
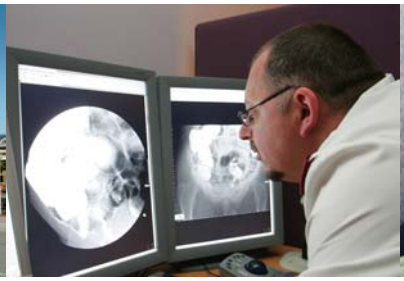


Annual report and accounts
April 2004 to March 2005

Chesterfield Royal Hospital NHS
NHS Foundation Trust

Chesterfield Royal Hospital NHS Foundation Trust
Annual Report and Accounts 2004/05

Chesterfield Royal Hospital NHS Foundation Trust
Annual Report and Accounts 2004/05:

Presented to Parliament under Schedule 1, paragraph 25(4) of the Health and Social Care (Community Health and Standard) Act 2003.

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Contents

Strategic statements

Our mission

- 'To be your hospital of first choice, placing the patient at the centre of everything we do'.

We chiefly provide secondary and specialist care, but also reach into the community, for example, in women's and children's services.

Our mission applies equally – wherever we provide patient care.

Our aims

- To provide local specialist and hospital centred healthcare, which responds to the needs of the people we serve.
- To work with other health and social care providers to make sure we deliver complementary and integrated services.
- To use the resources we have to provide high-quality care.
- To keep and build on our relationships as 'partners in care'
- To provide our staff with good career and educational opportunities, in a modern environment.

Our values

- To act with integrity – providing an open, honest and informed approach to everyone who uses our services.
- To respect the dignity of patients, recognising that each patient has their own individual needs.
- To give all our staff the opportunity to reach their individual potential while they are working for the trust.

Statement from the chairman

Personal perspective

I have been chairman at the Royal for over six years – but this last 12 months has been the most challenging time – in my view – the organisation has been through.

We have spent nine months of the financial year building our application for foundation trust status, and three months of the same financial year coming to terms with our new position within the National Health Service. As this report goes to press (July 2005), we are one of 32 establishments to have achieved the foundation trust aim. And we strongly believe it can only be of benefit to the health of our community.

It's clear that we have all had to learn quickly. We have had little time to adapt to how the organisation must run, in its new-found class of 'public benefit corporation'. However, we have the support of a 10,000 strong membership behind us – the staff and local people who backed our bid to become one of the country's first foundation trusts. While we remain firmly within the NHS, we are now accountable to them and the local people they elected to our Council of Governors. We have to return their faith in the Royal, and ensure we involve them in the corporation's future. It is an exciting time as we get to grips with our role.

As a board member I also hold some personal liability for ensuring the corporation succeeds – as do my board member colleagues (also see Board of Directors). It is up to us to provide the best in care for North Derbyshire and we are determined to do so. We hope we can continue to rely on our community for support, through them telling us what they want from their local hospital - not just for this forthcoming year – but for many years ahead.

Below and throughout this report you will find some more highlights from the year. You will also find more about our achievements, statutory duties and service development plans and how we have to report on these as a public benefit corporation.

Financial performance

April 2004 to March 2005 was a strong financial year. The corporation was in financial surplus throughout the year and achieved an overall year-end surplus of £42,000 (against a planned income and expenditure breakeven). £15,000 of this was realized in the last quarter of the year (that is as an NHS foundation trust).

The surplus was in fact less than the Board had hoped for. A late change in the accounting rules for fixed asset revaluation was imposed on foundation trusts. As a result, in March 2005, an extra charge was made against our income and expenditure of £338,000.

The corporation also had a recurrently balanced income and expenditure account throughout the year, placing it in a solid financial position going into 2005/06. Increasingly, emphasis is on preserving strong liquidity, and controls on cash and liquidity were strengthened.

At March 31 2005, the cash position was significantly ahead of plans the Board had approved for the foundation trust's working capital projections. The corporation had a closing cash balance of £6.1 million, compared with an original forecast of £2.5 million.

Operational performance

By the end of March 2005, maximum waiting times for elective treatment had fallen to three months for most specialities, with orthopaedic surgery having the longest waits at five months. Maximum outpatient waiting times were 13 weeks or below.

As a Board we agree that short waiting times remain a priority. By the end of the next financial year I hope to report that maximum waiting times for elective treatment are no higher than three months in every specialty, and that outpatient waits have reduced to 10 week maximums. These short waiting times will provide the corporation with market advantage over surrounding providers, as 'Choose and Book' comes to fruition (also see the Achievements section of this report).

Throughout the year, non-elective activity was above planned levels, both in our Accident & Emergency Department and admissions to our Emergency Management Unit (EMU).

We have extended EMU, to include a Clinical Decision Unit, Emergency Assessment Ward, Discharge Lounge and A&E Observation Ward. These new areas opened in January 2005, and have already contributed to the smooth passage of emergency patients through the hospital.

The quarterly national targets for treatment of A&E patients within four hours were all achieved. This meant we were the only hospital - in the Trent Strategic Health Authority at least - to gain £500,000 of national incentive funding as a result. This money will be used to upgrade and increase the facilities in the department during 2005.

Last July, we kept a three-star rating in the national performance tables. Early assessment of the corporation's performance against the Healthcare Commission's performance standards this year is good, as expected. All the key targets have been achieved.

Based on information currently available (and subject to the Healthcare Commission's data approval process), most of the other standards included in the balanced scorecard have also been achieved. We hope July 2005 will see us with a three-star rating once more.

Working with governors

As a Board we are mindful that a major change has occurred in the way we do business. We no longer work as a single entity. Every planned development, service change and new proposal affects the population we serve. We must work in partnership with our governing council to gain their opinions and receive their advice. They represent local people and we must listen to their views to gauge what our priorities should be. It is early days, and an interesting challenge, but we are making quick progress.

Governors have already had an opportunity to advise the Board on service development, in particular about the annual plan. We have only held four Council meetings (to July 2005), but we have already been able to engage governors in other advisory roles. For example, in new capital scheme developments, on working groups that are deciding improvements to patient care; and in direct patient care issues – such as cleanliness and infection control.

The future

At this present time we are confident that we are well-placed to succeed as an NHS foundation trust. We are on track to reduce waiting times even further, our financial position is stable and we have put new procedures in place to work as a public benefit corporation.

It is not the time however, to sit back and become complacent - far from it. There are risks in the health care 'market' that could impact on us – in the next few months and in the years ahead. We have had to take these into consideration, with prudent financial actions and sensible development targets. You can read more about risks in the operational and financial review.

This is a new-style of annual report to reflect Chesterfield Royal Hospital's change in status. I hope it provides you with an interesting insight of how a foundation trust runs. The achievements it contains however are, as in previous years, down to the hard work and commitment of more than 3,400 staff. We should not forget that. As a foundation trust their support is ever more valuable and on behalf of the Board, and in particular my non-executive director colleagues, I would like to thank everyone for the part they played in a successful 2004/05 year.

Michael Wall
Chairman

Statement from the chief executive

The view from the Board

On January 1 2005, my executive director colleagues and I transferred employment from the former Chesterfield and North Derbyshire Royal Hospital NHS Trust, to the renamed public benefit corporation of Chesterfield Royal Hospital NHS Foundation Trust.

For us this represented the fruition of more than 18-months of planning – to put your local hospital at the forefront of NHS development once again. We are now one of only 32 NHS foundation trusts in the country (at July 2005). And although we are enormously proud of this achievement, we did not opt to 'celebrate in style'! For us this was a transition. The Board knew that patients on January 1 2005 would be receiving the same excellence of care as they were on December 31 2004. Foundation status will give us freedoms we have never had before – but our aim is still the same – to provide the best healthcare to people in North Derbyshire and to make Chesterfield Royal their choice for care and treatment.

You will have seen in the chairman's statement that we have performed at consistently high levels throughout the last financial year.

Staff – in all areas of the corporation – have contributed to this success. I would wish to reiterate the chairman's thoughts - and on the Board's behalf I thank everyone who works in our organisation. Their support helped the Board to continue to strive to become a public benefit corporation, despite the rigorous test of the application. More than 3000 of our staff have opted to become members of the new establishment. They are behind our strategy and we value this commitment.

With both staff and community members, and an elected Council of Governors, the Board is accountable to local people in a way that has never before existed. It is fair to say that this has proved one of the most challenging aspects of the move to foundation status. How do we pass on information about the Royal to such a large group of people (a membership that continues to increase)? How do we consult on our plans in a meaningful way? How do we find out what local people want from their local hospital? We need to act quickly as patient and public involvement will impact on our future performance. It will be used as a measurement of our success.

This report covers just the first three months of foundation status – but we think we have made huge progress in providing services that local people can be proud of. Waiting times are among the lowest in the country – and perhaps we don't shout about that enough. We are also practical. This isn't the only 'target' that's important to our community. They want a clean hospital, up-to-date medical equipment, skilled staff, and to know we are using public money wisely.

We are already involving governors in our plans to improve the hospital environment, and we have consulted on proposals to restrict visiting hours. The aim of this, is to offer local people the opportunity to help us to reduce hospital-acquired infection, much of which is brought in from outside. We are waiting for results from this consultation as this report is written.

Improving performance is not always about making popular decisions. One action we took in 2004, did have a negative impact, but it was done for the right reasons.

Services at the Royal are constantly re-evaluated to make sure they provide best value. Last year we reviewed children's services - to ensure they were cost-effective, efficient and providing best-value. At the same time we examined ward use, to assess if we met the National Bed Inquiry (NBI) recommended ward occupancy level of 85%.

The exercise showed that across all areas in the hospital we perform at a level of about 86% level. However, some significant variations were visible in directorates. For example, medicine was working at 90%, while the children's wards were at levels between 45% to 55%.

We took the decision to re-evaluate children's beds, consulting with staff on proposals to reduce bed numbers to a final occupancy level of 75% to 80%. This is still better than the NBI standard and continues to allow for flexibility. The changes will deliver the same service - but in a different way.

We guaranteed there would be no decline in service and there would be no compulsory redundancies. Any financial savings released will be reinvested in medical specialties – the service under most pressure. This will enable us to achieve equality across the hospital.

This decision was a concern for local people, and we understand why. It is difficult to make decisions like this, especially when we know they will be unpopular in the short-term. Our job is to ensure all our services run in an effective and efficient way and this organisational change meets that aim. The change will not be completed until March 2006 to allow a steady and smooth transition.

This example shows why it is more important than ever for this hospital to be open and honest about how we operate. As a foundation trust, this will be exactly the type of change we will need to tell our members and governors about, so they have a clear picture of where the organisation stands. I welcome this opportunity and think it will offer local people a greater insight and I hope a better understanding of their local hospital – and the way it spends a £130million budget.

I hope this report illustrates that where we left off as an NHS trust, we will continue as an NHS foundation trust. I am delighted at the Royal's performance, and this report, although covering just one financial year, clearly shows how far we have come - and what we are already working on to make sure we aim for improvements year on year.

Eric Morton
Chief executive

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 and relatives or carers.

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

Cardiac catheter suite

This £1.5 million capital build scheme has created a state of the art, on-site, cardiac catheter suite. The new service means that patients no longer have to travel to Sheffield (at least 20miles away for some patients), or use a mobile facility, for specific cardiac treatments and examinations.

The suite opened in September 2004. It caters for diagnostic angiography and the insertion of permanent pacemakers. Patients also attend for follow-up appointments, in the hospital's cardio respiratory department.

A steady increase in patient numbers is planned with the corporation working closely with Sheffield University Hospitals NHS Foundation Trust in line with their service development plan (ie more patients will come to Chesterfield as cardiac surgery increases in Sheffield).

A reporting room, where consultants and patients can review findings, reception and waiting area, pre-procedure and recovery area, and catheter laboratory, where the procedure takes place, are all housed within the new suite.

A team of staff work within the unit led by a consultant Cardiologist. It includes six nurses, four radiographers, two cardiac physiologists and a receptionist.

Improving Working Lives

All trusts must reach Practice Plus level of the national Improving working Lives initiative by March 2006 - and the corporation is striving to achieve this. IWL will help the corporation to achieve its aim of being seen as a model employer that attracts and retains staff in all areas of employment. It is also used to promote sharing of good working practices across directorates..

A core steering group and several task groups (in areas such as communication, flexible working and training & development) – made up of staff, has been set up to work towards the IWL assessment planned for later this year. A project group is also in place to promote good policy for staff, but there is still a lot of work to be done in terms of encouraging more staff to become actively involved.

Education centre

Another £1.5million development, this scheme has modernised the hospital's education and training facilities.

Providing facilities for NHS staff across Chesterfield and North Derbyshire's health community, its amenities are also open to primary care for GP vocational training etc. It is also used for careers events to involve local schools and colleges in the hospital and encourage NHS career choices.
The centre houses an education library, e-learning facility, 170-seat lecture theatre, and a clinical skills laboratory.

