

Annual Report & Accounts 2014/15

Royal Devon and Exeter NHS Foundation Trust



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Chairman's Introduction

It is my pleasure to introduce our Annual Report, Quality Report and Accounts for 2014/15.

In my introduction last year, I explained that we will not be able to continue to do more for less each year unless we work in a fundamentally different manner, not only within the Royal Devon & Exeter, but across our local health and social care economy. While this remains true, the stoical efforts of our staff have enabled us to manage through very difficult times and I am delighted that over the last 12 months we have maintained:

- Our Green (the best) rating from Monitor for Quality
- Our '6' rating (the best) from the Care Quality Commission
- Exceptional performance against all of our key safety indicators (covering harm free care, mortality rates, infection control, incidents etc.)
- An improvement in staff engagement

These achievements are a credit to our staff and management at the RD&E and we were delighted that this was recognised by the leading sector publication - the Health Service Journal - which recognised our Chief Executive as the 11th most exceptional chief executive in the country. The praise for Angela's 'patient-focused gravitas and passion for quality improvement, as well as her staying power' sums up the ethos of the RD&E.

That is the good news, however. The pressures on the RD&E and the wider health service during the year were relentless. During the year the number of emergency admitted patients increased by almost 5% and the number of outpatients by 2.4% while at the same time the acuity and dependency of our patients increased. These pressures are now being felt throughout the year - not just in the winter period - and are impacting on the achievement of targets. Our failure to treat 85% or more patients urgently referred by GPs with suspected cancer within 62 days was particularly disappointing and the impact of cancelled elective surgery to accommodate the increase in emergencies will impact on our Referral to Treatment and other targets during the coming year.

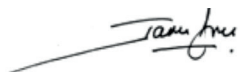
As expected, the combination of yet further reductions in tariffs (the national prices at which we treat patients), the increased demand from patients for emergency medicine (where we received only a portion of the reduced tariff and suffer large losses) reducing the level of surgical activity we are able to undertake and the increased costs associated with the recommended increase in nursing numbers has materially impacted on the RD&E's financial performance. In 2014/15, the deficit increased from £8.4m to £11.2m and this will increase materially again in 2015/16 as tariffs are further reduced.

So with all these challenges, is your Board disenchanted? Not at all. Your Board, supported by your Council of Governors, remains focused on its priorities, in terms of who matters and what matters. We will continue to focus on our patients, our communities and our staff and we will continue to prioritise quality, safety and patient outcomes. We will not permit this focus to justify financial inefficiency, nor however will we allow the ever reducing tariffs to impact on our high quality treatment of patients.

We firmly believe that we need to see better integration not only of healthcare but also social care to ensure that quality of care and financial efficiency are improved in tandem. We do not want to focus solely on managing sickness, however; we want to work with our communities, and health and social care colleagues, to maximise wellness. Your Board has been clear that it is willing to commit resource (management, people and finance) to help integrate services across the whole of health and social care in the Eastern part of Devon. We are working well with the majority of our partners; it is important that none are permitted to slow down the urgent changes that our communities should rightly demand.

Better integration of health and social care is, however, only part (albeit an important part) of the solution. Demand for, and expectations of, healthcare is growing much more quickly than the current spending commitment will allow. Either spending needs to be materially increased or demand and expectations reduced... or a combination of both. This is clearly a national debate for our politicians and, indeed, wider society. It is a debate that needs to be urgently started, however.

Finally, I would like to thank once more our staff and volunteers. Their commitment to ensuring high quality care in such difficult circumstances is admirable and I feel very privileged to act as their Chairman.



James Brent
Chairman

Chief Executive's Introduction

The past year at the RD&E has been one in which we have faced exceptional challenges, but also one where, despite this, we have achieved a huge amount for our patients. It has also been a year in which exciting new opportunities to enhance and integrate our care for patients have gathered pace.

Our vision is to provide safe, high quality, seamless services delivered with courtesy and respect and I am proud to report that our staff continue to make this vision a reality every day with the excellent care they deliver or support. Our headline achievements this year include:

- Lowest (best) possible safety, quality and financial risk scorings from the Care Quality Commission
- Key internal safety indicators remaining consistently 'green' (best) throughout the year
- Three consecutive years with no MRSA Bacteraemia and continued progress on reducing avoidable cases of Clostridium Difficile (C.Diff)
- Strong performance in national patient and staff surveys
- Recruited 454 new nurses
- Preferred bidder to provide community services in Exeter, Mid and East Devon
- Member of the innovative multi-agency Integrated Care Exeter (ICE) project
- Shortlisted for several national patient care awards

These achievements are all the more impressive when we consider the 2014/15 financial year has been one of the most demanding for many years. Our emergency admissions rose overall by around 5% whilst our available income to provide services fell. There were sustained periods of peak demand not just in winter but from April to June and during the autumn period too. In line with other acute hospitals, over the Christmas and New Year period we saw unprecedented levels of acutely ill patients over and above the levels we had planned for in our Winter Capacity Plan and the effects of this, combined with the cumulative impact of busy periods earlier in the year, proved a real test of our resilience.

In these circumstances, where our resources are stretched and we need to make tough choices, the Trust Board is clear that our highest priority is to protect the safety of our patients and the quality of services. This approach guides all of the decisions we took during this time and some of these, for example cancellation of some operations and procedures, were very difficult for all concerned. They are never taken lightly by staff and we take them only after consultant review of every individual case. Nevertheless, I am acutely conscious of the distress and anxiety cancellations can cause and we work tirelessly to avoid them as long as it is safe and appropriate to do so.

The increased demand we have experienced has also had a negative impact on our performance against some national targets. This has affected some of our stroke, fractured neck of femur and cancer patients and each day we walk the tightrope of balancing the differing needs and demands our services face. Our clinical staff are at the centre of our decision making processes which are designed to ensure as much as we possibly can that our actions are driven by clinical priority to maximise the gain and positive outcomes we can offer to all our patients. We remain committed to achieve our absolute best within the resources we have available but this is becoming increasingly difficult as we face unrelenting increases in demand for care alongside annual reductions in the income we receive for delivering care. Reassuring performance against our safety indicators has been maintained throughout the year which is a major tribute to the dedication and commitment of our staff despite the increasing level of challenge we face. In this context but still disappointingly, our financial position has worsened during the year and we have recorded a deficit of £11.2 million at year-end. Ensuring we deliver safe and high quality care amid rising demand and annual reductions in our income will remain a critical challenge for the foreseeable future. This is true for the RD&E but it is also recognised as a much wider challenge facing the care system across Devon and the NHS as a whole.

These challenges really do underline that the way the NHS and care services are currently arranged is unsustainable and needs to change. It is increasingly clear that much more could be done, through earlier interventions and a focus on keeping people fit and well to reduce the numbers of people requiring acute care in an emergency. Therefore the system needs fixing to make it work better for our patients and this became a key focus of attention for the RD&E Board over the course of the year. And this is where our biggest and most exciting opportunities lie.

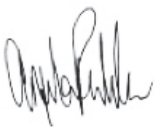
As the NHS Five Year Plan makes clear, fixing the system must not mean more top-down change. Through the Integrated Care Exeter (ICE) project - a project involving numerous partners to test and deliver radical change on how health and care can be delivered differently - we are beginning to identify local solutions for local problems. This is a real innovation that will pool resources from the public and voluntary sector together to fast-track a new approach.

Linked to ICE is our work on two other major initiatives designed to radically improve the way we deliver our care to patients and unlock many of the blockages, delays and inefficiencies that make the current system unsustainable.

Once again this year we have made progress in delivering the strategic objectives we developed in consultation with local people and our staff.

First is the preparatory work we have been carrying out on the transfer of adult community services in Exeter and East Devon which the RD&E was named preferred supplier. It is a great disappointment to us that this decision has been challenged thereby introducing further delay in this much needed change being implemented. We do not believe a delay is in the interests of the people who reside in the Eastern locality of Devon (or indeed to the wider NHS) and are disappointed that their views have not been appropriately listened to. Our ambition remains to 'wrap prevention and care around' our patients through having more leadership of community service closely aligned to acute care that is holistic, person centred and based within the localities served. Our population deserves this aspiration to be delivered and the Board will continue to work on delivering this objective as soon as possible. Second is the business case we prepared during the year for a significant investment in a new Electronic Patient Record (EPR) system that will make patient records digitally accessible and available in real-time to both patients and those responsible for their care across the system. Crucially, it is comprehensive and will be updated in real-time, so everyone involved in a patient's care including the patient themselves will be able to see the same information at the same time, wherever they are. This will do much to bring down the logistical and administrative barriers that can exist between one part of the health system and another. Poor co-ordination between numerous health and social care organisations can be one of the biggest frustrations our patients experience and lead to unacceptable delays and lapses in care. Investing in a new EPR will help us and our partners in Devon unlock some of the barriers that have impeded smooth co-ordination and integration, and will help us deliver the transformation in how our services are delivered both within the hospital but, crucially, along whole pathways of care.

Our patients and the public we serve are at the very heart of everything we do. Although there is no doubt we are in an era of unprecedented challenge in the NHS, it is through this adversity that all agencies involved along a patient's entire pathway are coming together to find a new way forward. We are not complacent and know on occasions we do not always deliver the high level of care we aspire to but the RD&E remains a beacon of high-quality clinical and management practice and we are determined to stay at the forefront of developing a more sustainable and efficient acute care service to the population of Devon. Ultimately, our aim is to support an integrated health and social care system which will enable our population to better manage their own health in their preferred environment, whilst maintaining high quality and safe medical interventions as appropriate. We do this through our committed and dedicated staff and the support we get from communities we serve.



Angela Pedder OBE

Chief Executive

About the Royal Devon & Exeter NHS Foundation Trust (RD&E)

The RD&E is a teaching hospital which provides specialist and acute hospital services to a core population of about 460,000 people in Exeter, and East and Mid Devon. We also provide services to patients from further afield because we have national and internationally recognised excellence in specialist fields, including the Princess Elizabeth Orthopaedic Centre (PEOC), the Centre for Women's Health (Maternity, Neonatology and Gynaecology services), Cancer Services, Renal Services, Exeter Mobility Centre and Mardon Neuro-Rehabilitation Centre.

Our main hospital sites are at Wonford and Heavitree in Exeter; but increasingly we are providing patient care closer to home, including managing the day case surgery activity in East Devon community hospital theatres, community midwifery services and renal dialysis units. The RD&E manages over 100,000 emergency department attendances, over 350,000 outpatient attendances and over 125,000 day case or inpatient admissions each year. We have 811 inpatient beds and 125 day case beds. During 2014/15 the Trust's income was £410million and it employed around 7,000 staff (actual head count numbers).

The Trust is the leading centre for high quality research and development in the South West peninsula, delivers undergraduate education for a full range of clinical professions and is the lead centre for the University of Exeter Medical School. It provides acute tertiary and secondary care services and some community services to its catchment population in the eastern part of Devon as well

as for some specialist tertiary services to a wider population across the wider south west region. The majority of the Trust's services are delivered at the Wonford Hospital and Heavitree Hospital sites in Exeter, with additional services delivered in partnership with other NHS providers at other locations in Exeter, Mid Devon, East Devon and North Devon and Torridge. Some specialist services are delivered more widely across Devon, Cornwall and parts of Somerset.

The RD&E has a high standing in the local community and we recognise the duty we have to uphold the highest standards to maintain the affection and respect with which we are regarded. In recent years, with the freedom which comes with our Foundation Trust status, we have become more engaged with local people about their needs and aspirations for their RD&E. This has been made possible by the involvement and contribution of the Council of Governors, supported by the Board of Directors, our staff, 19,000 members of the Trust and relations with local people and partner organisations.

The Trust has a strong track record of continuous improvement, innovation and redesign, with a care focus on safety and quality. The Trust has a strong emphasis on research, and translating research into clinical practice together with a good relationship with the University of Exeter to support this agenda. The Trust continues to deliver its Trust-wide programme of transformational change which is improving standards of performance and helping to create a new way of working for the future.

Highlights of the Year

The Trust has maintained a strong focus on ensuring that it continued to deliver safe, high quality patient care. Our Highlights section sets out some of our achievements during the year.

The RD&E can be justly proud of its successful track record of delivering safe and effective care to people in Devon and its surrounding area in a cost effective and sustainable manner. Continuation of this sustained excellent service to our population is at the heart of the work of the Board supported by our Council of Governors.

Spring 2014

Our Extraordinary People – Winner of Winners' Awards

In April we celebrated our first ever Winner of Winners event as part of our Extraordinary People Awards scheme.

"The RD&E has extraordinary staff doing exceptional things every day in a place where passion for the job is the norm."

This sentiment from awards compere Judy Spire (BBC Radio Devon) was echoed thought the night at the inaugural Extraordinary People – Winner of Winners event. The ceremony, held in Research Innovation Learning and Development Centre, was the culmination of a year's campaign to celebrate staff who go above and beyond to care for their patients. It was attended by winners from the three seasonal ceremonies who were in the running for the prestigious Winner of Winners titles.

Staff across the Trust were also invited to have their say by voting for the winner of the People's Award in the Excellent Care category – with the staff of Okement Ward emerging victorious for their dedication to high quality care. Finally, Executive Directors took the opportunity to celebrate the dedication of our longest serving volunteers, the Hospital Radio Team.

Chairman James Brent said the nominations received for the awards represented only 'a fraction' of the talent in the RD&E as a whole.

Chief Executive Angela Pedder said: *"Our winners are wonderful examples of personal passion and drive to do the very best for our patients and fellow staff."*

Rd&E Performs Highly in Care Quality Commission Annual Adult Inpatient Survey

Last year, adults admitted to the RD&E gave the Trust a resounding stamp of approval in the Care Quality Commission (CQC) 2013 adult inpatient survey.

The Trust scored highly across a wide range of measures covering each stage of the adult inpatient's journey, from waiting list through to care on a ward and then leaving the

RD&E. The scores show standards in care at the RD&E have remained consistently high since the last survey in 2012, with some areas improving still further. Taken together the scores place the RD&E among the best performing Trusts nationally.

Em Wilkinson-Brice, Chief Nurse/Chief Operating Officer, said: *"RD&E staff are to be congratulated on these excellent results. They are real evidence that all our staff are delivering very high standards of care and treatment and with dedication, courtesy and respect."*

RD&E Supports Dementia Awareness Week 2014

Patients and staff took part in a memory walk around the hospital grounds to raise awareness of dementia. The walk was part of a week-long programme of activities organised in support of the Alzheimer's Society's 'Dementia Awareness Week' in May.

Throughout the week visitors were encouraged to write on memory walls, a service took place in the Chaplaincy Centre, and inpatients were entertained by the RD&E's 'Rhythm of Life' choir. Staff also supported the Alzheimer's Society by organising a cake sale and raffle.

Throughout 2014/15 the RD&E has embarked on a programme of Dementia Awareness training for all staff. Training numbers were further boosted during Dementia Awareness Week, with over 230 staff attending sessions during the week.

Julie Vale, Senior Nurse for Older People said: *"We are working towards ensuring that all our staff have the knowledge, skills and confidence to ensure that patients with Dementia receive the right care and support."*

It's 'Ok to Ask' About Clinical Trials

The importance of taking part in clinical research was celebrated during International Clinical Trials Day in May. The event provides a focal point to raise awareness of the importance of research to improving health care, and highlights how partnerships between patients and clinicians are vital to high-quality, relevant research.

During International Clinical Trials Day, the National Institute for Health Research (NIHR) Clinical Research Network (CRN): South West Peninsula, which the RD&E hosts, was keen to promote the 'Ok to Ask' campaign, encouraging people to ask their doctor or local hospital if they are interested in taking part in research.

Along with public information stalls manned by the research team, the team arranged poster displays for clinical staff showcasing current Trust research. They also organised talks from patients who have already benefitted from taking part in clinical trials, including renal patient Elena Lilley who has described her experience as 'life changing'.

Volunteers Celebrated at Chairman's Tea Party

Last spring, over one hundred volunteers from across the RD&E gathered for a special afternoon tea hosted by Chairman James Brent and the Board. The event was designed to recognise the on-going commitment and dedication of all the volunteers at the RD&E and to say thank you for their hard work throughout the year.

There are well over three hundred volunteers who work at the RD&E and with partner organisations such as Exeter Leukaemia Fund (ELF), Friends of the Oncology and Radiotherapy Centre Exeter (FORCE) and Hospital Radio Exeter. They play a huge part in helping to improve the experience of being in hospital for patients and visitors, fulfilling roles such as meeting and greeting, running the trolley shop, and helping patients attend the Chaplaincy Centre.

Chairman James Brent said: *"Since joining the Trust, I have become very aware of how important our dedicated volunteers are in ensuring that the hospital is a friendly and hospitable environment for our patients and their visitors."*

Research, learning and Innovation – a new innovative multidisciplinary health education and research centre opened

The striking £27.5million Research, Innovation, Learning and Development (RILD) building was officially opened in June by principal guest and World Dementia Envoy Dr Dennis Gillings CBE, PhD.

RILD is a partnership between the RD&E and University of Exeter Medical School, and part-funded by the Wellcome Trust and the Wolfson Foundation.

One of RILD's key objectives is to take a truly multi-professional approach to research and education. Doctors, nurses, allied health professionals, managers and academic staff will all be trained and educated in RILD with one goal in mind – to improve the quality of patient care.

Also in June the Clinical Research Facility (CRF) opened its doors for an open day, where members of the public had the chance to take part in the Exeter 10,000 research study, go on a tour of the CRF with manager Dr Gillian Baker and meet researchers and clinicians, and hear a talk by Professor Andrew Hattersley, CRF Clinical Director and RD&E Research and Development Director.

RILD provides working space for around seventy research staff, and its simulation suite offers hands-on clinical learning and teaching. Patient studies, laboratory studies and then education of health care professionals of new findings will all occur in a single building. It also provides a forum for students, researchers and clinicians to come together and ensure that medical research is relevant for the needs of the NHS.

Summer 2014

RD&E Welcomes New Parkinson's Nurse Specialists

In August, two new Parkinson's Nurse Specialists joined the RD&E to improve care for patients with Parkinson's Disease. Stacey Andrew and Samantha Moore will help to ensure patients receive the right specialist care when they are in hospital. Their part-time posts have been funded by the charity Parkinson's UK for the first two years.

Their role also involves liaison with families, patients, nursing staff and community teams, as well as hospital-wide education on Parkinson's Disease.

Geoff King from Parkinson's UK said: *"We are very pleased to be working in partnership with the RD&E in the improvement of in-patient care for people with Parkinson's. This is a complex and varied condition which often requires a range of different and time specific medications, presenting a major practical and awareness challenge to ward staff. By developing these specialist posts, the Trust is taking a significant step forward in improving care for this vulnerable group of patients."*

Paediatric Oncology Rooms Refurbished Thanks to Richard's Wish

Children and young people who are having oncology treatment on Bramble Ward can now enjoy two newly refurbished rooms thanks to Dawlish charity Richard's Wish. Richard's Wish was set up in memory of 17 year old patient Richard Cridge who passed away in 2008.

The refurbished rooms, which have been designed with teenagers and young people in mind, were opened last summer by Richard's parents, Jo and Dave Cridge, along with representatives from the charity and the Exeter Foundation.

Dr Corinne Hayes, Consultant Paediatrician said: *"We are so grateful to Richard's Wish for all the work they do to support local children, teenagers and young adults having treatment for cancer. The changes to the cubicles have made a huge difference for our patients and their families. Richard was a remarkable young man and I know he would be proud of all the work his parents and wider family and friends do in his memory."*

Genetics Reveals Patients Susceptible to Drug-Induced Pancreatitis

In September, doctors discovered that patients with a particular genetic variation are four times more likely to develop pancreatitis if they are prescribed a group of drugs widely used in the treatment of Inflammatory Bowel Disease (IBD). In a study published in Nature Genetics, clinicians at the RD&E and the University of Exeter Medical School

have identified a group of patients whose genetic make-up means they are more than four times more likely to develop the serious side effect if they are prescribed thiopurine drugs.

Dr Graham Heap was part of a team led by gastroenterologist Dr Tariq Ahmad, working with the Medical School to coordinate genetic data from over 150 hospitals around the world. Dr Heap said: *"We can now theoretically identify which patients could be at increased risk of developing pancreatitis. We are hoping that this test will be formed into a tool kit of DNA based tests that also assess other important side effects of these drugs."*

Autumn 2014

Medical Imaging Team Receive Coveted ISAS Accreditation

In autumn 2014, the Medical Imaging Team were recognised for providing high quality radiology services to patients delivered by competent staff working in safe environments. They became one of just 16 NHS Trusts across the country to have achieved the UKAS Imaging Service Accreditation (ISAS), which has been awarded on behalf of the Royal College of Radiologists and the College of Radiographers.

A team of 12 staff worked tirelessly for 18 months to achieve the accreditation; a process which included thorough assessment processes, written information, audit, pathways, patient safety, cleanliness and quality, followed by a visit from the ISAS team.

Simon Harries, Clinical Lead for Radiology at the RD&E, said: *"The achievement rewards an enormous amount of effort and was made possible by the presence of a team that worked well together and grew during the process. This should be seen as a starting block and work has already commenced on submission for next year."*

Chancellor Visits RILD and Announces £1.6 Million to Unlock Genetic Secrets

In October, Chancellor of the Exchequer George Osborne visited the RD&E's and University of Exeter's RILD building, a centre of excellence in healthcare innovation. During his visit he announced £1.6 million of funding from the Medical Research Council (MRC) for the University of Exeter Medical School, to fund a state-of-the-art facility that will unlock some of the secrets of the genome.

Mr Osborne was accompanied by Nicky Morgan MP, Education Secretary and Minister for Women and Equalities, touring research facilities and meeting senior academics and managers. The visit was hosted by biopharmaceutical organisation Quintiles, and the Chancellor also awarded a Quintiles Women in Science student prize to BSc Medical Sciences student Eleanor White.

George Osborne said: *"It's fantastic to see the partnership here between Quintiles, Exeter University and the Royal Devon & Exeter NHS Foundation Trust and to meet with staff – many of them women in senior positions – who are leading the way in clinical research."*

RD&E's Intensive Care Unit Launch Charity Recipe Book

David Cameron, Michael Caines and Rick Stein are just some of the big names who provided recipes for 'Intensive Food', a charity cookbook in aid of the RD&E's Intensive Care Unit (ICU) Trust Fund. The recipe book, which contains

a collection of over three hundred recipes from ICU staff, friends and special celebrity guests, was launched in December. The ICU team, led by Consultant Nurse Carole Boulanger and Matron Marie Toghil, compiled the book, and all the proceeds from the sales will go towards providing extra comfort for ICU patients and their relatives.

The book covers a range of sweet and savoury recipes, each tied together with a chapter introduction from ICU Consultant Dr Roland Black. Highlights include a chapter from friends of the unit, a celebrity chapter, with high profile chefs such as Hugh Fearnley-Whittingstall, Rick Stein and Nathan Outlaw each supplying a recipe, and a special final chapter is dedicated to former ICU patient Rolf Clifton.

Winter 2014/15

Volunteering at the RD&E Helps Gretel Returns to Research

Volunteering at the RD&E can be mutually beneficial, as Dr Gretel Finch found out last year. Gretel has been able to return to her career in research thanks to the help and support she received whilst volunteering with us. After taking a career break to care for her young family, Gretel wanted to return to her career as a Research Scientist. She was keen to build up her confidence and skills again, so approached the RD&E. Gretel was soon using her experience to help the Infant Feeding Coordinators and Maxillofacial Surgeons with a tongue-tie audit and was gaining clinical practice hours towards her Lactation Consultant training.

Gretel said: *"My time volunteering at the RD&E significantly increased my confidence, skills and experience after such a long career break to apply for a Research Fellowship in maternal eating behaviour at the University of Bristol through the Daphne Jackson Trust."*

Devon NHS Staff Benefitting from Support of Schwartz Rounds

Over six hundred staff from the RD&E and Devon Partnership NHS Trust have benefitted from the emotional support provided by jointly run Schwartz Rounds. The Schwartz Rounds are 'grand round' style confidential sessions for staff to discuss social and emotional difficulties created by their work and to explore the human side of medicine. They were set up in light of the Sir Robert Francis' Inquiry into Mid Staffordshire NHS Foundation Trust in 2013.

The RD&E and Devon Partnership Trust were some of the first health organisations to get on board, joining forces in September 2013 to run the monthly sessions. The Trusts have just run their fifteenth Schwartz Round, and have seen approximately 675 members of staff attend their sessions to date. Staff who have attended the rounds have said that the sessions left them feeling 'revived' and 'inspired, and that they were 'grateful for the time to discuss issues and share thoughts in a safe forum'.

Strategic Report

Introduction

The context faced by NHS organisations like the Royal Devon and Exeter NHS Foundation Trust (RD&E) remained extremely challenging during 2014/15. A number of strategic issues - many highlighted in previous Annual Reports – have begun to have a real impact on the Trust during the year. Amidst these challenges the RD&E has

remained focused on ensuring that the safety and quality of the services that it offers the communities it serves remains paramount. Nevertheless, whilst continuing to maintain the quality and safety of care, the Trust has continued to make good progress on meeting its broader strategic objectives during the year.

Key Achievements 2014/15

- RD&E selected as one of eleven centres in England that will lead the 100,000 Genomes Project
- There hasn't been a single case of MRSA in the hospital for more than three years
- Approximately 1500 staff have received formal training sessions on our new way of working – Connecting Care – with 96% of areas using Communication Cells
- Our Trust-wide Values and Behaviours charter launched to help staff put our vision of providing safe and high quality services into action
- Two wards were amongst the first three acute hospital wards in the country to have been accredited by the National Gold Standards Framework Centre (GSF) for their end of life care
- Our Medical Imaging Team have become one of just 16 NHS Trusts in the country to be accredited by the UKAS (United Kingdom Accreditation Service) Imaging Service Accreditation (ISAS) for providing high quality radiology services
- Assistant Director of Nursing Alison Wootton won the award for NHS Emerging Leader of the Year at the Regional NHS Leadership Recognition Awards
- Two teams from the RD&E were shortlisted for a Health Service Journal (HSJ) Award in the "Compassionate Care" and "Patient Safety" categories
- The Emergency Team were shortlisted for a British Medical Journal (BMJ) award in the 'Team' category for their work on the sedation of patients during painful procedures.
- Professor Sian Ellard, Head of Molecular Genetics at the RD&E and Professor of Human Molecular Genetics at the University of Exeter Medical School, won an award from the inaugural Academy for Healthcare Science congress for her research work in neonatal diabetes
- Our new amalgamated magazine for members and staff was launched to widespread acclaim during the year
- The Devon Garden was selected by the Department of Health as one of 15 innovative dementia projects to be used to inform future policy and strategy
- Over one thousand staff have pledged their support to the #hellomynameis campaign
- 175 long service awards for staff with 25 years or more NHS service were awarded during the year
- Over 5,700 staff trained in Tier 1 Dementia and Delirium Awareness
- £27.5million new build Research, Innovation, Learning and Development Centre (RILD) opened in June by the World Dementia Envoy, Dr Dennis Gillings, CBE, PhD
- RD&E performs highly in Care Quality Commission 2013 annual adult inpatient survey
- 95% of RD&E staff would recommend the care and treatment provided by the Trust, according to the results of the national Staff Friends and Family Test
- The 2014 staff survey results show continued improvement across a range of indicators, including good results for staff engagement
- Our new "Orientation Day" induction for all new staff was launched in March 2015

At the national level, the NHS has been subject to on-going political debate amidst real concerns about overall performance and the level of funding for services which face ever rising demand. The focus on the NHS has arisen not only because of the relative proximity to the 2015 General Election but also because of the pressures faced by hospital Trusts across England. The 2014/15 winter period witnessed an exceptional level of demand from predominantly elderly patients with multiple health conditions requiring emergency hospital-based care right across the country. The knock on impact on a number of key healthcare targets – such as the four hour waiting times in Accident and Emergency – meant that the NHS remained in the headlines and a focus for concern almost every day. Operationally, the winter period saw a demand for acute care at an unprecedented level and this, coupled with continued issues in enabling those people to receive onward care outside an acute setting, had a real impact on many NHS Trusts. The RD&E, like many other hospitals, saw a sustained surge in demand during the winter months and this had a significant impact on the Trust's operational capacity. While this pressure was more intense than had been planned, the Trust also faced capacity issues outside the winter period – indeed September 2014 was a particularly busy and demanding month and this is usually a time when demand is at its least severe.

Alongside the operational pressures on hospital Trusts, much of the debate at a national level surrounding the NHS has focused on financial issues. In February, in its quarterly report, the healthcare regulator Monitor stated that over 50% of Foundation Trusts were struggling with their finances as a result of increased pressure on services. Nationally, Foundation Trusts faced a collective deficit of £321million which had risen from £254million, as at the end of quarter 3. During the period October to December 2014, Foundation trusts saw 2.7 million people in their A&E units, 8% more than the same period the year before, and they also treated more than 2.3 million non-emergency patients in the quarter; an increase of 7% on the same period in 2013. Not only has increased demand placed a service burden on hospital Trusts, the additional patients are only paid at 30% of the agreed cost of treating them. For the RD&E, this national rule, which was originally designed to incentivise reduced admissions into acute hospitals, results in the Trust losing over £7million a year.

The financial impact of operational pressures also comes on top of significant and on-going financial restraint in the NHS. While health spending has been protected during this Parliament, the price paid to acute hospitals for every patient treated has reduced by approximately 4% per annum or 20% over five years. In addition, the financial settlement for the NHS as a whole has not been in line with inflation which, in effect, means that the level of spending available for health care has declined year on year. Cumulatively, this on-going restraint, especially at a time of ever growing demand, has resulted in some of the

exceptional pressures witnessed during the year. Moreover, the Trust faces other financial anomalies. The Trust, along with other Trusts in the South West peninsula, is adversely affected by the application of a national Market Forces Factor (MFF) which further deflates the level of funding we receive for the patient care we provide. To illustrate this point, if the RD&E were based in Bristol we would be paid an additional £17million per annum to provide the same level of service as we do in Exeter.

In this bleak financial outlook, it is difficult to say with any certainty that a new government would identify and be able to afford significant new resources for the health and care sectors. Whatever Government is in power, the NHS as a whole will continue to face a £30billion savings gap in its finances and will continue to struggle with the level of savings required year on year. As reported last year, there are no health and care systems globally that have successfully reduced expenditure on healthcare at a rate of 4% a year. Yet, as the Commonwealth Fund found in a major comparative study of health systems in even developed countries, the UK comes out on top against a number of key factors including quality, access, efficiency, equity and healthy lives.

Amidst this uncertainty, NHS England published its "Five Year Forward View" (5YFV) in October 2014. The 5YFV, which was supported by all the national NHS bodies in England, sets out a positive vision for the future based around seven new models of care. In a brief report, the 5YFV underlines some of the key challenges facing the NHS in England including a further £30billion cost reduction over the next five years for the NHS as a whole. It seeks to set out a clear direction and vision for the future that will help the NHS meet these challenges. It recognises that radical redesign of existing services is central to ensuring that the NHS can continue to provide good care and that this will require new partnerships and ways of working that have not been developed in a way that is now required. It also argues for a rebalancing of effort with less emphasis on meeting acute care needs but more on public health care and approaches designed to enhance well-being, build resilience among the population and address the causes of chronic long term conditions. It puts forward a strong argument in favour of patients having much more control over their own care and to work with clinicians to mutually design their own care plans in a way that empowers patients. It also recognises that some facing long term conditions, often have significant knowledge about their symptoms and treatment options as well as understanding the health and care goals that individuals want to achieve.

As set out in Annual Reports over the last few years, the NHS has been subject to considerable top down changes in its structures and how it works during this Parliament. What is distinctive and refreshing about the 5YFV is that it provides the space for locally negotiated "bottom up" models to be developed within a framework of options that

are designed to hasten the integration of primary care, acute care and wider social care. Any change that results from this approach is likely to mean some shifts in how organisations work together. However, organising and negotiating these issues locally and in a way that meets local needs and is more accountable to the local population, is a major change from how these types of change have been rolled out in the past. This permissive approach – with seven different models being considered – set off a process to identify parts of the country that might be interested in pioneering some of the new approaches identified.

Many of the issues facing the NHS nationally have also impacted on the regional health economy. During the year, the Devon healthcare economy was identified by NHS England, the Trust Development Authority (TDA) and Monitor as one of eleven “challenged healthcare economies” in England. In its analysis it suggested that Devon faced a predicted funding shortfall of some £430m over the next five years and that its current pattern of provision of healthcare services was unsustainable. Additional support was provided to the Northern, Eastern, Western Devon Clinical Commissioning Group (New Devon CCG) and partners, to identify ways through which it could work together better to meet this formidable challenge.

The RD&E view is that, as currently configured and resourced, the current model of care in Devon is not sustainable due to:

- The demands placed upon it from an increasingly elderly population
- The increasing costs of drugs and devices
- Disjointed care pathways that still rely on paper-based records and where it remains difficult to share information between different parts of the care system
- A continuing reduction in finances available to the NHS and pressures on social care

Over the course of the next few years, much remains to be done to tackle some of the structural issues identified in the review made of how the local health economy in Devon works. One of the ways in which closer alignment between acute care and community services – which helps to create the necessary conditions for closer integration with care services – can be achieved is through much closer integration between an acute provider and the local community services in the locality it serves. Not only would better integration of geographically nearby services make sense for better managing the pressures on the acute sector, based on feedback from our members, a more joined up service linking community and nearby acute services would be in patients’ interests.

During the year, the Trust bid for the contract being let by NEW Devon CCG to provide community services in the Eastern locality of Devon. The Trust’s view was and

remains, that the RD&E was well placed to deliver the best outcomes for patients in a manner that was responsive and reflective of their needs and aspirations and most importantly in the best interests of society. Furthermore, the Trust believed its proposals for delivering integrated care were entirely consistent with national guidance and supported by a growing national and international evidence base that describes the most effective way to organise services for the benefit of local people. The approach taken by the Trust is based on the view that the leadership responsible for developing and implementing integrated care should sit under a single organisation; an accountable care organisation funded via a capitation approach. The service solutions under “integrated care” need to take a full pathway approach to holistic patient care, i.e. ensuring that each stage of the patient journey is cognisant of, and complements the care delivery that precedes and follows it. This usually requires a complete redesign of patient pathways. A critical aspect of successfully delivering this redesign of services is maintaining flexibility around workforce deployment and this is better achieved through a single leadership. The improvement in service quality and gain in efficiency of healthcare resources is achieved by reducing duplication of patient assessments and minimising hand-offs between organisations. The differentiation of care between the specialist and community elements of the service people received will be removed, maximising the potential for home-based care. Integration in this way facilitates greater personalised care.

Based on a procurement process run by NEW Devon CCG, the decision was made to designate the RD&E as its preferred provider for adult complex care for its Eastern locality. This was welcomed by the Trust. However, in December 2014 the decision made by the CCG was formally challenged by Northern Devon Healthcare Trust and referred to Monitor as the economic regulator for the sector. The outcome from this review is unknown but underlines some of the difficulties faced in developing a cohesive approach to addressing some of the issues facing the healthcare economy in Devon.

Despite this challenge, the RD&E remains committed to working towards a more integrated approach that better links together the health, care and wellbeing needs of the local population. One of the ways in which we have taken this ambition forward during the last year has been by working with our partners in Exeter on the Integrated Care for Exeter project (ICE). The RD&E, along with Devon County Council (DCC) and NEW Devon CCG set up a new Board in 2014, under the chairmanship of Phil Norey, the Chief Executive Officer of DCC. The ICE Board was set up by senior public and voluntary sector leaders in recognition that, to meet the needs of our changing and older population, we have to find another way of delivering public services. There is a growing body of international evidence that shows that, by working better together to jointly plan and deliver services in a genuine partnership with communities, there

is much the public sector can do to improve the delivery of services, achieve the outcomes people want and provide better value for money.

Over the last year the ICE Board has published an agreed vision for a new model of population health and wellbeing with a greater focus on early intervention and prevention; more care and support out of hospital and services designed around the needs of individuals and their family. In September 2014 DCC was successful in achieving a Transformation Challenge Award from the Department for Communities and Local Government to support the transformation work of the partnership and a joint Development Director took up post in January 2015. This funding is non-recurring money to run the programme test out new roles in the voluntary and community sector; undertake test beds for new models of prevention and to track outcomes to inform whole system transformation.

The ICE partnership now comprises 17 member organisations and in April 2015 completed a series of design workshops where over forty people from across the alliance have worked together to co-produce an innovative work programme for delivery during 2015-17. The aim is to test out a range of new models of care delivery based on the needs of populations in specific areas of Exeter, starting with the West, with a view to rolling out successful projects across the City and the rural and coastal parts of Devon where it is right to do so.

Over the next year, the ICE project intends to take a number of exciting initiatives designed to test new models of care and prevention such as the establishment of a specific initiative aimed at homeless people, the design and testing of a new health care team providing ward rounds in Care Homes supported by Telehealthcare, and "Discharge Home to Assess" so that decisions about on-going care are made at home and people do not have unnecessarily prolonged hospital stays whilst arrangements are being made for their on-going care.

During 2015 the project aims to improve the co-ordination and delivery of existing services including joining up more Community Health and Social Care Teams with Older People's Mental Health Teams and Care Navigators from the Voluntary and Community Sector to create a single, system for adults with complex needs within one team with a one team culture. We think this will give people a better experience of care which will feel joined up and connected around their needs. This will also help to improve the efficiency productivity of community services as care will be better co-ordinated.

In addition to the work undertaken on integration, the Trust has also spent time looking at the potential benefits of investing in a new Electronic Patient Record (EPR) system. The Trust needs to invest in a new system because its current systems are out of date and are becoming

increasingly not fit for purpose. The new EPR systems on the market do not simply replace and update old systems but, using new technologies and hardware, can help underpin redesigns of pathways of care. This will allow the removal of wastage and unnecessary processing that not only enhance efficiencies but also improves patient experience. In considering which EPR system to invest in and which would provide the greatest benefits, the Trust has, by working closely with clinicians and other staff, understood that the right system can provide the catalyst to completely transforming the way the Trust works both within and potentially beyond its four walls. As set out below, the potential investment that the Trust will make in a new EPR system in the year ahead has become pivotal to delivering the Trust's strategy.

Our Strategy

Socio-economic and Demographic Context

Last year's Annual Report set out some of the key health, socioeconomic and demographic issues facing the population of Devon (in the areas covered by Devon County Council). The key issues highlighted and which remain then relevant during the year include:

- Devon is the third largest county in England, covering 2,534 square miles. With over 750,000 residents it is also one of the most sparsely populated counties, with few large settlements and a dispersed rural population
- Devon has an older population profile than nationally, particularly in those aged fifty-five years of age and above, reflecting significant in-migration in this age group, and those aged eighty-five years and over, reflecting an ageing population and longer life expectancy. Between now and 2021, the numbers and proportion of the total population in the over 60s will increase. Devon is twenty years ahead of the rest of England with its older population profile, with a particular peak in those aged eighty-five years and over. Two local market towns, Seaton and Sidmouth, have today a population with the age profile that the rest of the country could expect to see in 2075. From 2011 to 2031, the number of people aged eighty-five and older is projected to rise by 77.6%. The number of people with life-limiting long-term conditions and those with dementia is predicted to increase rapidly. Furthermore, the catchment population for the Trust is more elderly than the population profile for Devon as a whole. The Trust is therefore likely to be ahead of the national curve in having to shape services to meet the needs of a more elderly population
- This overall pattern is even more marked in areas of East Devon and South Hams, whilst the population in Exeter is similar to the national average, but with an increased young adult population due to the University

- This population structure impacts on the use of health and social care services as we know that older age groups are the highest users of these services
- There is likely to be significant urban expansion within the Trust's catchment, with a local new urban development, Cranbrook, due to reach 30,000 population by 2020 and a number of other significant housing developments underway or planned. During the two years of this plan this may increase overall catchment population, but less significantly in the older age groups that use more acute healthcare services. It is more likely in Maternity and Paediatric services
- Devon's ethnic make-up is very different from that of England. Overall in England, almost 80% of people are White British, with the next highest proportion of people being Asian or Asian British (including Chinese) at almost 8%. The Devon population consists of almost 95% White British with the next highest percentage being 'White Other including Gypsy and Traveller' ethnic groups at 2.2%. Although still less diverse than nationally, Exeter is the local authority with the greatest variation in ethnic origin across Devon. Exeter has 88.3% of people identifying as White British compared to 94.9% in Devon overall, 4.3% White other compared to 2.2% and 3.9% Asian/Asian British compared to 1.2%
- The shape and makeup of the economy has a significant bearing on the health profile of residents in Devon. Nationally there are many factors impacting on the economy. The state of which has particular implications for the economy in Devon. Structurally, Devon is dominated by small and micro enterprises that tend to rely on debt to grow. Therefore the banks' reluctance to lend is challenging with regards to the growth of these enterprises. The county has an extensive geography with large rural areas which are long distances from main population centres. The high energy, and particularly fuel, prices are more problematic to an area such as Devon compared to that in other less rural areas. As a result of these factors, the poor national economic performance is biting harder for Devon businesses and communities than in some areas
- Within Devon, Exeter has a significant impact on the character of the Devon economy as a whole. When the hinterland of Exeter is included, Exeter is home to approaching 20% of Devon's resident population. To the North, South, East and West of Exeter, Devon is overwhelmingly rural. Exeter and the towns along the A38 corridor and the route of the Great Western Railway are relatively well connected. However, there are significant areas of the county which are remote from major centres of population and economic activity. Rurality and access to key economic markets is an important issue Devon's economy
- The rural nature of the area is what attracts many residents and tourists alike to Devon; however it makes planning and delivery of services to meet population needs a complex issue. Rurality can create problems of accessibility. This can affect all parts of the population, and is a particular problem for people who rely on public transport. With the increasing cost of fuel this is beginning to affect even more people. The distance that people have to travel to access services has a profound effect on whether people will actively choose to access services. This distance decay effect has an impact on people accessing health services from rural areas in comparison with urban areas
- The RD&E is one of ten acute providers in the South West. It is fourth in size based on turnover and staff numbers but, significantly, second in size based on inpatient admissions. It works closely with its neighbouring acute Trusts providing specialist services in Northern Devon, Torbay, Taunton and Yeovil

Vision and Strategic Objectives

Our vision remains to *"provide safe, high quality care, delivered with courtesy and respect"*. This is underpinned by three key strategic objectives:

- Maintaining sound operational delivery of existing clinical, research and teaching services
- Integrating core pathways from the community coming through to acute care within its acute services catchment area and out again into the community
- Further development of the Trust's acute services across a wider area by building upon the clinical networks and partnerships already in place

The Board and the senior leadership team have developed eight support strategies that together set out the way in which the Trust will strive to meet the five year ambitions it has set itself. The eight support strategies are:

- Clinical Service
- Workforce
- Information technology
- Estates
- Transformational change
- Stakeholder engagement and communication
- Business development
- Finance

Refreshing our Strategy

The socio-economic context and the associated healthcare needs of the population in Devon provides the backdrop against which the Trust's vision and strategy have been developed. It also provides the context and highlights some of the challenges which the health and care system in Devon will have to tackle now and into the future.

Although the Trust's strategy remains the same, in light of the shifting context (as set out above), new opportunities and the policy direction set out by the Government, the Trust has embarked on a process of refreshing and updating its strategy and, in particular, considering how it can best meet its strategic objectives. Having considered the direction set out for the Trust in its current strategy and taking into account the wider policy context, the Trust Board agreed that the fundamental shape of the strategy remains fit for purpose but that some reshaping of how the objectives are to be delivered was necessary. This work remains in progress at the time of writing but will set the course for the Trust over the coming year and beyond.

The strategy refresh begins from the understanding that, for the first time since the NHS was founded, there is a real opportunity to fundamentally change the way that people in Devon are supported in accessing and using health and care services through every stage of their lives. It is important that this opportunity is seized because, without radical change, our current systems will simply fail to adequately meet the needs of the population we serve.

Our Priorities

The refresh of our strategy has led us to identify three priorities that will help deliver our overall strategy.

Integration/New Model of Care

Working with our partners and within the organisation to develop and test new ways of working that start from meeting the needs of the individual. The new model of care focuses on wellness, prevention and ill health management, seeing patients as people and empowering them to be in control of their own care. The new model of care is about rethinking how we work and what we do together to meet the health and care goals of each individual. It is about intervening in a way that allows individuals - supported by primary care - to manage their health conditions and care requirements earlier and in a way that suits them. The RD&E is working with its partners to develop a new sustainable and personalised integrated care offer to communities in Exeter and east Devon. This is more than the RD&E providing additional care at home or services based out of community hospitals. Rather this is a new and far reaching vision for how services could be reinvented in a way that enables people to:

- Manage their own health and care needs in their own environment
- Focus on wellness, resilience and prevention
- Have a greater voice in managing their own care needs

The Trust intends to transform these community services by developing new models of integrated care, with a particular focus on:

- Single pathways of care between the acute hospital and community services for adults with complex care needs
- Frailty - improving the co-ordination of services wrapped around frail older people, providing a rapid and integrated response to crisis supported by intensive reablement aimed at minimising the hospital length of stay and maximising rehabilitation potential
- Long term condition management of "mostly well" and "pre-frail" people. This includes a fundamental review of how, why and where we deliver outpatient services for people with multiple long-term conditions that work to meet the holistic needs of the people (not just their disease management) and pulls on a wider range of service providers, in particular the voluntary sector and local community groups
- Increased delivery of outpatient services closer to the people they serve, making better use of existing community and social facilities and resources
- Work with the established social care and mental health teams to develop care co-ordination, system navigation and collaboration of multidisciplinary teams
- Work with Eastern Devon GPs to identify population groups with multiple health conditions and partnering with them to redesign services whilst promoting self-management and control for people, e.g. through patients holding their own health and care budgets

Acute Pathway Transformation (APT) Enabled by an Electronic Patient Record (EPR)

Putting in place appropriate technological solutions that support and enable this new way of working, which give people more control and information about their own health and which provides readily accessible and up to date clinical information is essential. The procurement of a new EPR system will serve as an enabler of integration as well as enabling radical redesign of patient pathways within the acute hospital.

The APT programme will work in tandem with the Integration Programme to deliver better and more joined up people-centred care which we are calling Future Care. It will deliver the following outcomes:

- **Outcome 1:** Improved quality and safety of care – improved access to accurate and timely information speeding up diagnosis and treatment
- **Outcome 2:** New models of care – enabling integration of care across multiple settings and supporting care to be delivered in the right place (e.g. remove from an acute setting)
- **Outcome 3:** Improved efficient working – to drive removal of waste, duplication of effort, productivity improvement to create more capacity across all staff groups for higher value and activity
- **Outcome 4:** A paperless environment – enabling achievement of national requirements relating to digital care records
- **Outcome 5:** Single integrated patient record – aiding faster decision making and higher quality outcomes through instant access to real-time information for stakeholders across the health and, in the future, social care system
- **Outcome 6:** Future proofing the IT capability and capacity – that is required to support the new model of care thereby replacing legacy software, systems and infrastructure

Provision of high quality, safe care delivered with courtesy and respect: Building the resilience and maintaining the quality and safety of the Trust's existing services. Ensuring that the delivery of our current service offer meets the needs of patients and is delivered safely, remains the central underpinning of everything that we do.

The Trust is working closely with neighbouring providers and commissioners to ensure that tertiary and specialised services are sustainable and meet commissioning requirements, recognising the particular access issues for the population of the South West. A number of services are likely to require particular focus in 2015/16, including Thoracic Surgery, Vascular Surgery, Specialised Respiratory Medicine, Cardiac Ablation and some Cancer services.

The Trust is continuing to plan for changes in specialised service provision in support of the Trust's longer term strategic aims and in support of local access to high quality services for our population. However, implementation of these plans is likely to be slower than previously intended.

Delivering Our Strategy

To achieve the changes required we will have to redesign how services are designed and implemented and where they are delivered to the population we serve. This will be based on reshaping how care is currently delivered across the entire health community in new and innovative ways that meet the best interests of patients. But it is much more than changing what we already do. We need to rebalance the focus of health and care spending to invest in new ways of keeping people healthy and well and supporting them in a way that reduces the need for acute interventions. We need to utilise new technologies in a very different way so that people can be better empowered to look after their own health and care. That is why, even in financially constrained times, we are exploring an investment in a new Electronic Patient Record (EPR) system that will not only support new ways of working but which itself, will provide new and better ways of working that is both in the interests of the people who require care but also our own staff.

In addition, the Trust's current support strategies will need to be reviewed in the next year to ensure that they contribute to the achievement of the Trust's strategic objectives.

Our Approach

- **Integration:** We have an ambition to create a sustainable, integrated and personalised care system in Devon that uses modern IT to enable people to manage their own needs where they want, that helps them stay well and which gives them a greater say over their own care
- **Transformation:** Our mission cannot be realised unless we invest in new technologies that will enable clinicians and care staff to have up to date information about an individual's needs and which can help reshape how we manage care now and in the future
- **Leadership:** We want to lead the change - working in partnership with others - in the way care services are organised, based on our reputation for delivering excellent safe care and our track record of innovation backed up by our first class research and development capabilities

Key Risks and Uncertainties

The Trust has a sound track record of delivering safe and effective care and this remains of paramount importance to the Trust Board. However, as resources tighten the Board recognises the need for increased scrutiny to ensure short-term actions to address financial pressures do not negatively impact on the quality and safety of care we deliver to our patients.

Local Health Economy Financial Position

The Devon Health Economy, with NEW Devon CCG as the commissioner, was identified in 2014/15 as a 'challenged health community'. Despite investment in turnaround capacity and external reviews, the position remains extremely challenging with a 2014/15 deficit of £27million and a cumulative deficit of £41million.

This financial position led to NEW Devon CCG proposing a series of 'Urgent and Necessary Measures' in 2014/15 which involved restrictions on access to some treatments and challenges to contractual payments to acute providers. Many of these measures were subsequently withdrawn to allow more time for consultation and revised plans are due to be developed and implemented in 2015/16. The Trust is working closely with NEW Devon CCG to address the longer term financial sustainability of the Local Health Economy via a challenged health community recovery programme known as 'NHS Futures'.

Trust's Financial Position

The Trust's financial position for 2014/15 has been extremely challenging. The Trust finished the year with an £11.2m deficit compared to a planned deficit of £8.9m. A significant increase in emergency patients above plan has been experienced for much of the year. This was particularly acute from December 2014 to March 2015 and has led to the cancellation of surgical patients and subsequent loss of elective income during the last quarter of the year.

