Annual report and accounts

April 2006 - March 2007

Chesterfield Royal Hospital NHS
NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust
Annual Report and Accounts 2006/07;

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Strategic statements

Our mission - we want:

- To be your hospital of choice.

Our aims - we will:

- Put you - the patient - at the centre of everything we do
- Offer the people the specialist hospital care they need
- Deliver complementary and integrated services by working with other health and social care organisations
- Create high-quality care from our resources
- Keep and build on our relationships as 'partners in care'
- Provide good career and educational opportunities for our staff
- Create a safe, clean, pleasant, modern and welcoming environment
- Find, recruit and keep exceptional staff

Our values - we believe in:

- Integrity, openness, accountability and honesty
- Respect, fairness, dignity and individual need
- Offering our staff opportunity to reach their goals and aspirations
- Promoting initiative; and providing support and encouragement
- Striving for excellence, sharing learning and adopting best practice

Our expectations - we expect:

- Everyone working for, and involved with our organisation to stand by these principles at all times
- You (our patients and visitors) to tell us when you think your experiences of our hospital are 'excellent' or not 'up to scratch'
- Everyone - staff, patients and visitors - to help us to reduce infection by washing their hands

Statement from the chairman

We are about to enter an unprecedented period of capital investment at the Royal, upgrading and extending our services and facilities. This is possible because of the quality of our financial management, suitably recognised as excellent by the Healthcare Commission (HCC), and gives tangible meaning to the FT slogan *"surplus with a purpose"*.

To meet the challenge of investment, and to cope with the changes in the national tariff (which controls how we are paid) we are taking 10% out of our running costs over a three-year period (ending March 2009). I am pleased to say that we are well on target to achieve this, and so far with only one compulsory redundancy.

We are looking forward to completing our workforce reviews later this year. We are confident the measures taken, although often difficult - like charging staff for parking and reviewing community midwifery - will enable future stability and create a platform for continued development and improvement.

During this testing year our staff have been wonderful, coping with high levels of activity, further reducing waiting times, and offering new services. Through this report I would like to thank them for their outstanding commitment and professionalism.

As always the past year has had its ups and downs.

The genito-urinary medicine service strived to address waiting times of up to nine days for routine appointments. These are now down to 48-hour maximums - a real achievement and improvement for patients.

As the year closed, it was pleasing to see results from the Healthcare Commission's (HCC) 2006 national in-patient survey. These put Chesterfield Royal in the top 20% of hospitals - for areas including cleanliness, waiting times, communications, pain control, information and care. We also heard the HCC praised our children's service - with a 'good' rating shared by only a minority of trusts surveyed. We are developing children's services at the Royal with a significant investment, as you will see in this report.

It was a disappointment to only receive a 'fair rating' for the quality of our service delivery. This score was awarded in the HCC's annual health check in 2006. We appealed against the decision, because although we met all the national 'core' standards, we believe that some of our scores in the new targets did not reflect our actual performance. Our appeal has not been successful, but we stand by our views.

The MRSA target was a particular issue for us - as we have very small target numbers to achieve. Organisations need to make year-on-year cuts in the number of reported hospital infections and were set a reduction target two years ago, based on their (then) position. We are performing well - and have one of the lowest rates of MRSA hospital infection in the East Midlands. In the past 12 months we achieved a 33% decrease, with 7 fewer instances of MRSA - 14 cases in all.

We feel this is a fantastic achievement. On this basis we are on course to deliver the national 2007/08 target (for us an absolute target of 12 cases in total). We hope our success with MRSA will be recognised by the Healthcare Commission and that our patients can see how well we perform compared with other hospitals.

However, we are not in denial about the importance of infection control. This will be a high priority over the coming year - for all infection, including MRSA and Clostridium-Difficile (Cdiff). We will make substantial efforts to reduce all infection rates and in April, the board agreed a £500,000 spending programme to back an infection control business case.

We are increasing and improving our cleaning operation, recruiting more specialist staff and reviewing antibiotic prescribing. We have installed more hand washing sinks in all wards, and are refurbishing our wards with wipe clean walls and microbial materials for lamps, sockets and buzzers. We are reminding staff and visitors with eye-catching warnings on corridor floors of the need to use gels and hand washing to "save lives" as they walk through the hospital.

Your help in this "battle" would be valued, individually and by reminding others. Also our visitors code asks people not to come to see patients when they are ill themselves - and that, like staff, they do not come back until they have been symptom free for 48 hours.

Another important focus over the next year is to make the 'patient experience' as positive as possible - from when patients and their families enter the site, to when they leave. A wide range of actions are planned to make sure we live by our values and deliver our mission – to make Chesterfield Royal 'Your hospital of choice'. We will also be asking staff, governors and our 10,000 members for suggestions to build on our current performance.

One aspect of this is the way we handle complaints. In October last year we began to review the process. We wanted to improve feedback to patients and their families and learn from any issues raised. Once again, the HCC highlighted how vital this review is. Their 'Spotlight on Complaints' report, covering July 2004 to July 2006, suggested that an unacceptably high number of complaint review cases, had to be referred back to us for further action. We believe our performance now is much improved, but we will continue to monitor it.

Last year I promised that one of my first tasks as chairman would be to review the effectiveness of our governance and communication processes - with both the board and council of governors.

I am delighted the council increasingly sets its own agenda, and now has two important new committees. The first, a patient and public involvement committee is under the chairmanship of Dr Christopher Day, one of our public governors. This committee independently checks all aspects of our patient experiences and recommends improvements where called for.

The second, is a nominations committee, which has set up what I believe is a best practice appraisal system for governors. This will appraise myself, the other non-executive directors, and the council. The board will also formally self-appraise. We value the crucial role played by governors and our members in the performance and future strategy of the corporation and I would like to extend my thanks for their commitment in this regard.

It has been a significant year for the way the corporation is governed. Four new non-executive directors have joined the board and the council of governors has been joined by ten new public or partner nominated governors. I would like to thank those who have left for their contribution to the corporation and welcome our new colleagues. Their presence and support reinforces the corporation's very special role in the community.

Richard Gregory OBE
Chairman

Statement from the chief executive

As the chairman says, this has been one of the most challenging years the Royal has experienced for a long-time. Not since the 1990s have we faced making cost savings on this scale.

Thankfully - unlike then - we have not had to close wards, or make large numbers of staff redundant to achieve efficiencies. Our foundation trust position - and our success the status has brought so far - has proved valuable. Organisations close by - in South Yorkshire and the East Midlands - have not been so fortunate and many hundreds of jobs in these areas are now under threat.

Financial stability is not negotiable as a foundation trust. And while our freedoms mean we are no longer accountable to the Department of Health, we remain affected by its policies. It has been understandably difficult for local people, patients and our staff to see why we are in this position. Frustrating as it is, I am nevertheless 'pleased' that we have found achievable solutions and have had just one compulsory redundancy at this time.

I would like to personally thank staff for their continued commitment, often in difficult circumstances. By the end of this year, most staff working at the Royal will have had their role reviewed and in many cases, jobs will have been restructured. Despite being in this situation, we have still achieved so much. The Royal is indebted to staff for their support.

Throughout our workforce review programme we vowed not to allow the need to save money, to affect services. It was therefore difficult to recommend a course of action in community midwifery that would lessen what we have in place now. I refer to our proposal to no longer support our eight-bedded midwifery-led maternity unit in Darley Dale, near Matlock. Realistically, the corporation felt it could not continue to subsidise this facility.

This review was the only one that resulted in proposals to provide services in a different way, as well as making the financial savings the service needs to achieve.

The consultation - carried out from January to April 2007 - proved hugely controversial. We received around 7,000 individual replies from local people and organisations - in the form of signed petitions, letters, emails and response forms. As promised, we have taken any form of response into account - and taken notice.

Over three-quarters of replies commented solely on the Darley Maternity Unit. It was immediately clear that we needed to make a decision about this particular issue and with Derbyshire County Primary Care Trust (PCT) we agreed a way forward. As a result, just four days after the consultation ended, the PCT agreed to support the Royal in reopening Darley to births and in-patient transfers.

The PCT will now develop a commissioning strategy for maternity services and the maternity unit will no longer be a feature of our consultation.

This consultation proved how much local people will get involved if they feel strongly about an issue. We are pleased that as a foundation trust, more than 10,000 people in North Derbyshire and the north of Amber Valley feel they want to be involved with Chesterfield Royal Hospital by signing up as members.

This year members have supported our plans to develop a new £5 million unit, on the Royal's site, that will house specialist children's services. This was a proposal we originally consulted on when we first applied for foundation status. It involves selling outdated, unsuitable accommodation in Chesterfield town centre (where these services are sited) and using the money to offset the project's cost.

We have only been able to go down this route because we are a foundation trust and we can show that our members, local people, patients and their families have given it their full support. They have helped to choose fabrics and furnishings for the unit and had a say in the 'overall look' - which they feel should be as 'unlike a hospital as possible'. I am delighted we have been able to work with people at this level.

We have been lucky to get such continued interest from our membership. To give something back, we have introduced a discount scheme for members - that has just started to take off. At the moment around 90 local businesses and organisations have signed up to offer our staff and community members discounts on goods and services. In return, we circulate a discount scheme magazine with our other information.

It offers our members 'a bit more' for their membership and interest - and it also allows us to put money back into the local business community.

Other foundation trusts have been interested in the scheme and may look to develop similar ideas.

As we are now well in to the new financial year, we are looking forward to even more success. We have signed up to becoming an early implementer of the new national target for waiting lists. By December - a year before most other hospitals - our patients who need routine care will have their first outpatient appointment, any diagnostic tests and surgery within an 18-week time-frame. This will be an incredible achievement. It will be difficult to reach, but I believe short waiting times are vital if patients are to make the Royal their choice.

I hope this report is an interesting reflection of 2006 to 2007.

Our staff have worked incredibly hard get us to where we are today. I thank them, on behalf of everyone on the board, for the excellent care they provide to patients. It has been an anxious year for them and it will take time for staff to feel their position is stable.

Our financial savings plan continues, but I am confident that while we must become more efficient, we will do so alongside a continued programme of development. For us, financial security is essential, but so are new services, investments and motivated staff. We will use next year to build on our successes and to provide local people with a hospital they are proud of.

Eric Morton
Chief executive

Policies and notes to the report

Accounting policies for pensions and other retirement benefits
The accounting policies for pensions and other retirement benefits are set out in note 1.18 to the accounts and the arrangements for senior employees' remuneration can be found in the remuneration report on page 82.

Details of company directorships and other significant interests
There are no significant interests held by board members which may conflict with their management responsibilities. Details of company directorships and other significant interests are included in this report on page 50.

External auditor
The corporation's external auditors for 2006/07 were:
The Audit Commission
Littlemoor House
Littlemoor
Eckington
Sheffield S21 4EF

External auditor's remuneration
The total cost of audit services for the year was £70,853. This was for the statutory audit of accounts for the year April 2006 to March 2007 and services carried out in relation to these.

The corporation did not purchase any further services from the external auditors that are outside Monitors' Audit Code. The corporation expects its external audit provider to act independently. Under the terms of engagement they are required to have control processes in place to ensure that this status is preserved and to notify the audit committee of any matter that could compromise the independence or objectivity of the audit team. The audit committee monitors this position and the auditor is required under ISA 260 to confirm this position in the annual governance report.

Political and charitable donations
There have been no political or charitable donations made during the financial year.

Significant events since balance sheet date
There are no significant events since the balance sheet date that are likely to have a material impact on both the corporation and the financial statements for the year ending March 31 2007.

Future developments linked between capital plans and operational development
The corporation is committed to the further modernisation of both facilities and services during 2007/08. Funds are committed for the forthcoming year for capital projects including the continuing replacement of the boiler house, completion of a children's specialist facility, upgrade of hospital wards and new medical equipment such as a CT scanner and an upgrade to the histology laboratory.

Policies for disabled employees and equal opportunities
The corporation's diversity and equality strategy and its supporting policies are the cornerstone of its approach to equality of employment opportunity. We recognise our responsibility to provide (as far as is reasonably practicable) job security for all employees.

Our policies aim to ensure that no job applicant or employee receives less favourable treatment where it cannot be shown to be justifiable on the grounds of:

- age
- gender
- marital status
- sexual orientation
- race
- nationality
- ethnic origin
- colour or disability

in relation to recruitment and selection, promotion, transfer, training, discipline and grievance and all terms and conditions of employment.

Policy applied for the continuing employment of disabled persons

As a foundation trust, we recognise the important role we must play as an active and socially responsible member of the local community and that our patients, clients and staff represent the community we serve.

Policy applied for career development of disabled persons

We know that having a committed and motivated workforce depends on staff feeling that they are treated with fairness, respect and dignity and that they have equal opportunities for self-development. We want to ensure that our staff are not discriminated against, or harassed, on the grounds of their ethnic origin, physical or mental ability, gender, age, religious beliefs or sexual orientation. Equally, if this happens, we want staff to feel confident about using our policies to raise concerns and to have them addressed.

Providing information to employees

Well-informed and involved staff lead to well-informed patients, relatives and public. Throughout the year staff have been consulted about issues that affect them in the way services are delivered; and changes to practice that affect their working environment or practice. This has been particularly important in relation to workforce reviews, which have led to major changes to staffing structures across the organisation.

Communicating with staff has remained a high priority. Staff at the corporation can access a variety of communication materials including:

- pay-slip bulletin - information pertinent to everyone (corporate development, personnel issues etc) circulated to every member of staff with their monthly pay-slip;
- membership magazine - with the authorisation of foundation trust status the staff magazine re-launched in 2005 as a membership magazine. It is distributed to all community and staff members of the foundation trust;
- e-mail briefings - regular briefings to all staff via their personal e-mail accounts, on a variety of subjects affecting the corporation - from service development to estates issues;
- staff suggestion scheme - staff can access the board of directors by e-mail or letter to ask questions, or put forward concerns, ideas and suggestions. All staff using the scheme are guaranteed a response direct from the chairman, chief executive or another executive director within a 20 working day standard;
- posters, leaflets, reports - produced specifically for staff;
- Intranet - the staff only section of the corporation's website facility. Another £30,000 has been invested in the website (intranet and internet) in the last 12-months, to make it easier for staff and the public to use. Staff can access policies and procedures, patient information, an on-line telephone directory and up-to-date news about the corporation - including finance reports, performance reports and minutes from key meetings such as the council of governors.

Action taken to encourage involvement of employees in the foundation trust

It is important that the corporation's employees are well informed and kept up-to-date about financial, economic, activity, risk and other factors that may affect performance and viability.

All staff have the opportunity to access the monthly finance and performance reports prepared for the board of directors. These are available through the communications department - or direct from the intranet.

Additional information is also provided - as and when required. For example, all staff have received details (with their monthly pay-slip) throughout the year about the corporation's financial position and proposed plans to maintain economic performance over the next three-years. The corporation is also looking to re-establish a regular, planned team communication system, specifically from the board of directors. At present, e-mail briefings are issued to directorate teams as and when required - and these are cascaded through the 'team communication' process, with the aim of informing the majority staff within 72-hours.

This year staff have also been invited to participate in two key consultation exercises, which have resulted in changes to service specifications and provisions. Their involvement in these issues - the community midwifery services review and a £5 million new-build project for specialist children's services - has been instrumental in shaping the final decisions.

Payment practice code

The national 'better payment practice code' requires the corporation to aim to pay all valid non-NHS invoices within 30 days of receipt (or the due date - whichever is the later). Performance this financial year shows that 97.0% of invoices paid complied with this measure.

	Number	£'000
Invoices paid April 2006 to March 2007	56,505	54,899
Invoices paid within 30-day target	54,812	51,895
Percentage paid within 30-day target	97.0%	94.5%

Service development achievements

These are just some examples of how services and facilities have improved during the last financial year. The list is by no means exhaustive, but highlights some of the key achievements we consider are making a real difference to staff, patients, relatives or carers and local people.

Other developments can be found throughout this report, including how we have involved our members, governors, patients and the public in decision making. You can also find out more about how the hospital continues to advance at: www.chesterfieldroyal.nhs.uk

Colorectal cancer screening
The corporation has been chosen as one of the pilot sites for colorectal cancer screening. This work will be undertaken with Derby Hospitals and will start in July 2007. Once up and running, the project is expected to lead to an earlier detection and treatment of bowel cancer.

Critical care
The directorate team was strengthened during the year with substantive appointments to the posts of general manager and senior matron, and matron for the intensive treatment unit (ITU) and post anaesthetic care unit (PACU).

The directorate has invested in the replacement of ventilators for ITU, installed ultrasonic washers and autoclaves to enhance the decontamination service and has upgraded and expanded ultrasound facilities to improve the care to the patients requiring central line insertions and nerve blocks.

The directorate has purchased a second cell salvage machine for patients undergoing orthopaedic surgery. The machine reduces the requirement for blood products during surgery. The directorate has also upgraded the moving and handling equipment particularly in the PACU.

Clinical care improvements include:

- Following successful trials by the colorectal and orthopaedics teams, wound soakers have been introduced. Wound soakers are a dissolvable bag of local anaesthetic that is inserted into a surgical wound before closure. The anaesthetic is then slowly released into the tissue around where surgery has taken place, giving pain relief directly to the site. This is an alternative pain relief method and reduces the need for epidural insertion.
- Nurse led discharge on the high dependency unit (HDU) for surgical patients has now expanded to medical patients. This has improved patient flow, reducing delays in patients being transferred to acute wards.

Electronic dictation
As part of the drive to improve services, the corporation has been reviewing the dictation practices and has undertaken a pilot to introduce a new system of tape free digital dictation. The system provides improved recording quality and uses an IT based workflow system to transfer dictation quickly from the author to the correct secretary by the IT network. Electronically moving dictated files around using this system will enable them to be quickly transcribed, so allowing for a more efficient and better quality service.

Electronic discharge summaries
Providing GPs with discharge information at, or soon after, discharge from the hospital is a long-term ambition of the corporation. The medical directorate has been involved in a pilot project to test an e-communication system, which will allow information to be available to the GPs at the time of the patient's discharge from the hospital. This project started in spring 2007 and if successful, will be rolled out to the other directorates soon after.

Foot clinic
One of the major problems facing diabetic patients is foot disease, with high-risk of gangrene and undesirable amputation. As part of the improvements in-service, the medical directorate has established a foot clinic. This has allowed a multidisciplinary approach to the problem, which in due course will allow a more rapid response to diabetic patients with foot disease.

Holywell ward
The corporation is able to offer Laparoscopic Cholecystectomy (gall bladder removal) and Tonsillectomy as day cases, under selection criteria. Both procedures were previously always overnight stays.

The nurses on Holywell have gained the skills to assess patients for crutches, which prevent the patients having to stay overnight to await physiotherapy assessment.

Nutrition and dietetics department
The department strengthened its team this year with the successful appointment of a nutrition support clinical educator.

The department and representatives from the corporation have begun work with the national patient safety team (NPSA). The corporation is part of a national pilot to identify some of the barriers in assessment of the nutritional status of hospital patients. Part of this work has seen the development of an action plan to help ensure those patients who are at greatest nutritional risk are identified and can be provided with the appropriate nutrition support. As one of the corporation's major barriers to assessing nutritional risk has been the lack of equipment to weigh patients who are bed bound, the corporation has purchased weighing and measuring equipment - enabling more patients to be weighed by the ward staff.

The other development within nutrition and dietetics has been the recently completed Primary Care Trust (PCT) review of clinic services, which commenced in 2004. Since this review the configuration of the clinics within the PCTs has changed and outpatients referred to the service have a choice about where they are seen. Nutritional and dietetic service outpatient clinics are now held at the Royal and at seven community locations.

Occupational therapy technical instructor for rehabilitation
Recognition of difficulties in accessing community rehabilitation beds, led to the creation by the occupational therapy department of a new technical instructor role for rehabilitation (the OT Rehab TI). The role of the OT Rehab TI is to provide a short period of rehabilitation to appropriate patients who are awaiting transfer to a community rehabilitation bed.

The OT Rehab TI has been in this post since March 2006, and has been working with patients to help them achieve their rehabilitation goals, in conjunction with families, carers, and other healthcare professionals and agencies.

Evaluation of the role has demonstrated many benefits, including an extremely positive reception from patients and from the multidisciplinary team. Another aspect of the work has been to address the number of medical patients remaining in an acute bed at the hospital - despite having been assessed as suitable for discharge to an intermediate care setting - because of lack of rehabilitation facilities for onward referral. The OT Rehab TI is able to provide this service to patients while they remain in an acute bed.

Ophthalmic department
The ophthalmic outpatient service is a full-time nurse led service providing glaucoma management and pre and post op assessment of cataract patients.

Over 80 opticians in the region have been accredited to refer patients directly to the hospital for cataract surgery, and to carry out the post-operative care following discharge from our nurse-led service.

The department also began providing a diabetic screening service from May 2006. This involved the recruitment of screeners and their subsequent training.

Within the orthoptic services, which support ophthalmology, a new role - field technician - was designed. This is full-time role, which enables the patient to have a field test on the same day they are due to see their consultant.

Outpatient clinic refurbishment

An extensive review of the fabric of the corporations' outpatient clinics has been undertaken during the year. Many clinics were found to be in need of redecoration and refurbishment, to provide the best environment for patients and ensure that infection control standards are maintained. The significant investment made has ensured patients and visitors will benefit from:

- new wipe clean areas;
- variable height furniture in waiting areas;
- the conversion of carpet to vinyl flooring in all clinical areas;
- TVs are provided in waiting areas for patient and visitor entertainment and information;
- Consulting rooms being updated with new curtains and screens, new furniture and adjustable height couches in every room;
- All clinic areas being decorated to provide a fresh new-look for visiting outpatients.

