



# Annual Report and Accounts 2011-12



**Royal Devon & Exeter  
NHS Foundation Trust**

**Annual Report and Accounts 2011-12**

**Presented to Parliament pursuant  
to Schedule 7, paragraph 25(4) of the  
National Health Service Act 2006**



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# 1. Our Year

## Welcome to our new Annual Report, Quality Account and Accounts 2011/12.

**In this extremely challenging year we are pleased to report that we have continued to provide excellent healthcare to the communities we serve in Devon and beyond.**

Our staff have, once again, worked exceptionally hard to ensure that patients coming to the Trust receive first class care delivered with courtesy and respect. We know that the bedrock for the success of our Trust is our dedicated and professional staff. Time and time again they strive to put patients first and we want to thank them for all they have done and continue to do. Each and every member of staff should be proud of the service they have offered to the people we serve during the last year.

We were delighted that our success in delivering good quality healthcare was recognised by Dr Foster, a leading provider of comparative information on health and social care services, when it announced that we were one of four excellent hospitals that received an award of “Trust of the Year” 2012. This underlines our outstanding achievement, both in outcomes and also how patients rate their experience of care. Once again it is testament to the commitment and innovation of our staff to better patient care and experience.

It is necessary to acknowledge that 2011-12 was a year in which we faced significant challenges. Although we had a mild winter, the numbers of elderly people admitted as emergencies placed considerable strain on our hospital. This had a knock on effect throughout the hospital. An acute Trust like ours is only part of a much wider and more complex health and social care system. That is why we worked with our partners to second our Chief Operating Officer to work across a number of health

and social care organisations to help put in place sustainable solutions so that some of the strain can be better managed. Within the Trust, over the winter period, we have invested in a specialist rehabilitation ward and this has increased the number of older patients leaving us and going straight home with on going support, instead of going to a community hospital or care home.

The NHS once again loomed large in national political debates with particular focus being on the new Health & Social Care Act. These prolonged debates created a backdrop of uncertainty exacerbated by ongoing financial challenges nationally and locally. These challenges have driven a need to look hard at what we do and how we do it and in many areas new innovations have proved to be of real benefit to patients. In the coming years we will need to look beyond our own boundaries to make changes in the way patients move through the healthcare system to make this more acceptable to them, as well as to improve efficiencies.

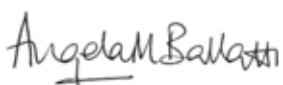
With these issues in mind, our new organisational strategy has placed delivering ever better patient care at its heart. Our Board recognised that, at a time of uncertainty, we needed to set out a clear course for the Trust that would enable it to continue to offer good quality healthcare but to do this in innovative and sustainable ways. This report looks in detail at our new strategy and the vision we share for the future of healthcare in Devon and beyond. In establishing our plans for the future we were assisted by our Governors, who again contributed not just to the development of our strategy but in a number of other ways as well, which are set out later in the Annual Report. Not least, the Governors make a positive contribution to our Quality Report which is contained as a section within the Annual Report & Accounts 2011-12.

Working with the Council of Governors, our relationship with our members goes from strength to strength. Our Members' Say events have now become an established part of our calendar benefitting both Members - who hear first hand some of the exciting innovations in healthcare - and also the Trust, because at these events we are able to seek the views of Members in a variety of ways. We are justly proud of these events and we look forward to hosting more Members' Say events in the coming year.

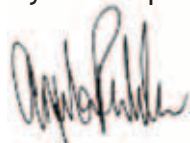
Research and development is the cornerstone of high quality patient care and remains a key part of our strategy. We continue to grow and develop our work in this area and in 2011 work started on a new research centre in partnership with the University of Exeter and the Wellcome-Wolfson Foundation. More details are provided later in this report.

We want to thank the many volunteers who give their time to helping patients and their families throughout the hospital. We know from the feedback we receive, that their help is greatly appreciated and, although they give their time for free, they are an essential part of delivering a friendly and caring service. We also acknowledge the importance of the charities associated with our Trust who provide essential assistance and support to many of our patients.

We hope that within this Annual Report you find much to support this brief summary of our successes in 2011-12. We plan to build on these successes during the next year to continue providing excellent health care delivered with courtesy and respect.



**Angela Ballatti**  
Chairman



**Angela Pedder OBE**  
Chief Executive

## Message from Angela Pedder OBE, Chief Executive

I would like to take this opportunity to place on record my thanks and that of the Board for the contribution that Angela Ballatti has made to the Royal Devon & Exeter over the last six years. Angela has brought considerable energy to the task of ensuring that the Board was operating as effectively as possible and, during her tenure, we have made great strides. Angela oversaw the development of our first strategy and has also provided leadership in developing the revision of our strategy to take us forward over the coming years. In addition, during Angela's tenure, the role of Governors has matured to the extent that Governors play a critical role in governing the Trust. On behalf of the Board, I would like to thank Angela and wish her well for the future.



## About the RD&E

The RD&E provides specialist and acute hospital services to a core population of about 400,000 people in Exeter, and East and Mid Devon. We also provide services to patients from further afield because we have nationally and internationally recognised excellence in specialist fields, including the Princess Elizabeth Orthopaedic Centre, the Centre for Women's Health (maternity, neonatology and gynaecology services), Cancer Services, Renal Services, Exeter Mobility Centre and Mardon Neuro-rehabilitation Centre. The RD&E has 797 inpatient beds and 80 day case beds. During 2011/12 the Trust spent £350 million and employed 6,700 staff. The Trust delivers over 300,000 outpatient attendances and over 115,000 day case or inpatient admissions per year, with additional diagnostic and community service activity delivered in local communities.

The Trust is the leading centre for high quality research and development in the South West peninsula, delivering undergraduate education for a full range of clinical professions and is a lead centre for the Peninsula College of Medicine and Dentistry. 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 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 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.

## Spring 2011

We were very proud when Staff Nurse Brenda Somerfield was voted the national winner of the Patient's Choice 'Clare Raynor Nurse of the Year Award' 2011.

Brenda, who is part of the Mere Ward team, is pictured right. Brenda was nominated by Mr Gerard Noel, for her nursing care of his late wife, Caroline.

Our innovative new Surgical Health Services Research Unit was opened, bringing together the resources, experience and knowledge to inform real advances in all stages of surgical treatment and improve patient care.

This unit was funded through collaboration between our Directorates of Surgery and Research and Development but it will also strengthen our links with local and national research partners.

- See page 21 of our Quality Account for an example of the groundbreaking work being done.

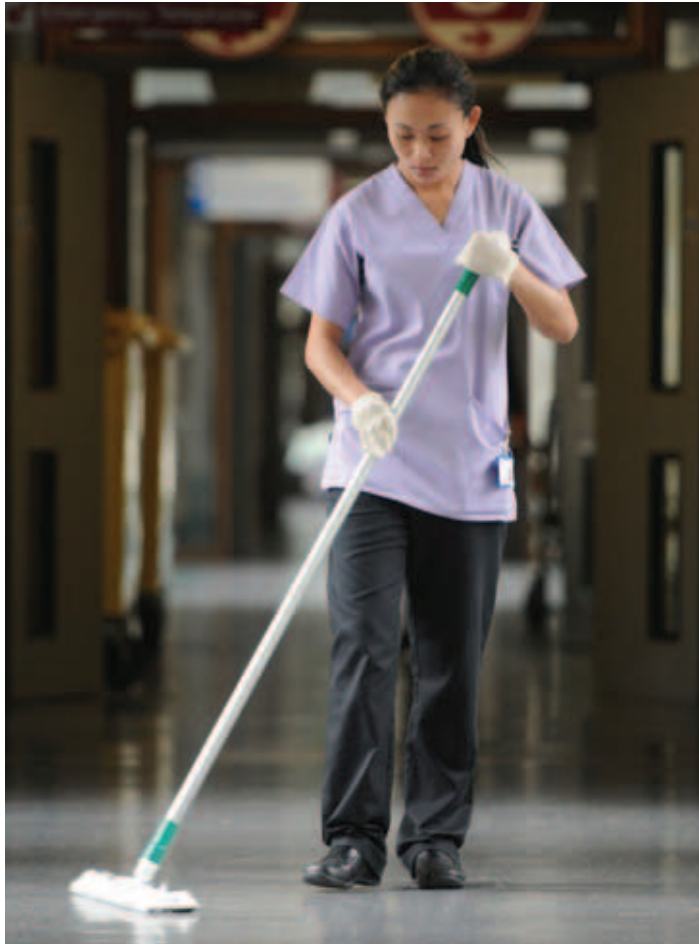
## Summer 2011

A significant milestone was achieved in a programme of changes designed to transform the care of patients coming into the RD&E as a medical emergency.