A significant proportion of the Cost Improvement Programme (CIP) was achieved on a recurrent basis in 2014/15 (£15.7million compared to the £16.6million plan), however the majority (£11.4million) was achieved by using central reserves and by assuming Commissioning for Quality and Innovation (CQUIN) income is recurrent. The in-year CIP achievement was £12.6million, representing 3.8% of patient income.

During planning for 2014/15 the expectation was that registered nurse vacancies would be significantly reduced by October 2014. Despite a significant focus on recruitment, a combination of staff turnover, high patient acuity and operational pressures caused by excess emergency demand have led to continued high levels of agency expenditure.

Total expenditure on agency nursing for 2014/15 was £7.6m compared to £3.6m in 2013/14. With a premium of approximately 60% compared to Agenda for Change rates for agency nursing staff this equates to an excess cost of around £4.6m.

Slippage on planned developments has offset the majority of the above financial shortfall.

Capacity and Demand

Over recent years the Trust has experienced emergency inpatient admissions growth of over 5% per annum in addition to an average growth in referrals per annum of around 9%. The Trust has accommodated this growth by productivity improvements (reduced LOS, improved theatre utilisation) and by some investment in increased bed numbers. However the Trust is reaching the point whereby projected growth cannot be contained in existing facilities.

This pressure on capacity has been exacerbated during 2014/15 due to the high number of emergency admissions (approximately 8.5% higher than 2013/14). Despite extensive actions by the Trust to create additional capacity (above that already planned during the winter period) there have been a significant number of cancellations of elective patients.

Target Performance

The Trust's performance across Referral To Treatment (RTT), Cancer, Diagnostic and Accident and Emergency (A&E) targets was challenged in 2014/15 to a much greater extent than in previous years. The cancellations of elective patients noted above, combined with increased referrals in some specialities, means elective surgery waiting list numbers have risen by 12.5% during 2014/15, increasing the backlog to be addressed and presenting a risk to the achievement of RTT targets during 2015/16. Cancer targets are also likely to continue to be challenging. Contract penalties are likely to be significant in 2015/16, in particular those for incomplete RTT pathways for which 1) penalty rates have increased and 2) performance will deteriorate further as a result of the recent emergency pressures and cancellations.

Going Concern

The Trust has prepared its annual operational plan for the year ending 31 March 2016, which includes a detailed cash flow forecast that helps provide assurance that the Trust should remain within its current cash facilities. The Directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. The Directors therefore consider it appropriate to continue to adopt the going concern basis in preparing the accounts.

Environment, Employee Matters, Social, Community & Human Rights Issues

As a public benefit corporation, the Trust takes its responsibilities towards the community it serves very seriously. We recognise the responsibility we have to:

- Meet the acute health needs of the population we serve as safely, effectively and efficiently as possible
- Ensure that in designing and delivering health services we fully take into account, and are influenced by, the views and opinions of our patients and patients to be. Our Members' Say events are a good example of where we listen and engage with members – who broadly correspond to the profile of the wider community - on important healthcare matters
- Take into account the impact we have on the environment because this will ultimately have an effect on the communities we serve. As we set out in the sustainability report section of this Report, we are committed to reducing our environmental impact
- Take into account our status as the largest employer in Exeter and surrounding area. This means that decisions we make may well have an impact on the local economy and the health and wellbeing not only of our staff but their families and communities as well
- Take into consideration our responsibilities, as an ethical organisation, to respect human rights and to ensure that our actions or decisions do not have an adverse impact on upholding human rights
- Uphold the tenets of the NHS Constitution which brings together in one place details of what staff, patients and the public can expect from the NHS
- Uphold the legal framework that exists to promote equality and diversity
- Take very seriously our commitment to ensuring that staff feel motivated, empowered and are clear about the difference they are making to patient care and the pursuit of our strategic objectives. The section in this Report on "our staff" sets out some of the work we have done to improve staff engagement and motivation.
- Ensure that the Trust is a positive place to work and that staff are supported appropriately. The Trust has a positive staff programme – engaging working lives – that brings together our approach to equality and diversity, support for health and wellbeing, staff benefits, staff engagement and training and development

Signed:



Angela Pedder OBE
Chief Executive

Patient Care and Quality Improvements

During the year the Trust continued to achieve the Care Quality Commission's (CQC) band 6 rating meaning that, based on the CQC's intelligent monitoring approach to risk, the RD&E was at the lowest possible threshold with 'no evidence of risk' against all indicators. This achievement was mirrored in the Quality and Safety indicators that are contained within the Board's monthly Integrated Performance Report. Here there was consistent excellent "green" performance during the year for the majority of indicators within the domains of Quality and Clinical Effectiveness. This indicates that despite the financial and operational pressures, the Trust has continued to perform well in regard to patient safety.

The Trust has worked hard during the year in seeking to achieve its Quality priorities for 2014/15 which included:

- Hydration
- Outpatient Experience
- Integrated Care Exeter (ICE)
- #hello my name is...
- Nursing, Midwifery and Allied Health Professions Vision
- Patient Safety Programme

These initiatives have all delivered benefits in line with, or exceeded expectations, with additional benefits not anticipated at the outset. Full details on the progress made against these priorities are set out in the Quality Report section of this Report alongside a number of other initiatives including:

- Devon Garden and Memory Walk
- 100,000 Genomes Project
- End of Life Gold Standard Framework
- Living With and Beyond Cancer Project
- Integration Programme
- Accident and Emergency (A&E) Survey Results and National Cancer Survey Results

In addition, over the last year a number of initiatives were taken forward through the Commissioning for Quality and Innovation Schemes (the CQUIN schemes are detailed on page 33 in the Quality Report).

Patient Safety Programme

The Patient Safety Programme sets out how we intend to achieve reductions in harm and mortality and improve safety, patient experience and reliability of care. The Programme has the following components:

- **Mortality:** we have developed a real time electronic mortality review process to review all unexpected deaths, to ensure lessons learnt are adopted more widely.
- **Human factors:** Human factors training recognises the effects of teamwork, tasks, equipment, workforce, culture and organisation of human behaviour on clinical practice. Recognising these human factors can help to improve the safety of fallible systems and that is why this training has been rolled out across the Trust and is part of the Trust's revamped induction/orientation day for all new staff
- **Reducing harm:** The Trust reached the standards for the NHS Safety Thermometer target of over 95% for 8 out of 12 months
- **Sepsis:** a six point care pathway has been introduced through admission areas to ensure early recognition and treatment of patients with sepsis within our care so contributing to a better outcome for patients
- **Acute Kidney Injury (AKI):** this stream of work aims to recognise those at risk, diagnose them early and treat them to reduce any further damage to the kidneys. This has been achieved by the Trust's AKI team who provide targeted education and support to those wards with higher numbers of potential patients. A bundle of care has been set out which is monitored on Safety Thermometer days. As a result the Trust has seen a marked improvement in compliance.

Nursing, Midwifery and Allied Health Professions Vision 2012-2015

The year 2014/2015 was the final year of the current Trust's Nursing, Midwifery and Allied Health Professions Vision which has been detailed in previous Annual and Quality Reports. The focus during the financial year was on maintaining the momentum of the programme by building on the work that has been put in place over the previous two years.

The first strand of the work undertaken during the year was on quality of care planning. These plans set out the key elements of care that a patient requires in consultation with the patient, carers and family members and then ensuring that it is carried out well. The plan plays an important role in ensuring that everyone involved in a patient's care is involved and is communicated with. During the year, the Trust has improved the participation of patients, families and staff in quality of care planning for patients. This step forward has been achieved through workshops with the stakeholders and the development of a resource pack, which has been incorporated into existing training programmes.

The leadership strand of the programme has built on the successes of the previous two years. Over the last year the focus has been on leadership capacity building for non-ward based matrons and therapists. The programme has been a success based on evaluation evidence.

“Compassion in Practice” concentrated on understanding what compassion meant to our staff, what stopped it from being given and what it felt like when it was delivered. To better understand compassion, the Trust worked with staff, patients and our engagement team. The Engagement Team undertook focus groups at a Members Say event to improve the understanding of our Members’ views on these questions. This feedback has been used to inform a new policy on compassion, privacy and dignity.

Compassion was built on further with the launch of the Clinical School awards. The Clinical School is a collaboration between the Trust and Plymouth University, with an aim of developing ideas for changing practice and undertaking research. A summary of the schemes is detailed in the Quality Report (page 7).

Ensuring that we have the right people in the right place at the right time has been another priority over the last year. On the basis of using a bespoke tool, data on nursing outcomes and professional judgement, the Trust was able to drill down into improving its detailed understanding of staffing requirements in different areas of the Trust and at different times. As a direct result of this analysis the Trust undertook a new investment in nursing as detailed in the Quality Report (page 7). As part of this work, the Trust also reviewed the skills of existing nursing staff in order to describe the competency requirements for both registered and unregistered staff. This information has been used to develop a bespoke approach to supporting overseas staff and ensure all newly qualified staff are supported in practice.

Complaints/Patient Experience Improvements and Key Issues

Learning from patient experience has been a high priority over the last year. The real time methods described in last year’s Annual Report - for example “what went well, even better if” - have been successfully embedded throughout the Trust. This has been achieved with the assistance of our Performance Assessment Framework which requires the clinical divisions to provide evidence of how they have improved patient experience. The “Demonstrating Difference” examples are also used as part of the Integrated Performance Report for the Board of Directors, ensuring that patient experience informs the Board.

Demonstrating Difference

The following examples demonstrate how we have sought to improve patient experience based on feedback:

In Cardiology a theme was identified from patient feedback that showed that results, including daily ECGs, were not being reviewed in a timely manner due to staff not being aware of their responsibilities. A system change was implemented by the ward clerk so that each bay has a colour coded clipboard where the papers, results and notes for action by the doctor within that bay are collated. The information is kept on the individual notes trolley relating to the doctor’s bay of patients and reviewed daily by the junior doctors. The doctor needs only to see the results and information relevant to his/her own patients reducing the risks of the results not being assessed or being assessed by the wrong person. This has been well received by the junior doctors and no further incidents of unreported results or missing information have been received.

The Trust Pharmacy put in place a Medication Safety Thermometer pilot in which Pharmacists, working with Doctors and Matrons on wards reviewed patients’ medicines and jointly identified where medication practice can improve. The review helped to ensure that patients were getting their medicines on time and has also educated staff to avoid missed doses in the future.

Through the “What went well” and “Even better if” feedback from patients and staff within the Orthopaedic Services a number of small changes have been introduced including:

- Privacy curtains in the bathrooms, to enable the nurse to go in and out of the bathroom without exposing the patients sitting on the toilet or in a state of undress
- Shelves in the bathrooms for patients to place their washing equipment

- Grills on the doors to enable sliding doors to be opened to allow better air circulation when required, without causing a safety risk to patients
- Herbal tea and decaffeinated tea and coffee has been introduced after requests from patients
- Feedback from the staff has resulted in porters now plugging in foot pumps and beds when the patients are brought back from X-ray so that patients are not delayed

The Friends and Family Test was proving difficult to implement within Maternity Services. As a result, to encourage women to complete the form, boxes have been introduced in each room and the cards left on the lockers. In addition, Maternity Support Workers were given the responsibility of ensuring that every woman who was discharged was personally given a card to complete.

Patient Experience Committee

Through the Patient Experience Committee there has been an increased emphasis on the clinical divisions reviewing real time feedback through scrutiny of complaints, external sources e.g., Patient Opinion and compliments identifying themes and evidence of how the divisions are making improvements. These reports are reviewed quarterly.

The quality of discharge has been a key focus as this is a recurrent theme in patient feedback. The Trust has put in place the "GOOD Project" (Good Outcomes On Discharge

project) which seeks to address some of the issues identified by patients. One of the initiatives taken by this project is the development of a specific checklist which includes key information to ensure that a patient is discharged safely. Compliance with the checklist has been monitored and the lessons learnt continue to be shared.

Over the last year we have continued to work on improving the experience of carers for those with Dementia. There have been 75 audits completed and two areas were identified for further improvement: enabling greater assistance at meal times; and enabling a carer to escort a patient for a procedure. These are being actively addressed.

During the year the Trust has become one of only two acute hospitals in the UK to be recognised for the care they provide to patients who are nearing the end of their lives. Yeo and Yarty at the RD&E have been accredited for their end of life care. The Gold Standards Framework (GSF) is a tool used to cascade and communicate care needs to patients who are within the last year of life. The Framework empowers staff to provide the right care, in the right place for the right person at the right time. The work will be rolled out to five other medical wards in the next year.

Ensuring we learn from patient experience is vital. By using real time feedback and experiences on what has and not gone well the Trust seeks to critically assess and improve its performance. Over the coming year the Trust will seek to further align patient experience and incident processes to ensure learning is maximised. Key lessons will continue to be shared with staff through the Incident Review Group.

Our Staff

Statement of Approach

During the year the Trust has continued to improve its approach to staff communication and engagement. This focus stems from the understanding that staff that are more engaged and have higher morale are more productive and provide higher quality care than those with lower levels of engagement and morale. The connection between a more engaged workforce and various productivity, quality and safety measures is well evidenced and the Trust was therefore pleased to see that its efforts during the year increased its overall performance in the 2014 Staff Survey. In particular, the Trust saw a significant boost to its overall staff engagement score – a basket of measures that quantify relative engagement – placing it in the top 30 for all acute Trusts in the country. The other key driver for investing more time and effort in staff engagement is that the Trust has embarked on a long term journey to transforming what it does and how it is delivered. Central to this transformation is the way in which the culture of the organisation – and critically its staff – will need to adapt to take on board the challenges facing the organisation.

At the heart of our approach to staff engagement are the values that set out what the organisation stands for. As set out last year, interested staff members spent time translating our values into a behaviour charter which sets out the types of behaviours that the Trust and its staff expects from all its employees. This values and behaviours charter has been used right across the Trust to remind all staff – through posters, leaflets and screensavers – of the behaviours expected of them. It has also been used to inform our recruitment processes so that new staff are recruited against our values and it forms the centre piece of a completely refreshed staff “orientation” day for all new recruits. Poor values also underpinned the work that took place on promoting compassion as a concept and as a way of behaving throughout the Trust. This work, which was informed by the Members views on compassion, was shortlisted for an award by the Patient Experience Network during the year. The Trust values are also used as part of the Trust’s revised Personal Development Plans which allow staff and managers to assess performance. As part of the roll out of the values, we focused on supporting the “#hellomynameis” campaign which encourages all staff to ensure that when interacting with patients or members of the public they always tell them their name. There is more on this work in our Quality Report.

Some of the other initiatives taken during the last year include:

Leadership Development

To ensure we create a single cohesive leadership team, the Trust implemented a multilevel approach to leadership development to embed the NHS Leadership Framework Standards. The main focus during the year has been delivering a range of mandatory and optional training and development courses for the tier of staff below the Senior Leadership Team. These courses have been run by the Executive Directors and other senior leaders to extend the capabilities of this “middle management tier to lead and inspire others to consistently deliver safe, efficient and high quality services to patients.

Connecting Care

Our front-line and middle management leadership capability has been enhanced through our Connecting Care roll out programme to enable them and their teams to lead the implementation of quality improvements to patient care. Every part of the Trust has now been inducted in the use of the Communication Cells which are at the heart of the programme and which are designed to foster effective team working and a joined up approach to problem solving.

Staff Engagement

The Trust has taken a number of initiatives over the year to step up its staff engagement work. We entered our second year of our highly successful awards scheme – Extraordinary People. The scheme, which identifies winners from a range of categories three times a year, culminates in an annual gathering to award the “Winner of Winners” as well as the “People’s Award” which is the ultimate accolade as it is the winner among all of our winners voted for by staff. The awards seek to celebrate all that is best about RD&E staff and over the year the judging panel has had the privilege of some uplifting and moving stories of individuals and teams that have gone out of their way to make a difference. Through the award scheme, the aim is to foster a renewed culture in which appreciation and reward are key.

Executive Briefings

To improve staff’s awareness and knowledge about the direction of the Trust and how it is handling current challenges, a series of Executive briefings – in which Directors spend time briefing staff and taking questions – took place throughout the year. These have been both well received and well attended.

Connecting Care in Theatres

Connecting Care's Communication Cell (Comm Cell) helps the Theatres team pinpoint issues facing the team more quickly than before, according to senior managers in General Theatres.

General Theatres has been using the Comm Cell information board since May after a period of training, and it is already giving their work a sharper focus.

The Comm Cell board is a central meeting point for staff in Theatres to come together once a week and review activity, performance, successes and any issues hampering the team from working at their best.

The information displayed on the Theatre Comm Cell is divided up into broad headings, such as People (Staff), Performance, What Went Well/Even Better If, Risks and Issues, Continuous Improvement and Problem Solving.

The issues raised can be both small, for example, a faulty door or a shortage of linen - and much larger, such as appropriate numbers of staff of duty. But in both cases, the Comm Cell promotes better team communication and gives managers a clearer opportunity to act on any intelligence staff give them.

Fred Cock, Cluster Manager, Critical Care, said: *"It ranges from small day-to-day niggles on to really big Divisional challenges in terms of workforce and operational planning and all the levels in between. For staff it is really healthy to see how that if they raise an issue, they will get a response."*

"It can be about making sure our evening and weekend lists are appropriately staffed, and looking at sessions that over-run because of the complexity of some patients."

"The Comm Cell gives us a vehicle and a focus for these conversations. If you put it up on the board everybody can see it. It is not just two people talking about it."

Rita McGrogan, Recovery Matron, added: *"It has given people a vehicle to raise issues and not get bogged down in day-to-day problems."*

This focus is critical in a complex area like Theatres.

Simon Rutter, Improvement Co-ordinator, Surgical Services, said: *"There are a lot of cogs that need to turn in Theatres so having that focal point helps us to communicate effectively. While there are big issues you can have just as much impact by doing small things."*

Although a swift response to issues is important, candour is also needed.

"I want staff to see the value of using the Comm Cell board. It shows the senior team are listening and taking appropriate actions," Fred said.

"But it always has to be an honest conversation. We have to be clear when we cannot fix something. There may be financial or operational constraints. But so far we have got a fairly good success rate. Sometimes fixing one issue can give rise to another issue that brings its own challenges."

Use of the Comm Cell in Theatres is still in its early stages and although Fred describes it as an 'enhancement' of how the team communicated before rather than a revolution, it is still a new way of working that will take time to settle.

"It is being used and staff are talking about it," said Simon.

"In the first week four to five issues were raised and we were able to turn these around very quickly. The issues came from all staff – theatre assistant and consultant. It's very new in the Trust and it is about bringing it into day to day work, and not something that is 'additional' to it. We want it to become natural."

Fred said: *"There is a healthy degree of scepticism about change as often changes have not always been beneficial. The surgical procedures we perform are critical to the patient's care and staff need great situational awareness at all times so changes need to be thought through carefully. The way the Comm Cell will prove itself is to show it makes a real difference, I see my role is to prove this change will work. What I like most about the Comm Cell is its high visibility."*

Simon hopes that once other areas get their own Comm Cells, wards and departments around the hospital – and crucially those with a stake in the patient pathway - will start to 'connect' up in new ways to patient care and root out communication issues.

He uses Did Not Attend (DNAs), where extensive preparations are made for a patient who does not appear for expected surgery, as one example of this. By using the Comm Cell to examine the DNA issue as a team, they can identify potential issues 'on either side' of Theatres that may have led to the DNA – for example in other departments such as Bookings, Outpatients or with the patients themselves. These can then be flagged up to these other departments and fed into their Comm Cells.

Simon said: *"Once everyone's Comm Cells are up and running then these parts will cement together. An issue that gets raised on our board might appear in a similar way on another board on a ward, but from their point of view. The Comm Cells can almost be like a spider's web. Ours can link to others in Surgery, Diagnostics or Medicine from departmental boards to ward ones."*

“Staff Say” Conversations

We continued to run the “Staff Say” conversations through the year with a focus on drilling down into some of the views and opinions that contributed to the Staff Survey scores. The aim of these sessions was to listen to staff and, through this process, better understand their views. These were productive sessions which provided rich feedback which have helped shape Divisional level staff engagement plans.

Summary of Performance

In 2014, the RDE, as part of its staff engagement strategy, undertook a sample survey of its staff. The response rate was 40% compared with the national average of 43%. The Trust was in the top 20% of Trusts nationally for eight of the key findings, an increase of two from 2013. The Trust was in the bottom 20% for one key findings compared with two in 2013.

Best 20%

- Work pressure felt by staff
- Staff suffering work- related stress
- Fairness and effectiveness of incident reporting procedures
- Experiencing physical violence from patients, relatives or public
- Staff experiencing harassment, bullying from patients, relatives or public
- Experiencing harassment, bullying or abuse from staff
- Feeling pressure to attend work when feeling unwell
- Staff believing the Trust provides equal opportunities for career progression or promotion

Worst 20%

- Staff receiving job relevant training, learning or development in last 12 months

Summary of Performance

Response rate	2013/14		2014/15		Trust Improvement / Deterioration
	RDE Trust	Acute Ave	RDE Trust	Acute Ave	
	47	47	40	43	Decrease of 7%

Trust 5 Top Ranking Scores 2014	Trust 2013	Acute Trust Ave 2013	Trust 2014	Acute Trust Ave 2014	Increase/decrease
KF 11 Staff suffering work related stress	36	37	31	37	5% improvement
KF 18 Staff experiencing harassment/ bullying/abuse from patients/relatives or public	24	29	21	29	3% improvement
KF 19 staff experiencing harassment/ bullying/abuse from staff	21	24	19	23	2% improvement
KF 20 Staff feeling pressure to attend work when unwell	25	28	21	26	4% improvement
KF 27 Staff believing the Trust provides equal opportunities for promotion	93	88	92	87	1% improvement

Trust 5 Bottom Ranking Scores 2013	Trust 2013	Acute Trust Ave 2013	Trust 2014	Acute Trust Ave 2014	Increase/Decrease
KF 6 Staff receiving job relevant training	77	81	78	81	1% improvement
KF 13 Staff reporting errors, near misses or incidents	88	90	89	90	1% improvement
KF 21 Staff reporting good communication with senior managers	24	29	28	30	4% improvement
KF 25 Staff motivation at work	3.80	3.86	3.81	3.86	No change
KF 28 Staff experiencing discrimination at work	8	11	12	11	4% deterioration

Future Trust Priorities

Over the last two years, at a corporate level, we have sought to focus action in the following related areas:

- Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver
- Percentage of staff reporting good communication between senior management and staff
- Staff job satisfaction
- Staff recommendation of the Trust as a place to work or receive treatment
- Staff motivation at work

In focusing on these areas, we recognised that these were some of the hardest indicators to change partly because what impacted on staff sentiment in these areas was largely a result of factors that were determined locally or were outside the RD&E's control. In other areas, such as training or appraisals, management action at a local level could make a quantifiable difference.

Good progress has been made on all but one of these indicators. Staff motivation (at 3.80) has stayed the same and remains below the national average (3.86) which suggests that more needs to be done at corporate, divisional and local levels to address this issue. In addition, continued action needs to be taken on communication between senior management and staff even though over the last two years we have seen a marked improvement. Based on feedback from the "Staff Say" sessions, the definition of senior management varies considerably from some who deem senior management to mean the Trust Board and Executives right through to those who consider senior management to be a line manager's line manager. This suggests that the work we have been undertaking over the last 18 months to provide more opportunities to hear and see senior managers at a corporate level - which has been largely welcomed as evidenced in "Staff Say" sessions and by the enhanced score over two years on this indicator - needs to be complimented by action at Divisional and local levels. The Trust has a number of on-going priorities where performance is not as satisfactory as we would wish. We will continue to concentrate on these as part of our staff engagement strategy. For 2015, we intend to undertake further in-depth work towards improvements in these areas. There is clear evidence of the link between high quality patient care and organisational culture as demonstrated in the Francis Report. We continue to align priorities agreed from our patient satisfaction surveys with staff satisfaction results at Trust and departmental level. A programme of work is being developed to monitor improvements from actions plans within year.

Staff Sickness Absence

Staff sickness absence	2014/15	2013/14
Total days lost	49,453	47,067
Total staff years	5,515	5,329
Average working days lost (per WTE)	9.0	8.8

Over the last year the review and redesign of core HR processes at the RD&E has been completed and are aligned to our corporate strategy to reinforce and enable the right behaviour of all staff. To support the Trust's commitment to the health and wellbeing of its employees and to encourage personal responsibility, an Attendance Policy has been implemented, replacing the existing Sickness Absence Policy. This new approach underpins the importance of understanding the causes of sickness absence, ensuring the right support is provided to staff as well as clarifying roles and responsibilities to establish effective management of attendance.

Equality and Diversity

Achievements

Overall

- 94% of our grades for the Equality Delivery System are seen to be "achieving" or better, which is a significant improvement on our grading of 75% last year. The only area marked as "developing" is the domain of "inclusive leadership" whereby the Board evaluates the equality impact of its decisions
- The staff and patient profile at our Trust is in line with the appropriate community benchmarks, as far as is reasonable to expect
- The Trust made the decision in August 2014 to embed Equality & Diversity support and advice separately within Human Resources (for staff) and clinical settings (for patients), to ensure that focus could be provided to both of these distinct groups

Staff

- Reported discrimination remains lower than the national average
- We are overall at national average in the staff survey for acting fairly as regards career progression and promotion, with no results for any protected characteristic being notably below that benchmark
- A high proportion of staff (90%+) have received the standard equality training
- No equality issues found in exit interview monitoring
- Delivered personal support on equality issues to thirty-four staff in 2014, most of which was disability-related
- Continued to work with specialist external partners to obtain the best advice and support for staff with disabilities
- Completion of the disability action plan, to raise awareness of disability issues with enhanced partnership working with Occupational Health
- Produced disability-awareness literature, for both staff with disabilities and their managers
- Continue to develop work experience placements for learners with disabilities, who continue to progress into employment with us
- Our proportion of ethnic minority staff has increased in line with the local community, who report a positive experience of working with us

- Our pay gaps, by protected characteristic, remain small
- A series of interviews with returners from maternity leave has indicated very high levels of satisfaction
- An in-depth review of the experience of overseas staff has contributed to enhanced support arrangements for this staff group

Patients & Carers

- Produced Outpatients and Anaesthetics leaflets, in Easy Read, and a programme in place to develop more throughout 2015
- Patients aged 65+ remain notably less likely than expected to be emergency readmissions, reversing last year's result
- Considerable energy maintained on Dementia agenda
- The Friends and Family test gives good scores for patients who are aged 65+ and those with disabilities
- Engaged in a consultation about interpretation services and policy /procedures revised as a result

Key Performance Indicators (KPIs)

a. Overall

The Equality Delivery System (EDS) is a national NHS system to provide an overview of how well NHS organisations are delivering equality and diversity, through grading against a maximum of 18 outcomes. We have graded against 17 outcomes, as one is not relevant for our core business.

Our grades are as follows:

Undeveloped	Developing	Achieving	Excelling
0	1	14	2

b. Overall staff equality

This indicator shows the level of discrimination from patients, public, or colleagues, in the findings for 2014:

Year in which staff survey was reported	RDE	National (acute and specialist trusts)
2014	9%	10%
2013	7%	11%
2012	9%	13%
2011	10%	13%
2010	6%	7%

This result places us in the best 20% of acute Trusts nationally.

Equality Objectives

The two equality objectives are given below with their accompanying performance indicators:

1. To continuously improve the care of our older patients

Measures:

Year-on-year improvement in the "equality gap" for patients aged 65+ as regards emergency readmissions and involvement in incidents.

We would expect that the proportion of patients aged 65+ who are emergency readmissions or involved in reported incidents would be the same as the proportion of all patients who are in that age group.

The latest results show slight improvement in both indicators, since last year:

	2014	2013	2012	2011
% patients from the 65+ age group who are "emergency readmissions"	36%	37%	34%	53%
% patients who are 65+ age group in reported incidents	57%	58%	59%	51%
% of all inpatients who are 65+ age group	39%	39%	43%	43%

It is especially pleasing that the equality gap has been closed.

2. To continuously improve our support of staff who have disabilities

Measures:

- i. Balance of notably negative and notably positive findings for staff with disabilities, in the staff survey findings reported in 2014.

Current situation:

- notably negative findings: 5
- notably positive findings: 0
- score: -5

Goal: year-on-year improvement

This result of -5 overall has improved a little since the 2011 survey, when the overall score was -7.

- ii. Discrimination reporting rate in the Staff Survey on the theme of disability.

Current situation:

1.0% in survey reported in 2014

Goal: year-on-year improvement.

This indicator has remained stable.

- iii. Percentage of staff in staff survey saying we have implemented reasonable adjustments:

Current situation:

70% (acute trust benchmark 72%)

Goal: to remain well above the national benchmark.

This indicator has worsened slightly.

Sustainability Report

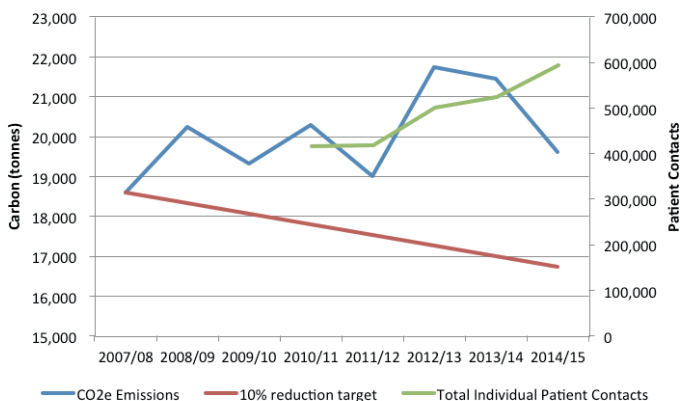
Sustainability has become increasingly important as the impact of peoples' lifestyles and business choices are changing the world in which we live. In order to fulfil our responsibilities for the role we play, the RD&E has the following strategic objective:

- Recognising our responsibility to the community & the environment

Responding to this challenge brings with it economic benefits, as well as social and environmental ones. Over the last year progress has been made in a number of areas. The following information has been produced in line with the NHS Sustainable Development Unit's (SDU) guidance. Where more accurate information has been made available, previous year's figures have been updated. Notably, the carbon emission factors made available for calculating emissions have been updated.

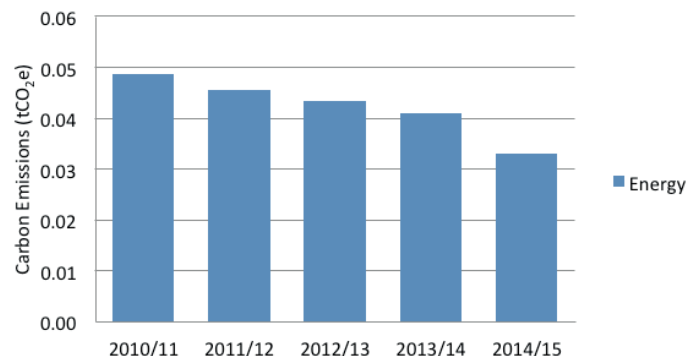
Carbon

RD&E Energy CO₂e Emissions & Patient Contacts

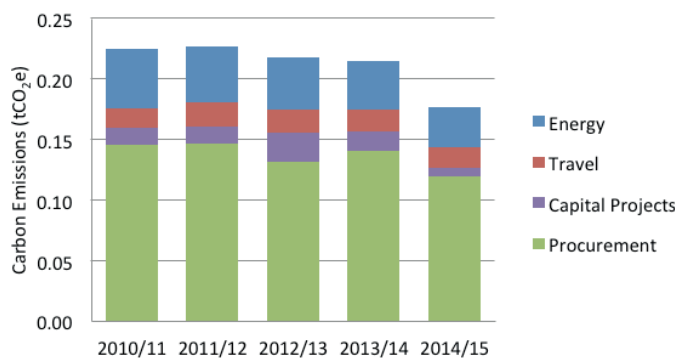


In 2010, the RD&E set itself a target of reducing its energy emissions by 10% of 2007/08 levels by 2015. The target was challenging as it meant that despite patient numbers increasing, a reduction in emissions was expected. The RD&E has opened several new buildings and patient numbers have increased by around 22% since the target was set. There was a spike in emissions during 2012/13 which coincided with the coldest spring for 50 years and the opening of two new buildings on the Wonford site. A carbon emissions reduction of 21% per patient contact has been achieved against 2010/11 levels (2007/08 patient data was not available); however the absolute reduction target has not been met.

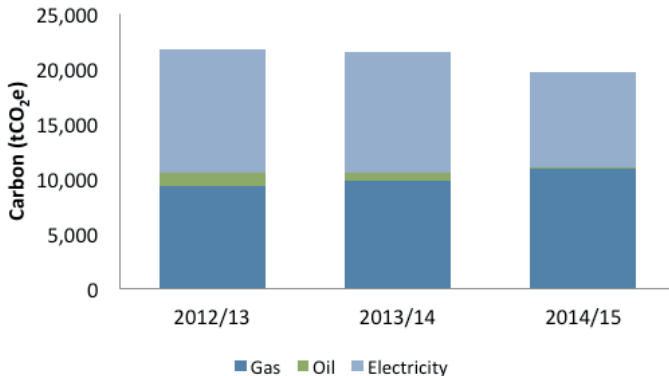
RD&E Energy Carbon Footprint per Patient Contact



RD&E Total Carbon Footprint per Patient Contact



Carbon Emissions - Energy Use



The carbon intensity has been reduced by a number of means. Highly polluting oil has been almost completely removed from use at the RD&E. Currently, only two small sites and emergency generators use this fuel source. In addition to removing oil, the refurbished combined heat and power engine (CHP) at Wonford hospital has been successfully run for the last year. This has contributed financial and to carbon savings. The two solar LPV arrays at Wonford have generated over 60,000kWh of renewable electricity, enough to supply around 18 houses for a year.

Since 2013, the electricity which the RD&E has been buying from the grid is from certified renewable sources; however carbon accounting rules do not allow for reporting it as carbon neutral. The RD&E has been working with several local authorities (Devon County Council, Exeter City Council,

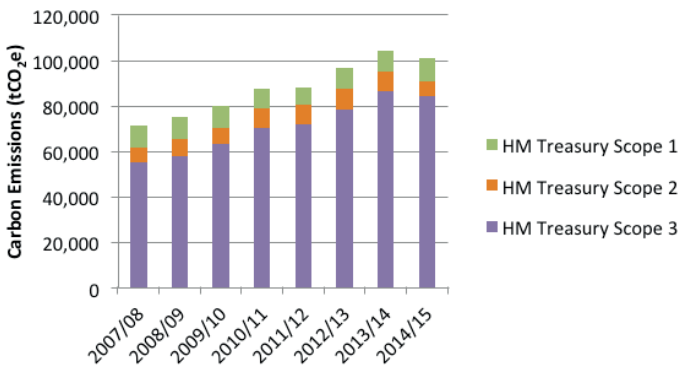
East Devon Growth Point, Teignbridge District Council and the University of Exeter) to develop a city-wide low carbon district heating scheme. This is a long term scheme which could reduce the Trust’s energy carbon emissions by some 10% and save thousands of tonnes of carbon across the city of Exeter.

In line with predictions from last year, a mild winter, improvements in efficiency and reductions in gas price have resulted in a 15% reduction in energy costs this year. An investment programme is being prepared to make further financial and carbon savings over the duration of the next Sustainable Development Management Plan period of 2015-2020.

Carbon Footprint

An organisation’s carbon footprint is the total amount of carbon which it emits going about its business. The overall carbon footprint for the RD&E is increasing, as more goods, services, energy and buildings are required to treat patients. Where there were gaps in the data, a piece of software provided by the SDU was used to calculate this profile based on RD&E financial spending.

HM Treasure Scope Aggregations

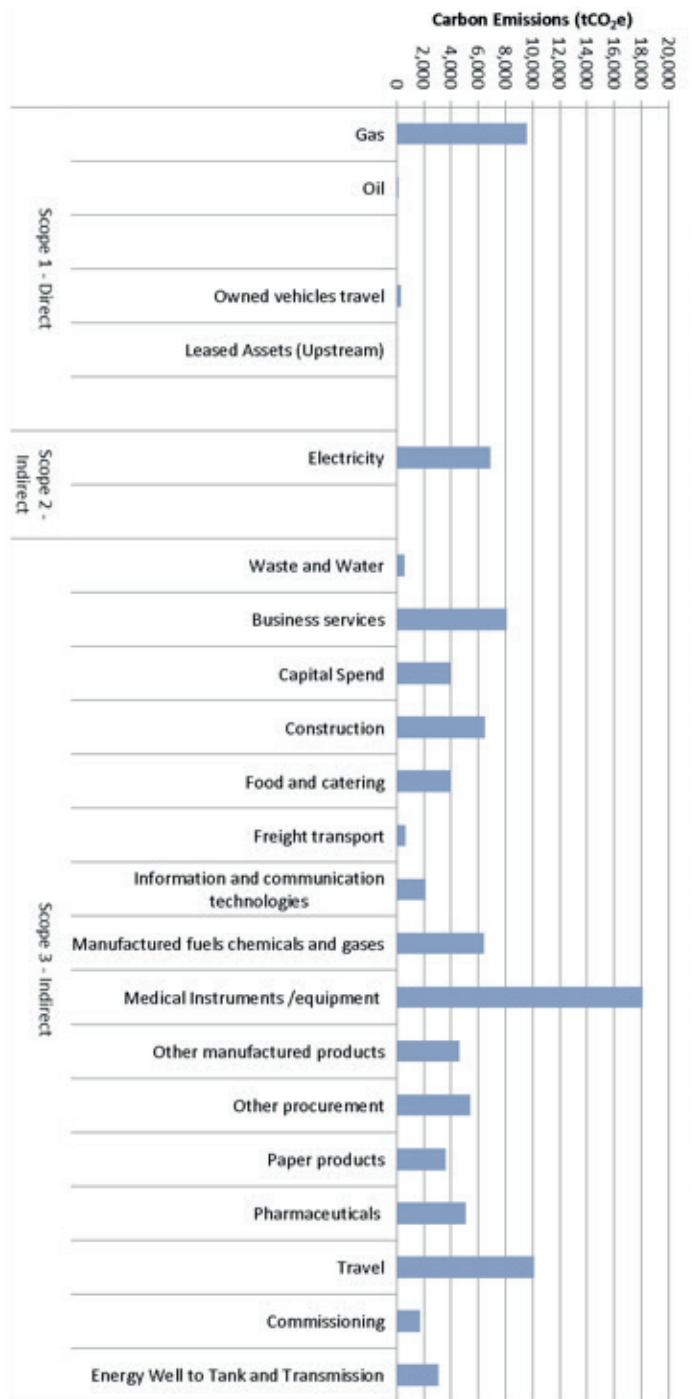


- **Scope 1:** All direct Green House Gas (GHG) emissions (gas, oil).
- **Scope 2:** Indirect GHG emissions from consumption of purchased electricity, heat or steam.
- **Scope 3:** Other indirect emissions, such as the extraction and production of purchased materials and fuels, transport-related activities in vehicles not owned or controlled by the reporting entity, electricity-related activities (e.g. transmission & distribution losses) not covered in Scope 2, outsourced activities, waste disposal, etc.

A new Sustainable Development Management Plan is being developed to help manage the emissions. The following table shows a detailed breakdown of the RD&Es emissions. Actual emissions based on usage are calculated for energy, water, waste and business travel. A Sustainable Development Unit (SDU) calculation tool is used to

determine emissions from other areas, based on the amount of money spent by the RD&E or from standard national statistics.

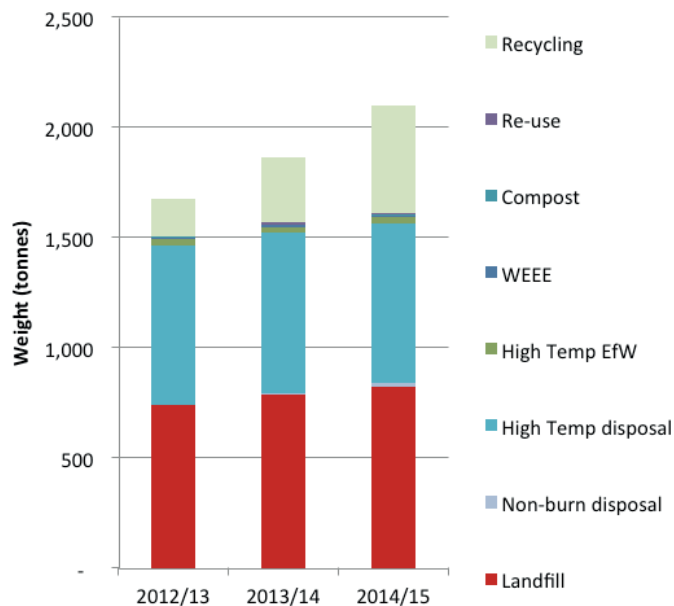
2014/15 Carbon Footprint Using the SDU Model and Treasury Scopes



Waste

The amount of waste produced at the RD&E has been increasing, but there are a number of exciting projects underway to manage this. The overall percentage of waste being recycled or reused is increasing year on year as more facilities are made available and more staff become aware of them. During the first three quarters of this year, approximately 24% of waste was reused or recycled.

Waste Breakdown



Work is underway to procure a waste contractor that will be able to offer a "zero to landfill" waste solution and support the RD&E in developing more source segregation options. This is scheduled to start in 2016. As part of this process the RD&E is working with a researcher to produce an academic study looking at the waste management systems in place. The study aims to help the RD&E to procure an appropriate provider and to inform a waste strategy which will improve recycling further.

Water

Water is a finite resource and it is important to manage its use. Each year the RD&E uses enough water to fill ninety-four Olympic sized swimming pools. Over the last few years, the RD&E has been conducting major works to upgrade the water mains around the site to locate and fix leaks. This year's water consumption is on target to be less than last year's and this may be attributed to the on-going leak detection and repair.

Water		2012/13	2013/14	2014/15
Mains	m ³	255,492	240,066	235,989
	tCO ₂ e	233	219	215
Water & Sewage Spend		£991,280	£90,877	£982,462

Green Travel

The annual travel audit suggests that around 55% of staff travel to work in a green way such as by bus, walking, cycling or car sharing. To support and encourage this, the RD&E has been working with Travel Devon to promote cycling and other low carbon, healthy ways of getting

around. Several events have been held over the year with local bike suppliers and Travel Devon coming in to provide staff with information and support on how to get round Devon in healthy and environmental friendly ways.

A new secure bike shelter is being opened at Bowmoor House. It is completely enclosed and has a digital access control fitted. The shelter was joint funded by the Trust's Staff Lottery and a government grant. There are now four bike shelters across the Wonford site that have controlled access for staff use only.

In addition to this the RD&E is working to "green" its fleet, the gardeners have a new electric vehicle which has zero tailpipe emissions and a nearly silent motor that is less intrusive than the old tractor.

Biodiversity

There are a wide variety of landscapes across the RD&E estate which offers the opportunity for wildlife to flourish. A recent survey identified well over 100 species of plants in the courtyards at the Wonford hospital. Studies have shown that plants and pleasant outdoor spaces can benefit patients and staff alike and it is important to make sure that wildlife also benefits from planting. To this end, a Biodiversity Action Plan (BAP) is being developed to enhance and protect the flora and fauna. It will ensure that consideration is given to planting native species or ones which will have a benefit to wildlife by providing food. The RSPB have been visiting Wonford Hospital to promote biodiversity across Devon, in the hospital and in people's back gardens. They have been impressed with the interest that staff, patients and visitors have shown in wanting to protect and improve conditions for wildlife.

Summary

The RD&E has been making steady progress with the difficult challenge of reducing carbon emissions and improving overall sustainability. The next year will see the introduction of a new Sustainable Development Management Plan and a list of technical solutions to the carbon challenge. Notably, an initial feasibility study has identified potential areas for solar PV arrays to be installed across the estate and more detailed work is underway to create a route forward with this. Sustainability is no longer a niche area of interest, more and more staff are requesting information on what is being done and what can be done to improve the Trust's performance in this field. More resources will be forthcoming to assist with this demand. As the requirement to reduce emissions and improve sustainability becomes more pressing, the RD&E will continue to meet these demands and integrate them with patient care to become a truly sustainable healthcare provider.

Our Governance

The Role of the Board of Directors

The RD&E is a NHS Foundation Trust that is constituted as a public benefit corporation. Its governance structure is founded on a constitution that is approved by the regulator, Monitor. The constitution sets out how the organisation will operate from a governance perspective and what arrangements it has in place, including its committee structures and procedures, to enable the Trust to be governed effectively and within the legislative framework. The Trust's constitution incorporates the legal and statutory requirements necessary to govern the Trust. In addition, Monitor has developed a Code of Governance which all Foundation Trusts must comply with (or explain if they choose not to comply). This details the necessary governance structures and processes that Foundation Trust should have in place.

Essentially, there are three basic components to the Trust's governance structure:

- The Membership
- The Council of Governors
- The Board of Directors

Members of the RD&E consist of members of the general public who choose to apply for membership and Trust staff (unless they opt out). Members are located in a defined number of constituencies. Members elect Governors and can also stand for election themselves.

The Council of Governors (CoG) consists of elected public Governors, staff Governors and appointed individuals from key stakeholder organisations (as defined in the constitution). Governors help bind the Trust to its patients, service users, staff and stakeholders. Governors are unpaid and volunteer part-time on behalf of the Trust. They are not Directors and therefore do not act in a directional capacity as their role is very different. The Trust Chairman is chair of both CoG and the Board of Directors.

Governors are the direct representatives of local communities. They collectively challenge the Board of Directors and hold them to account for the Trust's performance, as well as presenting the interests of Foundation Trust Members and the public and providing them with information on the Trust's performance and forward plan. Governors have a range of statutory powers as well as significant influence over the Trust.

The Board of Directors of the RD&E is ultimately and collectively responsible for all aspects of the performance of the Trust. The Board of Directors' role is to:

- Provide effective and proactive leadership of the Trust within a framework of processes
- Develop procedures and controls which enable risk to be assessed and managed
- Take responsibility for making sure the Trust complies with its Licence, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations
- Set the Trust's strategic aims at least annually, taking into consideration the views of the Council of Governors
- Be responsible for ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust
- Ensure that the Trust exercises its functions effectively, efficiently and economically
- Set the Trust's vision, values and standards of conduct and ensure the Trust meets its obligations to its Members, patients and other stakeholders and communicates them to these people clearly
- Take decisions objectively in the interests of the Trust
- Take joint responsibility for every decision of the Board, regardless of their individual skills or status
- Share accountability as a unitary Board
- Constructively challenge the decisions of the Board and help develop proposals on priorities, risk, mitigation, values, standards and strategy

The Board of Directors has both Executive and Non-Executive Directors (NEDs) with a majority of independent Non-Executive Directors. It is a unitary Board which means that both Executive and Non-Executive Directors share the same liabilities and joint responsibility for every decision of the Board. The Chief Executive is the nominated Accounting Officer and is responsible for the overall organisation, management and staffing of the NHS Foundation Trust, for its procedures in financial and other matters, and for offering appropriate advice to the Board on all matters of financial propriety and regularity.

In carrying out their role, Directors need to be able to deliver focused strategic leadership and effective scrutiny of the Trust's operations, and make decisions objectively and in the interest of the Trust. The Board of Directors will act in strict accordance with the accepted standards of behaviour in public life, which include the principles of selflessness, openness, honesty and leadership (The Nolan Principles).

The Board of Directors is legally accountable for services provided by the Trust and is responsible for setting the strategic direction, having taken account of the views of the Council of Governors, and for the overall management of the RD&E.

The Board is led by the Non-Executive Chairman. There are six Non-Executive Directors who, together with the Chairman, form a majority on the Board. The five Executive Directors manage the day-to-day operational and financial performance of the Trust.

The Board of Directors works on a unitary basis, being collectively responsible for the performance of the NHS Foundation Trust and exercising all the powers of the Trust. In so doing, Board members bear full legal liability for the operational and financial performance of the Trust.

The Board normally meets to conduct its core business at least ten times a year. At these meetings it takes strategic decisions and monitors the operational performance of the Trust, holding the Executive Directors to account for the Trust's achievements.

Board Meetings

The papers for the monthly Public Board meeting and the approved minutes of the previous meeting are published on the Trust's website in advance of the Board meeting. In advance of the legislation compelling NHS Foundation Trusts to hold their Board meetings in public, the RD&E decided in June 2012 to move to public Board meetings that were accessible to the public. These are meetings that take place in the public arena rather than public meetings, although members of the public have the opportunity to ask questions at the end of the public section of the meeting. Items of a confidential nature are discussed by the Board in private in a monthly confidential meeting. The issues discussed in the closed sessions tend to be commercial in confidence issues that may impede the conduct of the Trust's business if they were to be aired publicly. The 1960 Act on Admission to Public Meetings is used by the Board to help determine which topics are discussed privately and, over the course of the year, the Board has sought to discuss the majority of its business in the public session.

In addition to its ten formal Board meetings, the Board also hold a number of development and strategy sessions.

The framework within which decisions affecting the work of the Trust are made are set out in the Trust's published Standing Orders, Standing Financial Instructions and Scheme of Delegation, copies of which may be viewed on the Trust's website (www.rdehospital.nhs.uk) or on request from the Foundation Trust Secretary.

The composition of the Board is in accordance with the Trust's constitution and the Policy for the Composition of NEDs on the Board. The Board considers it is appropriately

composed in order to fulfil its statutory and constitutional function and remain within Monitor's Licence. In consultation with Governors, it has, through its recruitment of NEDs, been able to maintain a good quality and effective Board that is appropriately balanced and complete.

There is a clear division of responsibility between the Chairman and the Chief Executive. The Chairman heads the Board, providing leadership and ensuring its effectiveness in all aspects of its role, and sets the Board agenda. The Chairman ensures the Board receives appropriate information to ensure that Board members can exercise their responsibilities and make well-grounded decisions. The Chief Executive is responsible for running all operational aspects of the Trust's business, assisted by the team of Executive Directors.

The Chairman and all Non-Executive Directors meet the independence criteria laid down in Monitor's Code of Governance (Provision A.3.1). The Board is satisfied that no direct conflicts of interest exist for any member of the Board. There is a full disclosure of all Directors' interests in the Register of Directors' Interest which is available on the Trust's website or upon request from the Foundation Trust Secretary. Directors and Governors may appoint advisors to provide additional expertise on particular subjects if required.

The Board of Directors is accountable to the membership via the Council of Governors. The Chairman informs the Council of Governors about the work and effectiveness of the Board at each Council Meeting.

The business of the Trust is conducted in an open manner and annual schedules of meetings for the Board of Directors and Council of Governors are published 12 months in advance.