Patient handling

Over the last 12 months the corporation has invested £100,000 in replacing and upgrading patient handling equipment. The money has ensured that all manual and older style patient hoists have been replaced with electrical powered hoists. The purchases included:

- 12 hoists (approximately £1,500 each);
- Overhead tracking in the mortuary, imaging and Murphy ward;
- New patient trolleys and couches for outpatient departments and accident and emergency;
- Various slides, slings and non-slip pads;
- Standing aids.

The new hoists and patient handling aids will improve the working conditions of nursing staff and the standing aids will assist patients with their independence and mobility.

Pre-registration nurse training at Derby University - partnership working

Nurse training returned to North Derbyshire in September 2005. During 2006/07 Derby University and the corporation have made excellent progress working together and establishing a strong philosophy of partnership working.

Partnership working has been evident, and will continue to flourish, in the following areas:

- Student recruitment - staff from within the corporation are encouraged to take part in recruiting students on to the programme. These interviews are conducted by a member of staff from both the corporation and university, whenever possible, to ensure that both parties have an influence in the decision making process.
- In February 2007 the university held a 'roadshow' event in Chesterfield town centre to encourage students to apply for nurse training. The event was a great success with participation from the university, the corporation and students currently on the programme. Potential candidates were provided with advice about the academic study, curriculum, placement experiences and support available should they decide to enter the nurse-training programme.
- Student allocation/placement planning - since September 2005 the corporation and university have worked closely together, planning allocations for the students and ensuring there is enough capacity to support the numbers of nursing students.
- As well as working in partnership with Derby University, the corporation is working with Sheffield University and all three parties consider the capacity of the placement circuit. We meet twice yearly to look at the numbers of nursing students requiring placements, and the capacity available to us. The parties work together to agree the number of students an area can support at any given time.

- Mentor Preparation - Derby University deliver mentor preparation courses to ensure the staff supporting their students are fully prepared in the role of mentor. The course was designed to meet the current Nursing and Midwifery Council (NMC) Standards.
- Mentor/student support - Derby University and the corporation jointly deliver mentor updates on the rolling programmes, which occur across the corporation in all directorates. The university also supports mentor training on both the preceptorship programme as well as the workshops, which are delivered three times a year for corporation staff.

Derby University and the corporation continue to work together to deliver the pre-registration nurse training programme in North Derbyshire - to ensure students and mentors are fully supported in their roles. The clinical placement learning team will remain pivotal in ensuring continued partnership working between the university and the corporation.

Reduction in waiting times for patients in the genito-urinary medicine department (GUM)
During the year significant investment in staff and innovative working has ensured the majority of patients contacting the genito-urinary medicine (GUM) clinic are offered an appointment within the 48 hours. The corporation now offers a service that compares favourably with the best providers in England.

The GUM service offers appointments at two evening clinics per week, and patients do not have to be referred by their GP or other healthcare professional to gain an appointment, but can refer themselves. The national sexual health support team has applauded the improvement and the ongoing work during their recent visit to Chesterfield Royal.

Research and development
Over the last 12 months there have been exciting developments in the national picture for health research and the governance of research.

Chesterfield is now part of the Trent Comprehensive Local Research Network. This means the majority of research undertaken within the corporation will be coordinated from Nottingham, following the already established model for the cancer networks.

Chesterfield Royal has maintained its links with the North Trent Cancer Research Network and continues to have Western Park Hospital oncologists at the Chesterfield Royal site increasingly treating patients.

In a new development Dr Punnouse (medical consultant) has started work with the Stroke Research Network. As a result, there are four potential trials under discussion.

The department has continued its work with Cambridge Clinical Research and has secured some on-site accommodation for a research sister assigned to Chesterfield. This should allow the department to increase the number of patients entered into trials and the range of trials undertaken.

From a governance perspective the research policy and intellectual property policies have been approved. The department has spent some of the year developing a full database of all the projects being undertaken. As a result, the department can now audit all projects and can provisionally report that there are 143 active or proposed studies in the corporation.

In April 2007 the research department held an event in the education centre where it presented its annual report. The event featured stands from key stakeholders and project groups and presentations from industry, the library and other project groups supporting research at Chesterfield. The event was well attended and was an excellent opportunity to identify useful collaborations for the future.

School community nursing service

During the summer of 2006 the school nursing service in North Derbyshire began their planned expansion.

'Choosing Health Monies' was awarded by North East Derbyshire and Chesterfield Primary Care Trust (PCTs) to provide a named nurse for every secondary school and its cluster primaries. £318,000 was allocated in two stages. The first was in October 2006, and the second in April 2007. As a result of the funding, the service has been able to fund various posts, including nine extra school community specialist nurses, four school community nurses and three school health assistants.

The school community nursing service is involved in making links with the Every Child Matters agenda, and directly involved in addressing the choosing health key outcomes, tackling obesity and physical activities, sexual health, emotional health and well-being and safety issues. It is a very exciting and challenging time in developing a modernised school nursing service.

Security

The corporation has invested approximately £120,000 in the CCTV security systems during the year.

The investment allowed the corporation to upgrade and extend the access control system to all areas of the hospital. Intruder alarm systems have been installed at remote clinic sites at Edmund Street, Marsden Street and Buxton Health Centre and the corporation extended the use of the 'Blick Minder' lone worker alarm system to include pharmacy.

Sheffield Occupational Health & Safety Association (SOHSA)

Frank Smith Award 2007

SOHSA is an association for health and safety practitioners of all industries based in the South Yorkshire and North Derbyshire areas. The corporation is a member of the association and the environmental risk team take an active part. There are about 200 members of the association.

The Frank Smith Award is awarded annually to a person or organisation for a workplace based health and safety project or initiative. Frank Smith was a member of the association for many years and served as both chairman and president. When he died, his family gave a corporation fund to the association for this annual award.

The environmental risk team submitted the central services stress assessment project completed last year and won the award. The stress assessment was very detailed with the submitted project evidence consisting of:

1. Staff newsletter ('less central stress')
2. Minutes from meetings of the stress steering group
3. Staff briefing presentation
4. Assessment process records and assessment proforma
5. Department and directorate assessment reports
6. Focus group records
7. Action plans.

The SOSHA award committee members were very impressed with our project and have asked the environmental risk team to speak at the association's meeting in May.

The stress assessment is now being carried out of the remainder of the corporation and it is hoped to have the completed report by November 2007.

Specialist children's service

In order to develop and improve the specialist children's services, plans were drawn up to relocate the services on to the Chesterfield Royal Hospital site. The aim of the relocation was to:

- Improve the environment in which services are delivered
- Improve services for those requiring specialist care
- Create a dedicated children's centre in one location

As part of this work the involvement of parents/guardians, children and community members was key to ensuring the relocation of services meets the needs of the children and their families using the facilities. A 'fun day' event full of entertainment was held in March 2007 providing information and an opportunity for the local community to comment on plans and put forward suggestions.

Staff training

New training syllabi have been introduced during the year including:

- Conflict resolution training - The training is based on the NHS syllabus and includes basic breakaway techniques. The addition of breakaway techniques has been well received by staff.
- Inanimate load training - The training is provided to all non-patient handling staff.
- Waste management - This year saw the introduction of new national waste and environmental management legislation. The legislation increased the costs of waste disposal for the corporation. As a result, the corporation has undertaken some initiatives that have resulted in some major changes to the way waste is disposed of.

In 2005 the corporation had five different waste categories. Under the new waste and environmental management legislation the corporation is required to have 14. To try and mitigate the potential additional costs, a greater emphasis and importance was placed on recycling the various types of waste where possible. To ensure efficiency, all the sorting is undertaken at ward and department level. The waste is packaged and sent for treatment or disposal.

OPERATING AND FINANCIAL REVIEW - OFR

OFR: Operational reporting

Our history
There has been a Royal Hospital for around one hundred and fifty years, serving the population of Chesterfield and the surrounding towns and villages in North Derbyshire.

The hospital quickly built a reputation for high-quality services and excellent patient care, meeting local needs within available resources. This continues today. The hospital is modern and progressive and strives to make continual improvement for the benefit of its community.

On April 29 1984 the current hospital was opened in Calow, two miles outside Chesterfield's town centre. Nine years later, on April 1 1993, the Royal became one of the country's first NHS Trusts, remaining in the NHS and still under direct control of the Department of Health. NHS Trusts had more control over their own affairs, but central financial constraints remained.

Developments over the last 23 years have allowed the Royal to continually improve services and facilities for patients and staff. In the largest area of the hospital all the main surgical and medical specialties are provided, as well as clinical and non-clinical support services. These include:

- Intensive care, high dependency and coronary care units
- Emergency Services (including A & E)
- A theatre suite including specialist theatres for orthopedics and two post anaesthetic care units
- Pathology laboratories, physiotherapy and occupational therapy
- Diagnostic radiology, CT scanning and MRI scanning
- A cardiac catheter suite
- Osteoporosis centre
- Ten out-patient suites including a rapid access chest pain clinic
- Scarsdale Wing houses: antenatal clinic, chemotherapy unit, dialysis unit and day care unit dedicated to cataract operating theatre
- Nightingale Wing houses the children's services at the hospital. Its development allowed the hospital to integrate outpatient and in-patient wards.

In 2003, by achieving a three-star rating in the national 'league tables', the Royal was able to apply for NHS foundation trust status. Monitor (The Independent Regulator for NHS Foundation Trusts) approved the application in December 2004 and Chesterfield Royal Hospital NHS Foundation Trust began life on January 1 2005 as a 'public benefit corporation'.

As a foundation trust, the Royal remains firmly within the NHS. It is accountable to the local people it serves through their membership of the corporation and election to the council of governors. They are working with the corporation to shape the Royal's future and build a hospital they can be proud of. Foundation trust status is allowing the organisation greater freedoms and more control over the services we provide and develop. It also means for the first time that we have been using financial gains to our benefit, reinvesting them in-patient services and developments.

Our services
Serving North Derbyshire's population of around 375,000, Chesterfield Royal Hospital NHS Foundation Trust provides a full range of acute services - plus 24-hour accident and emergency care. We also have specialist children's services based in the community (such as family therapy services, children's physiotherapy, school nursing) and we manage a small maternity centre in Darley Dale, near Matlock.

Our specialties

We have a range of specialties, including:

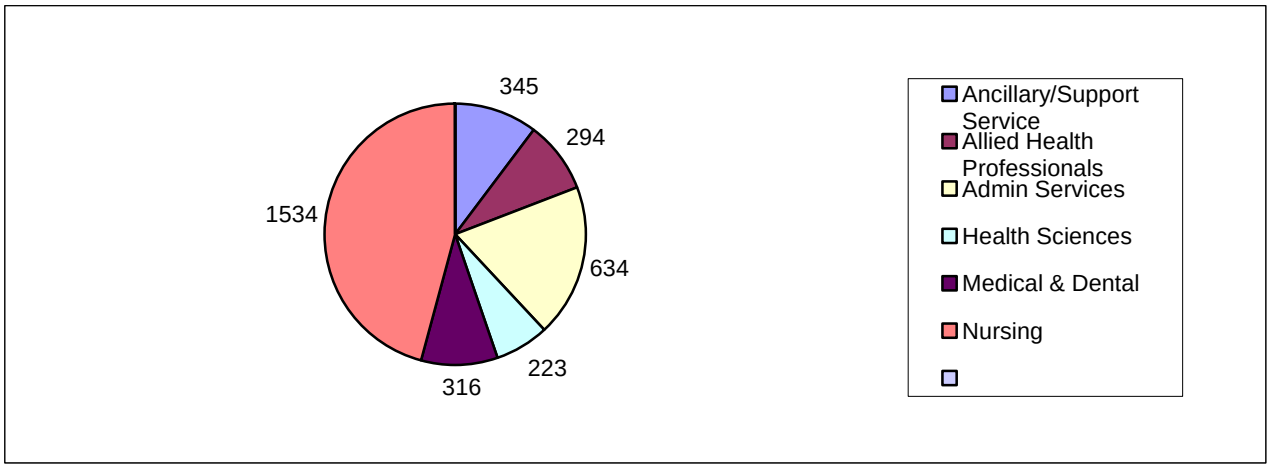
Accident and Emergency; Anaesthetics and Pain Management; Cardiology; Care of the Elderly; Child Health; Clinical Haematology; Coronary Care; Community Midwifery; Dermatology; Diagnostic Imaging; Ear, Nose and Throat; General Medicine; Genito-Urinary Medicine; General Surgery; Intensive Therapy; Maxillofacial Surgery; Medical Physics; Obstetrics and Gynaecology; Ophthalmology; Oral Surgery and Orthodontics; Pathology; Pharmacy; Physiological measurement; Radiology; Rehabilitation; Rheumatology; Trauma and Orthopaedics and Urology.

Other services available at the hospital includes:

- Children First - day nursery for babies and children (discounted rate and priority is given to staff);
- Chapel/Convenience store/ Newsagents/Flower and fruit shop;
- Health information point/ Patients Advice and Liaison Service (PALS);
- LINKS Restaurant and STROLLERS café and pizzeria;
- Minicom facilities through switchboard;
- Cashpoint facilities;
- Patientline a TV, radio and telephone system at the patient's bedside;
- Pay exit security car parks for patients and visitors;
- A help desk and volunteer 'meet and greet' service;
- Webzone internet service for staff.
- A membership discount scheme - entitles registered staff and community members to discounts at shops and organisations across the North Derbyshire area.

Our staff

The corporation employs 3,346 staff (at March 30 2007):



Organisational structure

As an NHS foundation trust the corporation has a council of governors and a board of directors.

The board of directors provides a business focus, setting the direction and developing plans.

The council of governors provides the community perspective, advising the board of directors of the views of the community, which they take into account in developing strategies.

The board of directors is supported by a number of subcommittees:

- Audit committee
- Remunerations committee
- Clinical governance committee
- Charitable funds committee

Further details of the committees can be found on page 40 of this report.

The corporation also has a hospital management committee (HMC) that decides, sets, implements and monitors policies and working arrangements.

Two subcommittees also support the council of governors:

- The Patient and Public Involvement (PPI) committee
- The nominations committee

Further details of these committees can be found on page 64 of this report.

Key aims and objectives - April 2006 to March 2007

We already have a history of successful service development and delivering the best for patients in the North Derbyshire area and beyond. We continued to improve services when we became an NHS Trust in 1993. As an NHS foundation trust we are building on that success, with further improvements and by engaging the support of the public and our partners.

The overall aim for the NHS foundation trust is encapsulated in the mission statement introduced twelve years ago (when the organisation first became an NHS Trust). This mission statement remains relevant and applicable today. Details of the statement are found on page 7 of this report.

We provide mainly secondary and specialist care predominantly in hospital, but also reaching out into the community, particularly with women's and children's services. Our mission applies equally - in whichever setting we provide care.

As part of its terms of authorisation, the corporation is required to have a service development strategy. This strategy will take the organisation through the next five years. Its main strategic themes are:

- provision of high-quality and timely healthcare, delivered in a way which focuses on positive experiences with the hospital, and ensures that patients, relatives and their carers, attend, and indeed return, to Chesterfield Royal Hospital as their provider of choice;
- services delivered in a modern estate, where the quality of the patient environment is continually improved to ensure it is fit for purpose, meets all legislative requirements, and delivered using the most appropriate and up-to-date technology;
- provision of services from within a strong support infrastructure, delivered by high-quality staff who are appropriately trained, feel valued and rewarded, and want to continue working within the corporation and identify with its success;
- maintenance of strong governance and management arrangements, which are fit for purpose and react to the changing NHS environment;
- underpinned by a strong financial framework, which ensures that the corporation is financially viable in both the short and medium term.

The organisation's aims and strategic themes are underpinned each year by corporate objectives. These centre on short-term goals for the organisation. For 2006/07 they concentrated on issues designed to deliver the various targets set out in the NHS Plan (plus other local action plans). In total, the corporation had 10 high-level objectives for 2006/07, covering all aspects of internal and external performance.

Each of the corporate objectives has specific goals for our individual directorates. Performance against every objective is monitored in detail each month, and reported to the hospital management committee, the board of directors and the council of governors, through a 'performance report'. In addition, bi-annual review meetings take place with each clinical directorate team, with additional review meetings if performance deviates from plan.

Performance review - April 2006 to March 2007

The corporation had another strong financial year achieving an underlying net surplus of £3.9m against a planned surplus of £700,000 and was in financial surplus throughout the year. In addition, a £1.5m surplus due to the inclusion of incomplete spells is included, which gives a gross surplus of £5.4m. The corporation also had a recurrently balanced income and expenditure account throughout the year placing it in a strong financial position going into 2007/08. Emphasis has also been placed on maintaining strong liquidity and cash was ahead of its planned position. At March 31 2007 the corporation had a closing cash balance of £16.0 million compared to an original forecast of £12.3 million. Further details on financial performance are set out later in the report.

Assessment of the Healthcare Commission core standards indicates that all areas are compliant. In addition the corporation's performance against the Healthcare Commission's existing national targets for the period is good, with all the standards directly attributable to the corporation having been achieved. Early assessment of performance against the Healthcare Commission's new national targets is also good, with just one area of concern.

Throughout the year, maximum-waiting times for elective treatment remained at three-months for the majority of specialties, with only orthopaedics showing a maximum four-month wait at the end of March (throughout the year the national guarantee was six-months). Maximum outpatient waiting times were reduced to eight weeks with waits in many specialties being much shorter, and the majority of diagnostic waits reduced to four weeks with the national guarantee being 13-weeks.

All patients referred to the hospital, during the year, with suspected cancer were seen in outpatients within 14 days of the referral being made, and all cancer patients received their first treatment within a month of a decision to treat being made. In addition, 98.4% of cancer patients received their first treatment within two months of urgent GP referral.

Non-elective activity was 3.1% above planned levels, and attendances in the Accident & Emergency Department 4.0% above plan, with targets for treatment of 98% of patients within four hours in the Accident & Emergency Department being achieved every week throughout the year, reaching 99% or above for 28 weeks.

Elective and day case admissions were 3.0% above planned levels, and first attendances in outpatients were 1.1% lower than plan.

Capital expenditure for the year amounted to £5.2m, which was marginally in excess of the planned position of £4.9m. This was due to the addition of a number of control of infection capital schemes during the year for which £0.3m public dividend capital (PDC) funding was received.

The main areas of capital expenditure were schemes to replace the hospital's boilers and to upgrade a number of the ward areas.

Following a year of constructive and amicable negotiations with our new major purchasers, Derbyshire County PCT, a contract for services in 2007/08 was agreed in March 2007. This provides for non-elective activity levels above those delivered in 2006/7, together with increases in elective activity levels to facilitate delivery of a maximum 18-week referral to treatment waiting time by December 2007- a year earlier than national targets.

Statement on the corporation at the end of the year

2006/07 was a testing year for Chesterfield Royal Hospital NHS Foundation Trust, as the corporation embarked upon a savings programme designed to reduce costs over the forthcoming three years.

The Department of Health's decision to reduce the tariff in February 2006, put our early development plans for 2006/07 in jeopardy, as national policy meant the corporation's income would be much less than expected - for at least the next two to three years.

Although this was not a position we had envisaged being in as a new foundation trust, the corporation remains responsible for its own budget and for continually investing in new equipment and facilities, and the only mechanism for achieving this is to make a surplus. Thus, in 2005/06 the corporation made a financial surplus of £3.8 million, to reinvest in services. Despite this achievement, to remain a financially sound, stable and viable organisation, it was necessary to take action quickly when the tariff was published, to ensure the changes would not put us 'in the red', or prevent us from continuing to improve patient care and patient services.

In April 2006, our board of directors sanctioned a savings plan, with the aim of achieving a 10% decrease in the cost of running the hospital, by the financial year 2008/09.

The corporation's past financial success meant that although there would still be difficult decisions to make, there would not be a requirement for significant numbers of job losses through compulsory redundancy, but with staffing costs accounting for 70% of our annual budget, reviewing the workforce was always going to be an important part of becoming more efficient.

Workforce reviews were launched to inspect all our staffing arrangements. The reviews have examined if we have the right combination of suitably skilled staff in all areas, from nursing to management. Reviews and consultations with staff completed during the year have seen the number of posts in the organisation decrease, with only one compulsory redundancy; most reductions were achieved through natural wastage. Staff considered 'at risk' were successfully redeployed throughout the organisation, although a handful asked for early retirement or voluntary redundancy.

Throughout this difficult time our staff have been a credit to the organisation, remaining professional and loyal.

Key constraints

External environment - the uncertainty surrounding future Department of Health policy decisions, and the potential for current policy to change - is considered a key constraint to planning the corporation's future financial and capacity requirements. An example of this is the potential for policy changes under payment by results and the effect this could have on the tariff rate paid for clinical activity.

Internal environment - key constraints around future planning of clinical activity and financial projections include:

- Physical and staffing capacity such as outpatient clinics, theatre availability, bed capacity and support services such as diagnostics.
- Having sufficient estate and infrastructure, including availability of medical equipment, to meet demand.
- Ability to change practice sufficiently to streamline pathways of care to deliver 18 weeks referral to treatment.

Key risks and management of risks

During the year the board of directors has considered the constraints and risks within the organisation and action plans are in place to alleviate these wherever possible.

Organisational issues

At the end of 2005/06 the council of governors and board of directors undertook a recruitment drive for the non-executive membership of the board of directors. The council of governors and board of directors collectively developed a skill matrix that identified the skills and qualities required for the chairman and non-executive directors.

In April 2006 the council of governors appointed a new chairman, Richard Gregory. Following his appointment further recruitment to the board of directors was undertaken. The non-executive membership of the board of directors was, with the exception of one non-executive, due for reappointment.