Our project 'Right Patient, Right Care, Right Place' took a step forward with the official opening of the new Acute Medical Unit by the Trust Chief Executive Angela Pedder, with Director of Nursing & Patient Care Em Wilkinson-Brice. Improvements included relocation of the Medical Triage Unit where our patients are assessed, allowing our Acute Consultant Team to work closer with community GPs; expansion of the unit to 48 beds within one dedicated area; increased consultant cover and the introduction of two nurse practitioners to monitor and escalate deteriorating patients and liaise with their relatives or carers.



# 1. Our Year



**Our West of England Eye Unit was the first in the country to develop the clinical role of a nurse practitioner to carry out procedures for the treatment of macular degeneration.**

Historically this procedure - involving an injection into the eye of a drug under local anaesthetic to prevent loss of vision - was only carried out by consultant eye surgeons. By training specialist nurses we have achieved continuity of care for our patients with their nurse and freed up theatres and consultant time for more complex operations. This approach has been commended by the Macular Disease Society and was shortlisted to the final 10 from 300 entries for a Royal College of Nursing Innovation Award.

## Autumn 2011

The cleanliness and maintenance of our hospital was rated highly in the PEAT (Patient Environment Action Team) inspection. We scored 'Good' across all three categories - food, environment, privacy and dignity.

- See on page 85 of this report Governor Martin Perry explains his PEAT inspection role.

**We relocated our pain management and physiotherapy outpatient clinic to upgraded facilities at Heavitree Hospital.** Often patients have appointments with both these services so by having them together under one roof it enables staff to work closely together when planning and providing treatment. The unit includes a gym and astro turf area for rehabilitation activities.

**We piloted and then introduced an electronic nursing handover sheet for all our surgical wards with updates and communication in a clear, timely and consistent way whilst the patient is in our hospital.**

## Winter 2011

**The positive global benefits for patients from diabetes research at the RD&E was recognised with the University of Exeter Outstanding International Impact Award.**

The work of Head of Molecular Genetics Professor Sian Ellard, Consultant Diabetologist Professor Andrew Hattersley and the award winning team including Peninsula College of Medicine and Dentistry colleagues Dr Maggie Shepherd and Dr Sarah Flanagan, involved the study of children diagnosed with diabetes within the first six months of their lives. This is a rare genetic form of diabetes, and by identifying the genes that cause the condition they were able to prove that the two commonest types are better treated with tablets

rather than insulin injections. This has revolutionised the diagnosis and care of these patients, who now have a normal life on tablets when previously they would have expected to be on insulin for the rest of their lives. The tablets also cost the NHS less which has global benefits in countries where insulin affordability is a significant issue.

**Clinical Biochemist Dr Tim McDonald** was also nominated in the Student Impact category, which recognises students or alumni who have already demonstrated significant societal or economic impact either through research or entrepreneurial activities. Only three years into his research career, Tim McDonald has increased the accuracy of diabetes diagnoses in the UK.

Tim developed a urine test to identify sufferers of monogenic diabetes, who are often misdiagnosed with more common type 1 or type 2 diabetes. His research has already directly improved patient care and the test is now used routinely across this Trust and samples received for testing from 40 others.

**The achievements and star qualities of our staff were celebrated at a special annual awards event.** The Chairman's Awards gives us an opportunity to nominate colleagues we believe go 'above and beyond' what is expected of them for this formal recognition. Eleven individuals and two teams from a range of professional roles and services received awards for their extraordinary efforts.

**Our Perinatal Mental Health Team won 'The Raising Standards' award for their care and support of women in pregnancy with mental health concerns.** The promotion of wellness in the months leading up to birth to improve patient experience and health before and after having a baby in this way is thought to be the first of its kind in the country. The award recognition from Devon Partnership NHS Trust applauded this approach as an excellent example of a successful collaboration between two specialist healthcare fields.



# 1. Our Year



## Spring 2012

**Plans to create a £19 million world class research centre reached a significant milestone with completion of demolition works.**

Over 90% of the Postgraduate Education Centre was dismantled and recycled mainly for road building materials. Over the coming months the new Research, Innovation, Learning and Development (RILD) Centre will be built and when completed later this year it will bring together skills, education and medical research on our Wonford Hospital site.

Our partners for this major capital project are Peninsula College of Medicine and Dentistry and the University of Exeter.

**Patients rated the outpatient clinic services and standard of care at the Royal Devon & Exeter highly - placing the RD&E in the top 20% of best performing NHS trusts in the country.**

The independent healthcare regulator, the Care Quality Commission, carried out its fourth survey on patient satisfaction with adult outpatient services in 2011. Our Emergency Department (A&E) and fracture clinics were among the hospital departments where patients aged 16 years or older were asked to share their views about their hospital experience. Patients gave their feedback on questions about appointments; waiting times in clinic; cleanliness; test, treatment and medication information; care and communications with doctors and other healthcare professionals; privacy; dignity; correspondence for GPs and who to contact after discharge if worried about their condition.

**Our stroke service was at the forefront of a research study reducing the time it takes for patients to receive vital clot-busting treatment.**

A computer simulation model was used to look at the whole emergency treatment process from when an ambulance is called to someone with a suspected stroke (blocked artery in the brain) to arrival at our hospital, scans to confirm the diagnosis and when clinically appropriate, a clot-busting drug treatment. Time is of the essence for this treatment to greatly improve recovery. Our radiology and emergency departments worked with our stroke team, ambulance service and researchers from the University of Exeter and Peninsula College of Medicine and Dentistry. Analysis of over 1,400 patient cases enabled them to identify bottlenecks in the system and take steps to speed up the process and access to this specialist care.

**We introduced the new role of the Ward Housekeeper on our Wonford Hospital wards to improve patient experience and focus on cleaning, patient food and hydration and maintenance of the ward environment.** See page 19 of our Quality Account for more information on our ward redesign of non-clinical services.



### Directors' Report

Since the Trust achieved Foundation status in 2004, the RD&E has continued to develop and improve the range and quality of the services it provides to the people of Devon. The Trust has continued to build on its history of clinical and research excellence, high quality care, and delivery of performance targets and financial stability, all of which have been produced by the highly valued work of the Trust's clinical and non-clinical staff.

In 2007, it developed an organisational strategy to navigate a path forward and to provide a focus for the improvements in service that the Board wanted to address. As heralded in last year's report, the Board completed its review of its previous strategy as a first step to ensure it was fully aware of the progress that had been made during this time and the challenges that remained.

As well as reviewing its previous strategy, the Board has spent time over the course of the year considering the significant changes taking place in the health and social care systems in England as a result of the rapidly changing economic, political and demographic landscape and the implications for the Trust. The dynamic external context reinforced the Board's view that it needed to set the future course of the organisation as clearly as possible but in a way that allowed it to respond to opportunities or threats as they arose.

The Board felt it was very important to set out a vision and direction for the future that allowed the Trust to continue to perform well and to provide good quality healthcare in a way that was sustainable and took into account the views of our users. In the course of thinking about the future direction of the Trust, the Board was convinced that maintaining the status quo or seeking to avoid the implications of the changes that were taking place in the wider economy, was not a viable option.

Rather, the Trust's strategy recognises that to be successful into the future it needs to build on its past successes, on the culture of excellence it has developed, in order to be able to continue to provide safe, high quality, and seamless services, delivered with courtesy and respect. The changing landscape also meant that

there were opportunities to improve and develop services and broaden the community served by the RD&E.

As it developed its strategy, embracing the views of the Council of Governors and our Members, the Board looked in some detail at some of the external factors and policy influences that would impact on its strategy and that needed to be taken into account. Within the influences on the emerging strategy, the Board examined some of the policy drivers affecting NHS organisations such as:

- redesigning services to make them fit for the future
- delivering services as cost effectively as possible
- providing more care closer to home
- integrating health and social care systems
- building the quality of care and providing it in a way that met patient expectations.

These policy drivers were analysed within a broader framework of:

- the economic challenges facing public sector organisations as a result of the recession and the subsequent period of austerity including the implications of the savings targets applied to all NHS organisations
- the considerable changes and uncertainty caused in the healthcare system in the debates surrounding the Health & Social Care Bill and some of the policy changes that have already been implemented that have impacted on the health economy

- understanding some of the challenges facing health and social care as identified in various reports over the course of the year, particularly in regard to the specific issues faced by frail elderly patients

- an in-depth examination of some of the broader trends that were already or would soon impact on the Trust such as advances in technologies (both medical and non-medical); demographic changes; the rising costs of drugs and other treatments; increased incidence of diseases caused by, for example, obesity

- environmental and sustainability requirements.

In addition, issues of direct relevance to the Trust were also taken into account including:

- the Trust's role as a teaching hospital within the Peninsula College of Medicine and Dentistry
- the Trust's strength as a base for research and development
- the attractiveness of the Trust as an employer
- a history of high achievement of quality, performance and financial targets.

