Chesterfield Royal Hospital NHS

NHS Foundation Trust

Annual report and accounts
April 2005 to March 2006

Chesterfield Royal Hospital NHS Foundation Trust
Annual Report and Accounts 2005/06;

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

This report is produced in line with guidance issued by Monitor - The Independent Regulator of NHS Foundation Trusts.

Content

Strategic statements

Our mission

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

We provide mainly 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 corporation.

Statement from the chairman

I joined the corporation at the start of a challenging year. It is an immense privilege to become involved with an organisation that prides itself on providing local people with high-class NHS services - right on their own doorstep.

I am following in the footsteps of Michael Wall, the Royal's chairman for the past six years. Through his leadership, and (from October 2005), that of acting chairman, John Raine - it is clear that the Board of Directors has used every opportunity to improve and develop the hospital. Already in the first 15-months of its new foundation status, financial freedoms have enabled more than £7million to be spent on capital projects, approximately double the previous annual rate. These include new medical equipment, ward refurbishments, an additional eye clinic and replacement of more than 500 beds.

The financial year ended with a retained surplus of £3.88million to be reinvested in future services. For 2006/07 we are predicting a much reduced surplus of £0.7million in order to cushion the effect of the savings we have been forced to make. Our prudent approach and the quality of our financial management will enable us to carefully plan the overall savings of approximately 10% over three years to make sure that no patient services are affected and any job losses are minimised, both of which are commitments by the board.

In May 2006 we announced the start of consultations on proposals from the first of our efficiency reviews - in nursing and midwifery - aimed at simplifying the nursing management structure and saving £2.3million pa, equivalent to around 43 posts, which is 4% of the nursing and midwifery workforce.

While we are one of the most efficient foundation trusts in the country we are not immune from the wider pressures within the NHS and are subject to risks outside our control, in this case the new national tariff. However my colleagues and I are confident that the corporation will be capable of not only maintaining current service quality but also continue to invest in future improvements.

Throughout this report you will see the Royal continues to perform well - achieving national standards that contribute to its three-star status. Waiting lists are among the lowest in the country - for routine surgery, out-patient appointments and diagnostic tests. We know local people regard fast access to services as vital, so they get the care and treatment they need quickly. This is why we are working with our commissioning colleagues to ensure these low waiting times continue - and indeed reduce further where possible.

We hope this remains one reason that patients - local or from neighbouring areas - make Chesterfield Royal their 'hospital of first choice'.

I am keen to ensure local people get involved with the corporation and help it to develop. We already have more than 10,000 local people interested - through membership of the corporation. And, as a foundation trust we are keen to build links with them using the public governors who were elected to a seat on the Council by these community members. One of the first tasks I have, as chairman, is to explore with governors, ways we can make this happen - and make it work effectively. I will also be reviewing with both the Board and the Council the effectiveness of all aspects of our governance and communication processes to make sure they are in the best shape possible to support our local accountability.

It is also vitally important for the Board to find out staff views and opinions. They have made the Royal the success it is today and they will be affected by our plans to make sure we remain 'in-balance' - financially speaking. It is my view that their support is ever more important as we progress through financial year 2006/07. The Board will be open and

honest about its proposals - and we will talk to staff directly to find out what they think, and continue to engage in fair and genuine dialogue.

I am delighted to introduce this latest annual report and accounts. It is interesting to see just how far the corporation has come in a short time. Foundation status has already shown its benefits and despite current financial pressures it is still on track to make Chesterfield Royal Hospital progressive and forward-thinking. With the support of our staff, financial stability and a commitment to continual improvement and investment we can fulfil our aim to make sure we provide the best services and facilities for patients.

Richard Gregory
Chairman

Statement from the chief executive
The view from the Board

The majority of executive and non-executive directors at Chesterfield Royal Hospital have worked together for many years. So, at the beginning of 2006, we were deeply saddened by the death of our colleague and vice-chairman, Nick Webber - who had been involved with the hospital since 1996. Nick shared our enthusiasm and commitment to provide local people with excellent local services. His drive and support will be missed by everyone who knew him - as Board colleague, patient and friend.

You will see from the chairman's statement that this has proved a successful year. The report highlights our achievements and developments - and demonstrates how our first full financial year as a foundation trust has benefited the population we serve and the staff who work for the new corporation.

It is equally clear that the Royal remains firmly within the NHS. This means that whilst we are no longer accountable to the Department of Health, we are affected by its policies and processes. Changes to the national tariff - which determines how much we get paid for the services we provide - do impact on us. This, as the chairman states, is why we find ourselves looking for cost efficiencies.

I appreciate staff, patients and local people will find it hard to understand why a successful organisation is faced with the possibility of reducing staff numbers to make sure it remains financially secure. Underpinning our proposals is a pledge that any decisions we take will not affect patient care and as far as possible, we will look to redeploy staff affected by any changes and minimise any redundancies. As a foundation trust we have no 'bail-out' options - so financial stability is a requirement that we must meet. It does mean that we are facing major challenges - this is possibly our most difficult period since the mid 1990s.

The current year will be a period of significant challenge and uncertainty for the Royal Hospital and our staff, but we must meet these challenges head on to ensure that the Royal Hospital remains successful and delivers the range and quality of services in the future that it does today.

One huge difference we have experienced in the last year, is how involved local people have become in decisions about the way the hospital works. You will see in the report that huge numbers of North Derbyshire residents have contributed, through consultation, to changes that affect everyone using the Royal. We have cut visiting hours to allow more time for cleaning to tackle the risk of infection - and become a smoke-free site - thanks to the backing of our members. It has demonstrated to us, that while involving people on a large-scale is challenging, it can prove workable and successful and we believe results in better decision-making. I support the chairman's view that we need to build-on this success to ensure the community continues to play a comprehensive role in our future.

For the first time in a while our Board has seen new faces. We welcome, Michael Hall - appointed as a non-executive director in July 2005 and new chairman, Richard Gregory in April 2006. Both of these appointments were made by committees that consisted entirely of governors - a further demonstration of local and partner involvement in corporation decisions. With Richard's appointment of course, we said farewell to Michael Wall. He, over a six-year term made an outstanding contribution to the Royal. His resignation was necessary following a full-time ministerial appointment as a District Judge. He will, I am sure, be pleased to see we continue to prosper as an NHS foundation trust - he was a keen advocate of the new status and what it could bring to health services in North Derbyshire.

I hope this report is an interesting reflection of 2005 to 2006. Our staff have worked incredibly hard to achieve so much - and I thank them, on behalf of everyone on the Board,

for what they have done. It is a superb indication of their commitment to provide excellent care and treatment for patients. I would also reassure them that we will keep them informed of any changes that could impact on their role within the corporation - appreciating that they will feel anxious and concerned about what the future holds. From our view, our staff are vital to our successes and our aim is to protect their position, alongside our need for financial security.

Eric Morton
Chief executive

Background

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

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

On 29 April 1984 the current hospital was opened in Calow, two miles outside Chesterfield's town centre. Nine years later, on 1 April 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 1 January 2005 as a 'public benefit corporation'.

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

Accounting policies for pensions and other retirement benefits
The accounting policies for pensions and other retirement benefits are set out in note 1.18 to the accounts and details of senior employees' remuneration can be found on page 72-74 of the remuneration report.

Details of company directorships and other significant interests
There are no significant interests held by board members, which may conflict with their management responsibilities. Details of company directorships and other significant interests are detailed in this report on page 47.

External auditor
The corporation's external auditors are:
The Audit Commission
Littlemoor House
Littlemoor
Eckington
Sheffield S21 4EF

External Auditors remuneration
The total cost of Audit Services for the year was £79,615. This was for the statutory audit of accounts for the year April 2005 to March 2006 and services carried out in relation to these.

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

Political and charitable donations

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

Significant events since balance sheet date

There are no significant events since the balance sheet date that are likely to have a material impact on both the corporation and the financial statements for the year ending 31 March 2006.

Future developments linked between capital plans and operational development

The corporation is committed to the further modernisation of both facilities and services during 2006/07. Funds are committed for the forthcoming year for capital projects including the continuing replacement of the boiler house, completion of a children's specialist facility, upgrade of hospital wards and new medical equipment.

Research and development

The last twelve months have seen significant transitions both internally and externally.

Externally

The year has seen the publication of a new national health research strategy: 'Best research for best health'. The strategy aims to strengthen and streamline systems for research management and governance, along with ensuring commissioned research focuses on improving health and care. This will radically change the allocation of research monies and will potentially provide more opportunities for local staff to secure grants.

Association with North Trent Research Cancer Network has seen more patients recruited during the year to assist in national trials looking at new and improved treatments for cancer. The network organises and plans research activity covering an area that includes Barnsley, Chesterfield and North Derbyshire, Doncaster and Bassetlaw, and Rotherham cancer units, as well as the Sheffield Cancer centre and Sheffield University.

The corporation is undertaking a number of commercial drug trials. These will support the development of future drugs and treatments to be used nationally for the benefit of all patients. For example, in the orthopaedic department, a new oral anticoagulant (anti-blood clotting) treatment is being trialed after hip operations to assess its ability to reduce the chance of any DVT (deep vein thrombosis) or other blood clots.

Internally

The corporation has appointed a research and development advisor to maintain and improve the high standards already associated with the corporation's research activities.

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. We recognise our responsibility to provide (as far as is reasonably practicable) job security for all employees.

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

- age

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

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

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

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

Providing information to employees
Well-informed and involved staff leads to well-informed patients, relatives and public. Throughout the year staff are consulted about issues that affect them in the way services are delivered and changes to practice that affect their working environment or practice.

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

- pay-slip bulletin – information circulated to every member of staff with their monthly pay-slip.
- membership magazine – with the authorisation of foundation trust status the staff magazine re-launched in 2005 as a membership magazine. It is distributed to all community and staff members of the foundation trust.
- e-mail briefings – regular briefings to all staff via their personal e-mail accounts, on a variety of subjects affecting the corporation.
- staff suggestion scheme – staff can access the Board of Directors by e-mail or letter to ask questions, or put forward concerns, ideas and suggestions. All staff that use the suggestion scheme are guaranteed a response direct from the chairman, chief executive or another executive director within a 20 working-day standard.
- posters, leaflets, reports – produced specifically for staff. 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 £25,000 has been invested in the website (intranet and internet) in the last 12-months, to make it easier for staff and the public to use. Staff can access policies and procedures, patient information, an on-line telephone directory and up-to-date news about the corporation - including finance reports, performance reports and minutes from key meetings such as the Council of Governors.

Action taken to encourage involvement of employees in the foundation trust

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

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

Additional information is also provided - as and when required. For example, at the end of March 2006, all staff received details (with their monthly pay-slip) about the corporation's financial position and proposed plans to maintain economic performance over the next three-years. E-mail briefings have also been issued to directorate teams explaining other efficiency strategies - and these are cascaded through the 'team communication' process, with the aim of informing all staff within 48-hours.

Service development achievements

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

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

Improved nutrition on wards

In an effort to improve nutrition - as well as making mealtimes 'special' - the corporation has been working with Sodexho (our commercial partner providing catering to the corporation) to develop new menus. Our public governors, patients, staff and members of the public have been considering the menus suggested and were invited to sample these before they were launched (in May 2006).

Nationally it is estimated that around 30% of patients in hospitals are malnourished. In an effort to improve the nutritional status of our patients the corporation has introduced a nutritional support nurse trainer. This nurse will work with our ward staff to identify patients who are undernourished when admitted, or who are at risk of becoming malnourished during their stay. Once patients are identified actions can be to support their nutritional needs. This may include supplying them with a special menu, consisting of nutritious, fortified meals.

As a number of patients will require a special diet during their stay (and we recognise ordering and receiving these meals has been problematic) the corporation and Sodexho have been working to produce these meals 'in-house'. This will allow dieticians and Sodexho staff to cater for individual dietary and nutritional requirements more appropriately.

ASPIRE – a skills programme in matching insulin requirements to eating and exercise

ASPIRE is an intensive insulin skills programme for people with type 1 diabetes and developed by the 'Royal' diabetes team. The course is based on diabetes educational models that have proven clinical and psychosocial outcomes that help people with type 1 diabetes to minimise their risks of developing both the short and long term complications of diabetes. Students are taught how to get the balance between their food intake and the amount of insulin they need, right. They learn how to count carbohydrates and how to calculate their insulin doses in order to achieve optimal blood glucose control. Various other aspects of

life with diabetes are also included in ASPIRE. For example, exercise and sick-day management. The course uses the principles of adult learning.

This is the first time that such an intensive insulin skills programme has been offered to people with type 1diabetes in North Derbyshire. The course has been running since October 2005 and early signs are that it is benefiting the students who have attended.

Coronary artery disease

Coronary artery disease is the leading cause of death and disability in the United Kingdom. To improve management of patients with suspected coronary artery disease, we have increased our facilities for rapid access chest pain clinics and coronary angiographies. The appointment of a third cardiologist has ensured that up to four sessions of coronary angiography and cardiac pacing are undertaken in the cardiac catheter suite each week. Consequently waiting times for coronary angiography are now a maximum three to four weeks.

The rapid access chest pain clinic is now available daily, (at the beginning of the year it was only available three times a week). In addition to this, the number of patients waiting for the radio-pharmacological cardiac stress test (MIBI heart scan) has reduced to single figures - there were more than 100 patients waiting for this test six months ago.

Stroke unit

Like coronary artery disease, stroke is another leading cause of death and disability in the United Kingdom. In the last 12 months we have worked to improve the numbers of specialist staff we have looking after stroke patients. Six nurses have completed a stroke diploma and another two are going through the diploma course at present. Most of the staff on Markham ward (where the unit is based) have attended a five-day long stroke course.

Improvements in cleanliness and hygiene

The corporation believes that cleanliness and hygiene on its wards is vitally important - and improves patients' experiences when they are admitted to hospital. Housekeepers - with the primary task of improving cleanliness and hygiene and reducing the risk of infection have been introduced across the organisation - including the A & E department. They work alongside all staff, including the Infection Control Team.