Board Focus

Over the year the RD&E's Board has led and governed the organisation successfully. Our focus has been on ensuring a sustainable and safe clinical and financial service. A clear governance and management system is in place (see Director's Report). The Board reviews in detail the Trust's safety, quality, financial and operational performance at every Board meeting.

Some of the key issues the Board focused on during the year included discussions and debates on:

- The Operational Resilience and Capacity Planning for 2014/15. The Board recognised that whilst winter is a period of increased pressure, establishing sustainable year round delivery requires a whole system approach. The Board's concern, therefore, was that a new baseline has been established which will threaten the capacity modelling done to date. In view of this, the Service Delivery Team remodelled a range of scenarios in

order to understand the capacity required to meet an increased demand should the activity levels continue

- At its June 2014 meeting the Board discussed the RD&E's response to the Northern, Eastern, Western Devon Clinical Commissioning Group's (NEW Devon CCG) community services strategy consultation document. The strategy was seen as an important document as it presented a strategy consistent with the RD&E's regarding integrated care
- The re-commissioning of Transforming Community Services (TCS), the announcement by the NEW Devon CCG that the RD&E was the preferred provider for adult complex care services in the Eastern Locality and the subsequent challenge to the procurement process made by the Northern Devon Healthcare Trust
- NHS Staff Survey Results 2013. The Board discussed how overall the results showed an improved picture. With staff such an important stakeholder, the number recommending the Trust as a place to work was seen by the Board as encouraging. It was acknowledged that the Trust now has in place more opportunities for staff engagement and staff feedback and the national NHS Staff Survey was just one tool among many
- The Trust's nursing establishment and staffing levels at night
- The Trust's performance with regard to the 62 day cancer target. The Board received assurance that the Divisions were focussed on improving performance and IMAS (NHS Interim Management and Support) had been invited to return to the Trust in September 2014 to undertake a health check on the Trust's systems. The Board were assured that the Trust's position regarding patients in, or at risk of, breach had not changed and the Trust would not refuse to treat patients who have, or were likely to, breach. The Board was assured that Monitor had been kept informed regarding the Trust's cancer performance
- The Electronic Patient Records (EPR) procurement project, with members of the Board meeting as part of the EPR Task & Finish Group. The Board of Directors was also regularly updated on the progress of the project
- Financial performance with an in-depth session at its July 2014 meeting on the 2014/15 Budget and the Cost Improvement Programme
- The Challenged Health Economies (now called NHS Futures) work. This is NEW Devon CCG's strategy for Devon and Plymouth and its vision for 2018/19. The Board received information on the steps in the programme to deliver the strategy
- The Infection Prevention & Control Annual Report 2013/14 and the Annual Programme for 2014/15

- The Board met as the Corporate Trustee for the Trust charity twice during the year
- The increased risk to Referral to Treatment (RTT) performance. The Trust had been achieving RTT targets at an aggregate level, but there were increased risks of failure due to the rise in GP referrals, the increased risk of cancellations of inpatient elective surgery over winter and the challenges in meeting the planned activity levels within Orthopaedics. The Board were appraised of the key risk factors and of the actions in place to manage the risk
- Research and Development. Professor Hattersley, Director of Research and Development at the Trust, provided a detailed view of the research and clinical trials undertaken at the RD&E in the previous year and highlighted how this made a difference to patient care. The Board also discussed the Trust's application to become a NHS Genomic Medicine Centre for the South West Peninsula. An announcement was made on 22 December 2014 that the RD&E had been successful in its application to be the NHS Genomic Medicine Centre for the South West Peninsula
- Received assurance of the Trust's compliance with NHS England Core Standards for Emergency Preparedness, Resilience and Response

Outside Interests

The Board regularly updates its register of interests to ensure that each member discloses details of company directorships or other material interest in companies which may conflict with their management responsibilities. Board members also have an opportunity at the start of each meeting to declare any interests which might impede their ability to take part in discussions and Directors are aware that such a declaration would be permissible at any time during a meeting, dependent on the issue being discussed and the potential for any conflict to arise. The Directors' Register of Interests is available from the Foundation Trust Secretary (01392 404551) or on the Trust website www.rdehospital.nhs.uk/trust/ft/documents.html and Directors can be contact via e-mail at rde-tr.foundationtrust@nhs.net.

Board Effectiveness and Evaluation

The Board continued to develop its effectiveness during the year primarily through its programme of "development days." Development days are seminar sessions that allow the whole Board to explore a range of issues and topics and develop and discuss ideas outside the formal setting of the Board. In addition, the Board held seminar and development sessions on the days in which the formal Board sessions took place. During the year, these development sessions were held in the morning followed by the formal Board meeting in the afternoon. However, from February 2015, this

changed so that the formal Board meetings took place in the morning allowing the rest of the day to be set aside for collective Board development.

These seminars and development sessions enable the Board to examine issues in more detail, to explore key strategic issues as well as develop the capacities of the Board collectively. These sessions are vital to continuously improve the performance of the Board and to ensure that the Directors are able to discuss and debate key issues confronting the Trust in real depth. The issues discussed over the last year include:

- Board/Governor development
- Safe Staffing at night
- Specialist commissioning
- The Trust's strategy and strategic plan
- Operational performance and demand management/ planning
- A master class in understanding the key issues impacting on RTT and Cancer target performance
- The key issues emerging from the Devon-wide Challenged Health Economy work
- The need for and potential added value from an Electronic Patient Record system
- The Board Assurance Framework
- Developing and freeing up additional strategic capacity

In addition to these sessions, the Board spent a day working together to ensure that, as a group, it was operating effectively and that it was collectively providing the leadership required. Based on initial discussions with each Board member, the day focused on what the Board needed to do to develop its capacities and how collective

and individual behaviours needed to adapt to meet the challenges that it and the Trust faced currently and into the future. The session sought to develop the Board "from good to great" and to ensure that it was equipped with the right collective approach and mind-set going forward.

The Chairman undertook appraisals of all those Non-Executive Directors (NEDs) that had been in post for a year or more. The process used a system that was co-designed and agreed by the Appraisals Working Group a group made up of the Chairman, the Senior Independent Director and the Governors who sit on the Nominations Committee. The process involved a questionnaire aimed at the specific role of NEDs that was used as part of a 360 degree feedback by fellow NEDs, Executive Directors and Governors.

Feedback on the performance of the NEDs was considered by the Chairman and fed back to the NEDs in appraisal meetings. Feedback on the performance appraisals was provided in the written form and verbally to the Nominations committee and an overview of the appraisals was discussed with the COG. All the appraisals undertaken were favourable with all NEDs reviewed performing at or above the expected level.

A similar process was undertaken for the Chairman. In this case there was a longer questionnaire linked to the specific role of the Chairman and the process was led by the Senior Independent Director. Feedback on the performance of the Chairman was provided to the Nominations Committee and a summary was provided to the full Council of Governors. This was also a very positive appraisal.

The Chief Executive undertook the appraisals of Executive Directors using a similar process including feedback from Non-Executive Directors. Feedback on the appraisals was provided by the Chief Executive to the Executive Director Remuneration Committee (EDRC). The Chairman undertook an appraisal of the Chief Executive and the results of this were fed back to the EDRC.

Board of Directors

Non-Executive Directors

JAMES BRENT - Chairman

James joined the Trust in May 2012. He was an investment banker for twenty-five years and established Akkeron Group which has key business activities in hotels, urban regeneration, retail and leisure (including Plymouth Argyle Football Club). He has combined his commercial ventures with a desire to contribute in a range of public sector settings as well, for example previously as Chairman of Plymouth City Development Company and now as Chairman of Plymouth University.

JANE ASHMAN - Non-Executive Director

Jane joined the Trust in April 2014. A Social Worker by profession for the last 34 years and a passionate believer in the integration of Health and Social Care, Jane was a Director of Social Services for nine years until 2009. As well as her Non-Executive Director role at the RD&E Jane is the independent Chair of two Safeguarding Adult Boards and undertakes Serious Case Reviews and Domestic Homicide Reviews for other agencies when the need arises. Jane is the Chair of the Trust's Organ Donation Group and is a member of the Patient Experience Committee.

PETER DILLON - Non-Executive Director

Peter joined the Trust in July 2013. After more than ten years with Deloitte, he now runs his own company advising businesses that require turnaround, stabilisation, cash management, budgeting, cost reduction or interim finance. In addition to the time he gives to the RD&E, Peter is also a Non-Executive Director in the Devon & Cornwall Housing Group, a social and affordable housing provider. Peter chairs the Patient Experience Committee and is a member of the Audit Committee.

JANICE KAY - Non-Executive Director

Janice joined the Trust in April 2014. She is Provost of the University of Exeter and Deputy to the Vice Chancellor. She line manages the University of Exeter Medical School among other key roles. She holds a number of national positions in Higher Education, including the HEFCE Strategic Advisory Committee on Quality, Accountability and Regulation. Janice is a member of Audit and Governance Committees.

DAVID ROBERTSON - Non-Executive Director

David joined the Trust in October 2010 and is a Fellow of the Institute of Chartered Accountants in England and Wales and a graduate in Business Studies. He was Finance Director of Viridor Limited, the waste management subsidiary of Exeter based Pennon Group plc, until March 2011. He was with the Pennon Group for twenty years, prior to which he

was with KPMG for fourteen years. He is also Chairman of South West Lakes Trust. David is Chairman of the Audit Committee.

MICHELE ROMAINE - Non-Executive Director

Michele joined the Trust in September 2012. She has held a number of senior roles in public sector organisations, including the BBC as its Director of Production. Ten years ago Michele helped steer the course for the BBC in a time of significant change setting the vision for the technology, people and the process change necessary to modernise the BBC's production capabilities. Michele has more recently served for three years as a Non-Executive Director on the Board of Salisbury NHS Foundation Trust. She continues to travel internationally through her consultancy business. Michele took over the role as Chair of Governance Committee in September 2014, and is a member of the Audit Committee.

ANDREW WILLIS - Non-Executive Director

Andy joined the Trust in February 2011 and also serves a Non-Executive Director of an NHS teaching hospital. Previous Board experience includes service on two NHS acute provider Boards and in the housing and education sectors. A corporate lawyer by profession, he has worked for City and regional law firms and now specialises in legal training. He is also a Leadership Associate of the King's Fund, focusing on corporate governance and NHS Board/Director development. Andy was appointed Vice Chairman and Senior Independent Director in April 2014 and was Chair of the Governance Committee from February 2012 to August 2014 inclusive. Andy chairs the Executive Director Remuneration Committee.

Executive Directors

ANGELA PEDDER OBE - Chief Executive

Angela joined the NHS in 1975. She was Chief Executive of St Alban's & Hemel Hempstead NHS Trust before taking up her post as Chief Executive at the RD&E in 1996. Angela was awarded the OBE in the New Year Honours List 2007 for services to the NHS and was awarded an Honorary Doctorate by the University of Exeter in July 2011.

MARTIN COOPER - Medical Director

Martin was appointed to the RD&E in 1988 as a Consultant General Surgeon with an interest in Upper GI and Breast disease. He had previously worked as a Lecturer and Consultant Senior Lecturer at the University of Bristol and spent 18 months in research at the University of Chicago. In addition to his clinical role, Martin has been involved in management throughout his career. He was Clinical Director

of Surgery from 1992 until 1997 and having a major interest in the management of cancer was the Clinical Director of Cancer Services from 1995 until 2009. Regionally, he was the Medical Director of the Peninsula Cancer Network from 2000 to 2007. Martin was then Joint Medical Director from 2009 until May 2013; he was then reappointed as the full time Medical Director in August 2013 and retired at the end of March 2015.

TRACEY COTTAM - Executive Director of Transformation & Organisational Development

Tracey has worked across multiple sectors in a range of senior leadership and consulting roles, and for 15 years worked with a range of NHS organisations. Since joining the RD&E in 2013, Tracey has been responsible for leading the Trust-wide Transformation Programme which is one of the core supporting strategies through which our overall corporate strategy will be delivered. Tracey will work alongside her teams from Human Resources, the Programme Management Office, Service Development and Communication & Engagement to ensure the appropriate support is provided to the Trust to enable successful delivery of our strategic plans.

SUZANNE TRACEY - Executive Director of Finance and Business Development

Suzanne was first appointed as Finance Director in 2002 to Eastern Birmingham PCT. She joined the Trust in August 2008 from Yeovil District Hospital NHS Foundation Trust, where she held the post of Director of Finance/Deputy Chief Executive. Suzanne is a Trustee for the Healthcare Financial Management Association and was appointed as President in 2011.

EM WILKINSON-BRICE - Chief Nurse/Chief Operating Officer

Em joined the RD&E in July 2010 after qualifying as a nurse in 1992 in Exeter. She subsequently worked in Oxford specialising in Cardiology and high dependency care. Em undertook a secondment to the Department of Health leading a project which introduced ward housekeepers to the NHS. A firm interest in facilities management alongside nursing resulted in Em taking the post of Director of Nursing and Facilities at Derby Hospitals NHS Foundation Trust prior to coming to Exeter. Em's role expanded to cover the Chief Operating Officer portfolio in January 2012.

Summary of Board Attendance 2014/15

P = Public C = Confidential	Apr-14		May-14		Jun-14		Jul-14		Sep-14	
	P	C	P	C	P	C	P	C	P	C
Mr J Brent	P	P	P	P	P	P	P	P	P	P
Mrs J Ashman	P	P	P	P	P	P	P	P	P	P
Mr M Cooper	P	P	A	A	P	P	A	A	P	P
Ms T Cottam	P	P	A	A	P	P	P	P	P	P
Mr P Dillon	P	P	P	P	P	P	P	P	P	P
Prof J Kay	P	P	P	P	P	P	A	A	P	P
Mrs A Pedder	P	P	P	P	P	P	P	P	P	P
Mr D Robertson	A	A	P	P	P	P	P	P	P	P
Ms M Romaine	A	A	P	P	P	P	P	P	P	P
Mrs S Tracey	P	P	P	P	P	P	P	P	P	P
Mrs E Wilkinson-Brice	P	P	P	P	P	P	P	P	P	P
Mr A Willis	P	P	P	P	P	P	P	P	P	P
P = Public C = Confidential	Oct-14		Nov-14		Jan-15		Feb-15		Mar-15	
	P	C	P	C	P	C	P	C	P	C
Mr J Brent	P	P	P	P	P	P	P	P	P	P
Mrs J Ashman	P	P	P	P	P	P	P	P	A	A
Mr M Cooper	P	P	P	P	P	P	P	P	P	P
Ms T Cottam	P	P	P	P	P	P	P	P	P	P
Mr P Dillon	P	P	P	P	P	P	P	P	P	P
Prof J Kay	A	A	P	P	P	P	P	A	A	A
Mrs A Pedder	P	P	P	P	P	P	P	P	P	P
Mr D Robertson	P	P	P	P	P	P	P	P	P	P
Ms M Romaine	P	P	P	P	P	P	P	P	P	P
Mrs S Tracey	P	P	P	P	P	P	P	P	P	P
Mrs E Wilkinson-Brice	P	P	P	P	P	P	P	P	P	P
Mr A Willis	P	P	P	P	P	P	P	P	P	P

Non-Executive Director Appointments

The Chairman and Non-Executive Directors are appointed by the Council of Governors (CoG) acting on the recommendation of the Nominations Committee, which is a committee of the COG.

The Chairman chairs the Committee when appointing Non-Executive Directors. Membership of the Committee can be found in the Governors section on pages 108 and 109.

The Chairman and Non-Executive Directors are initially appointed for three year terms, as approved by the CoG. Re-appointments for a further three year term can be made, subject to satisfactory appraisal and the approval of the Governors. Consideration of extension beyond six years is subject to rigorous review, in line with the agreed process.

Remuneration Report 2014/15

The membership of the Executive Director Remuneration Committee (EDRC) includes the Chairman and all the Non-Executive Directors. During the year, the Committee was chaired by Andrew Willis as the Senior Independent Director. The Chief Executive and, as necessary, other Executive Directors were invited to attend the meetings in an advisory role but are excluded on issues directly relevant to them by the Chairman of the Committee. The Committee is supported by the Deputy Director of Transformation & Organisational Development.

The Committee's main purpose is to set rates of remuneration, terms and conditions of service for the Chief Executive, Executive Directors and their direct reports, i.e. those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. During the year the role of the Committee has extended to include direct reports to the Executive Directors who moved to "spot" salaries outside national terms and conditions within the review of the Trust's senior management arrangements.

The Committee ensures effective succession planning is in place for the Chief Executive and Executive Director roles on behalf of the Trust.

Non-Executive Director and Chairman Remuneration is dealt with by the Non-Executive Director Remuneration Committee (NEDRC). The arrangements are set out on page 44.

Application of the New Remuneration Framework

As reported in last year's remuneration report, a new Remuneration Principles document replaced a policy framework, whilst drawing from the previous policy. The Remuneration Principles are for the Committee to work by and it was agreed to review them in two years' time. The principles guiding the Committee's decision making process are as follows:

Key Principles

1. The Committee's approach to remuneration will seek to position the Trust in a way that it is able to attract, retain and motivate Executive Directors and their direct reports of sufficient calibre to maintain high quality, patient-centred healthcare and effective management of the Trust's resources.
2. The Committee understands that senior level positions in the Trust operate in a regional/national context and that remuneration for these positions is primarily determined by the market. In order to remain competitive and

attract and retain high calibre staff, the salaries of senior staff must be regularly reviewed to ensure that they remain broadly competitive and that the salaries offered to incumbents do not denude over time so that they are out of line with comparable Trusts. Nevertheless, the Committee will avoid paying more than is necessary to recruit, retain and motivate Executive Directors and their direct reports and will take positions that are publicly defensible. Moreover, the Committee understands that its approach must strike an appropriate balance with the Committee's duty to ensure the effective stewardship of public resources.

3. The Committee will be rigorous in ensuring that potential conflicts of interest are recognised and avoided. Executive Directors and their direct reports will not be involved in deciding their own remuneration package.
4. On an annual basis, the Committee will consider the remuneration packages of all Executive Directors and their direct reports bearing in mind the performance of the Executive Directors and their direct reports in fulfilling their duties and in regard to the overall performance of the Trust.
5. The Committee will use external comparison data on the pay and conditions of Executive Directors in comparator Foundation Trusts no less frequently than every two years. This work will be undertaken on behalf of the EDRC by a competent and suitably qualified external organisation or senior Human Resources adviser. The EDRC will identify a suitable comparator subset of Foundation Trusts and Trusts from which it wishes to derive data. The Committee will make judgements on where it wants to position its relative remuneration package for Executive Directors and their direct reports in any one year in relation to comparison data from other Foundation Trusts. The EDRC will treat comparator data with caution not least so as to avoid undue pay inflation.
6. The Committee will seek to apply the principles fairly and transparently and on the basis of data and advice from competent external bodies/consultants or senior Human Resource adviser as necessary. The Committee understands that it will use the data it gathers and the framework set out in the principles to exercise the necessary judgment on pay and reward issues. The Committee will ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the organisation and will be based on judgements relating to:
 - Market rates for comparable roles in comparable organisations

- Interpretation of the data from an agreed comparator group
 - The size and scope of the role in question
 - Advice from the Chairman of the Trust in relation to the Chief Executive
 - Advice from the Chief Executive in relation to the Executive Directors and their direct reports
 - Affordability
 - Other NHS pay settlements
 - Wider implications that may arise from setting the remuneration packages of Executive Directors and their direct reports in relation to pay levels determined through national agreements within the NHS;
 - Any other factors deemed appropriate
7. The Committee will seek to achieve broadly standardised terms and conditions for example on notice periods for all posts which fall within the scope of the principles. The EDRC has resolved to move towards a situation in which there is a higher degree of conformity (a notice period of six months).
 8. The Committee will be transparent in the application of its remuneration principles. It is a requirement that details of the remuneration package for Board Directors are recorded in the Trust's Annual Report.
 9. The Trust recognises that the EDRC has the authorised responsibility to apply its independent judgement on matters within its remit within the wording and the spirit of the agreed principles. However, there may be times when a different approach is required which steps outside the scope of the principles and in these cases, particular care must be taken and clear justification must be given and recorded. Some circumstances which may require flexibility include temporary promotions; atypical employment conditions; specific issues related to individuals etc. The Committee will reserve the right to recruit an Executive Director or a direct report on a salary below the market value in cases where a development plan would enable the employee to reach the minimum standards to undertake the role at a satisfactory level. The Committee also reserves the right to pay additional payments to Executive Directors and their direct reports when deemed necessary because of exceptional circumstances. The occasions when additional payments are required will be limited. When considering using additional payments, the EDRC will need to be able to fully justify and explain why it has opted to take this course of action. It would only normally consider such action on the basis of a clear business case. Special care must be taken to ensure that

the use of additional payments is completely transparent and that consideration has been given to the impact on pay inflation among Executive Directors and their direct reports as well as to guard against accusations of bias or arbitrary practice.

Scope

1. The principles will apply to the pay, awards and terms of employment of the Trust's Chief Executive and Executive Directors and their direct reports and include the following components:
 - The core salary
 - Any supplementary payments to the Director over and above the core salary in recognition of extraordinary factors such as matching market forces in recruitment; exceptional endeavour etc
 - Additional non-pay benefits over and above the core salary including pensions, vehicle/lease car issues, mobile phones and other such benefits
 - The terms and conditions in regards to issues (such as notice periods, conditions attached at recruitment stage for professional development for example) etc
 - Arrangements for termination of employment and other contractual terms
2. On an annual basis the Committee will consider whether any issues have emerged which require consideration of any adjustments to existing remuneration packages such as:
 - At the beginning of a process to recruit a replacement Executive Director or direct report
 - When issues concerning inflationary uplifts within the NHS need to be considered – on an annual basis;
 - When changes are made to the size and scope of Executive Director or direct report portfolios

In-year Remuneration Decisions

As reported in last year's remuneration report, Mr Adrian Harris was appointed to the position of Medical Director from April 2015 and has acted in the capacity of Medical Director Designate during the past year, whilst completing the NHS Leadership Academy's Fast Track programme.

The Committee agreed the terms and conditions for the Medical Director which were in line with market rates effective from 1 June 2014. The contract is predominantly that of an Executive Director with a linked Medical and Dental Contract, with a standard Executive Director notice period of six months.

Directors' remuneration summaries are reflected in the table on page 68 and incorporate the 1% which has been applied to staff employed by the Trust on national terms and conditions of service from 1st April 2014.

During the year, the Committee approved the 'spot' salaries for four new posts: Operational Finance Director, Deputy Chief Nurse/Midwife, Deputy Director of Transformation and Organisational Development, and Development Director for Integrated Care in Exeter.

Attendance at EDRC Meetings 2014/2015

Name	June 2014	October 2014
J Brent	P	P
P Dillon	P	P
D Robertson	P	P
M Romaine	P	P
A Willis	P	P
Professor J Kay	P	P
J Ashman	A	P

P - Present A - Absent

Senior Managers Remuneration Policy

The Trust adopts the principles of Agenda for Change terms and conditions when considering Senior Managers pay, remuneration is set on a spot salary basis (see Annual Statement of Remuneration for decisions taken for the 2014/2015 year). The spot salaries are based on market testing to identify the market rate, the experience of the candidate is also taken into account. The Trust does not operate a performance related pay scheme. The Executive Directors are appointed on permanent contracts and have a six month notice period (the Chief Executive has a twelve month notice period). The Trust follows agenda for change principles in calculating severance packages for redundancy.

There were no new components of the remuneration package introduced during the year.

Element of pay (Component)	How component supports short and long term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period
Basic salary	Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership. Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives outlined in its annual priorities and its long term strategic goals.	Following market testing (undertaken every two years) which seeks to identify salary paid for similar role, individuals are remunerated by spot salary on a case by case basis. There is no predefined upper limit.	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March.
Benefits	N/A	N/A	N/A
Pension	Provides a solid basis for recruitment and retention of top leaders in sector.	Contributions within the relevant NHS pension scheme.	Contribution rates are set by the NHS Pension Scheme.
Bonus	N/A	N/A	N/A
Fees	N/A	N/A	N/A

Directors Remuneration

Salary and Pension entitlements of senior managers

Remuneration		Salary and Fees		Taxable Benefits		Pension related Benefits		Other Remuneration		Golden hello / compensation for loss of office		Total	
Name and Title	(bands of £5000) £000	(Rounded to the nearest £100) £	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000	(bands of £5000) £000
2014/15													
J Brent	45 - 50	-	-	-	-	-	-	-	-	-	-	-	45 - 50
J Ashman	10 - 15	1,800	1,800	-	-	-	-	-	-	-	-	-	10 - 15
P Dillon	10 - 15	2,200	2,200	-	-	-	-	-	-	-	-	-	15 - 20
J Kay	10 - 15	-	-	-	-	-	-	-	-	-	-	-	10 - 15
D Robertson	10 - 15	100	100	-	-	-	-	-	-	-	-	-	10 - 15
M Romaine	10 - 15	1,600	1,600	-	-	-	-	-	-	-	-	-	15 - 20
A Willis	15 - 20	4,500	4,500	-	-	-	-	-	-	-	-	-	15 - 20
A Pedder	180 - 185	-	-	-	-	-	-	-	-	-	-	-	180 - 185
M Cooper	145 - 150	100	100	-	-	-	-	-	-	-	-	-	145 - 150
T Cottam	110 - 115	-	-	-	-	20.0 - 22.5	-	5 - 10	-	-	-	-	140 - 145
S Tracey	140 - 145	200	200	-	-	25.0 - 27.5	-	-	-	-	-	-	170 - 175
E Wilkinson-Brice	140 - 145	100	100	-	-	30.0 - 32.5	-	-	-	-	-	-	175 - 180
Other Remuneration is a relocation payment for T Cottam.													
There were no annual performance-related bonuses or long-term performance-related bonuses paid to any individual in the financial year.													
The benefits in kind relate to the mileage allowance paid over and above the HM Revenue & Customs allowance.													
Ratio between highest paid director and median remuneration received by employees of the Trust													
Band of highest paid Director - as above											2014/15	2013/14	
Median remuneration received by employees within the Trust											180 - 185	180 - 185	
Ratio											27.6	26.4	
											6.6	6.9	

Salary and Pension entitlements of senior managers

Remuneration

Name and Title	Salary and Fees (bands of £5000) £000	Taxable Benefits (Rounded to the nearest £100) £	Pension related Benefits £000	Other Remuneration (bands of £5000) £000	Golden hello / compensation for loss of office (bands of £5000) £000	Total (bands of £5000) £000
2013/14						
J Brent	40 - 45	-	-	-	-	40 - 45
B Aird	10 - 15	-	-	-	-	10 - 15
P Dillon	5 - 10	300	-	-	-	5 - 10
D Robertson	10 - 15	100	-	-	-	10 - 15
M Romaine	10 - 15	400	-	-	-	10 - 15
A Willis	15 - 20	300	-	-	-	15 - 20
D Wright	10 - 15	200	-	-	-	15 - 20
A Pedder	180 - 185	-	-	-	-	180 - 185
C Berry	45 - 50	-	67.5 - 70.0	0 - 5	-	120 - 125
M Cooper	90 - 95	-	-	10 - 15	-	105 - 110
T Cottam	95 - 100	-	17.5 - 20.0	-	-	115 - 120
L Lane	50 - 55	300	30.0 - 32.5	-	90 - 95	175 - 180
V Lewis	5 - 10	-	0.0 - 2.5	5 - 10	-	10 - 15
S Tracey	140 - 145	100	40.0 - 42.5	-	-	180 - 185
E Wilkinson-Brice	140 - 145	-	137.5 - 140.0	-	-	275 - 280

Pension Benefits

Name and Title	Real increase in pension at age 60 (bands £2,500)	Real increase in pension related sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2015 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2015 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real Increase in Cash Equivalent Transfer Value at 31 March 2015
	£000	£000	£000	£000	£000	£000	£000
A Pedder Chief Executive	0.0 - 2.5	5.0 - 7.5	80 - 85	250 - 255	-	-	-
M Cooper Medical Director	0.0 - 2.5	0.0 - 5.0	0 - 5	0 - 5	-	-	-
T Cottam Director of Transformation and Organisational Development	0.0 - 2.5	0.0 - 5.0	0 - 5	0 - 5	46	21	25
S Tracey Director of Finance and Business Development	0.0 - 2.5	7.5 - 10.0	25 - 30	75 - 80	430	377	45
E Wilkinson-Brice Chief Nurse / Chief Operating Officer	0.0 - 2.5	7.5 - 10.0	45 - 50	135 - 140	708	791	-

As Non-Executive Directors do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive Directors.

A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member of the pension scheme at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.

Cash Equivalent Transfer Values (CETV) are not available for members that have reached the normal retirement age of 60 or who have commenced drawing their pension or are a deferred member. No CETV is therefore available, as at 31 March 2014 and 31 March 2015 for M Cooper. A CETV is also not available for A Pedder, as at 31 March 2014 and 31 March 2015, due to opting out of the pension scheme in 2013/14.

No lump sum is payable to members of the NHS Scheme (Amended 1 April 2008) and therefore no information is provided for T Cottam.

E Wilkinson-Brice has transitional protection from 1995 section to 2015 scheme (1 December 2015) and Normal Pension Age will change from 55 years of age to reflect state retirement age of 67 years of age.

Off Payroll Payments

Table 1: For all off-payroll engagements as of 31 March 2015, for more than £220 per day and that last for longer than six months

No. of existing engagements as of 31 March 2015	11
Of which...	
No. that have existed for less than one year at time of reporting.	3
No. that have existed for between one and two years at time of reporting.	5
No. that have existed for between two and three years at time of reporting.	2
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	1

All existing off-payroll engagements, outlined above, have at some point been subject to a risk based assessment as to whether assurance is required that the individual is paying the right amount of tax and, where necessary, that assurance has been sought.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015, for more than £220 per day and that last for longer than six months

No. of new engagements, or those that reached six months in duration, between 1 April 2014 and 31 March 2015	3
No. of the above which include contractual clauses giving the trust the right to request assurance in relation to income tax and National Insurance obligations	3
No. for whom assurance has been requested	3
Of which...	
No. for whom assurance has been received	2
No. for whom assurance has not been received	1*
No. that have been terminated as a result of assurance not being received.	0

**At 31 March 2015 the Trust was awaiting confirmation from the agency in respect of one engagement. The deadline for providing the confirmation had not passed.*

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2014 and 31 March 2015

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	12

Signed:



Angela Pedder OBE
Chief Executive

27 May 2015

Non-Executive Director Remuneration Committee

The Non-Executive Director Remuneration Committee (NEDRC) comprises five elected Governors and is chaired by the Lead Governor, CoG. The Committee is supported by the Deputy Director of Transformation and Organisational Development and the Trust Secretary.

Recommendations for any changes to remuneration for the Chairman and other Non-Executive Directors are made by the NEDRC for consideration by the Council of Governors at a general meeting. Similar to last year, the Committee did not meet during the year as it did not need to on the basis of decisions reached in 2012/13. The decisions set out that the NEDs would not receive any increase in remuneration over and above any changes made in uplifting salaries in line with that agreed for staff generally as part of the nationally agreed Agenda for Change.

Membership of the NEDRC

- Richard May (Lead Governor and Chairman of the NEDRC)
- Alison Wootton (Staff Governor)
- Linda Vijeh (East Devon, Dorset, Somerset & the Rest of England)
- Geoff Barr (Exeter & South Devon)
- Dianah Pritchett-Farrell (Mid, North, West Devon & Cornwall)

Element of pay (Component)	Fee Payable	Operation of the component	Performance metric used and time period
Basic salary	£12,910 pa	Spot salary (no change since 2008)	Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March
Additional Fees	£1,500 pa	Appointment to any additional role within the Non-Executive area (i.e. Chair of Audit Committee)	(see above)
Expenses	53p per mile	Reimbursement of mileage undertaken in the performance of Duty. The trust will be responsible for the Payment of Tax and Employees National Insurance contribution to the HMRC	

Audit Committee

The Audit Committee is a formal, statutory committee of the Board of Directors, chaired by Mr David Robertson (a Non-Executive Director with a financial background).

The primary role of the Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system. In particular it is responsible for providing assurance to the Board in relation to the financial systems and controls of the Trust.

Four Non-Executive Directors constitute the membership of the Committee.

The Audit Committee is also attended by representatives of the Trust's External Auditors, Internal Audit and the Counter Fraud Service.

Appointment of the Trust's External Auditors

An external audit tender was conducted in the 2014/15 financial year, in accordance with Monitor's recommendation that NHS Foundation Trusts should undertake a market testing exercise for the appointment of an external auditor at least once every five years.

An external audit team and external audit panel were established to undertake and manage the tender exercise and provide a recommendation to the Trust's Council of Governors (CoG).

The Chair of the Trust's Audit Committee, who is also a Non-Executive Director of the Trust, chaired both the external audit team and panel. The audit panel included three Governors who provided representation from the CoG.

The CoG received recommendations from the external audit tender panel and has awarded the external audit contract to KPMG LLP, for a five year period, commencing the 1 November 2014, replacing PriceWaterhouseCooper LLP.

Revaluation of Property and Land

The Trust's accounting policies requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property.

A full revaluation of the Trust's land and buildings was undertaken by professionally qualified valuers, in accordance with the Royal Institute of Chartered Surveyors valuation manual as at the 31 March 2014 and was included within the Trust's year ended 31 March 2014 audited accounts.

An internal desktop revaluation exercise, to calculate the change in value, has been undertaken this year by the Trust, applying the relevant BCIS indices that have been agreed

with the District Valuer. From these calculations the change in the fair value of the Trust's land and buildings was not considered to be material and therefore no revaluation adjustment has been included within this year's accounts.

As part of the internal desktop exercise a review of the assumptions underpinning the modern equivalent asset valuation was undertaken. It was agreed that the previous land and buildings assumptions were still appropriate.

The Audit Committee was satisfied that a property revaluation was not required for 2014/15 due to the change in value being immaterial. The Audit Committee were also given further reassurance, that the change in value was not material, from the review and audit work undertaken by the Trust's external auditors.

Consolidation of Charity Accounts

The accounting standard IAS 27 Consolidated and Separate Financial Statements became applicable for the first time in 2013/14 to NHS organisations in respect of NHS Charities. This meant that the Royal Devon and Exeter NHS General Charity may have been required to be consolidated within the Trust's accounts.

In 2013/14 it was agreed that the value of the Charity was immaterial in relation to the Trust's accounts and the Board of Directors therefore agreed not to consolidate the Charity's accounts. The Audit Committee were in agreement with this decision and is satisfied that the value of the Charity continues to be immaterial in relation to the Trust's accounts and has therefore agreed that it should not be consolidated within the Trust's accounts.

Recognition of Income

Over 95% of the Trust's income is received from other NHS organisations, with the majority being receivable from Northern, Eastern, Western Clinical Commission Group (NEW Devon CCG). The Trust participates in the Department of Health's agreement of balances exercise. This exercise seeks to identify all income and expenditure transactions and payable and receivables balances that arise from Whole Government Accounting (WGA) bodies. The Audit Committee is satisfied that by participating with this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA have been properly recognised and WGA receivable and payable balances are appropriately recorded. The Trust's external auditors have reviewed income recognition as part of their audit and have not identified any issues as a result of the work performed.

The Audit Committee met five times during 2014/15. The names of members and their attendance at 2014/15 meetings, are as follows:

Name	April 2014	May 2014	July 2014	Nov 2014	Feb 2015
P Dillon	P	P	P	P	P
D Robertson	P	P	P	P	P
M Romaine	P	A	P	P	P
J Kay					A

P - Present A - Apologies

Duties and Responsibilities of the Audit Committee

Governance, Risk Management and Internal Control

- The Audit Committee shall review the establishment and maintenance of an effective system of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives.
- In particular, the Audit Committee will review:
 - All risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board
 - The assurance processes that underpin the achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
 - The policies and procedures for all work related to fraud and corruption as set out in Secretary of State Directions and as required by NHS Protect
- In carrying out this work the Audit Committee will primarily utilise the work of internal audit, local counter fraud specialists, external audit and other assurance functions, but will not be limited to these functions. It will also seek reports and assurances from the Governance Committee, Directors and Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

- The Audit Committee shall ensure that there is an effective internal audit function, including the Counter Fraud function, established by management that meets mandatory NHS internal audit standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This will be achieved by:
 - Consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
 - Review and approval of the annual internal audit plan, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework
 - Consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
 - Consideration of the annual Head of Internal Audit's Opinion
 - Follow-up by the Governance Committee, or one of its sub-committees, where internal audit's work is an area covered by that committee, as set out in internal audit's plan
 - Ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust, and
 - An annual review of the effectiveness of internal audit

External Audit

- The Audit Committee shall:
 - Review and monitor the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements
 - Keep under review the level of non-audit services provided by the external auditor, taking into account relevant guidance
 - Make recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and
 - Approve the remuneration and terms of engagement of the external auditor.
- Further, the Audit Committee shall review the work and findings of the external auditor and consider the implications of and management's responses to their work. This will be achieved by:
 - Discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in their annual plan
 - Discussion with the external auditors of their evaluation of audit risks and associated impact on the audit fee, and

- Reviewing all external audit reports, including their report on the Quality Report and agreement of the annual audit letter, before submission to the board, together with the appropriateness of management responses

Other Functions

- 7 The Audit Committee will consider the work of other committees within the Trust, the work of which can provide relevant assurance to the Audit Committee's own scope of work. This will particularly include the Governance Committee because of its management of the Trust's Corporate Risk Register and the Clinical Audit function.
- 8 The Audit Committee will also:
 - Review material changes to standing orders and standing financial instructions and schemes of delegation and
 - Receive a report from management on the review of data quality included in the Quality Report

Financial Reporting

- 9 The Audit Committee shall review and, if thought appropriate, recommend to the Board adoption of the Annual Report and financial statements, focusing particularly on:
 - Specific enquiry into the question of whether the Trust keeps proper books of account
 - The integrity of the financial statements
 - The wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
 - Changes in, and compliance with, accounting policies and practices
 - Unadjusted mis-statements in the financial statements
 - Major judgemental areas, and
 - Significant adjustments resulting from the audit

Board of Directors Reporting Arrangements

- 10 The Chair of Audit Committee will provide a report highlighting the key issues arising from the Audit Committee to the meeting of the Board that directly follows the Audit Committee. The minutes of the Audit Committee will also be available to the Board.
- 11 The Annual Governance Statement, which is included in the Annual Report, reviews in considerable detail the effectiveness of the system of internal control. By concurring with this statement and recommending its adoption to the Board, the Audit Committee also gives the Board its assurance on the effectiveness of the overarching systems of integrated governance, risk management and internal control.

It is the responsibility of the Trust's Directors to produce the Annual Accounts included in this report. The external auditors provide an independent opinion on the Trust's accounts and also audit the overall position of the Trust's management and performance including an opinion on the quality of the system of internal control. The outcome of this work is reported in the Audit Opinion which is included in the accounts in this report and the Annual Management letter to the Board.

Compliance with the NHS Foundation Trust Code of Governance

The Trust Board has overall responsibility for the administration of sound corporate governance throughout the Trust and recognises the importance of a strong reputation. Monitor, the independent regulator for Foundation Trusts, published the NHS Foundation Trusts Code of Governance, a revised version of which was published early 2014.

The Royal Devon and Exeter NHS Foundation Trust has applied the principles of the NHS Foundation Trust Code of Governance on a comply or explain basis. The NHS Foundation Trust Code of Governance, most recently revised in July 2014, is based on the principles of the UK Corporate Governance Code issued in 2012.

Annual Governance Statement 2014/15

Scope of Responsibility

As Accounting Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS foundation trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the NHS foundation trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

The Purpose of the System of Internal Control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an on-going process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal Devon & Exeter NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal Devon & Exeter NHS Foundation Trust for the year ended 31 March 2015 and up to the date of approval of the annual report and accounts.

Capacity to Handle Risk

The Trust has a comprehensive governance system in place which has been developed and enhanced over a number of years and continues to be subject to regular review to ensure its continued fitness for purpose. The current governance architecture was established in October 2011. An Internal Audit interim and full review was undertaken in July 2012 and September 2013 and provided assurance that "the governance structure has been strengthened greatly". In October 2013 an external review of governance was completed by KPMG, the findings of which were very positive.

The Audit Committee monitors and oversees both internal control issues and the process for risk management. Audit Southwest (internal audit) and PWC/KPMG (external auditors) attend all Audit Committee meetings. (PWC were the Trust's external auditors who served from 2004 until 31 October 2014. KPMG started a five year term as external auditors commencing 1 November 2014.) The Audit Committee receives all reports of the Internal and External Auditors and reports regularly to the Board.

Risk issues are reported through the Governance Committee via the Safety and Risk Committee and the Trust's management structure. Management and ownership of risk is delegated to the appropriate level from director through to local management through the divisional management teams. There are established Governance Managers in post to support the Divisions in implementing robust risk and governance processes. Each Division has a Divisional Governance Group which meets regularly to manage risk and report and escalate concerns via the five sub committees of the Governance Committee. Performance management of any governance/risk action plans are managed via the Trust's Performance Assessment Framework (PAF) led by the Operations Director. Strategic risks are managed via the Board owned Board Assurance Framework. This document focuses on risks that could prevent the Trust from achieving its strategic objectives.

The Board has appointed a Senior Independent Director to be available to Governors and Members if they have concerns where contact through the normal channels of Chairman, Chief Executive or Director of Finance and Business Development, have failed to resolve them or for which such contact is inappropriate. In addition, the Trust has a Whistleblowing Policy to guide and protect staff who raise issues of concern.

All staff joining the Trust are required to attend Corporate Induction which covers key elements of risk management. This is further enhanced at departmental induction. Training courses are run on a regular basis and provide staff with the skills needed to undertake risk management duties. Staff are trained and equipped to manage risk in a way appropriate to their authority and duties. Risk management is included in the Trust's mandatory training programme and follow-up refresher training; the Trust's risk management policies and procedures are available on the Trust's intranet.

An electronic governance system, which has the ability to record and monitor incidents, complaints and risks, has been operational since June 2011. The system facilitates the reporting and management of incidents. It has been extended to include the complaints and risk register module and most recently the legal claims module to provide comprehensive reporting to support greater triangulation of incidents. During 2013/14 additional functionality to identify hotspots, which automatically pick up new trends in incident data, was established.

An established cohort of senior clinical staff and Governance Managers trained to conduct Serious Incidents Requiring Investigation (SIRI) is in place and additional staff are trained each year to add to the pool available. The Risk Management Team co-ordinates SIRIs and adverse incidents, which are reported and managed through the Incident Review Group (a sub group of the Safety and Risk

Committee). In addition to direct feedback to relevant clinical teams, Lessons Learned briefings, highlighting learning points, are made available to all staff via the local intranet. All SIRI investigation reports and action plans are shared with the Trust's lead commissioner, Northern Eastern Western Devon Clinical Commissioning Group (NEW Devon CCG).

The Risk and Control Framework

The Board of Directors is responsible for the strategic direction of the Trust. The Board of Directors has reviewed and approved a revised Risk Policy and updated, amended and approved the Board Assurance Framework accordingly. The Board Assurance Framework identifies the key risks and mitigations related to the Trusts' strategic objectives and key priorities. The Board Assurance Framework is reviewed by the Board of Directors' on a quarterly basis. The Corporate Risk Register is reviewed by the Governance Committee each time it meets. The Governance Committee reports to the Board of Directors quarterly. The Audit Committee considers the Board Assurance Framework and the Corporate Risk Register when setting Internal Audit's annual work plan.

The Board of Directors, as part of the Annual Plan reporting cycle, is responsible for the completion of the Annual Governance Statement. The Board has adopted a process by which evidence is identified for each element of the statement to provide assurance and support a decision of compliance or gap in compliance (i.e. risk). Where risk is identified this would be risk assessed, mitigating actions put in place and added to the appropriate risk register.

Any material gaps in controls of assurance are highlighted and reported to the Board of Directors. When identified, risks to the Trust's strategic objectives that cannot be immediately eliminated are placed on the Corporate Risk Register and action plans put in place to address any gaps. The Board of Directors' risk and control framework is supported by the Audit Committee and Governance Committee which provide assurance to the Board of Directors on risk and control management issues.

The chairs of the Audit Committee and the Governance Committee met once during 2014/15 to ensure that the agendas of the two committees are aligned and there are no gaps in assurance to provide continuity and oversight of agenda preparation and completion of follow-up actions. The Chair of the Governance Committee is a member of the Audit Committee.

The Governance Committee is chaired by a Non-Executive Director and provides oversight of the risk management process. The Committee takes a comprehensive oversight of the quality and safety of care provided by the Trust and provides assurance to the Board of Directors. The work of the Governance Committee is supported by five key sub committees:

- Integrated Safeguarding Committee
- Clinical Effectiveness Committee
- Safety and Risk Committee
- Patient Experience Committee
- Workforce Governance Committee

These five committees are responsible for monitoring and managing specific types of risk.

A review of the Governance System is currently underway to look at opportunities for further streamlining of processes, increased effectiveness and time saving. The outcome of the review will be reported back to the Board of Directors.

The Safety and Risk Committee chaired by the Chief Executive has a number of key sub-groups leading the Trust's management of safety and risk.

- The Patient Safety Group is accountable for delivery of the Trust's patient safety programme, review of adverse incidents and Mortality and Morbidity Reviews
- The Incident Review Group is chaired by the Lead Nurse for Safety and Risk and reviews all Serious Incidents Requiring Investigation (SIRI) and action plans
- Medical Gases Group
- Radiation Safety Group
- Infection Control and Decontamination Group

Other specialist groups whose work relates closely to safety and risk report via the Clinical Effectiveness Committee.

- Clinical Audit and Guidelines Group
- Medicines Management Group

During 2013/14, the Board reviewed its approach to mortality reviews and an enhanced approach has been introduced.

Risk Identification and Evaluation

The Trust has a Risk Management Policy which has been approved by the Board of

Directors and clearly sets out the process for identifying and managing risk and the Trusts' risk appetite. It incorporates a standard methodology in which risk is evaluated using a likelihood consequence matrix. The roles and responsibilities of staff in managing risk are defined and key posts highlighted. The Policy also includes the governance reporting structure and the terms of reference of the Governance Committee and all the committees reporting to the Governance Committee.

The Trust maintains a comprehensive Corporate Risk Register covering both clinical and organisational risk.

There are 23 current risks on the Corporate Risk Register. All identified risks have clear mitigation plans in place. Of the Trust's highest scoring risks two relate to mental health pathways (external factors), one relates to the Patient Transport Contract (external factor), one relates to environmental issues within the CIVAS section of the Pharmacy Department, one relates to transfusion of blood, one relates to capacity management, one relates to the Trusts' ability to achieve cancer waiting times, one relates to IT legacy systems, one is a risk relating to future capacity within the Resuscitation Room within the Emergency Department and one relates to antimicrobial stewardship. Robust action plans are in place and these risks are assigned to an appropriate executive lead and manager who are responsible for ensuring that the risk is either eliminated or managed appropriately. A robust system is in place to monitor progress of action plans, which is undertaken by both the Head of Governance and the Divisional Governance Groups to ensure that risks are proactively managed down to their end target score. A detailed report is produced by the Head of Governance to the Safety and Risk and Governance Committees each time they meet.

The Trust has Divisional level risk registers which feed into the Corporate Risk Register. At Divisional level, the risk registers contain lower level localised risks which can be managed by the relevant Division. The Corporate Risk Register contains the higher level risks and Trust-wide risks. This ensures that risks are identified, managed and escalated appropriately at all levels of the organisation. Risk assessments, including Health and Safety and Infection Control, are undertaken throughout the Trust. All areas of the hospital have trained Risk Management Officers and the Risk Management Department and Head of Governance facilitate Risk Surgeries to provide support and training and to ensure consistency in approach.

Other sources used to identify risks include:

- Complaints, Care Quality Commission and Health Service Ombudsman reports and recommendations
- Inquest findings and reports from HM Coroner
- Health and Safety Executive and regulatory body compliance inspections
- Medico-legal claims and litigation reports
- Health Scrutiny Committee reports
- Incident reports and trend analysis (via Datix software, identification of hot spots)
- Internal and external audit reports
- Performance Assurance Framework
- Feedback from Governors and Members
- Ward to Board Framework, Care Quality Assessment Tool (CQAT)
- Safety Thermometer

Risk to the achievement of the Trust's corporate strategy is considered, assessed and managed via the Board Assurance framework (BAF) which is discussed by the Board on a quarterly basis. The Board has identified non-achievement of the Cost Improvement Programme (CIP) associated with the requirement to achieve a 4% efficiency factor as the most significant risk to the achievement of the corporate strategy.

Information Governance

Information Governance and data security is managed by the Information Governance Steering Group lead by the Director of Finance and Business Development, the Trust's nominated Senior Information Risk Owner and Freedom of Information Lead. Information Asset Owners for critical systems have been identified; system risk assessments and Information Risk Management training is undertaken annually.

An Information Security Forum, chaired by the Medical Director as Caldicott Guardian, deals with all aspects of information security and data confidentiality. Risks to information security are reported directly to the Information Security Forum (a sub group of the Information Governance Steering Group) and recorded on the Corporate Risk Register. The Trust has completed the Information Governance Toolkit assessment and the Safety and Risk Committee and the Board of Directors has received a report regarding its system for control of Information Governance.

The Trust is green rated on the Information Governance Toolkit, achieving an overall score of 75%.

During 2014/15 the Trust had four Level 2 confirmed Information Governance Serious Incidents which were reported to the Information Commissioners Office in line with the Department of Health document "*Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation*".

The incidents, three of which were patient details found by a member of Trust staff on Trust premises and one involving patient details found by a member of public outside Trust premises, were fully investigated. The Information Commissioner has responded to all of the incidents, recommending that the Trust reviews the frequency and content of Data Protection Act training and consider what other methods could assist in maintaining a high level of data protection awareness amongst staff.

NHS England guidance and embedded legislation on the recording and monitoring of Elective Waiting Time data is complex and allows for local agreement and flexibility in how some rules are interpreted. To ensure that inherent risks and unintended consequences from local interpretation are monitored the Trust has a robust framework and meeting structure that supports and drives the Information Governance agenda. This provides the Trust Board via the

Safety and Risk Committee with the assurance that effective Information Governance best practice mechanisms are in place within the organisation.

The Trust actively promotes the importance of good Data Quality throughout the Trust to ensure accuracy, completeness and timeliness and the risks associated with any inaccuracies.