The scheme was part of an overall £5.9million Government funded development that also involved 're-claiming' the hospital's current education facility. This now houses three additional wards (60 beds) to deal with increased demand for emergency medical care and allow the Trust to reconfigure ward provision.

More consultants

Over the past year additional consultant appointments have increased the number working for the corporation from 106 in April 2004, to 115 by March 2005. Additional appointments have been made in the specialties of orthopaedics, ophthalmology, children's services, radiology, surgery (colorectal surgeon), histopathology, medicine (gastroenterologist), and oral and maxillofacial surgery

Top rating success in negligence scheme

In June 2004, there was fantastic news for staff from the maternity, child health and gynaecology directorate (the Women's and Children's Directorate from May 2005).

Assessors from the Clinical Negligence Scheme for Trusts (CNST) announced that the Royal had become only the second hospital in the country to achieve Level 3 (the highest) of the clinical negligence scheme for trusts (in maternity standards).

And not only that – but 100% of all standards, at all levels, were met across the board. This was outstanding for the directorate – and recognised how hard they worked.

Assessors also conducted a Trust-wide assessment of all remaining directorates – and confirmed that for the third time, the organisation had retained its level 3 rating. There are still only eight hospitals in the country with this score.

Facilities improvements in critical care

At a cost of £390,000, more operating tables and some theatre lights were replaced in November 2004. Alongside this scheme was an injection of extra capital totalling £38,000 in January 2005, to improve sterilising services in the Sterilisation and Disinfection Unit (SDU). The unit makes sure all resuable medical devices - including theatre equipment - is correctly decontaminated after use.

New ROOTs in orthopaedics

A new service offered by the orthopaedic directorate is moving hospital services into the home environment. The Royal Orthopaedic Outreach Team (ROOT) has been up and running since February 2005 with a team of four staff - nurse, physiotherapist and occupational therapist and a generic assistant.

Feedback has been positive. The ROOT scheme works closely with selected patients and their families and provides a seamless service from hospital to home. Patients are screened before their hospital admission to check if they are suitable for the programme. They are offered an enhanced rehabilitation programme while in hospital - and this treatment continues at home for an agreed time. While recovering at home there is a 24-hour contact number the patient can use in case of enquiry or emergency.

Diary record for intensive care patients

The intensive therapy unit constantly works towards improving patient care. This year has been no exception, and a 'patient diary' project is now fully in place. The diaries enable staff to provide a written overview of aspects of their care whilst in ITU, and allow family and carers to enter their thoughts too. The diaries are kept at the patients' bedside and proving invaluable for patients after they are discharged from the unit, as an aid in their ongoing recovery. The Critical Care directorate plans to evaluate the effectiveness of this project in 2005/06.

On target for patients

More operations took place in 04/05 compared to 03/04. An increase of 657 (with the greatest increase in cataract surgery) took the total number of operations to 13,128 - due to the hard work of reviewing theatre processes to make better use of resources. For example, staffing was further reconfigured and additional theatre porters recruited to ensure a more efficient system.

Operations cancelled for non-clinical reasons fell to 0.9% - better than the national target.

Orthopaedic waits down

Patients are waiting less time than ever before for hip replacements, hand surgery, knee surgery and other orthopaedic operations. The orthopaedic directorate has strived to achieve maximum waits for routine surgery of six-months and hit this standard at March 2005. Previously patients waited a maximum of nine-months and only a couple of years ago a wait of 12 to 18 months could have been expected. Next years' step is the challenging standard of three-month maximums.

Discharge improvements on time

The medical directorate introduced an 'estimated length of stay monitor' - with a standard to have at least two patient transfers or discharges completed by 11 am every day to free-up valuable medical beds. In September 2004, a multi-disciplinary day was held – with representatives from all concerned parties, including primary care trusts and social services - working to devise an action plan for what is needed in discharge. Improvements have been made in all areas that are under the directorate's control - although further work with partner organisations is still required.

Calling in at the centre

To improve services for patients the imaging directorate has but an x-ray call centre in place. It became fully operational in April 2004. By modernising services in this way – which means patients have a choice of appointment slots, DNA (did not attend) rates reduced by about 75%. Fewer appointment slots are wasted and clerical staff are happier that the booking system is more efficient.

A patient questionnaire was circulated at the beginning of the project, with a positive response. Patients are delighted with the new system, as they choose when they want to attend - to fit in with their lifestyle and commitments. Most importantly, they have personal control over their care and treatment.

Nurse diagnosis in place

Through a training and education programme, a nurse specialist is now in place in dermatology to diagnose certain types of skin cancer. This improves the quality of service offered, seeing patients quickly to improve their experience and help with patient flow through the service.

A genito-urinary medicine (GUM) nurse specialist has also been appointed to see patients and assist with diagnosis. This is better for the patients as they only have to see the one nurse when they come to clinic.

Cancer care nurse appointed

A strategic post that will significantly improve cancer care management in North Derbyshire was created last year - and a candidate already appointed to start in summer 2005.

The position of Macmillan Nurse Consultant of Cancer Care will be stationed at the Royal, funded by Macmillan for three years - with the Royal taking over if the project is successful. The consultant will concentrate on areas including the education of nurses, patient flow and patient experience.

This is the first time such a post has been created. To obtain a Nurse Consultant level post is an excellent achievement, and higher than most other hospitals can offer. It will provide a better career structure for the postholder.

Hitting the top target

Emergency Care has sustained the Government's A&E target of '98% of patients to be seen and admitted or discharged, within four hours of presentation', for five successive months. It was the only A&E unit in Trent to achieve all of the quarterly targets across the year – which has meant £500,000 in performance incentive monies.

The money will be spent on a number of capital build projects including a new minor injury/illness treatment suite – replacing the current 'see and treat' area. This should help to speed up treatment even further and will also improve privacy for patients.

Town centre location for screening

A 'satellite' breast-screening unit is now in place at Chesterfield primary care trust's headquarters about two miles away from the main Royal Hospital site. This project was supported by the PCT. The new unit means that patients no longer have to come to the Royal for their screening appointments, but attend this handy location right in the middle of the town centre. It also offers a less clinical alternative environment for their appointments – more relaxing for women who may be worried about having a mammogram.

Changing pay and conditions

The corporation has managed the changeover to the new national terms and conditions known as Agenda for Change. This has meant that a job and pay evaluation for every employee (except doctors and the most senior managers) in the corporation had to be carried out.

The year was spent reviewing job descriptions. Review panels - including members of working staff as well as management - were set up in September 2004 and finished evaluating staff roles in May 2005. By June 2005, 80 percent of staff had assimilated across to the new national pay scales.

Managing the process has gone well – particularly in relation to staff side and union representatives involved in the project task groups.

This is a huge change of culture for NHS staff – with Agenda for Change attempting to balance pay and conditions across the whole NHS organisation. There has been mixed feedback on the scheme from staff, and the corporation has tried to alleviate fears through a comprehensive, honest and open communications programme. It is expected that all staff will be assimilated by October 2005.

Archiving complete

A £700,000 project to install a computerised radiology system (PACS) in the corporation's imaging directorate began in the last financial year and was completed in this financial year. By the end of 2004, all clinical areas in the hospital linked to the new service – which allows staff to access all types of images from the results database, including MRI and CT scans,

Now that x-rays pictures are taken digitally, they can be archived on a database and retrieved at the touch of a button. Images are high-quality, instant and can be viewed from stations throughout the hospital. Once an image is stored it can be examined within two seconds.

Alongside this development is a £400,000 project to install a state of the art gamma camera in the department. Scans take less time to complete and through the PACS link data can also be sent to the Sheffield Medical Physics Department for analysis.

PACS is one of the biggest success stories for the information technology department at the Royal. Another bonus is that substantial financial savings will be gained from the implementation, which will also improve efficiency in Imaging.

Automation in place

During 2004 the pharmacy service installed automated facilities in its dispensary. In just a few months the use of robotics to dispense prescriptions has already proved itself – in terms of significant improvements in efficiency and improved patient safety. The money for the development came from the Trent Regional Transformation Fund and the scheme cost in the region of £200,000.

Porters' recycling habits

Portering staff at the Royal have reached new record levels for paper and cardboard recycling - with 20% of all domestic waste collected going through for recycling, about 100 tonnes a year. Although there is very little comparative data, it is thought that they are well ahead of the game in this field. The recycling of clinical waste is also being explored.

Support for limb problems

To give cross professional, and health community wide leadership for patients with upper limb problems, a clinical specialist post for orthopaedic upper limb patients was established in 2004.

Over the past year, once service protocols were established, various professions have been supported to improve patient care. New developments have included direct referral from A&E and having passed competencies with the orthopaedic surgeons, carpal tunnel syndrome therapy led clinics, to triage patients, freeing up some consultant time

The second post, for an Older Peoples Clinical Specialist was developed in April 2005, particularly to support the emergency care directorate and address the issues of inappropriate admission to hospital of older people. It provides leadership to older peoples care across the health community, making appropriate use of alternative services and keeping patients independent at home.

Still in its infancy the role has been welcomed and there is vast potential for the post to influence, guide and support older peoples services and the staff who provide them. Links have been made with other trusts and across therapy groups within the PCTs.

The importance of mealtimes

A trial project to highlight the importance of making mealtimes special, has proved so successful that it's set to be introduced across the hospital. Elizabeth Ward was the first to test the concept of protected mealtimes. For at least half an hour at lunchtime all but the most urgent clinical work stops and everyone concentrates on the mid-day meal.

It means that patients are served courses, instead of receiving starter, main course and dessert at the same time – and therefore possibly cold food. Protected mealtimes also makes lunch a social occasion and it allows staff plenty of time to make sure that vulnerable patients get the help they need with feeding.

Defibrillation installed throughout Royal

Around 400 patients suffer an unexpected cardio-respiratory arrest (heart attack) a year at Chesterfield Royal Hospital and approximately 30% of these patients required defibrillation in an attempt to regain a heart-beat.

This year new Advisory External Defibrillators (AED) were installed in most wards and departments. As a result, these patients can be defibrillated more quickly and by a greater number of hospital staff. The main principles and advantages of advisory defibrillation are:

- A minimal level of expertise is required The machines issue audible instructions to the user throughout the resuscitation process, automatically detect cardiac rhythms requiring defibrillation, and then prompt the user to deliver a shock when safe to do so.
- Defibrillation pads, which are placed on the patient's chest, are self-adhesive. Therefore a 'hands free' defibrillation technique can be used minimising risk to the user.
- The AED uses modern 'biphasic' technology meaning the defibrillator delivers two shocks simultaneously, increasing the likelihood of success and reducing the amount of energy the patient receives. This reduces potential damage to the heart that is often associated with defibrillation.

Library is well-read

The library facility in the new education centre went through a tough accreditation process this year - to measure its performance against national standards. There are three levels of achievement (Grade 0 - not met; Grade 1 - further development still required; Grade 2 - excellent), which together with the 11 "must have" criteria, determine the level of accreditation awarded.

The assessment is as gruelling as it would be for a clinical service. The assessors agreed that the key criteria had been met and the library achieved Grade 2 accreditation with many of the additional criteria classed as 'excellent'. The library provides a first-rate resource for all staff and for other NHS professionals in the North Derbyshire area. It now has the credentials that prove it.

Changing practice
Emergency Care has altered some of its clinical practices - to improve patient care and to give treatment sooner in the patient journey. Some of these changes include:

- Increasing the number of nurses that are able to request x-rays
- Enabling more staff to give analgesia (pain relief) and other first line medications
- Putting additional emergency nurse practitioners in the A&E department
- Expanded 'see and treat' services

Pathology standard achieved
In September 2004 Pathology achieved the required accreditation against the Clinical Pathology Accreditation Standard (CPA). The new accreditation was achieved for the first time since the group altered standards. This is a huge accomplishment for the directorate and will help to maintain the high-quality pathology service.

CPA 'approval' is needed for a number of contracts. Unlike other national schemes it does not give a grade, score or level of achievement. It only provides conditional accreditation against Chemistry and Haematology; Microbiology and the Histology, Cytology and Mortuary services.

Mortuary scheme on target
Funding was secured for a £1million capital mortuary development that will open by November this year. The £1million scheme will provide improvements for relatives - with two separate waiting areas and viewing rooms, one of which will be able to cater for the religious needs of the deceased and their relatives - for example, the Jewish tradition of ritual washing.

An extra post-mortem table is included in the scheme, increasing capacity from four to five; and additional fridge space will increase storage from 51 to 100. There will also be direct access to the body store, removing the need for bodies to be transported through areas where staff work – improving issues of privacy and dignity.