## 2. Our Trust



In developing our new strategic direction, the Trust's Board sought to take into account the views and aspirations of the population we serve and, in particular, use our corporate model as a public benefit corporation, to ensure that we understood and responded to the views of our Members. Over the past few years we have developed, through public membership and locally elected Governors, a range of ways to find out from local people what they expect and need from the RD&E. This feedback has been invaluable in shaping and planning future services.

An important strand in the development of the strategy was the interface with our Governors who continue to find new ways to better reflect the views of the broader community to the Trust. At its joint development day in September, Directors and Governors discussed the emerging organisational strategy as well as looking in depth at patient safety issues.

Our new strategic direction also took into account our partnering work with a number of organisations including NHS South West Strategic Health Authority, NHS Devon Primary Care Trust, Devon Partnership Trust (mental health and learning disabilities), Northern Devon Healthcare Trust, South Western Ambulance Service NHS Foundation Trust, Devon County Council Adult & Community Services, the Peninsula College of Medicine and Dentistry, and Exeter University.

## Strategic Directions 2011-2016

The Trust's Board approved the RD&E's new strategy direction for 2011-2016 during the year.

The Trust's vision is to provide

**“safe, high quality, seamless services delivered with courtesy and respect.”**

### Our three strategic objectives are:

- 1** Maintaining sound operational delivery of our existing clinical, research and teaching services.
- 2** Integrating pathways of care from community through to acute care and back into the community delivered through partnerships with others and by increasing the Trust's own integrated provision.
- 3** Further developing the Trust's acute services across a wider area by building upon the clinical networks and partnerships that are already in place.

The delivery of these objectives will be underpinned by a commitment to further enhancing the Trust's role in the development of education, research and development, and innovation within the region.

In delivering this vision, the Board underlined that in all that it does **the Trust must uphold its core values of:**

- **Honesty, openness & integrity**
- **Fairness**
- **Inclusion & collaboration**
- **Respect & dignity.**

The Trust considers that it has a high standing in the local community and beyond and we recognise that this gives us a duty to uphold the highest standards and thereby maintain the affection and respect with which the Trust is regarded. In recent years we have developed our capacity to engage with the communities we serve, ensuring that we respond to their needs and aspirations. This has been made possible by the contribution and engagement of the Council of Governors, supported by the Board of Directors, our staff and our links with local people and our Members. The strategy we have developed takes account of the priorities identified by our Members in surveys, focus groups and meetings and which can be broadly summarised as follows:

- a hospital where I am seen as soon as possible
- a hospital that has access to the latest technologies and drugs
- a well maintained environment that is clean, safe and modern
- a seamless NHS service from GP through to the hospital and beyond.

### Implementing the RD&E's Strategic Direction 2011-16

The Trust is at an early stage in implementing its new strategic direction. The following principles will help guide the implementation stage:

**Maintaining sound operational delivery of existing clinical, research and teaching services**

During a period of transformational change it is crucial for the Trust to ensure that it can deliver 'business as usual', therefore securing this delivery will be a key strategic objective.

The Trust has increased its turnover and volume of clinical, research and education activity significantly since 2004. However, the changed economic environment for the NHS, both nationally and locally, means that the Trust cannot build its future development on assumptions of increased funding in the local health community. On the contrary, in response to reductions in income the Trust is working in partnership to redesign services to deliver activity in innovative ways: at lower cost and closer to home.

The Trust is also planning to reduce its cost base in response to reduced tariff income. In redesigning how our services are delivered we are keenly aware that with any changes that we make or in situations where we can deliver services for less, we do not in any way compromise safety, and that we continue to promote improvements in quality and develop ever more robust governance arrangements.

### Integration

The solutions to the financial pressures and quality requirements are likely to include greater integration of community and acute services to deliver more efficient care closer to home and increased collaboration between providers (or rationalisation of provision) of some acute services. The Trust intends to develop and expand its services in these ways if it is to continue to be efficient and effective, but this will have to be done without additional cost to commissioners.

The Trust is also committed to developing greater integration of care to achieve “seamless services” - an issue identified by our Members as critically important. Services may be integrated vertically, between social care, primary healthcare, community healthcare and acute and tertiary healthcare; or they may be integrated horizontally, with common services being integrated across a wider geographical area. These forms of integration are not mutually exclusive and, in some circumstances, both vertical and horizontal integration may be desirable.

Early work has started in Tiverton where the Trust is working with partners and local GPs to redesign local services.

This should enable primary, community and secondary healthcare and social care to develop a model of service provision that may offer a blueprint for the development of services more widely. The anticipated benefits of the development of integrated community services are as follows:

- improved patient outcomes, so reduced need for long term care
- reduced hospital admissions and readmissions
- shared skills and staff rotation to improve staff satisfaction and quality of care
- reduced acute hospital length of stay and reduced cost
- continuity of care for service users and their carers.

### Acute hospital services

The Trust is already a provider of acute secondary and tertiary care beyond its local catchment area. Many tertiary services draw patients from a wider area and there are a number of networked arrangements whereby the Trust's clinicians work in other providers' hospitals. The Trust intends to build upon these arrangements to develop its acute services in partnership with others. The Trust will review its current networked arrangements and take opportunities, service by service, to collaboratively build on these where this is clinically and financially desirable. The anticipated benefits of the development of additional networked acute services are as follows:

- maintenance of critical mass for some services that might otherwise be too small for long term sustainability
- ability to attract specialist staff
- shared financial benefits of critical mass and equitable financial arrangements between providers
- improved governance and continuity of care arrangements for services operated across providers
- improved operational and clinical arrangements for the transfer of patients between acute hospitals
- improved access to the benefits of teaching, research and innovation
- maintenance of provision of specialist services in Devon, closer to patients' homes.

In the light of its new strategic direction the Trust is reviewing all clinical specialties and services and developing service strategies to support the delivery of the overarching strategy. This will include quality, safety, national guidance on future size and scope of service provision, financial viability and horizon scanning for new technologies that may alter services over the strategic period. The full programme of work will be concluded over the next 6-12 months.

## Patient Care & Quality Improvements

### Governance Review

Despite the financial challenges facing all public sector organisations, safety and quality remain the two areas which cannot be compromised. The Trust, in line with all NHS providers, manages Safety, Quality and Effectiveness through a framework called Governance.

Governance, in its simplest terms can be described as “ensuring we deliver the right care, at the right time, in the right way.” The Department of Health describe Governance as “achieving objectives, including value for money and upholding public service values.”

In light of the changing NHS, Government reforms, change of regulator and increased scrutiny of services, the RD&E Board of Directors commissioned a Trust-wide review of its Governance arrangements last year. The review started in April 2011, and reached a conclusion in October 2011. In summary the review streamlined reporting structures and has created a simple structure with clearer accountability. The respective roles of the Audit Committee and the Governance Committee were clarified.

The RD&E now manages Governance through the “Governance Performance System”, a structure of five main sub committees, and a number of sub groups which report upward through the Governance Committee to the Board of Directors.

The role of the Governance Performance System is to provide assurance that the care delivered meets regulatory requirements (set by Care Quality Commission) and the aims and objectives of the Trust; safety, quality and effectiveness. In addition the system is also responsible for the early identification and escalation of any areas of concern.

The Trust is currently six months into the revised Governance Performance System. A formal review of the new system will be undertaken in October 2012. It is still early days, but staff working within the new system report that the change has strengthened the Trust’s approach to Governance in terms of rigour and robustness.

## 2. Our Trust



### Carers

During November 2011 the Trust hosted a “Carers Matter” Campaign. The hospital Health Information Centre acted as a hub of information and campaign packs were sent out to all ward areas.

#### Campaign packs included:

- A revised version of the Carers policy
- A new “How would you like to be involved?” leaflet
- Carers information posters and leaflets
- Confirmation of special carer arrangements.

### Carer’s ID

Carers UK membership cards and Devon Virtual Carers Centre Alert Cards are recognised by our staff and can be used as a way of identifying you as a carer.

### Car parking

Carers may access free car parking instead of, but not as well as, the patient, when the person they are caring for is receiving treatment in any of the following departments: Cancer Services, Haematology, Renal Dialysis, Paediatric Oncology, Special Care Baby Unit, Diabetes, admissions directly from the Emergency Department and Disabled Badge Holders.

### Retail outlet discounts

Carers can receive up to 20 % discount within all the catering outlets on all in-house produced items (excluding bought in pre-packaged branded items) upon presentation of either the Devon Virtual Carers Centre Alert Card or Carers UK membership card.

The Carers Action Group approved a staff awareness training DVD which was made in house.