Assessment of Data Quality incorporating Referral to Treatment/Elective Waiting List Management is included in the Trust's annual Internal Audit work plan. The audit process provides independent assurance of the design and operation of controls in place.

The Trust's Access policy establishes a number of principles and definitions and defines roles and responsibilities to assist with the effective management of waiting lists relating to outpatient appointments, elective treatment, imaging and other diagnostic tests. Furthermore standard operating procedures are in place to support staff in applying a consistent and effective approach to Waiting List Management.

Detailed operational monitoring occurs across all specialties and in conjunction with internal metrics against data quality. These are applied to identify areas for improvement and are monitored on a regular basis.

The foundation trust is fully compliant with the registration requirements of the Care Quality Commission.

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the Scheme are in accordance with the Scheme rules, and that member Pension Scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. The Board of Directors receive assurance that we are meeting our legal obligations through an annual report received, on behalf of the Board of Directors, by the Governance Committee. Full evidence of legal compliance is also published on the Trust's external website. The Trust uses an NHS-designed tool, the Equality Delivery System (EDS), to ensure compliance with legal obligations and enable continuous improvement.

The foundation trust has undertaken risk assessments and Carbon Reduction Delivery Plans are in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Review of Economy, Efficiency and Effectiveness of the Use of Resources

The Trust's Annual Plan, including financial, performance, quality and governance targets, was approved by the Board of Directors in April 2014. Overall performance is monitored via an integrated performance report at the monthly meetings of the Board of Directors. Operational management and the coordination of Trust services are delivered by the Executive Directors. Performance of individual clinical Divisions is monitored formally on a monthly basis through the newly implemented Performance Assurance Framework which is led by the Operations Director.

The Trust's External Audit Management Letter includes commentary on the economical, effective and efficient use of resources. The Internal Audit Plan includes reviews which consider the economy, efficiency and effectiveness of the use of resources. The findings of internal and external audit are reported to the Board via the Audit Committee.

I can confirm that the Trust complies with the cost allocation of and charging requirements set out in HM Treasury and Office of Public Sector Information guidance.

Internal Audit has conducted reviews against the Care Quality Commission regulations, records management, data quality, and information governance. Reviews are conducted using a risk-based approach. In addition they have annual reviews of the Trust's risk management and governance arrangements.

Annual Quality Report

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 to prepare Quality Accounts for each financial year. Monitor has issued guidance to NHS foundation trust boards on the form and content of annual Quality Reports which incorporate the above legal requirements in the NHS Foundation Trust Annual Reporting Manual.

The content of the Trust's Quality Report for 2014/15 builds on the 2013/14 report. It has been agreed by the Board of Directors and incorporates the views and priorities of Governors and the views of Trust members in setting priorities for improvement in 2015/16. The development of the report is led by the Chief Nurse/Chief Operating Officer. The views of NEW Devon CCG, as lead commissioner, Healthwatch Devon and Devon County Council Health Scrutiny Committee have been sought.

The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Report as it does for other clinical quality and performance information. The data is subject to regular review and challenge at speciality, Divisional and Trust levels. In line with the Trust's commitment to openness and transparency,

the data included is not just limited to good performance and is publicly reported at least on a quarterly basis. The Audit Committee undertake a review of the data assurance underpinning the Quality Report and through this process and other review of data, the Board of Directors are assured that the Quality Report represents a balanced view.

During 2011/12, as part of the three year audit cycle, a programme to assess quality systems and data (similar to that in place for our financial systems), was agreed with our internal auditors and built into the Internal Audit plans for future years. This will be an on-going process and the Board of Directors will use the recommendations from this work to further improve the robustness of the process underpinning the Quality Report. A review was undertaken during 2014/15 and the next review is planned during quarter four of 2015/16.

Audit of Mandated Indicators

The Indicators audited were:

- Emergency readmissions within 28 days of discharge from hospital
- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways

KPMG has provided assurance on the process for recording Emergency readmissions within 28 days of discharge from hospital.

KPMG were unable to provide assurance on the Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways at the end of their reporting period. The Trust has two routes for receiving referral letters. Eighty percent of referrals are received by the Trust through an electronic referral system, Choose and Book. This system automatically records the date the referral letter is received by the Trust. The remaining twenty percent of referrals are received in traditional paper form. Part of the Trust's data recording process for paper communications is that they are date stamped to indicate the date received. In the sample of 50 patient records checked by KPMG five letters had not been date stamped confirming date of receipt, one letter had been stamped with two consecutive dates. The requirement to data stamp referral letters will be reinforced to all staff and will be monitored to ensure on-going compliance.

Review of Effectiveness

As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS foundation trust who have responsibility for the development and maintenance of the internal

control framework. I have drawn on the content of the quality report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee, Internal Audit, External Audit and the Head of Governance. The system of internal control is regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement are put in place.

The processes applied in maintaining and reviewing the effectiveness of the system of control includes:

- The maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on corporate risk
- Review of the Board Assurance Framework and receipt of Internal and External Audit reports to the Audit Committee
- Personal input into the controls and risk management processes from all Executive Directors, Senior Managers and clinicians
- The review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion which states that significant assurance can be given, that there is a sound system of internal control and that controls are generally being applied
- Evidence gathering for core Care Quality Commission regulations and registration
- The quarterly Intelligent Monitoring Reports produced by the Care Quality Commission
- Self-assessment against the Care Quality Commission's Essential Standards for Quality and Safety (reviewed by internal audit)
- Self-assessment against Monitor's Code of Compliance and Monitor's Governance Framework
- Performance monitoring by the Board of Directors of the Trust's strategy and operational milestones to achieve internal and external targets
- Results of the national patient and staff survey results and development of targeted action plans
- Delivery of the health and safety action plan
- The Trust's compliance with the Hygiene Code
- The Trust's unconditional registration with the CQC
- Safe Staffing Reviews

My review of the effectiveness of the system of internal control has been presented and approved by the Board of Directors. The Board of Directors and the Audit and Governance Committees have been kept informed of progress against action plans throughout the year.

Conclusion

There are no significant internal control issues I wish to report in respect of 2014/15.

Signed:



Angela Pedder OBE
Chief Executive

Date: 27 May 2015

Quality Governance Reporting

We have put in place a rigorous approach to governing the quality of our services. More details about these arrangements are included in our Quality Report as well as in the Annual Governance Statement (page 47 of this Report).

There are no material inconsistencies between the Annual Governance Statement, Board statements required by the Risk Assessment Framework, the Quality Report and the Annual Report.

The Board, through its sub-committees, regularly reviews the effectiveness of the Trust's system of internal controls.

Board Assurance Framework

The Board Assurance Framework (BAF) is a Board-owned document whose primary role is to inform the Board about the totality of risks or obstacles that may impede it from achieving its strategic objectives as outlines in the Trust's long-term Strategy document. The BAF also provides assurances that adequate controls are operating to reduce these risks to acceptable levels. Over the past two years the BAF has been on an evolutionary journey, in parallel with the redevelopment of the wider governance arrangements within the Trust. A review of the BAF by Internal Audit, undertaken in March 2015, declared *"It is our view that the overall assurance opinion on the design and operation of controls is Green"*.

Regulatory Ratings/CQC Reports and Response

Monitor assesses the performance of the Trust using key performance indicators, designated as Regulatory Ratings. There are two ratings:

- Continuity of Service Rating assessed 1, 2, 3 or 4 for each measure - the overall rating is the average of the two.
- Governance assessed on a scale of green, green/amber, amber, red.

Deriving the Continuity of Service Rating

The Continuity of Service Rating incorporates two common measures of financial robustness:

Liquidity: days of operating costs held in cash or cash equivalent forms, including wholly committed lines of credit available for drawdown and

Capital servicing capacity: the degree to which the organisation's general income covers its financial obligations.

Deriving the Governance Risk Rating

Monitor includes the following elements within the governance risk rating:

- Service performance
- Third party reports
- Failures to comply with board statements
- Annual Plan

Analysis

Quarter 1

One of the Monitor targets was not met for Quarter 1 resulting in Monitor giving a green governance rating.

- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (post breach re-allocation). The position for the quarter was 82.2% against a target of 85%

Quarter 2

Two of the Monitor targets were not met for Quarter 2 resulting in Monitor giving a green governance rating.

- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (post breach re-allocation). The position for the quarter was 81.1% against a target of 85%
- All cancers: 31-day wait from diagnosis to first treatment. The position for the quarter was 94.5% against a target of 96%

Quarter 3

Four of the Monitor targets were not met for Quarter 3 resulting in Monitor giving an under review governance rating.

- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (post breach re-allocation). The position for the quarter was 81.9% against a target of 85%
- All cancers: 31-day wait from diagnosis to first treatment. The position for the quarter was 93.7% against a target of 96%
- All cancers: 31-day wait for second or subsequent treatment, comprising surgery. The position for the quarter was 93.7% against a target of 94%

- Cancer: two week wait from referral to date first seen, comprising all urgent referrals (cancer suspected). The position for the quarter was 90.0% against a target of 93%

Quarter 4

Five of the Monitor targets were not met for Quarter 4 resulting in Monitor giving an under review governance rating.

- A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge. The position for the quarter was 93.8% against a target of 95%
- All cancers: 62-day wait for first treatment from urgent GP referral for suspected cancer (post breach re-allocation). The position for the quarter was 77.7% against a target of 85%
- All cancers: 31-day wait from diagnosis to first treatment. The position for the quarter was 88.4% against a target of 96%
- All cancers: 31-day wait for second or subsequent treatment, comprising surgery. The position for the quarter was 85.5% against a target of 94%
- Cancer: two week wait from referral to date first seen, comprising all urgent referrals (cancer suspected). The position for the quarter was 88.7% against a target of 93%

2014/15	Annual Plan	Q1	Q2	Q3	Q4
Continuity of service rating	3	3	3	3	TBC
Governance rating	Green	Green	Green	Green <i>Under review</i>	TBC

Disclosure to Auditors

So far as each Director is aware, there is no relevant audit information of which the RD&E's External Auditor is unaware. Each Director has taken all the steps that they ought to have taken as a Director in order to make themselves aware of any relevant audit information and to establish that the RD&E's External Auditor is aware of that information.

The Directors are aware of their responsibilities for preparing the accounts and are satisfied that they meet the requirements as reflected in the statement of Chief Executive's Responsibilities as the Accounting Officer at the RD&E. This can be found in the Annual Accounts for the RD&E. In summary, the accounts taken as a whole are fair, balanced and understandable and provide the information necessary for patients, Regulators and other stakeholders to assess the Trust's performance, business model and strategy.

Our Governors and Members

Council of Governors

The Trust's Council of Governors (CoG) remains an integral component of the RD&E's governance structure providing a real connection between the Trust and its members and wider community.

During 2014/15, the Council has continued to develop its joint roles of holding the Board of Directors accountable and representing the views of members and the wider public to the Trust. The Council plays a significant role because, as a result of its statutory duties and that individual Governors are elected, it has genuine influence over the Trust at a number of levels. Over the last few years, the Trust has supported the Council in developing its role and ensuring that it has the means and capacity to carry out its various duties effectively and with purpose. At the same time, the Trust has been mindful that the Council is an elected representative voluntary body that has a distinct role separate to that of the Board of Directors.

As reported last year, the clarification of Governors statutory roles by the Health & Social Care Act 2012 has helped focus Governors contribution to the working of the Trust. The Council has also continued to establish a positive, though not overly cosy, relationship with the Board as befits its role. Non-Executive Directors regularly attend CoG meetings for informal face to face encounters as well as more formally representing some of the work they are responsible for. A regular rota of Governors attending the public Board meetings has also gone some way to enabling the Governors to see the Board 'in practice' as well as help provide intelligence that individual Governors have used in contributing to the performance assessment of individual Non-Executive Directors.

The Trust has an "Engagement Policy" agreed between the CoG and the Board of Directors to help manage situations in which the Council's concerns about the performance of the Board of Directors or the welfare of the NHS Foundation Trust, have not been resolved through the normal channels. This policy was not required at any time during the year. In addition, the Senior Independent Director acts as an independent facilitator through which concerns about the Board or the Chairman can be managed if appropriate. This facility was not required during the year.

The Board and the CoG met on two occasions. The two bodies met as part of a joint development day to discuss the Trust's strategy as well as to hold informal discussion sessions on matters of mutual interest. The two bodies also met earlier in the year at the annual formal meeting between the two bodies where Governors heard and discussed updates from the Board on strategy; on transforming community services; on the Trust's financial position and from individual NEDs on their portfolios.

The CoG has continued to organise itself through three key working groups:

- CoG effectiveness
- Patient safety and quality
- Member and public engagement

These groups are responsible for identified elements of the agreed consolidated CoG business plan and to provide a Governor perspective on key issues within the groups' remit (i.e. they do not undertake executive functions that are the remit of the Trust).

The groups have a Chair and a Committee membership but are open to any member of CoG that wishes to participate. The Project Groups are accountable directly to the CoG and the Chairs report on progress and outcomes to every CoG meeting.

The Governor's Coordinating Committee, which is comprised of the Trust Chairman, the Lead Governor (and Deputy), the Chairs of the three working groups, a staff governor representative and secretariat staff, meets every quarter and focuses on coordinating the work of the CoG and ensuring that progress is being made against the business plan and facilitating cooperation between the CoG and the Board of Directors.

The work programmes of each of the working groups is amalgamated into a single CoG business plan which is overseen by the Coordinating Committee to ensure that Governor priorities and plans are kept on track.

In addition, three Governors sit on the Trust's Patient Engagement Group representing the views of Governors, members and the wider public.

During the last year, these groups have been busy implementing programmes of work linked to Governor's key roles and stated priorities and the details of the work of these Groups can be found in the Council's papers and minutes on the Trust website.

The following section sets out some of the key highlights for each of these groups over the year:

CoG Effectiveness of CoG Working Group

CoG Effectiveness Review

This group led the self-assessment process undertaken in 2014/15 for Governors individually and for CoG as a whole. Inspired by the use of the Trust's approach to patient engagement, the Group decided to use the same formula - "What works well, even better if..." to gather views on good practice and ideas for improvements. The

self-assessment outcomes and the actions taken to focus on improvements include improvements in the induction offered to new Governor's, and in planning ahead for Governor Development days.

Governors Reference File and Other Documents

The group reviewed and made necessary changes to update a wide range of documents and policies throughout the year. This was a major undertaking and a significant achievement. The group met on six occasions to discuss and agree updates to the Trust Constitution (a tidy up), the CoG Coordinating Committee terms of reference (ToR), Working Groups ToR, CoG Rules of Procedure, Members Meetings Rules of Procedure, and the Governors' Code of Conduct. The Group is also currently reviewing election/new Governor Information in time for the 2015 round of elections. In addition this group monitored Governor attendance at CoG meetings and reported any findings to the CoG Coordinating Committee for action as necessary.

Member and Public Engagement Working Group

This group exists to develop and implement the Trust's membership strategy and to contribute to the Trust's work on wider stakeholder and public engagement. Over the course of the year the group took a number of new initiatives as well as updated the membership plan. Highlights include:

Medicine for Members

A number of events in which Trust members can hear at first hand from clinicians at the RD&E about some of the new and innovative approaches to healthcare were held.

Links to the Wider Community

A number of efforts were made during the year to link to schools and leisure activities to promote membership and wider engagement. Three Governors are joining forces to consider how best to engage with community groups in Budleigh and Cullompton.

Hospital Radio

Throughout the year the Trust Hospital radio held interviews with Governors to interest listeners in the work of Governors and to encourage patients to sign up as members.

Membership Survey

A good response (30%) was received to this survey which was sent by email to members for whom the Trust holds these details. The survey asked Members about their experience of outpatients and what improvements they would like to see. This survey – and the follow-on discussion on Outpatient Services at the Members Say event in September 2014 helped to shape the Trust's thinking and approach to reforming Outpatient Services.

Recruitment

A new membership leaflet was produced and widely circulated. The Governors also held a number of sessions in Oasis Restaurant to encourage visitors and patients to consider becoming members. A membership recruitment stand was held at the Met Office in October 2014 which provided an opportunity for Governors to interest and recruit new members. Around fifty new members joined up as a result of this initiative.

Revised Membership Plan

The Group considered and agreed a new membership plan during the year aimed at promoting membership and recruiting new members as well as how engagement with members could be improved.

Patient Safety & Quality Working Group

This group focussed on Quality priorities for 2014/15 and also drafted the Governor comment included in the Quality Report. The Group has reviewed progress against the Indicators for 2014/15 – Hydration and Outpatients – and the information being supplied to CoG. It has also started work on selecting the quality priorities for 2015/16.

Nominations Committee

The Nominations Committee's schedule was less onerous than in previous years because it was not required to recruit any new Non-Executive Directors. Nevertheless it was involved in the revised NED appraisals process which it developed and agreed as well as being involved in assessing the outcomes from the process which were agreed at the October 2014 CoG meeting. As part of this process the Committee also appraised the Chairman and on the basis of this process proposed to the CoG that the Chairman be reappointed for a further three years. This was also agreed at the CoG meeting in October 2014.

Governor Training and Development

The role of Governor in a Foundation Trust (FT) is pivotal in representing the patient, public and staff viewpoints to FTs and holding the Boards of FTs accountable. To perform this role effectively, Governors as a whole need to be equipped to adequately carry out their duties to the best of their abilities. This is a Trust responsibility as set out in the NHS Act 2012 which clarifies that FTs must take steps to ensure that Governors have the skills and knowledge they require to undertake their role, but remaining mindful of their status as lay members of the Trust.

The RD&E already provides a range of training and development for Governors including:

- Induction/mentoring
- Development days
- Pre-CoG information sessions
- Sessions at the CoG
- Focus on the role of Governors
- Working Groups
- Engagement with the Board
- Liaison with other Governors at a national and regional level
- Public Board meetings
- Specific skills training (such as recruitment etc.)

During the year the Governors considered their training needs by undertaking a training need analysis. This was discussed at a CoG Development Day and priorities were identified. On the whole these priorities involved the requirement for additional knowledge or information as opposed to skills. Over the course of the year the main priority areas have been delivered at CoG Development Days or in the morning sessions in advance of CoG meetings. Those areas that have not yet been delivered are programmed into a timeline during the coming year.

Challenges of Providing Training and Capacity Building

An effective CoG that has the capacity and abilities to carry out its collective roles successfully is critically important to the functioning of the Foundation Trust model. However, providing effective training to Governors is not straightforward and any package of training needs to take into account the following issues:

- Governors bring different experiences to the table. Some Governors have extensive experience of the NHS for example, while others have none

- Governors are democratically elected and this means that there is no basic competency test or hurdle for Governors to surmount before they put themselves up for election. The result of this is positive because it means that Governors have a clear democratic mandate; the challenge is that Governors cover a broad spectrum of skills, competencies and abilities
- The Governor role is at the complex end in comparison to many other voluntary roles. The combination of understanding a complex area like healthcare and making contributions at both a strategic level and at a level of feeding back experiential information is incredibly challenging for many. We have found in our experience that it takes some time for Governors to begin to get to grips with the role however effective their training, induction and capacity building
- Along similar lines, the conceptual role of the Governor is open to interpretation and it remains easy to think the role is something other than what it is. This can lead to Governors replicating the work of the Board or pursuing a particular agenda or issue
- Some of the specific roles that Governors have to perform are fairly specialised such as taking a view about the effectiveness of the auditors or on potential transactions with other NHS providers. In the past the fairly rapid turnover of Governors was problematic as Governors left after six years. This has been addressed to a degree by extending Governor terms of office but there remains on-going issue about ensuring there is a core group of Governors who have experience and have the time to ensure that their knowledge and experience is handed over to a more recently elected cohort
- Governors' core role is to represent the views of members and the wider public and to ensure that these views are transmitted to the Board. In building the capacity of Governors and encouraging more training, there is a need to guard against the overt professionalisation of Governors and to recognise that they continue to represent a fundamentally lay perspective.
- The Trust has sought to ensure that Governors have good information to enable them to carry out their roles effectively. However, it is apparent that rather less emphasis has been placed on skills development in the past and that is an area that we may now need to address

Life Cycle of Governors

In order to ascertain the collective training and capacity needs of Governors, we used a simple concept of the Governor life-cycle to identify the differing needs that Governors as a whole have at certain key points in their Governor career. In considering the training needs of

Governors, it is important to ascertain the desired minimum level of knowledge and skills that all Governors would ideally have at certain stages. However, as the CoG act as a collective entity, it is not necessary for all Governors to have the same levels of experience or competence in all areas. The aim would be to offer the opportunities for all Governors to meet these minimum standards but acknowledge that not all Governors have the desire, competencies or ability to meet the minimal level. In the discussions with Governors at a recent development day, Governors sought to identify the minimum level of skills and knowledge required at each of these key stages.

Meeting the minimum requirements for training and development however is only part of the process. In developing the effectiveness of Governors, there are other issues that require further consideration over the coming year including:

- The provision of specialist training for Governors on issues such as mergers and acquisitions or on interviewing for NEDs and the balance between providing this to individuals versus the collective responsibilities of the Council as a whole
- The development of an approach to Governor team effectiveness and cohesion
- External changes in guidance, legislation or the external environment may impact on the future provision of governor training and development
- Better understanding of individual Governors existing skills, experiences and knowledge is required to ensure that they can be deployed appropriately
- There is a need to give further thought to continuity of expertise and handover to Governors.

Governor Profiles

East Devon, Dorset, Somerset and the Rest of England Governors 2015

Kay Foster

Kay was elected in September 2014 for a term of three years. Kay lives in Exmouth.

Kay is a retired State Registered Nurse and Midwife with over thirty years nursing experience. She held a Sisters post at the RD&E in ITU and CCU and also served in the Queen Alexandra's Royal Army Nursing Corp.

Kay is a member of the Patient Safety and Quality Group and she has worked with a number of staff in the clinical area, on observation and information projects at the RD&E.

Jill Gladstone

Jill lives in Otterton. Her varied nursing career included acute and emergency medicine, clinical audit and nursing adviser to the Health Service Ombudsman.

Jill was first elected in 2008 and re-elected for a further three year term in 2011 and 2014. Jill is a member of the Patient Safety and Quality working group as well as the Nominations Committee.

Alan Murdoch

Alan was elected in September 2014 so is in his first term as a Governor. Alan spent seventeen years in the RAF followed by employment in the electronics and scientific instruments industries before retiring as a Director with a Multinational company. Alan lives in Exmouth.

Barbara Roberts

Barbara is a retired State Registered Nurse, and State Certified Midwife. Following training in Guildford, and practice in England, she worked in Canada. On her return to England, Barbara trained as a Registered District Nurse, and then pursued management as a District Nursing Officer before retiring after 30 years nursing. Barbara, who lives in Sidmouth, was elected for a term of three years in September 2013.

Linda Vijeh

Linda has wide-ranging experience in the public, charitable and private sectors as a professional standards consultant, journalist and PR.

In addition to being a School Governor, a District and County Councillor, Linda is a keen Rotarian, a member of Taunton & Somerset Samaritans Committee, and a Trustee of Chard Museum. She is also active with the Somerset in Care Council and Somerset Rural Youth Project, where she is a board member.

Living in Somerset for over 25 years, Linda was first elected in 2009 and re-elected in 2012. She is a member of the Nominations Committee, the NED Remuneration Committee and the Patient Experience Committee, in addition to currently chairing the Member and Public Engagement Committee.

Lynne Wright

Lynne's background is in business management and public relations, she has a teachers' certificate in art pottery, and before moving to Devon served on the committees of two local charities and has also been secretary to the League of Friends of a cottage hospital.

She is a member of the 'Member and Public Engagement Group', is involved in the 'Frail and Older People Project' which looks at the needs of this group of patients including those with dementia and their carers. She also takes part in the 'Patient Led Assessment of the Care Environment' (PLACE) annual inspection of the hospital.

First elected in September 2010 Lynne was re-elected in 2013.

Exeter and South Devon Governors 2015

Keith Broderick

Keith is an accountant who took early retirement from the public sector in 2005. He lives in Exeter and was re-elected in 2011 and again in 2014. Keith is Chair of the CoG Effectiveness and Audit Working Groups and is a member of the CoG Coordinating Committee.

Geoff Barr

Geoff taught politics and other social studies at Exeter College for many years; however, he has now moved on to teach at the Open University and University of Exeter Medical School. He is an active member of the St Leonard's Practice Patient Participation Group and the practice research team. Alongside this Geoff is an active member of Keep Our NHS Public and 38 degrees. He is a member of Left Unity. Geoff was elected in 2013.

Kate Caldwell OBE

Kate was Director of Midwifery and Deputy Director of Nursing at the RD&E until 2002. Kate was a Non-Executive Director of Exeter Primary Care Trust (PCT) until 2006. She is also a trustee of Exeter Municipal Charities.

Kate was first elected in 2007, and re-elected in 2010 and again in 2013. Kate sits on the Nominations Committee and is the Treasurer of the League of Friends at the RD&E.

Tony Ducker

Tony was elected in September 2014 for a term of three years.

Tony spent his career in the NHS, including twenty-two years as a Consultant Neonatal Paediatrician in Kent. He served on various hospital and regional committees including a National Institute for Health and Care Excellence (NICE) guideline group. Since retirement Tony has worked with Clinical Commissioning Groups (CCGs) as Lead Clinician for the appraisal of neonatal units in East of England and South West England. Tony retired to South Devon 10 years ago.

Molly Holmes

Molly was elected in September 2014 for a term of three years.

Molly is a freelance consultant specialising in housing, health and supported living. Molly previously held posts of Non-Executive Director with Devon PCT and Torbay Care Trust. She was also Head of Partnerships with a national housing association. Molly lives in Exeter

Richard May

Richard, who lives in Exeter, is a chartered civil engineer, and latterly ran a waste management company providing a range of waste management services within Exeter and the surrounding areas. Richard was re-elected in September 2012 and was re-elected by the Council as Lead Governor in July 2013. He sits on the CoG Coordinating Committee as well as the Nominations Committee and Non-Executive Director Remuneration Committee.

Rachel McInnes

Rachel is a scientist who works in climate research at the Met Office. Originally from Scotland, she has lived in Exeter since 2009. Rachel was elected for a term of three years in September 2013, and sits on the Nominations Committee.

Mid, North, West Devon and Cornwall Governors 2015

James Bradley

James was elected in September 2014 for a term of three years.

James was a Chartered Environmental Health Officer who, having completed a military career, has worked in Local Government, the National Health Service and finally as an international consultant. He is vice chair of his local Patient Participation Group and a lay patient representative for the Mid Devon sub locality of the Eastern locality for NEW Devon CCG. He is a member of the CoG Effectiveness, Patient Safety and Quality and Membership & Public Engagement working groups.

James lives with his wife and cat in Okehampton.

Dianah Pritchett-Farrell

Dianah is a retired University Lecturer, Examiner, Quality Standards Assessor and Senior Probation Officer. She is an International Assessor for the General Social Care Council for Social Work, and a Parish Councillor.

Dianah lives near Crediton and has been a Governor since 2008 and was elected Chair of the National Foundation Trust Governors Association in 2011. Dianah is a member of the CoG Coordinating Committee, the Nominations Committee and is Deputy Lead Governor.

Anne Stobart

Anne was elected as a Governor in September 2012 for a term of three years. She has lived in Mid-Devon since 1990. Anne has taught in adult education, colleges and universities for over thirty years.

Anne has clinical, research and management experience in complementary health sciences, most recently in the School of Health and Social Sciences at Middlesex University and she retired from there in August 2010.

Christopher Wilde

Christopher was elected in September 2014 for a one year term.

Christopher has been an owner of a general dental practice, as well as a Managing Director of a limited company specialising in dental material research. Christopher was Chairman of a government-sponsored group (SW-Smart) of research companies. Christopher lives in Tiverton.

Staff Governors 2015

Paul Bedford

Paul was elected in September 2014 for a term of three years.

Paul has nearly thirty years NHS experience with fifteen years in finance and the remainder in Information Services, with eleven years at the RD&E. His work involves providing information for the RD&E's Safety Thermometer and supporting Child and Women's Health services. Paul's previous voluntary experience includes being a Treasurer for Salisbury League of Friends.

Hazel Hedicker

Hazel is a Project Manager, within the Transformation Team, having held several roles at the RD&E and within the NHS.

Hazel was elected for a term of three years in 2013.

Loveday Varian

Loveday has worked for the NHS as a hospital-based medical secretary for the past 30 years. She has worked at the RD&E for the last eleven years as a medical secretary within the renal team.

Loveday was first elected in 2009 and re-elected in 2012.

Alison Wootton

Alison is the Assistant Director of Nursing for Medical Services. She has been a nurse for nearly thirty years. Alison lives in Exeter with her family.

Alison was elected for a three year term in 2011 and re-elected in 2014.

Election Results

The following Governors were elected at the annual elections in 2014.

Public Governors

East Devon, Dorset, Somerset & the Rest of England (42.5% turnout)

- Jill Gladstone re-elected for a term of 3 years
- Kay Foster elected for a term of 3 years
- Alan Murdoch elected for a term of 3 years

Exeter & South Devon (34.1% turnout)

- Keith Broderick re-elected for a term of 3 years
- Tony Ducker elected for a term of 3 years
- Molly Holmes elected for a term of 3 years

Mid, North, West Devon & Cornwall

- James Bradley elected uncontested for a term of 3 years
- Christopher Wilde elected uncontested for a term of 1 year

Staff

- Alison Wootton re-elected uncontested for a term of 3 years
- Paul Bedford elected for a term of 3 years
- Helen Hooper elected for a term of 3 years

The Board confirms that all elections to the Council of Governors are held in accordance with the election rules as stated in the Constitution.

Governors can be contacted via email at rde-tr.foundationtrust@nhs.net

The Governors' Register of Interests is available for inspection from the Trust Secretary (01392 404551) or on the Trust website.

Summary of Attendance of Governors at CoG for 2014/15

Attendance at Council of Governor meetings from April 2014 onwards. Governors currently in post.

Date of meeting Name of Governor	Apr-14		Jul-14		Sep-14	Annual Members Meeting	Oct-14		Jan-15	
	Public	Conf	Public	Conf	Extraordinary confidential CoG meeting		Public	Conf	Public	Conf
Barr, Geoff ^	P	P	P	P	P	P	P	P	P	P
Bedford, Paul	*	*	*	*	*	P	P	P	P	P
Bradley, James	*	*	*	*	*	P	P	P	P	P
Broderick, Keith	P	P	P	P	P	P	P	P	P	P
Caldwell, Kate #	P	P	P	P	P	P	P	P	P	P
Ducker, Tony	*	*	*	*	*	P	P	P	P	P
Foster, Kay	*	*	*	*	*	P	A	A	P	P
Foxall, Peta	P	P	P	P	P	P	P	A	P	P
Gladstone, Jill #	P	P	P	P	P	P	P	P	P	P
Hedicker, Hazel #	P	P	A	A	P	P	P	P	P	A
Holmes, Molly	*	*	*	*	*	P	P	P	P	P
Leadbetter, Andrew	P	P	A	A	P	P	P	P	P	P
May, Richard # ^	A	A	P	P	P	P	P	P	P	P
McInnes, Rachel #	P	P	P	P	P	P	P	P	P	P
Murdoch, Alan	*	*	*	*	*	P	A	A	P	P
Pritchett-Farrell, Dianah #	P	P	P	P	P	P	A	A	P	P
Roberts, Barbara	P	P	P	P	P	P	P	P	A	A
Stobart, Anne	P	P	P	A	P	P	A	A	P	P
Varian, Loveday	A	A	P	P	A	A	P	P	P	P
Vijeh, Linda # ^	A	A	A	A	P	P	P	P	P	P
Wootton, Alison	P	P	P	P	A	A	P	P	P	P
Wilde, Christopher #	*	*	*	*	*	P	P	A	P	P
Wright, Lynne	P	P	P	P	P	P	P	P	P	P

Key:

*P - Present A - Apologies * Not in post*

indicates member of Nominations Committee

^ indicates member of Non-Executive Director Remuneration Committee

Other Governors in Post During the Year

- Vivien Dibling (until Sept 2014)
- David Giles (until Jan 2015)
- Helen Hooper (until Feb 2015)
- Rachel Jackson (until Sept 2014)
- Penny Lobb (until Sept 2014)
- Celia Powell (until Dec 2014)
- Cynthia Thornton (until Sept 2014)
- Ros Wade (until Sept 2014)

Our Members

Our Members

The Trust is a public benefit corporation that exists for the sole purpose of providing healthcare services to the population it serves. All Foundation Trusts are obliged, under statute, to have members. The Board of Directors are obliged to keep in touch with the opinions of members and the wider public as key stakeholders. Membership is a distinguishing feature of FTs which brings with it substantial benefits. As a membership organisation, the RD&E endeavours to reach out to inform members about what is happening at the Trust as well as listening to their concerns and opinions on service delivery, on how to improve patient experience and on influencing its longer term strategy.

About our Members

On the whole, the Trust's membership broadly reflects the average profile for the wider community served by the Trust. Key findings from an analysis undertaken of our members in comparison to the wider community showed that members are:

- Similar to the social-demographic groups found in our constituencies. The majority of members are, on the whole, comfortably well off
- Representative of the ethnic diversity within the wider public
- Are older than the general public served by the trust
- Marginally more likely to be female than males

For research purposes, engaging with members about their priorities, concerns and ideas for healthcare provides a "good enough" correlation with the broader community. This means that in our engagement with members, we can be confident that the views we hear can be said to be sufficiently overlapping to what members of the public generally would say. This provides a useful rationale for membership for Foundation Trusts.

Having a membership base allows a meaningful relationship to be developed between members and the Trust. Developing this engagement helps us to deepen our understanding of their views and opinions which we can correlate to the views of the wider community. Developing an on-going dialogue with members provides an opportunity for the Trust to develop its thinking, test ideas, and give members an overview of potential future strategic options which it can then engage with members on in a way that genuinely allows for influence and boundary setting (i.e. options which members would find unpalatable for example).

The on-going conversation with our members – expressed primarily through our Members' Say events, through surveys of members and in the feedback from Governors – is a very important aspect of the Trust's work that provides genuine added value in informing its work, whether that is in a relatively minor operational detail, potential service change, ways to improve services in the best interests of patients/public, or on bigger and more strategic issues. The feedback from the interactive activities and focus groups at Members Say helps provide an agenda for the Governors as well as providing insight into the views of members – and thus the public – for the Board of Directors.

This makes it even more important, therefore, that we have a membership base that corresponds ever more closely with the demographics of the broader population served by the Trust. Over the course of the year, a number of initiatives were undertaken to increase membership. However, over the last year, we have not made sufficient progress in encouraging a more diverse membership base in particular among those from a younger age range. Plans are afoot to try and address this issue during the coming year.

Members' Say

The Members Say events - in which around 200 Trust members are invited into the Trust for a day to hear from clinicians about key health-related topics as well as take part in interactive dialogue – remains the most significant way in which the Trust engages with its membership base. Members' Say events provide members with the opportunity to give voice to their views and influence the Trust in a number of different ways in line with the ethos of a public benefit corporation.

The model works well as a way of engaging a particular group of members and the outcomes of the activities and focus groups provides useful research data on the perceptions and views of members (and thus the public) on specific topics which can help inform and influence:

- Overall strategic direction of the Trust
- Strategic issues or "wicked" problems
- Service changes or improvements
- Experiential feedback and customer insight
- Lower level service changes or improvements

In considering the outcomes of the Members' Say events, it can be assumed that they represent the best possible interpretation of the broader views of the membership and thus the wider public and therefore provide a "good enough" basis for analysis.

The Members Say approach enables the Trust to identify, explore and understand the views, opinions, preconceptions and concerns of members on aspects of healthcare. As the profiling of our members on a range of indicators mirrors that of the wider population (being somewhat older and somewhat wealthier than the broader population), the views of members can be, with sufficient caveats, be seen as representing the broader views of the population serviced by the Trust.

In addition, Members' Say events provide part of the rationale for membership of the Trust: having the opportunity to attend an event is part of the benefits that being a member entails and holding such events demonstrates to existing and potential future members that membership means something and offers those that want it a way of becoming more actively engaged.

Members' Say, September 2014

Over 200 people attended this year's Members' Say event in the Research Innovation Learning and Development building on Saturday 27th September 2014. The annual event gives our Members the chance to have a say and contribute ideas and thoughts on our services. This year's theme focused on the future of healthcare and looked at how the RD&E is working hard to find new and more effective ways of providing good quality care, at the right time and in the right place.

Proceedings were kicked off with the 2014 Annual Members Meeting, where the Executive Team, including Chairman James Brent, Chief Executive Angela Pedder and Lead Governor Richard May, fed back an update on the Trust's progress throughout the year. The Trust's Annual Report and Accounts for 2013/14 were also presented, with copies of the 2013/14 Annual Report Summary being given out to attendees of the meeting.

The RD&E's ninth annual Members' Say then followed; an event designed to help us better understand the views and opinions of the communities we serve. The event included a range of interactive activities for Members, including the spending money challenge and the wish tree, as well as opportunities to give their feedback including focus groups and the 'Your Opinion Counts' survey.

There were two sets of focus groups – one set on Outpatient Services and another set on the Trust's reputation. The focus groups on Outpatients provided an opportunity to look in-depth at some of the answers given in the survey to test what lay behind the headlines. This discussion helped illuminate some of the earlier findings and influenced the

Trust's approach to a review of Outpatient Services. The focus group on the Trust's reputation undertook some prompted and unprompted discussion on the key factors that underpinned the RD&E's reputation which was helpful in helping the Trust to define its communications strategy.

Members also got an insight into work at the RD&E with 'Medicine for Members' talks on Early Supported Discharge for Stroke Patients and Safe and Compassionate Care for Frail Older People, as well as seminars on Compassionate Care and Clinical Research.

About eighty people attended the Clinical Research seminars. A number signed up to either participate in a research project or to join a lay steering committee. The majority were aware that we are a research-active hospital, but were very interested by the range of research questions that we were asking. Some patients had already participated in research and were vocal advocates of our work in the Q&A sessions.

The seminars on Compassionate Care updated members on the work done a year earlier on better understanding member perceptions about aspects of compassion. Members felt they had been listened to, that they had contributed and helped make a difference to the work the Trust has undertaken on compassion.

In between the sessions, Members could visit a range of information stands in the main foyer and talk to staff about their area of the Trust. These included stalls by our Parkinson's Nurse Specialists, Patient Services, the Infection Control Team, Health Watch Devon and Age UK. Visitors could get a check-up and advice in the Health Check Room, and the Glaucoma Bus was available in the car park for tours. Members also had the opportunity to meet their Governors representatives at a drop in session throughout the day.

Member and ex-Theatre Nurse Muriel Evans commented: "Today has been very interesting. I think people need to know all about your services, but it is a two way thing. We need to know how to look after the hospital as well as the hospital looking after us. You need a combination of the two to make healthcare better."

Margaret and Keith Evans have been Members since the Trust was founded, and this was their first Members' Say: "We have just come from the Medicine for Members lecture. We found it very informative and perhaps a look into the future of care for the elderly. It was useful to get feedback directly from medical staff, and some answers to questions that we have already been talking about."

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

ANNUAL ACCOUNTS

YEAR ENDED 31 MARCH 2015

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Statement of the Chief Executive's responsibilities as the Accounting Officer of the Royal Devon and Exeter NHS Foundation Trust

The National Health Service Act 2006 ("2006 Act") states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the NHS Foundation Trust Accounting Officer Memorandum issued by Monitor.

Under the 2006 Act, Monitor has directed the Royal Devon and Exeter NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis set out in the Accounts Direction. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Trust and of its income and expenditure, total recognised gains and losses and cash flows for the financial year.

In preparing the accounts, the Accounting Officer is required to comply with the requirements of the NHS Foundation Trust Annual Reporting Manual and in particular to:

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance: and
- prepare the financial statements on a going concern basis.

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable her to ensure that the accounts comply with requirements outlined in the above mentioned Act. The Accounting Officer is also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in Monitor's NHS Foundation Trust Accounting Officer Memorandum.

Signed:



Angela Pedder - Chief Executive

Date: 27 May 2015

INDEPENDENT AUDITOR'S REPORT TO THE COUNCIL OF GOVERNORS OF ROYAL DEVON AND EXETER NHS FOUNDATION TRUST ONLY

Opinions and conclusions arising from our audit

1 *Our opinion on the financial statements is unmodified*

We have audited the financial statements of Royal Devon and Exeter NHS Foundation Trust "the Trust" for the year ended 31 March 2015 set out on pages 8 to 33. In our opinion:

- The financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2015 and of the Trust's income and expenditure for the year then ended; and
- The financial statements have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15.

2 *Our assessment of risks of material misstatement*

In arriving at our audit opinion above on the financial statements the risks of material misstatement that had the greatest effect on our audit were as follow:

Valuation of land and buildings - £182 million

Refer to page 15 (accounting policy) and pages 26 to 28 (financial disclosures) and page 76 (Annual Report).

The risk: Land and buildings are required to be maintained at up to date estimates of year-end market value in existing use (EUV) for non-specialised property assets in operational use, and, for specialised assets where no market value is readily ascertainable, the depreciated replacement cost of a modern equivalent asset that has the same service potential as the existing property (MEAV). There is significant judgment involved in determining the appropriate basis (EUV or MEAV) for each asset according to the degree of specialisation, as well as over the assumptions made in arriving at the valuation and the condition of the asset. In particular the MEAV basis requires an assumption as to whether the replacement asset would be situated on the existing site or, if more appropriate, on an alternative site, with a potentially significant effect on the valuation.

An interim desk-top revaluation of all of the land and buildings, which did not involve the physical inspection of the assets, was undertaken by management using indices provided by the District Valuer at 31 March 2015. There is a high degree of judgement required in undertaking a desk-top revaluation, in particular relating to the assumptions made on the basis of use or condition of assets and the indices applied to the assets in order to assess potential increases or decreases in the valuation.

Our Response: In this area our audit procedures included:

- Assessing the competence, capability, objectivity and independence of District Valuer Services to provide relevant and appropriate indices for management to perform the interim desk-top revaluation exercise as at 31 March 2015;
- Critically assessing with the assistance of our own valuation specialist the appropriateness of the indices used within the interim desk-top valuation provided by the District Valuer;
- Considering those assets acquired or constructed during the year which were not subject to a desk-top valuation and challenging the judgement of management that the fair value of these assets was not significantly different from their initial cost;
- Challenging the bases and assumptions applied to individual assets by reference to property records held by the Trust, including the reconciliation of details provided for revalued assets to the fixed asset register and the benchmarking of indices applied to the revaluation with reference to third party data; and

- We also considered the adequacy of the Trust's disclosures about the key judgments and degree of estimation involved in arriving at the valuation and the related sensitivities.

NHS Income Recognition - £331 million

Refer to page 12 (accounting policy) and pages 21 to 22 (financial disclosures) and page 76 (Annual Report).

The risk: The main source of income for the Trust is the provision of healthcare services to the public under contracts with NHS commissioners, which makes up 83% of income from activities. The Trust participates in the national Agreement of Balances (AoB) exercise for the purpose of ensuring that intra-NHS balances are eliminated on the consolidation of the Department of Health's resource Accounts. The AoB exercise identifies mis-matches between receivable and payable balances recognised by the Trust and its commissioners, which will be resolved after the date of approval of these financial statements. For these financial statements the Trust identifies the specific cause, and accounts for the expected future resolution, of each individual difference. Mis-matches can occur for a number of reasons, but the most significant arise where:

- The Trust and commissioners record different accruals for completed periods of healthcare which have not yet been invoiced;
- Income relating to partially completed period of healthcare is apportioned across the financial years and the commissioners and the Trust make different apportionment assumptions; and
- There is a lack of agreement over proposed contract penalties for sub-standard performance.

Where there is a lack of agreement, mis-matches can also be classified as formal disputes and referred to NHS England Area Teams for resolution.

We do not consider NHS income to be at high risk of significant misstatement, or to be subject to a significant level of judgement. However, due to its materiality in the context of the financial statements as a whole NHS income is considered to be one of the areas which had the greatest effect on our overall audit strategy and allocation of resources in planning and completing our audit.

Our response: In this area our audit procedures included:

- Reconciling the income recorded in the financial statements to signed contracts with material commissioners and reviewing material variations agreed throughout the year to supporting activity, supported by explanations from the Trust;
- Assessing whether the Trust was in formal dispute or arbitration in relation to any material income balances and examining the supporting correspondence, including - if appropriate - any legal advice, for consistency with the treatment of these balances within the financial statements;
- Inspecting third party confirmations from commissioners, including the results of the AoB exercise with other NHS organisations and comparing the values disclosed within their financial statements to the values recorded in the Trust's financial statements; and
- Carrying out testing of a sample of invoices raised pre and post year end to determine whether income had been recognised in the appropriate period.

3 Our application of materiality and an overview of the scope of our audit

The materiality for the financial statements was set at £7.9 million, determined with reference to a benchmark of income from operations (of which it represents 2%). We consider income from operations to be a more stable benchmark for materiality than a surplus-related benchmark.

We report to the Audit Committee any uncorrected identified misstatements exceeding £0.25 million, in addition to other identified misstatements that warrant reporting on qualitative grounds.

Our audit of the Trust was undertaken to the materiality level specified above and was all performed at the Trust's head office in Exeter.

4 Our opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts is unmodified

In our opinion:

- The part of the Directors' Remuneration Report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2014/15; and
- The information given in the Strategic Report and the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

5 We have nothing to report in respect of the matters on which we are required to report by exception

Under ISAs (UK and Ireland) we are required to report to you if, based on the knowledge we acquired during our audit, we have identified other information in the Annual Report that contains a material inconsistency with either that knowledge or the financial statements, a material misstatement of fact, or that is otherwise misleading.

In particular, we are required to report to you if:

- We have identified material inconsistencies between the knowledge we acquired during our audit and the Directors' statement that they consider that the Annual Report and Accounts taken as a whole is fair, balanced and understandable and provides the information necessary for patients, regulators and other stakeholders to assess the Trust's performance, business model and strategy; or
- The Annual Report which includes the section on "Audit Committee" on page 76 does not appropriately address matters communicated by us to the Audit Committee.

Under the Audit Code for NHS Foundation Trusts we are required to report to you if in our opinion:

- The Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements; or
- The Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

We have nothing to report in respect of the above responsibilities.

Certificate of audit completion

We certify that we have completed the audit of the Accounts of Royal Devon and Exeter NHS Foundation Trust in accordance with the requirements of Chapter 5 of Part 2 of the National Health Service Act 2006 and the Audit Code for NHS Foundation Trusts issued by Monitor.

In accordance with paragraph 5.12 of the Audit Code, we report that, whilst we have issued a limited assurance opinion in relation to the content of the quality report and one of the mandated indicators (emergency readmissions within 28 days of discharge from hospital), we have not issued an opinion in relation to the Trust's other mandated indicator (referral to treatment - incomplete pathways).

Respective responsibilities of the Accounting Officer and Auditor

As described more fully in the Statement of Accounting Officer's Responsibilities on page 2 the accounting officer is responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the UK Ethical Standards for Auditors.

Scope of an audit of financial statements performed in accordance with ISAs (UK and Ireland)

A description of the scope of an audit of financial statements is provided on our website at www.kpmg.com/uk/auditscopeother2014. This report is made subject to important explanations regarding our responsibilities, as published on that website, which are incorporated into this report as if set out in full and should be read to provide an understanding of the purpose of this report, the work we have undertaken and the basis of our opinions.

The purpose of our audit work and to whom we owe our responsibilities

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Council of Governors of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.



Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor
Chartered Accountants
100 Temple Street, Bristol, BS1 6AG
28 May 2015

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2015 have been prepared by the Royal Devon and Exeter NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 in the form which Monitor has, with the approval of the Treasury, directed.

The Royal Devon and Exeter NHS Foundation Trust Annual Report and Accounts are presented to Parliament pursuant to Schedule 7, paragraph 25(4) of National Health Service Act 2006.

Signed:

A handwritten signature in black ink, appearing to read 'Angela Pedder', written in a cursive style.

Angela Pedder - Chief Executive

Date: 27 May 2015

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED
31 MARCH 2015

	Note	2014/15 £000	2013/14 £000
Income from activities	3	330,865	316,374
Other operating income	4	68,268	68,349
Operating income		399,133	384,723
Operating expenses - excluding property impairment charge	5	(403,751)	(381,293)
Property impairment charge	5 & 15.3	-	(5,316)
Operating (deficit)		(4,618)	(1,886)
Finance costs			
Finance income	10	114	142
Finance expense	11	(830)	(901)
PDC dividends payable		(5,884)	(5,782)
Net finance costs		(6,600)	(6,541)
(Deficit) for the year		(11,218)	(8,427)
Other comprehensive income			
Revaluation gains on property, plant and equipment		-	13,436
Total comprehensive (deficit) / surplus for the year		(11,218)	5,009

STATEMENT OF FINANCIAL POSITION AS AT
31 MARCH 2015

	Note	31 March 2015 £000	31 March 2014 £000
Non-current assets			
Intangible assets	14	1,226	1,008
Property, plant and equipment	15	206,235	209,089
Trade and other receivables	17	839	772
Total non-current assets		208,300	210,869
Current assets			
Inventories	16	8,025	6,713
Trade and other receivables	17	19,015	15,773
Cash and cash equivalents	21	27,367	38,420
		54,407	60,906
Current liabilities			
Trade and other payables	18	(30,846)	(29,075)
Borrowings	19	(1,271)	(1,270)
Provisions	20	(284)	(359)
Other liabilities	18	(2,377)	(1,517)
Total current liabilities		(34,778)	(32,221)
Total assets less current liabilities		227,929	239,554
Non-current liabilities			
Borrowings	19	(15,131)	(16,402)
Provisions	20	(376)	(374)
Total non-current liabilities		(15,507)	(16,776)
Total assets employed		212,422	222,778
Financed by taxpayers' equity			
Public dividend capital		151,792	150,930
Revaluation reserve		25,753	26,813
Income and expenditure reserve		34,877	45,035
Total taxpayers' equity		212,422	222,778

The notes on pages 12 to 33 form part of these accounts.