Saving lives

Staff, patients and the public are more aware than ever of the risks of healthcare associated infections (HCAI) such as Methicillin Resistant Staphylococcus Aureus (MRSA).

The NHS aims to halve rates of MRSA bacteraemias by March 2008. To help reach this goal the NHS Modernisation Agency set up 'Saving Lives'; a delivery programme to reduce all healthcare associated infections.

Saving Lives draws on good practice, comprehensive learning and the best initiatives to combat HCAIs.

An action plan was produced by the Infection Prevention and Control Nurse Specialists and presented to the corporation's Board of Directors, who endorsed the document.

Each directorate in the corporation has put its own plan in place, based on its specialties' needs. Reviews are taken to the corporation's Infection Prevention and Control Committee to monitor progress against the challenges of modern healthcare and expectations.

Visiting times

A further initiative to improve cleanliness on wards and reduce hospital-associated infections has been to change visiting times. This allows domestic staff to clean the wards for more hours of the day - when no visitors are present.

The corporation consulted on this huge change with its staff and community membership. It was an overwhelming success with around 5,000 people responding. As a result of the consultation the corporation changed its visiting arrangements and introduced a 'visitors' code':

- Visit during the allocated times of 2.30pm to 4.30pm and 6.30pm to 8.00pm.
- Use the alcohol gel to clean your hands (dispensers are situated at ward entrances and patient bedsides), or wash them with warm soapy water - before you visit the patient and again before you leave the ward.
- Make sure there are only two visitors at the patients' bedside - take turns if necessary.
- Do not bring children under the age of 11 to visit (unless the patient is their parent).
- Do not put food in the patient's locker if it needs storing in a fridge. Hand it to a member of staff for safekeeping. Please don't consume your own food and drink on the ward.
- If you are ill, please do not visit. You should be free of symptoms for 48-hours before you come onto the ward.

On target for patients

More elective operations were undertaken in 2005/06 compared to 2004/05 - 13,754 compared to 13,128, an increase of 4.6%. The corporation consistently undertakes more elective procedures year-on-year, enabling the maximum national target for patients waiting times to be met and maintained, for all patients choosing the corporation for their treatment.

Cancellations on the day of surgery have been reduced to 0.7%. The national standard for the year was 1.3%.

The year saw a further reduction in our waiting times for routine elective surgery. No patients waited in excess of three-months (except in general surgery and orthopaedics, where the maximum waiting time was four months).

There was also a reduction in our routine outpatient waiting times, with no patients waiting in excess of ten weeks from referral. The majority were waiting less than six weeks by 31 March 2006.

99.7% of cancer patients received treatment within 31 days of diagnosis and in the last three months of the year 97% began their treatment within 62 days of urgent GP referral.

Intravenous safety cannulation

Needlestick and sharps injuries are among the top four types of accidents that happen to NHS staff (according to National Audit Office figures).

In an attempt to reduce the numbers of incidents at the corporation, a 'Sharps Strategy Group' was established. The group comprises members from a wide range of departments including infection control, health and safety, genito-urinary medicine, theatres, accident and emergency, clinical skills and occupational health. The group's aims were to develop strategies to reduce injuries among all grades of staff; using education, sharps awareness events and audit, as well as a competition to design a poster to promote sharps safety.

The decision to evaluate safety devices was also made, as injuries involving large hollow bore, blood filled needles place health care workers at greatest risk of acquiring blood borne

disease such as HIV and Hepatitis C. Intravenous cannulas were chosen as the first device for evaluation.

A review of products currently available was undertaken and two product options chosen. Evaluations in clinical areas took place with staff involved completing a questionnaire about the quality of the product, including effects on and comfort for the patient, ease of use, and safety features.

After extensive evaluation a safer intravenous cannula was chosen for use across the corporation. The product features a self-activating safety clip, which shields the needle's sharp bevel when it is removed from the patient, preventing needlestick injuries.

The new cannula will cost no more than the product it replaces, and all staff will receive training to ensure they are at ease with the new product. The introduction of this safety device is a huge achievement and will have significant impact on improving safety for staff.

Appointment of night matrons

As part of the 'hospital at night' initiative, night matrons have been appointed. They play a pivotal role in the co-ordination of clinical teams during the night, reducing the need for junior doctors to work out-of-hours.

Ward occupancy

The corporation adjusted the size of the hospital's bed capacity - to ensure it could achieve an annual midnight target occupancy rate of 85%. To improve services for patients some surgical beds transferred to medical specialities. Ward offices were also re-located at the same time - to create additional bed capacity that can be used at peak times.

Changes to consultant and junior doctor working practices

Through the medical directorate, the corporation has increased consultant presence on the Emergency Management Unit - in order to supervise junior medical staff and provide patients and families with early and timely senior input.

The corporation is committed to improving the working lives of its junior doctors. Some changes to working practices in the medical directorate are helping to do this. A new on-call system means that most junior doctors will not have work for seven nights in a row (as they sometimes do at present). In addition, the directorate has made the rota more humane, by increasing numbers of junior medical staff and recruiting more consultants (one gastroenterologist and one cardiologist appointed last year).

Manual handling

In the last twelve-months there have been some significant changes in manual handling.

At a cost of £800,000, the corporation purchased 504 electric profile beds; replacing all beds across the hospital. This benefits patients, who can now move more easily and more independently. Replacing these beds was made possible by use of surplus funds that arose from 'payment by results'.

Overhead tracking was introduced into the mortuary ensuring safer manual handling for mortuary staff. 12 new Viking M hoists with a greater weight capacity and an improved range of functions have been introduced on to the wards.

We have increased our provision to weigh the heavier immobile patients with the purchase of three heavy-duty beds with integral weighing scales and two hoist weighing scales which can be attached to any of our new Viking hoists.

Training has continued during the year, with 1195 members of staff receiving manual handling training.

Satellite pharmacy

Continuing its transition to a 'ward-based' service, the pharmacy department opened its first 'satellite' dispensing facility in the summer of 2005. The new dispensary is situated on the Emergency Admissions Unit. It has provided the pharmacy with a facility to supply medicines for inpatients without the logistical delays associated with the movement of staff and medicines to and from the main hospital dispensary. The 'satellite' provides a valuable mechanism by which to improve patient access to the medicines.

Ward based drug preparation

Collaboration between senior nursing staff, the infection control team, the estates department, and the pharmacy service has led to the development of dedicated drug preparation areas in each of the corporation's major bed holding areas. The new service responded to audit findings, which revealed cramped and cluttered conditions for preparing intravenous medicines on wards.

The corporation's clinical risk group agreed to a programme of upgrades to wards in surgery, medicine and orthopaedics. These were aimed at establishing dedicated areas where nurses could prepare medicines without interruption in an environment promoting safe practice. It is expected that these areas will provide a significant incentive to improving safe medication practices at ward level.

Developments in ophthalmology

The corporation extended the ophthalmology service, appointing a seventh consultant and developing a second ophthalmology outpatient clinic at a cost of £290,000. From summer 2006 these developments will allow a diabetic retinopathy screening service for North Derbyshire to operate.

It's your choice

The national 'choose and book' project allows patients to choose where they would like to be treated and to get an appointment straight away. The corporation's 'Choose and Book' directory of services was published in June 2005. In the last three months of the financial year, 100% of our patients received a booked appointment at their convenience for first routine outpatient attendance and admission for routine elective surgery.

Capital projects

There have been a number of major building, refurbishment and medical equipment programmes undertaken during the year, including:

- New endoscopes and a computerised visualisation system at a cost of £378,000.
- New ventilators for the intensive therapy unit costing £104,000.
- A £882,000 scheme to replace the mortuary, providing the corporation with modern and up to date mortuary facilities.
- A £1.1million refurbishment of on-site staff residential accommodation.
- A new ophthalmology outpatient suite has been built to accommodate the increased number of patients which ophthalmology are now seeing. The new clinic cost £290,000.
- The first phase of our new children's facility was completed - with a £250,000 scheme to refurbish the children's ward.
- The first phase of our hospital boiler programme was also completed - with £260,000 spent to replace outdated facilities.

The emergency department was rewarded with £500,000 during the year after hitting each of the Government's targets on waiting times in the emergency department. The money was reinvested in patient care and the environment in emergency care:

- Four 'see and treat' rooms at the front of the emergency department, housed in a new building which will allow for further expansion at a later date if needed.
- A&E trolley replacement scheme
- Central cardiac monitoring
- Waiting area environment improvements
- New bereavement viewing area
- A&E entrance improvements
- Dedicated clinic consulting room
- Staff changing improvements
- Children's play areas

New monitoring system

The corporation is one of the first emergency departments in Europe to introduce a wireless central cardiac monitoring system. The system allows clinicians to monitor patients at the staff base station, as well as at the bed-side.

Accreditation for Sterilisation

The sterilisation and disinfection unit (SDU) undertakes the decontamination of all surgical instruments used within the operating department, wards and outpatients departments. The SDU has consistently achieved national quality standards and is monitored by an external independent organisation every six months. In 2005, a new quality standard was introduced (ISO13485: 2003) and the SDU is fully accredited. This standard allows the unit to provide a service not only to its internal customers, but also to external customers, such as GP practices, local hospitals and private practice.

Smoke-free hospital

The corporation introduced a new smoke-free strategy during the year. It came into force on 8 March 2006 - national no smoking day. The policy has been a great success improving the environment throughout the hospital buildings and grounds. The policy introduced no smoking for staff, contractors, patients and visitors inside the corporation's premises, grounds and gardens. Staff are also not permitted to smoke whilst driving corporation vehicles, whilst wearing uniform and in the corporation's residential premises.

Locker replacements

The corporation has long established arrangements for patients to store their medicines in dedicated lockers at their bedside. In appropriate circumstances this allows patients to administer their medicines themselves, and reduces delays in the supply of medicines when a patient is ready to go home.

However, the existing lockers were too small and had proved difficult to keep clean, so during 2005 and 2006, the entire complement of bedside lockers was replaced and upgraded - to provide improved storage facilities for medicines at the bedside.

Patient safety

The National Patient Safety Agency (NPSA) set up its National Reporting and Learning System (NRLS) in February 2004, following a development and testing phase with a number of NHS organisations (including Chesterfield Royal Hospital). The aim is to build an anonymous, national database of patient safety incidents.

Incidents are analysed in order to understand frequency of types of incidents, patterns and trends and underlying contributory factors.

The patient safety team report to the NRLS on a monthly basis detailing all patient safety incidents that have been reported, investigated and closed.

All NHS organisations in England and Wales are now connected to the new system.

Consent training

The patient safety team has been working hard to improve and develop the systems used to gain patient consent. They have provided training to a number of nursing staff that have demonstrated competence and knowledge of procedures in particular speciality areas such as ophthalmology, endoscopy, dermatology and cardiac catheter suite. The training allows the nursing staff to seek consent for specific procedures.

Root cause analysis investigations

The competency with which an organisation manages and learns from incidents has become one of the key markers of success in relation to risk management and clinical and corporate governance.

When the safety of a patient has been compromised it is important to look at the underlying causes of the incident, and what can be done to try and prevent a recurrence.

One of the elements of learning from incidents has been the development of the technique of Root Cause Analysis (RCA) for use within the healthcare setting.

The National Patient Safety Agency (NPSA) actively promotes RCA, and has provided training for senior staff involved in incident investigation within corporation. Ten senior members of staff from the corporation including the patient safety team, matrons and allied health professionals have attended these training sessions.

The patient safety team has now developed a half-day session based on the NPSA's training, and in September 2005, began a rolling programme of education, to cascade this to all grades and disciplines of staff involved in incident investigation across the corporation. It is planned to undertake four of these sessions per year.

New facilities for staff, patients and visitors

Another convenience store opened for business at the Royal in April 2006 - an extra facility for staff, visitors and patients.

Based in the foyer of the new entrance at the back of the hospital, it sells items including newspapers and magazines, sandwiches, drinks and snacks, cards, soft toys and toiletries.

It is part of a £140,000 improvement in facilities which includes, a new canopied entrance with automatic doors, a barrier controlled 'pay on exit' car park for patients and visitors who opt to use the new entrance, easy clean flooring and seating to reduce the risk of infection, a zebra crossing and drop kerbs to improve safety on the road way and a new rest area and vending facilities for ward staff.

Website and intranet development

In October 2005, the website and intranet went out to tender. Health-E-Web won the contract. The re-development work started in February 2006.

The main development to the website is improving access to information for all patients by incorporating a 'patient journey experience'.

The journey is an extension of the patient information section acting as a resource to find out information on the more serious illnesses. The journey contains a multi-media virtual tour of selected hospital services. The journey will also act as a virtual diary following a

patient from the initial diagnosis, through each stage of treatment and recovery. The journey is interactive allowing patients to find out further information by downloading leaflets or clicking on links to external sites.

Staff intranet

Over the past year, the staff intranet has undergone major changes. Consultation with staff showed that the intranet could be improved to include more information and be more user friendly. A £30,000 development project in 2004/05 transformed the intranet to what we see now.

Health-E-Web is continuing to develop the intranet further. The major development will be the re-design of the policies and procedures directory. The corporation proposes to eliminate all paper copies of the policies and procedures, the new on-line directory will support this and has the facility to retain previous versions & archive policies.

Another major development for the intranet will be the staff message board. The board will work on an email basis so staff email their comments anonymously on issues and changes affecting them within the corporation.