Other group priorities agreed for 2012 include;

- Monitoring the effectiveness of the existing Carers policy
- Involving Carers in leaving hospital arrangements

### Complaints Handling

Following on from an improvement event held in November 2011 the Trusts process has been revised for all complaints with a central focus on providing a swift and personal response to dissatisfied patients, relatives or carers. The revised process has been piloted in our surgical and trauma and orthopaedic directorates, resulting in improved performance. The revised process will be incorporated into a revised complaints policy which is due to be ratified in May 2012.

Sixteen training sessions on Effective Complaint Handling were held for staff during November and December 2011.

An electronic system for complaint management was rolled out across the Trust from December 2011, following completion of the Effective Complaint Handling training. This enables on line reporting of complaints, creation of a single comprehensive, electronic file for each complaint which can be accessed and completed by the directorates involved and the central team, and real-time data on the status of each case.

A fundamental part of the complaints process is to identify any learning and, where appropriate, take remedial action or make a service improvement. This system requires the directorate investigator, to identify lessons learnt as part of the complaint resolution. This enables the Patient Engagement and Experience team to produce a detailed report, which summarises examples of any changes made.

### Our Staff

Our staff are the lifeblood of our Trust. Our excellence depends on our staff delivering high quality healthcare time after time to all of our patients. This section highlights:

- some of the development issues we have tackled over the last year as part of our plan to make our staff fit for the future
- a statutory overview of the results of our staff survey
- a statutory overview of our approach to equality and diversity.

#### Health & wellbeing

The Trust has continued to improve the support of staff in maintaining health and wellbeing with occupational health services, facilities such as weight loss programmes and self referral for physiotherapy and counselling. Management and prevention of sickness is crucial in maintaining staff health and continuity of patient services. Over the past year, there has been a significant reduction in sickness levels representing an estimated saving of £500,000.

#### Workforce redesign and development

- **Clinical Health Apprenticeships.** The Trust successfully developed a new Advanced Apprenticeship programme designed to offer opportunities for local young people to start a career in healthcare and gain a work-based vocational qualification. This is a very exciting initiative for which the Trust was nominated for the Regional South West Apprenticeships awards and received commendation from the National Apprenticeship Scheme.
- **The NHS Graduate Management Training Scheme,** hosted by the NHS Institute for Innovation and Improvement, is a comprehensive programme that aims to equip graduates with the expertise needed to become successful leaders in the NHS. The RD&E has been very successful over the years in attracting and securing placements and at this year's graduation ceremony and attended by David Nicholson NHS Chief Executive, our Head of Management and Vocational Education Vera Byfield was named Programme Manager of the Year in recognition of the support that she provides to the trainees.

• **E-learning** - Staff now find it easier to update their training via **e-learning**. There are currently 27 modules available, 22 of which have been developed locally with the subject matter experts in the RD&E. Examples of the modules are:

- Infection Control
- Information Governance
- Manual Handling (theory)
- Mental Capacity Act/Deprivation of Liberty Safeguards
- Blood Transfusion Safety.

The average completion time for a module is a little over half an hour with generally very positive user feedback. Increasing access to this approach to learning means our staff have access to development opportunities at times that suit them and their workplace.

## Staff Survey

### Statement of Approach

The RD&E continues to experience positive results in the National Staff Survey and is placed in the top 20% of Trusts for many of the indicators. We believe that engaged staff have higher morale, are more productive and will deliver improved patient care. The Trust has identified a priority to improve staff engagement as research evidence identifies this as a pivotal indicator to achieving the RD&E vision and values of “Safe, high quality, seamless services delivered with courtesy and respect” and underpinned by values of “Honesty, Fairness, Inclusion and Collaboration, Respect and Dignity”.

Improving staff engagement continues to be fundamental to implementing the challenges and opportunities set out in the Trust Strategic Direction. Over the past year, we have continued to embed our staff engagement strategy “Enabling Excellence - Performance through People” across the Trust and alongside the Trust’s “Fit for the Future” programme. Through Trust-wide staff and management development programmes, the Trust continues to build capacity and capability to increase engagement and improve patient care. Staff communication has been enhanced with “CASCADE” team briefing to encourage staff feedback throughout the organisation and a new Reward and Recognition strategy has been developed for implementation in 2012.

### Summary of Performance

In 2011, the RD&E, as part of its staff engagement strategy, undertook a full census survey of its staff for the third year and is using this material to track trends across the Trust and within individual departments. The response rate was 41% for the full survey and 50% for the sample which feeds into national survey and key findings results. The Trust was in the top 20% of Trusts nationally for ten of the key findings and in the bottom 20% for two. Two of the top key findings were equal to the best score for acute trusts nationally.

#### Best 20%

- Staff appraised with PDRs
- Staff receiving health and safety training
- Staff suffering work related stress
- Staff experiencing physical violence from patients
- Staff experiencing physical violence from staff - equal to the best score for acute trusts
- Staff experiencing harassment, bullying from patients
- Staff experiencing harassment, bullying from staff
- Perceptions of effective action from employer towards violence and harassment
- Staff receiving equality and diversity training
- Staff experiencing discrimination.

#### Worst 20%

- Staff feeling satisfied with the quality of work and patient care they are able to deliver
- Staff reporting errors, near misses or incidents witnessed in the last month.

### Summary of Performance

| Response rate | 2010/11 |         | 2011/12 |         | Trust Improvement /Deterioration |
|---------------|---------|---------|---------|---------|----------------------------------|
|               | Trust   | Nat Ave | Trust   | Nat Ave |                                  |
|               | 59      | 54      | 50      | tba     | decrease                         |

| Trust 4 Top Ranking Scores 2011  | Trust 2010 | Trust 2011 | Nat Trust Ave 2011 | Increase/ decrease |
|--|------------|------------|--------------------|--------------------|
| KF 25- % staff experiencing harassment, bullying or abuse from patients                            | 11%        | 8%         | 15%                | 3% improvement     |
| KF 16- % staff receiving health and safety training in last 12 months                              | 90%        | 92%        | 81%                | 2% improvement     |
| KF 24- % staff experiencing physical violence from staff in last 12 months                         | 1%         | 0%         | 1%                 | 1% improvement     |
| KF 23- % staff experiencing physical violence from patients, relatives or public in last 12 months | 7%         | 5%         | 8%                 | 2% improvement     |

| Trust 4 Bottom Ranking Scores 2011  | Trust 2010 | Trust 2011 | Trust Ave 2011 | Increase/ Decrease |
|---|------------|------------|----------------|--------------------|
| KF1- % staff feeling satisfied with quality of work and patient care they are able to deliver | 73%        | 66%        | 74%            | 7% deterioration   |
| KF 21- % staff reporting errors, near misses or incidents witnessed in last month             | 95%        | 94%        | 96%            | 1% deterioration   |
| KF35- Staff motivation  | 3.80       | 3.75       | 3.82           | 0.05 deterioration |
| KF11- % staff receiving job relevant training or development in last 12 months                | 76%        | 76%        | 78%            | static             |

The Trust full survey provided similar responses to the CQC results shown above though our full survey KF 1 decreased from 71% to 69%, a 2% rather than 7% deterioration.

## 2. Our Trust



### Future Trust Priorities

The Trust has a number of ongoing priorities that have seen improvements over the past year, particularly staff receiving appraisals and Personal Development Reports, (we are now in the top 20% of Trusts for this key finding). The areas below, where performance is not as satisfactory as we would wish, are part of existing and continuing priorities. We will continue to concentrate on these as part of our staff engagement strategy. For 2012, 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. We are aligning 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 action plans within a year.

### Health and Wellbeing

We encourage staff to lead healthy lifestyles by promoting a number of initiatives both locally and nationally. Over the past year there have been a number of new and continuing initiatives locally. Our sickness absence rate continues to reduce and presently stands at 3.37%. Our staff survey demonstrates improvements in staff health. Work pressure and staff suffering work related injury has improved and the number of staff feeling pressure to attend work when ill has reduced from 39% to 27% in the last year. We are now producing a Trust-wide annual report on Health and Wellbeing.

- Our Occupational Health Department is seeking SEQOHS, (Safe Effective Quality Occupational Health Service) accreditation in April
- Our staff direct access physiotherapy service continues to deliver early intervention
- The successful weight loss clinic initiated last year with support from the staff lottery is now a self-funding project and continues to be very successful
- The Virtual Gym service is available free to all staff and their families.

## Equality and Diversity

### Achievements

#### Overall

- Our grades for the Equality Delivery System are all at "achieving", or 'better', apart from two, which are both "developing"
- The staff and patient profile at our Trust broadly matches the appropriate community benchmarks.

#### Staff

- Our proportion of ethnic minority staff has increased in line with the local community and they report a positive experience of working with us
- People with a disability are making much better progress through the recruitment and selection process and the rate of progress has also improved for staff from most minority groups
- We are among the best 20% of trusts nationally, for our low level of reported discrimination, acting fairly with regard to career progression and ensuring that staff have received equality training.