The Annual Accounts on pages 8 to 33 were approved by the Board of Directors on 27 May 2015 and signed on its behalf by :



Angela Pedder - Chief Executive

Date: 27 May 2015

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2015

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2013	149,736	15,597	51,242	216,575
Deficit for the year excluding property impairment charge	-	-	(3,111)	(3,111)
Property impairment charge	-	-	(5,316)	(5,316)
Revaluations - property	-	13,436	-	13,436
Transfer revaluation reserve element included in impairment charge	-	(1,949)	1,949	-
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(271)	271	-
Public dividend capital received	1,194	-	-	1,194
Taxpayers' equity at 31 March and 1 April 2014	150,930	26,813	45,035	222,778
Deficit for the year	-	-	(11,218)	(11,218)
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(1,060)	1,060	-
Public dividend capital received	862	-	-	862
Taxpayers' equity at 31 March 2015	151,792	25,753	34,877	212,422

Public dividend capital ("PDC")

PDC represents the excess of assets over liabilities at the time of establishment of the Trust. It also includes new PDC received to fund capital expenditure on schemes supported by the Department of Health central capital budgets. PDC has no fixed capital repayment period.

Revaluation reserve

The reserve reflects movements in the value of purchased property, plant and equipment and intangible assets as set out in the accounting policies.

Income and expenditure reserve

The reserve is the cumulative surplus / (deficit) made by the Trust since its inception. It is held in perpetuity and cannot be released to the Statement of Comprehensive Income.

CASH FLOW STATEMENT FOR THE YEAR ENDED
31 MARCH 2015

	Note	2014/15 £000	2013/14 £000
Cash flows from operating activities			
Operating deficit		(4,618)	(1,886)
Non-cash income and expense			
Depreciation and amortisation		11,712	11,572
Impairments		-	5,316
(Increase) / decrease in trade and other receivables		(3,371)	6,318
(Increase) in inventories		(1,312)	(2,254)
Increase / (decrease) in trade and other payables		1,798	(2,221)
Increase / (decrease) in other liabilities		860	(9,418)
(Decrease) / increase in provisions		(73)	116
Increase in tax liability payable		89	69
Loss / (gain) on disposal of property plant and equipment		31	(16)
Net cash generated from operations		<u>5,116</u>	<u>7,596</u>
Cash flows from investing activities			
Interest received		114	142
Purchase of intangible assets		(353)	(98)
Purchase of property, plant and equipment		(8,873)	(20,278)
Sale of property, plant and equipment		3	16,455
Net cash used in investing activities		<u>(9,109)</u>	<u>(3,779)</u>
Cash flows from financing activities			
PDC received		862	1,194
Loans repaid		(1,270)	(1,270)
Interest paid		(830)	(901)
PDC dividend paid		(5,822)	(5,653)
Net cash used in financing activities		<u>(7,060)</u>	<u>(6,630)</u>
(Decrease) in cash and cash equivalents		(11,053)	(2,813)
Cash and cash equivalents at 1 April		38,420	41,233
Cash and cash equivalents at 31 March	21	<u><u>27,367</u></u>	<u><u>38,420</u></u>

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

Monitor has directed that the accounts of the Trust shall meet the accounting requirements of the NHS Foundation Trust Annual Reporting Manual which shall be agreed with HM Treasury. Consequently, the accounts have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

The accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangibles assets, inventories at their value to the business by reference to their fair value.

Going concern

The Trust incurred a deficit of £11.2m for the year ending 31 March 2015. The Trust has prepared its annual plan for the year ending 31 March 2016, which includes a detailed cashflow forecast that provides assurance that the Trust will remain within their current facilities. The Directors have therefore a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they consider it appropriate to continue to adopt the going concern basis in preparing the accounts.

1.1 Income recognition

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services.

Revenue relating to patient care treatments (also known as spells) that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period. Where income is received for a specific activity which is to be delivered in the following financial year, that income is deferred.

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract, less the fair value of the asset.

1.2 Expenditure on employee benefits**Short-term employee benefits**

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the accounts to the extent that employees are permitted to carry forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as a defined contribution scheme.

Employers pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the Trust commits itself to the retirement, regardless of the method of payment.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.3 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

1.4 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance which are capable of being sold separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only where it is probable that future economic benefits will flow to, or service potential be provided to, the Trust and where the cost of the asset can be measured reliably.

Intangible assets are capitalised when they are capable of being used in the Trust's activities for more than one year and have a cost of at least £15,000.

Internally generated intangible assets

Internally generated goodwill, brands, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at fair value. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment (see note 1.5).

Amortisation and impairment

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

The carrying value of intangible assets is reviewed for impairment if events or changes in circumstances indicate the carrying value may not be recoverable.

Software

Software that is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Purchased computer software licences are capitalised as intangible assets where expenditure of at least £15,000 is incurred and amortised over the shorter of the term of the licence and their useful lives.

<u>Asset category</u>	<u>Useful life (years)</u>
Software licences	3 - 10

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Intangible assets (continued)

Research and development

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

- the project is technically feasible to the point of completion and will result in an intangible asset for sale or use;
- the Trust intends to complete the asset and sell or use it;
- the Trust has the ability to sell or use the asset;
- how the intangible asset will generate probable future economic or service delivery benefits, e.g. the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
- adequate financial, technical and other resources are available to the Trust to complete the development and sell or use the asset; and
- the Trust can measure reliably the expenses attributable to the asset during development.

Expenditure which does not meet the criteria for capitalisation is treated as an operating cost in the year in which it is incurred.

Where possible the Trust will disclose the total amount of research and development expenditure charged in the Statement of Comprehensive Income separately. However, where research and development activity cannot be separated from patient care activity it cannot be identified and is therefore not separately disclosed.

Other property, plant and equipment assets acquired for use in research and development are amortised over the life of the associated project.

1.5 Property, plant and equipment

Recognition

Property, plant and equipment are capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably and;
- has an individual cost of at least £15,000; or
- the items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £15,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up costs of a new building or on refurbishment, may also be "grouped" for capitalisation purposes.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Property, plant and equipment (continued)

Measurement and revaluation

All property, plant and equipment assets are measured initially at cost, representing the costs directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

Property assets

The fair value of land and buildings is determined by valuations carried out by professionally qualified valuers in accordance with the Royal Institute of Chartered Surveyors (RICS) Appraisal and Valuation Manual. The valuations are carried out primarily on the basis of depreciated replacement cost for specialised operational property based upon providing a modern equivalent asset. Existing use value is used for non-specialised operational property. For non-operational properties, including surplus land, the valuations are carried out at open market value. The frequency of revaluation is dependent upon changes in the fair value of property assets however, in line with Monitor's view, the frequency of property asset revaluations will be at least every five years.

Assets under construction are valued at cost and may subsequently be revalued by professional valuers when brought into use or when factors indicate that the value of the asset differs materially from its carrying value.

Non-property assets

For non-property assets the depreciated historical cost basis has been adopted as a proxy fair value. Non-property assets acquired up to 31 March 2008 were revalued through an annual uplift by the change in the value of the GDP deflator. These revalued assets are included in the non-property assets valuation, but further indexation of these assets has ceased.

Additional alternative open market value figures have only been supplied for operational assets scheduled for imminent closure and subsequent disposal.

Subsequent expenditure

Expenditure incurred after items of property, plant and equipment have been brought into operation, such as repairs and maintenance, is normally charged to the Statement of Comprehensive Income in the period in which it is incurred. In situations where it can be clearly demonstrated that the expenditure has resulted in an increase in the future economic benefits expected to be obtained from the use of an item of property, plant and equipment, and where the cost of an item can be measured reliably, the expenditure is capitalised as an additional cost of that asset or as a replacement.

Depreciation

Items of property, plant and equipment are depreciated on a straight-line basis over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits.

Useful lives are determined on a case by case basis. The typical lives for the following assets are:

<u>Asset category</u>	<u>Useful life (years)</u>
Freehold property - buildings	16 - 53
Freehold property - dwellings	32 - 37
Plant and machinery	4 - 20
Equipment - transport	5 - 7
Equipment - information technology	3 - 10
Equipment - furniture and fittings	5 - 10

Freehold land is considered to have an infinite life and is not depreciated.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Property, plant and equipment (continued)

The excess depreciation on revalued assets over the historical cost is released to the income and expenditure reserve. On disposal of an asset any remaining revaluation reserve balance is released to the income and expenditure reserve.

Impairment

The carrying values of property, plant and equipment assets are reviewed for impairment when events or changes in circumstances indicate their carrying value may not be recoverable.

Increases in asset values arising from revaluation are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, in which case they are recognised in operating income.

Decreases in asset values that are due to a loss of economic benefits or service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount to the lower of (i) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income.

1.6 Donated, government grant and other grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is recognised as income unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

1.7 Inventories and work in progress

Inventories and work in progress are valued at the lower of cost and net realisable value. Cost is determined using a first in, first out method.

Work in progress comprises goods in intermediate stages of production.

Provision is made where necessary for obsolete, slowing moving and defective inventories and work in progress.

1.8 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of the best estimate of the expenditure required to settle the obligation. The Trust uses HM Treasury's pension rate of 1.3% (2013/14 - 1.8%), in real terms, as the discount rate for early retirement and injury benefit provisions.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.8 Provisions (continued)****Clinical negligence costs**

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the Trust pays an annual contribution, which, in return, settles all clinical negligence claims. Although the NHSLA is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the Trust is disclosed at note 20. The provision relates to the excess payable on each of the Trust's cases administered by the NHSLA.

Non-clinical risk pooling

The Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the Trust pays an annual contribution to the NHSLA and in return receives assistance with the costs of claims arising. The annual membership contributions, and any 'excesses' payable in respect of particular claims are charged to operating expenses when the liability arises.

1.9 Value Added Tax

Most of the activities of the Trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable.

Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of non-current assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.10 Contingent liabilities

The Trust has contingent liabilities in respect of NHSLA legal claims arising in the normal course of activities. Where the transfer of economic liabilities in respect of legal claims is possible the Trust discloses the estimated value as a contingent liability in note 23.

1.11 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note, note 26, to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.12 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed regulation. By their nature they are items that ideally should not arise. They are therefore subject to specific control procedures compared with the generality of payments. They are divided into different categories, which govern the way the individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the Trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

The losses and special payments note is compiled directly from the losses and compensations register which reports on an accruals basis with the exception of provisions for future losses.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.13 Critical accounting estimates and judgements

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed.

Accounting judgement - Modern Equivalent Asset valuation

The majority of the Trust's estate is considered to be specialised assets as there is no open market for an acute hospital. The modern equivalent asset valuation is based on the assumption that any modern equivalent replacement hospital would be built on an alternative site within the Exeter locality.

Revisions to accounting estimates are recognised in the period in which the estimate is revised.

1.14 Leases

Operating leases

Where leases are regarded as operating leases and the rentals are charged to operating expenses on a straight-line basis over the term of the lease. Operating lease incentives received are added to the lease rentals and charged to operating expenses over the life of the lease.

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

1.15 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS trust, the Royal Devon and Exeter Healthcare NHS Trust. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

A charge, reflecting the forecast cost of capital utilised by the Trust, is paid over as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the Trust.

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and the average daily cash held with the Government Banking Service. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets in the pre-audit version of the accounts after adjusting for the average daily cash held within the Government Banking Service.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Financial instruments and financial liabilities

Recognition

Financial assets and financial liabilities which arise from contracts for the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements, are recognised when, and to the extent which, performance occurs i.e. when receipt or delivery of the goods or services is made.

All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition

All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership.

Financial liabilities are derecognised when the obligation is discharged, cancelled or expires.

Classification and measurement

Financial assets are categorised as 'loans and receivables'. Financial liabilities are classified as 'other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.16 Financial instruments and financial liabilities (continued)****Impairment of financial assets**

At the statement of financial position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision that is determined specifically on individual assets.

1.17 Corporation tax

The Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of an NHS foundation trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988). Accordingly, the FT is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the exemption is dis-applied then the FT has no corporation tax liability.

1.18 Consolidation of NHS charitable funds

The Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity. The Charity has not been consolidated within these annual accounts as the value of the Charity is low and consolidation into the Trust's accounts would have no material effect. Further information relating to transactions between the Trust and the Charity is disclosed in note 24.

2. Segmental analysis

The Chief Operating Decision Maker, who is responsible for the allocation of resources and the assessment of the performance of operating segments has been identified as the Trust's Board of Directors.

Throughout the financial year the Trust's Board of Directors received a monthly integrated performance report, that provided information against key standards and targets. The reports included financial performance information which has assisted the Board of Directors with their financial decisions. The monthly information provided to the Board of Directors has been similar to the primary statements within these accounts.

The Board of Directors received financial information at service line level. Note 2.1 provides details of the financial information reported by the operating segments.

NOTES TO THE ACCOUNTS

2.1 Segmental analysis (continued)

	Trust total				Reconciliation between segmental analysis and figures reported in SOCI		
	Surgical Services	Medical Services	Specialist Services	Corporate and other	SOCl balance	(Increase) / decrease to SOCI deficit	Note
	£000	£000	£000	£000	£000	£000	
NHS clinical income	111,763	110,347	102,408	5,307			
Non-patient income - staff	792	1,372	408	-			
RTA income	381	409	221	-			
Services provided	5,894	7,109	5,752	-			
Education income	5,782	5,668	2,345	-			
R&D income	5,880	10,068	1,630	-			
Non-patient income - other	4,803	5,959	4,797	10			
Total income *	135,295	140,932	117,561	5,317	399,247	(142)	[a]
<u>Pay costs</u>							
Medical staff	31,649	23,209	15,775	-			
Nursing staff	30,498	36,768	18,914	-			
Admin. staff	8,846	8,295	7,336	56			
AHP staff	7,381	8,829	10,955	-			
Other staff	3,088	3,577	1,649	36			
<u>Non-pay costs</u>							
Drugs	9,358	16,501	20,588	-			
Clinical supplies	19,001	13,798	13,879	-			
Non clinical supplies	1,579	1,771	614	-			
Other non-pay	10,490	13,167	7,079	879			
Total pay & non-pay expense *	121,890	125,915	96,789	971	410,465	64,900	[a] & [b]
Contribution	13,405	15,017	20,772	4,346			
Contribution %	9.9%	10.7%	17.7%	81.7%			
Overheads *	22,242	22,917	19,592	7			
[includes interest, depreciation, PDC and impairments]							
Net surplus / (deficit)	(8,837)	(7,900)	1,180	4,339	(11,218)	(64,758)	[b]
Net margin %	(6.5%)	(5.6%)	1.0%	81.6%			

* The segmental analysis discloses income and expenditure that is directly attributable at a service line level to a service line. The segmental analysis discloses expenditure that is not directly attributable at a service line level within overheads.

Note

[a] £114k finance income and £28k of other income is shown gross in the SOCI and net in the segmental analysis.

[b] Cost totalling £64,758k, which are not directly attributable at the service line level, have been allocated to overheads.

In the second quarter of 2013/14 the Trust delayed service line reporting until a new patient level costing system had been fully implemented. The new patient level costing system was fully implemented during the third quarter of 2014/15. Consequently segmental analysis was not provided to the Chief Operating Decision Maker for the year ended 31 March 2014 and as such no prior year comparatives are included.

NOTES TO THE ACCOUNTS

3. Income from activities

	2014/15 £000	2013/14 £000 * Restated	2013/14 £000
Elective income	80,878	82,446	82,455
Non-elective income	69,347	63,735	89,221
Outpatient income	51,784	51,118	57,139
Other NHS clinical income	116,662	107,352	75,836
A & E income	10,712	10,567	10,567
Private patient income	1,453	1,129	1,129
Other non-protected clinical income	29	27	27
	<u>330,865</u>	<u>316,374</u>	<u>316,374</u>
Income from commissioner requested services	329,383	315,218	315,218
Income from non-commissioner requested services	1,482	1,156	1,156
	<u>330,865</u>	<u>316,374</u>	<u>316,374</u>

* Changes to Monitor's guidance requires the Trust to disclose income received from maternity and critical care services within Other NHS clinical income. The prior year's comparatives have been restated as if prepared under the new guidance.

3.1 Income from activities - by source

	2014/15 £000	2013/14 £000
NHS foundation trusts	-	2
NHS trusts	136	195
CCGS and NHS England and Primary Care Trusts	327,663	313,818
Non-NHS - private patients	1,357	1,129
Non-NHS - overseas patients (non-reciprocal)	96	120
NHS injury scheme	1,011	647
Non-NHS - other	602	463
	<u>330,865</u>	<u>316,374</u>

NHS Injury Scheme income is subject to a provision for doubtful debts of 18.9% to reflect expected rates of collection based upon historical experience.

4. Other operating income

	2014/15 £000	2013/14 £000
Research and development	19,274	17,948
Education and training	13,517	12,939
Charitable and other contributions to expenditure	104	46
Non-patient care services to other bodies	23,465	26,511
Staff recharges	4,130	4,293
Profit on disposal of property	-	-
Profit on disposal of plant and equipment	4	29
Other	7,774	6,583
	<u>68,268</u>	<u>68,349</u>

Included within "Non-patient care services to other bodies" are laundry services, transport services, payroll services, IT services, finance services, estates services, pathology services, pharmacy services and drug sales totalling £12 million (2013/14 - £13 million).

Included within "Other income" above is catering income of £2.1 million, (2013/14 - £2 million), car parking income of £1.7 million (2013/14 - £1.6 million), nursery/crèche income of £1 million (2013/14 - £1 million), staff accommodation £0.6 million (2013/14 - £0.5 million).

NOTES TO THE ACCOUNTS

5. Operating expenses

	2014/15 £000	2013/14 £000
Services from other NHS foundation trusts	3,348	2,912
Services from NHS trusts	2,379	2,133
Services from other NHS bodies	656	1,443
Employee expenses - executive directors (see note 5.1)	876	1,018
Employee expenses - non-executive directors (see note 5.1)	149	140
Employee expenses - staff	237,285	223,643
Drug costs	46,690	40,404
Supplies and services - clinical (excluding drug costs)	45,314	41,007
Supplies and services - general	5,174	5,065
Establishment	2,290	2,039
Research and development - not included in employee expenses	14,016	12,874
Research and development - included in employee expenses (note 6.1)	4,091	4,085
Transport	1,272	1,465
Premises	14,159	15,236
Increase in bad debt provision	153	24
Depreciation	11,577	11,411
Amortisation of intangible assets	135	161
Impairments	-	5,316
Audit fees - statutory audit	79	80
Other auditors' remuneration	1	-
Clinical negligence	7,289	6,793
Losses, ex gratia and special payments	168	129
Loss on disposal of plant and equipment and intangibles	35	13
Other	6,615	9,218
	<u>403,751</u>	<u>386,609</u>
Operating expenses - excluding property impairment charge	403,751	381,293
Property impairment charge - note 15.3	-	5,316
	<u>403,751</u>	<u>386,609</u>

Included within "Other expenditure" above is consultancy costs of £1.5 million (2013/14 - £1.7 million), consultancy costs includes various services received in particular assisting with transforming future services to enable the Trust to operate more effectively and efficiently, academic health science network fees incurred by the Trust and proportionally recharged to other NHS Trusts, medical productivity review and report. Patient travel £1 million (2013/14 - £2.7 million), training courses and conferences £0.6 million (2013/14 - £0.7 million), operating lease expenditure £1.8 million (2013/14 £2 million).

The total employer's pension contributions are disclosed in note 6.1.

5.1 Directors' remuneration and other benefits

	2014/15 £000	2013/14 £000
Aggregate directors' remuneration	970	1,099
Employer's contribution to pension scheme	55	59
Total	<u>1,025</u>	<u>1,158</u>

In the year ended 31 March 2015 three directors accrued benefits under defined benefit pension schemes (2014 - six).

5.2 Other auditors' remuneration

The audit fee for the statutory audit including quality accounts in 2014/15 was £79,000 (2013/14 - £80,000 PricewaterhouseCoopers LLP (PwC)) including VAT not recoverable. This was the fee for an audit in accordance with the Audit Code issued by Monitor in March 2011. Fees of £1,000 (2013/14 - £nil) were incurred in respect of non-audit relating to VAT assurance services.

5.3 Auditors' liability

The Board of Governors appointed KPMG LLP as external auditors for the financial year ending 31 March 2015. The engagement letter signed on 8th December 2014, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million in the aggregate in respect of all services (2013/14 - £1 million and relates to the Trust's previous auditors PwC).

5.4 Operating leases

	2014/15 £000	2013/14 £000
Operating lease payments recognised in expenses	<u>1,833</u>	<u>1,983</u>

Lease expenditure relates to minimum lease payments and is charged to the Statement of Comprehensive Income in a straight line basis over the term of the lease.

Future aggregate minimum lease payments due under non-cancellable operating leases are as follows:

	2014/15			2013/14		
	Land and buildings £000	Other £000	Total £000	Land and buildings £000	Other £000	Total £000
No later than 1 year	452	328	780	452	331	783
Later than 1 year and no later than 5 years	923	74	997	1,145	223	1,368
Later than 5 years	<u>2,683</u>	<u>-</u>	<u>2,683</u>	<u>2,913</u>	<u>-</u>	<u>2,913</u>
	<u>4,058</u>	<u>402</u>	<u>4,460</u>	<u>4,510</u>	<u>554</u>	<u>5,064</u>

NOTES TO THE ACCOUNTS

6. Staff costs and numbers

6.1 Staff costs	2014/15	2013/14
	£000	£000
Salaries and wages	193,542	184,749
Social security costs	14,187	13,793
Employer contributions to NHSPA	22,378	21,695
Termination benefits	13	177
Agency and contract staff	12,132	8,332
	<u>242,252</u>	<u>228,746</u>
Analysed into operating expenses (note 5):		
Employee expenses staff	237,285	223,643
Employee expenses executive directors	876	1,018
Research and development	4,091	4,085
	<u>242,252</u>	<u>228,746</u>

6.2 Average number of persons employed including directors

	Permanent employees Number	Other employees Number	2014/15 Total Number	2013/14 Total Number
Medical and dental	660	-	660	649
Administration and estates	1,250	-	1,250	1,203
Healthcare assistants and other support staff	595	-	595	612
Nursing, midwifery and health visiting staff	2,264	-	2,264	2,169
Scientific, therapeutic and technical staff	756	-	756	737
Bank and agency staff	-	411	411	352
Total	<u>5,525</u>	<u>411</u>	<u>5,936</u>	<u>5,722</u>

6.3 Staff exit packages

Exit package cost	2014/15 Number	2014/15 £000	2013/14 Number	2013/14 £000
Less than £10,000	1	1	-	-
£10,000 to £25,000	1	12	1	10
£25,001 to £50,000	-	-	-	-
£50,001 to £100,000	-	-	1	59
£100,001 to £150,000	-	-	1	108
£150,001 to £250,000	-	-	-	-
Total number	<u>2</u>	<u>13</u>	<u>3</u>	<u>177</u>

Exit packages relate to staff voluntary redundancies and include employer's NIC.

7. Pensions

Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. It is not possible for the Trust to identify its share of the underlying assets and liabilities. Therefore, the scheme is accounted for a defined contribution scheme.

Employer pension cost contributions are charged to operating expenses as and when they become due.

The NHS Pension Scheme is subject to a full valuation every four years by the Government Actuary.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration was given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

Employer contribution rates are reviewed every four years following the scheme valuation, on advice from the Government Actuary. At the last valuation it was recommended that employer contribution rates should increase in 2015/16 from 14% to 14.3% of pensionable pay. During 2014/15 employees' pay contributions were tiered on scales from 5% to 13.3% of their pensionable pay.

8. Retirements due to ill-health

During 2014/15 there were 5 (2013/14 - 4) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £176,000 (2013/14 - £125,000). The cost of these ill-health retirements will be borne by the NHS Pensions Agency.

9. The late payment of commercial debts (Interest) Act 1998

In 2014/15 the Trust did not incur expenditure (2013/14 - £nil) arising from claims made under this legislation.

10. Finance income	2014/15	2013/14
	£000	£000
Interest on cash and cash equivalents	114	142
	<u>114</u>	<u>142</u>

NOTES TO THE ACCOUNTS

11. Finance expense	2014/15 £000	2013/14 £000
Loans from the Independent Trust Financing Facility	823	892
Unwinding of discount on provisions	7	9
Total	830	901

12. Better Payment Practice Code

	2014/15 Number	2014/15 £000	2013/14 Number	2013/14 £000
Total non-NHS trade invoices paid in the year	117,190	145,308	108,495	153,344
Total non-NHS trade invoices paid within target	112,267	132,637	104,794	143,754
Percentage of non-NHS trade invoices paid within target	95.80%	91.28%	96.59%	93.75%
Total NHS trade invoices paid in the year	2,778	35,543	3,406	28,217
Total NHS trade invoices paid within target	2,551	31,852	3,034	25,703
Percentage of NHS trade invoices paid within target	91.83%	89.62%	89.08%	91.09%

The Better Payment Practice Code requires the Trust to aim to pay all valid non-NHS invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

13. Losses and special payments	2014/15 Number	2014/15 Value £000	2013/14 Number	2013/14 Value £000
Losses:				
Cash losses	9	5	9	3
Bad debts and claims abandoned	51	52	82	3
Stores losses, including damage to buildings	23	66	20	44
Total losses	83	123	111	50
Special payments - Ex-gratia	86	46	91	79
Total losses and special payments	169	169	202	129

14. Intangible assets

14.1 Intangible assets at 31 March 2014

	Software licences £000
Fair value at 1 April 2013	2,386
Additions - purchased	98
Disposals	(79)
Fair value at 31 March 2014	2,405
Accumulated amortisation at 1 April 2013	1,315
Provided during the year	161
Eliminated on disposals	(79)
Accumulated amortisation at 31 March 2014	1,397
Net book value	
Purchased at 31 March 2014	1,008
Donated at 31 March 2014	-
Total at 31 March 2014	1,008

14.2 Intangible assets at 31 March 2015

Fair value at 1 April 2014	2,405
Additions - purchased	353
Disposals	(99)
Fair value at 31 March 2015	2,659
Accumulated amortisation at 1 April 2014	1,397
Provided during the year	135
Eliminated on disposals	(99)
Accumulated amortisation at 31 March 2015	1,433
Net book value	
Purchased at 31 March 2015	1,226
Donated at 31 March 2015	-
Total at 31 March 2015	1,226

NOTES TO THE ACCOUNTS

15. Property, plant and equipment

15.1 Property, plant and equipment at the statement of financial position date comprise the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2014	10,825	170,717	2,200	6,990	42,703	1,193	7,924	45	242,597
Additions - purchased	-	2,534	-	3,643	2,271	-	205	-	8,653
Additions - donated	-	52	-	-	52	-	-	-	104
Reclassifications	-	2,537	18	(5,865)	421	-	2,889	-	-
Disposals	-	-	-	-	(1,916)	(45)	(3,404)	-	(5,365)
Total at 31 March 2015	10,825	175,840	2,218	4,768	43,531	1,148	7,614	45	245,989
Accumulated depreciation at 1 April 2014	-	-	-	-	25,552	605	7,307	44	33,508
Provided during the year	-	6,737	95	-	3,767	158	819	1	11,577
Eliminated on disposals	-	-	-	-	(1,909)	(47)	(3,375)	-	(5,331)
Accumulated depreciation at 31 March 2015	-	6,737	95	-	27,410	716	4,751	45	39,754
Purchased at 31 March 2015	10,825	166,159	2,123	4,768	15,674	429	2,863	-	202,841
Donated at 31 March 2015	-	2,944	-	-	447	3	-	-	3,394
Total at 31 March 2015	10,825	169,103	2,123	4,768	16,121	432	2,863	-	206,235

There were no assets held under finance leases, hire purchase contracts or private finance initiative (PFI) at the statement of financial position date.

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NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

15.2 Property, plant and equipment at the prior year's statement of financial position date comprised the following elements:

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2013	15,765	145,921	2,300	26,460	40,188	1,136	8,033	45	239,848
Additions - purchased	-	1,930	-	13,617	3,936	-	47	-	19,530
Additions - donated	-	30	-	-	16	-	-	-	46
Reclassifications	-	30,471	-	(33,087)	2,194	57	365	-	-
Revaluation	(4,940)	6,895	(100)	-	(3,631)	-	(521)	-	1,855
Disposals	-	(14,530)	-	-	-	-	-	-	(18,682)
Total at 31 March 2014	10,825	170,717	2,200	6,990	42,703	1,193	7,924	45	242,597
Accumulated depreciation at 1 April 2013	-	-	-	-	23,410	449	6,703	43	30,605
Provided during the year	-	6,170	95	-	3,868	156	1,121	1	11,411
Impairments	5,050	266	-	-	-	-	-	-	5,316
Revaluation	(5,050)	(6,436)	(95)	-	-	-	-	-	(11,581)
Eliminated on disposals	-	-	-	-	(1,726)	-	(517)	-	(2,243)
Accumulated depreciation at 31 March 2014	-	-	-	-	25,552	605	7,307	44	33,508
Purchased at 31 March 2014	10,825	167,722	2,200	6,990	16,645	581	617	1	205,581
Donated at 31 March 2014	-	2,995	-	-	506	7	-	-	3,508
Total at 31 March 2014	10,825	170,717	2,200	6,990	17,151	588	617	1	209,089

There were no assets held under finance leases, hire purchase contracts or private finance initiative (PFI) at the statement of financial position date.

The Trust's land, buildings and dwellings were revalued as at 31 March 2014. The valuation was undertaken by the District Valuer, in accordance with International Financial Reporting Standards and also complies with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings that would give the same service potential as is provided by the actual estate that the Trust owns, note 15.3 provides further details.

NOTES TO THE ACCOUNTS

15. Property, plant and equipment (continued)

15.3 Impairment and revaluation of land, buildings and dwellings

The Trust's accounting policy requires a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. A full revaluation of the Trust's land and buildings was undertaken by professionally qualified valuers, in accordance with the Royal Institute of Chartered Surveyors valuation manual, as at the 31 March 2014 and was included within the Trust's year ended 31 March 2014 audited accounts. An evaluation of the fair value and assessment of the assumptions underpinning the modern equivalent asset valuation was undertaken as at 31 March 2015. From this evaluation and assessment it was calculated that the change in the fair value of the Trust's land and buildings was considered to be immaterial and the MEA valuation methodology was still appropriate. No revaluation adjustment is therefore required as at 31 March 2015. In 2013/14 there had been a net overall increase of £8.1m in the value of the Trust's Estate. A £5.3m impairment was incurred in 2013/14 and recorded in the property plant and equipment note 15.2 this was recognised as an impairment charged to the Statement of Comprehensive Income. An increase in value of £13.4m in 2013/14 was recognised within the revaluation reserve and was mainly due to a general rise in construction costs.

16. Inventories

16.1 Inventories held at year end

	31 March 2015	31 March 2014
	£000	£000
Drugs	2,203	1,740
Work in progress	79	91
Consumables	5,137	4,136
Energy	250	269
Inventories carried at fair value less costs to sell	356	477
Total inventories	8,025	6,713

16.2 Inventories recognised in expenses

	2014/15	2013/14
	£000	£000
Inventories recognised in expenses	60,847	55,522
Write-down of inventories recognised in expenses	66	44
Total inventories recognised in expenses	60,913	55,566

17. Trade and other receivables

	31 March 2015	31 March 2014
	£000	£000
Current		
NHS receivables	11,611	8,966
Non-NHS receivables	2,556	1,967
Provision for impaired receivables	(85)	(71)
Prepayments	2,930	2,580
Accrued income	1,155	1,158
Other receivables	161	183
PDC dividend receivable	282	344
VAT receivable	405	646
Total current trade and other receivables	19,015	15,773
Non-current		
Accrued income	839	772
Total trade and other receivables	19,854	16,545
Provision for impairment of receivables		
At 1 April	71	67
Increase in provision	153	24
Unused amounts reversed	(139)	(20)
At 31 March	85	71

The provision for impairment of receivables relates to specific receivables over 3 months old.

17.1 Analysis of impaired receivables

	31 March 2015	31 March 2014
	£000	£000
Ageing of impaired receivables		
Over three months	415	201

17.2 Ageing of non-impaired receivables

Up to three months	6,296	3,541
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NOTES TO THE ACCOUNTS

18. Current trade and other payables

	31 March 2015	31 March 2014
	£000	£000
NHS payables	3,390	3,932
Trade payables - capital	2,458	2,574
Other trade payables	4,856	2,858
Other taxes payable	4,556	4,467
Other payables	3,340	3,144
Accruals	12,246	12,100
	<u>30,846</u>	<u>29,075</u>
Other liabilities		
Other deferred income	<u>2,377</u>	<u>1,517</u>

19. Borrowings

	31 March 2015	31 March 2014
	£000	£000
Current		
Loans from Foundation Trust Financing Facility	<u>1,271</u>	<u>1,270</u>
Non-current		
Loans from Foundation Trust Financing Facility	<u>15,131</u>	<u>16,402</u>
Total borrowings	<u>16,402</u>	<u>17,672</u>
Amounts falling due within: -		
In one year or less by instalments	1,271	1,270
Between one and five years by instalments	5,082	5,084
Over five years by instalments	10,049	11,318
	<u>16,402</u>	<u>17,672</u>

Two loans are repayable to the Secretary of State for Health.

The first loan of £17 million, was entered into in the year ended 31 March 2006. It is a repayable over a 20 year period, ending 30 March 2026, by equal quarterly instalments. The interest rate of the loan is fixed at 4.55% per annum.

The second loan of £10 million, was entered into in the year ended 31 March 2007, and is repayable over a 25 year period, ending 30 March 2032, by equal quarterly instalments. The interest rate of the loan is fixed at 5.05% per annum.

20. Provisions

	Early retirements	Legal claims	Other	Total
	£000	£000	£000	£000
At 1 April 2014	125	333	275	733
Arising during the year	(3)	91	22	110
Utilised during the year	(10)	(55)	(15)	(80)
Reversed unused	-	(110)	-	(110)
Unwinding of discount	2	-	5	7
At 31 March 2015	<u>114</u>	<u>259</u>	<u>287</u>	<u>660</u>

Expected timing of cash flows:

	31 March 2015	31 March 2014
	£000	£000
In one year or less	284	359
Between one and five years	98	211
Over five years	278	163
	<u>660</u>	<u>733</u>

Legal claims relate to employee and public liability claims.

The "Other" category relates to injury benefit claims against the Trust.

Contingent liabilities relating to legal claims are shown in note 23.

The NHS Litigation Authority is carrying provisions as at 31 March 2015 in relation to Existing Liabilities Scheme and in relation to Clinical Negligence Scheme on behalf of the Trust of £63,408,000 (2014 - £43,777,000).

NOTES TO THE ACCOUNTS

21. Cash and cash equivalents

	31 March 2015 £000	31 March 2014 £000
At 1 April	38,420	41,233
Net change in the year	<u>(11,053)</u>	<u>(2,813)</u>
At 31 March	<u>27,367</u>	<u>38,420</u>
Broken down into:		
Cash at commercial banks and in hand	18	55
Cash with Government Banking Service	<u>27,349</u>	<u>38,365</u>
Cash and cash equivalents as in SoFP and Cash Flow Statement	<u>27,367</u>	<u>38,420</u>

Cash and cash equivalents represents cash in hand and deposits with any financial institution with a short term maturity period of three months or less from the date of the acquisition of the investment.

22. Capital commitments

Commitments under capital expenditure contracts, which relate to property, plant and equipment, at the statement of financial position date were £2,099,000 (2014 - £1,624,000).

23. Contingent liabilities

	31 March 2015 £000	31 March 2014 £000
Contingent NHSLA legal claims.	<u>-</u>	<u>-</u>

24. Related party transactions

The Trust is a public benefit corporation established under the NHS Act 2006. Monitor, the Regulator of NHS foundation trusts has the power to control the Trust within the meaning of IAS 27 'Consolidated and Separate Financial Statements' and therefore can be considered as the Trust's parent. Monitor does not prepare group accounts but does prepare separate NHS Foundation Trust Consolidated Accounts. The NHS Foundation Trust Consolidated Accounts are then included within the Whole of Government Accounts. Monitor is accountable to the Secretary of State for Health. The Trust's ultimate parent is therefore HM Government.

The Trust is under the common control of the Board of Directors.

Directors' remuneration and other benefits are disclosed within the operating expenditure, note 5.1.

NOTES TO THE ACCOUNTS

24. Related party transactions (continued)

The Royal Devon and Exeter NHS Foundation Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity ("Charity"), registered charity number 1061384, registered office Bowmoor House, Barrack Road, Exeter, EX2 5DW. The Charity's objective is for any charitable purpose and purposes relating to the National Health Service wholly or mainly for the Royal Devon and Exeter NHS Foundation Trust. The Trust has received during the year £58,000 (2013/14 - £58,000) revenue income and £104,000 (2013/14 - £46,000) capital contributions from the Charity. At 31 March 2015 the Trust was due £95,000 (2014 - £50,000) from the Charity. The Charity's most recent audited accounts were for the year ended 31 March 2014. The Charity held aggregated reserves of £1,422,000.

During the year the Royal Devon and Exeter NHS Foundation Trust has had a significant number of material transactions with the Department of Health ("DoH"), and with other entities for which the DoH is regarded as the parent of those entities. Income from activity - by source (note 3.1) and the operating expense (note 5) provides details of revenue transactions with those entities. Below are considered to be the significant material transactions.

	Income £000	Expenditure £000	Receivables £000	Payables £000
2014/15				
Department of Health (excludes PDC dividend)	18,549	32	3	0
Health Education England	13,618	-	2	87
NHS England (Includes Bristol North Somerset and South Gloucester LAT)	82,263	8	3,879	5
NHS North East West Devon CCG	219,333	499	3,617	2,487
NHS Somerset CCG	6,745	-	109	3
NHS South Devon and Torbay CCG	16,391	-	385	54
Northern Devon Healthcare NHS Trust	7,508	1,873	1,250	318
2013/14				
Department of Health (excludes PDC dividend)	16,561	359	63	58
Health Education England	13,305	-	-	-
NHS England (Includes Bristol North Somerset and South Gloucester LAT)	78,041	124	5,347	854
NHS North East West Devon CCG	211,070	1,627	-	2,371
NHS Somerset CCG	6,490	-	-	18
NHS South Devon and Torbay CCG	15,187	1	183	42
Northern Devon Healthcare NHS Trust	8,316	2,063	584	440

25. Financial instruments

A financial instrument is a contract that gives rise to both a financial asset in one entity and a financial liability or equity instrument in another entity. IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The financial assets and liabilities of the Trust are generated by day to day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Credit risk arises when the Trust is exposed to the risk that a party is unable to meet its obligation to the Trust in respect of financial assets due.

Financial assets mainly comprise monies due from clinical commissioning groups (CCG) and local area teams (LAT) for services rendered by the Trust in fulfilment of service agreements, and cash balances held on deposit. It is considered that financial assets due from these organisations pose a low credit risk as these entities are funded by HM Government.

A significant proportion of the Trust's cash balances are held on deposit with the Government Banking Service, and as such the credit risk on these balances is considered to be negligible.

Liquidity risk

Liquidity risk arises if the Trust is unable to meet its obligations arising from financial liabilities. The Trust's financial liabilities mainly arise from net operating costs, which are mainly incurred under legally binding annual service agreements with CCG and LAT, and liabilities incurred through expenditure on capital projects. Other liquidity risks are loans repayable to the Foundation Trust Financing Facility.

Income from contracted activities with CCG and LAT are based upon a nationally set tariff, which under Payment by Results is paid to the Trust in twelve monthly instalments throughout the year; any performance in excess of agreed targets is paid in accordance with the terms of the relevant contract. Payment by instalments allows the Trust to accurately forecast cash inflows and through the preparation and review of cash flow forecasts, as well as the controls in place governing the authorisation of expenditure, ensures that the Trust maintains sufficient funds to meet obligations as they fall due.

Market risk

Market risk arises when the Trust is exposed to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

NOTES TO THE ACCOUNTS

25. Financial instruments (continued)

Currency risk

The Trust receives income denominated in sterling. The Trust, on occasion, does enter in agreements to make payments in non-sterling denominated currencies. Non-sterling payments are principally short term liabilities and for non-significant amounts. Given this, the Trust does not consider that it is exposed to any material currency risk and therefore has elected not to hedge its exposure.

Interest rate risk

The Trust does not enter into contracts where cash flows are determined by the use of a variable interest rate.

Other price risk

The Trust enters into legally binding contracts with both its customers and suppliers that stipulate the price to be paid. As such it does not consider itself exposed to material other price risk.

25.1 Financial assets by category

	Loans and receivables £000
NHS receivables	8,966
Accrued income	1,930
Other receivables	2,079
Cash at bank and in hand	38,420
Total at 31 March 2014	<u>51,395</u>
NHS receivables	11,595
Accrued income	1,994
Other receivables	2,648
Cash at bank and in hand	27,367
Total at 31 March 2015	<u>43,604</u>

An analysis of any impairment of receivables is provided in note 17.1.

25.2 Financial liabilities by category

	Other financial liabilities £000
Borrowings	17,672
NHS payables	3,932
Other payables	6,002
Accruals	12,100
Capital payables	2,574
Provisions under contracts	733
Total at 31 March 2014	<u>43,013</u>
Borrowings	16,402
NHS payables	3,390
Other payables	8,196
Accruals	12,246
Capital payables	2,458
Provisions under contracts	660
Total at 31 March 2015	<u>43,352</u>

25.3 Fair value

For all of the financial assets and liabilities at 31 March 2015 and 31 March 2014 the fair value is equal to book value.

26. Third party assets

The Trust held £nil cash at bank and in hand at 31 March 2015 (2014 - £nil) relating to monies held on behalf of patients.

NOTES TO THE ACCOUNTS

27. Accounting standards issued and not adopted

The accounts have been prepared in accordance with the 2014/15 NHS Foundation Trust Annual Reporting Manual (FT ARM) issued by Monitor. The accounting policies contained in that manual follow International Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. Below is a list of recent standards issued but not yet adopted in the NHS. It is not known or it is reasonably estimated that when these accounting standards are adopted they will not materially affect the Trust's annual accounts.

IFRS 9 - Financial Instruments

IFRS 13 - Fair Value Measurement

IAS 19 (Amendment) - Employer Contributions to Defined Benefit Pension Schemes

IAS 36 (Amendment) - Recoverable Amount Disclosures

IFRIC 21 - Levies

Annual Improvements 2012

Annual Improvements 2013

Quality Report 2014/15

Royal Devon and Exeter NHS Foundation Trust



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Chief Executive's Introduction

As in previous reports, this year our annual Quality Report provides an honest and open assessment of the quality of services we provide as a Foundation Trust hospital to our members and the wider public we serve in Devon. Our report provides an overview of:

- The quality of our services over the last year and our performance
- Some of the achievements we have made during the year to build quality services
- The progress we have made against the priorities set out in last year's Quality Report
- Our priorities for the coming year

In addition, the report provides a commentary on our quality performance during the year from our Governors, our principal commissioners, Devon Health and Wellbeing Scrutiny Committee and Devon Healthwatch. The Quality Report is prepared in line with the requirements set out in the Quality Accounts legislation (part of the Health Act 2009) and Monitor's annual reporting guidance.

This is our seventh annual Quality Report. The Trust has always placed quality and safety at the heart of everything we do and it is interesting to look back over the last seven years to see the wide range of initiatives and projects undertaken to continually improve our performance. What strikes me, as I look back, is the ceaseless energy and commitment of our staff to strive to find better ways of improving safety and quality for our patients. This approach - the unwavering commitment to ever better quality care - sums up for me something important about our ethos as an organisation. The quality and safety of the services we provide to our patients is of paramount importance to us. In everything we do, quality and safety are the benchmarks against which we determine our priorities and are the principles which underpin the services we offer. All of our staff, in whatever job they have at every level, know that quality matters and each and every one plays an important role in making sure that these priorities are realised.

This report provides a number of examples where the Trust is working really hard to provide safe, quality care for patients delivered with courtesy and respect. I want to highlight a few of these examples because they help to illustrate some of the principles which underpin our approach to the quality of care.

I am confident that the overwhelming majority of patients who use our services have a positive experience. In the vast majority of cases people receive great care from a team of dedicated and professional clinicians backed up by an outstanding support team and they get the treatment and the outcomes they need. As an organisation we are really committed not just to achieving the right outcomes for our patients but also that we do this in a way that makes the experience as positive and stress-free as possible. In a demanding environment where operational pressures can impact on already busy staff, I know that how we communicate and interact with patients is really important. Based on feedback from patients, we get this right most of the time but I know that, on occasions, we do not always get this right.

In many cases patients will be nervous and uncomfortable in unfamiliar surroundings; they may be in pain or be really struggling to cope. In these situations the kind word, the gesture and compassionate and empathetic interaction can go a long way to putting people at ease. Over the year we have done some really exciting work to promote compassion as a core theme for both our clinical and non-clinical staff. We began by asking our members, patients and our staff about how you define compassion, how you measure it and whether it can be learned. Based on this feedback we have put together a programme of work designed to embed compassion in our work, in the types of people we recruit and how they are supported, and we have adopted a zero tolerance for staff that consistently fail to demonstrate compassion. This work was supplemented by the enthusiastic way we took up the campaign begun by Dr Kate Grainger, a Consultant based in Yorkshire who has terminal cancer, to remind NHS staff to introduce themselves and make a connection with patients they come into contact with. The "#hellomynameis" campaign has been a real success and one that we have used to encourage all of our staff to adopt when interacting with patients, relatives, carers and visitors. These small courtesies can go a long way to improving patient experience and to making often difficult situations more manageable. My view is that developing this connection with our patients in a friendly and accessible way is a hall mark of quality care.

The Gold Standards Framework (GSF) is a tool we have adopted to coordinate patients who are within the last year of their lives. The aim of this programme is straightforward: to develop an individualised approach that enables staff to truly understand the needs and wishes of the patients, carers and relatives. I am really delighted that two wards – Yarty and Yeo – have been accredited by the National GSF Centre for the approach they have taken. The RD&E is only one of two Trusts in the UK to be recognised for the improvement made to the quality and coordination of care and providing a bespoke approach

that genuinely meets the needs and wishes of patients at the end of their lives. This is a great example of how we are keen to take on and adopt new approaches and ideas and make them our own particularly where the outcomes are about real improvements in patient care. Developing approaches to care that place the patient at the centre is a cornerstone of our quality agenda and this is an excellent example of where getting things right for patients is really important.

The report provides a more detailed account of our work at the cutting edge of genomic technology and our success in becoming one of the first NHS Genomic Medicine Centres. This truly exciting and innovative new approach to medicine is one that will – over a relatively short time – begin to revolutionise the way that healthcare is designed and delivered. The potential for identifying and then targeting drugs at anomalies in people’s genes opens up a new world in which bespoke and individualised interventions that could fundamentally improve someone’s life chances will become a reality. One of the attributes that really marks out the RD&E as an acute hospital is that innovation, cutting edge new technologies and research is a core part of the offer we provide to patients and the wider community. This “value-added” component of our work is fundamental and helps drive our efforts to continuously reflect on and consider how we can improve the quality of care we provide.

Over the coming year our ceaseless approach to improving the quality of care will not waiver and, as this report outlines, we have exciting plans to enhance the quality of care by creating a sustainable, integrated and more personalised care system in Devon. Based on a modern IT system, we plan to develop new ways of enabling people to access care and manage this for themselves in a way that meets their individual needs and aspirations. We aim to lead a reformed system that enables people to help themselves and promote and protect their own wellbeing and in a way that assists them to live healthier lives. This focus, which takes us beyond the four walls of the hospital, is our next and important journey to enhance the quality of care.

Finally, on behalf of the Board as a whole, I want to express my thanks to our extraordinary staff and volunteers for their hard work and commitment during the year and their endeavours to ensure that quality and safety remain central.

To the best of my knowledge and belief, the information contained in this document is accurate and, on behalf of the Board, I am confident to stand by its contents.



Angela Pedder, OBE
Chief Executive

Progress on our 2014/15 Priorities

Governor Priorities

- Hydration
- Outpatient Experience

Hydration

Following a successful Nutrition and Hydration Awareness week in March 2014 the Council of Governors requested assurance that inpatients in this Trust had their hydration status assessed, their hydration priorities met and those requiring help or assistance with hydration are being identified.

How are Patients Assessed?

The new Hydration Policy launched in 2014 states that all inpatients will have their fluid balance measured in the first 24 hours in hospital. A new fluid chart is currently being trialled to facilitate more accurate recording and adherence to the Policy will be audited in 2015.

Currently there is not a national, peer reviewed dehydration risk assessment tool available to use in the acute setting. This Trust has seized this opportunity to develop one. Work is underway in association with the Clinical School to adapt and ratify GULP, a community dehydration risk screening tool used in Bedfordshire.

How are we Assured Our Patients' Priorities are Met?

The Care Quality Assessment Tool (CQAT) carried out regularly throughout the hospital questions and observes ward hydration practices. Identified hydration concerns are highlighted and addressed through this process.

The Nutrition Steering Group (NSG) reviews nutrition and hydration related incidents recorded on DATIX every six months. The introduction of the Hydration Policy driven through by the NSG in 2014 receives assurance through auditing that it is being adhered to.

How do we Identify Patients Who Require Help?

In 2014 the Trust introduced a smaller water jug to help and assist frail patients to help themselves to water more easily. We are planning to move to using red jug lids to alert nurses and other healthcare professionals that the patient has an identified hydration requirement. The red jug lids will link in with the Red Tray system which highlights assistance with eating is required.

How are the Care Teams Educated?

Nutrition and Hydration Matters in 2014 led to a monthly series of updates delivered to clinical staff by the Head of Nutrition and Dietetics and the Assistant Director of Nursing for Surgical Services. The training session included a review of the new hydration policy and changes to practice including the requirement to change water jugs two to three times daily and squash to be available for use on all wards to add to water to aid taste and increase hydration.

The Future Direction

- Nutrition and Hydration Week 2015 will focus on hydration. The Nutrition and Dietetics team will visit all wards during the course of the week, informing staff about recording of hydration by improving their knowledge of volume sizes in order to improve accuracy. Posters and information stands will be available for patients, staff and carers to be better aware of our hydration aims
- GULP, the dehydration risk assessment tool, to be ratified and nationally recognised in 2015
- Review the nil by mouth/pre-operative fluid management guidelines

Outpatient Experience

The aim of the Outpatient Redesign Project is to deliver services that meet the needs of our community. The starting point was to produce a vision of care, placing the patient at the centre, to shape what a good service should look like. The Outpatient Redesign Project was specifically designed not just to offer quick fixes to the current ways of delivering the service, but to offer a high quality, standardised long term pathway approach to delivering the services based upon our patients' needs.

The vision was designed as a result of the involvement of many people and groups: patients and carers with simple and complex needs who use the services, health professionals of all levels from all major clinical groups, who provide the services, as well as Trust staff and GPs and Primary Care Leaders who work to ensure patients have access to high quality specialist healthcare.

To give as many people as possible a voice, we held workshops, one to one sessions and engaged wider audiences through questionnaires and via social network sites. In total, nearly 1000 patients, carers and healthcare staff were involved in the design process.