The corporation used a specialist search consultancy - as it did for the recruitment of the chairman - asking the consultancy company to find appropriate candidates within the area. The agency advertised the opportunities in the national media and undertook some local searches.

The chairman and members of the council of governors formed an appointments committee. The committee undertook the interviews and successfully appointed to the three posts in the summer of 2006.

The board of directors reviewed its membership during this period and recognised there would be significant benefits from an additional non-executive directors post being introduced. The make up of the board of directors was equally split between the executive and the non-executive directors including the chairman, by adding an additional non-executive it would ensure there was further independence within the board. It was also recognised that the time demands being made on the current non-executive directors highlighted the need to increase the numbers of non-executives. Appointment to the fourth non-executive was made in the autumn of 2006.

OFR: Patient care

Information for patient and carers
Patient and public involvement (PPI) is an integral part of the corporation's work and has been strengthened by its foundation trust status. The corporation prides itself on listening and responding to patients to improve services delivered locally and ensure that they are patient-centred. By listening and responding to what patients say we can:

- Improve access and reduce waiting;
- Offer more information and choice;
- Build closer relationships;
- Provide safe, high-quality and co-ordinated care;
- Provide a clean, comfortable and friendly environment;
- Improve the patient's experience.

Patient and public involvement team
The corporation has a patient and public involvement team, which is based within the clinical standards and governance directorate. This team supports the corporation's PPI agenda, structures and activity. Working with staff from across the organisation the PPI team takes a lead on ensuring that the corporation listens and responds to patient's view in order to influence service delivery.

The PPI team also supports the PPI committee, which is a subcommittee of the council of governors; more details of the committee's work can be found on page 64 of this report.

The PPI team provides the following support to the PPI forum:

- Advice on corporation practice
- Assistance to influence the PPI strategy and development plan
- Regular updates on feedback from patients and the public
- Practical help and advice for PPI projects and initiatives
- Ensuring members are included in all appropriate changes and developments.

In addition the PPI team acts as a link to the independent PPI fourm. PPI forums are statutory bodies responsible for representing the views of the local population; there is one PPI forum for each NHS trust.

The PPI team, on behalf of the corporation, works in partnership with the Chesterfield Royal PPI forum to:

- Share good practice and identify areas for improvement;
- Facilitate their work within the corporation, e.g national audit of patient meals.

Information on handling complaints
The corporation takes complaints seriously and acts to ensure problems are resolved quickly, to improve experiences for future patients.

The handling process is monitored, to make sure services improve as a result of a complaint being made. Monitoring includes the reasons for complaints, response times and any action taken.

The Healthcare Commission (HCC) published 'Spotlight on Complaints' - a national review of complaint handling from 2004 to 2006. The report includes a section on how well complaints are handled locally. The corporation was highlighted in the report as having the '*highest number of independent review cases returned by the HCC for further local resolution '* (at 64%).

The HCC recorded that out of 23 closed review cases, it had returned 15 to the corporation for a further attempt to resolve the complainants' issues. Prior to the publication of the report the complaints department had undergone a wholesale review of its practices and although the report was of concern, the changes to the complaints handling process had already been actioned to try to reduce (a) the numbers of people requesting independent reviews and (b) the number of returns for more local resolution.

The complaints service was transferred to the chief executive's directorate in May 2006, under the line management of the head of communications. The service was reviewed and at the end of 2006, through workforce review, a staff restructuring exercise was completed. An assistant complaints adviser was appointed, so the service is no longer reliant on a single member of staff.

The department also has dedicated administrative support through the chief executive's office - so the advisers can concentrate on helping complainants, leading the investigation process and completing detailed responses. Other improvements to the complaints handling process have also been instigated. For example:

- Complaints are now 'graded' with different response timescales, depending on the issue a complainant raises (for example a complaint about a missing appointment letter would be 'green' and responded to within 5-7 days, a complex clinical complaint would be 'red' and the investigation would take the full 20-25 days).
- Complainants are contacted by phone and e-mail, rather than the process relying on written responses.
- Working with the complaints team, directors, general managers, matrons and the PALS service is providing invaluable support - resolving more issues at ward and department level - to try to prevent complaints reaching a formal stage.

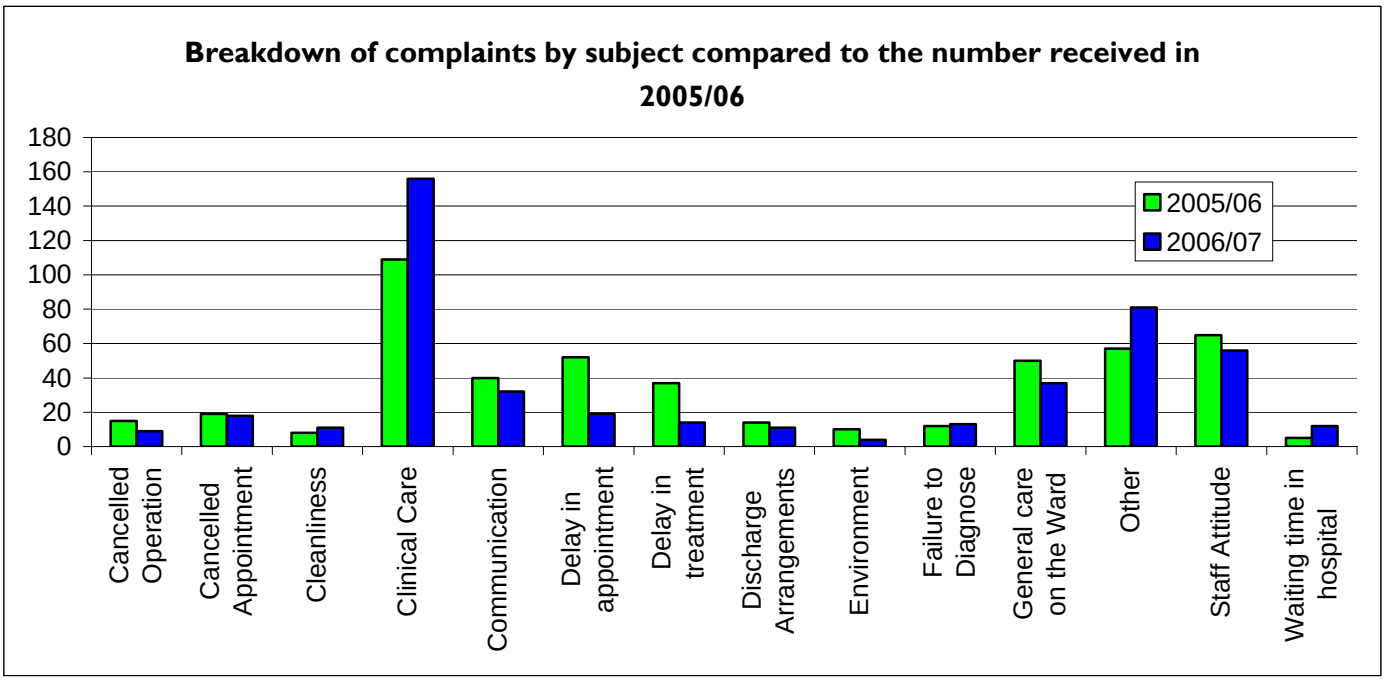
These actions and our plans for the complaints service should result in a better outcome in terms of the number of HCC review requests and the number referred for further local resolution. The total number of complaints 2006/07 was 473 (2005/06: 493). The breakdown of complaints is as follows:

	Cancelled Operation	Cancelled appointment	Cleanliness	Clinical care	Communication	Delay in appointment	Delay in treatment	Discharge arrangements	Environment	Failure to diagnose	General care on the ward	Other	Staff attitude	Waiting time in hospital	Total
Central Services	0	1	8	3	0	0	0	0	3	0	0	17	3	0	**35**
Clinical Development	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Critical Care	0	0	1	7	1	0	0	0	0	0	0	2	2	0	**13**
Emergency care	0	0	1	25	3	0	1	4	0	6	2	9	5	3	**59**
Finance	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Imaging	0	0	0	3	1	0	0	0	0	0	0	7	2	0	**13**
Medical Specialties	0	1	1	35	6	5	4	4	0	0	17	8	18	4	**103**

	Cancelled Operation	Cancelled appointment	Cleanliness	Clinical care	Communication	Delay in appointment	Delay in treatment	Discharge arrangements	Environment	Failure to diagnose	General care on the ward	Other	Staff attitude	Waiting time in hospital	Total
Not Specific	0	0	0	0	1	0	0	0	0	0	0	2	1	1	**5**
Orthopaedic Surgery	4	1	0	33	2	0	1	1	0	2	5	3	6	1	**59**
Pathology	0	0	0	0	0	0	0	0	0	0	0	2	0	0	**2**
Planning & Performance	0	5	0	0	5	3	0	0	0	0	0	13	5	0	**31**
Surgical Specialties	4	10	0	27	8	9	5	1	1	1	10	13	10	3	**102**
Women's and Children's	1	0	0	23	5	2	3	1	0	4	3	5	4	0	**51**
Total	**9**	**18**	**11**	**156**	**32**	**19**	**14**	**11**	**4**	**13**	**37**	**81**	**56**	**12**	**473**

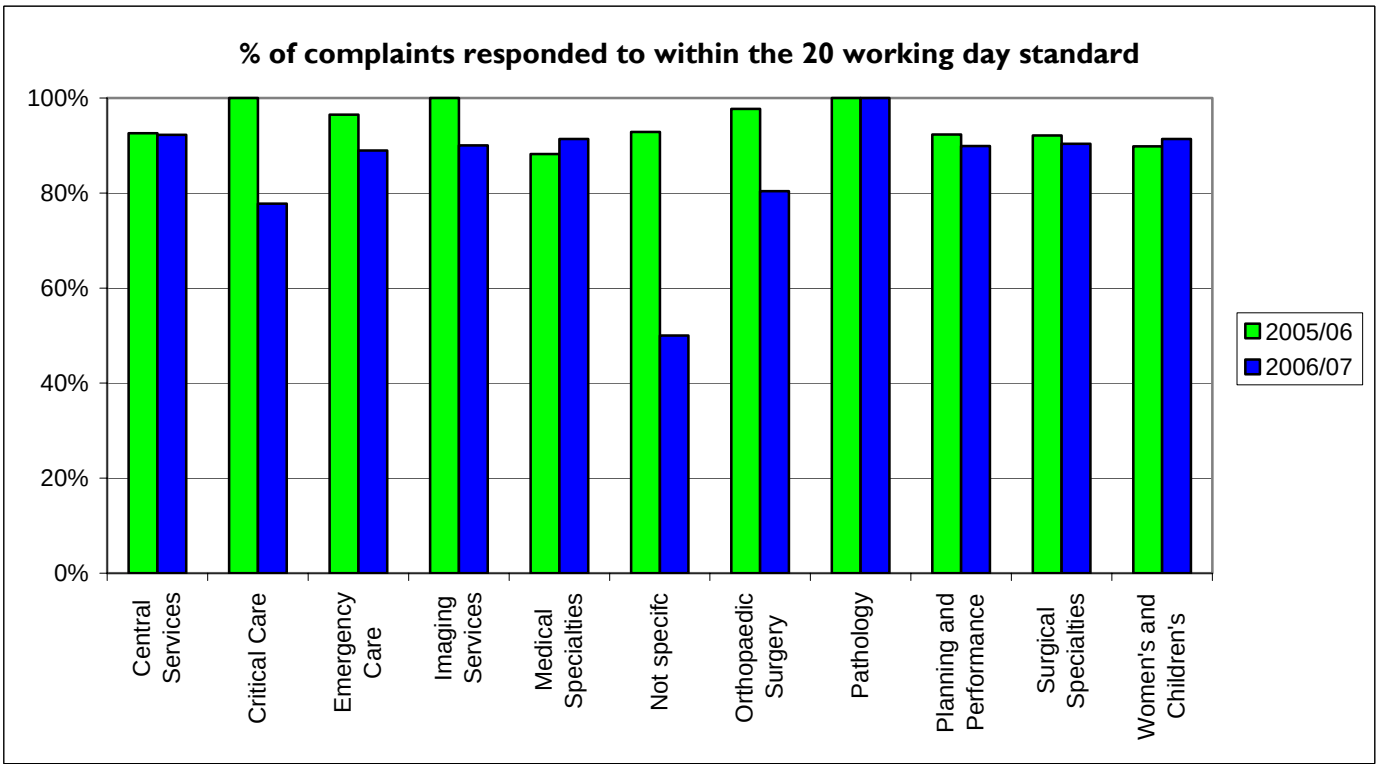
The table and graph below shows the number of complaints per category received during 2006/07, compared to 2005/06.

Subject	Cancelled Operation	Cancelled Appointment	Cleanliness	Clinical Care	Communication	Delay in appointment	Delay in treatment	Discharge Arrangements	Environment	Failure to Diagnose	Care on the Ward	Other	Staff Attitude	Waiting time in hospital
2005/06	15	19	8	109	40	52	37	14	10	12	50	57	65	5
2006/07	9	18	11	156	32	19	14	11	4	13	37	81	56	12



Response times

In addition to monitoring the reasons for complaints, the corporation aims to respond fully to all complaints within 20 working days (national standard - 25 working days) of receipt. During the year 87% of complainants received a full and final response within this timescale.



OFR: Stakeholder relations

Significant partnership alliances

The corporation attends commissioning consortium NORCOM (the North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium) meetings. This group makes collective decisions on planning and procurement, and reviews services for populations larger than an individual primary care trust or health community.

Chesterfield Royal Hospital NHS Foundation Trust is regularly represented at NORCOM meetings and participates in these speciality specific NORCOM networks:

- Critical care,
- Cardiac care,
- Oral and maxillofacial surgery,
- Ear, nose and throat,
- Cancer,
- Renal,
- Pathology,
- Neonatology,
- Children and child and adolescent mental health.

Close working relationships have been developed with the corporation's main commissioning partners, which account for around 97% of the patient care income.

Close working relationships within the Derbyshire Health and Social Care community remain good.

In addition, the corporation hosts services provided by other NHS organisations:

- Renal dialysis (Sheffield Teaching Hospitals NHS Foundation Trust)
- Chemotherapy (Weston Park Hospital NHS Trust)

Visiting consultants also hold specialist outpatient clinics at the Royal:

- Plastic surgery (Sheffield Teaching Hospitals NHS Foundation Trust)
- Neurology (Sheffield Teaching Hospitals NHS Foundation Trust)
- Nephrology (Sheffield Teaching Hospitals NHS Foundation Trust)
- Genetics (Sheffield Teaching Hospitals NHS Foundation Trust)
- Thoracic surgery (Sheffield Teaching Hospitals NHS Foundation Trust)

The corporation also has good partnership arrangements with representatives of the local community. In addition to the increased involvement of public governors and community members, the corporation also works closely with:

- the county council's Improvement and Scrutiny Committee (ISC)
- local health-related voluntary groups through the self-help group forum
- representatives of the local black and minority ethnic (BME) communities through the BME health and social care group
- cancer service users through the North Derbyshire cancer service users group

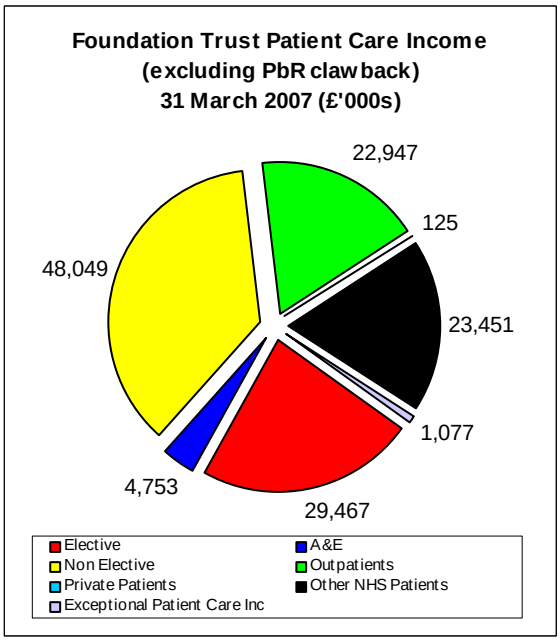
These partnerships allow for feedback on our services and they enable improvements to be identified that meet the needs of our local community.

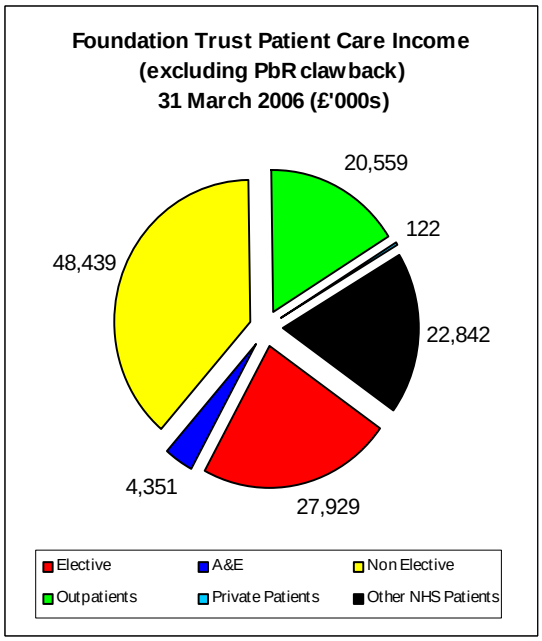
Finance

The accounts for the year ending March 31 2007 are included in full at Appendix A. Within this Annual Report & Accounts for the year ending March 31 2007 previous year comparators are shown.

Income from activities

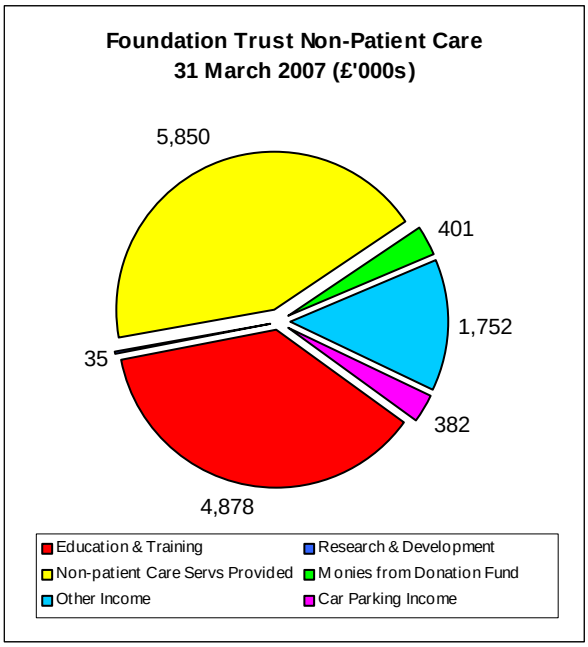
The total income from patient-care activities for the year 2006/07 was £126.9 million net of £1.9 million PbR clawback (2006: £120.6 million). This represents 90.5% (2006: 89.6%) of total income for the year. This is shown graphically below:

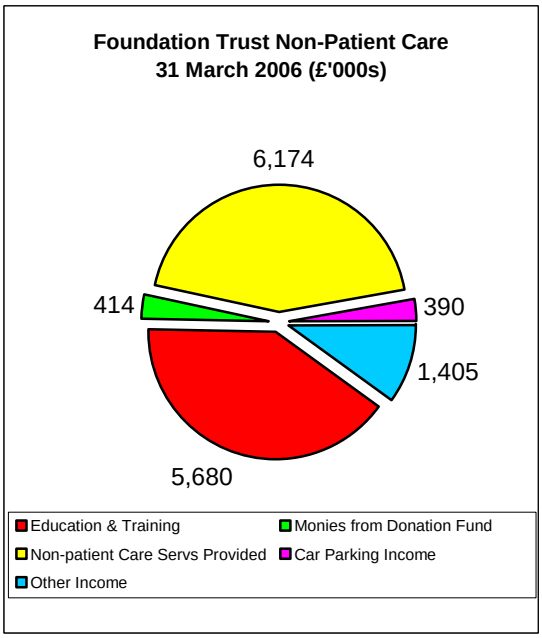




Income generated from non-healthcare activities

Included below are details of £13.30 million (2006: £14.06 million) of non-healthcare income received, which has been generated from the provision of non-healthcare services. This represents 9.5% of total income in year (2006: 10.4%).





Financial position

The corporation achieved a net financial surplus of £5.4 million (2005/06: £3.88 million). The 2007 surplus included £1.5 million of incomplete spell income (2005/06: nil) of which £1.08 million is shown as exceptional income. Incomplete patient spell income arose when the corporation was still treating patients at 31 March 2007, but income for their treatment had yet to be received. An estimate of the amount to be received for these patients was then accrued. Of the £1.5 million income accrued, £1.08 million actually related to the opening position as at April 1 2006 which was not accrued in the 2006 accounts.

An earnings before interest taxation depreciation and amortisation (EBITDA) of £10.6 million (2005/06: £10.4 million) was achieved. The net surplus was £4.7 million in excess of the plan. This was due to planned contingencies within the annual plan that did not fully materialise and staff turnover and delays in recruitment during workforce review process. This will be carried forward to fund future capital investment.

Cash increased to £16 million, and a working capital facility of £10 million was also in place, giving cash headroom in excess of £26 million, and placing the corporation in a healthy financial position. This £26 million equates to a liquidity risk rating of '5' in terms of Monitor's ratings (see table on page 34) for more details). This increase in the cash during the year reflects the strengthened controls and procedures that have been put in place to manage the liquidity of the corporation effectively. In 2006/2007 the corporation had no requirement to borrow against the prudential borrowing limit of £39.5 million set in its terms of authorisation, which consisted of £29.5 million new borrowing, and the working capital facility of £10 million.

