall there has been progress on the development of the Council of Governors. Governors have been involved in strategy and constitutional review and have been involved in the development of the annual plan for 2006/7.

The Trust's membership continues to grow and membership issues are not considered to present a high risk to future governance effectiveness.

The Trust has an effective set of relationships with NHS bodies and the local authority. This year saw the re-launch of our host Borough's, Hackney, local strategic partnership, now known as Team Hackney and the Trust is fully engaged with this. Attention will be given to ensure that the relationships with partners are effective and support the service development strategy.

The Trust's data quality, which was adversely effected by the installation of the new EPR system, has returned to pre-EPR levels. Further technical systems developments planned for this year will further stabilise the system, but the Trust is mindful of potential disruption during the period of installation.

The Trust has a good record of achievement of key national targets and standards, and is confident that the processes are in place for handling these. However pressure on our emergency services is high.

Additional investment was required in 2005/6 in order to achieve the emergency care access target. Any additional investment in this year would add to the financial risk the Trust is facing and may not therefore be an option. Careful review of performance against this key target will be required if we are to ensure continued achievement of it.

This year the Trust is required to work even harder and smarter to ensure financial stability. The management effort required to deliver the financial recovery programme, whilst maintaining and delivering high quality care, cannot be underestimated. Management capacity will need to be reviewed to ensure that it is adequate to the task.

For 2006/7 the performance assessment framework will change to reflect developing the '*Compliance Framework: Clinical Quality and Service Performance*'. The Trust's performance management framework will reflect these changes and align them to the Board Assurance Framework. The Assurance Framework is appended to this plan.

3.1.2 Significant risks

As stated there is a risk, which could be significant, of disruption to electronically based information systems in the hospital, during the installation period of a major new EPR system code upgrade, planned for this year. The upgrade will bring many advantages, but the installation is technically complex. Planning for both the installation and potential disruption to services during it is advanced.

3.2 Mandatory services risk

3.2.1 Commentary on mandatory services risk

Mandatory services continue to be provided in line with the Terms of Authorisation. Any issues arising from the implementation of the Financial Recovery Programme will be managed over the three year period through the "Variation of Authorisation" process if required.

3.3 Financial risk

3.3.1 Commentary on financial risk rating

The key drivers behind the Trust's financial risk rating are the I&E surplus margin and the liquidity rating. As noted elsewhere in this plan, the liquidity position is largely due to the Trust's historical balance sheet position. The management team believe that through the actions outlined in section 2.4, this rating will improve over time to a 4. This rating assumes a revised working capital facility of £15m.

3.3.2 Significant risks

If liquidity is addressed in this way, the other driver to the financial rating is the I&E margin. As noted in section 2.5, this would have to reduce to below –3% (£4m) in order to reduce the risk rating further. This would mean that less than 40% of the Financial Recovery Plan would be delivered, which the Trust considers to be highly unlikely. The Trust is currently engaged in a systematic verification of these plans, and is seeking an external partner to assist us with this exercise.

Other significant financial risks for 2006/7 included in the Assurance Framework are:

- failure of directorates to stay within target budgets
- loss of revenue due to changes to commissioned activity either as a result of out of hospital care initiatives, as a result of competition from other sectors, or as a result of failure to implement full direct booking within national timetable
- loss of revenue as a result of poor data quality, inaccurate clinical coding or system failure as a result of changes to the programme code for the Electronic Patient Record.

The Assurance Framework (appended) outlines the risk treatment plan for each risk identified.

Metric	**2006/7**	**2007/8**	**2008/9**
EBITDA margin	3	4	4
EBITDA, % achieved	4	4	4
ROA	3	4	5
I&E surplus margin	2	3	4
Liquidity rating	3	3	3
Weighted average	**3.1**	**4**	**4**

NB: 2006/7 figures assume a £15m working capital facility.

Section four

Declarations and self-certification

4.1 Board statements

The Board of Directors confirm that the attached declarations and Board's statements are true.

4.1.1 Risk and performance management

The Board of Directors is required to confirm that:

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

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

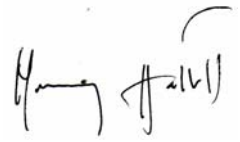
☒ The necessary planning, performance management and risk management processes are in place to deliver the annual plan.

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

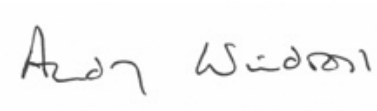
☒ The Board is satisfied that plans are in place to ensure that all relevant core national healthcare targets and standards (Please see Appendix B of the Compliance Framework) are met going forwards

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

Commentary in absence of full self certification



In capacity as Chief Executive & Accounting Officer



In capacity as Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the governors.

4.1.2 Board roles, structures and capacity

The Board of Directors is required to confirm that:

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

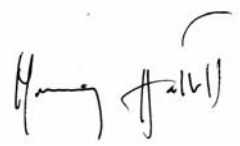
☒ The Board is satisfied that all directors are appropriately qualified to discharge their functions effectively, including setting strategy, monitoring and managing performance, and ensuring management capacity and capability.