This approach identified a number of general themes including communication, access, convenience, taking into account holistic needs, physical space and maintaining quality of life. Two themes cropped up consistently:

- The need to use technology to improve the way information is shared between those involved in someone's care, not least the patient or carer. Technology can be used to give people the opportunity to have much more control of their health and wellbeing
- The need to create a consistent way of delivering outpatient services, with a single accountable, and simple to understand, management structure. The current outpatients service is run in numerous areas and will benefit from reorganisation

The significant work undertaken in redesigning and redefining how we deliver outpatients has now been adopted by the Trust and is currently being woven into the main strategies that Trust has identified in order to deliver the Future Model of Care. The major Trust strategies that the outpatient work has been incorporated into include:

- **Integration:** A significant proportion of the future strategy for the Trust, and the local healthcare community, is in delivering a more integrated care package with our partners, including GPs, Social Care, Mental Health, Community and Voluntary Services. Outpatient services are one of the key elements and the work that we have done is underpinning the redesign of this aspect of care

- **Electronic Patient Record (EPR):** Having identified a preferred supplier, the Trust is currently working to evaluate the benefits of implementing an integrated healthcare system into the Trust and a decision is due at the end of April 2015. As part of the implementation of the EPR, a transformational redesign of pathways of care, using technology and its aids, will drive improvements in quality, safety and patient experience. The outpatient vision has been adopted and integrated into the complete redesign of delivering both outpatient care as we understand it today but also playing a major role in chronic health treatment and surveillance

In addition the Trust is considering a single management structure to ensure consistent, high quality outpatient services are delivered as identified as part of the work carried out during the Outpatient Redesign Project. This will ensure long term commitment to the goals, aspirations and needs set out in the vision that we have completed.

We have also identified an area where a lot of the principles can be piloted whilst the more major pieces of work described above can be completed. Work is underway to bring to life the vision for outpatients designed by patients, carers, healthcare professionals and the public at large. The West of England Eye Unit (WEEU) handles over 70,000 outpatient appointments per year (c20% of the Trust's total outpatient activity). As our community continues to age, appointments are expected to grow by 10-12% per year. Beginning in January 2015, we are working with WEEU's clinical and non-clinical leaders, Optometrists, patients and the Northern, Eastern & Western Devon Clinical Commissioning Group (NEW Devon CCG) as we seek to apply the principles from the vision, to improve services for our community and act as a test case for the redesign of outpatient services as a whole.

Progress on our 2014/15 Priorities

The Trust Priorities

- Integrated Care Exeter (ICE)
- #hellomynameis...
- Nursing, Midwifery and Allied Health Professions Vision
- Patient Safety Programme

Integrated Care Exeter (ICE)

During 2014/15 the ICE Board has developed a shared vision for a new model of care with a greater focus on population health and wellbeing. A jointly appointed Integration Development Director took up post in January 2015 and is working with partners on a three year delivery plan. The ICE Board has successfully secured a Government Transformation Challenge Award to support the delivery of the three year plan. Early pilots are underway testing out new voluntary sector roles, within health and care teams, aimed at giving people practical help after a hospital stay and helping others, referred from GPs to stay well and reconnect with their community.

Measures of success:

- People will tell us they have a better experience of care with services wrapped around their needs
- Care and support will feel more joined up than in the past and individuals will feel the system is more focussed on their personal needs
- More people will tell us their needs were understood and that they feel in control of their care
- Thirty people will have integrated personal commissioning plans
- Half as many people in the acute hospital experiencing a delayed transfer of care
- More people will experience a timely contact with a smaller number of people "in my living room"
- Five a day fewer unplanned hospital admissions
- Staff report higher levels of job satisfaction and satisfaction with the quality of care delivered

Pleased to meet you! – #hellomynameis...

Sometimes it is the little things that make all the difference. Saying hello and introducing yourself to patients, visitors and colleagues may seem like a simple thing to do, but saying it can have a big impact.

In July 2014 the Trust put its weight behind the #hellomynameis campaign aimed at encouraging all staff to remember these four little words when introducing themselves to patients, carers and visitors. The campaign aimed to remind staff to make a simple personal connection with people - just by saying hello and introducing themselves.

Trust Junior Doctors Olivia Jagger and Bethan Loveless played a central role in bringing the campaign to the Trust and were the driving forces behind a week of activities that saw over one thousand members of staff pledge their support.

They were inspired to take up the national campaign after hearing from its founder, Dr Kate Granger. Dr Granger is a Consultant in Elderly Care in Yorkshire with terminal cancer, who became frustrated with the number of staff who failed to introduce themselves during her time as a patient.

"It is not just about knowing someone's name, but it runs much deeper. It is about making a human connection, beginning a therapeutic relationship and building trust. In my mind it is the first rung on the ladder to providing compassionate care."

To promote the campaign, Bethan and Olivia, along with dozens of other Trust staff, helped to produce a series of videos with individuals explaining what #hellomynameis means to them. Staff also visited a stand in Oasis Restaurant to make their pledge and take a selfie photo with the campaign poster to share on Twitter. And to keep #hellomynameis at the top of the agenda, Bethan and Olivia visited Divisional Meetings and Care Matters training throughout the week, and also attended the new Junior Doctor Induction sessions.

Bethan said: *"Sometimes it is easy to think that you have introduced yourself to a patient when really you haven't. You don't have a lot of time as a Junior Doctor but this is a*

simple thing to do that can make a really positive impact. It's a small thing that doesn't take any time and costs nothing."

Olivia added: *"It is important that patients know we see them as individuals - that we value you as a person and not just a patient. Sometimes patients are letting you in on some really personal and challenging things and so it's important to humanise the situation."*

The message has since been included in the Trust's 'Values and Behaviours' and has been embedded into the Trust's new "orientation" day induction for all new staff. It has also received massive support on Twitter, using the #hellomynameis hashtag. Six months after its launch, the campaign was reignited at the national level. The Trust refreshed its campaign using the national momentum to encourage staff to use their name and make a pledge. A special film from Kate Granger thanking the Trust for its support and wishing us luck helped with the relaunch. Over the coming year the use of people's names when introducing themselves will be tracked through our Care Quality Assessment Tool (CQAT).

Nursing, Midwifery and Allied Health Professions Vision

We have continued to work on our three year strategy; most importantly we have kept up the momentum and continued to ensure that the work that has been put in place over the last two years has been maintained. Since 2013, there has been increased recognition, as described in the document "Hard Truths" (the Government's response to the Francis Inquiry), of the impact that nurses, midwives and therapists have on the experience of patients, carers and their families. The last year's achievements incorporate improvement in care planning, focus on leadership, ensuring staff with the right skills are in the right place, building on compassion and recognising staff.

Over the last year we have further improved how patients, families and staff participate in care by making improvements on how we plan care. The care plan describes the key elements of care that a patient requires; ensuring that this is done well is an important way of communicating the care to the patient, carer and family. To further enhance the skill of the nursing staff, a workshop was delivered to Matrons in August 2014, following on from which a resource pack was developed and shared with the remaining clinical teams.

To further build on this work we have ensured that students and those joining us from overseas have training sessions on care planning, to ensure that we continue to progress this important area. To make sure that the progress is sustained we have adapted our CQAT, so that we measure on a regular basis how well we do this.

Leadership

We fully recognise the contribution that effective leadership makes to the quality of care that our patients receive. Following on from the successful programme implemented in 2013, a further programme was developed and implemented for non-ward based Matrons and therapists. The programme was contributed to by our own senior staff including the Chairman and Chief Executive, who described the challenges of their roles and provided advice on how to be an effective leader. The programme has received excellent feedback and provided an opportunity to positively affect leadership behaviours in the future. An example of leadership in practice is detailed in the Clinical School section on page 7.

Staffing – the Right People, in the Right Place, at the Right Time

Over the last year we have responded to the Safe Staffing guidance produced by the National Institute of Clinical Excellence. This recommended a number of factors which need to be assessed at ward level to determine nurse and midwife staffing requirements throughout a 24 hour period.

The Trust has already implemented a bespoke tool which enables systematic assessment of how ill our patients are and how much care that they require. This information has been combined with specific nursing outcomes, detailed in the Ward to Board report, e.g. pressure ulcer rates, with the results from the CQAT, alongside which the Assistant Directors of Nursing apply professional judgement. Bringing all of this information together enables detailed scrutiny of the staffing levels to be made. To ensure that the process is robust we use a "star chamber" approach, whereby the Chief Nurse/Chief Operating Officer and the Deputy Chief Nurse/Midwife alongside the senior nursing and midwifery team, scrutinise the evidence and ensure that any proposals to adjust staffing levels are balanced. As a result of this approach, the following has been invested:

- £2.3 million in addition to investment last year to uplift the night and day time ward establishments across inpatient ward areas. This investment also included an additional Clinical Nurse Site Practitioner to support an improved Hospital at Night model that strengthens and enhances the delivery of patient safety and care and experience to our patients overnight
- The Medical Services Division has recruited a team of Band 2 nursing auxiliaries to support the requirement for specialising complex patients and reduce the reliance on agency staff

The skill of our staff has also been a key area of development. Over the last year we have ensured that we have defined the competency requirements of both our registered and unregistered staff. This has then been used

to develop a structured approach to supporting our newly registered staff, with a specific programme for those joining us from overseas. In addition we have ensured that all newly qualified staff are supported in clinical practice to acquire essential nursing skills. We have a similar approach for our unregistered staff supporting them in the achievement of a recognised Care Certificate.

Named Nurse and Consultant

The Francis Report made a number of recommendations on the need for there to be a named clinician who is accountable for a patient's care whilst they are in hospital. In addition, the Secretary of State for Health in England has supported the concept of having an accountable consultant and nurse with their "name over the bed". We have reviewed our local practice and whilst some areas already display "name over the bed", consistency will be achieved installing a board over every bed. Our League of Friends have kindly agreed to assist with the funding for this as it will help to improve the patient's experience; the order has been placed for these boards. They will be in use very shortly.

Compassion in Practice

Compassion was identified as a key strand of work for the continuation of the Nursing, Midwifery and Allied Health Professions Vision ahead of the subsequent national publications. We recognise that compassion is a core value and intrinsic to the behaviour of our staff. We wanted to understand what compassion meant to our staff, what stopped it from being given, and what it felt like when it was delivered. To explore this we worked with staff and patients and our Engagement Team to answer these questions; we then used this information to develop a new policy. The new policy recognises the fundamental importance of providing care within the boundaries of compassion, privacy and dignity. It sets out the expectation of the organisation in monitoring, delivering and promoting compassion, privacy and dignity. It provides a framework upon which patients, staff and the public can assess our performance. Plainly a policy alone will not ensure compassion. The policy sits alongside the Trust values, role modelling, leadership and culture.

The policy sets the framework, recognising that compassion has to be from the top, highlighting the importance of treating each other and our staff with kindness. Compassion is recognised as a core value and is used to inform our recruitment process. Staff will be assisted to develop their compassion skills, but there is zero tolerance for those who persistently lack this requisite skill. The work on compassion has been recognised and shortlisted for a national quality award.

Clinical School

The theme of compassion was built upon with the awards for the Clinical School. The Clinical School, a collaboration between the Trust and Plymouth University, was launched in 2014 to support nurses and midwives to develop ideas for changing practice and undertake research.

The Clinical School Nursing Awards required staff to demonstrate their innovative responses to issues raised in the Francis Report or the Chief Nurse's Compassion in Practice agenda. The four shortlisted candidates and their abstracts were:

- Cathy Allman – Compassionate Nursing at the RD&E
- Debbie Cheeseman – Observations of Care: I'm here but do you see me?
- Nigel Lawrence – Protecting and upholding the rights of patients with Treatment Escalation Plans and Resuscitation Records, when assessing mental capacity status
- Alex Moore – Reducing trolley time for Neck Of Femur (NOF) patients

The candidates presented their work to the judges, Chief Nurse/Chief Operating Officer Em Wilkinson-Brice and Deputy Chief Nurse/Midwife Tracey Reeves. Alex Moore, Charge Nurse from Durbin Ward, was announced the winner for his work on ensuring that patients who are admitted to the Emergency Department (ED) with a Neck of Femur (NOF) fracture are transferred onto a pressure relieving mattress (PRM) as soon as possible. In the past, patients with a NOF, who are often elderly and frail, had to wait on trollies whilst in ED which could be painful and put them at risk of pressure sores. Once they got to Durbin Ward they were transferred on to a PRM. However, thanks to the work of Alex and his team, and with the support of ED, there are now PRMs available in the ED so patients can be transferred within minutes of their arrival, improving the experience and outcomes for the patient.

Chief Nurse Em Wilkinson-Brice said, *"The Clinical School started as a little acorn earlier this year and we've got little oak trees growing already. These presentations show that nursing research is really important and compassion is a theme that is seen throughout; they remind me of why we do the job that we do. The reason we chose Alex as the winner is because he and his team were relentlessly focussed on removing a problem for patients and they demonstrated how leadership is important at every level. As his presentation showed - find a problem and stick with it until it is solved."*

Patient Safety Programme – Update

The Patient Safety Programme described how we intend to achieve reductions in harm and mortality and improve ward/department safety, improve patient experience and reliability of care as well as supporting and empowering our staff.

Mortality

We use one measure for mortality which adjusts our outcomes for the risk in our patient group. It compares the number of patients that would be expected to die, given the severity of their condition, when compared to national models against the number of patients who actually die. The Trust uses the Summary Hospital Mortality Indicator (SHMI). Since the introduction of SHMI our quarterly value has not been above the national average and out of the 13 quarters for which data is available five quarters have been better than expected.

Achievements:

- A reduction in weekend emergency mortality in the Medical Services Division following the introduction of Consultant board rounds at the weekends in nearly all the specialties
- No mortality outliers in elective/emergency care Trust-wide
- Development and testing of a real time electronic mortality review process to review all unexpected deaths which will go live in April 2015 to ensure lessons learnt are adopted more widely

Human Factors Training (Recognising the effects of teamwork, tasks, equipment, workforce, culture and organization of human behaviour and the ability to transfer this into clinical practice)

Through the revised Trust Induction Programme, over one thousand new clinical and non-clinical staff have received face to face interactive Human Factors Training. In addition, teams such as the Medical Emergency team that respond to all the cardiac and medical emergency calls have had bespoke training in the simulation suite to support their clinical skills and team work in these highly stressful situations. Work will continue to support this programme over the next year by training up to thirty Patient Safety Advocates to support our human factors training as well as delivering human factors training at ward level to improve medication safety.

Reducing Harm

The Trust has continued to perform well with compliance with the national NHS Safety Thermometer having reached the national target of over 95% for eight out of 12 months.

Paediatric Services and Maternity Services have also participated in the on-going national development of a Paediatric and Maternity Service Safety Thermometer.

Pressure ulcers, falls with harm, medication omissions and hospital acquired infections are examples of harm which can occur in a hospital setting. Harm is sub-optimal care which reaches the patient because of something we should, or did not, do. We have undertaken targeted work to reduce harm to our patients.

Skin Matters: Pressure Ulcer Reduction

Achievements:

- Over two years since a grade 4 pressure ulcer
- 40% reduction in grade 3 pressure ulcers
- 40% reduction in total pressure ulcers
- 23 wards /unit ward areas have not had a grade 3 pressure ulcer in over a year
- 85% of patients across the Trust receive full SKIN bundle care to reduce their risk of developing pressure ulcers

Sepsis

Each year in the United Kingdom around 65,000 people survive a life-threatening brush with sepsis (serious infection). The good news is that early recognition, rapid intervention using the Sepsis Six care pathway, and efficient referral to Critical Care teams where necessary will increase the number of people surviving and improve the quality of their lives. So what progress have we made at this Trust? Over the summer and winter months the ED, Acute Medical Unit, Paediatric and Acute Surgical teams have made some rapid improvements in implementing the Sepsis Six bundle in the department by use of a Sepsis Sticker and allocation of a "Sepsis nurse" on every shift and the use of a Sepsis Trolley in the Acute Medical Unit. In addition we have implemented a specific screening tool for all children presenting to the Paediatric Assessment Unit. For patients, this rapid assessment and treatment with antibiotics within an hour results in a better outcome.

Achievements:

- 85% of patients received the Sepsis Six bundle in the Emergency Department.
- All the Paediatric milestones required in the Sepsis CQUIN (Commissioning for Quality and Innovation) achieved.
- 37% reduction cardiac arrest calls Trust wide

Acute Kidney Injury (AKI)

Over two million people in the UK are already suffering from moderate to severe kidney disease (CKD), but it is estimated

a further one million people have kidney damage without knowing it. However, depending on the problem, early diagnosis and treatment can help slow down any further damage to the kidneys. Left unchecked, unfortunately CKD can lead to kidney failure which requires treatment by dialysis or a kidney transplant.

The Acute Kidney Injury team have been providing targeted education and support to eight ward areas where there have been the highest number of AKI flags. Each month on Safety Thermometer day they audit compliance with aspects of nursing and medical care which include screening for AKI, fluid intake, assessment and fluid chart management, screening for sepsis, medication review and appropriate investigation; this is known as the bundle approach. Compliance with all aspects of the bundle has now reached 56%. This is the first year we have measured this.

Think Glucose

The provision of consistent, effective and proactive inpatient care for people with diabetes is still inadequate in the NHS, leaving patients with a poor experience in terms of their diabetes treatment. National data confirms that, on average, a patient with diabetes spends longer in hospital than a patient without diabetes.

The Think Glucose programme provides a package of tried and tested products, learning and support to improve awareness and remove the obstacles to the treatment of patients with diabetes as a secondary diagnosis. Implementing an improved clinical pathway will improve the patient experience and the quality of their care.

Over the year the Diabetes Nurse Specialists have continued to publicise the key messages of Think Glucose through:

- Regular education sessions
- Making diabetes part of annual training for nurses in Medicine, Surgery and Orthopaedics
- Junior Doctor teaching for all foundation and medical core trainees
- Using the Communication Cells for driving improvement in relation to the Diabetes Triple Assessment

This involves assessing if the patient needs review by the inpatient diabetes team, has high risk feet (and needs review by the in-patient podiatrist) or needs review by a dietician.

Achievements:

- 60% of the triple assessments are now completed within 24 hours of admission
- 90% of the triple assessments are completed at some point during the hospital admission

Nutrition Matters

Please refer to page 3.

Junior Doctor Quality Improvement Academy (QI)

The Trust has supported a trainee-led QI Academy which was launched in Exeter under the leadership of the Medical Education Department. A Faculty was established consisting of enthusiastic trainees, senior clinicians and members of the Trust's Service Development Team. Over sixty Trainees, mostly Foundation doctors, attended the launch and suggested 17 QI projects, many of which would have a direct impact on improving patient safety.

Six months after the launch, a regional QI conference was organized to showcase the results of the local projects and other QI work in the region done by medical and non-medical staff. The key note speaker was Sir Mike Richards, Chief Inspector of Hospitals for the Care Quality Commission.

Six projects were presented as oral presentations and 30 as poster presentations, with prizes awarded for the best in each category. Several projects leading to improvements in patient safety were presented. These included:

- Improvement in communication with Phlebotomists to ensure there are no delays in taking blood for urgent tests required for safe patient management
- Doctors' Toolbox was set up to improve handover of information about roles and responsibilities when trainees rotate thereby reducing the well documented risk of errors which can occur when doctors rotate to new posts
- Improving the care of vascular access devices by producing a training video

The Junior Doctor Quality Improvement Academy was a shortlisted finalist in this year's prestigious Health Service Journal Awards.

Safe Discharge

As part of the GOOD Project (Good Outcomes on Discharge), the documentation to support discharging a patient from the Trust has been reviewed. The discharge checklist which includes key information to ensure that a patient is discharged safely was launched earlier in the year at an event which was attended by all the Ward Matrons and Senior Nursing Team, including the Chief Nurse/Chief Operating Officer. Compliance with the discharge checklist is monitored through the Trust's Safety Thermometer and results are shared with the ward team. There has been a reduction in serious incidents involving patient discharge following the introduction of the checklist. The GOOD project will continue and will focus on improving the discharge processes within the RD&E and in partnership with other partners in health and social care.

Medication on Discharge

To support nurses and enhance the quality of the information that patients and relatives receive in relation to medication on discharge, a nurse education package regarding medications on discharge has been completed and pharmacists are rolling this out to the inpatient wards.

Reducing Falls

Two inpatient wards have been part of a quality improvement initiative to improve inpatient falls with a network of other Foundation Trusts called NHS QUEST. The Matrons in the ward areas have been testing out new ideas to minimise the risk of patients falling. These include cohort bay nursing (ensuring a nurse is present at all times in the bay and is visible to patients at all times), undertaking a more structured approach to how care is organised at night, ('the perfect night shift') and a real time review of every patient that falls called SWARM which focuses in part on factors involving the ward environment. Championing these changes, the ward teams have seen a reduction in the variation of night time and day time incidents. The learning from this collaboration will be used as part of the 2015/16 Patient Safety Programme.

Medication Safety Thermometer

The Medication Safety Thermometer is a measurement tool for improvement that focuses on medication reconciliation, allergy status, medication omission, and identifying harm from high risk medicines such as insulin and warfarin.

The Medication Safety Thermometer follows a three step process in order to identify harm occurring from medication error. This includes data collection, review of harm and a safety huddle involving the nurses, doctor and ward pharmacist. Data is collected on one day each month, enabling wards, teams and organisations to understand the burden of medication error and harm, to measure improvement over time and to connect frontline teams to the issues of medication error and harm and make improvements to patient care over time. Five inpatient wards across the Trust have been involved in the national pilot, working with their ward pharmacists to make improvements in medication safety at ward level.

Improvements to Quality and Safety 2014/15

- Devon Garden and Memory Walk
- 100,000 Genomes Project
- End of Life Gold Standard Framework
- Living With and Beyond Cancer Project
- Integration Programme
- Accident and Emergency (A&E) Survey Results and National Cancer Survey Results

The Devon Garden and Memory Walk at the RD&E (Wonford)

The Dementia and Delirium Steering Group identified the priority of the provision of a garden space away from the clinical ward environment.

The aim was to design and build a therapeutic place for peaceful interaction between patients, their family and friends and hospital staff. The group also recognised the opportunity to create a place where patients could be assessed for cognitive levels and for mobility capacity in order to inform onward care.

Stephen Pettet-Smith, Arts Manager for the Trust and project lead, explains:

"The real breakthrough came with the announcement of the Department of Health's 'Improving the environment for people' challenge fund – which we gleefully bid for. The Trust also contributed charitable funds. The project is one of the national pilot schemes, and will now feature with seven other projects in a NHS England Building Note next year."

The key wards for dementia care are on the second floor of the hospital. Managing access for the patients was going to be an issue; the team turned this to an advantage by producing a Memory Walk along the route consisting of panels depicting a timeline of popular culture between the 1930s and 1980s.

The garden design takes inspiration from a village green and is planted in a cottage garden style. The 'Devon Banks' divide the space to promote privacy for families. The 'decades' incised seats echo the 'memory walk'.

The 'stories' telephone box uses technology to deliver stories of bygone times. The 'Tuneful' memories corner delivers popular music enabling patients' prime years to be recalled. The 'Cabinet of Scent', provides materials and objects, from coal tar soap to lavender, chosen to summon up memories.

The 'Pavilion' is a pleasant place to sit, however it is designed to become the stage for performing arts. A carefully designed and built feature naturally amplifies the sound of babbling water. Wrought iron seating continues the theme of village green.

100,000 Genomes Project - The Trust Leads the New South West Peninsula NHS Genomic Medicine Centre

In December 2012 the Prime Minister announced that the UK will sequence 100,000 genomes of patients with cancer or rare disease. The human genome is made up of 3 billion DNA bases (the "letters" of the genetic alphabet), organised into 20,000 genes that encode the proteins required to create and maintain life. DNA changes can cause rare diseases like cystic fibrosis and are also found in tumours. The aims of the project are to:

- Improve diagnosis of patients with rare disease
- Increase understanding of tumour biology to develop new targeted drug treatments
- Accelerate the uptake of genomic medicine in the NHS
- Stimulate and enhance UK industry and investment in genomics

Genomics England Ltd (<http://www.genomicsengland.co.uk/>) was set up by the Department of Health to deliver the project and in the autumn of 2014, NHS England led a procurement process to designate NHS Genomic Medicine Centres. These centres will be responsible for patient recruitment, provision of samples for sequencing/biobanking, validation and reporting of clinically relevant results.

An application to become one of the first NHS Genomic Medicine Centres was submitted by the Trust as the lead organisation for the South West Peninsula. The successful outcome provides recognition of Exeter's expertise in genomics, both within the Trust and University of Exeter Medical School, and the Trust's reputation as a leader in NHS transformation (https://medicine.exeter.ac.uk/news/title_427623_en.html). We will provide a total of 3,457 DNA samples for genome sequencing, receiving a payment of £200 per sample. The Academic Health Science Network will play a key role in co-ordination and sharing of innovation across the seven Trusts.

At the Trust treatment for patients with some forms of lung, colorectal and skin cancer is already guided by genetic testing of their tumours. The project will identify new genetic variants (variation between people's genes) that predict response to targeted drugs and lead to the development of new diagnostic tests and new cancer treatments. Some patients with rare diseases will receive a genetic diagnosis that explains the cause of their disease and informs other relatives as to their risk of developing the same disease. Ground-breaking research in Exeter by Professors Andrew Hattersley and Sian Ellard has identified genetic subtypes of diabetes that can be treated with tablets rather than insulin injections and this has changed the lives of patients throughout the world. The aim of the 100,000 Genomes Project is to diagnose and understand the cause of many other rare genetic diseases in order to improve treatment. In the longer term the expectation is that these results will fuel research discoveries and accelerate the implementation of genome sequencing as a diagnostic test.

The 100,000 Genomes Project is a hugely ambitious project that has not been undertaken on this scale anywhere else in the world. It will involve clinical staff across most medical specialties and pathology laboratories to process the blood and tumour samples. Genome sequencing of tumours processed using traditional methods is difficult and new methodologies will be developed to improve quality. Perhaps the biggest challenge is to provide the data informatics capability to obtain comprehensive details of each patient's disease and link this to their DNA sequence. The expectation is that this project will catalyse the development of improved electronic healthcare records and the Trust has been awarded £650,000 capital funding to facilitate this.

A key goal is to aid the implementation of genomic medicine in the NHS. This is challenging as most clinical staff have received very little genetics education and no training in genomics. New training resources to support the project are being developed by Health Education England (<http://www.genomicseducation.org.uk/>) and will be disseminated through the NHS Genomic Medicine Centres.

This is an exciting project and the South West Peninsula NHS Genomic Medicine Centre team looks forward to working with staff and patients throughout Devon, Cornwall and Somerset to deliver the vision of genomic medicine into the NHS.

End of Life Gold Standard Framework

The Trust has become one of only two acute hospitals in the UK to be recognised for the care they provide to patients who are nearing the end of their lives.

Two wards, Yeo and Yarty, and one at Royal Lancashire Infirmary, are the first to have been accredited by the National Gold Standards Framework Centre (GSF) for their end of life care.

The GSF is a tool used to co-ordinate and communicate care needs to patients who are within their last year of life. It has been used within the community and care home setting for many years but is a new initiative for acute hospital trusts. The two year programme, GSF Acute Hospitals Training, aims to enable the provision of integrated tailored care, by helping staff better understand the needs and wishes of patients. The framework accreditation empowers staff to provide the right care, in the right place for the right person at the right time.

Oncology ward Yeo and haematology ward Yarty have both demonstrated key improvements to the quality and coordination of care for patients, by facilitating early recognition of decline and offering advance care planning discussions to ensure it is in line with patient wishes. They have also improved the discharge process and reduced the length of patients' stay, where appropriate, enabling more people to live and die at home if they want to. Neil Toghill, Matron on Yarty Ward, said: *"I am very proud of my whole team in being awarded this accreditation. I feel our care and hard work for those patients in the end of life is second to none, and shows the multidisciplinary team are working together to ensure patient and family focused support and care."*

Representatives from the Trust received their award from Professor Sir Mike Richards, Chief Inspector of Hospitals at the Care Quality Commission, at an award ceremony on 27 March 2015 at the Royal College of Nursing.

The next steps include rolling out to five medical wards, ensuring all the tools are in place to support staff to deliver care in a sensitive compassionate manner and promoting the priorities of care for the patient and their loved ones.

Living with and Beyond Cancer Project - Partnership Working to Improve Patient Care and Transforming Patient Follow Up

With the number of people living with and beyond cancer increasing, their needs for managing their follow up care is also changing, with more now suitable for supported self-managed follow-up than ever before. In simple terms this means that from the point of diagnosis, we need to empower the patient by preparing them to self-manage, including: what to look out for, what support is available, early intervention, and how to re-access the acute service if they have concerns or symptoms of recurrence etc. Therefore, the Living with and beyond Cancer Project is all about the patient and how we continue to provide excellent care, whilst supporting their changing needs.

Based on stratifying treatment pathways into low, medium and high risk, the project provides a platform/tools to support the different approaches to follow up, or in many cases, discontinuation of follow up, using the National Cancer Survivorship Initiative (NCSI) Recovery Package.

With sponsorship from the NHS England Innovation Fund, together with support from FORCE (Friends of the Oncology and Radiotherapy Centre Exeter) and Macmillan, the tools being implemented include:

- A new Health & Wellbeing Clinic programme
- PSA (Prostate Specific Antigen) tracker remote monitoring system
- Electronic Holistic Needs Assessment (eHNA)
- Care planning and
- Treatment summaries

All support the patient to self-manage their follow up, keeping care closer to home, and patients in control and out of the acute service by avoiding unnecessary outpatient appointments; therefore enhancing patient experience and creating NHS capacity elsewhere.

To date we have received positive feedback from patients and their loved ones in the pilot areas and by working in partnership with the voluntary sector and primary care. The project will ensure we view the change across the entire pathway, including the wider healthcare community. This in turn will help ensure a seamless transition for the patient.

The building blocks for the project have now been developed and may be able to facilitate new ways of working in other chronic illnesses, as well as extending to all cancer sites. The project started in 2013 with the appointment of a Macmillan funded Project Manager. A phased approach was agreed to deliver the Recovery Package across all 12 cancer sites, starting with phase one: Breast, Colorectal, Skin and Urology cancer services. The progress achieved in phase one has now successfully secured further funding from Macmillan for an additional member of staff, together with funding for another two years for the Project Manager. Both posts will run concurrently and will help to accelerate the delivery of phase two and three.

From the outset, patient involvement and feedback has been integral to the project with patient representatives identified within each of the phase one sites and invited to attend all working group meetings. As users of the services, the patient representatives have shaped and influenced the project, for example, the Urology patient representative supported our grant application to the NHS England Innovation Fund, by highlighting the advantages to the patient to be remotely monitored and the impact that would have on his wellbeing. We were subsequently awarded the highest grant award possible for a single application.

Other feedback includes:

Patient comment from the Health & Wellbeing Clinic: *"After just one visit, I have met other people like me and now have information to support me through the months ahead. Thank you."*

Patient comment on the PSA Tracker: *"I am well and free from pain, my doctor pleased and cancer seems in remission, but I am particularly grateful for the PSA Tracker, to keep an eye on things."*

Patient comment on the Electronic Holistic Needs Assessments (eHNA): *"This is such a good idea, I feel better just doing this..."*

Once a full evaluation of phase one has been completed and any adjustments made on tools being implemented, the Recovery Package for phase two will start during May/June 2015 and will include Head & Neck, Lung, Haematology and Gynaecology cancer services, and potentially one or two other sites, subject to capacity.

There is also a series of planned communication events internally and externally, to raise awareness and inform stakeholders about the Recovery Package, including:

- Master Class for Senior Clinicians and their colleagues
- GP/Practice Manager Educational afternoon for all GP Practices within Exeter, East and Mid Devon
- Stall at key locations within the Trust such as Oasis and main reception to provide information about the Recovery Package
- Shared attendance with FORCE and Macmillan at community and public events, e.g. Devon County Show and local societies about the work we are doing, using the opportunity to promote greater discussion etc.

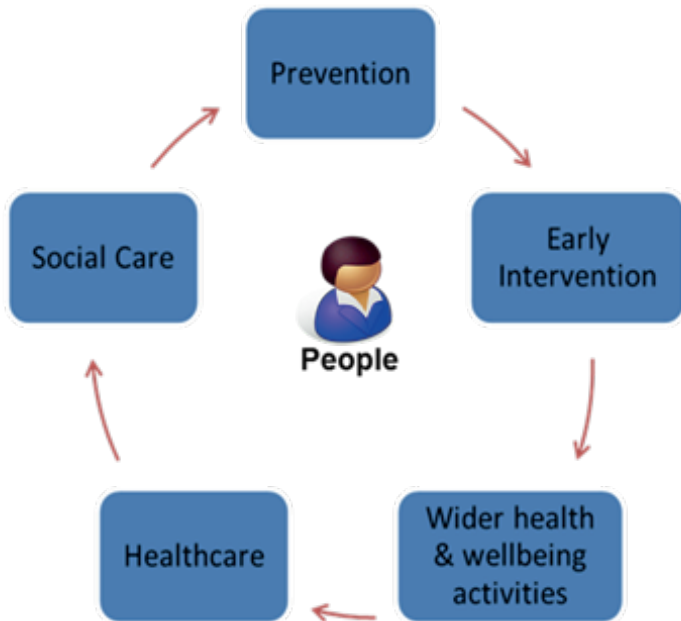
Finally, whilst mention has been made of the importance of our patient representatives' involvement within the project, the other key drivers for a successful outcome are our incredible staff, because without their engagement and willingness to pilot and accept change this project would not be possible.

Integration Programme

The Trust has an ambition to create a sustainable, integrated and personalised health and care system in Devon that uses modern IT to enable people to manage their own needs where they want, that helps them stay well and which gives them a greater say over their own care. The diagram overpage describes an integrated system of care which is built around the person and which has a lead organisation taking ultimate responsibility for the co-ordinated delivery of care.

Integrated System of Care

Our aim is for the Trust to take the lead in creating an effective, efficient and sustainable integrated system of care which, from the perspective of the individual (patient, relative or carer), is:



- Flexible, local and personalised
- Focussed on self-help and wellbeing
- Supportive of people living healthier lives in healthy communities

And where:

- Targeted resources follow need in a seamless way
- Our service offer is dynamic and sustainable
- Quality of care is continuously improved

Co-design with patients, carers and communities is a significant feature throughout our work to date and this will continue such that we will shift the focus from "patients" to "people", and from "What is the matter with you?" to "What matters to you?"

Care Design Group

Recognising Devon's unique complexity, frailty, ageing population and diverse geography, a Care Design Group has been established and 60 frontline staff spanning the whole health and care system (including voluntary sector organisations) came together in January 2015 to think about how services could be delivered differently in the future if all of the current health and care resources were combined.

In order to better help visualise and describe the kind of changes we need to build around individuals the Care Design Group used patient stories to think about how the future care of people could look with greater integration and co-ordination of a person's health and care needs. One example used was John's story:

John's Story

"John is 80 years old and lives alone in an upstairs flat in Exeter where he has lived for over 20 years. His wife died three years ago and his next of kin is his divorced daughter who lives in Basingstoke with two children. John lives with a heart and lung condition and mild to moderate dementia. He experiences recurrent falls and his mobility is declining. In addition, there are doubts about whether he is taking the medicines he needs reliably and is often reluctant to accept help. He has recently visited the Emergency Department (ED) at the local hospital."

By analysing and discussing John's story in detail the Care Design Group was able to describe a range of future services that would best meet John's care needs and personal goals. In the future John will be better helped to avoid a crisis and be supported to live independently in his own home through:

- **Better communication:** A coordinated team (GP, patch geriatrician, community nursing, third sector organisation) will be aware of John's care and his health needs.
- **Wellbeing:** John can participate more in community social activities and feel less 'lonely'.
- **Prevention:** John can attend classes at his local health and wellbeing hub helping him with strength training, falls prevention and nutritional advice.
- **Social Interaction:** He can visit the new café in the health and wellbeing hub as it is a chance to meet people with whom he has much in common and he can get a reasonably priced, healthy meal.

The proposed changes to community services will mean that John:

- Will get more support to do things himself.
- Will sit down with someone to set his own goals.
- Will have more carers.
- Will have all of his care co-ordinated in one place.
- Will be supported to remain at home or locally.

Model of Care

By using a variety of patient stories like John’s, the Care Design Group created a new framework “Model of Care” under which all new care models will be designed, tested and evaluated.

This new model of care focuses equally on wellness, prevention and ill health management, seeing patients as people, empowering them to be in control of their own care. While we recognise prevention is better than cure there is still a need to respond quickly and effectively to those patients who need urgent care, support and treatment.

The Care Design Group also identified some key infrastructure requirements that would need to be established in order to effectively and efficiently deliver these new models of care.

Further Care Design Groups are scheduled in 2015/16 to take this work on to the next level and identify some very real and practical models which can be rapidly piloted and tested for potential role out across the patch.

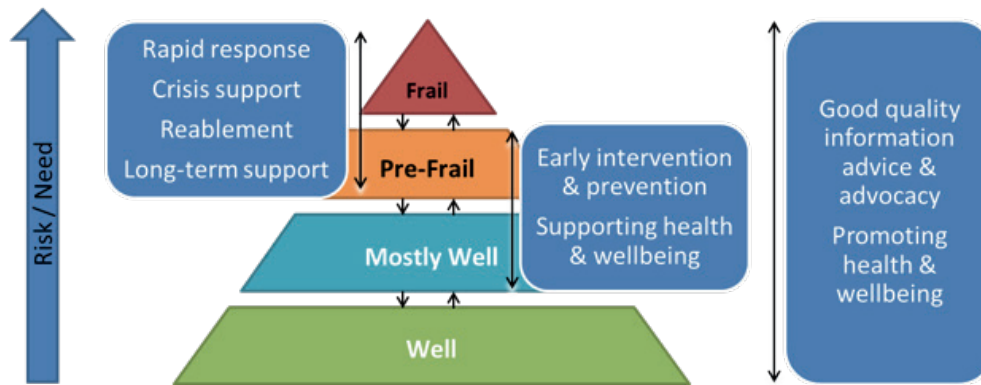
Transforming Community Services (TCS)

A key enabler to the Trust’s integration work is joining together the pathway for patients who move between the Trust and the community. In November 2014, the Trust was successful in being awarded preferred bidder status for the contract to provide community services for adults with complex care needs in the Eastern sector of Devon. This contract includes the provision:

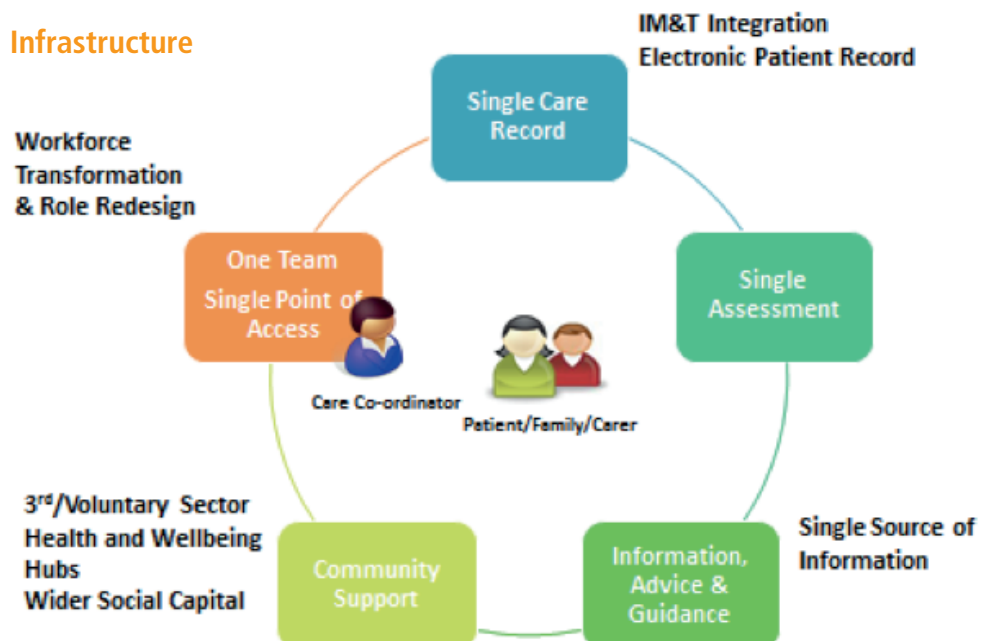
- Community hospitals
- Complex care teams
- Onward care teams
- Rapid response teams
- Community and district nursing
- Community therapy teams

As the Trust moves forward with the procurement of these services it will create a wealth of opportunity to integrate pathways of care between the hospital and the community setting in a seamless and more effective and efficient way.

New Model of Care Health and Care Interventions



Infrastructure



Accident and Emergency (A&E) Survey Results and National Cancer Survey Results

Over the last year we have received a number of National Survey results. Two survey results are featured to demonstrate the effectiveness of our services.

A&E

The national survey was undertaken between May and September 2014 and 850 patients that were seen during January, February and March 2014 were randomly selected. The national response rate was 34%, with our response rate being 41%. The overall conclusions from the results were that there were a large number of questions where there was an improvement between 2012 and 2014. Of 37 comparable questions, 30 scored higher this year than last, with 17 questions improved upon by at least 3%. The largest improvements were seen in relation to cleanliness of the department and privacy when discussing issues with the receptionist (up by 7%), whether patients felt that staff did everything to control pain and the availability of food and

drink saw even greater improvement (up to 11%). A local action plan has been developed to ensure that the work on improvement continues.

Cancer Patient Experience Programme

The survey included all adult patients with a primary diagnosis of cancer who had been admitted as an inpatient or as a day-case and had been discharged between the 1st September and the 30th November 2013. The national response rate was 64%; our response rate was 71%. Of those who responded, 94% rated their care as excellent or very good. Areas with continued improvement include: the input and role of the clinical nurse specialist, choice of treatment and involvement in decision making, information about support groups, getting understandable responses to questions, confidence and trust in treating doctors and nurses, staff doing all they could to control symptoms of treatment. Areas for further improvement include: advice on prescriptions, and provision of written information on assessment and care planning. Plans for each service providing cancer care and treatment are being monitored to ensure that the improvements are sustained.

Our Priorities for 2015/16

Governor Priorities

- Discharge
- Patients with multiple health needs

The Council of Governors discussed a list of priorities during their Development Day on 20 March 2015, agreeing the two priorities below.

Discharge

- Review of complaints under the category of Discharge: identify themes, learning and changes made as a result
- Focus on those patients who do not require an acute hospital bed: how can we support earlier discharge?
- Make a link with Mental Health: how many patients delayed awaiting mental health onward care?
- How does the Trust ascertain if there is anyone at home to look after the patient on discharge?
- Information provision "care after discharge": how can this be enhanced?

The discharge work is monitored and reports to the Hospital Operations Board which reports to the Executive Team and thereby to the Board of Directors.

Patients with Multiple Health Needs

- How can we improve the experience for patients? Look at data to identify numbers affected and in what specialties (including diagnostics?)
- How can we join up appointments to reduce multiple attendances
- Improvement of information flows to support the above
- What can be done to ensure health records are available for multiple appointments on the same day, on different sites, i.e. RD&E Wonford and Heavitree

This piece of work will be monitored and report to the Future Care Board which reports to the Executive Team and thereby to the Board of Directors.

Our Priorities for 2015/16

Trust Priorities

- **Nursing, Midwifery and Allied Health Professions Vision**
- **Future Care Programme**
 - Integration
 - Acute Pathways Transformation
- **Patient Safety Programme**

Nursing, Midwifery and Allied Health Professions Vision

We will develop a further three year Nursing Midwifery and Allied Health Professions Vision, within which we will feature the new "Code" which details the professional standards that registered nurses and midwives must uphold. We will use the four areas to develop our work. These are:

- Prioritise people
- Practice effectively
- Preserve safety
- Promote professionalism and trust

We will support our teams to provide evidence for revalidation, enabling our staff to provide evidence of fitness to practice and enable patients, carers and families to feedback as part of this process.

We will work together to deliver our Model of Care as described in the Future Care section on page 18. This will require us to continue to recruit and retain our staff but also develop new roles and continue to build the skills of our staff.

We will continue to focus on safe staffing and implement new guidance as it is published over the forthcoming year.

We will extend the Clinical School to incorporate our unregistered staff recognising the contribution that that they make to our patients, carers and their families.

The work of the Nursing, Midwifery and Allied Professions Vision reports to and is monitored by the Chief Nurse/Chief Operating Officer.

Future Care Programme

Integration Programme for 2015/16

Following on from the work already commenced this year (see pages 13-15), the work programme for 2015/16 is still being developed but will include work to deliver the following:

- Single pathways of care between the acute hospital and community services for adults with complex care needs.
- Frailty - improving the co-ordination of services wrapped around frail older people, providing a rapid and integrated response to crisis supported by intensive reablement aimed at minimising the hospital length of stay and maximising rehabilitation potential.
- Long term condition management of "mostly well" and "pre-frail" people. This includes a fundamental review of how, why and where we deliver outpatient services for people with multiple long-term conditions that work to meet the holistic needs of the people (not just their disease management) and pulls on a wider range of service providers, in particular the voluntary sector and local community groups.
- Increased delivery of outpatient services closer to the people they serve, making better use of existing community and social facilities and resources.
- Work with the established social care and mental health teams to develop care co-ordination, system navigation and collaboration of multidisciplinary teams.
- Work with Eastern Devon GPs to identify population groups with multiple health conditions and partnering with them to redesign services whilst promoting self-management and control for people, e.g. through patients holding their own health and care budgets.

Acute Pathway Transformation

The Trust is also embarking on another major change programme of Acute Pathway Transformation (APT) which will work in tandem with the Integration Programme described above to deliver better and more joined up people-centred care, which we are calling Future Care.

The APT programme puts in place appropriate technological solutions which will support and enable a new way of working, which will give people more control and information about their own health and which will provide readily accessible and up to date clinical information.

It will:

- Promote standardisation, instilling confidence in patients and people of what to expect when accessing our services, whilst retaining an individualised care plan
- Establish a single patient record for each person to support a more personalised approach to care, allowing monitoring of individuals and proactive care before they are taken to hospital
- Give patient record access to other health and care partners, such as GPs, thus restricting multiple collection and entry of data and enabling greater co-ordination of care
- Make information more readily available to patients, through on-line access, to promote awareness and management of their own health and a clearer voice in this management

The work of the Future Care Programme is monitored and reported through the Future Care Board which reports to the Executive Team and thereby to the Board of Directors.

Patient Safety Programme

Key highlights for this year will be:

- Delivering a structured day and night for patient care to reduce falls: by having a greater focus on some of the fundamentals of care and providing care in a systematic way we anticipate that we will further reduce patient falls
- Human Factors (continuing work of last year with additional focus on ward based human factors): we plan to further implement our human factors training to encompass all ward areas. We hope to further improve outcomes for patients and reduce incidents
- SKIN Matters: as a Trust we have made a significant impact on reducing the numbers and severity of pressure ulcers. We plan to continue this work over the next year to make further improvements
- Acute Kidney Injury: a sudden reduction in kidney function is both harmful and preventable. The goal of this work is to follow up and monitor those who have the condition and prevent further issues
- Sepsis including ward areas: the aim of this work with be to ensure that, through our direct admission areas including the Emergency Department, Medical and Surgical Assessment Units, we rapidly assess and treat patients with suspected sepsis

The work of the Patient Safety Programme is monitored and reported through the Safety and Risk Committee, up to the Governance Committee and thereby to the Board of Directors.

Review of Services

During 2014/15 the Royal Devon & Exeter NHS Foundation Trust provided and/or sub-contracted 54 relevant health services.

The Royal Devon & Exeter NHS Foundation Trust has reviewed all the data available to them on the quality of care in 2014/15 in 54 of these relevant services.

The income generated by the relevant health services reviewed in 2013/14 represents 100% per cent of the total income generated from the provision of relevant health services by the Royal Devon & Exeter NHS Foundation Trust for 2014/15.

Participation in Clinical Audits

During 2014/15 37 national clinical audits and 4 national confidential enquiries covered relevant health services that the Royal Devon & Exeter NHS Foundation Trust provides.

During that period the Royal Devon & Exeter NHS Foundation Trust participated in 89% (33/37) national clinical audits and 100% (4/4) national confidential enquiries for which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Devon & Exeter NHS Foundation Trust was eligible to participate in during 2014/15 are listed in Annex F.

The national clinical audits and national confidential enquiries that the Royal Devon & Exeter NHS Foundation Trust participated during 2014/15 are listed in Annex F.

The national clinical audit and national confidential enquiries that the Royal Devon & Exeter NHS Foundation Trust participated in, and for which data collection was completed during 2014/15 are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered by the terms of that audit or enquiry in Annex F.

The reports of 13 national clinical audits were reviewed by the provider in 2014/15 and the Royal Devon & Exeter NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in Annex F.

The reports of 15 local clinical audits were reviewed by the provider in 2014/15 and the Royal Devon & Exeter NHS Foundation Trust intends to take the following action to improve the quality of healthcare provided as detailed in Annex F.

Participation in Clinical Research

The number of patients receiving relevant health services provided or sub-contracted by Royal Devon & Exeter NHS Foundation Trust in 2014/15 that were recruited during that period to participate in research approved by a research ethic committee 5800.

Participation in clinical research demonstrates the Trust's commitment to improving the quality of care we offer and to contribute to implementation of evidenced-based patient care. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The high quality of the research at the Trust is demonstrated by the level of external grant funding which in 2014/15 exceeded £5.5million. The number of chief investigators with successful external grants increased during the year.

In 2014 there were 253 publications in peer reviewed journals, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

A number of trials involving patients with inflammatory bowel disease involving 168 sites across the world have led to discoveries about which patients are likely to develop adverse drug reactions to normal drug treatment. Results published in Nature Genetics show that the researchers have identified the genetic marker that predicts the likelihood of developing pancreatitis which occurs in 4% of Inflammatory Bowel Disorder patients.

Research into exercise testing of young people with cystic fibrosis has been published in the European Journal of Paediatrics. The research, in collaboration with the School of Sport and Health Sciences, showed that there was a high incidence of airflow limitation resulting from cardiopulmonary exercise testing. This information may be useful to clinicians when prescribing safe, yet effective exercise training interventions for these young patients.

The Trust is one of the highest recruiting NHS organisations to clinical trials in the South West Peninsula. The Trust was involved in conducting 356 clinical research studies in a wide range of specialties during 2014/15. Over 98% of studies were approved within 30 days of receiving a valid application.