Key financial risks

The key financial risks that could have a significant impact on the NHS Foundation Trust and how those risks are mitigated are detailed below.

- *Payment by Results (PbR)*
  All NHS foundation trusts are subject to PbR, whereby the corporation is paid for the level of activity it does, based on a tariff for each activity. Changes to PbR policy or the tariffs will affect activity and may result in the loss of future income. The corporation is adopting a cautious approach to this risk and has procedures in place to monitor the impact of PbR.
- *Non-patient care income*
  Levels of non-patient care income may not be secured at a level that as a minimum covers the full cost of service provision. To mitigate this, the corporation proactively negotiates and monitors contracts, including provider-to-provider agreements with other NHS organisations and education and training contracts.
- *Cost management*
  Inadequate cost management and inability to achieve cost improvement programmes could have a significant financial impact on the corporation. Directorate financial positions are tightly monitored and recovery plans are in place (if required). Early detection of cost management failure is essential and procedures are in place to identify any anomalies.
- *Capital cost management*
  Capital programmes may not be completed within the planned framework and this may impact on the liquidity of the corporation if they are not managed correctly. The corporation has regular close monitoring of the capital expenditure budget to ensure that overspends are managed and to ensure that sufficient funds are available to allow the capital programme to progress.

This list of risks is by no means exhaustive and the corporation undertakes regular detailed risk assessments to put controls and procedures in place to pre-empt the impact of risks before they arise.

Monitor (the independent regulator of NHS foundation trusts), also oversees the corporation's financial performance on a quarterly basis using specific financial risk ratings. The corporation's performance against Monitor's 2006/07 financial risk ratings are shown on page 34:

		2006/07 (plan)		2006/07 (actual)	
Metric	Weighting	% Ratio	Rating	% Ratio	Rating
EBITDA margin	25%	5.6%	3	7.5%	3
EBITDA % achieved	25%	104.0%	5	143.7%	5
Return on assets	12.5%	4.1%	4	8.1%	5
I&E surplus margin	12.5%	0.5%	3	3.1%	5
Liquid ratio (days)	25%	33.7	4	53.1	5
Weighted average rating			3.9		4.5

The corporation achieved a financial risk rating of '4' in the first three-quarters of the year and a rating of '5' in the final quarter - on Monitors' scale of 1 to 5 (a score of 1 being 'high-risk' and 5 'low-risk'). The corporation is forecast to maintain a 'low-risk' score of at least '4' for 2007/08.

Planned investment activity

The corporation's investment (in terms of capital expenditure) for 2006/07 is shown below. £5.2 million (2005/06: £7.6 million) was spent mainly on new medical equipment including a digital mammography unit for the imaging department, plus commencement of the modernisation and improvement of the existing wards and improvements to the boiler house. Also, the design and planning of the new children's building, a £4.8m scheme at Chesterfield Royal Hospital commenced with an estimated completion of July 2008. In addition, £61,000 (2005/06: £36,000) of charitable capital expenditure was donated to the corporation during the year from its charitable funds.

Capital investment - major schemes for the 2006/07 financial year	Total 2006/07 £000's
Boiler improvements	1,008
Ward upgrades (including medical gases)	877
New children's build	357
Spend to save schemes	353
Minor building schemes	1,024
Equipment	1,144
IT schemes	348
NHS capital expenditure	**5,111**
Donated assets	61
Total capital expenditure	**5,172**

Because the corporation is a NHS foundation trust, buildings used in the provision of healthcare are classed as 'protected' assets, whereas other buildings and all equipment are 'unprotected'. The table below shows the expenditure for each of these categories:

Capital investment analysis for the 2006/07 financial year	Total 2006/07 £000's
Protected asset investment	3,474
Unprotected asset investment (i.e. equipment including IT)	1,637
Donated capital investment	61
Total capital expenditure	**5,172**

Land interests
There were no significant differences between the carrying amount and market value of the corporation's holdings of land.

Accounting policies
Accounting policies are consistent with the prior year - with the exception of income recognition in relation to incomplete patient spells, which is now assessed to be material.

The corporation has to account for income during the year in relation to services actually provided. With respect to patient services, incomplete patient spells can occur when the treatment of patients has commenced, but income for the activity has not yet been received. This is called a partially completed spell. The corporation must accrue the income for the activity they have done up to March 31 2007, but only if it is material to the corporation. This has been assessed and, unlike in previous years, was judged to be material to the financial statements for the year. Therefore, income has been included in financial statements for the current period in respect of incomplete spells.

Investments
The corporation made no investments through joint ventures or subsidiary companies and no other financial investments were made. No financial assistance was given or received by the NHS foundation trust.

Private patient income
Under the corporation's terms of authorisation, the proportion of private patient income to the total patient related income should not exceed its 2002/03 proportion. The allowable percentage for the corporation was 0.2%. The private patient income from April 1 2006 to March 31 2007 was £125,000 (2005/06: £122,000) - compared to total patient related income of £126.9 million (2005/06: £120.6 million). This represents a proportion of 0.10% (2005/06: 0.10%). The corporation is therefore compliant with this obligation for both periods.

Value for money
The corporation has a record of implementing cost improvement programmes (CIP) designed to improve efficiency. In 2006/07 the corporation was required to deliver a recurrent 5% efficiency plus a further 2.5% deflation of tariff. This has been achieved from a combination of directorate specific proposals plus implementing a centralised workstream approach to deliver a 10% saving over three years from 2006/07 to 2008/09. In 2006/07 the required 5%, has been supported non-recurrently by a proportion of the PbR gain, pending realisation of the recurrent workstream savings. In total £5.890 million (2005/06: £1.812 million) was achieved:

Description	2006/07 (12 months) £000s	2005/06 (12 months) £000s
Productivity increases	539	1,439
Procurement savings	752	204
Income generation	0	47
Savings on reserves	292	122
Workforce reviews	1594	0
Non-recurrent PbR gain	2713	0
Total	**5890**	**1,812**

The economy, efficiency and effectiveness of the use of resources are monitored regularly and detailed reports are supplied to the board of directors, hospital management committee and made available to the council of governors and joint consultative committee. Internal systems and procedures are in place to ensure that value for money remains a primary aim of the corporation. More details can be found on the 'Statement of Internal Control' included in Appendix A.

Charitable funds

All charitable fund expenditure is classed as granted to the hospital from its charities. Items over £5,000 are capitalised and included in the corporation's closing fixed assets on its balance sheet. The charitable fund annual report and accounts 2006/07 is published separately and is available from the corporation on request.

Going concern

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adapt the going concern basis in preparing the accounts.

……..

Eric Morton
Chief Executive
6 June 2007

Disclosures on corporate governance arrangements

Board of Directors - April 2006 to March 2007
An effective board of directors should head every NHS foundation trust, since the board is collectively responsible for the exercise of the powers and performance of the NHS foundation trust.

The board of directors has a business focus - developing, monitoring and delivering plans. The board members have collective responsibility for all aspects of the performance of the corporation including financial performance, clinical and service quality, management and governance.

The board consists of a chairman, deputy chair/senior independent director, chief executive, non-executive directors and executive directors. Its role includes:

- Setting targets, monitoring performance and ensuring the resources are used in the most appropriate way.
- Providing active leadership of the NHS foundation trust within a framework of prudent and effective controls, which enables risk to be assessed and managed.
- Making sure the NHS foundation trust performs in the best interests of the public, within legal and statutory requirements.
- Responsibility for ensuring the quality and safety of healthcare services, education, training and research delivered by the NHS foundation trust and applying the principles and standards of clinical governance set out by the Department of Health, the Healthcare Commission and other relevant NHS bodies
- Being accountable for the services provided and how public funds are used, and exercising those functions effectively, efficiently and economically.
- Making sure the NHS foundation trust complies with its 'terms of authorisation' (set by Monitor (the Independent Regulator of NHS Foundation Trusts))
- Having specific duties relating to audit, remuneration, clinical governance, charitable funds and risk assurance.
- Deciding the corporation's strategic direction - in consultation with the council of governors.
- Setting the corporation's values and standards of conduct and ensure that its obligations to its members, patients and other stakeholders are understood and met.
- Working in partnership with the council of governors.

All members of the board of directors have joint responsibility for every decision of the board of directors regardless of their individual skills or status.

Operation of the board of directors and council of governors
The board of directors and the council of governors operate as two individual forums working in partnership with each other. The council of governor meets every six to eight weeks and twice a year the council of governors and the board of directors hold a joint meeting to discuss strategy. The board of directors meets monthly (except in August and December).

The role and responsibilities of the council of governors are carried out in accordance with the constitution and the corporation's authorisation. Further detail is provided later in the report.

The board of directors manages the corporation; the board exercises all the powers of the corporation subject to any contrary provisions of the 2006 Act as given effect by the constitution. The board of director's roles and responsibilities are set out above.

Board evaluation

The board has undergone significant change over the last 12 months. In April 2006 the council of governors appointed the new chairman and in August/September 2006 there was the appointment of four new non-executive directors. Finally in September, a non-executive director resigned to become chairman of the newly formed Derbyshire County Primary Care Trust (PCT) and a further new non-executive director was appointed in November.

The board has concentrated on understanding the business of corporation and evaluating its current position. The board has built on the self-assessment undertaken in September 2005 and spent some time assessing the collective skills brought to the board by the new non-executive directors.

The appraisal system

(a) The non-executive director

Each non-executive director is required to complete a questionnaire prior to an appraisal meeting with the chairman. At the appraisal meeting the chairman and non-executive director will complete a report. The chairman will present this report to the council of governor's nominations committee. The committee will consider the report and make recommendations for approval by the full council of governors (in closed session).

(b) The chairman

Each member of the council of governors and board of directors is requested to complete an anonymous questionnaire. The questionnaire is returned to an independent third party for collation into a draft report. This report is considered by the senior independent director and the vice-chairman of the council of governors and a meeting is held with the chairman. The final report is presented to the nominations committee for consideration and recommendations are put forward to the full council of governors (in closed session).

The balance, completeness and appropriateness of the membership of the board.

The board of directors has assured itself that its membership is balanced, complete and appropriate. In 2005 the board of directors and council of governors identified the key skills required by board members. During the recruitment of new non-executive directors in 2006, those skill requirements were considered.

Since the recruitment of the non-executive directors the board of directors has undertaken several strategy sessions assessing the collective skills of the board.

Composition of the board of directors

The board of directors consists of the following:

(a) these non-executive directors
   (ii) a chairman;
   (iii) five non-executives (one of whom is nominated as the senior independent director and deputy chairman).

(b) these following executive directors
   (i) a chief executive, who is also the accountable officer;
   (ii) a director of finance and contracting;
   (iii) a medical director, who is a registered medical practitioner;
   (iv) a director of nursing, who is a registered nurse;
   (v) a corporate secretary, who acts as the secretary to the corporation and has responsibility for the personnel aspects of the human resources functions of the corporation.

The role of the senior independent director (SID)

The board of directors considers the views of the council of governors. There may be circumstances when the council of governors might be in disagreement with the board of directors and as a result of the chairman being the chairman for both the council of governors and the board of directors, he has a conflict of interest with regard to the issue. The corporation has nominated an independent non-executive director to act as the 'senior' non-executive director or senior independent director (SID). Governors are able to approach the SID to discuss problems and issues when 'normal' communication routes through the chairman have broken down. The board of directors appoints the SID for the term of office of the non-executive director. The SID attends the council of governor meetings regularly.

The role of the SID is to also undertake the appraisal of the chairman with the vice-chairman of the council of governors.

Chairman and non-executive directors appointment and termination

One role of the council of governors is to appoint and dismiss the chairman and non-executive directors. In line with the corporation's constitution, three-quarters of the council of governors has to approve any decision of this nature.

When a vacancy arises for a non-executive director or chairman the council of governors will form an appointments committee to consider candidates proposed by a specialised search agency. The agency will advertise the opportunities in the national media and undertake some local searches. The appointments committee undertake the interviewing of a selection of the candidate and make a recommendation of appointment and propose it to the full council of governors.

Following the successful appointment of a non-executive director/chairman the corporation tailors an induction programme to suit the individual.

Chief executive appointment and termination

Appointment of the chief executive is through an appointments committee consisting of the chairman and non-executive directors. The appointment is subject to the approval of the council of governors.

The removal of the chief executive requires a majority vote of the chairman and non-executive directors, and is not subject to approval of the council of governors.

Executive directors appointment and termination

Appointment of an executive director will be through a board nominations committee comprising the chairman, chief executive and the other non-executive directors.

A committee comprising the chairman, chief executive and other non-executive directors has the ability to remove an executive director from his post. A majority vote of the committee would be required.

Meetings with non-executive directors

The chairman holds a number of meetings with the non-executive director without the executive directors present. Meetings are held on an ad-hoc basis and are either group or one to one meetings.

The senior independent director holds an annual meeting with the non-executive directors without the chairman present as part of the annual appraisal system of the chairman's performance. Additionally, the senior independent director will meet with the non-executive directors on any other occasion without the chairman as is deemed appropriate.

Remuneration

NHS foundation trusts must disclose the remuneration paid to senior managers, that is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust'.

These disclosures are made in the annual accounts for the periods April 2006 to March 2007.

Remuneration of the chairman and non-executive directors
An important role of the council of governors is to consider the remuneration of the chairman and the non-executive directors. The council of governors has charged the council of governor's nominations committee to undertake this duty and make appropriate recommendations to the council of governors.

In 2006, the chairman and non-executive directors agreed they would not receive the annual uplift in line with other corporation staff. However, the council of governors did come to the view, in the 2005 review, that the remuneration for the chairman and non-executive directors should in general be uprated annually, with a periodic benchmarking review to ensure the levels of remuneration remain in line with comparable roles elsewhere.

Further details of the working of the remuneration committee are within the remuneration report on page 82 of the annual report.

Remuneration of the chief executive and executive directors

A remuneration committee determines the remuneration of the chief executive and executive directors

The membership of the committee during 2006/07 was as follows:

- Pam Liversidge - non-executive director and chairman of the committee
- Richard Gregory - chairman of the corporation
- Michael Hall - non-executive director, deputy chairman, senior independent director and chair of audit committee,
- John Raine - non-executive director (member until 30 September 2006).

The committee met in February 2007 to consider the remuneration of the chief executive and executive directors. Further details of the working of the remuneration committee are within the remuneration report on page 82 of the annual report.

Sub-committee of the board of directors
The board of directors has delegated decision-making authority to the remuneration committee, the audit committee, the charitable funds committee and the clinical governance committee. These committees are required to provide the board with written minutes of their proceedings.

Audit committee
This committee receives reports from internal and external auditors and undertakes detailed examination of financial and value-for-money reports received by the board of directors.

The committee's terms of reference are as follows:

- monitor the integrity of the financial statement of the corporation and any formal announcements relating to the corporation's financial performance;
- monitor governance, risk management and internal control;
- monitor the effectiveness of internal audit function;
- review and monitor external audit's independence and objectivity and the effectiveness of the audit process. Develop and implement policy on the employment of the external auditors to supply non-audit services;
- review of standing orders, financial instructions and scheme of delegation. Review of schedule of losses and compensation;
- review of the annual fraud report;
- provide assurance to the board of directors on a regular basis;
- report annually to the council of governors, identifying any matters in respect of which it considers that action or improvement is needed.

The committee meets four times a year at the end of each financial quarter. Each meeting considers the business that will enable the committee to provide assurance to the board of directors that systems and processes in operation within the corporation are functioning effectively.

The membership of the committee during 2006/07 was as follows:

- Michael Hall, non-executive, deputy chairman of the board of directors, senior independent director and chairman of the committee.
- Youself Taktak, non-executive director (member until August 31 2006)
- Pam Liversidge, non-executive director (member from September 1 2006)
- Deborah Fern, non-executive director (member from September 1 2006)

As part of its annual report the audit committee reviews the arrangements by which staff of the Chesterfield Royal NHS Foundation Trust raise issues of concern in confidence about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters. The review includes consideration of the proportionate and independent investigation of such matters and appropriate follow up actions.

The list of activities below shows some of the work the committee has undertaken during the year, it has:

- considered 23 internal audit reports and reviewed the recommendations associated with the reports;
- reviewed the progress against the work programme for internal and external audit and the counter fraud service;
- considered the annual accounts and associated documents and provided assurance to the board of directors;
- considered, reviewed and tested the corporate risk register and assurance framework and provided assurance to the board of directors;
- reviewed the standing orders, standing financial instructions and scheme of delegation and provided assurance to the board of directors as to their effectiveness;
- considered and approved various regular reports relating to financial management of the corporation;
- considered and approved various ad hoc reports about the governance of the corporation;
- considered and approved the corporations proposed approach to the Code of Governance published by Monitor;
- promoted the counter fraud service;
- maintained close links with the clinical governance committee;
- supported the governors in the appointment of external auditors;
- received the quarterly reports from Monitor;
- provided on going monitoring of the financial status of the corporation;
- addressed consultation documents such as the review of Monitor's compliance framework.

<u>Charitable funds committee</u>
This committee is responsible for making sure money donated to the hospital is spent wisely. The committee's terms of reference identify the following duties:

- receiving reports such as income and expenditure statements, reports on any irregularities in respect of fund-raising and audit reports;
- responsible for the formulation of the investment policies;
- receiving, reviewing and considering recommendations for the use of funds.

The membership of the committee during 2006/07 was as follows:

- Deborah Fern, non-executive director and chairman of the committee
- David Whitney, non-executive director
- Michael Hall, non-executive director (member of the committee until July 25 2006)
- John Raine, non-executive director (member of the committee until September 30 2006)
- Paul Briddock, director of finance and contracting

As a result of changes in membership in the committee, the year has been spent assessing the current expenditure proposals and reviewing charitable fund policies. Time has been spent strengthening the links between the committee and the operational directorates helping them to understand the policies and proposals in existence.

Clinical governance committee

This committee is responsible for monitoring clinical standards in the hospital. Its main duties are defined in its terms of reference and include:

- receiving clinical incidents and complaints;
- ensuring a strategic framework is developed in order to meet national, regional and local policy;
- receiving reports;
- ensuring that multiprofessional and multiagency work is further developed with partnership working;
- distribution and use of clinical information;
- guiding the development of key performance measures for clinical quality;
- developing a systematic approach to clinical effectiveness;
- proactively reviewing systems including the relationship between the clinical governance and the management processes;
- reviewing patient safety data and trends;
- monitoring directorate clinical governance;
- monitoring outcomes of clinical accreditations for example NHS Litigation Authority (NHSLA) clinical risk standards;
- ensuring multiprofessional learning and workforce is developed;
- monitoring the clinical aspects of the corporation's risk management strategy;
- promoting education in the corporation on a wide range of clinical governance issues;
- overseeing the planning and implementation of clinical audit and research;
- providing assurance to the board of directors that clinical systems and processes in operation within the corporation are functioning effectively.

The membership of the committee is in two parts, the core membership and the advisory group. The core membership fulfils the decision-making aspect of the committee and the advisory group supports the core in making those decisions.

Core group

- David Whitney, non-executive director and chairman of the committee (from August 31 2006)
- Richard Gregory, chairman of the corporation and member of the committee
- Yousef Taktak, non-executive director and chairman of the committee (until August 31 2006)
- Bill Lambert, medical director
- Ron Clarke, director of nursing

Advisory group:

- Gail Collins, cinical director, women's and children's directorate
- Jeff Glaves, consultant radiologist
- Kate Hoffman, clinical education adviser (until June 2006)
- Lesley Reilly, Senior Matron, medical specialties (from August 2006)

- Katherine Lendrum, consultant, accident and emergency
- Lisa Howlett, head of clinical governance
- Martin Shepherd, head of medicines management
- Maxine Simmons, head of education and workforce development
- Nichola Lawrence, deputy director of nursing (from November 2006)
- Rod Collin, clinical director, pathology directorate
- Sheharayer Asad, consultant orthopaedic surgeon
- Simon Dale, consultant anaesthetist
- Sue Frost, head of physiotherapy and occupational therapy
- Sue McDermott, deputy director of nursing and head of patient safety (until June 2006)
- Lesley Makin, head of patient safety
- Nick Everitt, consultant surgeon

During the year the clinical governance committee has overseen the following areas of action:

- The development of a single protocol for the management of pulmonary embolisms replacing two slightly different speciality-specific protocols.
- Changes to corporation's policy and processes in order to meet the requirements of the Human Tissue Act.
- The development of action plans as a result of reviews of patients' care following untoward incidents, near misses or inquests.
- The development of the patient and public involvement annual plan.
- Development of the blood transfusion policy to address concerns about the process in extreme emergencies.
- The development of corporation and directorate training plans.
- Changes to the process in e-booking and booked admissions following concerns raised about potential clinical risks associated with these processes.
- Introduction of a 'STOP' moment in theatres to reduce the risk of wrong-site surgery.
- Introduction of a process to ensure clinicians are notified of unexpected imaging results in a timely manner.
- Introduction of a process to address Monitor's requirements in relation to clinical quality.
- The review of recommendations from National Confidential Enquiries and the ongoing monitoring of the corporation's action plan as a result of these.
- The review of recommendations following the Healthcare Commission investigation into maternity services.
- A review of incident reporting by grade of staff to assure the corporation that staff from all grades and professions are reporting incidents.
- Review of the organisation-wide clinical risk register.
- Review performance in relation to infection control and cleanliness with regard to achieving the core Healthcare Commission standards.