#### Patients

- We have a high level of compliance for implementing our system to identify the needs of patients with disabilities
- We have taken our most in-depth look, ever, at patient equality and are pleased that there are very few equality issues emerging
- We have gathered our first data evidence looking at the profile and satisfaction of LGBT (Lesbian, Gay, Bisexual, Transgender) patients. Although this evidence is limited, we were pleased that patient numbers and satisfaction levels were broadly in line with or above expectations
- We have produced an action plan, in conjunction with local community groups, to ensure the experience of our ethnic minority patients is the best it can be.

### Key performance indicators (KPIs)

#### 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 18 outcomes.

Our grades are as follows:

| Undeveloped | Developing | Achieving | Excelling |
|-------------|------------|-----------|-----------|
| 0           | 2          | 15        | 1         |

Our priority is to address the outcomes assessed as "developing", by better considering equality issues when we plan and deliver service change and embedding the Trust values which clearly reflect equality and diversity.

#### Patient Equality

We have two KPIs, covering how well we look after patients when they are with us (involvement in patient incidents) and how effective our treatments are (emergency readmissions).

We have analysed our performance against these indicators for all of the protected characteristics covered in the source data. As a result of this analysis, our priority is to close the equality gaps for patients aged 65+, as they are a highly significant patient group and also are represented in the figures for deprived postcodes. We will continue to strive for equality for all patient groups.

## 2. Our Trust

### Staff Equality

This indicator shows the level of discrimination reported by staff for our Trust in the staff survey from patients, public, or colleagues compared to the national norm for the acute sector.

The result for the survey taken in 2010 and analysed in 2011 was as follows:

|      | RD&E | National (acute and specialist) |
|------|------|---------------------------------|
| 2010 | 10%  | 13%                             |
| 2009 | 6%   | 7%                              |

There has been an increase in staff reporting discrimination, however this often happens when organisations are going through significant change. Also, the increased training locally and nationally around equality and diversity raises awareness of potential issues and how staff should respond. The Trust's position is lower than the national norm and our position relative to the norm has improved.

## Equality Objectives

Based on our data analysis, EDS results and consultative work to date, we have identified two equality objectives.

These will be embedded in our strategic processes, to ensure we deliver a Trust-wide response to them.

They are as follows:

### 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 patient incidents.\*

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

The current situation, as reported in the Equality Data Report 2012, is as follows:

| Patient group | Patients age 65+ as a % of all patients reporting a "harm incident"      | Patients age 65+ as a % of all inpatients and outpatients |
|---------------|--|---|
| Aged 65+      | 51%  | 38%   |
|               | Patients age 65+ as a % of all patients who are "emergency readmissions" | Patients age 65+ as a % of all inpatients only            |
| Aged 65+      | 53%  | 43%   |

\* These indicators only affect a very small proportion of patients

### 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.

#### Current situation (2102):

|                            |     |
|----------------------------|-----|
| notably negative findings: | 10  |
| notably positive findings: | 0   |
| score:                     | -10 |

#### Goal: year-on-year improvement

ii. Discrimination reporting rate in the staff survey on the theme of disability.

#### Current situation:

0.6% in survey taken in 2010 (improved from 0.7% in previous year)

#### Goal: year-on-year improvement

iii. % in staff survey saying we have implemented reasonable adjustments:

#### Current situation:

84% (acute trust benchmark 70%)

#### Goal: to remain well above the national benchmark.

### Stakeholder relations

We place considerable emphasis on working with and alongside our partners in health and social care. Indeed, the secondment of our Chief Operating Officer at the beginning of the calendar year demonstrated that we are keen to play a full part in managing the transition of patients across the boundaries of the organisations involved in health and social care.

Locally, we continue to work closely with NHS Devon and we have also stepped up our engagement with GPs and emerging Clinical Commissioning Groups. The Board recognises that stakeholder engagement is now mission critical and that is why, during the year, it agreed a comprehensive engagement strategy that is being taken forward as part of the implementation of our new strategy. As part of this, we aim to build on our relationships with local Trusts as well as other public and private providers of healthcare activities. Clinical partnerships with neighbouring Trusts have continued to develop and expand. We also recognise the importance that we need to attach to the development of positive ongoing relationships with providers of social care and we have engaged in a series of meetings with local authority counterparts during the year.

We continue to enjoy a good working relationship with the Devon Health and Wellbeing Scrutiny Committee. The Chair and Deputy Chair attended an informal Board session during the year and our Chief Executive, Angela Pedder, gave evidence to the Committee early in 2012.

Our partnering with the University of Exeter continues to go from strength to strength. The work on new joint research centres on our site in partnership with the University of Exeter and the Wellcome-Wolfson Foundation underlines the strategic importance of research and development at the Trust.

## Sustainability

### Saving Carbon

The NHS carbon footprint in England was reported in 2010 to be approximately 21 million tonnes of carbon dioxide equivalent and had risen from the 18 million tonnes published in 2009, largely due to growth in the NHS. Some 24% of the NHS carbon footprint relates to energy, 17% is travel and 59% is the result of procurement.

The latest NHS carbon footprint shows carbon emissions have stopped rising and are leveling off at around 20 million tonnes per year. To combat the effects of climate change the NHS has a target of reducing its carbon footprint by 10% by 2015 (using 2007 as a base year).

The Trust has developed its carbon reduction strategy and we are committed to achieve the changes necessary to reduce our carbon emissions and improve our environmental impact. Our ambition is to become a low carbon sustainable organisation and ensure the appropriate behaviours are encouraged in our staff, patients and visitors.

### Saving Energy

The Trust spent over £3 million on energy in 2011/12 with approximately 20,000 tonnes of carbon emissions. In order to meet the carbon reduction targets, the Trust has set itself sustainability objectives which include reducing its building energy carbon emissions to around 14,500 tonnes by 2015; and being able to generate on-site up to 50% of the hospital's electricity demand. A Sustainable Energy Strategy has been developed and was approved by the Trust Board in 2011 as a plan for managing energy and developing alternative energy sources in an optimum way in relation to the service needs.

The Trust is carbon trading through both the European Union greenhouse gas emission allowance Energy Trading Scheme (EU ETS) and the UK Carbon Reduction Commitment (CRC) Scheme. In 2011, the Trust's regulated emissions were reported to be approximately 20,500 tonnes of CO<sub>2</sub> and the Trust's standing from the first year of CRC performance reporting is 70 out of 159 NHS organisations. Our carbon emissions had risen from the previous year's figure of 18,228 tonnes largely because of the inclusion of transport diesel fuel and some peripheral community sites that are occupied by our services.

#### The Sustainable Energy Strategy embraces:

- Where the Trust wants to be in terms of improved energy performance, use of renewable energies and new technologies leading to greater resilience and sustainability
- How we will get there in terms of developing realistic and feasible options for energy efficiency, carbon reduction and renewable energy schemes. It identifies a number of energy/carbon reduction schemes and will support the prioritisation process as to which schemes to take forward and when
- The priorities, showing what early investment is needed for improvement schemes that will best enable the Trust to meet its 2015 carbon reduction target; and drive towards being more sustainable both environmentally and financially.

#### Our strategic sustainability objectives are:

- To increase use of renewable energy solutions to fulfil 50% of the Trust's energy demands by 2015 and reduce reliance on fossil fuels and grid energy
- To reduce primary energy consumption (gas, oil and electricity) in the drive towards meeting the 2015 carbon reduction target.

## 2. Our Trust

- To use smart technologies to automatically meter the consumption of primary energy utilities and to automatically turn off lighting and non-essential equipment
- To further develop our rolling programme of energy improvements to the Trust's existing buildings based upon routine energy audits
- To demonstrate that our planned capital developments meet the Building Research Establishment Environmental Assessment Method (BREEAM) 'Excellent' standard using the BREEAM Healthcare methodology.

The Sustainable Energy Strategy sets out opportunities for replacing fossil fuel grid energy with energy from renewable and on-site micro generation sources, improving energy efficiency and reducing energy consumption through better housekeeping. Amongst the wide variety of renewable energy systems assessed the following schemes have been prioritised:

- Solar photovoltaic scheme: approved for installation in 2012
- Improvements to the Combined Heat and Power unit (CHP): approved for 2012
- Energy from waste scheme: feasibility established and scheme proposed for 2013/14
- Second CHP: planned for 2013/14.
- Ground source heat pumps: proposed for 2014/15
- The introduction of a scheme for biomass boilers in 2014/15 may become part of a wider district heating/energy scheme, subject to the outcome of a feasibility study with Exeter City Council.