Operating and financial overview (OFR)

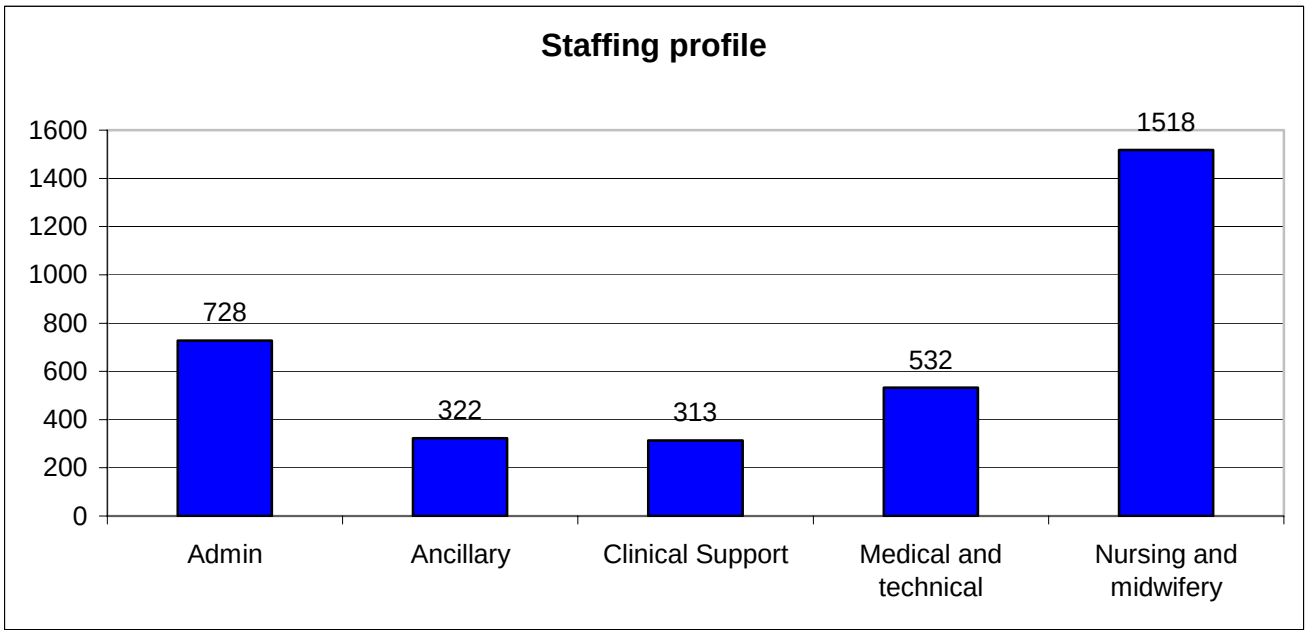
OFR: Operational reporting

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 3413 staff (at 20 April 2006):



Our specialties

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

Organisational structure

As an NHS foundation trust the corporation has a Board of Directors in place, with a business focus - setting the direction and developing plans for the future. A Hospital Management Committee (HMC), determines, sets, implements and monitors policies and working arrangements.

Key aims and objectives April 2005 to March 2006

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

The overall aim for the NHS foundation trust, is encapsulated in the mission statement introduced twelve years ago (when the organisation first became an NHS Trust). This mission statement remains relevant and applicable today:

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

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

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

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

The organisation's aims and strategic themes are under-pinned each year by corporate objectives. These centre on short-term goals for the organisation. For 2005/06 they concentrated on issues designed to deliver the various targets set out in the NHS Plan (plus

other local action plans). In total, the corporation had 10 high-level objectives for 2005/06, covering all aspects of internal and external performance.

Each of the corporate objectives has specific goals for our individual directorates. Performance against every objective is monitored in detail each month, and reported to the Hospital Management Committee, the Board of Directors and the Council of Governors, through a 'performance report'. In addition, bi-annual review meetings take place with each clinical directorate team, with additional review meetings if performance deviates from plan.

Performance review April 2005 to March 2006

2005/06 was another successful year for Chesterfield Royal Hospital NHS Foundation Trust, with the corporation achieving all its major goals.

Assessment of the Healthcare Commission core standards indicates that all areas are fully compliant. Early assessment of the corporation's performance against the Healthcare Commission's performance standards for the period is also good, as expected, with all the standards directly attributable to the corporation having been achieved.

2005/06 was another strong financial year. The corporation achieved a surplus of £3,877,000 (against a planned surplus of £2,900,000) 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 2006/07. 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. At 31 March 2006 the corporation had a closing cash balance of £11.8million - compared to an original forecast of £7.7million.

Throughout the year, maximum-waiting times for routine elective treatment remained at three-months for the majority of specialities, with just general surgery and orthopaedics showing a maximum four-month wait at the end of March 2006. Maximum routine outpatient waiting times reduced to ten weeks or below, and the majority of diagnostic waits reduced to six weeks. Agreements for 2006/07 will enable the maximum waiting time for elective treatment to be no higher than three months in every specialty from the summer, and 10 weeks for outpatients.

Throughout the year, all patients referred to the hospital with suspected cancer were seen in outpatients within 14 days of the referral being made, and 99.7% of cancer patients received their first treatment within a month (31 days) of a decision to treat being made. Since January 2006, 97% of cancer patients received their first treatment within two-months (62 days) of urgent GP referral.

The quarterly accident and emergency target for treatment of 98% of patients within four hours were all achieved and the additional facilities in the department were completed by Autumn 2005 (see page 19 for details).

Capital expenditure for the year amounted to £7.6million, which was above the planned position of £6.9million. This was due to the inclusion of a number of additional capital schemes during the year.

The main areas of capital expenditure were a £882,000 mortuary replacement, a £1.1million upgrade to on-site staff residential accommodation, £2.7million on new equipment, commencement of a scheme to replace the boiler house, refurbishment of the accident and emergency department and a new ophthalmology outpatient suite.

Following constructive and amicable negotiations with our major purchasers, a contract for services in 2006/07 was agreed by 30 April 2006. This provides for increases in activity

levels above those originally estimated, albeit prudently, in our Service Development Strategy, but essentially provides for similar activity levels and maximum waiting time guarantees to those delivered in 2005/06.

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

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

The continued progress in maintaining good working relationships with partner health and social care organisations, such as primary care trusts (PCTs), social services and surrounding NHS trust or foundation trust hospitals is a key constraint along with the uncertainty created by orgnaisational changes in the PCTs and Strategic Health Authorities.

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.

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

Relationships
Relationships with local commissioners have continued to be open and constructive. Since becoming a foundation trust we have continued to play an active and collaborative role in the local health community, whilst 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 an open, constructive and mutually respectful relationship with Monitor (The Independent Regulator for NHS Foundation Trusts) and his team and our Council of Governors. Relationships with other partner bodies have not been ignored over this period and strong bonds remain. These can be evidenced in positive reports from bodies such as the Multi-Professional Deanery, Royal Colleges, Clinical Pathology Accreditation and local authority Overview and Scrutiny Committee.

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

Organisational issues

Health and Safety - stress management standards
The corporation has been implementing the Health and Safety Executive's (HSE) stress management standards and was invited to participate in a national pilot into the stress management standards, offering the following benefits:

- The work was a good link with Improving Working Lives (IWL).
- The pilot offered the corporation an opportunity to undertake further work into an area identified as a key issue by the annual staff survey.
- An opportunity to work with both the HSE and other organisations and learn from their experiences.
- During the pilot period no enforcement notices would be issued by the HSE relating to the stress management standards.
- The HSE are also using the pilot sites to understand the impact of the stress management standards and it is therefore an opportunity for us to influence the shaping of the standards for the future.

The pilot formally commenced on 4 July 2005 and will last for a period of around eighteen months.

Key elements of the pilot work include:

- Hosting around thirty-five separate briefing sessions with directorate staff to explain the work and the HSE standards.
- Agreeing to use the HSE questionnaire for the standards and its audit tool (which we have been able to use to collate the results).
- Establishing a steering group comprising of managers and staff from the central services directorate.
- Providing regular meetings and bulletin briefings to the steering group.
- Holding focus groups to establish action plans, once data was collated from departments.

Improving working lives (IWL)
As part of the national improving working lives initiative, the corporation was awarded practice plus status in February 2006, following a validation visit in December 2005. The validation initiative and the ongoing work of the internal task groups will help the corporation to achieve its aim of being regarded as an effective employer that attracts and retains staff.

The external validation team highlighted a number of areas of good practice including the corporation's staff handbook, the education centre and central learning support provided to staff - along with the structure in place within the organisation to deliver the improving working lives principles.

The task groups will continue to focus on areas of work including communications, flexible working, and training and development. Another staff open day will take place in the summer of 2006 to highlight what benefits are available to staff, and to share good practice across the corporation.

Agenda for Change (AfC)
The corporation has completed the changeover to the new national terms and conditions known as Agenda for Change, with all appropriate staff assimilated to the new pay system by October 2005. To complete this process, all posts were evaluated using a nationally agreed job evaluation process. Staff and management representatives worked together on evaluation panels.

The process has meant a significant culture change for NHS staff. The corporation has tried to address staff concerns in the most effective and timely way by developing a process of handling concerns with staff-side representatives. This has included staff having access to a review process - with all review panels being completed by April 2006.

The corporation is currently piloting the NHS Knowledge and Skills Framework (KSF) in a number of different departments with feedback available later in 2006.

Linked to this, the corporation has been developing an electronic system called 'Oncore'. This is designed to ensure that all training undertaken (internal and external) by staff members is recorded and attributed to the individual. It forms part of their portfolio and is used during a personal review where development objectives are reviewed.

Education

Nurse training is once again taking place in North Derbyshire - for the first time in ten years.

It means that students from the area will no longer have to travel to Sheffield or Derby to get their nursing qualifications. They can have their placement and education closer to home.

Derby University currently allocate 20 places per intake to North Derbyshire students, but the new nursing school hopes to boost that figure to around 100 places a year with two intakes annually. A permanent site for the partnership school between North Derbyshire Health and Education Centre and the University of Derby has yet to be confirmed. The options include an extension to the Education Centre at Chesterfield Royal Hospital, or for Derby University to rent accommodation local to the hospital.

The NVQ Centre at Chesterfield Royal Hospital NHS Foundation Trust continues to expand the portfolio of awards delivered throughout the corporation. New additions include:

- NVQ Level 3 Health - Allied Health Professional (AHP) Support Speech and Language Therapy
- NVQ Level 3 Health - AHP Support Physiotherapy and Occupational Therapy
- NVQ Level 3 Health - AHP Support Clinical Imaging
- NVQ Level 3 Health - General Healthcare Support
- NVQ Level 3 Health - Perioperative Care Support - Surgical Support
- NVQ Level 2 Health - Perioperative Care Support
- NVQ Level 2 Health and Social Care
- NVQ Level 2 Clinical Laboratory Support
- NVQ Level 3 Health - Decontamination

Safer medicines administration through e-learning

Improving the safe and effective administration of medicines throughout the hospital is being given a major boost - through the development of an e-learning system. This is dedicated to assessing the knowledge and competency of nurses in this critical area of clinical practice.

In collaboration with senior nurses and the University of Derby, the pharmacy service has led the development of an interactive e-learning system that can be used by nursing staff to test their knowledge of a diverse range a clinical and organisational matters relating to drug administration. Using scenario based questioning the system provides "real time" feedback and includes educational material linked to each area of questioning. The system has been established within the nursing preceptorship programme for newly qualified staff, and is soon to be introduced across the corporation for use by all new members of staff.

The system has been awarded the 2005 Novartis Pharmacy Innovation Award and a paper describing the development and benefits of the system has been accepted for publication in the Nursing Times. In the light of the potential benefits of this system to improve safe prescribing practice, Trent multi professional Deanery has commissioned the pharmacy to develop a similar product for use in newly qualified doctors.

OFR: 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 point in time. Where variances do occur, they are acted on and changes implemented to 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 emphasised. 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 summarises 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 the Council of Governors and the Joint Staff Side Consultative Committee. In addition, it is discussed in detail with senior managers through the Strategy and Performance Group. The data and subsidiary reports used to compile the performance report are available electronically to authorised managers and other staff, and are also incorporated in the regular integrated finance and activity report.

The year 2005/6 was the first year of implementation of the payment by results (PbR) system, with the corporation receiving income directly related to the treatment that patients were actually given. In this new environment, it is essential that all patient activity is accurately recorded and processed, to ensure that potential income is not lost to the organisation. In addition, there has been even more emphasis on ensuring that managers and clinicians have the information they need to ensure that all care is provided in the most effective and efficient way possible.

Internal reporting therefore retains a critical importance, both at an organisational level, where the corporation's monthly performance report is constantly reviewed for accuracy and relevance, and at a directorate level, where a range of key reports are available electronically.

Specific areas where new developments have taken place during the year include:

- Strengthening of reporting on availability of casenotes to improve accuracy and timeliness of clinical coding - essential for defining the cost of a patient's treatment.
- Measurement of waiting times for diagnostic tests.
- Working towards measuring 'episodic' waits - the time between referral from a GP and treatment actually taking place - with a view to preparing to meet the planned national 18-week waiting target.
- Increasingly sophisticated measurement of cancer treatment.

The corporation monitors its financial performance each month. 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 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.

Throughout the year maximum waiting times for elective treatment remained at three-months for the majority of specialties (with general surgery and orthopaedics at four-months). The corporation consistently undertakes more elective procedures year-on-year, enabling the maximum national target for patients waiting times to be met and maintained, for all patients choosing the corporation for their treatment.

The maximum outpatient waiting times reduced to ten-weeks or below and the majority of diagnostic waits reduced to six-weeks. Looking ahead to 2006/07, it has been agreed with our commissioners that the maximum waiting time for elective treatment is no higher than three-months in every specialty and ten-weeks for outpatients. There is a national target that by 2008 patients should not wait longer than 18-weeks from referral to the start of treatment. The corporation is working with primary care trusts and its own directorates to achieve this.

Information for patient and carers

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

- Improve access and reduce waiting
- Offer more information and choice
- Build closer relationships
- Provide safe, high quality and co-ordinated care
- Provide clean, comfortable and friendly environment

Information on handling complaints

The corporation takes complaints seriously - taking action to ensure problems are acted on. This improves experiences for future patients. The complaints team has recently been re-structured and strengthened and at the end of the financial year, the complaints team transferred to the chief executive's directorate. The move will strengthen links between the complaints and communications departments, whilst continuing the close working relationship with the Patient Safety Team.