In addition, the committee received the following reports:

- Medicines management annual report
- Library services annual report
- East Midlands breast screening programme annual report
- Infection control annual report
- The North Trent critical care audit report
- Maternity risk management strategy

Risk management

Chesterfield Royal Hospital NHS Foundation Trust is aware of the importance of managing risk properly and has taken the decision that the board of directors assumes responsibility for ensuring the corporation meets all its legal obligations and corporate objectives. Therefore the board reviews risks regularly through the various board reports.

Board of director biographies

Under section 17 and 19 of schedule 7 of the National Health Service Act 2006, the chairman, chief executive, executive and non-executive directors were appointed to the corporation's board of directors as follows:

Chairman: Richard Gregory
Initially appointed April 12 2006 to April 11 2009

Richard's board experience covers banking, media, regional development, higher education, innovation and the arts.

Currently he is a non-executive director of National Australia Group Europe Ltd which includes the roles of Yorkshire Bank chair, chair of the Yorkshire Bank Pension Trust, director of Clydesdale Bank PLC, and a member of the group's audit and risk committees.

He is also the senior non-executive director of Chesterfield based Imagesound PLC, chair of Yorkshire Science, a non-executive director of Sheffield University Enterprises Ltd, chair of the Science City York Stakeholder Board, and a non-executive director of Business in the Community Ltd.

He is a former chairman of Sheffield Hallam University and former deputy chairman of Yorkshire Forward. His executive career was in ITV, with Granada and Yorkshire Tyne Tees. He was managing director of Yorkshire TV from 1997 to 2002, the culmination of a 22-year career, which covered news, programme making, production and broadcasting.

Awarded the OBE in June 2004, Richard lives in Hope and is married with two grown up daughters. The family has lived in the Peak District for 30 years.

He has always relished combining private and public sector roles and is delighted to be working in the NHS and with his local district general hospital.

Deputy chairman and senior independent director (from November 29 2006)
Non-executive director: Michael Hall
Initially appointed July 5 2005 to July 4 2008

Originally from Manchester, Michael qualified as a chartered accountant in 1963 and has worked in most aspects of commercial financial management culminating in the position as financial director of an international group with a turnover of £200 million and 3000 employees.

Michael joined the University of Derby in November 1991. His role as deputy vice-chancellor encompassed the implementation of a commercial approach and attitude. Specific responsibilities included the various facilities provided in the institution to accommodate the learning process, for example: catering, facilities, including conferences, estates, finance, residences, reprographics and rooming.

Following his retirement in 2002, he was asked to serve as acting chief executive of Derby Cityscape creating the urban regeneration for the City of Derby. Subsequently, he was asked to chair Business Service East Midlands, an East Midlands development agency activity formed to review the existing business support arrangements for small and medium-sized enterprises, supported by business link.

During this time Michael was asked to chair the committee formed to explore the possibility of merging the boards of North and Southern Derbyshire chambers of commerce, and subsequently became the first president of the Derbyshire chamber of commerce, where he is still a member of the board, and has served on the national committee of the British chamber of commerce for the past three years.

Michael's other interests include foundation governor of Derby High School and the Anthony Gell School in Wirksworth, chairman of the Derbyshire strategic board for young enterprise and chairman of the Derbyshire community foundation.

Non-executive director: John Raine
Initially appointed to October 31 1998
Re-appointed November 1 2006 to October 30 2008
Resigned September 30 2006
John Raine was chief executive of Derbyshire County Council from 1988 to 1997. Before entering local government in 1973, he worked for 16 years in journalism and public relations and is a member of the chartered institute of public relations.

He was appointed as a non-executive director of the hospital trust board in 1998 and in recent years has followed interests in the fields of disability and criminal justice. He accepted a Department of Trade and Industry ministerial appointment in 1997 as chairman of the hearing aid council, which regulates private sector hearing aid dispensing and chaired the Derbyshire Association for the Blind from 1997 until 2004.

When the probation services were restructured in 2001, he was appointed by the Home Office as chair of the new Derbyshire Probation Board. In 2004, he was elected chairman of the association of probation boards, which is the employers' body for the probation service in England and Wales. In that capacity he represents the interests of the 42 probation boards in the current Home Office. He is involved in developing the new national offender management service (NOMS), also serving on a ministerial strategy board for NOMS.

John has lived in the Chesterfield area since joining a freelance news agency and then the Sheffield Star and Telegraph as a reporter in 1959.

John resigned as a non-executive director with effect from September 30 2006 to take up the role as chairman of the newly formed Derbyshire County Primary Care Trust (PCT).

Non-executive director: Dr Yousef Taktak
Initially appointed to October 31 2006
Resigned August 31 2006
After gaining a PhD in Immunology in 1989, Yousef worked with the World Health Organisation as a research fellow. He then joined the NHS as a clinical scientist and consultant at Addenbrookes hospital in Cambridge, where he was responsible for routine service and research within the clinical immunology department.

In 1993, after gaining his Cranfield MBA, he joined the cardiovascular medical devices industry as a scientific manager with Biocompatibles International plc, before moving on to setting up his own consultancy business.

In 1996, Yousef founded PolyBioMed Limited and managed the company as chief executive, developing and commercialising medical devices technologies. He sold the business to the Lombard Medical Group in 2001 and took up post as group director of business development.

More recently, he has set up and is a director of Avanticare Limited, a technology-based company involved in developing innovative and advanced wound care products. Yousef is also a director of Avantigenesis Limited, a drug delivery company, and a governor of Highfields School in Matlock.

Yousef resigned as a non-executive director on August 31 2006 to allow him time to concentrate on other business opportunities.

Non-executive director: Pam Liversidge
Appointed July 6 2006 to July 5 2009
Pam is the principal shareholder and managing director of an engineering company. She holds current appointments as a freeman of the company of cutlers, a guardian of the Sheffield assay office and a governor of Sheffield Hallam University. She is also a fellow of the Royal Society of Arts, a fellow of the Royal Academy of Engineers, a fellow of the City and Guilds Institute and a member of the council of the City and Guilds Institute.

A former director of Sheffield training and enterprise council and a former chairman of Sheffield business link, Pam is a mechanical engineer by background and was the first woman president of the Institution of Mechanical Engineers. She began her career in the steel industry in Sheffield and worked for several companies in senior engineering and managerial roles, including as a director of a public utility, before setting up her own business.

She lives in Bamford.

Non-executive director: David Whitney
Appointed August 1 2006 to July 31 2009
David is director of clinical management at Keele University, where he runs the clinical leadership programme. He is a visiting professor at Sheffield University, where he teaches on the master programmes in public health, is a business adviser for Cambian Healthcare and Educations, and a non-executive director of Westfield Contributory Health Scheme.

An NHS manager by background, David was a director of Trent Regional Health Authority from 1985 to 1990 and chief executive of Central Sheffield University Hospitals NHS Trust from 1990 to 2001.

He lives in Hathersage.

Non-executive director: Deborah Fern
Appointed September 1 2006 to August 31 2008
Deborah is an entrepreneur, who began her career working for Rolls Royce where she qualified as a chartered secretary and an accountant. She later founded and ran, for 15 years, a training company delivering government programmes primarily for disadvantaged and disaffected people - which she sold in February 2006. Deborah was a member of the Learning and Skills Council adult learning committee and Leicester board. Currently Deborah is a director of Derbyshire Association for the Blind, patron and chair of NSPCC Midlands fundraising board, is the Derbyshire regional chair for Coutts & Co, and also studying for a joint honours degree at Derby University.

Deborah lives in Darley Dale and is a member of the parochial church council for Darley Dale.

Non-executive director: Janet Birkin
Appointed November 2 2006 to November 1 2009
Janet began her career at Marks and Spencer where she worked for more than thirty years, ending her career as the company's regional head of human resources for the East Midlands. She was appointed last year as the chairman of Derbyshire Police Authority, having been a member of the Authority since 2001. She served as a County Councillor (1988 to 1992) and a member of the Derbyshire Probation Service management board (1993 to 1995). Janet was appointed as a trustee director of Marks and Spencer Pension Trust Ltd in 2006.

Janet lives in Chesterfield and is a JP.

Chief executive: Eric Morton
The chief executive, Eric Morton, came into post in December 2001, having previously been employed by the NHS trust as deputy chief executive and director of finance and corporate services since January 1993. He is a qualified accountant and a member of the Chartered Institute of Public Finance & Accountancy, and a fellow of the Chartered Association of Certified Accountants. He is past chairman of the Healthcare Financial Management Association, and current vice-chairman of Chesterfield College.

His professional accountancy training was completed with Doncaster Council, followed by various posts in several local authorities. He joined the National Health Service in 1987, as senior assistant regional treasurer with Trent Regional Health Authority. He moved to the Northern General Hospital in Sheffield as its finance director, steering it to Wave 1 NHS trust status. He became director of finance at North Derbyshire Health Authority in 1990, before transferring to the Chesterfield Royal Hospital three months before it became an NHS trust.

Director of nursing: Ron Clarke
Ron Clarke has also been a director since the former NHS Trust's beginning in 1993. After completing his professional training, Ron held several clinical posts before embarking on a management career. With his employment mainly in the Leeds area, Ron's previous management roles include that of patient service manager, and director of nursing and assistant general manager.

In his original role as director of nursing, Ron was responsible for professional leadership and advising on both nursing and clinical quality. He has since taken over joint responsibility with the medical director for the clinical standards and governance directorate, which leads on clinical governance, patient safety control of infection, research, patient involvement, education and training, and workforce planning and development.

Corporate secretary: Terry Alty
Terry Alty, previously the NHS trust's executive director of personnel and hospital services, was appointed in December 1993. He joined the NHS in 1984, after working in local government and education. He held posts at Trent Regional Health Authority in public health and policy development, and at North Derbyshire Health Authority in business planning, commissioning and contract management. He joined Chesterfield Royal Hospital as contracts manager in April 1993.

He is responsible for human resource strategy and employment, and for corporate governance and corporate management functions (secretary to the board and executive team).

Director of finance and contracting: Paul Briddock
Paul Briddock joined the trust in March 2003. He is a chartered accountant, having trained with Coopers and Lybrand, where he worked between 1990 and 1994, qualifying as an accountant in 1993.

Paul began his career in the NHS in 1994, joining Sheffield Children's Hospital NHS Trust to develop the trust's financial systems. Following a secondment to the role of senior finance manager at the Trent Regional Health Authority in 1996, he returned to the Children's to become deputy director of finance in 1997. Subsequently he became their director of finance from 1999 to 2003.

During his time at the Children's Hospital, Paul helped to set up the North Trent Children's Commissioning forum. He worked closely with commissioners to develop and complete a wide range of business cases, which resulted in a large investment in the trust's services and capital infrastructure.

Paul is responsible for the financial management of the corporation, and leads contract negotiations with commissioners, and capital planning for the organisation.

Medical director: Bill Lambert
Bill Lambert is a practising general surgeon, specialising in vascular surgery. He has been at the forefront of the establishment and successful operation of the trust's medical management and clinical directorate structure since his appointment as a consultant surgeon in 1984. He was one of the country's first clinical directors, appointed in theatres in 1986, and has continuously held medical management positions since then.

Bill became the trust's second medical director in 2000, and together with the director of nursing, is co-director of the clinical standards and governance directorate, which was established to integrate the research, clinical educational and workforce planning agendas across the medical, nursing and allied health professions. He is professionally accountable for clinical directors, chairs the clinical management team and is the corporation's Caldicott guardian.

The following attend the board in an advisory capacity:

Corporate director of planning and performance: Nikki Tucker
With over 21 years experience working in the hospital, Nikki Tucker is responsible for planning and performance. With additional responsibility for information and IT, together with patient access, corporate development and service improvement, she is also professionally accountable for the corporation's general managers.

Nikki was previously responsible for liaison and negotiation with GP fund holders when the trust operated in a 95% GP fund holding environment in the 1990s, and has since been continually involved in commissioning/contracting. In the late 1990s she undertook a radical overhaul in the management of the corporation's waiting lists, which resulted in a beacon status award for the hospital, and since that time she has been engaged in a variety of waiting list management reviews across the country. She led the corporation's participation in the national pilot for the 'Variations in Outpatient Performance Project', which has resulted in significant changes to the way outpatient services are booked, planned and delivered at the convenience of patients, not only in Chesterfield, but throughout the wider NHS, and more recently this has enabled the trust to become an early adopter for implementation of the national choose and book system.

Corporate director of allied clinical and facilities services: Andrew Jones
Andrew Jones has 29 years of NHS experience. Having been employed at the Royal for 15 years, he has responsibility for management of the estate and facilities services. In addition he takes the lead for the allied health professions and medicines management.

Andrew led the sale of the hospital laundry to a commercial contractor, the reorganisation of the patient meals service, through a 15-year partnership arrangement, and the commercial development of the hospital front entrance in the style of a 'shopping mall'. He also led a reorganisation of the management of the trust's estate service in the mid 1990's, which resulted in involvement with NHS Estates on a national basis. More recently he has led the successful application for the trust to become a pilot for introduction of local pharmacy services, the only acute trust in the country to have this facility.

Andrew is outgoing national chair of the Health Facilities Management Association (HeFMA), which represents facilities management throughout the NHS. He has previously been a member of Sheffield Hallam University's Facilities Management Graduate Centre.

Attendance by board members at meetings

	Board of Directors	**Audit Committee**	**Clinical Governance Committee**	**Remuneration Committee**	**Charitable Funds Committee**
Richard Gregory	Attended all board meetings	Not applicable	Attended all meetings from October 2006 (except January 2007)	Attended annual meeting	Attended Trustee meeting January 24 2007
Eric Morton	Attended all meetings (except July 25 2006)	Not applicable	Not applicable	Not applicable	Attended Trustee meeting January 24 2007
Terry Alty	Attended all meetings (except October 25 2006)	Attended all meetings except December 13 2006	Not applicable	Not applicable	Attended Trustee meeting January 24 2007
Bill Lambert	Attended all meetings	Not applicable	Attended all meetings	Not applicable	Attended Trustee meeting January 24 2007
Ron Clarke	Attended all meetings (except September 15 2006)	Not applicable	Attended all meetings	Not applicable	Attended Trustee meeting January 24 2007
Paul Briddock	Attended all meetings	Attended all meetings	Not applicable	Not applicable	Attended all meetings
Michael Hall	Attended all meetings	Attended all meetings	Not applicable	Attended annual meeting	Attended July 25 2006 and Trustee meeting January 24 2007
Pam Liversidge	Attended all meetings from July 25 2006 (except October 25 2006)	Attended all meetings from July 25 2006 (except October 17 2006)	Not applicable	Attended annual meeting	Attended Trustee meeting January 24 2007
Deborah Fern	Attended all meetings from September 15 2006 (except January 24 2006)	Attended all meetings from October 17 2006	Not applicable	Not applicable	Attended November 5 2006 meeting (apologies sent to January 24 2007 Trustee meeting)
David Whitney	Attended all meetings from September 15 2006	Not applicable	Attended all meetings from November 2006	Not applicable	Attended November 5 2006 and Trustee meeting January 24 2007
Yousef Taktak	Attended all meetings. Resigned from the Board of Directors with effect from August 31 2006	Attended all meetings. Resigned with effect from August 31 2006	Attended all meetings until August 2006. Resigned with effect from August 31 2006	Not applicable	Not applicable
John Raine	Attended all meeting (except for April 26 2006). Resigned from the Board of Directors with effect from September 30 2006	Not applicable	Not applicable	Not applicable	Not applicable

Register of director's interests
The corporation holds a register listing any interests declared by members of the board of directors. They must disclose details of company directorships or other positions held, particularly if they involve companies or organisations likely to do business, or possibly seeking to do business with the corporation. The public can access the register at:

www.chesterfieldroyal.nhs.uk or by making a request in writing to:

The corporate secretary
Chesterfield Royal Hospital NHS Foundation Trust
Calow
Chesterfield S44 5BL

or by e-mailing: communications@chesterfieldroyal.nhs.uk

At March 31 2007, the board of directors had declared these interests:

1. Public limited companies (PLCs) (with the exception of those of dormant companies):

Richard Gregory, chairman
Non-executive director, National Australia Group Europe Ltd
Non-executive director, Clydesdale Bank PLC: Chairman, Yorkshire Bank
Non-executive director, Sheffield University Enterprises
Non-executive director, Imagesound PLC
Director, Richard Gregory Consulting Ltd
Non-Executive Director, Business in the Community Ltd
Chairman, Yorkshire Science

John Raine, non-executive director (April 1 2006 to September 30 2006)
Chairman, Derbyshire Probation Board (Ministerial Appointment)

Yousef Taktak, non-executive director (April 1 2006 to October 31 2006)
Director, Avanticare Ltd UK
Director, Biointermed Ltd, Ireland

Michael Hall, non-executive director, deputy chairman and senior independent director
Chairman, ASIST Derbyshire Ltd
Chairman, Construction Cosmetics Ltd
Chairman, Derby Playhouse Ltd
Chairman, Derbyshire Community Foundation
Trustee, Multi-Faith Centre, University of Derby
Chairman, Red Mill Industries
Managing Director, Selective Financial Services Ltd
Managing Director, Selective Financial Services (Investment) Company Ltd
Director, Derbyshire Chamber

Pam Liversidge, non-executive director
Managing director, Quest Investments Ltd
Quest Investments (properties) Ltd (Dormant company)
Director, Tool and Steel Products Ltd
Director, MeDis Diagnostics Ltd
Sheffield Hallam Property Company Ltd (2004) (Dormant company)
Wakeco (237) Ltd (2004) (Dormant company)
Director, Whirlow Grange Ltd (2005)
Rainbow Seed Fund (2006) (Dormant company)

David Whitney, non-executive director
Non-executive director, Westfield Contributory Health Scheme, Sheffield
Business adviser (part time), Cambian Healthcare and Education

Deborah Fern, non-executive director
Consultant, Fern Training and Development Ltd (concluded November 30 2006)
Sole director, Pathways (HR&D) Ltd
Regional chairman for Derbyshire Coutts & Co

Janet Birkin, non-executive director
Trustee director, Marks and Spencer Pensions Trust Limited

2. **Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS:**

John Raine, non-executive director (April 1 2006 to September 30 2006)
Chairman, National Association of Probation Boards (Elected Appointment)

Pam Liversidge, non-executive director
Director and shareholder MeDIS Diagnostics Ltd

David Whitney, non-executive director
Shannon and Whitney Leadership Associates

3. **Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS:**
The board of directors made no declarations under this section

4. **A position of authority in a charity or voluntary organisation in the field of health and social care:**

Richard Gregory, chairman
Janet Birkin, non–executive director
Michael Hall, non–executive director, deputy chairman and senior independent director Pam Liversidge, non–executive director
Eric Morton, chief executive
Ron Clarke, director of nursing
Terry Alty, corporate secretary
Trustees, Chesterfield Royal Hospital Charitable Trust Funds

David Whitney, non-executive director
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
Trustee, Neurocare Sheffield
Trustee, Westfield Charitable Trustees

John Raine, non-executive director (April 1 2006 to September 30 2006)
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
Trustee, Chesterfield Churches Housing Association

Bill Lambert, medical director
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
President, Midlands Association for Amputees and Friends (MAFF)

Yousef Taktak, non-executive director (April 1 2006 to October 31 2006)
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
Governor, Highfields School, Matlock

Paul Briddock, director of finance and contracting
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
Associate member of the governing body, All Saints School, Sheffield

Deborah Fern, non-executive director
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
Director, Derbyshire Association for the Blind
Honorary Council Member, NSPCC
Member of the National Appeals Board, NSPCC
Patron, NSPCC
Chairman, Midlands Appeal Board for FULL STOP campaign, NSPCC

5. **Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:**

Eric Morton, chief executive
Vice-Chair, Chesterfield College

John Raine, non-executive director (April 1 2006 to September 30 2006)
Director, Derbyshire Association for the Blind

Paul Briddock, director of finance and contracting
Member, Independent Panel for Members' Allowances Bolsover District Council

Michael Hall, non-executive director, deputy chairman, senior independent director
Member. Derbyshire Learning and Skills Council

David Whitney, non-executive director
Keele University Centre for Health Planning and Management

6. **Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks:**

Richard Gregory, chairman
Non-executive director, Clydesdale Bank PLC

Eric Morton, chief executive
Vice-chair, Chesterfield College

Michael Hall, non-executive director
Member, Derbyshire Learning and Skills Council

Paul Briddock, director of finance and contracting
Member, Independent Panel for Members' Allowances Bolsover District Council

Pam Liversidge, non-executive director
Chairman, Local Area South Yorkshire FSC, Yorkshire Bank
Member, governing council, City and Guilds Institute

David Whitney, non-executive director
Sheffield Centre for Health and Related Research (SCHARR – University of Sheffield)
Member, External Prioritisation Panel, National Patient Safety Agency
Former non-executive director, High Peak and Dales PCT (Resigned July 31 2006)
Reviewer, Healthcare Commission
Project director, Sheffield PCT (concluded October 1 2006)

Resolutions of disputes between the board of directors and the council of governors
The board of directors promotes effective communications between the council of governors and the board of directors.

The chairman of the corporation also acts as chairman the council of governors. The chairman's position is unique and allows him to be able to have an understanding of a particular issue expressed by the council of governors. Where a dispute between the council of governors and the board of directors occurs, in the first instance the chairman of the corporation would endeavour to resolve the dispute.

Should the chairman not be willing or able to resolve the dispute the senior independent director and the vice-chairman of the council of governors would jointly attempt to resolve the dispute.

Should the senior independent director and the vice chairman of the council of governors not be able to resolve the dispute, the board of directors, pursuant to section 15(2) of Schedule 7 of the 2006 Act, will decide the disputed matter.