Informing the directorates
With a move to NHS foundation trust status, there has been an increased requirement from all directorates to have high quality, accurate information about their activity. There have been a number of changes to the way that information is delivered - including new reports and fast-track reports - so directorates can control their activity and understand work patterns.

Recruitment success
In a difficult climate Chesterfield Royal has successfully recruited two new consultant histopathologists - to bring the quota back up to the optimum level of five. There are around 30 to 40 vacancies of this kind in the country at any one time.

Without the new histopathologists, service times would have to be compromised, but because of the appointments a fully efficient department will continue to operate.

Working towards national IT

A computer system that will be used by every hospital and GP surgery in the country is under construction through the Department of health's national programme. The hospital's own information technology department is getting prepared for its implementation – planned for 2006.

The project will cost the corporation in the region of £1 million - with a proportion of funding coming from central monies. It is hoped the system will make a massive difference to staff and patients - moving away from paper records to a computer based approach. This should reduce errors and save money by streamlining operational processes.

It's your choice

Chesterfield Royal is a leader in the national choose and book project. It allows patients to choose where they would like to be treated and to get an appointment straight away – all while still in the GP surgery.

The first hospital in Trent Strategic Health Authority, and the East of England to go live on the project, its aim is to have 50% of outpatients booked in this way by October 2005 and 100% by December 2005. A reasonable amount of patients have already booked appointments through the choose and book system - despite a few national technical difficulties.

EMU expands

The emergency care directorate has considerably expanded over the past year. Its emergency care unit (EMU) has grown to incorporate 16 clinical decision unit beds. A discharge lounge has been opened in the unit, which frees up beds across the whole trust – but also means that patients ready to go home can wait in comfort for their family and friends to collect them. The scheme also included establishing short stay observation facilities for patients in A&E – improving care for patients referred by their GPs and for other A&E admissions.

Audit office examines safety

Representatives from the National Audit Office spent a day with the patient safety team earlier this year. This was good recognition for the team, as they came with the understanding that the Royal operates a good patient safety system. The full report is due out in July 2005 and the hospital is set to feature.

Help with hearing

North Derbyshire is in the final phase of the Department of Health's programme to modernise hearing aid services (MHAS). The audiology department has been completely restructured and all patient data is now collated, analysed and stored on a dedicated audiology patient management system.

Digital Signal Processing (DSP) aids offer most users a better sound quality. New patients (those who have never had a hearing aid fitted before) are given this new type of aid. Existing patients are in a programme to for refitting.

The new aids should provide a greater degree of patient satisfaction - encouraging more users to wear their aids regularly. They are also more reliable, reducing the number of appointments required to support existing users with maintenance. Fitting began in November 2004 and to date (as this report was written) over 1300 patients now have digital aids.

Home-Based Support Service

Children with life limiting conditions and their families can call on the Home-Based Support Service for help. The new service is the result of a successful bid to the New Opportunities Fund (money from the national lottery) for a three-year period.

The project offers short term breaks for families within a community setting. It is run by a member of the Community Children's Nursing Team and supported by a team of trained carers. Many of the children have complex health care needs, and their families find it hard to provide 24-hour care continuously. The uptake by families has been very positive.

New day case procedure helping women

A new technique in surgery is helping women cope with the often embarrassing condition known Stress Urinary Incontinence (SUI). The day case procedure was introduced to the UK three years ago, and one of the Royal's consultants is among the first to receive training in the new procedure – called TVT.

An audit of the first 20 patients to have this surgery showed it has been 100% successful in treating STI and improving symptoms in those with mixed urinary incontinence.

The Royal is now a training centre for the technique, offering both an in-house and travelling training service.

Fighting infection

In September 2004, to help the fight against hospital-acquired infection, the National Patient Safety (NPSA) agency issued an alert. It stated that all hospitals should implement alcohol based hand rub at the patients' bedside by April 2005.

Hospital-acquired infection is associated with 5,000 patient deaths each year across the country, and costs the NHS £1 billion a year. International studies show that infection rates can be reduced by 10 to 50% when healthcare staff regularly clean their hands.

The corporation opted to install hand rub at each bedside and in all areas were direct patient care is undertaken. This was done between January and March 2005. Staff working in children's areas have individual 'clip on' dispensers, to protect the younger client group they serve.

An NPSA pilot with six acute hospitals has shown that when alcohol-based hand rub is provided and supported by an awareness campaign, hand hygiene rises significantly. It is estimated that 450 lives and £140 million a year could be saved if the success of the pilot is replicated nationally.

Operating and financial overview (OFR)

Operational reporting

Chesterfield Royal Hospital NHS Foundation Trust

Our history

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

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 29 April 1984 the current hospital was opened in Calow, two miles outside Chesterfield 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.

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, but accountable to the local people it serves through their membership 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 will allow us greater freedoms and more control over the services we provide and develop. It also means for the first time we can use any financial gains to our benefit, reinvesting them in patient services.

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, near Matlock.

Our staff

The corporation employs 3455 staff (at March 31 2005):

Administration, Management and Estates = 775
Ancillary = 345
Clinical Support = 265
Medical & Technical = 564
Nursing & Midwifery = 1506

Our specialties

We have these specialties:

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

Organisational structure

Pre foundation trust, the corporation was managed by a Trust Board, with day-to-day responsibility for running services placed with a management team.

As a foundation trust the corporation has a Board of Directors in place, with a business focus – developing plans for the future. Management Team has become a Hospital Management Committee, retaining its objectives of overseeing day-to-day affairs, and setting, implementing and monitoring policies and working arrangements.

Key aims and objectives 2004 to 2005

We already have a history of successful service development and delivering the best for patients in the Chesterfield and North Derbyshire area. We continued to improve services when we became an NHS Trust in 1993. As an NHS foundation trust we intend to build 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 eleven years ago (when the organisation first became an NHS Trust). This mission statement remains relevant and applicable today:

'*your hospital of first choice*', *placing the patient at the centre of everything we do*

We provide 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.

Our aims and values from that time also remain entirely relevant to our approach as an NHS Foundation Trust. These are:

Aims

- *to provide local specialist and patient centred health care, which responds to the needs of all the people that we serve*
- *to work with other health and social care partners to ensure we deliver complementary and integrated services*
- *to use the resources we have to provide high quality care*
- *to maintain and build on our relationships as 'partners in care'*
- *to provide our staff with good career and educational opportunities, in a modern environment*

Values

- *to act with integrity – provide an open, honest and informed approach to everyone who uses our services*
- *to respect the dignity of patients, recognising that each patient has their own individual needs*
- *to give all our staff the opportunity to reach their individual potential whilst they are working for the Trust*

Before NHS foundation trust authorisation, we prepared a service development strategy. This is designed to 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 the 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 are 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 Foundation Trust 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 Foundation Trust is financially viable in both the short and medium term

The organisation's aims and strategic themes are under-pinned each year by corporate objectives. These centre on short-term goals for the organisation. For 2004/05 they concentrated on issues designed to deliver the various targets set out in the NHS Plan (plus other local action plans). In total, the trust had forty objectives for 2004/05 - twenty-three related to achieving Healthcare Commission standards included in the annual performance ratings.

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 and the Board of Directors, 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.

Our most significant and far-reaching objective for the year was to secure foundation trust status, and this was achieved in January 2005 (see performance review 2004 to 2005).

Performance review 2004 to 2005

2004/05 was another successful year for the organisation – in particular, attaining NHS foundation trust status from 1 January 2005. This puts Chesterfield Royal Hospital NHS Foundation Trust (known as 'the corporation') in an excellent position to progress with its Service Development Strategy (which relies on the new freedoms granted to NHS foundation trusts).

Early assessment of the corporation's performance against Healthcare Commission performance standards is good, as expected. All the key targets have been achieved. Based on the information currently available (and subject to the Healthcare Commission's data ratification process), the majority of the standards included in the balanced scorecard have also been achieved. The Healthcare Commission will publish finalised positions, together with assigned star-rating categories on 27 July 2005.

2004/05 was a strong financial year. The corporation achieved a £42,000 surplus against a planned income and expenditure breakeven - and was in financial surplus throughout the year. The corporation also had a recurrently balanced income and expenditure account throughout the year, placing it in a strong financial position going into 2005/06. Increased emphasis has been placed on maintaining strong liquidity, and controls on cash and liquidity were strengthened. Cash was significantly ahead of its planned position in the corporation's three-year working capital projections (which were approved by the Board as part of the foundation trust application). At 31st March 2005, the corporation had a closing cash balance of £6.1 million, compared to an original forecast of £2.5 million. Further details on financial performance are set out in section 1.2.

Following constructive and amicable negotiations with our major purchasers, a contract for services in 2005/06 was agreed and signed by 31 March 2005. This provides for increases in activity levels above those originally estimated - albeit prudently - in our Service Development Strategy.

By the end of March 2005, maximum waiting times for elective treatment had fallen to three months for the majority of specialities, with orthopaedic surgery being the longest wait at five months. Maximum outpatient waiting times were 13 weeks or below. Agreements for 2005/06 will enable the maximum waiting time for elective treatment to be no higher than three months in every specialty by the end of the calendar year, and at 10 weeks for outpatients. These comparatively short waiting times will provide the corporation with market advantage over surrounding providers, particularly as 'Choose and Book' for patients comes to fruition.

Throughout the year, non-elective activity was above planned levels, both in presentations to our Accident & Emergency department and admissions to our Emergency Management Unit. Extensions to the Emergency Management Unit (now encompassing a Clinical Decision Unit, Emergency Assessment Ward, Discharge Lounge and A&E Observation Ward) were completed by January 2005, and have already contributed to the smooth passage of emergency patients through the hospital. Quarterly targets for treatment of patients within four hours in the Accident & Emergency Department were all achieved. As a result £500,000 of incentives monies were received. These will be used to upgrade and increase the facilities in the department during the summer of 2005.

The corporation has invested in a Research Department. This will develop an infrastructure and culture to allow clinicians to undertake research and to develop research capacity by supporting 'novice' researchers. A Multi-professional Research Strategy Group, led by the Medical Director, is in place and through this group a strategy has been developed; and a number of priority research teams with specialist interests identified.

Key constraints
The main constraints on the corporation's activities are:

External environment
The uncertainty of 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 affect this could have on the tariff rate paid for clinical activity.

A further risk to our continued progress is maintaining good working relationships with partner health and social care organisations, such as primary care trusts, social services and surrounding NHS trust or foundation trust hospitals.

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

- Ability to attract and retain key staff
- 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

The Board of Directors has considered the constraints and risks listed above, and action plans are in place to alleviate these wherever possible.

Relationships
Throughout the year, as we have moved through the foundation trust application and authorisation process, working relationships have been re-assessed and re-positioned to reflect the new status whilst preserving close inter-agency co-operation.

Relationships with local commissioners have continued to be open and constructive, and have been strengthened by consultation on the application to become a foundation trust and on the service development strategy. Since becoming a Foundation Trust we have continued to play an active and collaborative role in the local health community while also being able to encourage and support our partners differently through our autonomy in the way we relate to the Strategic Health Authority and Department of Health.

A major feature over the 12 months has been the establishment of open, constructive and mutually respectful relationships with the Independent Regulator and his team. Relationships with other partner bodies have not been ignored over this period and strong bonds remain and can be evidenced in positive reports from bodies such as the Multi-Professional Deanery, Royal Colleges, CPA and local authority Overview and Scrutiny Committee.

In addition we have developed our links with the voluntary sector such as the Hospital League of Friends, Derbyshire Association for the Blind, Cancer Users Group and the Patient and Public Involvement Forum.

Organisational issues

Improving Working Lives

The Improving Working Lives Standard (IWL) is a blueprint by which NHS employers and staff can measure the management of human resources. Organisations are kite-marked against their ability to demonstrate a commitment to improving the working lives of their employees.

All trusts must reach Practice Plus level of the national Improving working Lives initiative by March 2006 - and the corporation is striving to achieve this. IWL will help the corporation to achieve its aim of being seen as a model employer that attracts and retains staff in all areas of employment. It is also used to promote sharing of good working practices across directorates.

A core steering group and several task groups (in areas such as communication, flexible working and training & development) – made up of staff, has been set up to work towards the IWL assessment planned for later this year. A project group is also in place to promote good policy for staff, but there is still a lot of work to be done in terms of encouraging more staff to become actively involved.

Agenda for change

Agenda for Change is the name for the new NHS national terms and conditions. It applies to all directly employed NHS staff, except very senior managers and those covered by the Doctors' and Dentists' Pay Review Body. A collective agreement for Agenda for Change was reached with the NHS unions at the NHS Staff Council on 23 November 2004. National rollout began on 1 December 2004, with pay and most terms and conditions backdated to 1 October. The aim is for 100% assimilation of all NHS staff (less those who wish to remain on local contracts) by the end of 2005.