### Saving Waste

The Waste Management Group's main focus during 2011/12 has been on ways of reducing waste at ward level, expanding recycling across the Trust and reducing the cost of waste disposal. The following projects were implemented:

- A daily audit system in the wards was introduced across all areas of the Trust and is enabling better segregation and minimisation of waste
- Recycling was extended to cover more non-clinical areas throughout the Wonford and Heavitree hospital sites
- On-going controls to reduce food wastage were reviewed
- Development of the on-going training scheme on waste management for all appropriate staff
- Preparations for further segregation of waste streams for implementation in May 2012
- A new cardboard baler for recycling cardboard was commissioned.

### Transport and travel

The Trust's annual transport and travel carbon footprint is estimated to be in excess of 1,700 tonnes of CO<sub>2</sub> (transport fleet, patient transport, staff car miles, rail, air and vehicle rentals but not including the bus services, staff commuting to work, patient and visitors travel or travel associated with purchased goods).

The Trust's own transport fleet covers around 1.1 million miles each year and is responsible for approximately 390 tonnes of CO<sub>2</sub>. The Energy Savings Trust completed a Green Fleet Review in 2011 and identified opportunities for reducing carbon emissions and for making cost savings. The following are examples of measures which we are introducing:

- Optimising vehicle usage in 2011 by partitioning within vehicles to provide flexibility for them to carry different categories of goods and thereby reduce numbers of journeys e.g. laundry, linen and instruments
- Reorganisation of vehicle routes in 2012.
- Investigating the feasibility of using electric vehicles. A Zero emissions vehicle will be trialled on some of the local routes for a period in 2012
- Restricting more vehicle top speeds to improve their fuel efficiency.

All our new HGV Vehicles meet the current Euro 5 regulations in respect of emissions and are classed as EEV (Environmentally efficient vehicles). This means that they already meet the emission standard for Euro 6 ahead of its 2013/14 implementation.

The Staff Travel Group and Bicycle User Group have continued to promote active travel and sustainable travel options to help reduce demand on car parking and vehicle dependence. Staff, visitors and patients are encouraged to consider alternatives to using their car when coming to the Trust's hospitals.



## 2. Our Trust

### Performance

The following table summarises the Trust's performance with prior year comparatives:

| Area                              |                    |                         | Metric Tonnes | Metric Tonnes | Metric Tonnes | Cost £     | Cost £     | Cost £        |
|-----------------------------------|--------------------|-------------------------|---------------|---------------|---------------|------------|------------|---------------|
|                                   | Stream             | Disposal Methods        | 2009/10       | 2010/11       | 2011/12       | 2009/10    | 2010/11    | 2011/12       |
| Waste minimisation and management | Clinical           | Offsite incineration    | 810           | 770           | 753           | £292,259   | £258,070   | £250,718      |
|                                   | Domestic           | Compaction and landfill | 654           | 660           | 641           | £59,990    | £66,000    | £70,382       |
|                                   | Paper              | Collection and recycle  | 45            | 45            | 47            | £660       | £700       | £802          |
|                                   | Confidential waste | Shred and recycle       | 60            | 65            | 67            | £19,323    | £21,000    | £21,487       |
|                                   | Cardboard          | Batch and recycle       | 115           | 125           | 130           | £2,513     | £2,513     | £2,513        |
|                                   | Metals             | Collection and recycle  | 50            | n/a           | n/a           | £150       | £0         | £0            |
|                                   | Utilities          | Metric                  | 2009/10       | 2010/11       | 2011/12       | 2009/10    | 2010/11    | 2011/12       |
| Use of finite Resources           | Water              | Cubic metres            | 237,233       | 220,100       | 253,670       | £759,885   | £715,500   | £878,545.74   |
|                                   | Electricity        | Kilowatt hours          | 14,553,992    | 17,948,500    | 18,271,040    | £1,271,588 | £1,425,600 | £1,727,381.76 |
|                                   | Gas                | Kilowatt hours          | 42,824,834    | 40,195,000    | 37,563,728    | £1,065,250 | £1,052,500 | £1,134,785.11 |
|                                   | Oil                | Litres                  | 325,869       | 330,000       | 290,980       | £176,552   | £210,000   | £217,083.47   |
| Greenhouse Gas Emissions          | Scope 1            | Direct                  |               |               |               |            |            |               |
|                                   | Scope 2            | Indirect                |               |               |               |            |            |               |
|                                   | Scope 3            | Travel                  |               |               |               |            |            |               |

### Raising Awareness

Sustainability is a complex subject. Education and understanding of the issues are key to providing the impetus for any worthwhile and lasting behavioural change in a large organisation such as the NHS. Challenging staff, patients and visitors to think and behave in more sustainable ways, whether at work, at home or in the wider community is a social responsibility for the NHS and one that we have a duty to meet.

In October 2011 the Sustainability Committee organised a very well received “Sustainability awareness” event, opening with a hospital lecture delivered by Professor Michael Depledge, Chair of Advisory Board, European Centre for Environment and Human Health, and followed by an afternoon of talks, presentations and discussion with a multidisciplinary audience.

In March 2012, the Trust contributed to the national “NHS Sustainability Day of Action”.

As well as building on these events in 2012/13, we plan to strengthen educational contacts and links with colleagues at the University of Exeter Centre for Energy and the Environment and the Met Office.

# Quality Report 2012

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## ▶ Chief Executive's introduction

### *Welcome to our fourth Annual Quality Report.*

Our Quality Report 2011/12 provides an overview of our performance in providing high quality care for the communities we serve in the region. It also sets out our plans to improve the quality of services in specific areas by identifying key priorities and how we intend to reach them.

The Annual Quality Report gives us the opportunity to restate the central importance we place on delivering the highest possible quality of care for each and every patient that uses the services we provide. Our commitment to quality outcomes means that we aim to provide a good quality service at all times and in every circumstance to all of our patients. In publishing the Report, we aim to be transparent about our own (and others') assessment of the quality of care we provide. The Board recognises that transparency, and the ability of third parties to assess and scrutinise our performance, helps us to focus on tracking evidence-based performance on quality issues in a way that helps improve services. In addition, and equally importantly, it nurtures our already existing culture of continuous improvement and innovation.

The Report sets out our achievements during the last year in delivering quality healthcare based on the priorities set out in last year's Report and in the previous year. We are proud of the progress we have made during the last year in a number of areas including:

- the use of the "This is me" passport for dementia patients
- the work on ward redesign
- work on promoting high quality nursing practice to ensure that, whilst in our hospital, patients will be safe, comfortable and cared for at all times
- reducing the incidence of pressure ulcers.

These quality improvements are making a real and positive difference to clinical outcomes for patients. By engaging proactively with our own staff in how we deliver quality improvements, we are often able to make changes at no additional cost or in a way that actually delivers efficiency savings.

We recognise that, on occasions, we do not always get it right and we may not meet patients' expectations or our own rigorous quality standards. In these circumstances, our commitment is to be open about what went wrong and to ensure that we learn and integrate this learning into on-going and continuous improvement.

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# Part One

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Last year, we established some guiding principles for delivering quality healthcare and these principles remain as relevant today as they were then:

- Ensuring quality is at the centre of everything we do.
- Striving to consistently meet or exceed the expectations of our service users.
- Delivering our services with respect and courtesy to our patients, their carers and our staff.
- Maintaining the very highest quality standards and building a culture where we will not settle for being good - we want to be excellent.
- Continuously learning and promoting innovation to ensure we provide the best care not only today but in the future.
- Acting with honesty and transparency in everything we do.

One of the functions carried out by our Board is to ensure that the Trust is meeting its aims in providing good quality healthcare. At Board meetings and in other fora, Directors are consistently identifying the linkages between different sources of information on the Trust's performance to ensure that there is no compromise on either safety or quality. Particular attention is paid to examining and understanding the causal and non-causal connections between different metrics and that any unexpected movements in the data can be properly explained and evidenced. At a time of financial restraint and service re-design, the Board understands the vital importance of ensuring that Directors maintain both a broad overview of quality performance against a range of metrics and also the ability to drill down into specific issues where there is a need to deepen the Board's understanding so that, when necessary, corrective action can take place.

One increasingly important element of the information that Directors consider when assessing quality is the views of our patients and members. The award we received this year as one of four "Trusts of the year" from Dr Foster, recognised that we already do well on how patients rated their care, the extent to which they were involved in their own care and how they were treated. Our new Engagement and Experience Committee (which reports to the Board's Governance Committee), is charged with improving the Trust's intelligence on the views and experiences of our patients, the Trust's Members and the wider community. The Committee has also begun to connect the information we hold on patient experience and the outcomes from our staff survey to better understand potential linkages between staff attitudes and patient-perceived quality. Our priorities for quality healthcare are informed by the feedback we receive from patients but also in the work we do with our Members at our Members' Say events. These events allow us to track - over time - the changing priorities and interests of our Members on different aspects of healthcare which we can then reflect in our quality priorities (see Annual Report for more detail on the Members' Say events). Our

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# Chief Executive's introduction

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Governors also play a key role in reflecting back to us the views of our Members. A new working group of Governors - the Patient Safety and Quality Group - has helped to provide a focus for channelling the views of Governors on quality.