The operation of the board of directors and council of governors including high-level statement of decisions taken by each.
The board of directors and council of governors recognises the importance of the operational relationship of both forums. The opinion of the council of governors is sought by the board of directors on all strategic issues considered by the corporation. The governors are invited to discuss issues in detail at the council of governors meetings and advise the chairman of their views. The chairman ensures their views are considered at the board of directors meeting as part of the decision making process.

As part of the process of working together the council of governor and the board of director meet jointly twice a year. The agendas developed for those meetings reflect the issues both forums need to discuss. The joint discussion ensures the board of directors has a full appreciation of the views of the council of governors and the community they represent and the council of governors has an opportunity to understand the reasons and thoughts of the board of directors.

Code of Governance compliance
Monitor published the Code of Governance at the end of October 2006. The code was released on a 'comply or explain' basis. The corporation reviewed its governance arrangements to establish in which areas it complied and in which areas it was appropriate to explain. The corporation complies with the Code in all areas except the following:

Requirement	**The corporation has elected not to comply with this requirement**
C.2.1 Approval by the board of governors of the appointment of a chief executive should be a subject of the first general meeting after the appointment by a committee of the chairman and non-executive directors. Re-appointment by the non-executive directors followed by re-approval by the board of governors thereafter should be made at intervals of no more than five years. All other executive directors should be appointed by a committee of the chief executive, the chairman and non-executive directors and subject to re-appointment at intervals of no more than five years	**Explanation** The chief executive and executive directors have their performance reviewed on an annual basis by the remuneration/nominations committee as part of the annual evaluation appraisal system. The remuneration committee considered the issue of five-year contracts and took into account that executive directors hold substantive contracts and are not subject to reappointment at five-year periods for the following reasons: a) Executive directors are subject to regular review of performance and existing procedures allow for appointment to be terminated if the performance is not satisfactory without the need for formal re appointment. b) The scope for refreshing the board exists as executive director posts turnover. The board has the option of restructuring the executive directors responsibilities through organisation change in accordance with local human resource policies and procedures. c) Fixed term appointment will create a short-term focus on the part of the executive directors, which in turn will create divergence between managerial and clinical perspective and could be detrimental to the engagement of clinicians, which is vital to the success of any foundation trust. **The corporation has elected not to comply with this requirement**

C2.2 Non-executive directors may serve longer than nine years (e.g. three three-year terms), subject to annual re-election. Serving more than nine years could be relevant to the determination of a non-executive director's independence (as set out in provision A.3.1).	**Explanation** So ensuring compliance with the Constitution no non-executive director should have more than two re appointments or serve more than three terms for a maximum of three years each because of the need to maintain independence and refresh the skill set of the non-executive director. We do not intend to extend appointment beyond nine years on the basis of annual reappointment. **The corporation has elected not to comply with this requirement**
Main Principle All directors and elected governors should be submitted for re-appointment or re-election at regular intervals. The board of directors should ensure planned and progressive refreshing of the board of directors.	**Explanation** The chief executive and executive directors have their performance reviewed on an annual basis by the remuneration/nominations committee as part of the annual evaluation appraisal system. The remuneration committee considered the issue of five-year contracts and took into account that executive directors hold substantive contracts and are not subject to reappointment at five-year periods for the following reasons: a) Executive directors are subject to regular review of performance and existing procedures allow for appointment to be terminated if the performance is not satisfactory without the need for formal re appointment. b) The scope for refreshing the board exists as executive director posts turnover. The board has the option of restructuring the executive directors responsibilities through organisation change in accordance with local human resource policies and procedures. c) Fixed term appointment will create a short-term focus on the part of the executive directors, which in turn will create divergence between managerial and clinical perspective and could be detrimental to the engagement of clinicians, which is vital to the success of any foundation trust. **The corporation has elected not to comply with this requirement**
E1.1 Any performance-related elements of the remuneration of executive directors should be designed to align their interests with those of patients, service users and taxpayers and to give these directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the remuneration committee should follow the following provisions: (i) The remuneration committee should consider whether the directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match the long term interests of the public. Upper limits should be set and disclosed. (ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS foundation trust. Consideration should be given to criteria, which reflect the performance of the NHS foundation trust relative to a group of comparator trusts in some key indicators. (iii) In general, only basic salary should be pensionable.	**Explanation** The remuneration committee considered the introduction of performance related and pay element to the executive remuneration. It was agreed it should not be introduced because it could substantially undermine the ability to achieve targets and standards. This is because the commitment to achieve targets and standards has been gained on the basis of the benefits for the organisation and patient services. This commitment will be at risk if PRP is introduced. The process of review of performance of executive directors provides a more than adequate approach for dealing with under performance with the possibility of terminating the employment if unsatisfactory performance persists. **The corporation has elected not to comply with this requirement**

Insurance cover

The corporation has arranged appropriate insurance to cover the risk of legal action against its directors. The corporation has purchased directors and officers liability insurance, which supplements the directors and officers liability insurance acquired from the NHS Litigation Authority (NHSLA).

Code of conduct

The board of directors operates a code of conduct that builds on the values of the corporation and reflects the high standards of respect, fairness dignity and individual need. The board of directors follows the policy of openness, integrity and transparency in its proceedings and decision-making wherever possible and has clear guidance a potential conflict of interest occurs how that should be dealt with.

Related party transaction
Under Financial Reporting 8 "Related Party Transactions", the corporation is required to disclose, in the annual accounts, any material transactions between the NHS foundation trust and members of the board, members of the key management staff or parties related to them.

Any such disclosures can be found in the annual accounts for the period April 2006 to March 2007.

Council of Governors
The council of governors (CoG) roles and responsibilities are laid out in the constitution. The CoG met eight times last year to discuss and comment on a number of aspects of the functioning of the corporation.

The CoG's prime role is to represent the local community and other stakeholders in the stewardship of the corporation. It has a right to be consulted on the corporation's strategies and plans and any matter of significance affecting the corporation or the services it provides.

The CoG is specifically responsible for the:
- appointment and removal of the chairman and other non-executive directors.
- approval of the appointment of the chief executive.
- appointment and removal of the auditors.

The CoG will consider and receive:
- the annual accounts, auditors' report and annual report.
- views from staff and community members on matters of significance affecting the corporation or the services it provides.

Every NHS foundation trust has a board of governors, which is responsible for representing the interests of NHS foundation trust members, and partner organisations in the local health economy.

The corporation has been working with its local community to embrace the change; and as a public benefit corporation it is now accountable to the local people and staff who have registered for membership and to those elected to seats on the CoG.

The governors on the council act in the best interest of the NHS foundation trust and adhere to the values and code of conduct of the corporation.

The council of governors holds the board of directors to account for the performance of the corporation.

The governors provide information on the corporation, its vision and its performance to the constituencies and the stakeholder organisations that either elected or appointed them.

During the year a great deal of consideration has been given to the effectiveness of the council. As a result the council of governors now receive details of significant projects and strategies at the meetings before the discussion is held at the board of directors meeting. This ensures that the comments of the council of governors are taken into account when the board is making a decision.

Elections
The corporation's council of governors was originally elected in November 2004, in preparation for the NHS foundation trust's authorisation on January 1 2005. Elections were hosted by Electoral Reform Services (ERS) to ensure they were independent and impartial. At that time around 5,500 community and 3,100 staff members of the foundation trust had the opportunity to firstly nominate themselves to become a governor if they so wished, and then to vote for the governors they wanted to represent them.

Terms of office were also allocated by Electoral Reform Services (ERS). Staggered appointments were made in the first-ever elections to establish a rolling programme for public governor appointments.

In November 2006, ERS hosted the corporation's third elections in three constituency areas.

Seats were vacant in the following areas:

- Three in Chesterfield
- One in Bolsover and
- Two in North East Derbyshire.

An election was also held for an additional seat in the Derbyshire Dales and North Amber Valley constituency, following a change to the corporation's constitution. This increased the number of public governors on the council from 16 to 17.

The Council

The CoG works with the board of directors in an advisory capacity, bringing the views of staff and local people forward, and helping to shape the corporation's future. Their role includes:

- Representing the interests and views of local people.
- Regularly feeding back information about the corporation, its visions and its performance to the community they represent.
- Selecting and appointing non-executive directors and the chairman of the corporation.
- Appointing the corporation's auditors.
- Attending meetings of the CoG.
- Receiving an annual report from the board of directors.
- Monitoring performance against the corporation's service development strategy and other targets.
- Advising the board of directors on their strategic plans.
- Making sure the strategic direction of the corporation is consistent with its terms of authorisation as agreed by Monitor (The Independent Regulator of NHS Foundation Trusts).
- Being consulted on any changes to the corporation's constitution.
- Agreeing the chairman and non-executive directors' remuneration (pay).
- Providing representatives to serve on specific groups and committees.
- Working in partnership with the board of directors.
- Inform Monitor if the corporation is at risk of breaching its terms of authorisation, if the concerns cannot be resolved within the corporation.

The CoG reviewed its structure and composition during the year and adjusted the governor membership to reflect the reconfiguration of the Strategic Health Authority and Primary Care Trust. They also agreed to add a further public governor from the Amber Valley.

The CoG at Chesterfield Royal Hospital NHS Foundation Trust currently has 29 governors (one seat is vacant for the voluntary sector; they are currently in the process of identifying an individual):

Public governors - 17 elected
Staff governors - four elected
Partner governors - eight appointed

- one from the Primary Care Trust
- three from the local authorities
- two from local universities
- two from the patients forum, self-help forum or local voluntary groups

Following elections in November 2006, there have been some changes to public governors representation in three of the corporation's constituencies. These are shown on page 57.

Our governors - Public governors

There are five constituencies represented by 17 elected public governors:

Governor	Elections	Appointed from	Initial Term	Term of office ends
Bolsover constituency				
Keith Bowman (Resigned 30 November 2006)	2004	January 1 2005	Two years	December 31 2006
Kate Caulfield	2006	January 1 2007	Three years	December 31 2009
Vanessa Holleley-Wood	2004	January 1 2005	Three years	December 31 2007
John Jeffrey	2005	January 1 2006	Three years	December 31 2008
Chesterfield constituency				
Aileen Dawson-Pilling	2006	January 1 2006	Three years	December 31 2009
Dr Chris Day	2004	January 1 2005	Three years	December 31 2007
Mererid Edwards	2004	January 1 2005	Two years	December 31 2006
Mererid Edwards (re-elected)	2006	January 1 2007	Three years	December 31 2009
Terry Gilby	2005	January 1 2006	Three years	December 31 2008
Ruth Grice	2004	January 1 2005	Two years	December 31 2006**
Janet Portman	2005	January 1 2006	Three years	December 31 2008
Mick Portman	2006	January 1 2007	Three years	December 31 2009
Sheila Smith	2004	January 1 2005	Three years	December 31 2007
John Webber	2004	March 2 2005*	Two years	December 31 2006**

*Appointed following governor resignation

North East Derbyshire constituency				
Bernard Everett	2006	January 1 2007	Three years	December 31 2009
Ruth Francis (Resigned 30 June 2006)	2004	January 1 2005	Two years	December 31 2006
Bimal Ghosh-Dastidar	2005	January 1 2006	Three years	December 31 2008
Barry Jex	2004	January 1 2005	Three years	December 31 2007
Ralph Milne (Resigned 31 August 2006)	2004	January 1 2005	Three years	December 31 2007
Joyce Newton	2006	January 1 2007	Three years	December 31 2009
Derbyshire Dales constituency				
Pamela Wildgoose	2004	January 1 2005	Three years	December 31 2007
Peter Woolhouse	2006	January 1 2007	Three years	December 31 2009
High Peak constituency				
Pauline Fisher	2004	January 1 2005	Three years	December 31 2007

** Stood for re-election in 2006, but was not re-appointed

Brief descriptions of public constituency can be found in the Membership section of this report.

Staff governors

There are four staff classes. The governors are:

Medical and dental class	***Appointment term***
Dr Philip Rayner	3 years until December 31 2007

Nursing and midwifery class	***Appointment term***
Eileen Mallender	3 years until December 31 2007

Allied health professionals, pharmacists and scientists class	***Appointment term***
David Allen (Retired)	3 years until December 31 2007
Michael Edwards*	3 years until December 31 2009

All other staff class	***Appointment term***
Philip Cousins	3 years until December 31 2007

* Following the retirement of David Allen, staff elections for this class were held in February 2007. Michael Edwards was appointed to the vacant seat and the election was uncontested.

Partner governors

There have been a number of changes to the partner governors during the year; they are identified in the table below.

Primary Care Trust (PCT)	***Appointment term***
Dr David Collins (Dr Collins resigned his seat on April 11 2006)	3 year term until December 31 2007
Dr David Black (Dr Black resigned his seat on September 30 2006)	3 year term until December 31 2007
Maggie Boyd appointed January 4 2007	Balance of the three year term until December 31 2007

Local Authority governors (appointments co-ordinated by the Derbyshire Local Government Association)	***Appointment term***
Councillor John Willams (Retired December 31 2006)	3 years until December 31 2007
Councillor Eion Watts	3 years until December 31 2007
Councillor Carol Walker	3 years until December 31 2007
Councillor David Allen	3 years until December 31 2009

Strategic Health Authority governors (appointed in accordance with a process agreed with the former Chesterfield and North Derbyshire Royal Hospital NHS Trust)	***Appointment term***
Mr Robert Waterhouse (Resigned September 27 2006) Within the reconfiguration the Council of Governors agreed that the new strategic health authority would not have a seat on the council.	3 years until December 31 2007

Education governors (appointed by the Universities of Sheffield and Derby appointed in accordance with a process agreed with the former Chesterfield and North Derbyshire Royal Hospital NHS Trust)	***Appointment term***
Professor Susan Read (Retired on October 31 2006)	3 years until December 31 2007
Anne Peat appointed November 28 2006	Balance of three year term until December 31 2007
Aileen Hammersley	3 years until December 31 2007
Voluntary sector governors (appointed by representatives for the Patient's Forum, Self-Help Forum, League of Friends, and North Derbyshire Voluntary Action)	
Rosemary Parkyn (Resigned from her seat July 31 2006) The seat remains vacant	3 years until December 312007
Joyce Cupitt	3 years until December 31 2007

Attendance at the council of governors meeting during the year April 2006 to March 2007
During the year a record is kept of the attendance at council of governor meetings. Below is the table showing, which Governors have attended during the year.

Each year the nominations committee review attendance on behalf of the full council of governors and take appropriate action to address any concerns about attendance.

	12/04/06	22/05/06	05/07/06	27/09/06	02/11/07	12/12/06	17/01/07	07/03/07	**Total**
Dave Allen, staff governor	1	1	1	1	0	0	Retired 31/12/06		4
David Allen, appointed governor	Appointed following the retirement of John Williams							1	1
David Black, partner governor	0	0	1	0	Resigned 30/09/06				1
Keith Bowman, public governor	1	0	1	0	0	Resigned 30/11/06			2
Maggie Boyd, partner governor	Appointed following resignation of David Black						0	1	1
Kate Caulfield, partner governor	Appointed as a governor at 2006 elections						0	1	1
David Collins, partner governor	0	Resigned 11/04/06							0
Phil Cousins, staff governor	1	1	1	1	1	1	1	1	8
Joyce Cupitt, partner governor	1	1	0	1	1	1	1	1	7
Aileen Dawson-Pilling, public governor	Appointed as a governor at 2006 elections						1	0	1
Chris Day, public governor	1	1	0	1	1	1	1	1	7
Mererid Edwards, public governor	0	0	1	1	0	1	1	0	4
Mick Edwards, staff governor	Appointed in staff election in February 2007							1	1
Bernard Everett, public governor	Appointed as a governor at 2006 elections						1	1	2
Pauline Fisher, public governor	0	0	1	1	1	1	0	1	5
Ruth Francis, public governor	0	0	Resigned 30/06/06						0
Bimal Ghosh-Dastidar, public governor	1	1	0	1	1	0	1	1	6
Terry Gilby, public governor	1	1	0	0	1	0	1	1	5
Ruth Grice, public governor	0	1	0	0	1	0	Not reappointed		2
Aileen Hammersley, partner governor	1	1	0	1	1	0	0	1	5
Vanessa Holleley-Wood, public governor	1	0	1	0	1	0	1	1	5
Barry Jex, public governor	1	1	1	0	1	1	1	1	7
John Jeffery, public governor	1	0	1	1	1	1	1	1	7
Eileen Mallender, staff governor	1	1	0	1	1	1	1	0	6
Ralph Milne, public governor	1	1	1	Resigned 31/08/06					3
Joyce Newton, public governor	Appointed as a governor at 2006 elections						1	0	1
Ros Parkyn, partner governor	0	0	1	Resigned 31/07/06					1
Anne Peat, appointed governor	Appointed following Susan Read's retirement					0	1	1	2
Janet Portman, public governor	1	1	1	1	1	1	0	1	7
Mick Portman, public governor	Appointed as a governor at 2006 elections						1	1	2
Philip Rayner, staff governor	1	1	1	1	0	1	1	1	7
Susan Read, partner governor	1	1	0	1	Retired 31/10/06				3
Shelia Smith, public governor	1	1	1	1	1	1	1	1	8
Carol Walker, partner governor	1	1	1	1	0	1	0	1	6
Bob Waterhouse, partner governor	1	1	0	0	Resigned 27/09/06				2
Eion Watts, partner governor	1	0	0	1	0	0	0	0	2
John Webber, public governor	0	1	0	0	0	0	Not reappointed		1
Pam Wildgoose, public governor	1	0	1	1	1	1	1	0	6
John Williams, partner governor	0	0	0	0	0	0	Retired 31/12/06		0
Peter Woolhouse, public governor	Appointed as a governor at 2006 elections						1	1	2

Register of governors' interests

The corporation holds a register listing any interests declared by members of the CoG. Governors must disclose details of company directorships or other positions held, particularly if they involve companies or organisations likely to do business, or possibly seeking to do business with the foundation trust. The public can access the register at: www.chesterfieldroyal.nhs.uk or by making a request in writing to:

The corporate secretary
Chesterfield Royal Hospital NHS Foundation Trust
Calow
Chesterfield S44 5BL

or by e-mailing: communications@chesterfieldroyal.nhs.uk

At March 31 2007, the Council of Governors had declared these interests:

1. **Directorships including non-executive directorships held in private companies or Public Limited Companies PLCs (with the exception of those of dormant companies):**

   Vanessa Holleley-Wood, public governor, Bolsover constituency
   Company secretary, Headtex Ltd, IT Consultants

   Barry Jex, public governor, North-East Derbyshire constituency
   Non-executive director, Restore South Yorkshire PLC

   Dr David Black, partner governor, primary care trust (governor until 30 September 2006)
   Director, Your Asia Holidays

   Ruth Grice, public governor, Chesterfield constituency (governor until 31 December 2006)
   Executive director, Lenard Cheshire (Business side)

2. **Ownership part-ownership or directorship of private companies business or consultancies likely or possibly seeking to do business with the NHS:**

   Vanessa Holleley-Wood, public governor, Bolsover constituency
   Company secretary, Headtex Ltd, IT Consultants

   Ralph Milne, public governor, North-East Derbyshire constituency (governor until 31 August 2006)
   Director, Ralph Milne Limited, Interim Management Services

   Dr David Collins, partner governor, primary care trust (governor until 30 April 2006)
   Partner, Dr Collins, Merriman and Emslie, Clowne Health Centre

   Councillor Carol Walker, partner governor, local authority
   1 per cent of Autochair limited

3. **Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS:**
   There were no declarations under this section

4. **A position of authority in a charity or voluntary organisation in the field of health and social care:**

   Pamela Wildgoose, public governor, Derbyshire Dales constituency
   Hon secretary, Matlock League of Hospital Friends

Mererid Edwards, public governor, Chesterfield constituency
Trustee, Grace Tebbutt House, Sheffield

Ruth Grice, public governor, Chesterfield public constituency (governor until December 31 2006)
Trustee, Leonard Cheshire

Terry Gilby, public governor, Chesterfield public constituency
Director, Ashgate Hospice

Rosemary Parkyn, partner governor, voluntary sector (governor until 31 July 2006)
Chair, Lymphoedema Support Group (Chesterfield and North Derbyshire)

Barry Jex, public governor, North East Derbyshire constituency
Trustee Fare Share, South Yorkshire

Bernard Everett, public governor, North East Derbyshire constituency
Volunteer, Ashover Social Care Scheme

5. Any connection with a voluntary or other organisation contracting for NHS services or commissioning NHS services:

David Allen, staff governor, allied health professionals, pharmacists and scientists (governor until December 31 2006)
Councillor, Derbyshire County Council

Keith Bowman, public governor, Bolsover constituency (governor until November 30 2006)
Councillor, Bolsover District Council

Vanessa Holleley-Wood, public governor, Bolsover constituency
Employee of Derbyshire County Primary Care Trust

Ruth Francis, public governor, North-East Derbyshire constituency (governor until June 20 2006)
Employee of North Eastern Derbyshire Primary Care Trust

Terry Gilby, public governor, Chesterfield constituency
Councillor, Chesterfield Borough Council

John Webber, **public governor, Chesterfield constituency (governor until December 31 2006)**
Governor, Chesterfield College

Robert Waterhouse, partner governor, Trent Strategic Health Authority (governor until September 27 2006)
Employee of Trent Strategic Health Authority

Rosemary Parkyn, partner governor, Voluntary (governor until July 31 2006)
Volunteer, Red Cross, Therapeutic Care

Dr David Black, partner governor, primary care trust (governor until September 30 2006)
Director of Public Health, Chesterfield PCT

Dr David Collins, partner governor, primary care trust (governor until April 30 2006)
Member of the Professional Advisory Committee, North Eastern Derbyshire Primary Care Trust

John Williams, partner governor, local authority (governor until December 31 2006)
Council Leader, Derbyshire County Council

Carol Walker, partner governor, local authority
Councillor, Derbyshire Dales District Council

Eion Watts, partner governor, local authority
Council Leader, Bolsover District Council

6. **Any connection with an organisation, entity or company considering entering into or having entered into a financial arrangement with the NHS foundation trust including but not limited to, lenders or banks:**

David Allen, staff governor, allied health professionals, pharmacists and scientists (governor until December 31 2006)
Councillor, Derbyshire County Council

Keith Bowman, public governor, Bolsover class of the public constituency (governor until November 30 2006)
Councillor, Bolsover District Council

Dr Christopher Day, public governor, Chesterfield class of the public constituency
Surveyor, Health Quality Service

Terry Gilby, public governor, chesterfield class of the public constituency
Councillor, Chesterfield Borough Council

Aileen Hammersley, partner governor, University of Derby
The Derby University has training links with the corporation

Professor Susan Read, partner governor, University of Sheffield (governor until October 31 2006)
The Sheffield University has training links with the corporation

Eion Watts, partner governor, local authority
Council Leader, Bolsover District Council

Carol Walker, partner governor, local authority
Councillor, Derbyshire Dales District Council

John Williams, partner governor, local authority (governor until December 31 2006)
Council Leader, Derbyshire County Council

Governor expenses
Governors are not remunerated, but are entitled to claim expenses for costs incurred while undertaking duties for the corporation as a governor, (i.e. travel expenses to attend the CoG meeting). The total amount of expenses claim during the year from April 1 2006 to March 31 2007 by governors was £1,095.38.