One of the complaints teams' priorities for 2006/07 is to develop a more robust training programme for directorate staff, in dealing with and resolving complaints.

To ensure complaints help to improve and enhance services aspects of the complaints process are monitored. This includes the reasons for complaints, response times and action taken following complaints.

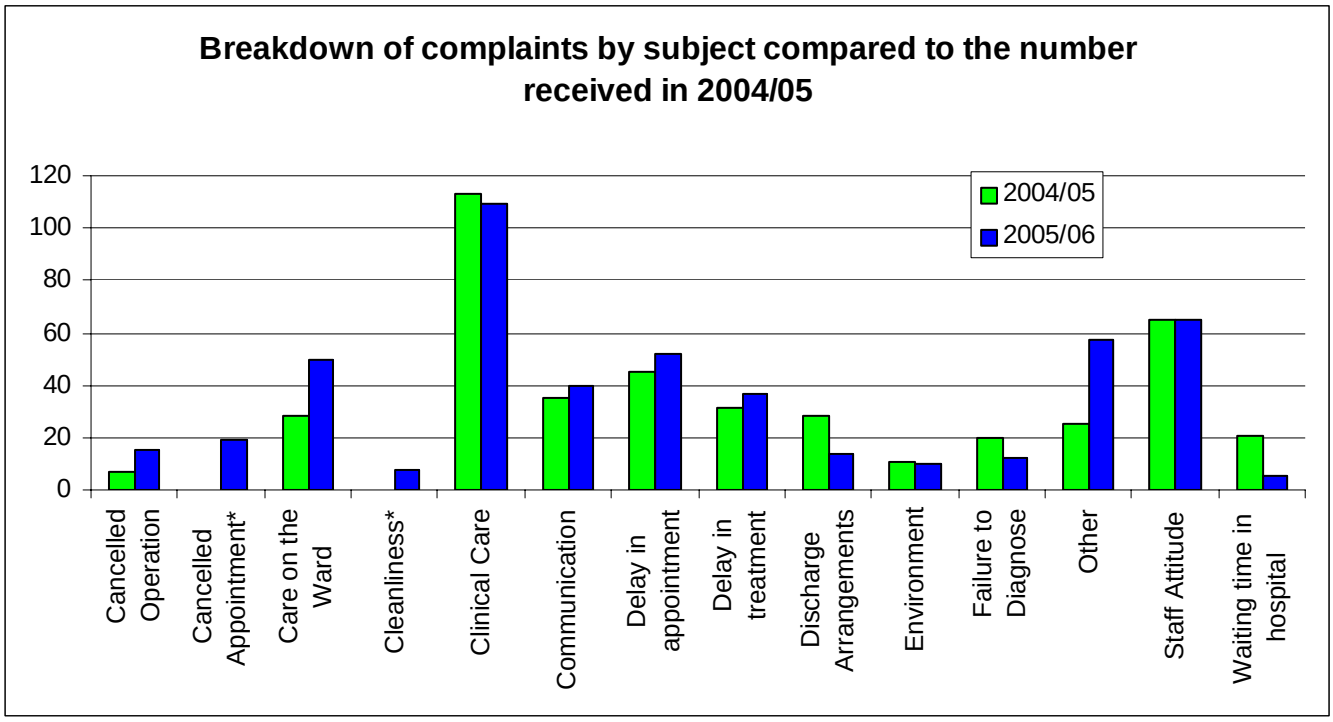
During the year the corporation received a total of 493 complaints out of more than 250,000 individual patient care episodes. The table on page 29 shows the breakdown of complaints by reason and directorate.

	Staff attitude	Cancelled Appointment	Clinical Care	Cleanliness	Communication	Cancelled Operation	General care on the ward	Delay in treatment	Delay in appointment	Discharge arrangements	Environment	Failure to diagnose	Other	Waiting time in hospital	Total
Critical Care	3	1	4	0	2	2	0	0	0	0	0	0	2	0	**14**
Central Services	4	0	1	3	3	0	0	1	0	0	5	0	10	0	**27**
Emergency Care	12	0	20	1	3	0	5	4	1	3	2	3	2	1	**57**
Finance	0	0	0	0	0	0	0	0	0	0	0	0	1	0	**1**
Imaging	0	0	2	0	2	0	0	1	3	0	0	0	1	0	**9**
Medical Specialities	18	2	19	2	16	0	28	9	5	6	0	1	12	1	**119**
Not Specific	1	0	1	0	0	0	0	1	1	0	2	0	6	2	**14**
Orthopaedic Surgery	6	0	16	1	2	5	2	6	2	3	0	0	0	1	**44**
Pathology	0	0	0	0	1	0	0	2	1	0	0	0	3	0	**7**
Planning and Performance	1	0	0	0	1	0	0	0	4	0	0	0	7	0	**13**
Surgical Specialities	13	16	21	1	9	8	11	11	32	2	1	6	8	0	**139**
Women's and Children's	7	0	25	0	1	0	4	2	3	0	0	2	5	0	**49**
Total	**65**	**19**	**109**	**8**	**40**	**15**	**50**	**37**	**52**	**14**	**10**	**12**	**57**	**5**	**493**

The table and graph below shows the breakdown of complaints by subject and compares the number received in 2004/05 with 2005/06.

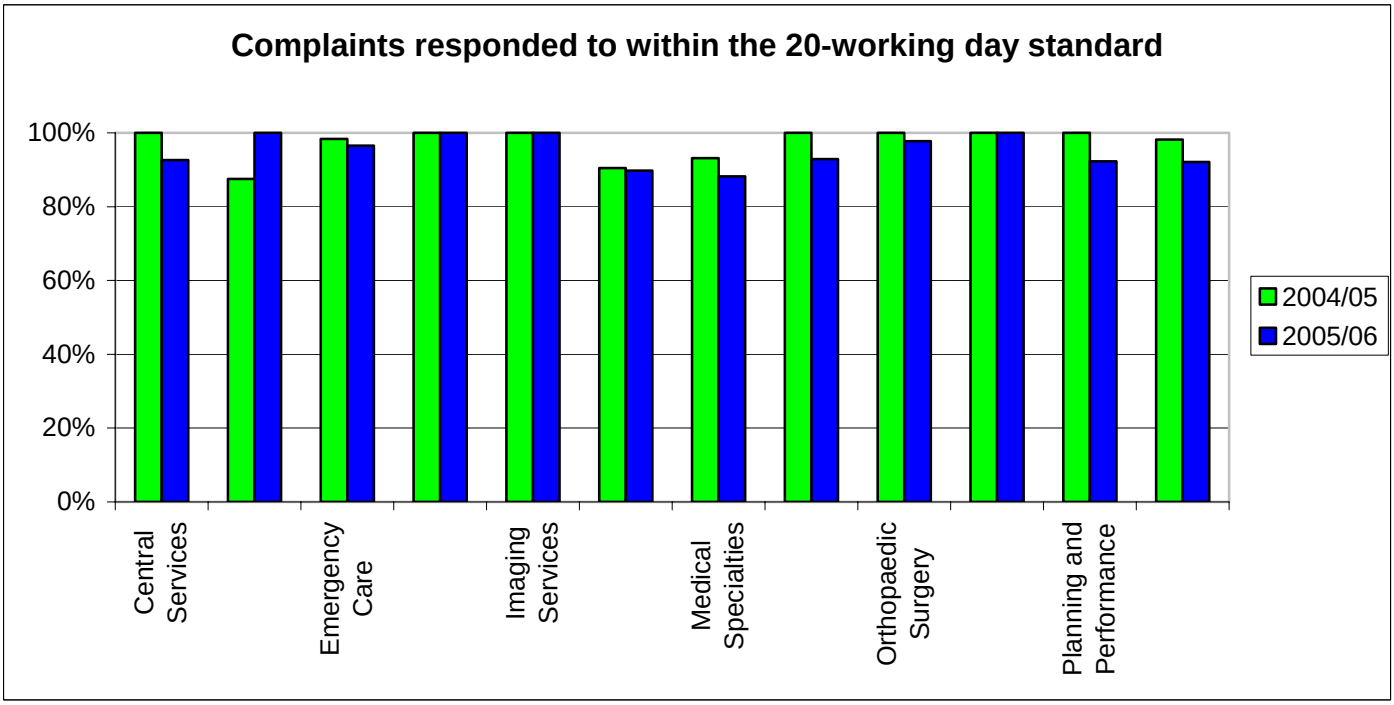
Subject	Cancelled Operation	Cancelled Appointment *	Care on the Ward	Cleanliness*	Clinical Care	Communication	Delay in appointment	Delay in treatment	Discharge	Environment	Failure to Diagnose	Other	Staff Attitude	Waiting time in hospital
2004/05	7	0	28	0	113	35	45	31	28	11	20	25	65	21
2005/06	15	19	50	8	109	40	52	37	14	10	12	57	65	5

*New categories in 2005/06



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 92% of complainants received a full and final response within this time scale.



OFR: Stakeholder relations

Significant partnership alliances

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

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

- Critical Care
- Cardiac Care
- Oral and Maxillofacial Surgery Ear, Nose and Throat
- Cancer
- Renal
- Pathology
- Neonatology
- Children and Child and Adolescent Mental Health

Close working relationships have been developed with the corporation's main commissioning partners, which account for around 95% of its patient care income.

Close working relationships within the North Derbyshire Health and Social Care community remain good. However, the uncertainty surrounding *Creating a Patient-led NHS* is affecting colleagues in primary care and at the Strategic Health Authority, whilst the corporation remains the stable influence in the health economy.

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

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

Visiting consultants also hold specialist outpatient clinics at the Royal:

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

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

- the local authority's 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.

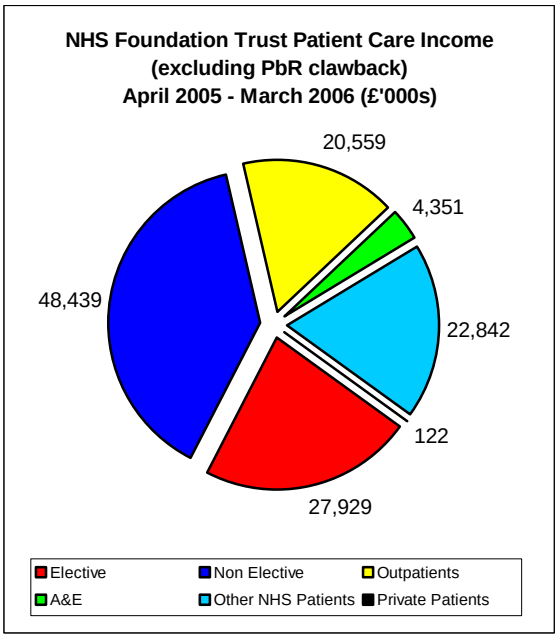
Finance

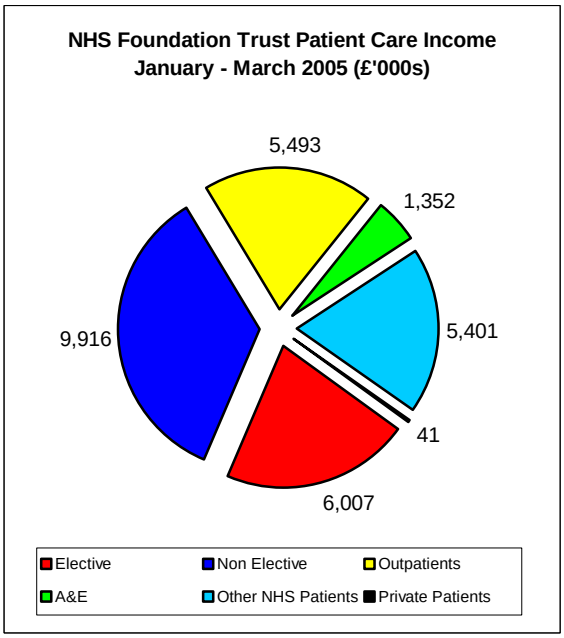
The accounts for the periods 1 April 2005 to 31 March 2006 are included in full at Appendix A.

Within this Annual Report and Accounts for the year ended 31 March 2006, all comparative figures relate to the three months from 1 January to 31 March 2005 to reflect only the period from which the corporation was operating as an NHS foundation trust.