A job and pay evaluation for every employee at Chesterfield Royal has been carried out and by June 2005, 80 percent of staff had assimilated across to the new national pay scales. It is expected that all staff will be assimilated by October 2005.

Patient care

Monitoring arrangements

The Royal has a strong performance management ethos, and a history of robust internal monitoring arrangements. A detailed picture of the corporation's position, with respect to all targets, can be obtained at any particular point in time. Where variances do occur, they are acted on and changes implemented in reporting processes. This is reflected in a consistently high level of achievement in meeting targets, and, in a minority of instances where targets have not been met, clear reasons for shortfalls being understood. Finance and activity data are integrated, and remedial action to resolve any variation in performance outside tolerance levels is structured around regaining acceptable performance, based on realistically achievable targets.

The performance management approach is integrated across all levels of the organisation. All reports derive from a common set of data, collected from a small number of strategic systems. The corporation attaches great importance to accuracy in recording activity and other metrics and strong adherence to data quality standards is emphasized. Through the Health Informatics Service the corporation's information analysis and reporting functions are integrated with IT systems management, data quality and end-user training, ensuring consistency and providing a feedback mechanism.

At strategic level, the Director of Planning and Performance issues a comprehensive performance report each month. This summarizes progress towards targets, compared with past performance. The report is issued to the Board of Directors and Hospital Management Committee, as well being made available to senior managers through the Strategy and Performance Group. The data and subsidiary reports used to compile the performance report are available electronically to authorized managers and other staff, and are also incorporated in the regular integrated finance and activity report.

To meet the ever more challenging demands placed on a Foundation Trust, new developments in internal reporting processes are being instituted. This has already resulted in a new weekly internal 'fast-track' activity data report being issued to directorates, and a monthly summary of consultant activity, aimed at supporting consultant contract monitoring. Further changes are expected following an on-going internal review of information requirements, with a view to streamlining processes.

Work also began this year to assess the corporation's compliance against the core national healthcare standards. This shows we are well prepared for changes planned for 2005/06.

The corporation monitors financial performance monthly. The Board of Directors and Hospital Management Committee receive a detailed finance report, covering areas including: income and expenditure performance, a summary of directorate performance against budget, detailed analysis of activity (including financial projections of activity variances from plan), cashflow and balance sheet performance against plan, plus monitoring of the agreed capital expenditure programme. The report details variances from plan and includes action plans to deal with any issues of concern, and projections in the areas noted above for the remainder of the financial year.

Progress towards targets

Waiting Times

Waiting times are a priority. By committing to targets over a number of years, the corporation now has waiting times that compare favorably to most hospitals in the country. In the coming year it is intended to drive down both inpatient and outpatient waiting times across all specialties to a new low level (see *Performance review 2004 to 2005).*

Looking ahead, work has also started on reducing the wait for diagnostic tests and reviewing total time from referral to admission. There is a national target that by 2008 patients should not wait longer than 18-weeks from referral to the start of treatment. The calculation of diagnostic waits will be especially challenging.

The wait that cancer patients experience - from referral to the first definitive treatment - is also being scrutinized. Processes are being streamlined wherever possible, and again, the wait for diagnostic tests reduced. This will ensure the corporation achieves targets related to referral to treatment time, specifically for cancer patients. These are due to be introduced in December 2005.

Cancer Improving Outcomes Guidance

The corporation is committed to achieving improved outcomes for cancer patients - by adopting national guidance on good practice (issued by the National Institute of Clinical Excellence. This may require some restructuring of cancer services within health communities. The corporation is participating in these discussions to make sure North Derbyshire patients receive a service that is of an excellent clinical standard, but which is also easily accessible.

Choose & Book

Giving patients a choice of when they would like to attend for outpatient and inpatient treatment is a central feature of the NHS Plan. Patients at the Royal are now routinely given a choice of date and time as part of the booking process.

During 2004/05 the corporation has worked with local service commissioners to extend this feature – so that choice is offered at the point of referral in several specialties. Choice for cardiology patients who require an onward referral (that is to another NHS hospital), for a coronary artery bypass graft, angioplasty or valve repair is also offered 'in house' through the cardiology department.

The roll out of choice at referral is to be completed by December 2005, facilitated by the introduction of a national computer system, 'Choose & Book'. This will allow patients to make an informed choice about where they want to go for their outpatient treatment (with the option of four or five providers in most specialties).

The Royal is an early adopter site for 'Choose & Book' and went 'live' with it in September 2004. There are very few hospitals in the country using this new facility. For that reason the process is still evolving, with specialties and local general practitioners coming on board in phases. However, the commitment the corporation has given to becoming an early adopter, reflects the priority the Royal has given to the concept of patient choice.

Information for patient and carers

We believe that patients, their relatives and carers must have as much information as we can provide, to enable them to play their part in their care and treatment. Throughout the last 12-months we have continued to develop the information we supply:

Meeting the requirements of the informed consent standard in the Clinical Negligence Scheme for Trusts (CNST), means we now have more than 400 patient information leaflets. These all explain the risks and benefits of treatment and any other options the patient has available to them. These help with the informed consent process and contribute to the corporation's achievement of level 3 (the highest) of the CNST scheme.

Achieving this level of the scheme reduces the corporation's insurance premium to the NHS Litigation Authority by more than £700,000.

All the information produced for patients – from maps of how to find the hospital, to information about specific operations and treatments can be found on the hospital's website

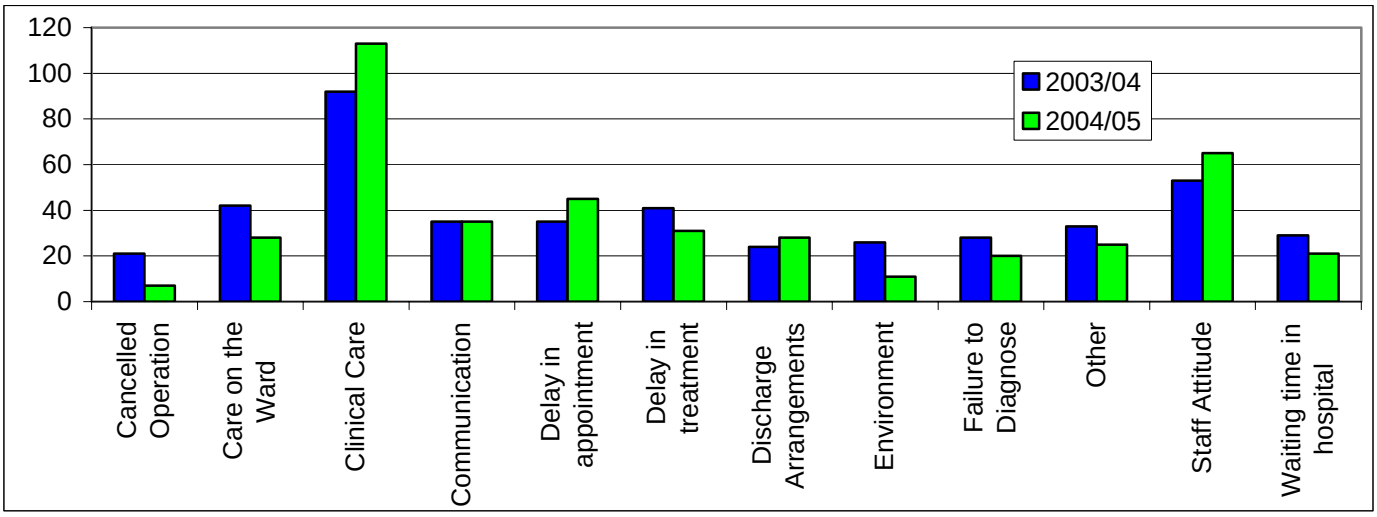
Complaints handling

We welcome complaints – using the issues to improve and change the care and services it provides. Last year more than 250,000 patients were seen in out-patients, Accident and Emergency. Thousands more came into hospital to stay or for day case procedures.

During the year a total of just 430 complaints were received by the corporation, compared with 459 during 2003 to 2004. The table below shows the breakdown of complaints by reason and directorate:

	Cancelled Operation	Care on the Ward	Clinical Care	Communication	Delay in appointment	Delay in treatment	Discharge Arrangements	Environment	Failure to Diagnose	Other	Staff Attitude	Waiting time in hospital	**Grand Total**
Central Services	0	2	5	1	2	1	4	1	2	0	4	1	**23**
Critical Care	0	0	0	3	3	0	0	1	0	0	1	0	**8**
Emergency Care	1	2	26	4	4	4	1	1	3	1	10	4	**61**
Imaging Services	0	0	8	1	1	1	1	0	1	0	3	1	**17**
Women's and Children's	1	3	20	3	7	4	5	1	3	6	7	3	**63**
Medical Specialties	3	10	20	11	7	5	7	4	3	6	11	2	**89**
Not specifc	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Nursing & Clinical Developments	0	0	0	0	0	0	2	0	0	0	0	0	**2**
Orthopaedic Surgery	0	3	12	2	7	5	4	0	1	4	2	3	**43**
Pathology	1	0	1	2	1	0	0	0	0	1	3	0	**9**
Planning and Performance	0	1	1	0	1	0	1	0	0	0	1	0	**5**
Surgical Specialties	1	7	21	8	12	11	3	3	7	7	22	7	**109**
Grand Total	**7**	**28**	**114**	**35**	**45**	**31**	**28**	**11**	**20**	**25**	**65**	**21**	**430**

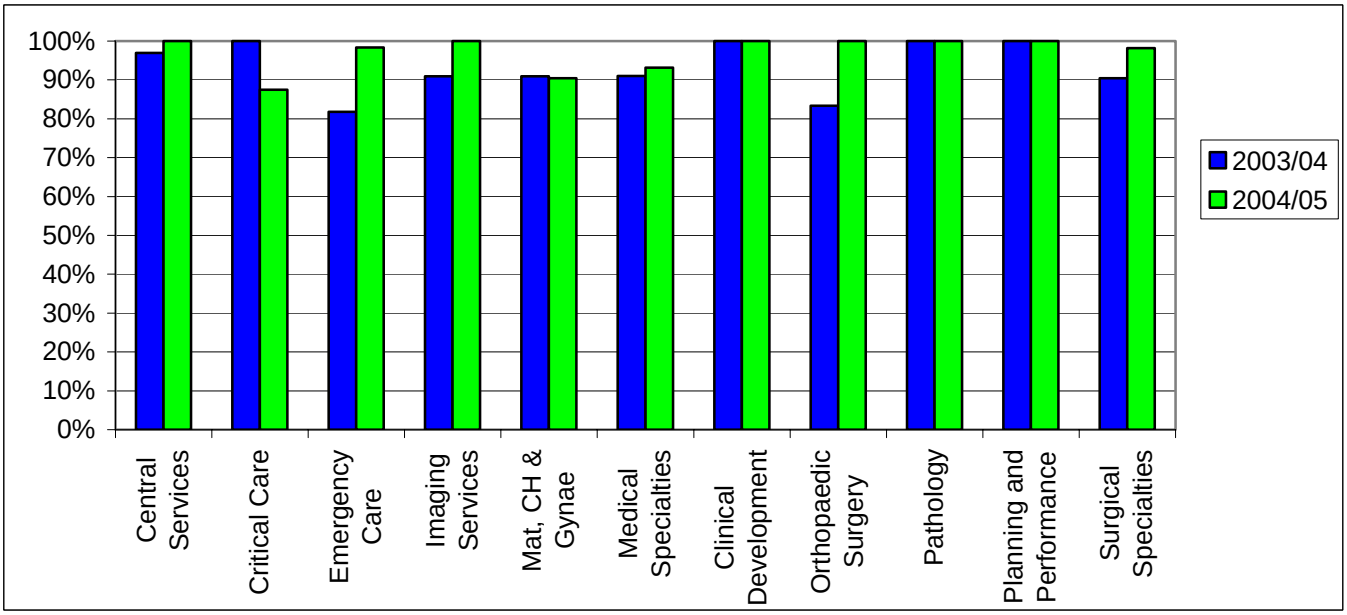
The graph below shows the breakdown of complaints by subject and compares the number received in 2003/04 with 2004/05.



Response times

In addition to monitoring the reasons for complaints, the corporation aims to respond fully to all complaints within 20 working days of receipt. During the year 2004/05, 96% of complainants received a full and final response with 20 working days, compared with 90% the previous year.

The graph below shows the performance by directorate comparing 2003/04 with 2004/05.