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. Much of the format and structure of this document is prescribed by Monitor's Annual Reporting Guidance, which incorporates the requirements of the Health Act 2009 and the NHS Quality Account Regulations 2010.

I am confident that, together with our Annual Report, members of the public will be able to make their own assessments of the quality of healthcare we provide and our ambitions to continue to enhance quality over the coming year.

Signed



Angela Pedder OBE

Chief Executive

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# Part Two

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## ▶ Our priorities for 2012/13

A Governor working group focusing on patient safety and quality consulted with all Governors to identify some of the quality improvement issues they would like to see become priorities over the next financial year. On the basis of this consultation and in view of the outcomes from our surveys of Members and the interactive activities and focus groups at our Members' Say events, a number of issues were identified.

- Governors were very interested in what the Trust is currently doing and plans to do on the issue of managing the healthcare needs of patients that are elderly, frail and have co-morbidities. Given this interest in what the Trust can do to improve the quality of healthcare for this group of patients, Governors welcomed the decision made by the Trust's Engagement and Experience Committee to focus all further engagement work over the coming year on helping to better understand patient experience for the frail and elderly. Governors were keen to track the development of this work during the next financial year.
- Communications between our staff and patients was also an issue that Governors debated. In general there was satisfaction that good progress had been made in this area over the last year but that more remains to be done as this was an area identified by Members and in patient surveys. This issue was identified in the previous Quality Report and therefore this provided a suitable focus for on-going work in this area. Governors also discussed the complex issues related to the timely leaving of inpatients from hospital and the extent to which delays in this process should be considered a priority. This was an issue on which further consideration, analysis and information was felt to be required before selecting a specific priority area and indicator. It was also recognised that this issue is being addressed by the Trust in its priorities for next year.
- The other issue that was identified by Governors was the need for patient dignity and respect. Our surveys of our membership (both public and staff Members) has shown that this issue has been identified as a top priority. In the national patient surveys the Trust does well, in that a high proportion of patients say they were treated with dignity and respect. However, on the basis of the Governors' focus on the frail elderly as a grouping of patients that the Trust needed to focus on, it was agreed that patient dignity should be a key priority.

The Trust collates data on issues concerning dignity from the national patient surveys and also its own Nursing Quality Assessment Tool (NQAT). This tool audits nursing documentation, ward practice, and patient satisfaction. We are able to link information emerging from NQAT with the National Inpatient Survey to identify any issues that require action.

Therefore the priority issue for Governors on dignity is to ensure that the Trust continues to treat patients, particularly the frail and elderly, with genuine and real respect and that an individualised approach is taken to ensure that patients' needs for dignity are known about, respected and acted upon at all times.

The metric that will help provide assurance that this is being met will be through maintaining or increasing the proportion of patients that say they are being treated with dignity and respect in both the National Inpatient Survey and our own monitoring tool, NQAT.

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# Part Two

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## Clinical effectiveness

### *Strengthen nursing leadership at ward level*

The RD&E currently has Ward Matrons providing day-to-day visible leadership at ward level. There is plain evidence that clear, authoritative and visible leadership at ward level is valued by our patients and staff and leads to improved quality of care in terms of safety and feeling ‘well looked after’. During 2012/2013, we will strengthen the model of leadership at ward level by ensuring that Ward Matrons are given the time to lead, together with opportunities and support to enhance their skills consistently across the Trust. This is the key focus of the second part of our two-year ward re-design project. A suite of key performance indicators will be developed for Ward Matrons which will be used to evaluate the effectiveness of this change and of individual ward matrons. A subset of these indicators will be reported to the Board monthly as part of the Trust’s Ward to Board report.

### *Develop a strong value-based vision for Nurses, Midwives and Allied Health Professionals*

We want the way our patients and their relatives or carers expect to be treated at the RD&E to be reflected in a clear value-based vision developed by nurses, midwives and Allied Health Professionals (occupational therapists, physiotherapists, pharmacists, radiographers).

This group of clinical professionals will develop a three-year vision that will support the wider corporate strategy. At the heart of the vision is patient care which is delivered with knowledge, skills and confidence by compassionate, caring staff today and into the future. There will be a three year implementation plan with clearly articulated milestones which will be monitored by the Director of Nursing and Patient Care through the Joint Professions Committee.

### *Develop a patient discharge service to improve co-ordination and delivery of care*

We want our patients to experience no delays when they are ready to leave our hospital and to receive the right information and on-going care in the community. We will be working with our local strategic partners and our own Patient Engagement Group to identify ways to achieve this and reduce unnecessary re-admission to the RD&E. Our staff will be actively involved in exploring and developing new ways of working, including improvements to the referral process for patients with on-going care needs when they leave our hospital; early intervention for physiotherapy and occupational therapy, and increasing voluntary sector patient advocacy in support of clinicians, carers and families for the planning of discharge arrangements. This will be monitored and evaluated by the Trust’s Senior Operational Group and the Trust’s Integrated Performance Report.

## *Improve patient flow when they come to the RD&E for planned surgery*

We are looking at all our planned surgical services across the hospital to develop ways of improving patient experience by being more efficient. We want to provide smooth co-ordinated services from diagnosis and preparation for surgery through to recovery and leaving hospital.

Since April 2010 we have run operating theatres in local community hospitals and increased the amount of Day Case surgery carried out in these theatres to release the main Wonford hospital theatres for more complex and emergency cases. By Day Case surgery we mean patients who do not need to be kept in hospital overnight after their operation or treatment.

Over 43,000 day case patients however receive their treatment at Wonford hospital and we want to look closely at how we do this work because we believe patient experience and the use of resources can be better. We considered a number of options including a dedicated day case unit at Wonford for surgery patients and identified two ward areas suitable for Day Case surgery cases including planned orthopaedics and specialist surgery work. Advantages of this approach include a single place for all our planned surgical patients when they come to our hospital; the ward location close to theatres and reducing the need to cancel Day Case surgery work to alleviate Trust-wide bed capacity pressures. This work continues and we expect changes in other clinical services will evolve including emergency surgical care.

This will be monitored and evaluated by a Trust Access meeting and reported to the Trust's Senior Operational Group.

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# Part Two

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## ▶ Safety

### *Invest in technology to improve management of patient records*

We believe modernisation of patient record management with the introduction of eNotes technology will enable clinical decisions to be made at the point of patient care, supported by easy but secure access to historic and current medical history. The digitising and electronic storage of patient information is scheduled for adoption first by our orthodontics, oral surgery and paediatric Cystic Fibrosis services. Improved security, access to and management of hospital health records should make patient care safer and more efficient. The main decision-making project group for eNotes will be chaired by a Medical Director. This will be monitored and evaluated by the Trust's Senior Operational Group and the Trust's Integrated Performance Report.

## ▶ Patient experience

### *Develop an integrated discharge service for patients at the end of their life so they die in their preferred place of care wherever possible*

We plan to run a six month pilot across five wards or services to co-ordinate discharge from our care for patients at the end of their life. This will be for patients whose death is imminent but also those with advanced progressive conditions expected to die within 12 months. The principle aim of this work is for patients to die in their preferred place of care, to engage healthcare professionals on their attitude to death and dying and to promote earlier discussion about the wishes, concerns and priorities of patients about the end of their life. We intend to capture the experience of relatives and carers of deceased patients to share with our staff as part of an education programme and to inform service improvements. This will be monitored and evaluated by the Patient Experience Group.

Running along side the pilot will be an external training programme led by the national lead for Gold Standard Framework. This programme will run over three years aiming for accreditation on completion. The programme will include education advanced care planning, symptom control, preferred place of care & end of life register. This will be monitored by the Patient Experience & Engagement group.

## *Statement of assurance from the Board of NHS Services provided;*

### **Review of services:**

During 2011/12 The Royal Devon and Exeter NHS Foundation Trust provided and/or subcontracted 42 NHS services.

The Royal Devon and Exeter NHS Foundation Trust has reviewed all the data available to them on the quality of care in these 42 NHS services.

Income generated by the NHS services reviewed in 2011/12 represents 100% of the total income generated from the provision of NHS services by the Royal Devon and Exeter NHS Foundation Trust for 2011/12.

### **Audit - Participation in clinical audits:**

During 2011/12, 44 national clinical audits and 4 national confidential enquiries covered NHS services that the Royal Devon and Exeter NHS Foundation Trust provide.

During 2011/12 the Royal Devon and Exeter NHS Foundation Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that Royal Devon and Exeter NHS Foundation Trust were eligible to participate in during 2010/11 are listed in Annex D.