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

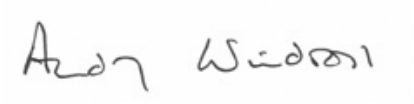
☒ The management team have the capability and experience necessary to deliver the annual plan.

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

Commentary in absence of full self certification



In capacity as Chief Executive & Accounting Officer



In capacity as Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the governors.

4.1.3 Compliance with the terms of authorisation

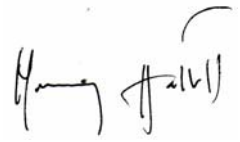
The Board of Directors is required to confirm that:

☒ The Board will ensure that the NHS foundation trust remains at all times compliant with the Authorisation and relevant legislation.

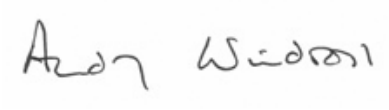
☒ The Board has considered all likely future risks to compliance with the Terms of Authorisation they face going forwards, the level of severity and likelihood of a breach occurring and the plans for mitigation of these risks.

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

Commentary in absence of full self certification



In capacity as Chief Executive &
Accounting Officer



In capacity as Chairman

Signed on behalf of the Board of Directors, and having regard to the views of the governors.

Section five

Membership

5.1 Membership report

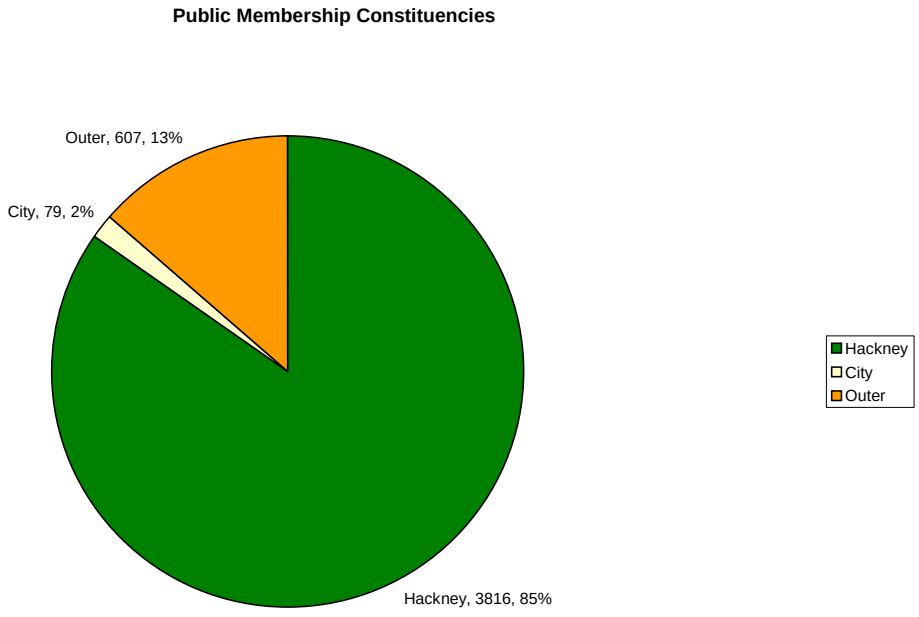
Public constituency	**Last year (Plan)**	**Last year (Actual)**	**Next year (estimated)**
At year start (April 1) or date of authorisation as appropriate	3392	3392	4525
New members	395	1247	-
Members leaving	8	114	-
At year end (March 31)	3779	4525	4525
Minimum number of members required under Schedule 1	42	42	42
Staff constituency	**Last Year (Plan)**	**Last year (Actual)**	**Next year (estimated)**
At year start (April 1) or date of authorisation as appropriate	1229	1229	1143
New members	267	230	-
Members leaving	132	16	-
At year end (March 31)	1364	1443	1443
Minimum number of members required under Schedule 1	40	40	40
Total membership			**5968**

5.2 Membership commentary

The membership of Homerton continues to grow. The membership is invited to identify areas of interest; and the Trust uses this information to engage and involve members in specific activities throughout the year.

5.2.1 Constituencies

Public constituencies: the public constituencies are defined in terms of people, including patients, over the age of 16 who live in the London Borough of Hackney, the City of London and the Outer area. The Outer constituency includes all North East London Strategic Health Authority residents, plus residents from Camden, Islington, Haringey and Enfield where the hospital has established patient income streams. Current and former Homerton patients are eligible to become members in the public constituencies. Although there is no differentiation between public and patient members, it is possible to identify self-declared patients on the membership database.



The Trust embraces the concept of a wide membership base, with no limit on the number of people who can register as members, as long as they are eligible. Active membership is highest within Hackney.

In order to develop a membership that is reflective of the local population, the Trust analyses the membership data to identify geographical areas or groups that are under-represented. The most

recent analysis indicates that membership is concentrated in the Hackney constituency and broadly mirrors the local demographic. Following a recent targeted membership recruitment campaign, public membership has increased significantly. There have been no changes in constituency boundaries, but the Trust will undertake further analysis of these post-election.