Taking action

These are some improvements made after complaints were received from patients, relatives or visitors:

- A local policy was developed in medicine and surgery in relation to referrals for senior medical reviews. This action followed an incident where a patient's wait for a review was delayed unnecessarily.
- A patient complained that a letter sent by the hospital was too faint to read. As a result of this printer ribbons are now changed every four days and staff are regularly checking print quality.
- A review of discharge arrangements was carried out after a patient was sent home with an IV cannula still in place. A new discharge checklist has been introduced.
- An anonymised complaint was used at inductions for Obstetric and Gynaecology Senior House Officers. This was to raise awareness, after an inappropriate method of examination was used on a patient with a cyst.
- The pharmacy has reviewed its stock procedures after a complaint that relevant medication was not available.
- Deaf awareness training is being implemented for staff, following a complaint about the treatment of a deaf patient.
- A change in process has been introduced to ensure that no ear, nose and throat patients are discharged without a final medical review.

Stakeholder relations

Partnerships and alliances

The corporation is a member of the commissioning consortium North Derbyshire, South Yorkshire and Bassetlaw Commissioning Consortium (NORCOM). 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 is regularly represented at NORCOM meetings and participates in these specialty specific NORCOM networks:

- Critical Care
- Cardiac
- Oral and Maxillofacial Surgery and 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 95% of its patient care income. They are: Chesterfield Primary Care Trust, North Eastern Derbyshire Primary Care Trust, and High Peak and Dales Primary Care Trust.

Working closely with partners ensures the continual improvement of services across the health community. In particular, there is a shared commitment to challenge traditional models of service provision and to reframe service delivery where appropriate.

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

- renal dialysis (Sheffield Teaching Hospitals Trust)
- chemotherapy (Weston Park Hospital Trust)

Visiting consultants also hold specialist outpatient clinics at the Royal:

- plastic surgery (Sheffield Teaching Hospitals Trust)
- neurology (Sheffield Teaching Hospitals Trust)
- nephrology (Sheffield Teaching Hospitals Trust)
- genetics (Sheffield Teaching Hospitals Trust)
- thoracic surgery (Sheffield Teaching Hospitals Trust)

To develop a north Derbyshire base to provide academic training for pre- registration nursing students, the corporation is working in close partnership with the Multi-Professional Deanery and Derby University. The communication systems and methods of working have been described by the Deanery as 'an example of excellent partnership working between service and academia.' This partnership is enabling the corporation to actively inform the educational provision of the nursing students. It promotes fitness to practice at the point of qualification and encourages the ethos of a 'home trust' philosophy. This will help support future nursing recruitment and retention.

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

- the Patient and Public Involvement Forum
- the Overview and Scrutiny Committee
- 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

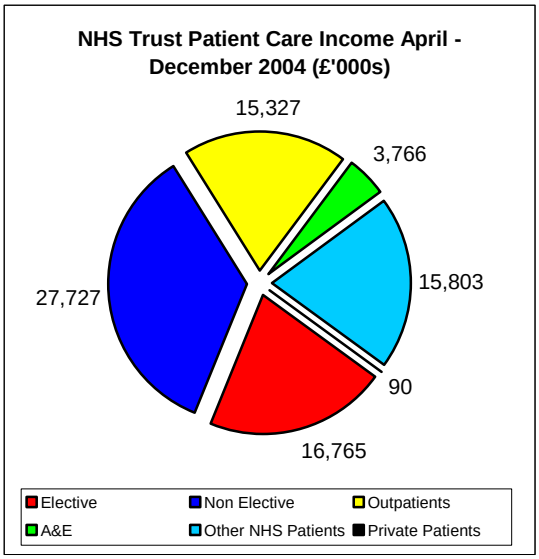
These partnerships allow for feedback on our services and they enable improvements to be identified that meet the needs of our local community.

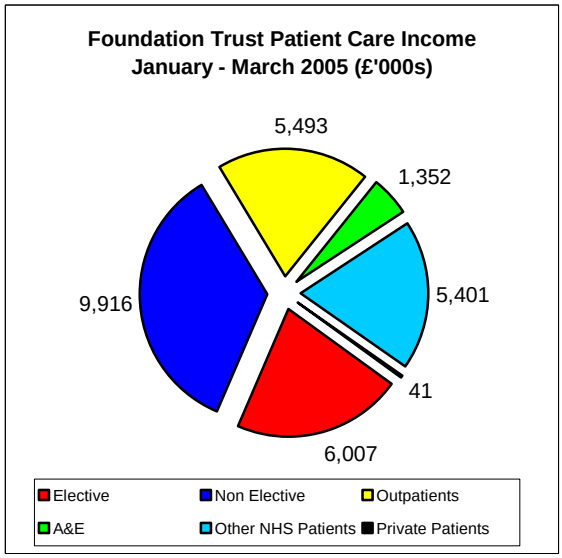
Finance

The accounts for the periods 1 April 2004 to 31 December 2004 and 1 January 2005 to 31 March 2005 are included in full at Appendix A and B.

Income from activities

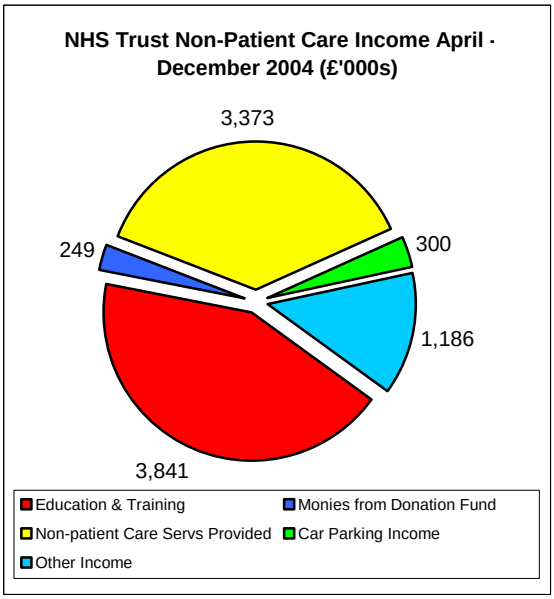
The total income from patient-care activities for the year 2004-05 was £107,688,000. This represents 89.07% of total income for the year. This is shown graphically below, for the nine-month period the trust was a NHS Trust, and the three-month period the trust was a foundation trust.

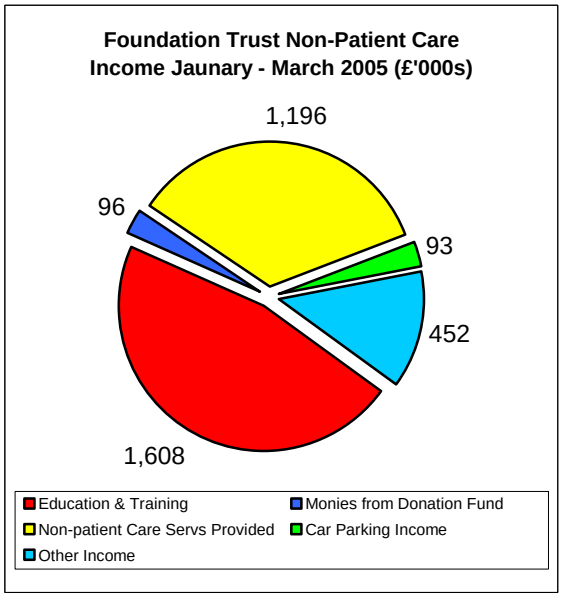




Income generated from non-healthcare activities

Included below are details of £12,394,000 of non-healthcare income received in 2004-05, which has been generated for the provision of non-healthcare services. This represents 10.3% of total income in year.





Financial position

The corporation achieved all its financial targets in year, including achieving a financial surplus of £27,000 against a breakeven position as required for the nine months to December 2004. In the 12-month period to 31 March 2005, the corporation achieved £8 million Earnings Before Interest Taxation Depreciation and Amortisation (EBITDA) - slightly ahead of plan. Additionally, a net surplus of £42,000 for the 12 months (£15,000 for the 3 months to 31 March 2005) after absorbing an exceptional loss on revaluation of £339,000 was achieved.

Cash increased to £6.1 million, and a working capital facility of £4 million was also in place. This gives cash headroom in excess of £10 million, and the corporation a healthy liquidity position. This will be further strengthened in 2005-06, by extending the working capital facility to £10 million, to provide further cash headroom for the corporation. The corporation had no requirement to borrow against the Prudential borrowing limit of £13 million set in its terms of authorization, in 2004-05, which consisted of £9 million new borrowing, as well as the working capital facility of £4 million.

Planned investment activity

The corporation's investment, in terms of capital expenditure, is shown below for the 2004-05 financial year. A total of £6.8 million was spent mainly to provide enhanced patient care and education accommodation and to replace medical equipment. In addition £895,000 of charitable capital expenditure was granted to the Trust in year from its charitable funds.

Capital investment – major schemes for the 2004-05 financial year	April-Dec 2005 £000's	Jan-March 2005 £000's	Total 2004-05 £000's
Provision of new wards and new education centre	2,618	412	3,030
Cardiac Catheter Suite	388	6	394
Minor building schemes	554	471	1,025
Automated Pharmacy Robot	282	9	291
Digital Hearing Aids	267	14	281
Equipment	589	820	1,409
Other government modernisation schemes	360	28	388
NHS capital expenditure	5,058	1,760	6,818
Donated capital expenditure	839	56	895
Total capital expenditure	5,897	1,816	7,713

As a 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 spend in each of these categories.

Capital investment analysis for the 2004-05 financial year	April-Dec 2005 £000's	Jan-March 2005 £000's	Total 2004-05 £000's
Protected asset investment	2,465	867	3,332
Unprotected asset investment (ie. equipment including IT and the education centre)	2,593	893	3,486
	5,058	1,760	6,818
Donated capital investment	839	56	895
Total capital expenditure	5,897	1,816	7,713

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 were consistent with previous years - with the exception of the revaluation of assets. The main change here was on revaluation - due to a revised interpretation of Financial Reporting Standard 11 (FRS11) (as noted in the Foundation Trust Manual of Accounts issued by Monitor in April 2005). This led to a charge of £338,000 against the income and expenditure account. This is treated as an exceptional charge in the 1 January to 31 March 2005 accounts. Under previous accounting interpretation this would have been charged to the revaluation reserve, and would have had no impact on the income and expenditure account.

Investments

The corporation made no investments through joint ventures or subsidiary companies and no other financial investments were made. No financial assistance was given/received by the NHSFT.

Private patient income

Under the corporation's terms of authorization, 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 1 January to 31 March 2005 was £41,000 - compared to total patient related income of £28,210,000. This represents a proportion of 0.15%. The corporation is therefore compliant with this obligation.

Value for money

The corporation has a record of implementing cost improvement programmes (CIP) designed to improve efficiency. For 2004-05 a £927,000 CIP was achieved:

Description	£000s
Reduction in theatre lists/clinics	147
Procurement savings	95
Income generation	226
Productivity increases	292
Savings on reserves	167
Total	927

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 2004-05 is published separately and is available from the corporation on request.

Board of Directors

Trust Board

April 2004 – December 2004

Before authorisation as a foundation trust a Trust Board managed the hospital. They decided the future of the hospital – agreeing strategy and direction; overseeing the hospital's clinical and financial performance; and ensuring provision of the right services and that these gave value for money. The Trust Board was not involved in the day-to-day running of the hospital.

The Board was made up of: the chairman; five executive directors (senior people employed by the trust) and five non-executive directors – (people from outside the National Heath Service (NHS)).

At Board meetings, everyone had equal status.

Note: The chairman and non-executive directors were paid an expenses allowance for their work. This pay is disclosed in the annual accounts for April 2004-December 2004 and is in line with guidance determined by the Secretary of State for Health.

For this period the Board comprised:

Michael Wall, chairman
Eric Morton, chief executive
Bill Lambert, medical director
John Raine, non-executive director
Nick Webber, vice-chairman
Paul Briddock, director of finance
Ron Clarke, director of nursing and clinical development
Terry Alty, director of personnel and hospital services
Yousef Taktak, non-executive director

(see Board of Directors for further information)

Elaine Brookes, non-executive director

As the trust's design 'champion' Elaine worked on several capital schemes during her three years with the organisation. She left the trust in June 2004 after moving outside North Derbyshire, and was therefore no longer eligible to sit on the Board.

Sarah Bossom, non-executive director

After almost seven years as a non-executive director, Sarah left the trust in October 2004. She had been the trust's 'champion' for both children's and older people's services and had played a key role in setting up the trust's clinical governance committee.

Board of Directors

January 2005 – March 2005

On authorisation as a foundation trust, a new Board of Directors was established. This Board has a business focus - developing, monitoring and delivering plans. Board members also have some personal liability for the foundation trust's success.