Income from activities

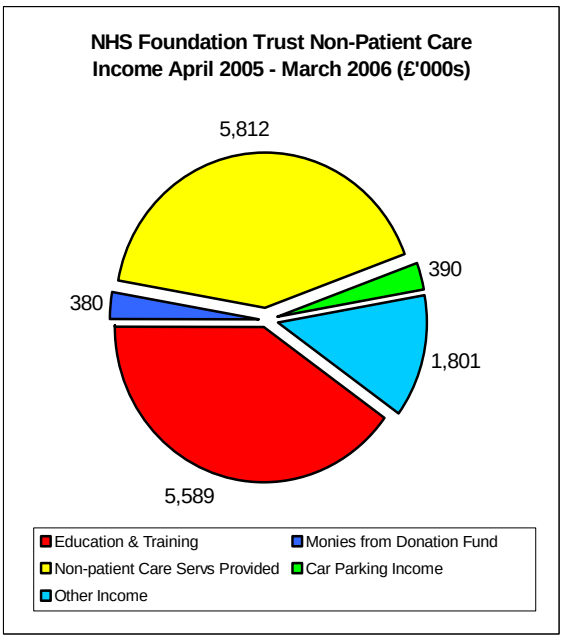
The total income from patient-care activities for the year 2005/06 was £120.6million net of £3.6million PbR clawback (January - March 2005: £28.2million). This represents 89.56% (January - March 2005: 89.12%) of total income for the year. This is shown graphically below:

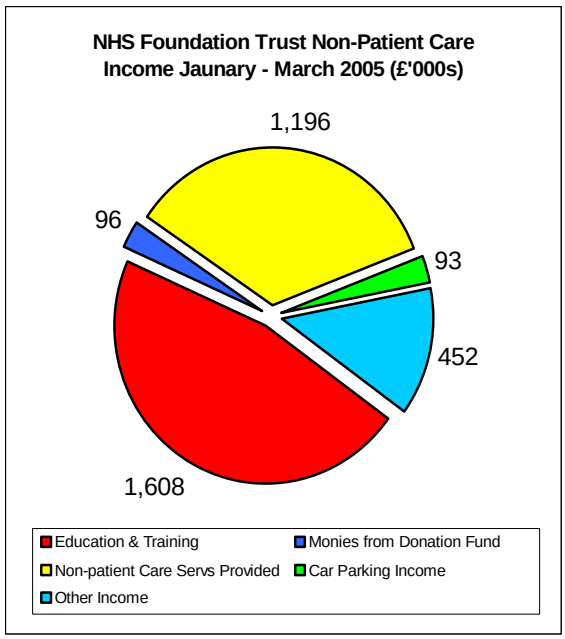




Income generated from non-healthcare activities

Included below are details of £14.06million (January - March 2005: £3.45million) of non-healthcare income received, which has been generated for the provision of non-healthcare services. This represents 10.4% of total income in year (January - March 2005: 10.9%).





Financial position

The corporation achieved a net financial surplus of £3.88million (January - March 2005: £15,000) and Earnings before Interest Taxation Depreciation and Amortisation (EBITDA) of £10.4million (January - March 2005: £2.3million). The net surplus was in excess of the net surplus planned for the year and mainly arose due to interest received (£0.62million) and a net effect of over performance on activity (£0.2million).

Cash increased to £11.8million, and a working capital facility of £10million was also in place, giving cash headroom in excess of £21.8million, and the corporation a healthy financial position. This increase in the cash of the corporation during the year, reflects the strengthened controls and procedures that have been put in place to manage the liquidity of the corporation effectively. In 2005-2006 the corporation had no requirement to borrow against the prudential borrowing limit of £28.2million set in its terms of authorisation, which consisted of £18.2million new borrowing, as well as the working capital facility of £10million.

Key financial risks

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

- *Payment by Results (PbR)*
  All NHS Foundation Trusts are subject to PbR, whereby the corporation is paid for the level of activity it does, based on a tariff for each activity. Changes to PbR policy or the tariffs will affect activity and will result in the loss of future income. The corporation is adopting a cautious approach to this risk and has procedures in place to monitor the impact of PbR.
- *Non-patient care income*
  Levels of non-patient care income may not be secured at a level that as a minimum covers the full cost of service provision. To mitigate this, the corporation proactively negotiates and monitors contracts, including provider-to-provider agreements with other NHS organisations and education and training contracts.
- *Cost management*
  Inadequate cost management and inability to achieve cost improvement programmes could have a significant financial impact on the corporation. Directorate financial positions are tightly monitored and recovery plans are in place (if required). Early

detection of cost management failure is essential and procedures are in place to identify any anomalies.

- *Capital cost management*
  Capital programmes may not be completed within the planned framework and this may impact on the liquidity of the corporation if they are not managed correctly. The corporation has regular close monitoring of the capital expenditure budget to ensure that overspends are managed and also to ensure that sufficient funds are available to allow the capital programme to progress.

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

Monitor, (The Independent Regulator of NHS Foundation Trusts), also monitors the corporation's financial performance on a quarterly basis using specific financial risk ratings. The corporation's performance against Monitor's 2005/06 financial risk ratings are shown below:

		2005/06 (plan)		2005/06 (actual)	
Metric	Weighting	% Ratio	Rating	% Ratio	Rating
EBITDA margin	25%	7.4%	3	7.5%	3
EBITDA % achieved	25%	100%	5	104%	5
Return on assets	12.5%	6.8%	5	7.9%	5
I&E surplus margin	12.5%	2.2%	5	2.9%	5
Liquid ratio (days)	25%	32.3	4	32.4	4
Weighted average rating			4.3		4.3

The corporation achieved a financial risk rating of 4 for each of the four quarters during the year on Monitors' scale of 1 to 5 (a score of 1 being 'high-risk' and 5 'low-risk'). The corporation is forecast to maintain a 'low-risk' score of at least 4 for 2006/07.

Planned investment activity

The corporation's investment (in terms of capital expenditure) for 2005/06 is shown on page 35. A total of £7.6million (January - March 2005: £1.7million) was spent mainly on new medical equipment including colonoscopes, and new equipment for the ophthalmology, radiology and A&E departments, plus the modernisation and improvement of existing staff accommodation and hospital facilities. In addition, £36,000 (January - March 2005: £56,000) of charitable capital expenditure was granted to the corporation during the year from its charitable funds.

Capital investment - major schemes for the 2005/06 financial year	Total 2005/06 £000's
Refurbishment of mortuary	882
Upgrade of staff accommodation	1,174
Specialists children's facility	407
A&E extension and improvements	389
Boiler replacement	260
Medical gases upgrade	140
Ophthalmology outpatients suite	290
Minor building schemes	1,356
Equipment and IT	2,711
NHS capital expenditure	7,609
Donated capital expenditure	36
Total capital expenditure	**7,645**

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

Capital investment analysis for the 2005/06 financial year	Total 2005/06 £000's
Protected asset investment	3,492
Unprotected asset investment (i.e. equipment including IT)	4.117
	7,609
Donated capital investment	36
Total capital expenditure	**7,645**

Land interests

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

Accounting policies

Accounting policies are consistent with the prior year - with the exception of accounting for government grants and income recognition in relation to incomplete patient spells.

In previous years, government grants that were used to fund capital expenditure were shown as a 'government grant reserve' on the balance sheet. NHS foundation trusts are now required to account for government grants in accordance with Statement of Standard Accounting Practice 4, and therefore show government grants used to fund capital expenditure as 'deferred income' on the balance sheet. This change in accounting policy has given rise to a prior period adjustment and as a consequence, the prior year balance sheet, statement of total recognised gains and losses, the cashflow statement and certain notes to the financial statements (attached at Appendix A) have been restated.

The corporation has to account for income during the year in relation to services actually provided. With respect to patient services, incomplete patient spells can occur where the treatment of patient has commenced, but income for the activity has not yet been received. This is called a partially completed spell. The corporation must accrue the income for the activity they have done up to 31 March 2006, but only if it is material to the corporation. This has been assessed and was found not to be material to the financial statements for the year or for the previous period. Therefore, no adjustment has been made to the financial statements for the current or prior period in respect of incomplete spells.

Investments

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

Private patient income

Under the corporation's terms of authorisation, the proportion of private patient income to the total patient related income should not exceed its 2002/03 proportion. The allowable percentage for the corporation was 0.2%. The private patient income from 1 April 2005 to 31 March 2006 was £122,000 (January - March 2005: £41,000) - compared to total patient related income of £120.6million (January - March 2005: £28.2million). This represents a proportion of 0.10% (January - March 2005: 0.15%). The corporation is therefore compliant with this obligation for both periods.

Value for money

The corporation has a record of implementing cost improvement programmes (CIP) designed to improve efficiency. For 2005/06 a £1.812million CIP (January - March 2005: £0.233million) was achieved:

Description	2005/06 (12 months) £000s	2005 (3 months) £000s
Productivity increases	1,439	110
Procurement savings	204	24
Income generation	47	57
Savings on reserves	122	42
Total	**1,812**	**233**

The economy, efficiency and effectiveness of the use of resources are monitored regularly and detailed reports are supplied to the Board of Directors, Hospital Management Committee and made available to the Council of Governors and Joint Consultative Committee. Internal systems and procedures are in place to ensure that value for money remains a primary aim of the corporation. More details can be found on the "Statement of Internal Control" included in Appendix A.

Charitable funds

All charitable fund expenditure is classed as granted to the hospital from its charities. Items over £5,000 are capitalised and included in the corporation's closing fixed assets on its Balance Sheet. The Charitable Fund Annual Report and Accounts 2005/06 is published separately and is available from the corporation on request.

Going concern

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

Eric Morton
Chief Executive
14 June 2006

Disclosure of corporate governance arrangements

Board of Directors
April 2005 to March 2006

The Board of Directors has a business focus - developing, monitoring and delivering plans. Board members also have some personal liability for the corporation'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' (set by Monitor (the Independent Regulator of NHS Foundation Trusts)).
- Having specific duties relating to audit, remuneration, clinical governance, charitable funds and risk assurance.
- Deciding the corporation's strategic direction - in consultation with the Council of Governors.
- Working in partnership with the Council of Governors.

Board evaluation
During the last twelve months the board has undertaken two evaluation studies of its performance.

- In September 2005 the board undertook a self-assessment with the support of Mersey Internal Audit agency. The self-assessment demonstrated the skills and abilities that exist in the board. Two key themes that emerged from the evaluation were: the structures and function of the board and its relationship with the rest of the organisation were clear and fit for purpose and; actions and behaviours of the board were constructive and co-operative, working in the best interests of the corporation and the public

- During October 2005 the corporation held a joint meeting with the Council of Governors to explore the composition of the board. The Council along with the Board debated the skills needed by the Board. A consensus view was formed. This view was compared with the current composition of the Board and any gaps are being taken into account for the appointment of the non-executive directors during 2006.

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

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

The CoG is specifically responsible for the:

- Appointment and removal of the chairman and other non-executive directors.
- Approval of the appointment of the Chief Executive.
- Appointment and removal of the Auditors.

The CoG will consider and receive:

- The Annual Accounts, Auditors' Report and Annual Report.
- Views from staff and community members on matters of significance affecting the corporation or the services it provides.

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

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 Board of Directors as follows:

Chairman: Michael Wall
Initially appointed to 30 November 2006 (Resigned his appointment 20 October 2005)
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.

From 1999, Michael was also 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.

Following his appointment to a full-time District Judge position it was necessary for Michael to resign from his appointment as chairman of the corporation. This took affect from 20 October 2005. Mr John Raine was appointed by the Council of Governors as Acting Chairman of the corporation and served in the capacity from 20 October 2005 to 12 April 2006. On 12 April 2006, at a meeting of the Council of Governors, Mr Richard Gregory's appointment as chairman of the corporation was ratified by the Council.

Vice-chairman and non-executive director: Nick Webber
Initially appointed to 14 July 2006
Sadly, after suffering from Motor Neurone Disease for several years, Nick passed away in February 2006. He is greatly missed and is recognised for his valuable contribution over the years as a non-executive director of the corporation.

Nick joined the Trust in 1996. He served on the remuneration committee, the audit committee - which he has previously chaired - and he also chaired the charitable funds committee. He also acted as the corporation's Complaints Convenor, and chaired and served on Mental Health Appeals during the time the organisation had responsibility for mental health services. Through personal involvement and experience, and apart from his management and business skills, Nick had a particular focus on all areas of patient accessibility and providing service excellence.

Born, raised and educated locally, Nick 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.

Up until his retirement from full-time employment 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.

Non-executive director and Acting Chairman (20 October 2005 – 12 April 2006): 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 1998 and in recent years has followed interests in the fields of disability and criminal justice. He accepted a Department of Trade and Industry Ministerial appointment in 1997 as chairman of the Hearing Aid Council, which regulates private sector hearing aid dispensing and chaired the Derbyshire Association for 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.

Following the resignation of Michael Wall the Council of Governors appointed John as acting chairman, pending a permanent appointment.

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 a

Director of Avantigenesis Limited, a drug delivery company, and a Governor of Highfields School in Matlock.

Non-executive director - Michael Hall
Appointed 5 July 2005 to 4 July 2008
Originally from Manchester Michael qualified as a Chartered Accountant in 1963 and has worked in most aspects of commercial financial management culminating in the position as Financial Director of an international group with a turnover of £200million and 3000 employees.

Michael joined the Derby University in November 1991. His role as Deputy Vice Chancellor encompassed the implementation of a commercial approach and attitude. Specific responsibilities included the various facilities provided in the Institution in order to accommodate the learning process, eg: Catering, Facilities, including Conferences, Estates, Finance, Residences, Reprographics and Rooming.

Following his retirement in 2002, he was asked to serve as Acting Chief Executive of Derby Cityscape creating the urban regeneration for the City of Derby. Subsequently, he was asked to Chair Business Service East Midlands, an East Midlands Development Agency activity formed to review the existing business support arrangements for small and medium-sized enterprises, supported by Business Link.

During this time Michael was asked to Chair the Committee formed to explore the possibility of merging the Boards of North Derbyshire and Southern Derbyshire Chambers of Commerce as he had previously served on both these Boards. He subsequently became the first President of the Derbyshire Chamber of Commerce where he is still a member of the Board and has served on the national committee of the British Chamber of Commerce for the past three years.

Michael is also a Foundation Governor of Derby High School and the Anthony Gell School in Wirksworth and has served as Chairman of the Derbyshire Strategic Board for Young Enterprise.

Chief executive: Eric Morton
The chief executive, Eric Morton, came into post in December 2001, having previously been employed by the NHS trust as deputy chief executive and director of finance and corporate services since January 1993. He is a qualified accountant and a member of the Chartered Institute of Public Finance & Accountancy, and a Fellow of the Chartered Association of Certified Accountants. He is past Chairman of the Healthcare & Financial Management Association, and current Vice-Chairman of Chesterfield College 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 former NHS Trust's beginning in 1993. After completing his professional training, Ron held several clinical posts before embarking on a management career. With his employment mainly in the Leeds area, Ron's previous management roles include that of patient service manager, and director of nursing and assistant general manager 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 their director of finance from 1999 to 2003.

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

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

Medical director 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 in1986, and has continuously held medical management positions since then.

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, corporate development and service improvement, she is also professionally accountable for the corporation's general managers.