Related party transactions
Under Financial Reporting 8 "Related Party Transactions", the corporation is required to disclose, in the annual accounts, any material transactions between the NHS foundation trust and members of the CoG or parties related to them.

Any such disclosures can be found in the annual accounts for the period April 1 2006 to March 31 2007.

Other key committees
These committees also play a key role in the running of the council of governors and corporation:

Nominations Committee
The nominations committee has developed during the year. The function of the committee is to strengthen the governance of the CoG. The committee has been authorised by the CoG to undertaken a number of key tasks including:

- Overseeing the recruitment of non-executive directors via an appointments committee convened for the purpose;
- Conduct and manage the appraisals of the chairman, non-executive directors and CoG;
- Review and make recommendations to the CoG on the annual uprating of the remuneration of the chairman and non-executive directors;
- Oversee the periodic review of the remuneration packages for non-executive directors via a committee convened for the purpose;
- Consider and review the position of the governors in respect of any concerns relating to attendance, conduct or eligibility;
- Any other function as maybe determined by the CoG from time to time.

The nominations committee does not have decision-making powers, but does make recommendations to the CoG.

The nominations committee oversees the appointment of a non-executive director and chairman; a subcommittee of the CoG called an appointments committee would be formed to specifically undertake the appointments process. The appointments committee would receive candidate information proposed by a specialist recruitment agency. The agency will advertise the opportunities in the national media and undertook some local searches. The appointments committee will undertake the interviewing and selection of the candidate and make a recommendation to the full CoG for appointment by the full council. Following the successful appointment of a non-executive director/chairman the corporation designs and tailors an induction to suit the individual and he/she is provided with appropriate information.

The membership of the nominations committee is:
The chairman of the corporation;
Four public governors (one is the vice chairman of the CoG);
Two staff governors; and
Two partner governors.

The committee is expected to meet a minimum of four times a year to complete the delegated business.

The committee was formed in December 2006 and has agreed its terms of reference with the CoG and designed its work programme. The committee has met three times since its inception. At those meetings it has reviewed the design and recommended the appraisal system for the chairman, non-executive directors and CoG to the CoG; and secured approval from the CoG for the system. The committee has also considered the Code of Governance published by Monitor and recommended the action plan to the CoG.

Patient and public involvement committee (PPI committee)
In order to strengthen the corporation's PPI governance and recognise the special role and responsibility of the CoG in representing the local community a PPI committee was developed to encompass membership from the public governors, voluntary sector, education and partnership groups. The committee has made its first steps into becoming more integrated within the corporation and being directly involved in finding out what patients think. Initial work has included the following:

- Ward visits to talk to patients about their experience of the hospital
- Cleanliness checks within the hospital

- An audit to evaluate access to the hospital site
- Helping to shape medical staff education at a network level
- Monitoring feedback from patients to identify trends and appropriate actions
- Completed a commentary on the corporation with regard to the Healthcare Commission's - 'Standards for Better Health'
- Enhancing links with the PPI forum
- Examining patient experiences, patient journeys, meals, the environment and staff attitude
- Contributing to the site development strategy
- Looking at ways to interact with the corporation's membership
- Monitoring complaints

The objectives of the committee are to:

- Build a partnership between the corporation, patients and the public which is central to the modernisation of the health service. Patient and public involvement contributes to achieving the following objectives:
    - Strengthening accountability to local communities
    - Developing local health services which genuinely respond to patients and carers
    - A sense of ownership and trust
- Monitor the corporation's performance in meeting patient and public involvement responsibilities and to make recommendations to the corporation's PPI Review Group.

The membership of the committee is:

- Eight public governors (one public governor chairs the meeting);
- One voluntary sector governor;
- One education governor;
- One Primary Care Trust (PCT) governor;
- Chairman of the corporation.

The function of the committee is to:

- Be actively involved in the patient and public involvement agenda;
- Read briefing papers prior to meetings and updates distributed between meetings;
- Review and influence the corporation's strategy and development plan, and be consulted on changes and developments;
- Ensure that the CoG is updated on the PPI agenda including feedback from patients and the public, sharing good practice and action plans developed to improve local services;
- Review reports and action plans and scrutinise these to ensure appropriate action has been identified to support a patient centred approach;
- Where required, represent the CoG on related projects and initiatives e.g. environment checks, patient meals, standards for better health and staff education;
- Develop links with the Patient Advice and Liaison Service (PALS) and complaints department;
- Nominate one or more representatives to serve on the patient council set up by Sheffield University's medical school.

The committee focuses on:

- Food
- Cleanliness
- The environment
- Complaints and feedback, including the Patient Advice and Liaison Service (PALS)
- Site facilities, e.g. car parking, signposting
- 'Mystery shopping'
- All other aspects of customer service to patients and the public

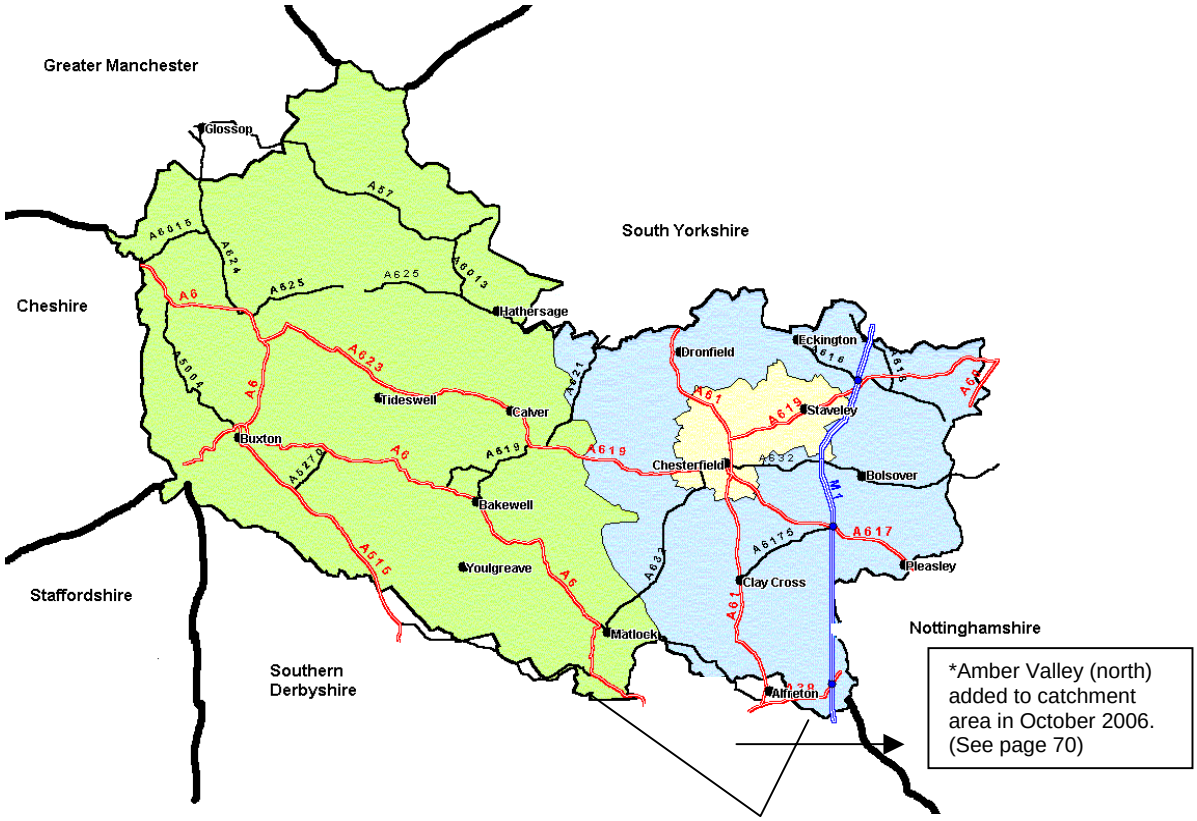
Membership

Engaging an active membership is still a relatively new way of working and a challenge for the corporation. We must involve staff, patients, healthcare partners, local people and others in the decisions we need to make, to improve and develop services and facilities.

As an NHS foundation trust staff, patient and public involvement is built-in to our corporate governance and decision-making processes. This is to help to decide what the local issues are, what the priorities should be and what's best for the community.

Public constituency - eligibility requirements

Those over the age of 16 who live in North Derbyshire (see map below) and the wards in the North Amber Valley* are eligible for community membership.



Our strategy is to build a broad membership, evenly spread geographically across our catchment area. We would wish our membership to reflect different age, gender, ethnicity and socio-economic groups. To meet this aim we have carried out a complete profiling of membership over the past twelve months (breakdowns on page 67).

Breakdown of community and staff membership

We have developed a membership strategy and since April 2004 our membership base has steadily grown. By March 31 2007 we had a combined membership (staff and community) of 13,176.

The breakdown for community and staff membership now and for the future looks like this:

Public constituency:

	2006/2007	2007/2008	2008/09
Members at year start (April 1)	10,189	10,063	11,063*
New members	554	1500*	500*
Member 'wastage' deceased/leaving area/resigning	680	500	300*
Members at year end (March 31)	**10,063**	**11,063***	**11,263***

Staff constituency:

	2006/2007	2007/2008	2008/09
Members at year start (April 1)	3,157	3,113	3,213*
New members	362	200*	200*
Members opting out/leaving employment/resigning	406	300*	350*
Members at year end (March 31)	**3,113**	**3,213***	**3,063***

Notes: *Estimated figures and projections
Chesterfield Royal Hospital NHS Foundation Trust does not operate a patient constituency.

Constituencies

Public constituency composition

The corporation's public constituency is defined as 'those people residing in specific wards of local authorities within the Derbyshire County Primary Care Trust area'. It represents a catchment population of more than 370,000. In October 2006, after a review of the constitution, the catchment was expanded to take in the north of the Amber Valley - as more than 300 residents from that area were registered as members, but were not entitled to voting rights etc.

Residents of the following local government administrative areas are eligible for membership of the NHS Foundation Trust:

Chesterfield Borough (all wards)
Bolsover District (all wards)
North East Derbyshire District (all wards)
Derbyshire Dales District (the wards of Bakewell, Bradwell, Calver, Chatsworth, Darley Dale, Hartington and Taddington, Hathersage and Eyam, Lathkill and Bradford, Litton and Longstone, Masson, Matlock All Saints, Matlock St Giles, Stanton, Tideswell and Winster and South Darley)
High Peak Borough (the wards of Barms, Blackbrook, Burbage, Buxton Central, Chapel East, Chapel West, Corbar, Cote Heath, Hayfield, Hope Valley, Limestone Peak, New Mills East, New Mills West, Sett, Stone Bench, Temple and Whaley Bridge)
Amber Valley Borough (the wards of Alfreton, Alport, Belper Central, Belper East, Belper North, Belper South, Crich, Heage and Ambergate, Ironville and Riddings, Ripley, Ripley and Marehay, Somercotes, Swanwick and Wingfield).

Co-terminosity

In the north of the county, the PCT has co-terminosity with several local authority boundaries:

- Chesterfield Borough Council
- North East Derbyshire District Council
- Bolsover District Council
- High Peak Borough Council
- Derbyshire Dales District Council
- Amber Valley Borough Council

Around 95% of the patients treated at Chesterfield Royal Hospital NHS Foundation Trust as inpatients, day cases and outpatients live in these areas

However residents in some council wards also look to adjacent acute providers for their routine care:

North East Derbyshire and Bolsover District - Sheffield, Worksop and Mansfield
Derbyshire Dales and Amber Valley - Southern Derbyshire and Mansfield
High Peak - Stockport, Manchester and Macclesfield.

Eligible population information and community membership make-up

Population

Derbyshire has a population of 743,000[2] and this is forecast to increase by 11.4% to 827,600 by 2028[3]. Each of the county's nine main towns has populations of over 20,000 (Belper, Buxton, Chesterfield, Dronfield, Glossop (eligible for community membership of Chesterfield Royal Hospital NHS Foundation Trust), Ilkeston, Long Eaton, Ripley and Swadlincote), with the largest concentration of population in the Chesterfield area. In contrast, some 16% of Derbyshire's population live in sparsely populated rural areas.

Only 1.5% of the population of Derbyshire classify themselves as being from ethnic minority backgrounds, a much smaller proportion than the 9.1% average for England as a whole. Of the districts, only Erewash, Chesterfield and South Derbyshire have sizeable ethnic minority populations. The largest of the three broad minority ethnic groups is the Indian group, which makes up 0.4% of the total population.

A very high proportion of Derbyshire's population was born in England (95.5%). This compares with 87.4% for England. 1.4% of the county's population was born outside the European Union.

[2] ONS 2003 mid year estimates.

[3] ONS-based 2003 Subnational Population Projections.

Source: Derbyshire County Council Race Equality Scheme 2005 - 2008

Community membership (as at February 2007)

Constituency	Total number of members	Total population of constituency*	Number eligible for membership* (aged 16 years and over)	Number of members as a percentage of eligible population
Bolsover	1,434	73,180	60,190	2.4
Chesterfield	4,418	99,980	82,710	5.3
Derbyshire Dales & North Amber Valley	1,178	69,760**	58,320**	2.0
High Peak	457	91,140	74,820	0.6
North East Derbyshire	2,691	97,290	81,300	3.3

*Source: Registrar General's Mid-Year Estimates 2005, Office of National Statistics (ONS)

**Figures only include Derbyshire Dales, as a breakdown to account for the North of Amber Valley only - ie those who are eligible for community membership of Chesterfield Royal Hospital NHS Foundation Trust is not available.

Age report

Derbyshire has an older age structure than England with 16.7% of the population being in the 65+ age group. There are fewer children in the 0-15 age group (19.6%) compared to the national average (20.2%). The proportion of population of working age is only marginally lower in Derbyshire (63.6%) than in England as a whole (63.9%). The age structure of Derbyshire's ethnic minority population is significantly younger with around one third (33.2%) under 15 years old, compared to just a fifth (19.5%) of white people.

Source: Derbyshire County Council Race Equality Scheme 2005 - 2008

Community membership by age (at February 2007)

Age	Number of members	Percentage of membership
Age 16 to 35:	829	8.1
Age 36 to 50:	1,986	20
Age 51 to 65:	3,191	31
Age 66 to 80:	2,664	26
Age 80+:	781	7.7
Age not stated:	729	7.2

Eligible population by age in each class of the constituency (at February 2007*)

Population age groups (ONS)	Eligible in Bolsover (approx)	Eligible in Chesterfield (approx)	Eligible in Derbyshire Dales/North Amber Valley** (approx)	Eligible in High Peak (approx)	Eligible in North East Derbyshire (approx)
15-34	16,810	23,210	12,750	20,270	20,420
35-49	16,640	22,630	15,720	22,100	21,390
50-64	14,060	19,140	15,850	17,870	21,120
65-79	9,210	12,660	10,030	10,430	13,560
80+	3,470	5,070	3,970	4,150	4,810
Total population of constituency eligible for membership	60,190	82,710	58,320	74,820	81,300
Total population of constituency	73,180	99,980	69,760	91,140	97,290

*Source: Registrar General's Mid-Year Estimates 2005, Office of National Statistics (ONS)

**Figures only include Derbyshire Dales as a breakdown to account for the North of Amber Valley only - ie those who are eligible for community membership of Chesterfield Royal Hospital NHS Foundation Trust is not available.

Actions to note: The Communications Department is currently working to restructure its age statistics into the same groupings used by the office of national statistics. This will allow a like for like comparison of the age of members in each of the constituency, against eligibility.

Ethnicity - membership at February 2007

Groupings	Bolsover	Chesterfield	Derbyshire Dale and North Amber Valley**	High Peak	North Derbyshire	Totals
Asian Bangladeshi		2				2
Asian Indian	2	9	1		4	16
Asian Other		5			2	7
Asian Pakistani		9			1	10
Black African	2	1			1	4
Black Carribean	2	20			2	24
Black Other		1		1	1	3
Mixed White and Asian	1	5			1	7
Mixed White and Black African					1	1
Mixed White and Black Carribean		1				1
Other Chinese		4	5			9
Other					2	2
Unknown	74	288	61	17	144	584
White British	1341	4016	1100	430	2507	9394
White Irish		21	6	6	16	59
White Other		36	5	3	9	55
Total	**1434**	**4418**	**1178**	**457**	**2691**	**10,178**

**Figures only include Derbyshire Dales as a breakdown to account for the North of Amber Valley only -
ie those who are eligible for community membership of Chesterfield Royal Hospital NHS Foundation Trust is not available.

Socio-economic factors

This year, using information provided by Derbyshire County Council we have drawn off 2001 census information for all constituency classes. This information is useful to gain an overall picture of each constituency in terms of targets for membership eg ethnic minority populations, single parents.

We have also used a consumer classification to look at our membership in greater detail. ACORN is a geodemographic tool used to identify and understand the UK population and the demand for products and services. It can be used to make informed decisions on where direct marketing campaigns will be most effective.

ACORN categorises all 1.9 million UK postcodes, which have been described using over 125 demographic statistics and and 287 lifestyle variables within England, Scotland, Wales and Northern Ireland.

For example, we know from the ACORN analysis of our basis membership in January 2006 we are lacking members in lower age categories and ethnic minority populations. In this recent profile, to address these two areas, it indicates we should target membership at postcode area with groups including:

Starting out
Aspiring singles
Blue collar roots
Post industrial families
Prosperous professionals

Staff constituency composition

The staff constituency comprises:

1. Permanent members of staff
2. Temporary members of staff who have been employed in any capacity by the organisation for a minimum continuous period of one year.

For directly employed staff membership operates on an opt-out basis - ie. all qualifying staff automatically members unless they seek to opt out.

All permanent contract holders are eligible for membership from the date they take up their employment.

The staff constituency is broken down into four classes:

1. Medical and dental
2. Nursing and midwifery
3. Allied health professionals, pharmacists and scientists
4. All other staff (including administrative and clerical staff, health care assistants etc).

By sub-dividing the staff constituency in this way, representation from each major staff grouping, and therefore a balanced contribution from staff members is achievable.

Breakdown of membership within constituencies:

Constituency	**Number of members (at April 1 2007)**
Medical and dental	211
Nursing and midwifery	1352
Allied health professionals, pharmacists and scientists	304
All other staff	1246
Total	**3113**
Class	**Membership %**
Medical and dental	6.8
Nursing and midwifery	43.4
Allied professionals	9.8
All other staff	40.0

Membership management
The corporation continues to purchase a service from its current external supplier.

This enables membership growth to be specifically targeted in line with ACORN profiling and census information. It is helping to ensure that the current membership remains engaged and active.

Staff membership is managed within the corporate membership function of communications. This is a cost-effective option and it has also allowed staff the option of transferring to community membership (if eligible) when they leave corporation employment.

Membership management is reviewed every two years - with the next review due in October 2007.

Membership growth
In the autumn of 2006, a major membership cleansing exercise was carried out. This meant that over the year 680 members were removed from the database because they were deceased, had resigned or had moved from the eligible catchment area. The corporation regards intense data cleansing as vital to ensure a true picture of membership always appears on the database. Even with the cleansing exercise completed, the corporation has already met its March 2008 community membership target of 10,000 members.

In terms of growth for the next two years, the corporation intends instead to look to consolidate the existing level of membership and concentrate activity on targeted campaigns - with small growth in numbers, but a better reflection of diversity. For example, looking to increase membership in the 16-25 and 35-50 age range categories. A 40,000-membership recruitment mailout will take place in May 2007 with a target growth of 1500 members mainly aimed in these age categories.

The corporation is also meeting with local ethnic minority groups and is running a recruitment campaign with schools, colleges, sports clubs etc - aimed at 16-35 year olds.

The growth in membership prompted the corporation, to consider the number and distribution of seats for public governors, and in tandem with this, to consider the "enfranchisement" of the people outside constituency areas in the Amber Valley who wish to be registered but have no voting rights under the current terms of the constitution.