The Board consists of a chair, chief executive, non-executive directors and executive directors. Its role includes:

- Making sure the NHS foundation trust performs in the best interests of the public, within legal and statutory requirements
- Being accountable for the services provided and how public funds are used
- Making sure the NHS foundation trust complies with its Terms of Authorisation
- Having specific duties relating to audit, remuneration, clinical governance, charitable funds and controls assurance committees
- Deciding the trust's strategic direction - in consultation with its membership and Council of Governors
- Working in partnership with the Council of Governors

Under section 19 of schedule 1 to the Health and Social Care (Community Health and Standards) Act 2003, the chairman, chief executive, executive and non-executive directors were appointed to the corporation's new Board of Directors as follows:

Chairman: Michael Wall

Initially appointed to 30 November 2006

Born in Nottingham, Michael attended Sheffield University and obtained an honours degree in Law, before passing his solicitors finals at Chester College of Law in 1983. Michael became a trainee solicitor, and was admitted as a solicitor in February 1986. In December 1987 Michael became a partner in Blakesley and Rooth Solicitors of Chesterfield.

In 1998 he became a partner at the Anderson Partnership (formerly Kelly and Anderson) specialising in Property Litigation, where he works to this day.

Currently, and since 1999, Michael has been a part-time District Judge of the High Court and County Court, assigned to the Midlands Circuit.

He is a former Chairman of Rent Assessment Committees and Leasehold Valuation Tribunals for the Midlands Rent Assessment Panel and former Vice President of the Northern Rent Assessment Panel.

As well as his other commitments, Michael is a Non-Executive Director of Amber Valley Housing Ltd and New Era Housing Association Ltd, the latter providing support to people with disabilities nationwide. He is also Vice-Chair of the New Dimensions Group.

Vice-chairman and non-executive director: Nick Webber
Initially appointed to 14 July 2006
Nick joined the Trust in 1996 as a non-executive director. He serves on the Remuneration Committee, the Audit Committee - which he has previously chaired - and he currently chairs the Charitable Funds Committee. He has also acted as the trust's Complaints Convenor. Also he has chaired and served on Mental Health Appeals during the time the trust had responsibility for mental health services. Through personal involvement and experience, and apart from his management and business skills, Nick has a particular focus on all areas of patient accessibility and providing service excellence.

Born, raised and educated locally, Nick has spent much of his working life based in and around the Derbyshire and Yorkshire area. A career in the Automotive and then the Automotive Glass industry resulted in him leading one UK's largest and most respected nationwide service providers. Nick was instrumental in the creation and success of a unique major automotive glass production facility locally.

For last five years, up to his retirement from full-time employment on ill health grounds in 2001, Nick acted for the main board of his companies' PLC parent group. His role involved researching and advising on UK and European business expansion and acquisition. He also represented both them and his industries trade bodies on issues of relevant legislation at the European Parliament. Nick suffers from Motor Neurone Disease.

Non-executive director: John Raine
Initially appointed to 31 October 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 a non-executive director on the hospital trust board in 1988 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 Blind People from 1997 until 2004.

When 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.

Non-executive director: Dr Yousef Taktak
Initially appointed to 31 October 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 novel and advanced wound care products. Yousef is also Chief executive of Biointerface GmbH and a Governor of Darley Dale Primary School in Matlock.

Chief executive: Eric Morton
The chief executive, Eric Morton, came into post in December 2001, having previously been employed by the 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 of Technology.

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 and clinical development: Ron Clarke
Ron Clarke has also been a director since the 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 at the Leeds General Infirmary.

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 for the Clinical Development Directorate, which leads on clinical governance, 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 HR 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 the trusts' 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 and co-director of clinical development: 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 1986, and has continuously held medical management positions since then in surgical specialties.

Bill became the Trust's second Medical Director in 2000, and together with our Director of Nursing, is co-director of the Clinical Developments 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 20 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 and service improvement, she is also professionally accountable for the Trust's heads of performance and 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 1990's she undertook a radical overhaul in the management of the Trust'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 Trust'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 26 years of NHS experience. Having been employed at the trust for 13 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 to become 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 also currently national chair of the Health Facilities Management Association (HFMA), which represents facilities management throughout the NHS. He has previously been a member of Sheffield Hallam University's Facilities Management Graduate Centre.

Termination of appointments

Chairman and non-executive directors

The Council of Governors has the ability to 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.

Chief executive

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

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

Remuneration

NHS foundation trusts (and previously NHS 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 2004 to December 2004 and January 2005 to March 2005.

Remuneration of the chairman and non-executive directors

A remuneration committee comprising: one staff governor, one partner governor and three public governors determines the salary and allowances paid to the chairman and non-executive directors. Their decisions have to be ratified by the Council of Governors.

For the period January to March 2005, the chairman and non-executive directors transferred from the NHS trust to the NHS foundation trust on their existing terms and conditions, under the proviso of the corporation's constitution.

The Council of Governors established a remuneration committee in May 2005 to determine remuneration for April 2005 to March 2006:

- Dr Philip Rayner, staff governor, medical and dental class of the staff constituency
- Councillor Terry Gilby, public governor, Chesterfield class of the constituency
- Pauline Fisher, public governor, High Peak class of the public constituency
- Pamela Wildgoose, public governor, Derbyshire Dales class of the public constituency
- Rosemary Parkyn, partner governor, appointed governor, voluntary sector partners

Remuneration of the chief executive and executive directors

A remuneration committee determines the salary and allowances paid to the chairman and non-executive directors.

For the period January to March 2005, the executive directors transferred on their existing terms and conditions, under the proviso of the corporation's constitution.

The corporation has an established remuneration committee to determine remuneration for April 2005 to March 2006:

- Michael Wall, Chairman
- Nick Webber, Vice-Chairman and Non-Executive Director
- John Raine, Non-Executive Director and Chairman of the Audit Committee

Other key committees

These committees also play a key role in the running of the corporation and were in place before foundation trust authorisation:

Audit Committee

This receives internal and external audit reports and undertakes detailed examination of financial and value-for-money reports received by the Board of Directors. Membership:

John Raine, non-executive director (in the chair)
Nick Webber, non-executive director
Yousef Taktak, non-executive director

The membership of the audit committee is to be reviewed. This follows the appointment of Michael Hall in July 2005 as non-executive director (finance) and audit committee chairman (designate).

Charitable Funds Committee

This is responsible for making sure money donated to the hospital is spent wisely. Membership:

Nick Webber, vice-chairman/non-executive director (in the chair)
John Raine, non-executive director
Paul Briddock, director of finance and contracting

Clinical Governance Committee

This is responsible for monitoring clinical standards in the hospital. Membership:

Core group
Yousef Taktak, non-executive director (in the chair)
Bill Lambert, medical director
Ron Clarke, director of nursing and clinical development

Advisory group:
Core group members plus:
Gail Collins, clinical director, women's and children's
Jeff Glaves, consultant radiologist
Kate Hoffman, clinical education advisor
Katherine Lendrum, consultant, accident and emergency
Lisa Howlett, head of clinical audit and clinical governance support
Martin Shepherd, head of therapy services and medicines management
Maxine Simmons, head of education and workforce development
Nichola Lawrence, head of nursing, surgical specialties
Rod Collin, clinical director, pathology
Sheharayer Asad, consultant orthopaedic surgeon

Simon Dale, consultant anaesthetist
Sue Frost, head of physiotherapy
Sue McDermott, deputy director of nursing, head of patient safety

Risk management governance committee
This holds responsibility for ensuring the corporation meets legal obligations, such as the terms of foundation trust authorisation, its constitution, health and safety legislation etc. Membership:
Michael Wall, chairman (in the chair)
Eric Morton, chief executive
Terry Alty, corporate secretary
Paul Briddock, director of finance and contracting
Andrew Jones, director of allied clinical and facilities services (attending in an advisory capacity)

Register of director's interests

The corporation holds a register listing any interests declared by members of the Board of Directors. Directors 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 Derbyshire S44 5BL

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

At March 31 2005, the Board of Directors had declared these interests:

Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies):
Michael Wall, chairman
Department of Constitutional Affairs, ministerial appointment - Deputy District Judge of the High Court and County Court
Chairman, New Era Housing Association Ltd
Chairman designate, New Dimensions Group Ltd (Chairmanship effective from September 2005)*
Non-Executive Director, Amber Valley Housing Association Ltd
Non-Executive Director, Five D Homes Ltd

*Interests updated at May 2005

John Raine, non-executive director
Chairman, Derbyshire Probation Board (Ministerial Appointment)

Yousef Taktak, non-executive director
Director, Avanticare Ltd UK
Director, Biointermed Ltd, Ireland

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
Chairman, National Association of Probation Boards (Elected Appointment)

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

A position of authority in a charity or voluntary organisation in the field of health and social care:
Michael Wall, chairman
Eric Morton, chief executive
John Raine, non-executive director
Nick Webber, vice-chairman
Paul Briddock, director of finance and contracting
Ron Clarke, director of nursing and clinical development
Terry Alty, corporate secretary
Trustees, Chesterfield Royal Hospital Charitable Trust Funds

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

Yousef Taktak, non-executive director
Trustee, Chesterfield Royal Hospital Charitable Trust Funds
Governor, Highfields School, Matlcok

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
Director, Derbyshire Association for the Blind

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:
Eric Morton, chief executive
Vice-Chair, Chesterfield College

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 2004 to December 2004 and January 2005 to March 2005.

Council of Governors

One of the main changes in the move across to foundation trust status revolves around the local community. For the last three months of the financial year, the organisation has had to adjust to a completely new way of working. As a public benefit corporation it is now accountable to the local people and staff who have registered for membership and been elected to seats on the Council of Governors.

On-going consultation and providing the local population with information about plans and proposals is at the forefront of this change.

Elections

The corporation's Council of Governors was 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. Around 5500 community and 3000 staff members of the foundation trust had the opportunity either to nominate themselves to become a governor, or to vote for the governors they wanted to represent them.

Terms of office were also allocated by Electoral Reform Services and are listed below in the 'Our governors' section of this report. Governor appointments in future will take a three-year term of office. However, staggered appointments were made in the first-ever elections to establish a rolling programme for public governor appointments.

The Council

The Council of Governors 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. The role of the Council includes:

- Representing the interests and views of local people in North Derbyshire and those of trust staff
- Regularly feeding back information about the trust, its visions and its performance to the community they represent
- Selecting and appointing non-executive directors and the chairman of the corporation
- Appointing the Trust's auditors
- Attending meetings of the Council
- 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 Trust is consistent with the Terms of Authorisation agreed by the Independent Regulator
- Approving any changes to the NHS Foundation Trust'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

The Council at Chesterfield Royal Hospital NHS Foundation Trust has 30 governors:

Partner governors:

- Two primary care trust representatives
- Three local authority representatives
- One representative from Trent Strategic Health Authority
- Two representatives from local universities
- Two representative from the Patients Forum, Self Help Forum or local voluntary groups

Public governors:

- 16 public representatives (elected)

Staff governors:

- Four staff representatives (elected)

Our governors

Public governors

There are five constituency classes* represented by 16 public governors:

Bolsover class of the public constituency	*Votes*	*Appointment term*
Keith Bowman	239	2 years
Kevin Pettinger	224	1 year
Vanessa Holleley-Wood	243	3 years

Chesterfield class of the public constituency	*Votes*	*Appointment term*
Dr Christopher Day	367	3 years
John Webber*	224	1 year
Kathleen Rowley	252	2 years
Mererid Edwards	310	2 years
Ruth Grice	274	1 year
Sheila Smith	407	3 years
Terry Gilby	245	1 year

** It was agreed at the Council of Governors meeting on March 3 2005 that John Webber would be appointed (as the next runner-up in the elections), following the resignation of Joyce Newton, public governor, Chesterfield class of the public constituency.*

Derbyshire Dales class of the public constituency	*Votes*	*Appointment term*
Pamela Wilgoose	148	3 years

High Peak class of the public constituency	*Votes*	*Appointment term*
Pauline Fisher	191	3 years

North East Derbyshire class of the public constituency	*Votes*	*Appointment term*
Barry Jex	214	3 years
Marjorie Barraclough	189	1 year
Ralph Milne	237	3 years
Ruth Francis	210	2 years

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

Staff governors

There are four staff constituency classes represented by four governors:

Medical and Dental class of the staff constituency	*Votes*	*Appointment term*
Dr Philip Rayner	Uncontested	3 years

Nursing and midwifery class of the staff constituency	*Votes*	*Appointment term*
Eileen Mallender	241	3 years

Allied Health Professionals, Pharmacists and Scientists class of the staff constituency	*Votes*	*Appointment term*
David Allen	61	3 years

All other staff class of the staff constituency	*Votes*	*Appointment term*
Philip Cousins	230	3 years

Partner governors

Primary Care Trust (PCT) governors (appointments co-ordinated by Chesterfield Primary Care Trust through a process agreed with the other PCTs)