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

Corporate director of allied clinical and facilities services: Andrew Jones
Andrew Jones has 28 years of NHS experience. Having been employed at the Royal for 15 years, he has responsibility for management of the estate and facilities services. In addition he takes the lead for the allied health professions and medicines management.

Andrew led the sale of the hospital laundry to a commercial contractor, the reorganisation of the patient meals service, through a 15-year partnership arrangement, and the commercial development of the hospital front entrance 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 outgoing 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.

Appointment and termination of appointments

Chairman and non-executive directors
The Council of Governors has the ability to appoint and dismiss the chairman and non-executive directors. In line with the corporation's constitution, three-quarters of the Council of Governors has to approve any decision of this nature.

When a vacancy arises for a non-executive director or chairman the Council of Governors will form an appointments committee to consider the applicants proposed by a specialised search agency. The appointments committee will make a recommendation to the full Council of Governors for the appointment to be approved by the full committee.

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.

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

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.

Appointment of an executive director is through a committee comprising of the chairman, chief executive and the other non-executive directors.

Remuneration

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

These disclosures are made in the annual accounts for the periods April 2005 to March 2006.

Remuneration of the chairman and non-executive directors

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

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, voluntary sector partners.

The committee considered the scope and complexity of the chairmanship and of the non-executive director roles in a foundation trust, having regard to guidance produced by the Foundation Trust Network and to the relative size of the corporation in relation to other foundation trusts. It made recommendations on the level of remuneration which were approved by the Council of Governors in July 2005.

The rates of remuneration for the chairman and non-executive directors with effect from 1 April 2005 are set out in the annual accounts section of the annual report. The rates are reviewed annually in line with the general uprating of pay for staff.

Remuneration of the chief executive and executive directors

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

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.

On John Raine's appointment as acting chairman of the corporation in October 2005, the membership of the remuneration committee was reviewed. In view of the committee having concluded its business and not needing to meet again during 2005/06, it was agreed that the membership of the remuneration committee should remain as it was for the time being. Due to the sad death of Nick Webber the membership of this committee is now under review.

Further details of the working of the remuneration committee are within the remuneration report on page 72 of the annual report.

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

Audit Committee
This committee receives internal and external audit reports and undertakes detailed examination of financial and value-for-money reports received by the Board of Directors. Its terms of reference identify the committee's duties as follows:

- Governance, risk management and internal control.
- Internal audit.
- External audit.
- Financial reporting.
- Other duties including, standing orders, financial instructions and scheme of delegation. Review of schedule of losses and compensation. Review of the annual fraud report.

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

On the appointment of John Raine as Acting Chairman for the corporation, Michael Hall was appointed Chairman of the Audit Committee. Due to the sad death of Nick Webber the membership of this committee is now under review.

Charitable Funds Committee
This committee is responsible for making sure money donated to the hospital is spent wisely. The committee's terms of reference identify the following duties:

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

Membership:
Nick Webber, vice-chairman/non-executive director (in the chair)
John Raine, non-executive director
Paul Briddock, director of finance and contracting
Michael Hall, non-executive director joined the committee on 13 December 2005.

Due to the sad death of Nick Webber the membership of this committee is now under review.

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

- Ensuring a strategic framework is developed in order to meet national, regional and local policy.
- Receiving reports.
- Ensuring that multi-professional and multi-agency work is further developed along with partnership working.
- Dissemination and use of clinical information.
- Guiding the development of key performance measures for clinical quality.
- Developing a systematic approach to clinical effectiveness.
- Proactively reviewing systems.
- Reviewing patient safety data and trends.
- Monitoring directorate clinical governance.

- Monitoring outcomes of clinical accreditations.
- Ensuring multi professional learning and workforce is developed.
- Monitoring the clinical aspects of the corporation's risk management strategy.
- Promoting education in the corporation on the wide range of clinical governance issues.
- Overseeing the planning and implementation of clinical audit and research.

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 directorate
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 medicines management and therapy services
Maxine Simmons, head of education and workforce development
Nichola Lawrence, head of workforce review
Rod Collin, clinical director, pathology directorate
Sheharayer Asad, consultant orthopaedic surgeon
Simon Dale, consultant anaesthetist
Sue Frost, head of physiotherapy
Sue McDermott, deputy director of nursing and head of patient safety

Risk management committee
Chesterfield Royal Hospital NHS Foundation Trust is conscious of the importance of managing risk appropriately and has taken the decision that the Board of Directors assumes responsibility for ensuring the corporation meets all its legal obligations. Therefore the board reviews risks on a monthly basis through the regular reports it receives.

Attendance by board members at meetings

	Michael Wall	Eric Morton	Terry Alty	Bill Lambert	Ron Clarke	Paul Briddock	John Raine	Yousef Taktak	Michael Hall	Nick Webber
Board of Directors	Attended all board meeting until his departure from the corporation in October 2005	Attended all Board meetings	Attended all Board meetings except 24 October 2005	Attended all Board meetings except 29 June, 28 September 24 October 2005	Attended all Board meetings	Attended all Board meetings except 25 May 1 June 2005	Attended all Board meetings except 1 June 2005	Attended all board meetings except 30 November 2005	Joined the Board in August 2005 attended all board meetings except 27 February 2006	Attended all board meetings except 25 May, 1 June, 30 November 2005 20 January, 27 February 2006.
Audit Committee	Not applicable	Not applicable	Attended all Audit Committee meetings	Not applicable	Not applicable	Attended all Audit Committee meetings except 29 April 2005	Attended as Chairman until appointed as Acting Chairman of the corporation	Attended all Audit Committee meetings	Appointed Chairman of the Audit Committee at the November meeting. Attended all Audit Committee meetings.	Attended all Audit committee meetings except for meeting on 24 February 2006
Remuneration Committee	Attended annual meeting held in September 2005	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Attended annual meeting held in September 2005	Not applicable	Not applicable	Attended annual meeting held in September 2005
Clinical Governance	Not applicable	Not applicable	Not applicable	Attended all meetings	Attended all meetings	Not applicable	Not applicable	Attended all meetings except 8 June 2005, 12 October 2005 and 8 February 2006	Not applicable	Not applicable
Charitable Funds	Attended Trustees meeting 28 September 2005	Attended Trustees meeting 28 September 2005	Attended Trustees meeting 28 September 2005	Attended Trustees meeting 28 September 2005	Attended Trustees meeting 28 September 2005	Attended all meetings held	Attended all meetings held except 27 March 2006 apologies sent	Attended Trustees meeting 28 September 2005	Attended meetings from 28 September except for 13 December 2005	Attended all meetings

Register of director's interests

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

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

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

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

At the 31 March 2006, the Board of Directors had declared these interests:

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

Michael Wall, chairman (April 2005 to October 2005)
(Declarations for Michael Wall are only made up to departure from the corporation in October 2005)
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
Non-Executive Director, Amber Valley Housing Association Ltd
Non-Executive Director, Five D Homes Ltd

John Raine, non-executive director (April 2005 to October 2005), acting chairman (November 2005 to April 2006)
Chairman, Derbyshire Probation Board (Ministerial Appointment)

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

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

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

   John Raine, non-executive director (April 2005 to October 2005), acting chairman (November 2005 to April 2006)
   Chairman, National Association of Probation Boards (Elected Appointment)

3. **Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS:**

   The Board of Directors made no declarations under this section

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

   Michael Wall, chairman up to October 2005
   Eric Morton, chief executive
   Nick Webber, vice-chairman
   Michael Hall, non executive director
   Ron Clarke, director of nursing and clinical development
   Terry Alty, corporate secretary
   Trustees, Chesterfield Royal Hospital Charitable Trust Funds

   John Raine, non-executive director (April 2005 to October 2005), acting chairman (November 2005 to April 2006)
   Trustee, Chesterfield Royal Hospital Charitable Trust Funds
   Trustee, Chesterfield Churches Housing Association

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

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

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

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

   Eric Morton, chief executive
   Vice-Chair, Chesterfield College

   John Raine, non-executive director (April 2005 to October 2005), acting chairman (November 2005 to April 2006)
   Director, Derbyshire Association for the Blind

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

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

Eric Morton, chief executive
Vice-Chair, Chesterfield College

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

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

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 2005 to March 2006.

Council of Governors
One of the main changes in the move across to foundation trust status revolves around the local community. The corporation has been working with its local community to embrace the change; and as a public benefit corporation it is now accountable to the local people and staff who have registered for membership and to those elected to seats on the Council of Governors.

Elections
The corporation's Council of Governors was elected in November 2004, in preparation for the NHS foundation trust's authorisation on 1 January 2005. Elections were hosted by Electoral Reform Services (ERS) to ensure they were independent and impartial. At that time around 5500 community and 3100 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. Staggered appointments were made in the first-ever elections to establish a rolling programme for public governor appointments.

In November 2006 ERS hosted the corporation's second elections in three constituency areas. Four seats were vacant - two in Chesterfield, one in Bolsover and one in North East Derbyshire. Results can be seen on page 50.

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. Their role includes:

- Representing the interests and views of local people.
- Regularly feeding back information about the corporation, its visions and its performance to the community they represent.

- Selecting and appointing non-executive directors and the chairman of the corporation.
- Appointing the corporation's auditors.
- Attending meetings of the Council of Governors.
- Receiving an annual report from the Board of Directors.
- Monitoring performance against the corporation's Service Development Strategy and other targets.
- Advising the Board of Directors on their strategic plans.
- Making sure the strategic direction of the corporation is consistent with its terms of authorisation as agreed by Monitor (the Independent Regulator of NHS Foundation Trusts).
- Approving any changes to the corporation's constitution.
- Agreeing the chairman and non-executive directors' remuneration (pay).
- Providing representatives to serve on specific groups and committees.
- Working in partnership with the Board of Directors.

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

Public governors:
- 16 public representatives (elected)

Staff governors:
- Four staff representatives (elected)

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

Following elections in November 2005 there have been some changes to public governor representing three of the corporation's constituency classes. These are shown below.

<u>Our governors- Public governors</u>
There are five constituency classes* represented by 16 elected public governors:

Governor	Elections	Appointed from	Initial Term	Term of office ends
Bolsover class of the constituency				
Keith Bowman	2004	1 January 2005	Two years	31 December 2006
Kevin Pettinger	2004	1 January 2005	One year	31 December 2005*
Vanessa Holleley-Wood	2004	1 January 2005	Three years	31 December 2007
John Jeffrey	2005	1 January 2006	Three years	31 December 2008
* Did not stand for re-election in 2005 due to long-term illness				
Chesterfield class of the constituency				
Dr Chris Day	2004	1 January 2005	Three years	31 December 2007
Sheila Smith	2004	1 January 2005	Three years	31 December 2007
John Webber	2004	2 March 2005	Two years	31 December 2006*
Mererid Edwards	2004	1 January 2005	Two years	31 December 2006
Ruth Grice	2004	1 January 2005	Two years	31 December 2006
Kathleen Rowley	2004	1 January 2005	One year	31 December 2005**
Terry Gilby	2004	1 January 2005	One year	31 December 2005

Terry Gilby	2005	1 January 2006	Three years	31 December 2008
Janet Portman	2005	1 January 2006	Three years	31 December 2008

* Appointed March 2005 following a governor resignation
** Stood for re-election in 2005, but was not re-appointed

North East Derbyshire class of the constituency

Barry Jex	2004	1 January 2005	Three years	31 December 2007
Ralph Milne	2004	1 January 2005	Three years	31 December 2007
Ruth Francis	2004	1 January 2005	Two years	31 December 2006
Majorie Barraclough	2004	1 January 2005	One year	31 December 2005*
Bimal Ghosh-Dastidar	2005	1 January 2005	Three years	31 December 2008

* Stood for re-election in 2005, but was not re-appointed

Derbyshire Dales class of the constituency

Pamela Wildgoose	2004	1 January 2005	Three years	31 December 2007

High Peak class of the constituency

Pauline Fisher	2004	1 January 2005	Three years	31 December 2007

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

Staff governors

There are four staff constituency classes. There have been no elections during the year. The governors are:

Medical and Dental class of the staff constituency	***Appointment term***
Dr Philip Rayner	3 years until 31 December 2007

Nursing and midwifery class of the staff constituency	***Appointment term***
Eileen Mallender	3 years until 31 December 2007

Allied Health Professionals, Pharmacists and Scientists class of the staff constituency	***Appointment term***
David Allen	3 years until 31 December 2007

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

Partner governors

There have been no changes during the year.