The Trust collaborates with the University of Exeter Medical School, hosting the NIHR (National Institute for Health Research) Clinical Research Facility for experimental medicine. A total of 2400 participants were recruited into research studies during 2014/15 at this facility. Research focuses on understanding mechanisms of disease and introducing improvements into patient care.

Goals Agreed with Commissioners

A proportion of the Royal Devon & Exeter NHS Foundation Trust income in 2014/15 was conditional on achieving quality improvement and innovation goals between the Royal Devon & Exeter NHS Foundation Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2014/15 and for the following 12 month period are available electronically at www.rdehospital.nhs.uk.

The 2014/15 NHS Planning guidance continued the potential for Trusts to earn additional income, conditional upon achieving quality improvement and innovation goals. The Trust agreed a suite of schemes for which the Trust could earn an additional £5.635m of income in 2014/15. In 2013/14 the Trust received payment to the value of £3.828m.

Quality Schemes

A summary of these CQUINs is set out below.

1. Patient and Staff Experience

The Friends and Family Test (FFT) is a nationally designed tool that is designed to measure patients' experiences in using health care services, and staff experiences in delivering them. It asks patients "How likely are you to recommend our ward / A&E department to friends and family if they needed similar care or treatment?", and asks staff "How likely are you to recommend this organisation to friends and family as a place to work?" and "how likely are you to recommend this hospital to friends and family if they needed care or treatment?"

a. Staff Friends and Family Test

In 2014/15 the Trust was asked to ensure that staff were invited to respond to the questions as to whether they would recommend the Trust as an organisation to work for, and if a family member or friend required care or treatment, how likely they would be to recommend the hospital as a place to receive such care.

2014/15 Target:

To implement the Staff FFT in line with national guidance.

2014/15 Achievement:

Staff FFT successfully delivered within the Trust.

Results from Quarter 2 (July–September 2014) indicate that 77% of staff who responded would recommend the Trust as a place to work and 95% would recommend it as a place to receive care and treatment.

b. Increased Response Rates for Patients Responding to the Emergency Department (ED) and Inpatient Friends and Family Test

This indicator measures the proportion of patients attending our ED or who were admitted to a ward, who responded to the FFT.

2014/15 Target:

To achieve a response rate in Q1 that is at least 15% for patients attending the ED, rising to 25% in Q4, and a response rate of at least 20% in Q1 for patients that are admitted, rising to 30% in Q4.

2014/15 Achievement:

In Quarter 1 the Trust's response rates were 43.5% for the ED (April 44.5%, May 49.5%, June 36.7%) and 27.4% for the Inpatient (April 24.45%, May 26.93%, June 30.97%) FFTs respectively.

In Quarter 4, the Trust's response rates were 44.8% for the ED (January 53.9%, February 46.7%, March 37.3%) and 42.1% for the Inpatients (January 40.0%, February 38.0%, March 48.2%) FFTs respectively.

c. Increased Response Rate for the Inpatient Friends and Family Test

This indicator seeks to go further than the indicator outlined immediately above, and is drawn solely from the responses of patients who were admitted in Q4, with a particular focus upon March 2015.

2014/15 Target:

To achieve a response rate to the Inpatient FFT of at least 40% either in aggregate across Quarter 4, or for the month of March 2015.

2014/15 Achievement:

In Quarter 4, the Trust's response rate was 42.1% for the Inpatient FFT (including a response rate of 48.2% for the month of March 2015).

2. Pressure Ulceration

In order to build further upon the reduction in hospital-acquired pressure ulceration, a local variation to the national CQUIN was developed in collaboration with Northern, Eastern & Western Devon Clinical Commissioning Group (NEW Devon CCG). This locally developed CQUIN seeks to support a community wide focus upon the prevention of pressure ulcers, through:

a. The collection and supply of data relating to patients admitted to the Trust with existing pressure damage that identifies the setting in which harm occurred

2014/15 Target:

Q1 – Provision of training to enable data collection in a timely and measurable way in admissions areas.

Q2 – Collection of data for patients that come into hospital with pressure damage, to enable thematic analysis to be undertaken regarding the settings in which pressure damage is occurring in the community.

Q3 – Through validation of existing data set, and collaboration with social care partners, identify health and social care providers involved in the care of those admitted to the hospital with pressure damage.

Q4 – Work collaboratively with NEW Devon CCG and local health economy partners to produce focussed training material which is offered to health and social care partners, with a particular invitation to those providers identified from the validated data.

2014/15 Achievement:

Q1 – Training provided.

Q2 – Data collected.

Q3 – Data validated.

Q4 – Study day for care home and social care staff advertised to care agencies and care homes in Exeter and East Devon. Venue, programme and speakers organised.

b. Collaboration with NEW Devon CCG and the Tissue Viability Team at Northern Devon Healthcare NHS Trust to develop a training package for care homes and domiciliary carers to enhance the understanding of pressure ulcer prevention for care home and domiciliary staff

2014/15 Target:

Q4 – Work collaboratively with partners from NEW Devon CCG and Northern Devon Healthcare NHS Trust to produce a leaflet for Care Agencies regarding pressure damage, which can also be used by Community Nurses when communicating with Care Agency staff in the patients' homes. The leaflet to cover the basics of what is pressure damage and moisture damage, how to prevent it and when and how to escalate to health professionals. The leaflet will be placed on the Trust's website, and be proactively circulated to those agencies identified through the data collected in Q1 along with an invitation to attend the training event. It will also be made available to NEW Devon CCG and Devon County Council for onward distribution as appropriate.

2014/15 Achievement:

Q4 – Draft leaflet produced and shared with commissioners.

c. To design and implement a data collection tool to measure compliance with the pressure ulcer prevention pathway in hospital

2014/15 Target:

Q1 - Development of an audit tool for gathering data for five patients in each area every month, as part of the Safety Thermometer.

Q2 – Collection of baseline data.

Q3 – Agreement of compliance target.

Q4 – Delivery of 85% compliance on each of the five named wards, and delivery of a compliance rate of 85% throughout the hospital (in aggregate).

2014/15 Achievement:

Q1 – Audit tool developed.

Q2 – Baseline data collection.

Q3 – Compliance target agreed.

Q4 – A compliance rate of at least 85% throughout the hospital (in aggregate) and a compliance rate of 85% on four of the five named wards delivered.

3. Dementia

a. Dementia Screening

This indicator represents the Trust's progress in meeting new national guidelines in relation to the early recognition of undiagnosed dementia. This indicator requires that the Trust identifies patients who may be exhibiting symptoms of dementia, assesses them and refers them on to appropriate care.

i) Dementia Case Finding

2014/15 Target:

That for three consecutive months, or in aggregate across each quarter, at least 90% of all patients aged 75 and above who are admitted as an emergency inpatient, are asked the dementia case finding question within 72 hours of admission, or already have a clinical diagnosis of delirium on initial assessment or a known diagnosis of dementia.

2014/15 Achievement:

Q1 – April 78.11%, May 89.03%, June 92.88%

Q2 – July 93.10%, August 96.81%, September 91.35%

Q3 – October 92.90%, November 94.59%, December 97.82%

Q4 – January 96.2%, February 95.6%, March 95.9%

ii) Dementia Diagnostic Assessment and Investigation

2014/15 Target:

That for three consecutive months, or in aggregate across each quarter, at least 90% of all patients aged 75 and above admitted as emergency inpatients who have scored positively on the case finding question, or who have a clinical diagnosis of delirium, are reported as having had a dementia diagnostic assessment including investigations conducted during their inpatient admission.

2014/15 Achievement:

Q1 – April 100.0%, May 100.0%, June 100.0%
 Q2 – July 100.0%, August 100.0%, September 100.0%
 Q3 – October 100.0%, November 100.0%, December 100.0%
 Q4 – January 100.0%, February 100.0%, March 100.0%

iii) Dementia: Referral for Specialist Diagnosis

2014/15 Target:

That for three consecutive months, or in aggregate across each quarter, at least 90% of all patients aged 75 and above who are admitted as emergency inpatients who have had a diagnostic assessment (in whom the outcome is either "positive" or "inconclusive") are referred for further diagnostic advice or follow up.

2014/15 Achievement:

Q1 – April 100.0%, May 99.57%, June 100.0%
 Q2 – July 100.0%, August 100.0%, September 100.0%
 Q3 – October 100.0%, November 100.0%, December 100.0%
 Q4 – January 100.0%, February 100.0%, March 100.0%

b. Dementia Training

This indicator reflects the leadership and delivery of a training programme regarding the specific care needs of those with dementia and delirium. This has been targeted towards clinical members of staff within our ED and key wards in which more than 40% of discharged patients are 75 years of age or older.

2014/15 Target:

Q1 – that at least 52% of staff on the specified wards, for whom the training has been identified as beneficial, have received the training
 Q2 – that at least 63% of staff on the specified wards, for whom the training has been identified as beneficial, have received the training

Q3 – that at least 74% of staff on the specified wards, for whom the training has been identified as beneficial, have received the training

Q4 – that at least 85% of staff on the specified wards, for whom the training has been identified as beneficial, have received the training

2014/15 Achievement:

Q1 – 53% compliance
 Q2 – 64% compliance
 Q3 – 80% compliance
 Q4 – 88% compliance

c. Audit of Carers of People with Dementia

This indicator involves a monthly audit of carers of people with dementia to test whether they feel supported.

2014/15 Target:

To conduct a monthly audit of carers of people with dementia, and to share the results of these audits within the organisation.

2014/15 Achievement:

Audit conducted and results shared with the Board of Directors.

4. Inpatient Diabetes

National best practice guidance has demonstrated that patients with Diabetes who are referred to a Specialist Diabetes team for an assessment of their diabetes needs in a timely manner following hospital admission, have a shorter length of stay and better health outcomes, than those not receiving specialist assessment.

2014/15 Target:

Q1 – Develop a process to ensure that all wards are conversant with the "Think Glucose" assessment and are able to use the tool to identify patients who need diabetes specialist assessment and update the whiteboard to generate a referral.

Q2 – 30% of inpatients that have been identified as diabetic, have a diabetic "Think Glucose" assessment, including requirement for specialist review, within 24 hours of their admission.

Q3 – 45% of inpatients that have been identified as diabetic, have a diabetic "Think Glucose" assessment, including requirement for specialist review, within 24 hours of their admission.

Q4 – 60% of inpatients that have been identified as diabetic, have a diabetic "Think Glucose" assessment, including requirement for specialist review, within 24 hours of their admission.

2014/15 Achievement:

- Q1 – Achieved
- Q2 – Achieved
- Q3 – Achieved
- Q4 – 59.81%

5. Paediatric Sepsis

This scheme relates to the design and implementation of a programme to support the early identification of sepsis in paediatric patients.

Q2 Target – Initiation Phase

- Identification of a Clinical Lead for the Paediatric Sepsis programme
- Collection of baseline data on the number of children presenting with feverish illness and sepsis in the last 12 months
- Produce a draft Parent Information Guide for giving to parents/carers when a feverish child is discharged home having not been diagnosed as septic. Share Parent Information Guide with other Devon-wide healthcare providers
- Identify a list of relevant staff requiring training
- Prepare an implementation plan to support communication across the Trust in relation to the sepsis pathway work programme

Q3 – Implementation Phase

- Implement sepsis scoring pathway, consistent with Paediatric Sepsis Six bundle
- Complete training for all relevant clinical staff in respect of the sepsis pathway work programme
- Finalise and produce Parent Information Guide for giving to parents/carers when a feverish child is discharged home having not been diagnosed as septic.
- Delivery of Trust-wide staff communications in line with implementation plan.

Q4 – Completion Phase

- Audit implementation of sepsis scoring pathway/ documentation consistent with NICE (National Institute for Health and Care Excellence) Green/Amber/Red status
- Audit implementation of treatment processes consistent with Paediatric Sepsis Six bundle
- Identification of organisational lead for sepsis pathway, including adults and children aged 5–16, for continuation of work programme in 2015/16.

2014/15 Achievement:

- Q2 – Achieved
- Q3 – Achieved
- Q4 – Audit conducted of implementation of sepsis scoring pathway and consistency of documentation with NICE Green/Amber/Red status Audit indicated 100% recording of Green/Amber/Red status. Audit of implementation of treatment processes consistent with Paediatric Sepsis Six bundle conducted, including identification of recommendations where Sepsis Six was not followed. Organisational lead for sepsis pathway for 2015-16 identified.

6. Emergency Gynaecology

This scheme incorporates the development of an emergency gynaecological service to offer rapid, responsive care for appropriate referrals.

2014/15 Target:

Q2 –

- Identify the patient cohort and appropriate intervention rates for the 2014/15 year, including identification of an appropriate baseline and methodology for data collection
- Following identification of baseline

Q3 – Deliver quarterly improvement target.

Q4 – Deliver quarterly improvement target, and produce evaluation report, including identification of appropriate forums to share information across the wider health community to support pathways of care.

2014/15 Achievement:

- Q2 – Achieved
- Q3 – Achieved
- Q4 – In Quarter 4 the attendance levels for the emergency Gynaecology Service were comparable to those observed in the baseline period; the volume of clinics held and the proportion with consultant or associate specialist attendance was maintained. 90% of those referred for emergency gynaecology treatment were seen within 48 hours. Evaluation report produced.

7. Medicines Management (Medicines Optimisation)

The scheme incorporates a number of specific actions and measures to improve the reporting of medication related incidents, with a particular focus upon medication incidents at times of care transfer, and in relation to those who are frail and elderly.

2014/15 Target:

Q1 – To undertake a baseline audit. Map the medicines incident pathway, including how near misses are dealt with and recorded. Share at Peer Review meeting, hosted by NEW Devon CCG Medicines Optimisation Team.

Undertake baseline audit of volumes of medication incidents, including detail of harm, analysis of incidents where information is not fully complete, and volumes of near miss medication incidents.

Q2 – Identify three highest priority areas regarding medication related incidents for action within the Trust. Develop an action plan to address these priority areas and any differences in reporting identified between provider organisations.

Q3 – Analyse incidents relating to medication at times of transfer of care, and in relation to those who are frail and elderly, and share themes at Peer Review meeting hosted by NEW Devon CCG Medicines Optimisation Team.

Q4 – Benchmark to assess whether there has been an improvement in incident reporting, including in the identified three priority ward areas to the target level. Evaluate action plans, including the recommendations for continued reductions in incidence of medication related incidents at times of transfer, and in relation to those who are frail and elderly.

2014/15 Achievement:

Q1 – Pathway mapped. Baseline audit undertaken.

Q2 – Priority areas identified and agreed. Action plan to address priority areas and any differences in reporting also agreed.

Q3 – Analysis shared at Peer Review meeting.

Q4 – Benchmarking conducted. Action plans evaluated, including the recommendations for continued reductions in incidence of medication related incidents at times of transfer, and in relation to those who are frail and elderly.

8. Survivorship

This scheme supports the development of the survivorship programme for those living with and beyond cancer. In particular it focuses on supporting the empowerment of patients to manage their own condition, through the development of risk stratified pathways for each of four tumour sites (Colorectal, Skin, Prostate and Breast). These pathways will enable clinicians to ensure agreed low risk patients are supported through new models of care, including patient education, support events including health and wellbeing clinics, holistic assessments of needs, and direct access back to hospital where needed, to lead as healthy and active a life as possible for as long as possible.

2014/15 Target:

Q2 – Identify risk stratified pathways across the four tumour sites (Colorectal, Skin, Prostate and Breast), identifying numbers potentially for each patient group in order to set trajectories. Ensure that patients receive treatment summary and holistic needs assessment at end of acute phase. Provide summary of total number of acute patients, patients eligible for programme and numbers of patients referred.

Q3 – Ensure that patients receive treatment summary and holistic needs assessment at end of acute phase. Provide summary of total number of acute patients, patients eligible for programme and numbers of patients referred.

Q4 – Ensure that patients receive treatment summary and holistic needs assessment at end of acute phase. Provide summary of total number of acute patients, patients eligible for programme and numbers of patients referred. Compose a report highlighting roll out of survivorship including patient engagement and next steps including lessons learned.

2014/15 Achievement:

Q2 – Pathways developed for each of Breast, Colorectal, Prostate (Urology) and Melanoma (Skin) tumour sites, including risk stratification. Anticipated numbers of patients for each tumour site identified, recognising that new referrals to the programme will fluctuate according to clinical condition. PSA (Prostate Specific Antigen) tracker launched in Urology and patients identified to commence programme, all of whom have received holistic needs assessment and treatment summaries. Implementation of offer of holistic needs assessments and treatment summaries to appropriate patients across each of the four tumour site pathways.

Q3 – Patients receiving treatment summaries and holistic needs assessments at end of acute phase.

Q4 – End of year report drafted and shared with commissioners. Patients receiving treatment summaries and holistic needs assessments at end of acute phase.

9. Acute Kidney Injury

This scheme measures the proportion of patients admitted in an emergency for whom it was flagged that they may have a stage of acute kidney injury (AKI), who were assessed by the specialist AKI team during their inpatient stay.

2014/15 Target:

Q2 – To maintain an inpatient team and embed a system of alerting the acute kidney injury (AKI) team to patients with a flag for AKI. The process for flagging patients with potential AKI to be communicated across the organisation. A target that at least 20% of all patients identified as having a stage of AKI will be assessed by the AKI team during their inpatient stay.

Q3 – A target that at least 30% of all patients identified as having a stage of AKI will be assessed by the AKI team during their inpatient stay.

Q4 – A target that at least 40% of all patients identified as having a stage of AKI will be assessed by the AKI team during their inpatient stay.

2014/15 Achievement:

Q2 – Awareness campaign delivered through education sessions given by AKI outreach team. Online guidelines circulated. Link nurses identified on targeted wards. Quarterly target met that at least 20% of all patients identified as having a stage of AKI will be assessed by the specialist AKI team during their inpatient stay.

Q3 – Target met that at least 30% of all patients identified as having a stage of AKI will be assessed by the AKI team during their inpatient stay.

Q4 – Target met that at least 40% of all patients identified as having a stage of AKI will be assessed by the AKI team during their inpatient stay.

10. Breast Cancer (Mammography)

This scheme seeks to support a significant reduction in times waited by patients to receive the results of mammography scans.

2014/15 Target:

Q2 – Establish baseline position. Develop and implement plans for improvement.

Q3 – At least 30% of patients will receive their mammography results within two weeks.

Q4 – Achieve reduction in wait, so that at least 50% of patients wait no longer than 72 hours, 65% patients wait no longer than one week, and 90% of patients wait no longer than two weeks.

2014/15 Achievement:

Q2 – Baseline position established. Plans for improvement developed and implemented.

Q3 – 68% of patients receive their mammography results within three working days, 92% within seven working days and 99.6% within ten working days.

Q4 – 55% of patients sent results in three working day (72 hours), 92% of patients sent results within five working days (one week) and 97% of patients sent results within seven working days.

11. Planned Care Sustainability

As a pre-requisite to the remaining elements of this CQUIN scheme, this CQUIN requires the identification of an executive lead for the decommissioning agenda, and the transmission of an organisational communication to Trust staff regarding the whole systems approach to managing demand for planned care

a. Organisational Preparedness

2014/15 Target:

Q1 – Identification of an executive lead for the decommissioning agenda, and the transmission of an organisational communication to Trust staff regarding the whole systems approach to managing demand for planned care.

2014/15 Achievement:

Q1 – executive lead identified and organisational communication transmitted.

b. Rapid Referral Review

This element of the Planned Care Sustainability CQUIN centres on the creation of services in specific specialties whereby referrals to the Trust are reviewed within two working days to identify:

- Whether an outpatient appointment is required, and if so which clinic type
- Whether the referral should be directed to another specific specialty
- Whether specific diagnostic(s) are advised
- What advice on further management of the patient in primary care is appropriate
- Whether a consultant upgrade of the urgency of the referral to the two week wait standard is necessary

2014/15 Target:

Q2 – Complete actions to meet the requirements of the agreed “go-live” checklist in each of the following specialties: ENT, Urology, Colorectal, Rheumatology, Pain Management, Diabetes, Dermatology, Nephrology. Complete actions to meet the requirements of the agreed “go-live” checklist in Gynaecology, Paediatrics, Respiratory and Neurology.

Q3 – Complete actions to meet the requirements of the agreed “go-live” checklist in Gastroenterology, Cardiology, Plastic Surgery, Haematology, Geriatric Medicine.

Q4 – Achievement of at least 95% of referrals responded to within two working days for each specialty for the remainder of the financial year one month after “go-live”. Participation in two primary-secondary care reviews of the outcomes of rapid referral review process.

2014/15 Achievement:

Q2 – “Go-live” checklist requirements met in all specialties.

Q3 – Actions to meet the requirement of the “go-live” checklist completed in all required specialties.

Q4 – At least 95% of referrals were responded to within two working days for each of the following specialties – Colorectal, Diabetes and Endocrinology, ENT (Ear, Nose and Throat), Gynaecology, Haematology, Healthcare for Older People, Neurology, Pain Management, Rheumatology. There was partial delivery in two other specialties. Participation in reviews of the outcomes of the rapid referral review process where agreed.

c. Targeted Follow Up

This element of the Planned Care Sustainability CQUIN is designed to support the creation of an agreed plan to reduce the volume of follow up outpatient appointments.

2014/15 Target:

Q2 – Develop and agree a plan to support a reduction in follow up appointments.

Q3 – Deliver milestones agreed within the plan.

Q4 – Deliver milestones agreed within the plan.

2014/15 Achievement:

Q2 – Plan produced to support reduction in follow up outpatients.

Q3 & Q4 – Following commissioner discussions, some aspects of the plan produced in Quarter 2 were not implemented, however, work was undertaken in Quarters 3 and 4 to develop schemes to reduce the number of follow up outpatient appointments, in the spirit of this CQUIN scheme. This work was recognised by commissioners as having largely delivered the intended benefits of the CQUIN scheme.

d. Access to Senior Clinical Opinion

This element of the Planned Care Sustainability CQUIN is designed to support optimal decision making in primary care, whereby clinical specialties in the hospital provide access to senior medical opinion for non-urgent enquiries from primary care.

2014/15 Target:

Q2 – provision of access to senior clinical opinion to primary care for non-urgent enquiries, with responses provided within two working days.

2014/15 Achievement:

Q2 – Access provided by phone or email within agreed cohort of clinical specialties.

e. GP Education

This element of the Planned Care Sustainability CQUIN is designed to provide a quarterly programme of GP education, drawn from all major specialties, linking the programme of GP education where possible, to trends in educational need identified in calls and emails to access senior clinical opinion, outcomes of rapid referral review, new pathways (where these have been jointly agreed in advance) and referral trends.

2014/15 Target:

Q4 – Completion of a quarterly education programme to the plan signed off by the Joint Delivery Team.

2014/15 Achievement:

Q4 – During the course of Q4 NEW Devon CCG agreed that clinical pathway review should be undertaken in place of GP education sessions. Pathways have been reviewed in accordance with an on-going review programme.

12. Building Multi-Disciplinary Care in the Community for Adults with Complex Needs (Patch Geriatrician)

This scheme involves the design of a geriatrician (physician focussing on healthcare needs of older people) component to the next stage of community-based healthcare for adults with complex needs in the Eastern locality of Devon. This model will be focussed on integration, prevention and continuity of care throughout the whole pathway.

2014/15 Target:

Q1 & Q2 – In collaboration with the NEW Devon CCG lead for frail older people:

- produce a baseline describing the total number of geriatric follow ups that have occurred in the previous twelve months in either a community or acute hospital setting
- define follow up protocols for the speciality of healthcare for older people that can be used to ensure targeted follow up of patients, and provide capacity and flexibility for urgent appointments to access specialist opinion in community settings across the locality
- Jointly develop a criteria to identify those patients who are currently seen in the acute hospital who could be seen in a community setting
- Audit against the criteria above in order to identify the total number of outpatients (new or follow ups) that are currently seen in the acute hospital who could be seen in a community setting
- Develop an action plan to define a trajectory for delivery in Q2, Q3 and Q4 describing the increasing number of complex older people seen by geriatricians in the community under the agreed delivery model.
- Develop an action plan setting out the actions required of both commissioner and provider to provide consultant geriatrician sessions in community settings to deliver local outpatient care, to agree potential models of delivery for activity that will be delivered outside the acute setting, and to identify a named geriatrician for each patch/natural community who will begin to develop links with the local onward care team

Q3 – Deliver trajectory agreed in Q1 and Q2

Q4 – Deliver trajectory agreed in Q1 and Q2

2014/15 Achievement:

Q1 and Q2 – Milestone delivered

Q3 – Trajectory delivered

Q4 – Trajectory delivered, including production of operational plan to support the move of activity from acute hospital setting, to community base(s).

13. Improving the Discharge Processes and Coordination of Onward Care of Complex Adults from Inpatient Settings

This scheme involves the creation of a formal process of learning and continual improvement for the discharge processes from an acute hospital inpatient setting across East Devon to other settings of care, including community hospitals, home and other places of residence.

2014/15 Target:

Q1 and Q2 – Lead a review of the Trust's existing systems of discharge of complex older people from the acute inpatient setting, through a process mapping event led by the Trust with contribution from other health and social care providers. Create an action plan for the Trust to describe the structure/process for continual improvement for patients discharged from an acute hospital setting, the initial changes being made, and the measures that will be used to assess the impact of changes.

Q3 – Delivery of the agreed action plan. Development of a dashboard of indicators with measures to monitor the on-going productiveness of the system within the Trust.

Q4 – Delivery of the agreed trajectory.

2014/15 Achievement:

Q1 and Q2 – Patient pathway event held with representation from key stakeholders, and present state and future pathways agreed. Action plan developed for improving the discharge process within the Trust. Discharge checklist developed and implemented. Telephone survey of patients discharged from the Trust undertaken and completed. Discharge booklet written to help inform complex patients. Measures identified for on-going monitoring and improvement.

Q3 – Criteria-led discharge event held for Trust clinical staff to support consideration as to whether some specialties might have nurse or criteria-led discharge in place. Dashboard developed.

Q4 – Trajectory delivered, including:

- Audit of patients exceeding nine days from admission to referral including identification of lessons learned
- Trend analysis of referrals perceived to be inappropriate and identification of actions to change
- Survey of staff and patients regarding perceived strengths and weaknesses of discharge process and
- Refinement of a range of mechanisms to improve communication, including redevelopment of electronic referral form, and of Patient Transfer System.

14. Domestic Abuse Training Programme

This scheme measures the proportion of staff in the Trust's ED and of staff working within Maternity and Gynaecology within the Child & Women's Health Division who have received training in the detection, recognition and support of those who may experience domestic abuse.

2014/15 Target:

Q2 – That at least 60% of staff in ED and 45% of staff in Child & Women's Health Division for whom the training has been identified as advantageous, have received the training. Report on the number of cases identified as the number of referrals made.

Q3 – That at least 70% of staff in ED and 65% of staff in Child & Women's Health Division for whom the training has been identified as advantageous, have received the training. Report on the number of cases identified as the number of referrals made.

Q4 – That at least 75% of staff in ED and 75% of staff in Child & Women's Health Division for whom the training has been identified as advantageous, have received the training. Report on the number of cases identified as the number of referrals made. Complete evaluation report including detail of lessons learned, and analysis on referrals to MARAC (Multi-Agency Risk Assessment Conference).

2014/15 Achievement:

Q1 – Report given on volume of cases identified and referrals made.

Q2 – 60% of staff in ED and 60% of staff in Child & Women's Health Division for whom the training has been identified as advantageous have received the training. Report given on volume of cases identified and referrals made.

Q3 – 61% of staff in ED and 67% of staff within Child & Women's Health Division for whom the training has been identified as advantageous have received the training. Report given on volume of cases identified and referrals made.

Q4 – 89% of staff in ED and 75% of staff in Child & Women's Health Division have received Domestic Abuse training. Number of cases identified and volume of referrals made provided. Evaluation report completed, including details of lessons learned and analysis of referrals.

Care Quality Commission

The Royal Devon & Exeter NHS Foundation Trust is required to register with the Care Quality Commission and its current registration status is registered in full without conditions.

The Care Quality Commission has not taken enforcement action against the Royal Devon & Exeter NHS Foundation Trust during 2014/15.

The Royal Devon & Exeter NHS Foundation Trust has not participated in any special reviews or investigations by the Care Quality Commission during the reporting period.

NHS Number and General Medical Practice Code Validity

The Royal Devon & Exeter NHS Foundation Trust submitted records during 2014/15 to the Secondary Users Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
 - 99.8% for admitted patient care
 - 99.8% for outpatient care
 - 97.6% for accident and emergency care
- Which included patient's valid General Medical Practice Code was:
 - 99.9% for admitted patient care
 - 99.9% for outpatient care
 - 99.3% for accident and emergency care

Information Governance

The Royal Devon & Exeter NHS Foundation Trust Information Governance Assessment Report overall score for 2014/15 was 75% and was graded "satisfactory".

Clinical Coding

The Royal Devon & Exeter NHS Foundation Trust was selected for a Payment by Results clinical coding audit during the reporting period by Monitor, to be conducted by Capita. However, the work, which is scheduled by Monitor, will not be completed until late May 2015, therefore error rates are unavailable. The results will be published in the 2015/16 Quality Report.

Core Indicators

Indicator Description	Data	The Royal Devon and Exeter NHS Foundation Trust considers that this data is as described for the following reasons:	The Royal Devon and Exeter NHS Foundation Trust intends to take/ has taken the following actions to improve this percentage/ proportion/ score/rate/ number, and so the quality of its services, by:	Source of measure	Definition
<p>12. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to -</p> <p>(a) the value and banding of the summary hospital-level mortality indicator ("SHMI") for the trust for the reporting period; and</p> <p>(b) The percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.</p>	<p>July 2013 - June 2014:</p> <p>SHMI - 0.9137 (as expected) (9 trusts higher than expected, 113 as expected and 15 lower than expected) Palliative Coding 18.5% (Highest 49.0%, Lowest 0.0%, National average 24.6%)</p> <p>April 2013 - March 2014:</p> <p>SHMI - 0.928 (as expected) (9 trusts higher than expected, 115 as expected and 17 lower than expected) Palliative Coding 16.4% (Highest 48.5%, Lowest 0.0%, National average 23.6%)</p> <p>January 2013 - December 2013:</p> <p>SHMI - 0.906 (as expected) (7 trusts higher than expected, 119 as expected and 15 lower than expected) Palliative Coding 12.8% (Highest 46.9%, Lowest 1.3%, National average 22.0%)</p> <p>October 2012 - September 2013:</p> <p>SHMI - 0.895 (lower than expected) (8 trusts higher than expected, 116 as expected and 17 lower than expected) Palliative Coding 8.6% (Highest 44.9%, Lowest 0.0%, National average 20.9%)</p>	<p>1. There is a nine month cross over between each reporting period.</p> <p>2. The value in the most recent period has decreased very slightly, however with the significant cross over in time periods this makes it difficult to draw any useful conclusion.</p>	<p>The Trust will continue to monitor this data regularly via the Safety & Risk Committee and the monthly Board Integration Performance Report. The Patient Safety Group has also commenced quarterly review of this data at a more detailed Diagnosis Group level to identify potential areas for improvement.</p>	<p>HSCIC Indicator Portal</p>	<p>National Definition</p>

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<p>18. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's patient reported outcome measures scores for -</p> <p>(i) groin hernia surgery,</p> <p>(ii) varicose vein surgery,</p> <p>(iii) hip replacement surgery, and</p> <p>(iv) knee replacement surgery, during the reporting period.</p>	<p>Case mix-adjusted average health gains comparing pre- and post-operative 'EQ-5D Index' scores (a combination of five key criteria concerning patients' self-reported general health)</p> <p>(i) Groin hernia surgery: Apr-14 to Sep-14 - 0.111 (National 0.081, Lowest 0.009, Highest 0.125) Apr-13 to Mar-14 - 0.116 (National 0.085, Lowest 0.008, Highest 0.139) Apr-12 to Mar-13 - 0.075 (National 0.085, Lowest 0.013, Highest 0.153)</p> <p>(ii) Varicose vein surgery: Apr-14 to Sep-14 - N/A* (National 0.1, Lowest 0.054, Highest 0.142) Apr-13 to Mar-14 - 0.135 (National 0.093, Lowest 0.023, Highest 0.150) Apr-12 to Mar-13 - N/A* (National 0.093, Lowest 0.015, Highest 0.176)</p> <p>(ii) Hip replacement surgery: Apr-14 to Sep-14 - 0.493 (National 0.442, Lowest 0.35, Highest 0.501) Apr-13 to Mar-14 - 0.460 (National 0.436, Lowest 0.342, Highest 0.545) Apr-12 to Mar-13 - 0.444 (National 0.438, Lowest 0.319, Highest 0.539)</p> <p>(iv) Knee replacement surgery: Apr-14 to Sep-14 - 0.279 (National 0.328, Lowest 0.249, Highest 0.394) Apr-13 to Mar-14 - 0.337 (National 0.323, Lowest 0.215, Highest 0.416) Apr-12 to Mar-13 - 0.336 (National 0.318, Lowest 0.209, Highest 0.416)</p> <p><i>* N/A refers to values that have been suppressed due to low patient numbers</i></p>	<p>Results for varicose vein surgery are not published due to the small number of procedures undertaken within the Trust and the need to maintain patient confidentiality. It is not possible to correlate the figures for groin hernia surgery and hip replacement surgery during Apr-14 to Sep-14 against the previous two year period due to the fact that it is for a six month period only.</p>	<p>The data will be reviewed by the Surgical Division through their Governance structure.</p>	<p>HSCIC Indicator Portal</p>	<p>National Definition</p>

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<p>19. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients aged -</p> <p>(i) 0 to 15; and</p> <p>(ii) 16 or over,</p> <p>readmitted to a hospital which forms part of the trust within 28 days of being discharged from a hospital which forms part of the trust during the reporting period.</p>	<p>(i) 0 to 15:</p> <p>2011/12 - 7.88% (National N/A*, Lowest 6.40%, Highest 14.94%)</p> <p>2010/11 - 7.33% (National N/A*, Lowest 6.41%, Highest 14.11%)</p> <p>2009/10 - 7.59% (National N/A*, Lowest 6.04%, Highest 15.35%)</p> <p>(ii) 16 or over:</p> <p>2011/12 - 10.01% (National 11.45%, Lowest 9.34%, Highest 13.8%)</p> <p>2010/11 - 10.09% (National 11.43%, Lowest 9.2%, Highest 14.06%)</p> <p>2009/10 - 9.73% (National 11.18%, Lowest 8.95%, Highest 13.18%)</p> <p><i>* National values for this age range are no longer published. 'Lowest' and 'Highest' values are from the 'Large acute' trust category of which the RD&E is assigned.</i></p>	<p>1. Numbers (better than) national performance.</p> <p>2. Increase broadly in line with national trend.</p>	<p>The Good Outcome on Discharge (GOOD) Project was set up in 2014, seeking to improve the process of discharge and transfer of care from hospital and reduce inappropriate readmission to hospital. A Discharge Checklist and patient information leaflet are being implemented across the hospital, and community wide workshops have taken place with patients, carers and health and social care providers to identify areas for improvement.</p>	HSCIC Indicator Portal	National Definition
<p>20. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the trust's responsiveness to the personal needs of its patients during the reporting period.</p>	<p>Average weighted score of five questions relating to responsiveness to inpatients' personal needs (score out of 100)</p> <p>2013/14 - 72.7 (National 68.7, Lowest 54.4, Highest 84.2)</p> <p>2012/13 - 73.5 (National 68.1, Lowest 57.4, Highest 84.4)</p>	<p>The Trust continues to ask these questions as part of the care quality assessment tool (a real time audit).</p>	<p>The Patient Experience Committee reviews the full report and oversees any actions required.</p>	HSCIC Indicator Portal	National Definition

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<p>21. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.</p>	<p>2014 - 78.53% (National position across all Acute Trusts 64.71%, Lowest 38.17%, Highest 89.27%)</p> <p>2013 - 77.89% (National position across all Acute Trusts 64.50%, Lowest 39.57%, Highest 88.51%)</p>	<p>Capita, who oversee the Staff Survey, are an approved Survey Contractor having met the necessary data quality standards. The 2014 Survey results were compared to previous responses and of the 27 key findings, only 10 recorded a statistically significant move.</p>	<p>A workshop for all Hospital Operations Board (HOB) members on the outcomes of the Staff Survey, "Staff Say" meetings and the leadership training module on staff engagement held. This will provoke actions at a corporate, Divisional and local levels which will be compiled into a single plan.</p>	<p>HSCIC Indicator Portal</p>	<p>National Definition</p>
<p>21.1 Friends and Family Test – Patient. The data made available by National Health Service Trust or NHS Foundation Trust by the Health and Social Care Information Centre for all acute providers of adult NHS funded care, covering services for inpatients and patients discharged from Accident and Emergency (types 1 and 2)</p> <p><i>Please note: there is a not a statutory requirement to include this indicator in the quality accounts reporting but NHS provider organisations should consider doing so.</i></p>	<p>Inpatients - Percentage Recommended</p> <p>January 2015 - 95.6% (National 94.4%, Lowest 51.2%, Highest 100.0%)</p> <p>December 2014 - 93.8% (National 94.7%, Lowest 77.9%, Highest 100.0%)</p> <p>Accident and Emergency - Percentage Recommended</p> <p>January 2015 - 87.7% (National 88.1%, Lowest 55.2%, Highest 98.1%)</p> <p>December 2014 - 85.6% (National 86.2%, Lowest 53.5%, Highest 99.8%)</p>	<p>This information scrutinised alongside a suite of patient feedback information. On a quarterly basis this is reviewed by the Patient Experience Committee.</p>	<p>The Trust reviews this data monthly at a Divisional level as part of the Trust Performance Assurance Framework (PAF).</p>	<p>HSCIC Indicator Portal</p>	<p>National Definition</p>

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23. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism during the reporting period.	<p>2014/15 (Quarters 1-3) - 95.60% (National position across all NHS acute providers 96.03%, Lowest 87.73%, Highest 100.00%)</p> <p>2013/14 - 95.56% (National position across all NHS acute providers 95.70%, Lowest 82.05%, Highest 100.00%)</p> <p>2012/13 - 89.23% (National position across all NHS acute providers 93.87%, Lowest 86.86%, Highest 100.00%)</p>	The focus has been on sustained improvement against this target. There has been a steady improvement in performance over 2013 compared to 2012. This has been achieved through a relentless focus by ward clinical teams to ensure that all eligible patients are risk assessed in a timely manner.	On-going work with clinical teams to strive for 100% risk assessment. Monthly performance is reviewed at divisional level through the PAF meetings.	HSCIC Indicator Portal	National Definition
24. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the rate per 100,000 bed days of cases of C difficile infection reported within the trust amongst patients aged 2 or over during the reporting period.	<p>2013/14 - 11.5 (National 14.7, Lowest 0.0, Highest 37.1)</p> <p>2012/13 - 19.6 (National 17.4, Lowest 0.0, Highest 31.2)</p> <p>2011/12 - 37.0 (National 22.2, Lowest 0.0, Highest 58.2)</p>	<p>A significant reduction in the rate of C. Diff infection was achieved in 2012/13 for two reasons:</p> <p>The 'Start Smart and then focus' antimicrobial stewardship programme was implemented, part of which included significant changes to the local antimicrobial prescribing formulary in September 2012 promoting the use of lower risk antimicrobial agents for empirical treatment.</p> <p>Revised diagnosis and reporting guidelines were published by the DH (Gateway 17215) in March 2012 which clarified that only EIA GDH and toxin +ve cases should be reported whereas in 2011/12 EIA GDH +ve, toxin -ve PCR +ve cases were also reported by this organisation.</p>	<p>Control measures as described in DH/PHE guideline Clostridium Difficile:</p> <p>How to deal with the problem continue to be applied within the organisation. Emphasis on antimicrobial stewardship continues with review of surgical prophylaxis and treatment formulary. An external expert review of control measures and performance was sought in July 2013 which concluded that the organisation had 'impressive systems in place and clear commitment from the staff'. A small number of minor recommendations were made that have already been incorporated into the infection control work plan.</p>	HSCIC Indicator Portal	National Definition

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<p>25. The data made available to the National Health Service trust or NHS foundation trust by the Health and Social Care Information Centre with regard to the number and, where available, rate of patient safety incidents reported within the trust during the reporting period, and the number and percentage of such patient safety incidents that resulted in severe harm or death.</p>	<p>Total Patient Safety Incidents</p> <p>October 2013 to March 2014 - 5593 (National* 179344, Lowest 2422, Highest 12152)</p> <p>April 2013 to September 2013 - 4340 (National 164251, Lowest 2235, Highest 11573)</p> <p>Patient Safety Incidents per 100 admissions</p> <p>October 2013 to March 2014 - 9.34 (National 8.69, Lowest 4.63, Highest 14.91)</p> <p>April 2013 to September 2013 - 7.24 (National 7.96, Lowest 4.87, Highest 12.84)</p> <p>Number of Patient Safety Incidents that resulted in severe harm or death</p> <p>October 2013 to March 2014 - 3 (National 660, Lowest 1, Highest 69)</p> <p>April 2013 to September 2013 - 14 (National 552, Lowest 1, Highest 46)</p> <p>Patient Safety Incidents that resulted in severe harm or death per 100 admissions</p> <p>October 2013 to March 2014 - 0.01 (National 0.03, Lowest 0.00, Highest 0.12)</p> <p>April 2013 to September 2013 - 0.02 (National 0.03, Lowest 0.00, Highest 0.08)</p> <p><i>* The National figure for this indicator covers all Acute Teaching organisations as designated by the NRLS of which the RD&E is assigned.</i></p>	<p>The data is directly uploaded from Datix and subject to vigorous data quality checks by the Trust and NRLS.</p>	<p>The Trust has targeted areas of lower reporting to ensure a consistent open reporting culture across all areas. This work is on-going.</p>	<p>HSCIC Indicator Portal</p>	<p>National Definition</p>

Monitor Dashboard

Indicator	Trend	Position for Quarter	Target	Monitor Weighting	Risk for Period	Risk for Year
Area 1 RTT Admitted		91.9%	min. 90%	1.0	High	Low
Area 2 RTT Non-Admitted		97.5%	min. 95%	1.0	Low	Low
Area 3 RTT Incomplete		92.7%	min. 92%	1.0	High	Low
Area 4 A&E - 4 Hour Target		93.8%	min. 95%	1.0	High	Low
Cancer 62 Day GP Urgent (pre breach re-allocation)		74.4% (104 of 407)	n/a	n/a		
Cancer 62 Day Screening (pre breach re-allocation)		91.7% (4 of 48)	n/a			
Area 5.I Cancer 62 Day GP Urgent (post breach re-allocation)		76.7% (95 of 407)	min. 85%	1.0	High	High
Area 5.II Cancer 62 Day Screening (post breach re-allocation)		91.7% (4 of 48)	min. 90%		Medium	Low
Area 6.I Cancer 31 Day Subsequent Surgery		85.2% (40 of 271)	min. 94%	1.0	High	Low
Area 6.II Cancer 31 Day Subsequent Drug		98.8% (3 of 256)	min. 98%		Low	Low
Area 6.III Cancer 31 Day Subsequent Radiotherapy		96.7% (14 of 426)	min. 94%		Medium	Low
Area 7 Cancer 31 Day First Treatment		88.4% (85 of 735)	min. 96%	1.0	High	Low
Area 8.I Cancer 14 Day GP Urgent		88.8% (399 of 3578)	min. 93%	1.0	High	Low
Area 8.II Cancer 14 Day Symptomatic Breast		99.4% (1 of 173)	min. 93%		Low	Medium
Area 14 C. difficile due to lapses in care		1 (7)	max. 30 annual	1.0	Low	Medium
Area 19 Learning Disability Compliance	Not applicable	Compliant	Compliant	1.0	Very Low	Very Low

Trend graphs run from April 2012 to March 2015

- Indicates that the target has been achieved for the quarter
- Indicates that the target has not been achieved for the quarter
- Indicates that the target is not enforced

Monitor Indicators and CQUIN

Indicator Group	Indicator Description	Data	Source of measure	Definition
Monitor Indicators - Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – admitted pathways	2014/15 - 92.7% 2013/14 - 93.5% 2012/13 - 88.6%	Unify2 Submission	National Definition
Monitor Indicators - Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – non-admitted pathways	2014/15 - 97.8% 2013/14 - 98.2% 2012/13 - 98.1%	Unify2 Submission	National Definition
Monitor Indicators - Access	Maximum time of 18 weeks from point of referral to treatment in aggregate – incomplete pathways	2014/15 - 94.1% 2013/14 - 94.6% 2012/13 - 91.9%	Unify2 Submission	National Definition
Monitor Indicators - Access	A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	2014/15 - 95.6% 2013/14 - 96.7% 2012/13 - 96.2%	Unify2 Submission	National Definition
Monitor Indicators - Access	All cancers: 62-day wait for first treatment from: urgent GP referral for suspected cancer (post breach re-allocation)	2014/15 - 81.7% (Q1-Q3) 2013/14 - 83.9% 2012/13 - 83.6%	Open Exeter	National Definition
Monitor Indicators - Access	All cancers: 62-day wait for first treatment from: NHS Cancer Screening Service referral (post breach re-allocation)	2014/15 - 97.6% (Q1-Q3) 2013/14 - 97.7% 2012/13 - 96.9%	Open Exeter	National Definition
Monitor Indicators - Access	All cancers: 31-day wait for second or subsequent treatment comprising: surgery	2014/15 - 95.3% (Q1-Q3) 2013/14 - 96.7% 2012/13 - 92.4%	Open Exeter	National Definition
Monitor Indicators - Access	All cancers: 31-day wait for second or subsequent treatment comprising: anti-cancer drug treatments	2014/15 - 99.9% (Q1-Q3) 2013/14 - 99.9% 2012/13 - 99.8%	Open Exeter	National Definition
Monitor Indicators - Access	All cancers: 31-day wait for second or subsequent treatment comprising: radiotherapy	2014/15 - 96.5% (Q1-Q3) 2013/14 - 98.9% 2012/13 - 98.7%	Open Exeter	National Definition
Monitor Indicators - Access	All cancers: 31-day wait from diagnosis to first treatment	2014/15 - 94.7% (Q1-Q3) 2013/14 - 97.5% 2012/13 - 96.3%	Open Exeter	National Definition
Monitor Indicators - Access	Cancer: two week wait from referral to date first seen comprising: all urgent referrals (cancer suspected)	2014/15 - 92.8% (Q1-Q3) 2013/14 - 95.4% 2012/13 - 95.5%	Open Exeter	National Definition
Monitor Indicators - Access	Cancer: two week wait from referral to date first seen comprising: for symptomatic breast patients (cancer not initially suspected)	2014/15 - 96.4% (Q1-Q3) 2013/14 - 93.7% 2012/13 - 96.5%	Open Exeter	National Definition
Monitor Indicators - Outcomes	Clostridium (C.) difficile – meeting the C. difficile objective	2014/15 - 6 cases due to lapses in care (target 30) 2013/14 - 28 (target 39) 2012/13 - 46 (target 67)	Public Health England - HCAI Data Capture System	National Definition
Monitor Indicators - Outcomes	Certification against compliance with requirements regarding access to healthcare for people with a learning disability	2014/15 - Compliant 2013/14 - Compliant 2012/13 - Compliant	Internal Audit	National Definition

Indicator Group	Indicator Description	Data	Source of measure	Definition
Indicator Mandated in Monitor Quality Report Guidance	<p>Emergency re-admissions within 28 days of discharge from hospital</p> <p>Indicator construction</p> <p>Percentage of emergency admissions to a hospital that forms part of the trust occurring within 28 days of the last, previous discharge from a hospital that forms part of the trust.</p> <p>Numerator</p> <p>The number of finished and unfinished continuous inpatient spells that are emergency admissions within 0 to 27 days (inclusive) of the last, previous discharge from hospital (see denominator), including those where the patient dies, but excluding the following: those with a main speciality upon re-admission coded under obstetric; and those where the re-admitting spell has a diagnosis of cancer (other than benign or in situ) or chemotherapy for cancer coded anywhere in the spell.</p> <p>Denominator</p> <p>The number of finished continuous inpatient spells within selected medical and surgical specialities, with a discharge date up to March 31 within the year of analysis. Day cases, spells with a discharge coded as death, maternity spells (based on specialty, episode type, diagnosis), and those with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the spell are excluded. Patients with mention of a diagnosis of cancer or chemotherapy for cancer anywhere in the 365 days prior to admission are excluded.</p>	<p>(i) 0 to 15: 2014/15 - 9.73% 2013/14 - 8.61% 2012/13 - 8.61%</p> <p>(ii) 16 or over: 2014/15 - 10.75% 2013/14 - 9.60% 2012/13 - 9.01%</p> <p>(This data is calculated using the Trust's internal data systems in order to provide a more up to date view of re-admissions. Core indicator 19 is calculated by the HSCIC using SUS data)</p>	Internal Reporting	National Definition
Additional Indicators as chosen by Trust	Patient Safety - The NHS Safety Thermometer - Harm Free Care	2014/15 - 95.4% 2013/14 - 95.3% 2012/13 - 94.2%	Safety Thermometer	National Definition
Additional Indicators as chosen by Trust	Patient Safety - Incidence of Pressure Ulcers	2014/15 - 0.28% (target 0.8%) 2013/14 - 0.24% (target 0.8%) 2012/13 - 0.34% (target 0.8%)	Internal Reporting	National Definition
CQUIN Indicator	1c. Friends & Family Test (Increased Response Rates for ED & Inpatient Friends & Family Tests)	Q1 - ED - 43.5% (Target 15%) Q1 - Inpatient - 27.4% (Target 25%) Q4 - ED - 44.8% (Target 20%) Q4 - Inpatient - 42.1% (Target 30%)	Unify2 Submission	National Definition

Indicator Group	Indicator Description	Data	Source of measure	Definition
CQUIN Indicator	1d. Friends & Family Test (Increased Response Rate for Inpatient Friends & Family Test)	Q4 - 42.1% (Target 40%)	Unify2 Submission	National Definition
CQUIN Indicator	2a. Safety Thermometer (Pressure Ulceration)	<p>Q1 - Audit tool developed to gather data for 5 patients in each area every month as part of the Safety thermometer day (Target - Development of an audit tool for gathering data for 5 patients in each area every month)</p> <p>Q2 - Baseline data collated (Target - Collection of Baseline data)</p> <p>Q3 - Compliance trajectory agreed (Target - agreement of a realistic compliance target which will incorporate the principle of a partial reward in the event of partial achievement)</p> <p>Q4 - Required improvement made in 4 of the 5 specified wards. Compliance rate of at least 85% across the hospital in aggregate achieved. (Target to achieve each of the following (a) each of the following five wards (Bolham, Bovey, CCU, Culm West and Mere) to reach a compliance rate of at least 85% across the span of Q4 and (b) a compliance rate of 85% is achieved throughout the hospital (in aggregate) across the span of Q4</p>	Safety Thermometer	Local Definition agreed with NEW Devon CCG
CQUIN Indicator	3a. Dementia (FAIR Assessments)	<p>Q1 - Case Finding 78.11% (April), 89.03% (May), 92.88% (June) Assess & Investigate 100.0% (April), 100.0% (May), 100.0% (June) Refer 100.0%(April), 99.57% (May), 100.0% (June)</p> <p>Q2 - Case Finding 93.10% (July), 96.81% (Aug), 91.35% (Sept) Assess & Investigate 100.0% (July), 100.0% (Aug), 100.0% (Sept) Refer 100.0% (July), 100.0% (Aug), 100.0% (Sept)</p> <p>Q3 - Case Finding 92.90% (Oct), 94.59% (Nov), 97.82% (Dec) Assess & Investigate 100.0% (Oct), 100.0% (Nov), 100.0% (Dec) Refer 100.0% (Oct), 100.0% (Nov), 100.0% (Dec)</p> <p>Q4 - Case Finding 96.2% (Jan), 95.6% (Feb), 95.9% (Mar) Assess & Investigate 100.0% (Jan), 100.0% (Feb), 100.0% (Mar) Refer 100.0% (Jan), 100.0% (Feb), 100.0% (Mar)</p>	Unify2 Submission	National Definition
CQUIN Indicator	3b. Dementia & Delirium (Training Programme)	<p>Q1 - Lead Clinician confirmed; training programme designed, agreed and implemented, and 52% of identified staff in priority areas trained (target 51%)</p> <p>Q2 - 63.67% of identified staff in priority areas trained (target 63%)</p> <p>Q3 - 79.64% of identified staff in priority areas trained (target 74%)</p> <p>Q4 - 88.32% of identified staff in priority areas trained (target 85%)</p>	ESR (Electronic Staff Record)	National Definition
CQUIN Indicator	4. Inpatient Diabetes Assessment	<p>Q1 - Process created to ensure that all wards are conversation with the "Think Glucose" assessment and are able to use the tool to identify patients who need diabetes specialist assessment and update the whiteboard to generate a referral (target achieved)</p> <p>Q2 - Achieved. (Target 30%)</p> <p>Q3 - Achieved. (Target 45%)</p> <p>Q4 - 59.81% (Target 60%)</p>	Internal Reporting	Local Definition agreed with NEW Devon CCG

Indicator Group	Indicator Description	Data	Source of measure	Definition
CQUIN Indicator	9. Acute Kidney Injury (AKI)	<p>Q1 - Achieved. (Target - Maintain inpatient team and embed system of alerting AKI team for patients with a flag for AKI. To communicate the process across the organisation to maximise benefit and to assess baseline performance based on 2013/14 experience).</p> <p>Q2 - Achieved (target 20%)</p> <p>Q3 - Achieved (target 30%)</p> <p>Q4 - Achieved (target 40% of all patients identified as having a stage of AKI will be assessed by the AKI team during their inpatient stay)</p>	Internal Reporting	Local Definition agreed with NEW Devon CCG
CQUIN Indicator	10. Reducing Waiting Times for Patients Receiving Results of Mammography	<p>Q1 - Baseline set, and plans developed for improvement (Target - set baseline and develop plans for improvement)</p> <p>Q2 - Plans for improvement implemented (Target - implement plans for improvement)</p> <p>Q3 - 68% of patients sent results in 3 working days, and 92% of patients sent results in 7 working days (Target - reduction in wait from 4 weeks to 2 weeks for an agreed % of patients)</p> <p>Q4 - 55% of patients sent results in 3 working days (72 hours), 92% of patients sent results within 5 working days (1 week), and 97% of patients within 7 working days (Target - 50% of patients sent results within 72 hours, 65% within 1 week, 90% within 2 weeks)</p>	Internal Reporting (CRIS & CDM)	Local Definition agreed with NEW Devon CCG
CQUIN Indicator	14. Domestic Abuse Training	<p>Q1 - Plan finalised, awareness campaign scoped and implemented. Referral figures provided. (Target - Finalise plan, scope and implement Awareness Campaign. Report on total number of cases identified and total referred to social services).</p> <p>Q2 - 60% of staff in ED (Emergency Department) and 60% of staff in Child & Women's Health Division have received Domestic Abuse Training. Number of cases identified and volume of referrals made provided. (Target - ensure that at least 60% of staff in ED and 45% of staff in Child & Women's Health Division have received Domestic Abuse Training. Provide figures on total number of cases identified and total number of referrals to social services)</p> <p>Q3 - 61% of staff in ED and 67% of staff in Child & Women's Health Division have received Domestic Abuse Training. Number of cases identified and volume of referrals made provided. (Target - ensure that at least 70% of staff in ED and 65% of staff in Child & Women's Health Division. Provide figures on total number of cases identified and total number of referrals to social services)</p> <p>Q4 - 89% of staff in ED and 75% of staff in Child & Women's health Division have received Domestic Abuse Training. Number of cases identified and volume of referrals made provided. (Target - ensure that at least 75% of staff in ED and 75% of staff in Child & Women's Health Division have received Domestic Abuse Training. Number of cases identified and volume of referrals made provided)</p>	ESR (Electronic Staff Record)	Local Definition agreed with NEW Devon CCG

Statement from the Council of Governors

Annex A

Once again it is an enormous privilege not only to comment on the Trust's Quality Report but also to have the opportunity to tell the members of the Trust how the Council of Governors contributes to the Trust's work.