Dr David Collins – 3 year term

Dr David Black – 3 year term

Local Authority governors (appointments co-ordinated by the Derbyshire Local Government Association)

Councillor John Willams – 3 years

Councillor Eion Watts* - 3 years

Councillor Carole Walker* - 3 years

*Appointments from May 2005 – December 2007

Strategic Health Authority governors (appointed in accordance with a process agreed with the former Chesterfield and North Derbyshire Royal Hospital NHS Trust)

Mr Robert Waterhouse – 3 years

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)

Professor Susan Read – 3 years

Eileen Hammersley – 3 years

Voluntary Sector governors (appointed by representatives for the Patient's Forum, Self-Help Forum, League of Friends, and North Derbyshire Voluntary Action)
Rosemary Parkyn
Joyce Cupitt

Register of governor's interests

The corporation holds a register listing any interests declared by members of the Council of Governors. 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 Derbyshire S44 5BL

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

At March 31 2005, the Council of Governors had declared these interests:

Directorships including non-executive directorships held in private companies or PLCs (with the exception of those of dormant companies):
Vanessa Holleley-Wood, public governor, Bolsover class of the public constituency
Company Secretary, Headtex Ltd, IT Consultants

Barry Jex, public governor, North-East class of the public constituency
Director, Restore South Yorkshire PLC

Dr David Black, partner governor, primary care trust
Director, Your Asia Holidays*

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

* Declarations made April 2005

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 class of the public constituency
Company Secretary, Headtex Ltd, IT Consultants

Dr David Collins, partner governor, primary care trust
Partner, Dr Collins, Merriman and Emslie, Clowne Health Centre

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

A position of authority in a charity or voluntary organisation in the field of health and social care:
Pamela Wildgoose, public governor, Derbyshire Dales class of the public constituency
Hon Secretary, Matlock League of Hospital Friends

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

Terry Gilby, public governor, Chesterfield class of the public constituency
Director, Ashgate Hospice

Ruth Grice, public governor, Chesterfield class of the public constituency
Services Users Committee, L Cheshire Care; Organisational reviewer L Cheshire Organisation

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

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
Councillor, Derbyshire County Council

Vanessa Holleley-Wood, public governor, Bolsover class of the public constituency
Employee of North-Eastern Derbyshire Primary Care Trust

Keith Bowman, public governor, Bolsover class of the public constituency
Councillor – Bolsover Distric and Derbyshire County Councils

Ruth Francis, public governor, North-East Derbyshire class of the public constituency
Employee of North-Eastern Derbyshire Primary Care Trust

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

Kathleen Rowley, **public governor, Chesterfield class of the public constituency**
Governor, Chesterfield College

Robert Waterhouse, partner governor, Trent Strategic Health Authority
Employee of Trent Strategic Health Authority

Dr David Black, partner governor, primary care trust
Employee of Chesterfield Primary Care Trust

Dr David Collins, partner governor, primary care trust
Member of the Professional Advisory Committee, North-Eastern Derbyshire Primary Care Trust

John Williams, partner governor, local authority
Council Leader, Derbyshire County Council

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:
Dr Philip Rayner, staff governor, medical and dental
Chairman, East Midlands Ambulance Professional Advisory Group

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

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

Professor Susan Read, partner governor, University of Sheffield
The University of Sheffield has training links with the corporation

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 Council of Governors or parties related to them.

Any such disclosures can be found in the annual accounts for the period April 2004 to December 2004 and January 2005 to March 2005.

Membership

Engaging an active membership is a new way of working and a challenge for the corporation. We have been working to set up a sound membership base throughout the year (from April 2004), before authorisation as an NHS foundation trust.

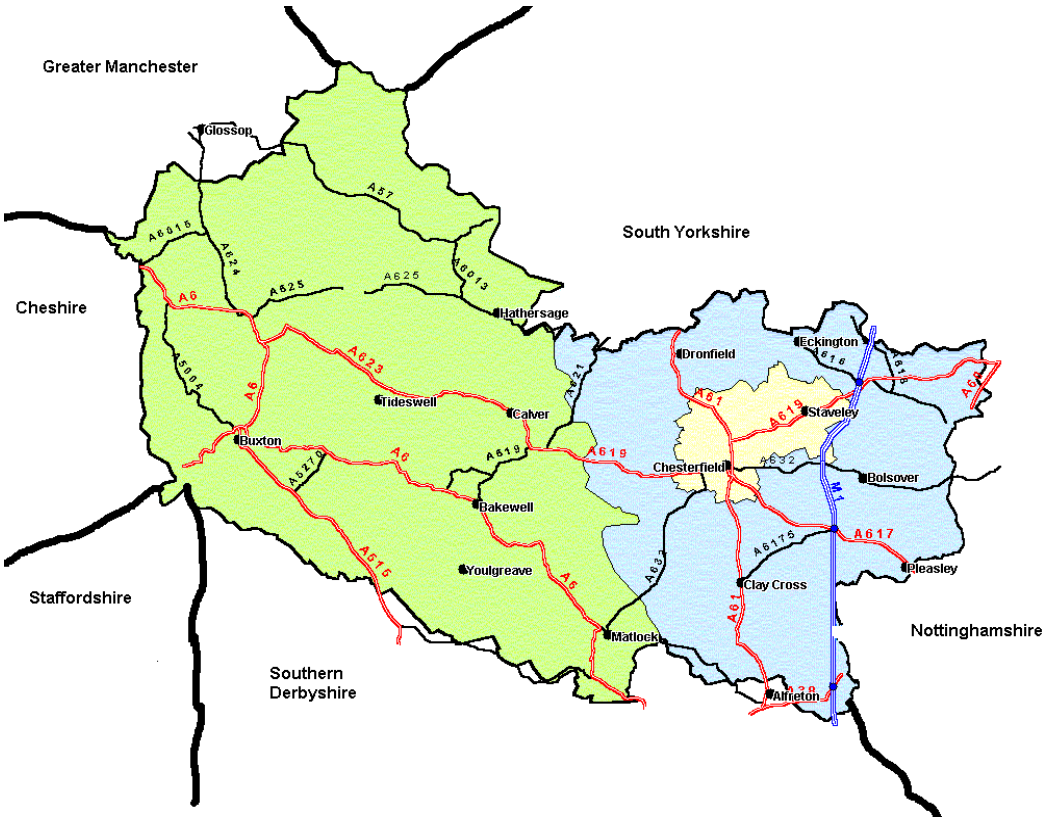
We must involve staff, patients, healthcare partners, local people and others in the decisions we need to make, to improve and develop services and facilities.

As an NHS foundation trust staff, patient and public involvement will be built-in to our corporate governance and decision-making processes. This will 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).

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.



Public constituencies

Public constituency composition

The corporation's public constituency is defined as 'those people living in the local authorities covered by the three North Derbyshire Primary Care Trusts' (PCTs). This represents a population of 367,965.

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

- **Chesterfield Borough Council** (all wards) - population 98,852
- **Bolsover District Council** (all wards) - population 71,766
- **North-East Derbyshire District Council** (all wards) - population 96,940
- **Derbyshire Dales District Council** (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) - population 43,402
- **High Peak Borough Council** (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) - population 57,005

Around 95% of the patients treated within Chesterfield Royal Hospital NHS Trust as inpatients, day cases and outpatients live in the primary care trust areas of Chesterfield PCT, North-Eastern Derbyshire PCT and High Peak and Dales PCT.

Co-terminosity

In terms of co-terminosity of PCTs with local authority boundaries, the PCTs map as follows:

- Chesterfield PCT is co-terminous with Chesterfield Borough Council
- North-Eastern Derbyshire PCT is co-terminous with the councils of North-East Derbyshire and Bolsover.

However residents in some wards of both North-East Derbyshire and Bolsover District Councils, look to bordering acute providers for their routine care in Sheffield, Worksop and Mansfield.

- High Peak and Dales PCT comprises the northern part of Derbyshire Dales District Council and the southern part of High Peak Borough Council.

However, in practice, few referrals are made to Chesterfield Royal Hospital from the residents in the High Peak. Most referrals are made to hospitals in Stockport, Manchester and Macclesfield.

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 (North Derbyshire) area (see above)

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.

Breakdown of community membership

We have developed a membership strategy and since April 2004 our membership base has steadily grown. By March 2005 we had a combined membership (staff and community) of around 10,000.

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

	2004/2005	2005/2006 (estimate)	2006/2007 (estimate)
Community members at April 2004	500	6,642	7,500
Community members at March 2005	6,642	7,500	8,500
Community members at June 2005*	6,709	8,000	8,800

**** There are an another 282 members outside the constituency area, for example in the Amber Valley and Nottinghamshire areas. They wish to be registered because of their links with the hospital (but have no voting rights under the current terms of the constitution).***

Breakdown of public membership within constituencies (March 2005):

Constituency	Population served	Number of members	% of population served
Bolsover	71,766	945	1.3
Chesterfield	98,852	1943	2.0
Derbyshire Dales	43,402	1012	2.3
High Peak	57,005	467	0.8
North-East Derbyshire	96,940	2002	2.1
Other* (see note above)		273	

Staff constituency – eligibility requirements

The staff constituency comprises:

Permanent members of staff and 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 –that is all qualifying staff automatically become members unless they seek to opt out.

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

Staff constituency

The staff constituency is broken down into four classes:

- Medical and dental staff
- Nursing and midwifery staff
- Allied health professionals, pharmacists and scientists
- 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.

	2004/2005	2005/2006 (estimate)	2006/2007 (estimate)
Staff members at April 1 2005	0	3,157	3,200
Staff members at March 31 2005	3,157	3,200	3,200

Breakdown of staff membership within constituencies (March 2005):

Constituency	Number of members
Medical and dental	213
Nursing and midwifery	1386
Allied health professionals, pharmacists and scientists	305
All other staff	1253

Membership strategy (summary)

The corporation has changed its forecast growth in membership for 2005/06 and 2006/07, reflecting expectations that staff membership will be slightly higher and steady organic growth in public membership will continue, but at a slower rate.

The corporation needs to concentrate on building membership on its doorstep – Chesterfield. The comparative growth in membership numbers in other classes of the public constituency areas was not expected when the structure of the council of governors was determined. Thus, there is an imbalance, relative to the other classes, between the membership number in Chesterfield and the number of governors it has. A similar but less acute issue applies to Bolsover.

There is also a need to look to increase membership in the 16-35 and 36-50 age groups.

Building membership

Right from the start the corporation held a strong belief that membership should be 'voluntary' - to show definite willing and interested participation. Our membership recruitment objectives for 2004/05 will stay the same in the coming year:

- 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 to 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 keep 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 various methods to deliver the message about membership
- To set up a two-way feedback system, so staff and community members have suitable channels to feedback their ideas and concerns, raise issues, ask questions and find out more information

Methodology

Over the financial year we have gained membership through a variety of public relations and marketing tools. These included:

- Advertising membership through a variety of media and other mediums - within the hospital and its premises and via external sources
- Using a radio membership recruitment campaign in conjunction with local station Peak 107fm
- Producing membership recruitment information
- Devising a communications pack for members and potential members
- Placing regular feature and news items with local media
- Producing regular and easily accessible information for staff
- Maximising the potential of the trust's intranet and website for information, communication and democratic purposes

- Establishing a clear brand for membership and membership materials
- Using a 24 hour freephone number 08000 56 56 27 for people to register as members
- Attending community forums, citizen's panels and other local meetings throughout North Derbyshire, to consult on the NHS foundation trust application and to encourage membership registration
- Using an external company to host a recruitment drive with a mailshot to 100,000 addresses in North Derbyshire

Within 12months we grew our community membership from 0 to more than 6,500. We consider this a success that we can continue to build on.

Future plans

Our membership strategy embraces tactics for achieving membership success in these areas:

Membership diversity
Membership growth and interaction
Opportunities for elections
Members, governors and board of director involvement
Education

Some of the methods we intend to use include:

- Distributing 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

- Establishing new links and 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

- Working to improve links with local communities - particularly where there is social exclusion or where residents are minority groups currently under represented in membership

- Establish definitions for tiered membership - recognising and categorising members by their interests

- Identify how trust locations can be used as community resources and membership information points

- Work with Electoral Reform Services to adopt fair electoral processes that encourage participation of all active members. Establishing 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 mediums

- 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

- 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 trust, its community involvement and membership opportunities

- Hosting membership recruitment and health promotion days in local town centres

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

Public interest disclosures

Consultation with employees

A well-informed staff leads to well-informed patients, relatives and public. Throughout the year communicating with staff has remained a high priority. Staff at the corporation has access to a variety of communication materials including:

- pay-slip Bulletin – information circulated to every member of staff with their monthly pay-slips
- staff magazine – with the authorisation of foundation trusts status the magazine will re-launch in 2005 as a membership magazine. Distribution will be to community and staff members of the foundation trust
- e-mail briefings – regular briefings to all staff personal e-mail accounts on a variety of subjects affecting the corporation
- 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
- posters, leaflets, reports – produced specifically for staff. For example – the staff charter, staff handbook, comments and suggestions leaflet, and infection control campaign
- Intranet – staff only section of the corporation's website facility. Around £30,000 has been invested in the website in the last 12 months, to make it easier for staff and the public to use. Investment in the intranet has resulted in staff being able to access policies and procedures, patient information, on-line telephone directory and up-to-date news about the corporation – including minutes from key meetings such as the Council of Governors.