Primary Care Trust (PCT) governors (appointments co-ordinated by Chesterfield Primary Care Trust through a process agreed with the other PCTs)	***Appointment term***
Dr David Collins	3 years until 31 December 2007
(Dr Collins resigned his seat on 11 April 2006)	
Dr David Black	3 years until 31 December 2007

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

Strategic Health Authority governors (appointed in accordance with a process agreed with the former Chesterfield and North Derbyshire Royal Hospital NHS Trust)	***Appointment term***
Mr Robert Waterhouse	3 years until 31 December 2007

Education governors (appointed by the Universities of Sheffield and Derby appointed in accordance with a process agreed with the former Chesterfield and North Derbyshire Royal Hospital NHS Trust)	***Appointment term***
Professor Susan Read	3 years until 31 December 2007
Eileen Hammersley	3 years until 31 December 2007

Voluntary Sector governors (appointed by representatives for the Patient's Forum, Self-Help Forum, League of Friends, and North Derbyshire Voluntary Action)	
Rosemary Parkyn	3 years until 31 December 2007
Joyce Cupitt	3 years until 31 December 2007

Attendance at the CoG meeting during the year April 2005 to March 2006

	2/3/05	11/5/05	5/7/05	8/9/05	20/10/05	7/12/05	18/1/06	1/3/06	**Total**
Dave Allen, staff governor	1	0	1	1	0	1	0	1	5
Eileen Mallender, staff governor	1	1	0	1	1	1	1	1	7
Phil Cousins, staff governor	1	1	1	1	1	1	1	1	8
Philip Rayner, staff governor	1	1	1	0	0	1	1	1	6
Alieen Hammersley, partner governor	0	0	1	0	1	0	1	0	3
Barry Jex, public governor	1	1	1	1	1	0	1	1	7
Bimal Ghosh-Dastidar, public governor	Appointed governor from January 06						0	0	0
Bob Waterhouse, partner governor	1	1	1	1	1	0	1	0	6
Carol Walker, partner governor	Appointed governor from May 05	1	0	0	1	1	1	1	5
Chris Day, public governor	1	1	1	1	0	1	1	1	7
David Black, partner governor	1	1	1	1	1	0	1	1	7
David Collins, partner governor	1	1	0	1	1	0	1	0	5
Eion Watts, partner governor	Appointed governor from May 05	0	0	1	0	0	0	0	1
Janet Portman, public governor	Appointed governor from January 06						1	1	2
John Jeffery, public governor	Appointed governor from January 06						1	1	2
John Webber, public governor	1	1	1	1	1	0	1	1	7
John Williams, partner governor	0	0	0	0	0	0	0	0	0
Joyce Cupitt, partner governor	1	0	1	0	1	1	0	1	5
Kath Rowley, public governor	1	0	0	0	1	0	No longer eligible – seat lost in 2005 elections		2
Keith Bowman, public governor	1	0	0	0	1	1	1	0	4
Kevin Pettinger, public governor	1	1	0	0	0	0	No longer eligible – seat lost in 2005 elections		2
Marjorie Barraclough, public governor	1	1	1	1	1	1	No longer eligible – seat lost in 2005 elections		6
Mererid Edwards, public governor	1	1	0	1	0	0	1	1	5
Pam Wildgoose, public governor	0	1	1	0	1	0	1	0	4
Pauline Fisher, public governor	0	1	1	0	1	1	0	1	5
Ralph Milne, public governor	0	0	0	1	1	1	1	0	4
Ros Parkyn, partner governor	1	1	1	1	1	1	1	1	8
Ruth Francis, public governor	1	1	0	0	0	0	0	0	2
Ruth Grice, public governor	1	0	1	1	1	1	1	0	6
Shelia Smith, public governor	1	1	1	1	1	1	1	1	8
Susan Read, partner governor	1	1	0	1	1	1	1	1	7
Terry Gilby, public governor	1	0	1	1	1	1	1	1	7
Vanessa Hollely-Wood, public governor	1	0	0	0	0	1	0	1	3

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 31 March 2006, the Council of Governors had declared these interests:

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

   Vanessa Holleley-Wood, public governor, Bolsover class of the public constituency
   Company Secretary, Headtex Ltd, IT Consultants

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

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

   Ruth Grice, public governor, Chesterfield class of the public constituency
   Executive Director, Leonard Cheshire (Business side)

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

   Vanessa Holleley-Wood, public governor, Bolsover class of the public constituency
   Company Secretary, Headtex Ltd, IT Consultants

   Ralph Milne, public governor, North-East class of the public constituency
   Director, Ralph Milne Limited, Interim Management Services

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

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

3. **Majority or controlling share holdings in organisations likely or possibly seeking to do business with the NHS:**

   There were no declarations under this section

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

   Pamela Wildgoose, public governor, Derbyshire Dales 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

   Ruth Grice, public governor, Chesterfield class of the public constituency
   Trustee, Leonard Cheshire

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

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

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

   David Allen, staff governor, allied health professionals, pharmacists and scientists
   Councillor, Derbyshire County Council

   Keith Bowman, public governor, Bolsover class of the public constituency
   Councillor, Bolsover District Councils

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

   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

   John Webber, **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

   Rosemary Parkyn, partner governor, Voluntary
   Volunteer, Red Cross, Therapeutic Care

Dr David Black, partner governor, primary care trust
Director of Public Health, Chesterfield PCT

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

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

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

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

David Allen, staff governor, allied health professionals, pharmacists and scientists
Councillor, Derbyshire County Council

Keith Bowman, public governor, Bolsover class of the public constituency
Councillor, Bolsover District Council

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

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

Aileen Hammersley, partner governor, University of Derby
The 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

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

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

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

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 2005 to March 2006.

Membership

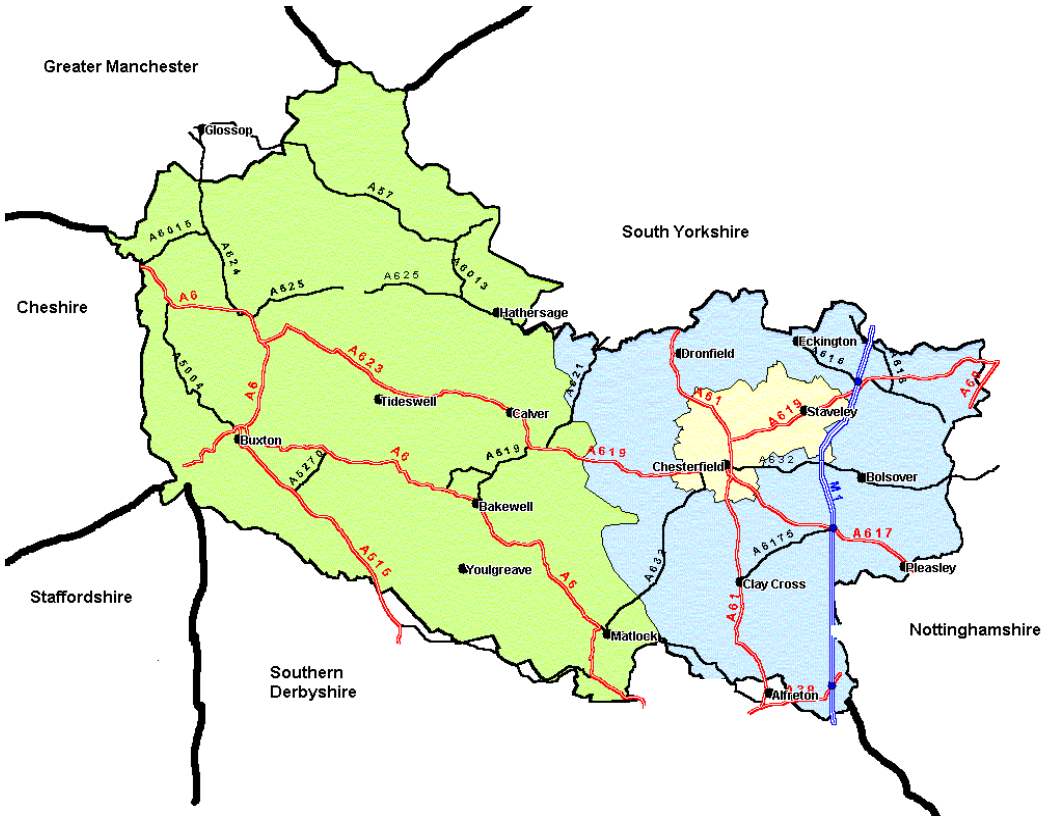
Engaging an active membership is a new way of working and a challenge for the corporation. During the year we have continued to add to our membership base.

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

As an NHS foundation trust staff, patient and public involvement is built-in to our corporate governance and decision-making processes. This 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 constituency composition

The corporation's public constituency is defined as 'those people living in the local authorities covered by the current 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 Founation Trust as inpatients, day cases and outpatients live in the current primary care trust* areas of Chesterfield PCT, North-Eastern Derbyshire PCT and High Peak and Dales PCT.

*Primary Care Trusts will re-configure in October 2006.

In 2006 the corporation will consider if the current catchment area outlined in its constitution should be extended. There are currently more then 300 associate members in the north Amber Valley who wish to be involved in with the corporation. However, they currently have no voting rights.

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 area.

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

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

Breakdown of community membership

We have developed a membership strategy and since April 2004 our membership base has steadily grown. By 31 March 2006 we had a combined membership (staff and community) of just over 10,000.

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

	2005/2006	**2006/2007**	**2007/2008 (estimated)**
Community members at 1 April 2005	6,955	10,189	10,489
Community members at 31 March 2006	10,189	10,489 (estimated)	10,989 (estimated)

* There are another 310 members outside the constituency area, for example in the north Amber Valley area. They wish to be registered and involved because of their various links with the hospital (but have no voting rights under the current terms of the constitution).

Breakdown of public membership within constituencies (31 March 2006):

Constituency	**Population served**	**Number of members**	**% of population served**
Bolsover	71,766	1420	2.0
Chesterfield	98,852	4265	4.3
Derbyshire Dales	43,402	1046	2.4
High Peak	57,005	466	0.8
North-East Derbyshire	96,940	2682	3.0
Other* (see note above)	N/A	310	N/A

Staff constituency composition
The staff constituency comprises:

- Permanent members of staff
- 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.

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, estates, health care assistants etc.

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

Breakdown of staff membership within constituencies (31 March 2006):

Constituency	**Number of members**
Medical and dental	213
Nursing and midwifery	1386
Allied health professionals, pharmacists and scientists	305
All other staff	1253
Total	**3157**

Breakdown by class relative to size of staff group

Class	**Group %**	**Membership %**
Medical and dental	8.6	6.7
Nursing and midwifery	43.3	44.0
Allied health professionals, pharmacists and scientists	9.0	9.6
All other staff	39.1	39.7

Future membership

Membership management
In October 2005, the corporation reviewed its requirements for managing membership (in order to deliver our membership strategy). The decision to manage community membership in-house was revoked and the corporation opted to continue to purchase services from its current supplier.

This was felt to be the better solution at present, to grow the membership in an extremely targeted way and to ensure current membership remained engaged and active. The corporation felt it was unable to do this, without considerable investment,

in a way that would achieve very specific membership growth and ensure one hundred percent current membership validity.

Staff membership management however, has been integrated into an existing corporate function. This has been a cost-effective option and it has also allowed staff the option of transferring to community membership (if eligible) when they leave corporation employment.

Membership management will be reviewed every two years.

Membership growth

In December 2005, it was clear that the corporation's community membership was imbalanced. In particular, membership figures for the Chesterfield class of the constituency were out of 'sync' with the number of governor representatives on the Council of Governors.

Membership for Chesterfield was also lacking in the specific postcode areas of S40, S41 and S43 - three areas often regarded as 'poorer' in socio-economic terms.

To redress this situation, the corporation worked on a membership recruitment exercise with its membership management contractor. Around 40,000 households in North Derbyshire were targeted - with 80% of these to postcode areas described.

As a result, with an 8% response rate - 3234 new community members registered and membership in the Chesterfield class of the constituency doubled.

Due to this projects' success, the corporation has already met its March 2008 community membership target of 10,000 members.

Therefore, for the next two years, the corporation intends to look to consolidate the existing level of membership and concentrate activity on targeted campaigns - with small growth in numbers, but a better reflection of diversity. For example, looking to increase membership in the 16-25 and 35-50 age range categories.

Building membership

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

- To ensure all current and future staff working for the corporation (including contracted-out staff) are aware of staff membership, what it means for them and to encourage them not to decline membership.
- To encourage staff leaving the corporation to transfer their membership to a community status (if they are eligible to do so).
- To strive to for the composition of community membership to reflect diversity - geographically spread across our stated 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 source ways of making membership attractive and accessible.
- To define the rights 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.

Methods and processes

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

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

Membership communications and 'marketing'

- Procedure in place for dealing with applications for membership.
- Produce applications forms and advertise membership through a variety of media and other mediums - within the hospital and its premises and via external sources.
- Membership recruitment information.
- Devise a communications pack for members and potential members.
- Aim to place regular feature and news items with local media.
- Produce regular and easily accessible information for staff.
- Develop and maximise the potential of the corporation's intranet and website for information, communication and democratic purposes.
- Clear brand established for membership materials.
- Provide all new members with consistent and relevant information about the corporation and the role they will play as members.
- Consider new formats of communications for ease of use and user appeal - video, CD, DVD, email.
- Continue to use the 24-hour free phone number 08000 56 56 27 for membership purposes.
- Regular membership involvement in specific campaigns and projects.
- Produce election information to help members understand the role of a governor and to encourage more members to stand in elections.

Membership diversity

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

Targeted membership growth/interaction

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

Opportunity for election

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

Members, board and governor inclusion and involvement

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

Public governors have been involved on several working groups, including:

- Research strategy group.
- Modernisation of the emergency department.
- Hospital at night project group.

- Patient environment action team (PEAT).
- Second ophthalmology clinic capital scheme.
- 'Think clean' day.
- 'Think food' day and the development of new patient menu meals
- Children's services development capital scheme.
- Standards for Better Health published by the health care commission.
- Children's champion.
- Refurbishment of the main entrance.

Education

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

General

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

Election of governors

Elections to the corporation's Council of Governors were held in November 2005. This year, due to staggered appointments put in place from January 2005, four seats fell vacant - one each in the Bolsover and North East Derbyshire classes of the constituency and two in the Chesterfield class. Three out of four governors opted to stand in the elections again - with just one gaining re-appointment to their position.

The three new governors took up their seats on the Council of Governors in January 2006. Details of the Council current membership can be seen on page 50.

The Board of Directors confirms that elections were held in accordance with the rules stated within the corporation's constitution. This is verified in the election report of 5 December 2005, as follows:

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

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

The 2006 elections will take place in November, with the following seats falling vacant:
Three seats - Chesterfield class of the constituency
One seat - Bolsover class of the constituency
One seat - North East Derbyshire class of the constituency

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

As outlined on page 60, the corporation is two years ahead of where it expected to be in terms of community membership. For this reason, plans up to March 2008 will focus on small campaigns to reflect diversity, rather than actual membership numbers. There are some areas of membership that require specific projects to increase numbers - for example attracting more members aged 16 to 25.

Staff membership has remained static and this position is not expected to change. As the corporation looks at making efficiencies and savings over the next three years, the likelihood is that staff membership may actually drop. The aim is that it is 90% or more of the total number of staff employed at any time.