This year has been a real on-going challenge to the Trust to maintain the quality of care, of which it is justly proud, in spite of the difficulties faced by the National Health Service nationally.

The two Governor priorities for the year - Outpatients and Hydration - have given Governors real opportunities to contribute to the work of the Trust and be involved in the deliberations in these areas of work. There is no doubt that in spite of the enormous pressure of work, all members of the Trust staff continue to do their utmost to deliver the best possible care to our patients.

Governors welcome the many new initiatives described in this year's report, one of which was the "#hellomynameis" campaign. This initiative is going well. The League of Friends is funding the boards to be placed behind patients' beds with Consultant's name and patient's name and other useful information for both visitors and patients.

The new post of Clinical Nurse Site Practitioner on night duty is to be celebrated too.

It is good to see the Trust encouraging the nursing staff with the launch of the Clinical School Nursing Awards, enabling them to use their research to improve care. It is also reassuring to read of the many schemes in place to reduce harm including the avoidance of Acute Kidney Injury (which requires further audit to continue improvement), the rapid assessment for sepsis and the Medication Safety Thermometer.

The Governors continue to be pleased with the "Members Say" events where members of the Trust have an opportunity to put forward ideas, attend talks, attend the Annual Members' Meeting and meet other members.

During the past year, Governors have been supporting the work of the hospital by taking part in the carers' audit, and the PLACE (Patient Led Assessments of the Care Environment) visits (inspections relating to cleanliness, condition of the environment and facilities to preserve privacy and dignity) in different areas across the hospital. Some Governors were able to attend the Extraordinary People Awards - another opportunity to appreciate the extraordinarily high quality of care provided by the Trust.

Governors have also participated in the Outpatients review, attended Board meetings, workshops on the improvement of patient information leaflets, ward observations and visits as well as observation of the Audit Committee and membership of the Patient Experience Committee.

The Council of Governors looks forward to working with the Trust on the two new Governor priorities for 2015/16:

- a) Discharge
- b) Improving the experience for patients with multiple needs.

Catherine Caldwell, OBE MSc

Public Governor for Exeter and South Devon

Statement from the New Devon CCG

Annex B

Thank you for giving NHS Northern Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) the opportunity to comment on the 2014/2015 Quality Report from the Royal Devon and Exeter NHS Foundation Trust (RDEFT).

The purpose of the Quality Report is to reflect and provide information on the quality of services and improvements made and NEW Devon CCG is pleased to see the documented progress on the 2014/15 priorities and the impact they have had directly or indirectly on patient experience.

It is clear from your Quality Report and the work we have been involved in together over the last year that your values and beliefs have underpinned the work that has made improvements and changes to patient safety, experience and effectiveness. We would wish to make particular comment on some of the many areas of success.

The hydration work is welcomed as this can make a real difference to patient health outcomes. The data in the report highlights the reduction of pressure ulcers and their severity and has demonstrated success in reducing harm as part of the wider Patient Safety Programme and we support the on-going collaborative work to make even more improvements in this area.

The national #hellomynameis campaign that was pledged by over one thousand staff at the RDEFT is an example of how small changes and straightforward acts can make a big difference to individuals. The recognition on social media and from the founder of the campaign, Kate Granger, demonstrates this impact which also reflects a staff commitment to the values of the RDEFT.

The RDEFT are to be congratulated on the national recognition they received for being one of only two acute hospitals in the country to be accredited by the National Gold Standards Framework Centre (GSF) for their end of life care. This includes in particular improvements made by the staff on Yeo and Yarty wards by using the GSF tool to recognise early decline, discuss advance care planning, and improving the discharge process to enable more people to be at home if they want to. This work continues in to the next year as it is rolled out across medical wards. Patient experience has also been enhanced by the joint work with charities FORCE and Macmillan which has included patient representatives alongside staff and experts.

The approach to human factors in the Patient Safety Programme is welcomed in terms of support to staff and patients and highlighting the importance of factors such as team work and behaviour. This demonstrates a willingness to learn from events and to be honest and accepting about what might have gone wrong.

NEW Devon CCG has been working with RDEFT to understand the breach in the cancer 62 day and 31 day urgent referrals and remains concerned about the safety and timeliness of responses. We will continue to work with RDEFT on this over the forthcoming year.

NEW Devon CCG acknowledges and supports the Trust priorities for the year ahead which give promise to further improvements in patient and staff experience, and quality and safety. We look forward to making our vision for future healthcare services through Transforming Community Services into a high quality service that assists patients to manage their health and care at a point as close to home as possible.

Both organisations have a shared vision with respect to patient safety, quality and experience and NEW Devon CCG looks forward to working with you in 2015/16 to support your continued effort to provide good quality and effective services for our large and varied population.

Lorna Collingwood-Burke

Chief Nursing Officer

Statement from Healthwatch Devon

Annex C

Commentary provided by Healthwatch Devon in response to the Quality Report 2014/15 produced by the Royal Devon and Exeter NHS Foundation Trust (RDEFT)

Healthwatch Devon welcomes the opportunity to provide a statement in response to the Quality Report produced by the RDEFT this year. Our response is based on our involvement with and knowledge of the Trust and its work, as well as on the feedback we receive about the quality of the services they provide, to all that come into contact with them.

With reference to progress in relation to the first Governor priority for 2014/15, Hydration, it is clear that the Trust has worked well to introduce initiatives such as new water jugs and new monitoring processes to measure fluid consumption and to access those at risk. An audit is anticipated and we would be interested to see the results of this in the coming months.

The second priority for the year was Outpatient Experience. This is a topic that Healthwatch Devon has received a number of individual experiences about. Where it works well, people are provided with supporting information in advance of and following appointments, they are communicated with in a way that they understand and appointment timings and transport is seamless. Where we have heard things have not gone well, this relates to: difficulties with telephone systems; cancelled appointments on the day; inconvenience of appointments; treatment delays; directions within hospital unclear; administration errors; and inconsistent access to interpreters. We recognise the need for overall improved management systems and technology. However, we believe that for some of the issues that we hear about, simpler measures could be taken in the interim period, while waiting for bigger system changes to be implemented, such as an improved, 'person'-friendly telephone system, or improved access to a range of interpretation/translation services.

Healthwatch Devon notes the Governor priorities for the coming year: Discharge and Patients with Multiple Health Needs and we will be mindful of these priority areas when engaging with people about their experiences at the hospital.

Hospital discharge has recently been the focus of community engagement for Healthwatch, both locally and nationally. Our findings have been shared with Commissioners and local NHS Provider Trusts for their consideration and response. More than half of the experiences we captured took place at the RD&E hospital. People praised the quality of care they received on the wards by staff and we are encouraged to learn of the work that has been carried out by the Trust around 'Compassion', 'Safe Discharge' and 'Medication on Discharge'. However, the causes for concern that we have identified centred around timeliness in relation to care assessments and care packages being in situ on return home; provision and quality of information provided to patients, carers and relatives and coordination of care between different organisations. We look forward to receiving the Trust's response to our report of people's experiences of hospital discharge and would welcome working together with the Trust to support improvement work where possible.

The Trust's aim for a person centred approach to developing "an effective, efficient and sustainable integrated care system" is to be commended and is an aim that Healthwatch Devon is keen to share from a consumer perspective, based on the stories we hear. Being responsive to people's individual needs is a key theme that we have identified through people's stories, with timeliness of communication, diagnosis and treatment being key to improving the quality of people's lives, even more so if a patient is receiving end of life care. John's story featured in this account echoes many of those that we capture through Healthwatch Devon's information and advice service and it is through our close working with service delivery partners CAB Devon (Citizens Advice Bureau) and the other user led organisations that we work with, that we can offer support, advice and information to those who need it.

With reference to the CQUIN (Commissioning for Quality and Innovation) performance indicators, we are encouraged to see compliance has either been achieved, or is on the way to being achieved, for indicators such as Friends and Family Test; Patient Safety (Incidence of Pressure Ulcers); Reducing Waiting Times - Mammography Results; Dementia (Fair Assessments); Dementia and Delirium Training Programme; Inpatient Diabetes Assessment; Acute Kidney Injury; and Domestic Abuse Training.

The anticipated failures are (although year-end results cannot be confirmed until Q4 2014/15 results are included) the A&E 4 hour target and a number of the cancer waiting times targets especially 62 day GP Referral to Treatment, 31 day First Treatment, 31 day Subsequent Surgery.

In respect of A&E waiting times, we acknowledge that this situation mirrors what is happening nationally and in other parts of the South West. Healthwatch Devon recently reported findings in relation to where people go if they are seeking non-urgent medical treatment and this report revealed that many people are unsure of their options and therefore go to A&E as a first choice. Others reported difficulties in getting GP appointments in Devon and others reported being signposted to A&E, when this was not necessary, all factors having an impact on the capacity to see people within targeted waiting times.

In respect of cancer waiting times, there appears to be little improvement over the year according to the CQUIN performance indicators. Healthwatch Devon would be keen to know whether patients, whose treatment has breached the target, are informed of this and whether a risk assessment is done by a clinician and is communicated to the patient. We believe that the surgical robot has been operational for at least two years now so we would guess that the delays are possibly due to capacity issues, but we would be keen to learn more.

Healthwatch Devon reports its consumer experience findings directly to the Trust's Patient Experience Committee and going forward, will be keen to develop a two way dialogue so that we can demonstrate to people who share their experiences with us, where feedback has been heard and where experiences have influenced particular work streams for service improvement.

Statement from the Health and Wellbeing Scrutiny Committee

Annex D

Devon County Council's Health and Wellbeing Scrutiny Committee has been invited to comment on the Royal Devon and Exeter NHS Foundation Trust Draft Quality Report 2014/15 which includes the priorities for 2015/16. All references in this commentary relate to the reporting period 1st April 2014 to 31st March 2015 and refer specifically to the Trust's relationship with the Scrutiny Committee and its members.

The Scrutiny Committee believes that the Quality Report 2014-15 is a fair reflection and gives a comprehensive coverage of the services provided by the Trust, based on the Scrutiny Committee's knowledge. The Chief Executive of the Foundation Trust has maintained a good relationship with scrutiny and has had specific contact with the Scrutiny Committee Chair, providing briefings and reports as issues have arisen. The Scrutiny Chair and Scrutiny Officer were also invited to speak to the Council of Governors to increase their knowledge about the role of scrutiny.

The RD&E presented to the Scrutiny Committee in September 2014 with a Service update and information on patient flow. This followed concern from the Scrutiny Committee on the rising demand for services, particularly in A&E. The RD&E identified consequences including increases in medical outliers in surgical beds, risk of on the day surgery cancellations, and increase in the transfer of care delays, as well as significant financial impacts and pressure on staff. The Scrutiny Committee was confident in the RD&E's strategy to mitigate the impact of rising demand including closer working with Social Care colleagues, redesigning of flow and care pathways at the RD&E, an agreement to expand the Early Supported Discharge – Stroke scheme, commencement of the ICE (Integration in the City of Exeter) project and the GOOD Project (Good Outcomes On Discharge). The Committee does have enduring concerns about future rises in demand upon services.

The Committee is pleased to see the inclusion of discharge as one of the Governor priorities in light of the concerns raised at Committee. The Committee recognises the reduction in serious incidents involving patient discharge with the introduction of the GOOD project. In addition, the Committee would like to commend the RD&E on the reduction in weekend mortality. Finally to mention the 'nutrition matters' work as a simple issue that once addressed can dramatically speed up outcomes.

The enduring challenge from the Francis Review provoked to scrutiny has been to look for improvement in health care through critical friend challenge. In the climate of austerity this rigor becomes even more vital. The Committee welcomes a continued positive working relationship with the RD&E in 2015/16 and beyond.

Statement of Directors Responsibilities for the Quality Report

Annex E

The directors are required under the Health Act 2009 and the National Health Service Quality Accounts Regulations to prepare quality accounts for each financial year.

Monitor has issued guidance to NHS foundation trust boards on the form and content of annual quality reports (which incorporate the above legal requirements) and on the arrangements that NHS foundation trust boards should put in place to support data quality for the preparation of the quality report.

In preparing the quality report, directors are required to take steps to satisfy themselves that:

- the content of the quality report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual 2014/15;
- the content of the quality report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2014 to March 2015
 - papers relating to Quality reported to the Board over the period April 2014 to March 2015
 - feedback from Commissioners dated 12 May 2015
 - feedback from Governors dated 8 May 2015
 - feedback from local Healthwatch organisations dated 12 May 2015
 - feedback from Overview and Scrutiny Committee dated 14 May 2015
 - the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 2014/15
 - 2014 national patient survey
 - 2014 national staff survey
 - The head of internal audit's annual opinion over the trust's control environment dated 19 May 2015
 - CQC Intelligent Monitoring Reports dated March 2014, July 2014 and December 2014.
- the quality report presents a balanced picture of the NHS foundation trust's performance over the period covered;
- the performance information in the quality report is reliable and accurate;
- there are proper internal controls over the collection and reporting of the measures of performance included in the quality report, and these controls are subject to review to confirm that they are working effectively in practice;
- the data underpinning the measures of performance in the quality report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review; and
- the quality report has been prepared in accordance with Monitor's annual reporting guidance (which incorporates the Quality Accounts Regulations) as well as the standards to support data quality for the preparation of the quality report.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the quality report.

By order of the Board.



date: 27 May 2015

Chairman



date: 27 May 2015

Chief Executive

Clinical Audit

Annex F

National Clinical Audit/Confidential Enquiry Title	Eligible?	Participated 2014/15	% Participation Rate
Acute Coronary Syndrome or Acute Myocardial Infarction (MINAP)	Yes	Yes	75%
Adherence to BSC & NANS Standards for Ulnar Neuropathy at Elbow Testing	Yes	Yes	100%
Adult Community Acquired Pneumonia (British Thoracic Society)	Yes	No	N/A
Bowel Cancer (NBOCAP)	Yes	Yes	100%
Cardiac Rhythm Management (CRM)	Yes	Yes	100% (Electrophysiology stats not available)
Case Mix Programme (ICNARC)	Yes	Yes	100%
Congenital Heart Disease (Paediatric cardiac surgery) (CHD)	No	No	N/A
Coronary Angioplasty (PCI)	Yes	Yes	100%
National Diabetes Audit (Adult)	Yes	Yes	783 cases submitted (denominator not available)
Diabetes (Paediatric) (NPDA)	Yes	Yes	99.5%
Elective Surgery (National PROMs Programme*) - Hernia	Yes	Yes	49.3%
Hip	Yes	Yes	105.9%
Knee	Yes	Yes	115.2%
Vein	Yes	Yes	34.9%
<p>*Quality Health (QH) have advised that the reason the participation rate is higher than 100% is due to the time lag in the submission of the Hospital Episodes Statistics (HES) data. There are many Trusts who have participation rates over 100% and QH have said that the RD&E's gives no cause for concern.</p>			
Epilepsy 12 Audit (Childhood Epilepsy)	Yes	Yes	100%
Fitting Child (College of Emergency Medicine)	Yes	Yes	43 cases submitted (min 10 with max 50 cases)
Head and Neck Oncology (DAHNO)	Yes	Yes	100%
Hip Fracture Database (NHFD)	Yes	Yes	100%
Inflammatory Bowel Disease (IBD) - Biological Therapy Audit	Yes	Yes	70% (66 cases submitted)
Lung Cancer (NLCA)	Yes	Yes	100%
Maternal, New born and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	100%
NCEPOD: Gastrointestinal Bleeds Study	Yes	Yes	100%
NCEPOD: Sepsis Study	Yes	Yes	100%
NCEPOD: Lower Limb Amputation	Yes	Yes	100%
NCEPOD: Tracheostomy Care	Yes	Yes	100%
Mental Health in the ED (College of Emergency Medicine)	Yes	Yes	50 cases submitted (up to 50 cases required)

National Clinical Audit/Confidential Enquiry Title	Eligible?	Participated 2014/15	% Participation Rate
Mental health clinical outcome review programme: National Confidential Inquiry into Suicide and Homicide for people with Mental Illness (NCISH)	No	No	N/A
National Adult Cardiac Surgery Audit	No	No	N/A
National Audit of Intermediate Care	Yes	No	N/A as Trust does not provide intermediate care
National Cardiac Arrest Audit (NCAA)	Yes	Yes	100%
National Chronic Obstructive Pulmonary Disease (COPD) Audit Programme - Secondary Care Workstream	Yes	Yes	100%
National Comparative Audit of Blood Transfusion: Audit of Transfusion in Children & Adults with Sickle Cell Disease 2014	Yes	Yes	100%
National Comparative Audit of Blood Transfusion: Patient Information & Consent 2014	Yes	Yes	25%
National Emergency Laparotomy Audit (NELA)	Yes	Yes	100%
National Heart Failure Audit	Yes	Yes	230 cases submitted (on-going data submission to 1 June 2015)
National Joint Registry (NJR)	Yes	Yes	1715 cases submitted (denominator not available)
National Prostate Cancer Audit (NPCA)	Yes	Yes	100%
National Vascular Registry	Yes	Yes	194 cases submitted (denominator not available)
Neonatal Intensive and Special Care (NNAP)	Yes	Yes	100%
Non-Invasive Ventilation - Adults (British Thoracic Society)	Yes	No	N/A
Oesophago-Gastric Cancer (NAOGC)	Yes	Yes	100%
Older People - Cognitive Assessment (College of Emergency Medicine)	Yes	Yes	56 cases submitted (100 cases max)
Paediatric intensive care (PICANet)	No	No	N/A
Pleural Procedures (British Thoracic Society)	Yes	No	N/A
Prescribing Observatory for Mental Health (POMH)	No	No	N/A
Pulmonary Hypertension (National Pulmonary Hypertension Audit)	No	No	N/A
Renal Replacement Therapy (Renal Registry)	Yes	Yes	100%
Rheumatoid and Early Inflammatory Arthritis	Yes	Yes	23 cases submitted in the reporting period 1 February to 29 September 2014
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	99%

The reports of 13 national clinical audits were reviewed by the provider in 2014/15 and the Royal Devon & Exeter NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit / Confidential Enquiry Title	Actions
British Thoracic Society (BTS) Audit of the Management of Paediatric Pneumonia 2012-13	<p>The report found that blood tests and cultures collected reduced from 57% in 2011-12 to 35% in 2012-13. The BTS advises selective use only as they do not aid patient management.</p> <p>The guideline advice on antibiotic choice was not followed in 30% of cases. This has increased from 14% in 2011-12.</p> <p>The Trust aims to achieve the following results through presentation of audit findings and local guidelines which were presented to the paediatric department on 30th September 2014:</p> <ul style="list-style-type: none"> ● To further reduce the number blood-tests being done on children with pneumonia ● To further improve adherence to Trust antibiotic guidelines for antibiotic prescribing in paediatric pneumonia
College of Emergency Medicine (CEM) Management of the Patient with Sepsis in the Emergency Department	<p>The Trust remains at or above the National upper quartile in vital sign measurement, glucose measurement, use of oxygen, administering iv fluids, obtaining blood cultures prior to giving antibiotics and measuring urine output in the Emergency Department (ED).</p> <p>The ED is not meeting the CEM standards of 95-100% compliance in several fields, although this is reflected nationwide. The ED is at the median for measuring lactate, and below the median (90% compliance against median of 94%) for giving antibiotics before leaving the department, though the results are improving.</p> <p>After the last round of audit, the following interventions were implemented to address shortcomings, focusing on education, documentation and processes:</p> <ul style="list-style-type: none"> ● Educational talks are regularly given during departmental handover meetings, as well as at audit meetings ● A Nurse Sepsis Champion is leading nursing care on this topic, raising awareness and education ● A sepsis bundle is used for all patients identified with sepsis, and patients with sepsis are identified earlier due to the new Rapid Assessment and Treatment system, whereby a senior decision maker takes the handover alongside the Nurse in Charge ● Use of sepsis stickers in the notes, a sepsis trolley to hasten administration of antibiotics and a patient group directive (PGD) for antibiotics prescription <p>The above interventions have improved performance in the department but the need to continue to improve to meet CEM standards remains.</p>
National Audit of Seizures in Hospitals (NASH) 2	<p>The report highlighted areas of good performance which included that 96% of patients are seen within 4 hours in ED. However, the audit highlighted that there was no Epilepsy Specialist Nurse in post. This has been addressed by the appointment of an Epilepsy Nurse Specialist who has been in post since October 2014.</p>
National Chronic Obstructive Pulmonary Disease (COPD) Audit: Resources and organisation of care in acute NHS units in England and Wales 2014	<p>The audit report indicated that the Trust scored extremely well. Key strengths of our service relative to other Trusts' are the presence of a Respiratory Consultant at morning report seven days a week and the number of Nurse Specialists available to see patients with COPD. Moreover we have five High Dependency Unit beds available to patients with exacerbations of COPD which is above the national average. It was noted however that there was a relative lack of access to a dedicated dietician.</p>

National Clinical Audit/Confidential Enquiry Title	Actions
National COPD Audit: Clinical audit of COPD exacerbations admitted to acute units in England and Wales 2014	<p>The audit report indicated that the Trust performed well particularly in the following areas:</p> <ul style="list-style-type: none"> ● Lower than average inpatient mortality 2.8% versus (v) 4.3% nationally ● 94% seen by a respiratory consultant (57% nationally) within a median of 17 hours (22 hours nationally) ● Oxygen prescription was better than the national average (89% v 55%) with 91% having appropriate target saturations ● Better recording of spirometry and Medical Research Council breathlessness scores than nationally (83% v 46% and 97% v 61% respectively) ● Multi-disciplinary decision on ceiling of care with greater patient involvement than nationally ● Higher proportion of patients managed on a respiratory ward than nationally (89% v 42%) ● More people discharged under care of COPD team/Early Supported Discharge (ESD) than nationally (60% v 40%) <p>However, the following areas required improvement:</p> <ul style="list-style-type: none"> ● Median length of stay 5 days (4 days nationally) ● Only 50% of smokers given smoking cessation advice, however this is a similar picture nationally ● Fewer arterial blood gas measurements than national average <p>Consequently the Trust intends to take the following actions:</p> <ul style="list-style-type: none"> ● Discuss the merits of arterial blood gas measurement as opposed to venous blood gas ● Educate ward teams regarding smoking cessation advice and recording the fact that this has been given to the patient

National Clinical Audit/Confidential Enquiry Title	Actions
National Adult Diabetes Inpatient Audit 2013	<p>The report indicated:</p> <ul style="list-style-type: none"> ● Low rates of admission due to diabetes (particularly a fall in those admitted with active foot disease 6.7% v 11.5% in 2010) ● 56.7% of patients with diabetes were reviewed by a member of the specialist diabetes team (national average 34%) in spite of having significantly smaller inpatient diabetes team and less hours of specialist nurse working time (0.5 hrs per patient v 1.66 hrs of national average) ● A reduction in the number of episodes of mild and severe hypoglycaemia (BG<3mmol/L) episodes 6.3% v 17% in 2010 and an increase in patients feeling that they could take care of their own diabetes (61% up from 35% in 2010 and national average 54%) ● 100% of patients felt that they received enough emotional support with regards to their diabetes and 83% were satisfied or very satisfied with the care they received ● 37.5% of patients received a foot assessment within 24 hrs of admission (down from 75% in 2013) and there was a fall in the percentage of patients admitted with active foot disease that were reviewed by the specialist foot care team (71% from 91% in 2012 – national average 59%) ● Higher than average management errors (39% v 22%) and insulin errors (32% v 20%) ● 57% of patients felt that the team caring for them worked together well <p>The following actions were agreed to further improve patient care:</p> <ul style="list-style-type: none"> ● Appointment of inpatient diabetes dietician ● Appointment of inpatient podiatrist ● Increase in inpatient diabetes specialist nurse hours and initiation of seven day working ● New targets for 'Think Glucose' continual audit ● CQUIN for diabetes assessment within 24 hours (target of 60% by April 2015) which will include referral criteria to specialist diabetes team, diabetes dietician and diabetes podiatrist ● Modification of Ward Whiteboard ● Education of junior doctors and ensure diabetes assessment completed at Acute Medical Unit board round ● Discussions with pharmacy team to check prescription charts for insulin and diabetes drugs <p>There will be no national audit in 2014 due funding constraints. As a result, the Trust has decided to carry out a local audit instead.</p>

National Clinical Audit/Confidential Enquiry Title	Actions
National Emergency Laparotomy Audit – Phase 1	<p>The report demonstrated that the Trust performed well in the following areas:</p> <ul style="list-style-type: none"> ● Provision of a single pathway or policy for the care of the unscheduled adult general surgical patient - established with Emergency Laparotomy Pathway Quality Improvement Care Bundle (ELPQuIC) ● Provision of the required four-tier surgical on call (Foundation, Core Trainee, Registrar, Consultant) ● A formal pathway for the involvement of diagnostic and interventional radiology in the care of Emergency General Surgery patients (ELPQuIC showed service provided by Radiology Department is excellent) ● Provision of 24 hour pathology services ● Formal protocol for management of patients with sepsis ● Provision of consultant-delivered anaesthesia 24 hours/day ● Seniority of staff present in theatre according to calculated risk (almost universally consultant surgeon and anaesthetist) ● Formal pathway for formal calculation of risk that provides an estimation of perioperative mortality & location of post-operative care according to calculated risk ● 24 hour consultant-led critical care provision <p>The report also found that there was no dedicated area for assessment of Emergency General Surgery (EGS) patients, separate from elective admissions. It also found that the Surgical Consultant is not 'free from all elective and non-acute commitments for the whole period whilst they are covering emergency general surgical workload' and that there is no dedicated Emergency General Surgical theatre between 13.00-17.00 on weekdays.</p> <p>The following actions have therefore been proposed:</p> <ul style="list-style-type: none"> ● Changes to consultant surgical rota/staffing to free from non-emergency commitments, increasing availability of consultant surgeons to lead timely diagnosis and treatment ● Consideration of development of a Surgical Admissions Unit, so that management of EGS patients can be appropriately prioritised without competition for facilities from the elective workload ● Formal arrangement for rapid availability of staffed theatre for Emergency General Surgery patients (not necessarily 'exclusive' availability)
National Joint Registry – 2013	<p>The report highlighted that the Trust is a high volume centre for lower limb joint replacements when compared to the national average. The data from the audit demonstrates that the Trust exceeds both the national benchmark and the national average, and in particular, showed exceptional outcome results for total hip replacements. There were no areas of poor performance.</p>

National Clinical Audit/Confidential Enquiry Title	Actions
National Confidential Enquiry into Patient Outcome and Death (NCEPOD) Tracheostomy Study	<p>The NCEPOD report found that the Trust performed well locally in the management of temporary tracheostomy. However, issues were raised in the report relating to documentation of tracheostomy and training. Consequently, the Trust intends to take the following actions to address these issues:</p> <ul style="list-style-type: none"> ● Tracheostomy to be recorded on IT system (CareVue) as a surgical procedure with checklist ● Consent to be documented on CareVue ● Provision of training, three times a year, for ward staff and Trust induction for medical staff ● Unplanned tracheostomy changes recorded in Morbidity and Mortality data ● All wards now have provision of cuff pressure monitoring ● Guidelines available for ward management of tracheostomy provided by the Intensive Care Unit Tracheostomy team ● Decision for previous extubation formally discussed and documented by multidisciplinary team on ward round ● Trust to utilise national patient safety guidelines and e-learning
Sentinel Stroke National Audit Programme (SSNAP)	<p>The total organisational score received by the Trust was 79.2, graded as C on a scale of A-E (high to low). The national median total organisational score was 73.5, placing the Trust still above, but close to the national average. In order to return the Trust Stroke Service to the top grades (A or B) of the audit by the next round in 2016, the following actions are proposed:</p> <ul style="list-style-type: none"> ● The development of a true hyper-acute stroke unit meeting the necessary criteria for such a unit ● The further development of the outpatient transient ischaemic attack (TIA) service to encompass assessment and appropriate investigation of cases of suspected TIA/minor stroke seven days a week ● The full provision of Early Supported Discharge/Specialist Stroke Team
UK Inflammatory Bowel Disease (IBD) Audit (4th Round)	<p>The fourth round of the audit was the most complex and detailed audit to date, including five elements, of which the Trust participated in four. The results demonstrated that the Trust has a comprehensive, high quality IBD service with more than 90% of questions graded A (excellent).</p> <p>There were areas for improvement and the Trust has proposed the following actions to ensure adherence to National IBD standards and improve patient care:</p> <ul style="list-style-type: none"> ● Bed managers, IBD specialist nurses and ward manager to ensure all IBD patients with active disease will be managed on the appropriate ward ● Review of infusion service to include personnel delivering service ● All IBD patients with active disease admitted to hospital to be reviewed by IBD specialist nurse ● To work with the commissioners to develop a community IBD nursing post ● Installation of the Inflex IBD patient management system ● Review of psychological/psychiatric provision to provide support for IBD patients

National Clinical Audit/Confidential Enquiry Title	Actions
<p>National Comparative Audit of Blood Transfusion (NCABT) Programme - Consent Audit</p>	<p>The NCABT is a rolling programme of audits looking at the care delivered with respect to the transfusion of blood components and blood products. This audit focussed on the Trust's compliance with SABTO (Safety of Blood, Tissues and Organs) national recommendations 2010 regarding patient consent for blood transfusion. The Trust was audited against two standards with the following results:</p> <ul style="list-style-type: none"> ● Consent for blood transfusion was documented in the medical notes in 43% of cases nationally but 0% of the 10 cases examined at the RD&E. There was documented evidence of written information given to patients in 19% of cases nationally and 0% for this Trust ● Good compliance with transfusion training for medical staff (documented within previous two years), 75% for the Trust and 81% nationally <p>The audit included a patient survey which was completed by 6 patients. This showed that 50% of patients stated that someone had spoken to them about transfusion and 33% had been involved in the transfusion decision making process. Evidence that consent has been documented will be part of an electronic ordering system for blood and blood components which will be developed as part of the blood tracking system being implemented by the Trust in 2015.</p>
<p>National Lung Cancer Audit (National Audit of Mesothelioma 2008-2012)</p>	<p>Information relating to this audit was presented at a Peninsular Network level. Network teams performed well against a number of indicators including:</p> <ul style="list-style-type: none"> ● Time to diagnosis ● Histological confirmation ● The proportion of patients having anti-cancer treatments ● Median survival ● One year survival <p>Nationally, data completeness and/or service compliance was identified as sub-optimal for the following: performance status, staging, co-morbidity, multidisciplinary team discussion, histological/cytological confirmation, subtype classification, coding for surgical procedures and contact with Clinical Nurse Specialist. The report did not include organisational performance against these indicators. The Trust intends to review locally held data for 2008-12 in relation to key fields. The action plan will be updated in response to the local data review.</p>

The reports of 15 local clinical audits were reviewed by the provider in 2014/15 and the Royal Devon and Exeter NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

Local Clinical Audit Title & Aim	Actions
<p>Assessment of Agreed Blood Ordering Schedule</p> <p>Aim: to assess if the Trust is meeting the standards of the agreed blood ordering schedule prior to surgery for elective and emergency admissions</p>	<p>This audit demonstrated that, during the initial two cycles, compliance with Trust policy was 72%. A sticker was designed that was placed on the Anaesthetic Chart when the patient attends the Preparation for Surgery visit, if they required a sample as per the Agreed Blood Ordering schedule. This sticker identified which patients needed a valid sample. It was completed when samples were taken, highlighted the problems with antibodies and made it clear whether a second sample had been taken and was therefore imminently processed. Following introduction of the sticker 95% of patients had a valid "Group and Save" status.</p> <p>The sticker has subsequently been amended, and the following actions have been agreed to further include compliance:</p> <ul style="list-style-type: none"> ● Further education, especially of Foundation Doctors ● Liaison with the Preparation for Surgery Team to include patients within Child and Women's Health
<p>Compliance with Gentamicin IV Protocol</p> <p>Aim: to assess compliance with the Trust Gentamicin IV extended interval protocol for adults in medicine and surgery</p>	<p>This audit demonstrated that all patients audited received gentamicin for less than five days, meeting the 100% target. However, the remaining targets regarding prescribing and monitoring were not achieved. Consequently the following actions were agreed to improve patient care with a re-audit due in December 2015:</p> <ul style="list-style-type: none"> ● Create and distribute a gentamicin safety briefing ● Develop an antimicrobial guidelines smart phone app to improve access to antimicrobial guidelines and dosing calculator ● Additional education and training for ward and pharmacy staff ● Investigate the possibility of a pan-Devon gentamicin policy ● Work with senior nurses and the pharmacists to improve the recording of heights and weights on the drug chart
<p>Consent for Procedures within Obs & Gynae</p> <p>Aim: to ensure the valid consent to treatment is being taken appropriately, in line with the Trust's Consent Policy</p>	<p>The audit found that compliance was high with regards to consent for procedures. However, there was only evidence of patients receiving written information about their procedure in 60% of cases.</p> <p>In order to reach 100% compliance, the following action was put in place:</p> <ul style="list-style-type: none"> ● Findings and detailed guidance for adherence to the RD&E Consent Policy provided to Obstetricians, Gynaecologists and Clinical Nurse Specialists
<p>Fault Reporting Label for Medical Devices</p> <p>Aim: to establish the current standards for completion of the Fault Reporting Label for medical devices</p>	<p>The audit highlighted that Fault Reporting Labels were fully completed in only 7% of cases. Due to the risk and safety issues relating to incorrect processes being followed, and inappropriate documentation being used, the actions below were agreed to improve compliance:</p> <ul style="list-style-type: none"> ● Training and education, review of current documentation and discussion with key stakeholders ● Alert and staff training via an information pack ● Medical Device Library to be supported to complete DATIX forms when damaged medical devices are returned inappropriately
<p>Gaining Consent for Child Protection Examinations (Re-audit)</p> <p>Aim: to assess whether we are following national guidelines of obtaining and documenting informed consent for child protection medicals</p>	<p>The audit demonstrated that 74% of reports had consent documented; 48% of reports were sent out within three days; and 83% of reports were sent on/copied to the Social Worker.</p> <p>The following actions were agreed:</p> <ul style="list-style-type: none"> ● Teaching sessions for all relevant staff ● Improve knowledge of proforma through communication with administrative staff

Local Clinical Audit Title & Aim	Actions
<p>Home Haemodialysis Audit</p> <p>Aim: to measure dialysis adequacy, biochemistry markers and quality of life for patients transferring from unit or satellite haemodialysis to home haemodialysis</p>	<p>Patient numbers in this audit were too low to come to any firm conclusions about the effectiveness and benefits of home haemodialysis. However, it was found that iron targets and erythropoiesis-stimulating agent (ESA) dosing should be reviewed to better manage haemoglobin. The Trust also aims to improve compliance with National Institute for Health and Care Excellence (NICE) guidance which recommends that 10% of the dialysis population should receive home haemodialysis (HD).</p> <p>The following actions were agreed to increase the number and manage haemoglobin:</p> <ul style="list-style-type: none"> ● Encourage self-care and shared care within units ● Work towards training patients directly from low clearance ● Continue to offer Gambro and NxStage home HD ● Patients to see dietician at consultant clinic ● Review target iron levels and ESA dosing
<p>Hyponatraemia in Oncology Patients</p> <p>Aim: to assess how many inpatients on Yeo ward have hyponatraemia and whether they are being appropriately investigated and managed</p>	<p>The audit found that hyponatraemia was not always mentioned on the discharge summary for the relevant patients. It also found that not all patients were having all of the required tests if their serum sodium levels were below a certain point.</p> <p>The following actions were put in place to increase compliance and ensure that patients with hyponatraemia are appropriately managed:</p> <ul style="list-style-type: none"> ● Local guideline produced and published ● Training provided on appropriate coding to new junior doctors
<p>Identifying glaucoma patients with visual field loss outside the Driver and Vehicle Licencing Agency's (DVLA) acceptable limit success rate (Initial Audit & Re-audit)</p> <p>Aim: to monitor the efficacy of a stamp & signature method for identifying glaucoma patients with visual field loss outside the DVLA's acceptable limit</p>	<p>The initial audit results indicated that there was a poor success rate in the stamp and signature method to fully record a patient's driving status; 20% of total notes audited had no stamp, while 77% had partially completed stamps. Although the stamp itself was designed to collect the necessary information, staff were responsible for ensuring its completion. The data also indicated that 72% of partially completed stamps failed to indicate whether the visual fields were reportable to the DVLA, 100% of partially completed stamps failed to indicate whether the patient was notified of their visual fields and 96% of partially completed stamps did not have a second clinician signature. In order to improve stamp completion the following actions were agreed:</p> <ul style="list-style-type: none"> ● Ensure that 100% of notes that pass through glaucoma clinic are stamped by liaising with administrative members of the glaucoma team ● Liaise with responsible glaucoma clinicians and remove the barriers to stamp completion ● The stamp does not indicate what type of licence the patient holds. As the criteria for Group 1 and Group 2 licences differ, practitioners were encouraged to remember there are different rules for Group 2 drivers ● Letter to General Practitioners (GP) to include any cases where defects are picked up in patients who have not told the DVLA. The stamp does not indicate whether the GP has been notified of the patient's visual field <p>A re-audit took place following the above interventions which indicated that there had been a significant improvement in the completion of visual field stamps. The number of notes with stamps had increased from 80% to 98% with a greater proportion of those being fully completed, increasing from 4% to 73%. When looking at the proportion of fully completed stamps amongst the total number of patient notes, similar figures were noted with an improvement of 3% to 68%. The results were presented at the departmental meeting, with hopes of further improvement and a further audit cycle to improve visual field stamp completion to 100%.</p>

Local Clinical Audit Title & Aim	Actions
<p>Management of Staphylococcus Aureus Bacteraemias</p> <p>Aim: to review the Trust's usual management of patients with staphylococcus aureus bacteraemia</p>	<p>The audit found that not all results had been reviewed by a microbiologist, some samples lacked the appropriate authorisation comment, and not all patients were being reviewed weekly by junior doctors.</p> <p>The following actions were put in place:</p> <ul style="list-style-type: none"> ● Improve documentation of advice in medical notes and authorisation comments on laboratory reports ● Implementing the use of a standard proforma ● Developing a standard report comment for Staphylococcus Aureus Bacteraemias
<p>Methotrexate Treatment in the Dermatology department</p> <p>Aim: to find out if patients on methotrexate are being monitored appropriately according to best practice guidelines and to identify areas where there is potential for change</p>	<p>The results of the audit showed that baseline blood tests are carried out in line with national guidelines. Although 83% of patients had a baseline chest x-ray, only 64% had this within six months of starting methotrexate therapy as recommended by the national guidelines. The following action has been agreed to improve compliance with this guideline:</p> <ul style="list-style-type: none"> ● The use of a new pre-assessment checklist to confirm that the patient has had a baseline chest x-ray within six months prior to starting methotrexate treatment
<p>Orthoptic Notes Audit</p> <p>Aim: to assess documentation of treatment, follow timescale, diagnosis and if a letter was sent to GP, within the orthoptic department</p>	<p>The audit found that the documentation of Orthoptic reports at outreach clinics was not as good when compared to the documentation of those patients seen at the West of England Eye Unit (WEEU). Recording dates on all entries was not consistent; although the date is on the initial page of report, it was not always documented on subsequent pages. Recording the diagnosis has improved since the previous audit in 2012, however not all areas used the same terminology.</p> <p>The following actions were agreed to improve documentation:</p> <ul style="list-style-type: none"> ● WEEU considering standardising terminology ● Individuals were made aware of their mistakes and omissions in order to improve reporting in patient notes
<p>Potassium & Phosphate levels in Haemodialysis Patients</p> <p>Aim: to compare current levels of potassium and phosphate in haemodialysis patients to current recommended guidelines</p>	<p>The audit found that 28% of patients had raised phosphate levels, compared to only 3.5% having raised potassium levels. It was also found that not all patients were being reviewed every four to six months.</p> <p>In order to improve compliance, the following actions were put in place:</p> <ul style="list-style-type: none"> ● Increase visual information in all renal units ● Information about binders - timing and doses to be displayed ● Phone review of patients if they are reaching the six month review stage if there is no planned attendance at a Satellite Unit
<p>Prophylactic Antibiotic Use in Open Lower Limb Fractures</p> <p>Aim: to identify the degree of compliance with the local guideline 'Antibiotic prophylaxis guidelines for open fractures of the lower limb'</p>	<p>The audit found that all patients were offered systemic antibiotics; however this was within 180 minutes of injury in only 50% of cases. Of the patients that underwent surgery, 41% were prescribed antibiotics to prevent surgical site infections, but only 35% had the prophylaxis stopped within 72 hours, as per the guideline.</p> <p>The following actions were put in place:</p> <ul style="list-style-type: none"> ● Training and education for all relevant members of staff ● Guidelines updated

Local Clinical Audit Title & Aim	Actions
<p>The Appropriateness of Antimicrobial Prescribing in the Maxillofacial Department Outpatient Setting</p> <p>Aim: to ensure antimicrobial prescribing is in line with national and trust protocols</p>	<p>This audit showed that 36% of prescriptions were given for post-operative prophylaxis. Some patients with no indication for antimicrobials were still given a prescription despite no evidence base to suggest that this would be clinically beneficial. National guidance and evidence is lacking for the majority of cases. The available data was not robust enough in order to allow a blanket protocol for prescribing, and it was acknowledged that it was important to consider the Cochrane Review recommendation that fit and well patients receiving lower third molar extractions should not be given prophylactic antimicrobials.</p> <p>The following actions have been agreed to improve compliance with antimicrobial prescribing:</p> <ul style="list-style-type: none"> ● Evidence provided to team and implementation of a protocol to prevent routine prescriptions being given to fit and well patients following surgical tooth extractions ● Ensure an indication is recorded in the patient's notes if the clinician thinks the prescription is justified
<p>Time taken to treat paediatric facial lacerations requiring General Anaesthesia (GA) for closure by the Oral and Maxillofacial Surgery Department</p> <p>Aim: to establish whether there are any unnecessary delaying factors and whether these could be improved</p>	<p>The audit found that lacerations requiring treatment were not treated within six hours in the majority of cases. It was not possible to fully analyse the non-compliance as the reason for delays was not routinely recorded. Patients transferred from North Devon had the longest time to treatment and also had a significant inpatient stay. This was attributed to the practice of having these patients present the day after their injury to prevent an overnight stay pre-operatively where possible, and the distance preventing some patients being discharged home the night after their general anaesthetic. It was found that children treated with procedural sedation have a door-to-discharge time of 4hr 22 min, in comparison with 16 hours if admitted for general anaesthetic, and a median time from laceration to closure of 4hr 20min, compared with 10hr 40min if admitted for general anaesthetic. Consequently, the following action was agreed:</p> <ul style="list-style-type: none"> ● To consider procedural sedation in the emergency department where possible, especially where patients have been transferred from distant sites

Independent Auditor's Report to the Council of Governors of Royal Devon and Exeter NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Royal Devon and Exeter NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Devon and Exeter NHS Foundation Trust's Quality Report for the year ended 31 March 2015 (the 'Quality Report') and certain performance indicators contained therein.

Scope and Subject Matter

The indicators for the year ended 31 March 2015 subject to limited assurance consist of the following two national priority indicators:

- Percentage of incomplete pathways within 18 weeks for patients on incomplete pathways ("Referral to Treatment – incomplete pathways"); and
- Emergency readmissions within 28 days of discharge from hospital ("Emergency readmissions").

Respective Responsibilities of the Directors and Auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the NHS Foundation Trust Annual Reporting Manual issued by Monitor.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The Quality Report is not consistent in all material respects with the sources specified in the Detailed Guidance for External Assurance on Quality Reports 2014/15 ('the Guidance'); and
- The indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes for the period April 2014 to May 2015;
- Papers relating to Quality reported to the Board over the period April 2014 to May 2015;
- Feedback from the Commissioners dated 12 May 2015;
- Feedback from local Healthwatch organisations dated 12 May 2015;
- Feedback from the Overview and Scrutiny Committee dated 14 May 2015;
- Feedback from the Council of Governors dated 8 May 2015;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, 2014/2015;
- The 2014/15 national patient survey;
- The 2014/15 national staff survey;
- Care Quality Commission intelligent monitoring reports 2014/15; and
- The 2014/15 Head of Internal Audit's annual opinion over the Trust's control environment.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Royal Devon and Exeter NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2015, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do

not accept or assume responsibility to anyone other than the Council of Governors as a body and Royal Devon and Exeter NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance Work Performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- Evaluating the design and implementation of the key processes and controls for managing and reporting the indicators;
- Making enquiries of management;
- testing key management controls;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the NHS Foundation Trust Annual Reporting Manual.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Royal Devon and Exeter NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2015:

- The Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual;
- The Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- The “Emergency readmissions” indicator in the Quality Report subject to limited assurance has not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

Our testing of the “referral to treatment – incomplete pathways” indicator identified instances where data included within the indicator could not be agreed to supporting patient records. As a result we are not able to issue a limited assurance opinion in respect of the “referral to treatment – incomplete pathways” indicator.

Jonathan Brown

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27 May 2015