As a result of this, the corporation made formal proposals to Monitor in October 2006 to enlarge the Derbyshire Dales class of the public constituency to take in the northern area of the Amber Valley. This, in turn, meant the enlarged class warranted a second seat on the Council of Governors, and the corporation's proposal included an increase in the number of seats for public governors from 16 to 17. This additional seat was filled with the new governor taking up their role on January 1 2007.

Building membership

The corporation continues to believe that membership should be 'voluntary' - to illustrate definite willing and interested participation. Our membership recruitment objectives are:

- To ensure all current and future staff working for the corporation (including contracted-out staff) are aware of staff membership, what it means for them and to encourage them not to decline membership
- To strive for the composition of community membership to reflect diversity - geographically spread across our proposed catchment area and reflecting age, gender, ethnicity and socio-economic groups
- To maintain accurate and informative databases of members to meet regulatory requirements and to provide a tool for membership development
- To define the right and responsibilities of membership to strengthen the partnership between the corporation and its members
- To recognise and use members as a valuable resource
- To provide targeted communications that offer timely, consistent and regular messages about membership
- To use a variety of methods to deliver the message about membership
- To establish a two-way feedback system, so that staff and community members have appropriate channels to feedback their ideas and concerns, raise issues, ask questions and find out more information

Methods and processes

These are some of the methods and processes the corporation has adopted as part of its annually reviewed membership strategy. This is not an exhaustive list - new strategies and ways of working need continual reassessment as the corporation's membership develops.

'Membership' in the methods and processes below refers to both staff and community - unless stated:

Membership communications and 'marketing'

- Procedure in place for dealing with applications for membership - includes, freepost address, freephone, email and weblink
- Produce applications forms and advertise membership through a variety of media and other mediums - within the hospital and its premises and via external sources
- Membership recruitment information
- Devise a communications pack for members and potential members
- Aim to place regular feature and news items with local media
- Produce regular and easily accessible information for staff
- Develop and maximise the potential of the corporation's intranet and website for information, communication and democratic purposes
- Clear brand established for membership materials
- Provide all new members with consistent and relevant information about the corporation and the role they will play as members
- Consider new formats of communications for ease of use and user appeal - video, CD, DVD
- Regular membership involvement in specific campaigns and projects
- Produce election information to help members understand the role of a governor and to encourage more members to stand

Membership diversity

- Distribute membership information to a wide variety of public areas - GP surgeries, pharmacists, opticians, libraries, supermarkets, community forums, local ethnic minority and women's groups etc.
- Provide information to local businesses and schools with membership registration details
- Continue to recruit to community membership 'internally' - through information supplied via out-patient clinics and on wards and by the Patient Advice and Liaison Service
- Develop existing relationships with community forums, citizen's panels and other local groups - to present membership and foundation trust information at meetings
- Explore initiatives for ensuring membership diversity - by targeting under represented areas or groups
- Work to improve links with local communities - particularly where there is social exclusion or where residents are minority groups currently under represented in membership

Targeted membership growth/interaction

- Develop the in-house staff membership management service - including appropriate monitoring systems to enable transfer of staff to community membership and to ensure increased participation in future elections.
- Establish and maintain an accurate and accessible register of community members
- Establish a computer database capable of pulling out specifics to produce membership profiles - such as postcodes, age range, ethnicity
- Establish definitions for tiered membership - recognising and categorising members by their interests
- Identify how corporation locations can be used as community resources and membership information points

Opportunity for election

- Work with ERS to adopt fair electoral processes that encourages participation of all active members.
- Maintain guidelines for running elections, including policies on canvassing, election expenditure and election material
- Work with local media and other organisations (such as local councils) to feature elections and the community governor role in newspaper, magazine and radio media
- Organise election briefing events for members who are potential governor candidates
- Ensure <u>all</u> members are fully informed about elections and the opportunity to become a governor

Members, board and governor inclusion and involvement

- Develop mentoring programmes for elected representatives to encourage new candidates
- Identify opportunities for interaction between the board of directors and the council of governors
- Produce a members rights and responsibilities definition - to be supported and adopted by the board of directors and the council of governors
- Recruit 'champions' from community governors to represent local people in capital projects, national initiatives and other corporation plans
- Make evaluation of the membership strategy a key role for the council of governors
- Draw up a learning and development programme for elected governors so they can fulfil their role
- Use membership information to support consultation campaigns - to ensure membership involvement in service and other development plans
- Ensure members are regularly updated and informed and offer feedback opportunities
- Explore opportunities for closer links and understanding of the corporation and its work - open days for members, presentations, member meetings for example

Education

- Work with other organisations (such as social services, education) to develop educational material promoting community involvement - with emphasis on young people and other under represented groups
- Explore ways of working with schools and the local education sector to promote the corporation, its community involvement and membership opportunities

General

- Evaluate membership response to different levels of information and methods of delivery
- Undertake a risk assessment of membership systems
- Work with the Foundation Trust Network to explore good practice and membership initiatives

Election of governors from the community membership base

Elections to the corporation's council of governors were held in November 2006. This year, due to staggered appointments put in place from January 2005, six seats fell vacant - one in the Bolsover, two in the North East Derbyshire classes of the constituency and three in the Chesterfield class. There was also a new seat for the Derbyshire Dales and North Amber Valley constituency. Three out of the six governors opted to stand in the elections again - with just one gaining re-appointment to their position (Chesterfield constituency).

Interest in the elections was good, with just one uncontested seat (Derbyshire Dales and North Amber Valley). Elections for the Chesterfield seats resulted in 25 candidates. Turn out in all elections was around the 40% mark.

Governors elected in the 2006 elections took up their seats on the Council in January 2007.

The board of directors confirms that elections were held in accordance with the rules stated within the corporation's constitution.

This is verified in the election report of December 1 2006, as follows:
'...This concludes my report of the voting in the above election. The election was conducted in accordance with the rules and constitutional arrangements as set out previously by the Trust, and Electoral Reform Services (ERS) is satisfied that these were in accordance with accepted good electoral practice. I further confirm that all candidates were eligible for the above constituencies....'

Matthew Reeve
Returning Officer, ERS
On behalf of Chesterfield Royal Hospital NHS Foundation Trust

The 2007 elections will take place in November, with the following seats falling vacant:
Two seats - Chesterfield class of the constituency
One seat - Bolsover class of the constituency
One seat - High Peak class of the constituency
One seat - Derbyshire Dales and North Amber Valley class of the constituency
One seat - North East Derbyshire class of the constituency
One seat - Medical and dental class of the staff constituency
One seat - Nursing and midwifery class of the staff constituency
One seat - All other staff class of the staff constituency

Plans to maintain and grow the membership

The prime source for recruiting members is, and will remain, those people who have an existing relationship with the Royal Hospital, either as past and present patients or carers, including voluntary groups, or those who are potential users of the service as residents of North Derbyshire (or the corporation's defined catchment area).

The corporation is ahead of where it expected to be in terms of community membership. For this reason, plans up to March 2008 will focus on small campaigns to reflect diversity, rather than actual membership numbers. There are some areas of membership that require specific projects to gain membership - for example increasing members aged 16 to 35.

Staff membership has remained static and this position is not expected to change. As the corporation looks at making efficiencies and savings over the next three years, the likelihood is that staff membership may actually drop - and this is reflected in the estimated figures.

The challenge

The key challenge for most (if not all) membership organisations is to secure sustainable membership growth. For Chesterfield Royal Hospital NHS Foundation Trust this means attracting two separate membership audiences:

- Existing and future staff
- Constantly increasing numbers of local people from its catchment area.

To be a successful membership organisation the corporation has to do more than offer 'membership'. The challenge is to strengthen relationships with members and to make sure they feel they can be involved and influence future decisions.

Members need open and honest communication from the corporation. As well as telling them of plans, proposals and developments, there may be times when they need to be told about pressures and issues - and the difficult decisions required as a result.

The corporation's full membership strategy can be found on-line at www.chesterfieldroyal.nhs.uk

Public interest disclosures

Throughout the year staff and community members have been consulted about issues that affect them in the way services are delivered or mean changes to practices that affect how staff work. This has been particularly important in relation to workforce reviews, which have led to major changes to staffing structures and new developments across the organisation.

Communicating with staff has remained a high priority. Staff at the corporation can access a variety of communication materials including:

- pay-slip bulletin - information pertinent to everyone (corporate development, personnel issues etc) circulated to every member of staff with their monthly pay-slip.
- membership magazine - with the authorisation of foundation trust status the staff magazine re-launched in 2005 as a membership magazine. It is distributed to all community and staff members of the foundation trust.
- e-mail briefings - regular briefings to all staff via their personal e-mail accounts, on a variety of subjects affecting the corporation - from service development to estates issues.
- staff suggestion scheme - staff can access the board of directors by e-mail or letter to ask questions, or put forward concerns, ideas and suggestions. All staff using the scheme are guaranteed a response direct from the chairman, chief executive or another executive director within a 20 working-day standard.
- posters, leaflets, reports - produced specifically for staff.
- Intranet - the staff only section of the corporation's website facility. Another £30,000 has been invested in the website (intranet and internet) in the last 12-months, to make it easier for staff and the public to use. Staff can access policies and procedures, patient information, an on-line telephone directory and up-to-date news about the corporation - including finance reports, performance reports and minutes from key meetings such as the council of governors.

As an NHS foundation trust, the corporation consults with both staff and community members in a structured, well-planned and specific way. Consultation with members means the corporation involves local people and staff in decisions - to improve and develop services and facilities; and in turn enhance our patients' experiences. During 2006/07, staff and community members were invited to comment on the following strategic plans:

A review of community midwifery services

The workforce review of this service resulted in proposals to provide services in a completely different way. The consultation focussed on the proposals, why change was required and how local people could contribute to the debate. The consultation included plans to close an eight-bedded maternity unit. At the end of consultation this option was withdrawn due to pressure from members and local people. A full report and final analysis was due to be published in June 2007, so members could see why certain decisions were made.

Every child matters

This consultation laid out plans to invest £5 million into specialist children's services, building a new unit on the Royal Hospital's site. The plans proposed that old, out-dated facilities that currently house these services would be sold - and the money used to offset a portion of the new development.

A public governor was an integral part of the working party for this scheme and attended meetings with the Improvement and Scrutiny Committee. The ISC and the public consultation backed the proposals to develop this new unit and work begins in mid-2007.

Details of consultations, and results are stored on the corporation's website at www.chesterfieldroyal.nhs.uk

Consultation with local groups and organisations

Patient and Public Involvement (PPI)
Building a partnership between the corporation, patients and the public is central to modernising the health service. Patient and public involvement contributes to:

- Strengthening accountability to local communities
- Developing local health services which genuinely response to patients and carers
- A sense of ownership and trust

The corporation values the views of its patients, visitors and community members in order to improve the services delivered locally and ensure that they are patient-centred. By listening and responding to what patients have to say the corporation is able to share good practice and identify areas for improvement.

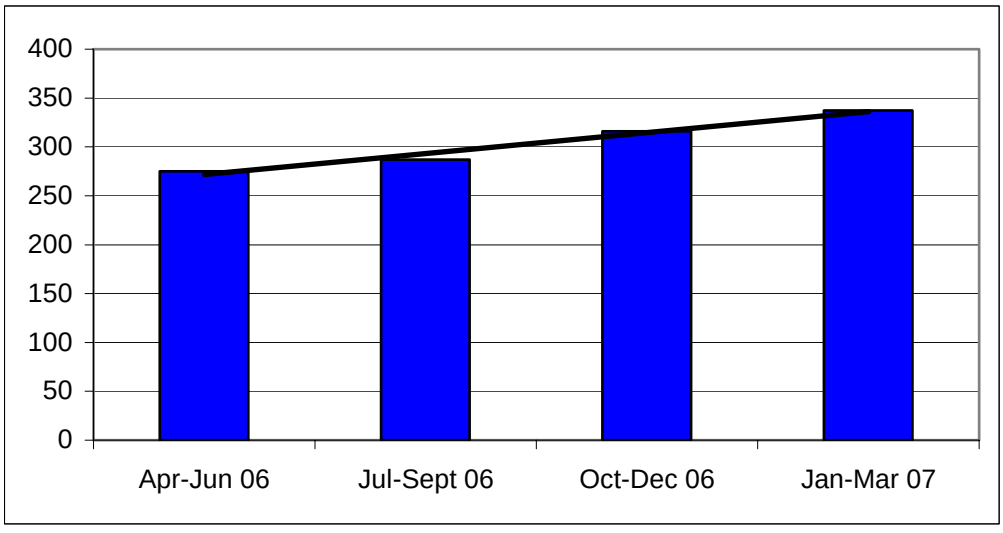
The following details examples of how the corporation has involved patients and the public during the period 2006/07.

Patient Advice and Liaison Service (PALS)
The service:

- Acts as a first point of contact for patients and their families to raise concerns, or requests for information
- Refers patients on to external or advocacy services where requested to do so
- Provides accurate information on all aspects of the corporation and related healthcare issues
- Ensures all issues are addressed as speedily as possible

Activity
A large proportion of the cases dealt with by PALS are resolved immediately - ensuring that the patient and their relatives or carers receive a high standard of service. However, the service also works hard to ensure that issues do not recur in the future, for other patients.

This report details PALS queries received by quarter from April 2006 to March 2007. The graph below shows the total number of enquiries received.



The table below shows a breakdown by subject of the cases PALS dealt with during this period:

Subject (primary)	Apr-Jun 06	Jul-Sept 06	Oct-Dec 06	Jan-Mar 07	Total
Car parking	2	3	2	8	19
Communication failure	6	7	9	8	25
Good practice/compliment	5	2	4	23	14
Information	80	96	96	99	349
Problem or concern	103	105	120	107	427
Signpost to other services	22	18	22	16	86
Suggestion	14	10	20	16	56
Transport issue	43	46	43	60	169
Total	**275**	**287**	**316**	**337**	**1145**

Response times

Unlike complaints the PALS does not have a target for responding to enquiries, although it aims to ensure that all issues are addressed as speedily as possible. The table below shows the breakdown of response times for queries by quarter.

Response time (working days)	Apr-Jun 06	Jul-Sept 06	Oct-Dec 06	Jan-Mar 07	Total
Same day	217	219	230	257	923
2 to 3 days	30	40	44	45	159
4 to 5 days	5	12	18	11	46
6 to 10 days	9	7	13	10	39
11 to 15 days	8	1	7	4	20
16 to 20 days	2	0	1	3	6
Over 20 days	5	8	3	7	23
Total	**275**	**287**	**316**	**337**	**1215**

Patients as Educators

Supporting staff and continuing their development to provide quality services is extremely important and this year the corporation piloted on a small scale the use of patients as educators. Patients have been involved in the training of new nurses and the corporation's customer care course by highlighting the patient's perspective including good and bad experiences. This is something that the corporation is looking to develop in order for staff to have insight and hear direct from those that have an experience.

National Patient Survey

The corporation takes part in the annual programme developed by the Healthcare Commission for national patient surveys in order to evaluate the patients experience and develop patient centred services. During 2006, the national survey focused on adult inpatients and as a result of the findings an action plans was developed. The action plan included the following aspects:

- Introduction of ward based teams to improve patient meal service delivery e.g. temperature.
- Agreed cleanliness standards for the Patientline equipment (bedside radio, TV and telephone system).
- Review and improve information for patients transferred from the coronary care unit to a main ward.
- Exploring the further introduction of nurse-led discharges on the ward.

- Continue to audit the levels of cleanliness on wards.
- Reduce delays experienced when patients discharged e.g. more access to pre-packed medications, computer generated discharge prescriptions on medical wards.
- Establish a plan to support patient self-administration of medicines in defined areas.
- Reduce delays in patients receiving medicines whilst on the ward e.g. analgesia by investigating the role of ward pharmacy staff in facilitating the administration of a selection of medicines.

Endoscopy
Patients gave overwhelmingly positive comments when asked to complete a survey about their experience of attending the endoscopy suite. The results highlighted good practice and areas for improvement. As a result the following action points were developed:

- Improving the information provided to patients when giving consent for the procedure to be undertaken.
- Help patients to find the department with ease by providing clear instructions and a map.
- Redesigning the patient trolley and screening area to protect the patients privacy.
- Implementation of a pain score tool to assess pain and sedation scores.
- Improvements to the aftercare of patients by quicker turnaround times of results.

Prostate evening clinic
A change in working practice to meeting waiting times and provide patients with choice and access gave patients the opportunity to attend the prostate outpatient clinic during the evening. 83% of respondents were happy to attend the evening clinic and that 90% felt that evening clinic activity should be increased. Obviously there were some concerns about travelling in the dark during winter but it must be remembered that prostate cancer is a disease of the older population and many of the patients are elderly. Patients are offered the choice of evening or daytime appointments. With the general positive uptake and feedback on evening clinics this has been introduced on a permanent basis.

North Derbyshire cancer services user group
The group focuses on improving and influencing the delivery of local cancer services continues to go from strength to strength. The following highlights some of the key areas which they have a been involved:

- Members of the group play an influential role in critiquing patient information and helping to continue the development of patient log books to support patients throughout their journey.
- Commenting on the end of life pathway and putting forward ideas and suggestions to develop this aspect of a patients journey.
- Assisting in improving car parking facilities for disabled users near the education centre to ensure easy access.
- Supporting the introduction of patients accessing bloods before attending for treatment.
- Voicing support to increase the numbers of patients treated at a local level.
- Represented the group at a local, network and national level to share good practice.

Methotrexate injections - home delivery service for children with rheumatic disease
The rheumatology/paediatric team at Chesterfield see a small but significant group of children with rheumatic diseases. The mainstay of treatment for these children is oral Methotrexate. A number of these children with resistant disease will need Methotrexate injections to control their symptoms and improve their long-term health status. In the past it has been difficult to implement this particular therapy safely because of the Control of Substances Hazardous to Health (COSHH) regulations. Methotrexate is also a drug which causes concerns for the Control of Safe Medicines (CSM).

As an interim measure in order to provide the children with the most appropriate treatment, the hospital pharmacy provided pre-filled syringes, which could be either sent to the GP surgery (via the van delivery system) or collected from the hospital by the parents/carers on a weekly basis. Collection and disposal of the waste was difficult to co-ordinate.

Adults were transferred onto a home delivery service in 2005 and are now well established with community prescribing of their drugs once stable on treatment. In order to provide this service for children a bid was submitted to the medical directorate to be able to provide a similar service for the children but this would be hospital prescribed. Parents/carers and children were invited to a consultation evening.

Improvements in service delivery:

- Delivery of pre-filled syringes to pre determined address
- Delivery of eight week supply of medication and all the ancillaries needed for the safe administration
- Collection and disposal of the cytotoxic sharps bin
- Cytotoxic spillage kit

A training package is available for those parents/carers or children who wish to self administer - the training usually delivered by the community paediatric nurses.

Remuneration report

The remuneration committee

NHS foundation trusts must disclose the remuneration paid to senior managers, that is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust'.

These disclosures are made in the annual accounts for the periods April 1 2006 to March 31 2007.

Remuneration of the chairman and non-executive directors

In 2006, the chairman and non-executive directors agreed as a one-off that they would not receive the annual uplift in line with other corporation staff. However, the council of governors did come to the view, in the 2005 review, that the remuneration for the chairman and non-executive directors should in general be uprated annually, with a periodic benchmarking review to ensure that the levels of remuneration remain in line with comparable roles elsewhere.

Remuneration of the chief executive and executive directors

The corporation has an established remuneration committee. The membership was reviewed on the appointment of the new chairman and new non-executive directors and comprises:

- Pam Liversidge, non-executive director and chairman
- Richard Gregory, chairman of the corporation
- Michael Hall, non-executive director and deputy chairman.

Remuneration policy

With the exception of the chief executive and the executive directors, all employees of the corporation, including senior managers, are remunerated in accordance with the national NHS pay structure, *Agenda for Change.* It is the corporation's policy that this will continue to be the case for the foreseeable future.

The remuneration of the chief executive and the four other executive directors is determined by the board of directors' remuneration committee (see above). In reviewing remuneration, the committee has regard to the corporation's overall performance, the delivery of the agreed corporate objectives for the year and the pattern of executive remuneration among foundation trusts and the wider NHS.

The chief executive and the three whole-time executive directors (director of finance and contracting, director of nursing and clinical development, and corporate secretary) are paid a flat-rate salary. The part-time executive director (medical director) is paid a flat-rate management allowance separate from his salary as a consultant general surgeon.

There is no performance-related element, but the performance of the executive directors is assessed at regular intervals and unsatisfactory performance may provide grounds for termination of contract.

The 'service contract' for the chief executive and executive directors is the contract of employment. This is substantive and continues until the director reaches the age of sixty-five, when it terminates automatically unless there is agreement to extend it. Otherwise, the notice period for termination by the corporation is twelve months and for termination by the director, six months. The contract does not provide for any other termination payments.

Details of the service contract for each executive director:

Post title	From	Unexpired term (years)*		
		0 - 10	11 - 20	21 - 30
Chief executive	01.01.02	✓		
Director of finance and contracting	17.03.03			✓
Director of nursing	01.04.93		✓	
Corporate secretary	13.12.93		✓	
Medical director	01.04.00	✓		

* This distribution is shown because the directors have not given consent for age to be disclosed

The provisions for compensation for early retirement and redundancy are as set out in section 16 of the Agenda for Change: NHS Terms and Conditions of Service Handbook.

Remuneration of senior managers during the year
NHS foundation trusts must disclose the remuneration paid to senior managers, that is: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS foundation trust'.

These disclosures are made in note 5.3 of the financial statements to March 31 2007.

Eric Morton
Chief executive
06 June 2007

Ends