The corporation intends to undertake a review of its constitution in the autumn of 2006. Membership is one area governors will be asked to examine - in particular how members who currently fit in the 'other' category (that is those who have registered but have no voting rights at present), can obtain full membership rights. This could be done by expanding the catchment area covered by the Derbyshire Dales, or by establishing a new constituency class and actively seeking to increase membership numbers in this area.

Membership in the Derbyshire Dales class has also reached levels that were unexpected when the corporation established itself as an NHS foundation trust. The council will also need to consider if the membership is accurately reflected in the number of governors on the council.

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 can access a variety of communication materials including:

- pay-slip bulletin - information circulated to every member of staff with their monthly pay-slip.
- membership magazine - with the authorisation of foundation trust status the staff magazine re-launched in 2005 as a membership magazine. It is distributed to all community and staff members of the foundation trust.
- e-mail briefings - regular briefings to all staff via their personal e-mail accounts, on a variety of subjects affecting the corporation.
- staff suggestion scheme - staff can access the Board of Directors by e-mail or letter to ask questions, or put forward concerns, ideas and suggestions.

All staff use the suggestion scheme are guaranteed a response direct from the chairman, chief executive or another executive director within a 20 working-day standard.

- posters, leaflets, reports - produced specifically for staff. 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 £25,000 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, an on-line telephone directory and up-to-date news about the corporation - including finance reports, performance reports and minutes from key meetings such as the Council of Governors.

Consultation with members and the public

As an NHS foundation trust, the corporation consults with both staff and community members in a structured, well-planned and specific way. Consultation with members means the corporation involves local people and staff in decisions - to improve and develop services and facilities; and in turn enhance our patients' experiences. This year consultation on two major changes for the corporation took place:

- Visitors code of conduct

A combined staff and community membership of around 10,000 people had an opportunity to comment on new proposals to change visiting across the corporation.

As part of plans to reduce hospital-associated infection, members were asked if visiting hours should be reduced. In exchange, more cleaning would take place on wards and a new visitors code, would be adopted - including a ban on more than two patients per bedside.

Almost 5,000 (nearly 50% of the membership) responses were received. And over 96% were in favour of the new code. However, the corporation was asked to extend afternoon visiting from a proposed one, to a two-hour slot - to help visitors travelling long distances. The corporation agreed this would be more reasonable and agreed to alter its proposals. The consultation - which took place in July 2005 - led to major changes in the way the hospital operates, with total support from staff, patients and local people.

- Smoke-free site

A smaller response - 1,038 comments in total - was received in January 2006, after the corporation consulted on its smoke-free site strategy.

But 98% of these overwhelmingly backed the idea of Chesterfield Royal Hospital NHS Foundation Trust banning smoking - not only in its buildings, but also in its grounds and gardens.

So, from national no-smoking day on 8 March 2006, the new policy came in to play. And the corporation responded to members' requests for help in kicking the habit - with direct referrals to the local stop smoking service, discounted nicotine products available to all through the pharmacy shop and access to nicotine replacement therapy as part of in-patient care plans.

Smoke-free has been well-policed by a team of dedicated security staff. And as a result, the site is clean, pleasant and a welcome environment for all.

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

Consultation with local groups and organisations

Patient and public involvement

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 corporation's work, which has been strengthened by becoming a foundation trust.

Patient Advice and Liaison Service (PALS)

The service:

- Acts as a first point of contact for patients and their families to raise concerns, or requests for information.
- Can refer patients on to external or advocacy services (when asked to do so).
- Provides accurate information on all aspects of the corporation and related healthcare issues.
- Ensures all issues questions and concerns are addressed as speedily as possible

Number of queries received by PALS:

Date	Number of queries
April 2004 to March 2005	470
April 2005 to March 2006	777*

* The aim of the service is to deal with all queries as quickly as possible - 79% of these were dealt with and resolved on the same day.

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

- Following comments made by a patient the answerphone message for the Dexa Scanning Clinic was reviewed and amended.
- Some patients attending out-patient suite 4 have to use an enema half an hour before attending for care and treatment. Patients were unclear that they could go to suite 4 half an hour before their actual appointment if they needed support and help with regard to the enema. The patient information has been revised.
- Information sessions for patients requiring knee and hip replacements are held regularly within the corporation. Patients attending were sometimes unclear of where to attend. The patient letter has now been revised to include clear instructions and a detailed map on the reverse.

- Staff in the Ear, Nose and Throat clinic have been reminded to keep patients informed of waiting times and potential delays.
- As a result of queries relating to staff attitude, the PALs service has developed a protocol to ensure appropriate action is taken. The protocol was developed in conjunction with senior matrons in the corporation.
- During the year the information available from the corporation's Health Information Point has been reviewed and updated. It now includes locations for accessing support on drug and alcohol use. This is in line with Healthcare Commission standards about providing easy access to health promotion information.
- The care and treatment of patients with learning disabilities was raised as an issue and discussions have been held with the Learning Disabilities Service to review current arrangements and provide information to clinical staff.
- The corporation's suggestion scheme is currently being reviewed following comments made by patients and staff.

National patient survey

The corporation takes part in the annual programme for national patient surveys in order to evaluate the patients experience and develop patient centred services. During 2005, the national patient survey focused on adult inpatients and the findings have been used to develop an action plan. As a result of the survey the corporation plans to:

- Review the arrangements for preparing discharge medications for patients and test alternatives in order to improve turnaround times.
- Improve information provided to patients regarding their discharge and involve them in the discussions held to plan their discharge home.
- Access compliance against the corporation's code of conduct for visitors.
- Review access to out-of-hours scanning facilities for stroke patients in order to improve their care and treatment.
- Improve the quality of patient meals in the hospital and develop special diets for patients.
- Raise staff awareness about hand hygiene.
- Raise staff awareness about communicating with patients about their care and treatment and issue good practice guidelines to all staff.

New patient meals and menus

As part of the corporation's work to improve patient meals, staff have been working in partnership with a group of patients, self help group forum members and public governors to review new patient menus. The group considered the new meal provision to ensure suitable meal combinations could be selected by patients. In addition, the group reviewed the information for patients to ensure it was easy to understand, along with identifying any further improvements, which could be made. Suggestions included the following:

- Improve the variety and quality of special diets
- Increase availability of traditional dishes such as roasts and casseroles
- Explanation more about ingredients used in meals
- Have adequate crockery and cutlery on the wards

Emergency Management and Clinical Decision Units

The patient's experience of attending the Emergency Management Unit and Clinical Decision Unit was evaluated. The findings highlighted that the majority of patients had

a positive experience and felt that the service was patient centred. The findings were also used to identify areas for improvement, which included the following:

- Defining the roles and priorities for staff with regard to serving beverages and food. Patients were concerned about domestics cleaning and serving food. An additional housekeeper has been appointment to support this function.
- Tests and investigations can prevent patients accessing food and beverages on the units, so a system has been put in place to ensure that meals can be obtained throughout the day. This initiative will be supported by the housekeeper.
- Positive feedback was evident in respect of the patient's Discharge Lounge.
- Work has been undertaken to improve patient information about 'take-home' medicines.
- Extremely positive comments about cleanliness were received and shared with other areas in the corporation - promote good practice.

Special care baby unit support group

A premature birth can bring many different and extreme emotions and responses in families. Parents' main priorities centre on the care of their baby, and there is little time to consider their own feelings. While parents support their baby, they need to be supported themselves. A support group can give staff an opportunity to establish genuine dialogue with families of special care babies and develop greater insight into their concerns. During May 2005 a support group was set up with great success and continues to be well attended. The group has focused on providing parents with emotional support, hosting talks on special or current topics and importantly sharing experiences.

Genito-Urinary Medicine (GUM)

An evaluation of the patient's experience of attending the GUM clinic was undertaken during 2005. The findings were extremely positive demonstrating that the service was patient-centred and protected the privacy and dignity of individuals. The findings were also used to support the following initiatives within the clinic to improve local services:

- Implementation of local targets to reduce waiting times.
- Review of methods by which patients could be reminded to attend their appointments to promote best use of resources for example use of text messages.
- Review of how and when patients receive their results and the support required for this.

Epilepsy service user group

The corporation provides a hospital-based service to a large number of patients with epilepsy and in order to improve theses services, a user group was formed in partnership with the clinical team. The aim of the group is to enable joint working to influence local services, represent the views of epilepsy patients and their families, identify gaps in existing services and affect change by contributing to ongoing developments. During 2005/06 the group has supported the 'copying letters to patient's initiative' and established a sub-group to develop individual management care plans in line with the guidance issues by NICE (National Institute for Clinical Excellence).

North Derbyshire cancer services user group

The North Derbyshire Cancer Services User Group is supported by Chesterfield Royal and Macmillan Cancer Support, and since its beginning in 2004, has gone from strength-to-strength. The group continues to work in partnership with healthcare

professionals in order to promote patient-centred services for cancer patients and their families. The following highlights some of the work that took place during 2005/06:

- Patient representatives from the group were involved in the appointment of the Nurse Consultant for cancer services.
- A room for relatives of terminally ill patients has been opened. This allows relatives to stay overnight and be close to their loved one.
- Representatives from the group have been involved on a number of working groups - both locally and across the network. In addition, some have taken part in the peer review process, where the group was said to be a model of excellence.
- Made steps to tackle the end of life aspects of a patients journey to influence the pathway for patients and their families.
- Supported the pilot of patients having their blood tests taken the day before attending for treatment.
- Given feedback on the psychology service available for cancer patients.
- Reviewed draft patient information and made suggestions to improve the quality of information.

Cancer patients care and treatment

During 2005/06 the corporation underwent a cancer peer review, with the quality of cancer services provided at the Chesterfield Royal Hospital, undergoing assessment. As part of this work a number of surveys were carried out to evaluate the experiences of cancer patients. Overall, the findings from the evaluations were excellent and supported a number of developments across the corporation. These developments included:

- Patients receiving a written summary of their consultation.
- Each patient having a nominated keyworker responsible for their care and treatment - to improve communication and co-ordination of their overall journey.
- Improved availability and standard of patient information, including access to information about benefits and financial support.

Health and safety performance and occupational health

The Health and Safety Executive undertook a formal inspection of the corporation in October 2004. Their final report was critical of the corporation's position at the time and concluded that the organisation fell short of expected standards.

Following the HSE's report, the Board of Directors took direct and immediate action to change the way health and safety was managed across the corporation:

- Board level accountability was strengthened - with overall responsibility for health and safety allocated to the Director of Allied Clinical and Facilities Services.
- Every directorate's head of performance or general manager was given the responsibility for the day-to-day management of health and safety, acting on issues and concerns in their area.
- An action plan was developed to address all the recommendations in the HSE's report. This was shared and agreed with the Health and Safety Executive.

The HSE revisited the corporation in December 2005 and declared that: '*as considerable progress had been made by the corporation against the action plan, they would not be undertaking any further formal review of the plan and therefore considered it to be complete'.*

Actions undertaken during the year include:

- Policy work - work is being undertaken to revise the risk management strategy in-line with the latest guidelines. The corporation's health and safety at work policy has been revised, together with the codes of practice that support it.
- Organising - there has been a significant reorganisation of roles and responsibilities. Three additional members have been added to the environmental risk team. As a consequence, they are able to supply more support to directorates and improve the infrastructure supporting fire safety and security across the organisation.
- Day-to-day responsibility for health and safety at directorate level sits with the heads of performance or general managers.
- A Health and Safety Management Committee has been established.
- Planning and implementing - the implementation of policies and procedures is through the health and safety management committee. Training has been received at appropriate levels.
- Measuring and reviewing performance - health and safety and associated risks now form part of the annual overall corporate objectives for the corporation.
- Audit - health and safety is now included as part of the organisation's corporate assurance process and our processes are independently audited.
- Incident reporting - the corporation has a centralised system that records both clinical and non-clinical incidents. Examples of the type of incidents recorded on the system are: violence and aggression, manual handling, slips, trips and falls, needle stick injuries and cuts.

Payment practice code

The national 'better payment practice code' requires the corporation to aim to pay all valid non-NHS invoices within 30 days of receipt (or the due date - whichever is the later). Performance this financial year shows that 96.7% of invoices paid complied with this measure.

	Number	£'000
Invoices paid March 2005 to April 2006	52,558	48,006
Invoices paid within 30-day target	50,814	46,708
Percentage paid within 30-day target	96.7%	97.3%

Remuneration report

The remuneration committee

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

These disclosures are made in the annual accounts for the periods April 2005 to March 2006.

Remuneration of the chairman and non-executive directors

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

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, 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.

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

On John Raine's appointment as acting chairman of the corporation in October 2005, the membership of the remuneration committee was reviewed. In view of the committee having concluded its business and not needing to meet again during 2005/06, it was agreed that the membership of the remuneration committee should remain as it was for the time being. Due to the sad death of Nick Webber the membership of this committee is now under review.

Remuneration policy

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

The remuneration of the chief executive and the four other executive directors is determined by the Board of Directors' remuneration committee (see above). In

reviewing remuneration, the committee has regard to the corporation's overall performance, the delivery of the agreed corporate objectives for the year and the pattern of executive remuneration among foundation trusts and the wider NHS.

Following an external evaluation by Hay of the executive director roles in 2004, the remuneration committee has between October 2004 and April 2006 phased in an increase in basic salary recommended by Hay.

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

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

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

Details of the service contract for each executive director:

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

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

The provisions for compensation for early retirement and redundancy are as set out in sections 45 and 46 of the General Whitley Council, which are replicated in section 16 of the Agenda for Change: NHS Terms and Conditions of Service Handbook.

Remuneration of senior managers during the year

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

These disclosures are made in note 5.3 of the financial statements for the periods April 2005 to March 2006.

Eric Morton
Chief executive

Ends

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NHS Foundation Trust

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