Staff constituency: the staff constituency is made up of people on permanent employment contracts or those who have worked at the Trust for at least 12 months. Contracted staff or staff holding honorary contracts who have worked at the Trust for at least 12 months are also eligible to become members of the staff constituency.

The staff constituency is divided into two classes - clinical and other. This year the Trust introduced an opt-out membership for staff. No staff members have chosen to opt-out on appointment.

5.2.2 Future membership

The membership plan for the future arises out of the Membership Development Strategy targets. The strategy was reviewed this year and no significant changes were proposed. In the coming year, the Trust will continue to work on membership development and will focus on under-presented geographical areas and groups to ensure that the diversity of the community is represented. Another key objective for 2006/07 is to continue with the programme of community visits.

5.2.3 Governors

The governors have identified some key objectives to help the Trust meet its stated strategic aims. This year the governors will take key messages out to the membership based on the acronym MORE: Membership matters, Ownership and accountability, Reputation and relationships, Enterprise.

The key objectives are:

- be clear and consistent to the membership about pressures and challenges facing the hospital in 2006/7
- celebrate and promote Homerton “good news” to the membership to encourage patient choice
- use membership data to seek consumer views about local services in collaboration with the PCT and local authorities
- communicate important messages about local health services, in partnership with the PCT, and using local authority publications
- each governor to undertake a minimum of two membership meetings this year and feedback to the Council of Governors.

5.2.4 Election of governors

Elections will take place in June 2006 and will be held in accordance with the election rules; and will be conducted by the Electoral Reform Balloting Services on behalf of Homerton. The following 8 seats will be contested:

Hackney Public	3
City	1
Outer	2
Staff	2

Section six

Financial projections

As separate document

Section seven

Supporting schedules

As separate document

Appendix

Assurance framework

DRAFT

Assurance Framework 2006-2007

Homerton University Hospital NHS Foundation Trust

Risk ID	Source of Risk	Summary/description of risk	Related HC standard (where applicable)	Consequence	Likelihood	Risk Score (May 06)	Summary of Risk Treatment plan	Responsible director	Source of assurance
Risks to Corporate Objective 1. To provide Financial Stability									
1.1		Failure to achieve Financial Recovery Plan		5	3	**15**	Turnaround Plan	CC	Regular reporting to Board of Directors, Monitor Finance rating
1.2		Failure to manage working capital		5	2	**10**	Revised working capital facility, stronger treasury management arrangements, asset review	CC	Regular reporting to Board of Directors, Monitor Finance rating
1.3		Failure to stay within set budgets		5	3	**15**	Revised budgetary framework	CC	Regular reporting to Board of Directors, Monitor Finance rating
1.4		Breach of quality and access targets as consequence of Financial Recovery Plan		4	3	**12**	Revised Performance Management Framework	CC/TF	Regular reporting to Board of Directors, Monitor Finance rating
1.5		Loss of revenue due to inaccurate clinical coding		4	3	**12**	Clinical review of coding	CC	PCT activity report, routine internal monitoring
1.6		Patient Activity levels fall below contracted levels due to Patient Choice		4	2	**8**	Marketing Strategy	CC/TF	Contract monitoring, GP benchmarking
1.7		Future management arrangements for data centre		4	2	**8**	Option appraisal of relationship with CfH	TF	Project implementation plan
1.8		EPR stability after coding upgrade		4	3	**12**	Project and Risk Plan in place	TF	EPR Programme Board
1.9		Inability to secure a Non Executive Chair and two Non Executive Director appointments		3	3	**9**	Recruitment process	PB	Appointment to posts
Risks to Corporate Objective 2. To achieve Access Targets									
2.1		Failure to implement full direct booking		4	3	**12**	Developing Project Plan	TF	Project milestones
2.2		Failure to achieve emergency care target		3	3	**9**	Maintain existing workplan	TF	Regular reporting to Board of Directors, Monitor Governance rating
Risks to Corporate Objective 3. To achieve HCC Standards which will ensure a high quality, safe environment that will foster Patient Choice									
3.1		Failure to sustain existing low rates of Hospital Acquired Infection		4	2	**8**	Continued work of Infection Control Team, education and training, adherence to Winning Ways	GY	Regular reporting to Infection Control Committee, ongoing surveillance
3.2		Failure to progress against Developmental Standards		2	4	**8**	Response to HCC consultation, continue to monitor performance against Core Standards, Developmental Standards identified within Clinical Governance development plan	GY	Dr Foster software, 2007 Performance Ratings
3.3		Destabilisation of workforce during period of financial constraint		3	3	**9**	Clear communication strategy with staffside to staff	AP	Staff turnover rate
3.4		Failure to improve Patient Experience		3	3	**9**	Education and training, Essence of Care, Good Attitude	GY	Level of Patient complaints, patient survey results