All staff that put themselves forward through the suggestion scheme are guaranteed a response direct from the chief executive or another executive director within a 10 working-day standard.

Throughout the trust's application for foundation trust status, staff were told about latest developments and were invited to comment through the official consultation process. The corporation issued staff specific bulletins and news through the pay-slips, by e-mail and on the intranet. Staff meetings were also held across the organisation. About 300 staff (10% of the workforce) attended and they reported back to colleagues on the application and the consultation itself.

In October of 2004, 800 hospital staff were picked at random to take part in the national staff survey. Results from this are used, by among others, the Healthcare Commission, to help to determine future indicators for the performance ratings.

The corporation supports this national consultation exercise as an independent way of finding out staff views and concerns. It helps to shape action plans for the future that will improve working practices and procedures. It also supports the corporation in its aim of achieving the practice plus level of the NHS Improving Working Lives scheme.

Consultation with members and the public

Consulting with a membership is a new experience for the organisation. In the past, as an NHS trust, consultation was ad-hoc, only taking place when significant service changes were planned. The public were consulted on in 'pockets', perhaps through particular groups, such as the self-help group forum.

As a foundation trust, consultation with both staff and community members must be structured, well-planned and specific. Consultation with members means involving them in the decisions we need to make - to improve and develop services and facilities; and in turn enhance our patients' experiences.

The Trust held a ten-week consultation with exisiting members (just 500 at this stage), staff, partner organisations and the local public to discover what they thought about the proposals to become an NHS foundation trust. The consultation was carried out using these methods:

- **Full consultation document**
  Approximately **3000** copies sent to key stakeholders with covering letters. This included: primary care trusts, educational establishments, voluntary groups, charitable organisations, general practitioners, dentists, opticians, pharmacists, parish and local councils, local members of parliament, hospital service providers (catering, laundry), local authorities, unions, other hospital trusts, social services.

  The full document was also available to the public, patients, visitors, carers on wards, departments, help desks, from local libraries etc. and was downloadable from the Trust's website.

  The document contained a pull-out section questionnaire, covering seven questions about service development plans and membership/governance proposals. Recipients were invited to use this as a guide, or to respond separately by letter or e-mail as preferred.

- **Summary consultation document**
  A shorter summary was available in the hospital to the public, patients, visitors, carers etc. from wards, departments and help desks and was downloadable from the Trust's website. It was also circulated for display/pick-up to local libraries, general practitioner surgeries, dental surgeries, pharmacists, opticians, local businesses (for example supermarkets, restaurants, DIY stores). Around **30,000** copies were distributed in this way.

  The summary document included a freepost return slip - to allow people to request the full consultation document and to register for advance membership.

- **Household mailshot**
  A targeted distribution to the Trust's proposed catchment area using weekly free press. The summary consultation document was delivered to around **150,000** households.

In addition, local groups and partner organisations were also consulted (see below), a radio campaign was put in place and the local media promoted the consultation exercise. Information was also available with a feedback form on the website and patients had the opportunity to comment using forms available in out-patient clinics or on meal trays.

More than 1000 individual comments were received from the consultation, and responses were used to complete the final application document.

Thanks to this first consultation, local people were able to directly change the plans in our application document. The Council of Governors was expanded as a result, and the service development strategy altered - to take into account local peoples' preference for better children's facilities based at the Royal Hospital site, rather than in unsuitable, old accommodation, in Chesterfield's town centre.

The corporation has also opted to consult members on proposals to restrict visiting times, with the aim of reducing hospital-acquired infection rates. This consultation went ahead in June 2005 (as this report was written), with results going to the Council of Governors (in July 2005) for their views. By this date, the corporation had amassed a consultation membership base of almost 7000 community members and just over 3000 staff members, and 40% responded to the consultation.

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

Consultation with local groups and organisations

Consultation on the application to become an NHS foundation trust also included meeting with local community forums, citizen's panels, pensioners associations and our partner organisations. Executive directors from the trust attended to present the proposals that would form the application for foundation status. Around 30 meetings took place, with about 700 people in attendance in total to hear about the plans and get an opportunity to have their say.

Derbyshire County Council's Social Care & Health Improvement and Scrutiny Committee undertook its first assignment last year – reviewing cardiac disease prevention and rehabilitation services across the North Derbyshire health community.

Their review report made 17 recommendations with some relevant to cardiac rehabilitation services based at Chesterfield Royal. To address some of the issues the cardiac rehabilitation care pathway was revised. The main change involved introducing a one-stop clinic where patients would attend six weeks after heart attack or by-pass surgery. They would then be placed in one of three rehabilitation routes depending on their needs.

This is a good example of how bringing agencies together can lead to improvement and change. Although no direct policies or prescriptive work came out of the review, the process was useful in terms of getting organisations to talk to each other.

Patient and public involvement

User involvement is one of the best ways of ensuring that service improvements are driven by real and current needs, and the aspirations of people who use (or could use) the services provided. This is in preference to organisations making assumptions about what those needs are. Patient and public involvement is an integral part of the Trust's work, which has been strengthened by becoming a foundation trust.

Activity for the past year was based around the five elements of the national agenda to improve patients' expereinces of the NHS:

- Improved access and waiting
- More information and choice
- Building closer relationships
- Safe, high quality and co-ordinated care
- Clean, comfortable and friendly environment

National Patient Survey
The corporation takes part in the annual programme for national patient surveys. During 2004 the surveys covered Accident and Emergency services and Outpatients.

In our Accident and Emergency department staff used the findings to develop services by:

- Increasing training for staff in the care of children
- Increasing numbers of staff able to carry out initial triage assessment, discharge patients, request pain relief and x-rays.
- Introducing a housekeeper role to improve levels of cleanliness in the department.
- Buying new trolleys and central cardiac monitoring equipment.

In our Outpatient Clinics staff used the findings to improve patient experience in line with national guidance published by the Royal College of Physicians:

- Improving information about waiting times, members of staff in clinic
- Protecting the patients privacy and dignity whilst in clinic
- Provisions for patients to give ongoing feedback and suggestions about their experience
- Increasing staff awareness about meeting the communication needs of patients, for example where the first language is not English, or they have sight or hearing impairment

North Derbyshire Cancer Services User Group
With support from Macmillan Cancer Relief, the Royal has developed a partnership group between service users and health care professionals. The aim of the group is to influence local cancer services and work in partnership to improve these for patients and carers. The group has made progress in improving the patient experience in several areas:

- Supporting the development of patient log books - in line with good practice identified by the Colorectal Cancer Team.
- Developing patient information with healthcare professionals.
- Establishing a link with Weston Park Hospital to promote continuity of care.
- Following an audit of refreshment provisions water fountains will be provided in all outpatient areas.

Prostate Cancer Support Group
In Chesterfield, until 2004, there had been no ongoing support for patients (or their families), diagnosed with prostate cancer. Patients themselves highlighted this lack of support at a focus group and as a result a support group was initiated. The aim of the group is to provide ongoing support to patients with prostate cancer and their families.

The support group has been a huge success. Feedback from members demonstrates the wide spectrum of benefits that people derive from such support. We have plans to develop the group even further in 2005 and may perhaps set up a second group to cope with the demand.

X-ray Appointment Call Centre
A new call centre system was introduced so that patients can easily book appointments direct with the X-Ray department. To review patient satisfaction a survey was sent to a sample of patients. This resulted in the opening times of the service being extended to meet patients' needs.

Pharmacy Outpatients
An evaluation of the experiences patients had attending the Pharmacy Department was undertaken - resulting in a number of action points to improve the environment. The findings supported plans to redesign the 'counselling booths' to protect the privacy of patients when they receive their medication and advice.

Patient Diaries – Intensive Therapy Unit
An patient diary intiative was introduced for patients and their relatives/carers on the Intensive Therapy Unit. This supports their recovery and fill in the gaps from their stay in hospital. The diaries are completed by staff and relatives to keep a record of the patients stay, including photographs.

Dermatology
Positive feedback from dermatology patients was used to support the business case for the development of nurse led clinics in outpatients.

Total Hip Replacement – Education Sessions
Education sessions are held for patients before they attend hospital for a hip replacement to prepare them for their operation. The education sessions were evaluated and as a result staff are developing a 'prompt' list suggesting questions that patients may want to ask their consultant before the operation. In addition, the information provided to this group of patients was updated, to include more details about anaesthetics and what happens when they go home.

Road Layout
A working group including staff and patients was charged with improving the road layout at the front of the hospital and the main entrance. As a result of their work the layout has been improved to ensure easy access for disabled patients and safe movement of traffic.

Patient Advice and Liaison Service
The Patient Advice and Liaison Service acts as a first point of contact for patients and their families to raise concerns, or requests for information. Through this service patient feedback has resulted in a number of improvements to the hospital experience for patients and their families:

Policies for disabled employees and equal opportunities

The corporation's diversity and equality strategy and supporting policies are the cornerstone of its approach to equality of employment opportunity.

These 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.

We review and recognise our legal responsibilities, and encourage good practice at all levels. We also recognise that patients, clients and staff represent the community at large and that we have an important role to play as an active and socially responsible member of the local community.

In particular, we recognise the need to enable all employees to have equal opportunity for self-development, removing barriers and taking appropriate and effective steps to achieve this.

We know that having a committed and motivated workforce depends on staff feeling that they are treated with fairness, respect and dignity and have equitable access to working arrangements that allow an appropriate work/life balance. While 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 feeling confident in using our policies to raise concerns and have them addressed..

Health and safety performance and Occupational Health

In November 2004, a team from the Health and Safety Executive assessed the organisation against its key standards. The three-day audit was designed to look at good practice in existence, as well as to highlight issues of concern requiring action.

Lead Inspector for the HSE during the visit gave a frank report concluding that: "The Trust fell well short of expected standards. Many areas were not compliant with current health and safety expectations and it was clear that risk assessments were not taking place.

"It is evident the Board and senior managers have not given the same priority to this as they have to clinical risk management. It needs to be in the Trust's corporate objectives. There have been different interpretations of what's required by directorates and health and safety has had a low profile. The Trust needs to bring health and safety up to the standard it has achieved in the area of clinical risk."

With such a negative feedback the Board took direct action to change the way health and safety is managed. Changes took place immediately. Board level accountability was strengthened - with overall responsibility for health and safety in the hands of Andrew Jones, the Trust's Corporate Director of Allied Clinical and Facilities Services. Day-to-day ownership of health and safety is on the agenda of directorates' heads of performance and general managers. Other transformations included:

- Setting up a new health and safety management group - to examine key topics and to share good practice.
- Putting health and safety on Board of Director meetings.
- Put 60 staff through risk assessment training
- Significantly invested time and finances in to health and safety objectives
- Established a health and safety team in the organisation – with four new staff appointments
- Set up a working group to look at the issue of stress among staff
- Raised the profile of health and safety through regular communications with staff throughout the organisation

Although disappointing, the audit was viewed positively – as it provided the Board with a clear and exact picture of where the organisation was, where it should be and what needed to be done to get there.

Consequently, as a result of the direct action taken by the corporation, the Health and Safety Executive's final report listed 59 recommendations. There were no improvement notices to meet.

The corporation's occupational health service had been reviewed in 2003/04. This followed an internal audit report that identified scope for improved working arrangements to achieve faster access to medical advice. On the retirement of its own occupational health physician, the corporation had secured externally provided consultant occupational health support from another NHS provider.

During 2004/05, following further review, the whole service was outsourced to the same provider, with additional investment to extend the scope of the service in light of the Health and Safety Executive's audit report.

Payment practice code

The 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. The in-year performance shows 96.7% of invoices paid complied with this measure.

	Number	£'000
Bills paid in period	45,864	33,801
Bills paid within target	44,370	32,725
Percentage paid within target	96.7%	96.8%

External auditor

The corporation's external auditors are:

The Audit Commission
Littlemoor House
Littlemoor
Eckington
Sheffield S21 4EF

Audit cost disclosures

The total cost of Audit Services for the year was £145,000. This was for the statutory audit of accounts for the nine months ended December 2004 and the three months ended March 2005, and services carried out in relation to these.

ends

Chesterfield Royal Hospital NHS
NHS Foundation Trust

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