The national clinical audits and national confidential enquiries that the Royal Devon and Exeter NHS Foundation Trust participated in during 2011/12 are listed in Annex D.

The national clinical audits and national confidential enquiries that the Royal Devon and Exeter NHS Foundation Trust participated in, and for which data collection was completed during 2011/12, are listed in Annex A alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

The reports and recommendation of 13 national clinical audits were reviewed by the Trust in 2011/12. Annex E presents the actions which are being taken by the Royal Devon and Exeter NHS Foundation Trust to improve the quality of healthcare provided.

The reports of 69 local clinical audits were reviewed by the Trust in 2011/12. Annex F presents the actions which are being taken by the Royal Devon and Exeter NHS Foundation Trust to improve the quality of healthcare provided.

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# Part Two

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## Clinical research participation

The number of patients receiving NHS services provided or sub-contracted by the RD&E in 2011/12 that were recruited during that period to participate in research approved by a research ethics committee was 9200. This represents an increase of 27% from 2010/11.

Participation in clinical research demonstrates RD&E's commitment to improving the quality of care we offer and to making our contribution to wider health improvement. Our clinical staff stay abreast of the latest possible treatment possibilities and active participation in research leads to successful patient outcomes.

The RD&E is the highest recruiting NHS organisation to clinical trials in the South West Peninsula. The RD&E was involved in conducting 515 clinical research studies in a wide range of specialties during 2011/12. During this period there were over 270 clinical staff participating in research approved by a research ethics committee. Over 80% of studies were approved within 30 days of receiving valid application.

The RD&E hosts the South West Diabetes Research Network, South West Stroke Research Network, Peninsula Comprehensive Research Network and South West Research Design Services, thus playing a significant role in the region for the National Institute of Health Research (NIHR).

The RD&E collaborates with the Peninsula College of Medicine & Dentistry, hosting the NIHR Peninsula Clinical Research Facility for experimental medicine. A total of 8500 participants were recruited into research studies during 2011/12 at this facility. Research focuses on understanding mechanisms of disease (mainly in diabetes and cardiovascular patients) and introducing improvements into patient care.

The high quality of the research at the Trust is demonstrated by the level of external grant funding which over the last three years averaged £3.0 million per annum.

Also, in the last three years, 384 publications have resulted from our involvement in NIHR research, which shows our commitment to transparency and desire to improve patient outcomes and experience across the NHS.

## Goals agreed with Commissioners

### *Use of CQUIN payment framework*

A proportion of the Royal Devon & Exeter NHS Foundation Trust's income in 2011/12 was conditional on achieving quality improvement and innovation goals agreed between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of NHS services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2011/12 and for the 12-month period are available electronically at [www.rdehospital.nhs.uk](http://www.rdehospital.nhs.uk).

The 2011/12 NHS Operating Framework continued the potential for Trusts to earn additional income, conditional upon achieving quality improvement and innovation goals. NHS Devon, on behalf of all commissioners, and the Trust agreed a suite of schemes for which the Trust could earn an additional £4.2 million of income. In 2010/11 the Trust received payment to the value of £3.2 million.

### *NHS Number and General Medical Practice Code Validity*

The RD&E submitted records during April 2011 - January 2012 to the Secondary Uses service for inclusion in the Hospital Statistics that are included in the latest published data. The percentage of records in the published data:

#### **Valid NHS Number:**

|       |                                 |
|-------|---------------------------------|
| 97.8% | for admitted patient care       |
| 99.3% | for outpatient care; and        |
| 87.0% | for accident and emergency care |

#### **Valid General Medical Practice Code:**

|       |                                 |
|-------|---------------------------------|
| 100%  | for admitted patient care       |
| 100%  | for outpatient care; and        |
| 99.1% | for accident and emergency care |

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# Part Two

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## ▶ Statements from the Care Quality Commission (CQC)

The Royal Devon and Exeter NHS Foundation Trust is required to register with the Care Quality Commission (CQC) and its current registration status is registered in full without conditions.

The CQC has not taken any enforcement action against the Royal Devon and Exeter during 2011/12.

The Royal Devon and Exeter has participated in special reviews or investigations by the CQC relating to the following areas during 2011/12:

14th April 2011, as part of a random selection of Acute Trusts, a targeted inspection programme focusing on Dignity and Nutrition. The CQC found that the Royal Devon and Exeter was meeting both of the essential standards for quality and safety. To maintain these standards the CQC suggested some minor improvements were made. The improvements, approved by the Board of Directors, reached full implementation in October 2011 and included the adaption of the “Do not attempt resuscitation form”, the development of a new care plan for patients with confusion, dementia, delirium and learning disabilities and the identification of discreet dining areas and the purchase of a variety of distraction aids for meal times.

9th and 10th November 2011, a scheduled, routine planned review. The CQC found that the Royal Devon and Exeter was meeting all the essential standards of quality and safety. To ensure maintenance of these standards for the future, the CQC suggested some minor improvements were made. An action plan, approved by the Board of Directors has been developed which has included the review of the current nursing care plans to support improved documentation of personalised delivery of care. An audit has also been undertaken of 200 inpatient case notes to identify and assess areas of best and poor practice in terms of documentation of decision-making and use of the “Do not attempt resuscitation form”. These pieces of work are on-going and their progress is being monitored by the Governance Committee.

21st and 23rd March 2012, a responsive review of compliance of all providers of Termination of Pregnancy Services following national concerns. The review focused on process and documentation. The Trust is currently awaiting the formal report.

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***The Royal Devon and Exeter NHS Foundation Trust Information Governance Assessment Report overall score for 2011/12 was 68% and was graded green.***

The Trust has recently submitted its Information Governance Toolkit assessment. Achieving a level 2 on all 45 requirements. The target score across the board was set at 66% by Connecting For Health and the Royal Devon and Exeter NHS Foundation Trust has reached an overall score of 68%. Action plans are in place to ensure the Trust maintains it's performance on Information Governance for 2012/13.

The Royal Devon and Exeter NHS Foundation Trust was subject to the Payment by Results clinical coding audit during the reporting period(April 2011 - March 2012) by the Audit Commission and the error rates reported in the latest published audit for that period for diagnoses and treatment coding (clinical coding) were;

|                      |      |
|----------------------|------|
| Primary diagnoses    | 8.0% |
| Secondary diagnoses  | 9.2% |
| Primary procedures   | 4.3% |
| Secondary procedures | 3.0% |

Please note: These results should not be extrapolated further than the actual sample audited; the sample included medical oncology and a random selection of inpatient/daycase services provided by the Trust.

# Part Two

## 2011/12 Quality Schemes

The Trust agreed with commissioners the following suite of schemes as the priority quality improvement goals in 2011/12. These goals formed the basis of the CQUIN (Commissioning for Quality and Innovation) Framework in 2011/12.

- 1. VTE Risk (Venous Thrombotrophylaxis Assessment)** - This CQUIN scheme measures the proportion of adult inpatients for whom a VTE risk assessment was undertaken within 24 hours of admission.

|    | Target | Achievement |
|----|--------|-------------|
| Q1 | 82.00% | 83.59%      |
| Q2 | 85.00% | 87.23%      |
| Q3 | 88.00% | 90.20%      |
| Q4 | 90.00% | 90.29%      |

- 2. Patient Experience** - This indicator draws together the response of patients to 5 questions, identified by the Department of Health, and drawn from the 2011 National Inpatient Survey. The responses form an index-based score. Higher scores reflect better performance. The Trust's score of 71 compares favourably against national benchmarks for equivalent hospitals.

- 3. Nutrition** - This CQUIN scheme measures the proportion of adult inpatients for whom a MUST (Malnutrition Universal Screening Tool) assessment is undertaken within 24 hours of admission. The following challenging trajectory was agreed with commissioners, against which the Trust has made considerable progress. Further detail regarding achievement of this priority goal is outlined later in this report.

|    | Target | Achievement |
|----|--------|-------------|
| Q1 | 55.00% | 74.27%      |
| Q2 | 67.00% | 77.35%      |
| Q3 | 78.00% | 75.27%      |
| Q4 | 90.00% | 85.03%      |

- 4. Dementia** - This CQUIN scheme included the development of "This is Me" documentation for those who are cognitively impaired, and piloting use of the documentation with patients and their carers on wards within the hospital. Further detail regarding this priority goal is outlined in a case study on page 17.

- 5. Pressure Ulcer Screening** - This scheme measures the proportion of adult inpatients who were risk-assessed within 24 hours of admission for the likelihood of developing pressure sores

|    | Target | Achievement |
|----|--------|-------------|
| Q1 | 92.20% | 96.53%      |
| Q2 | 92.75% | 96.33%      |
| Q3 | 93.25% | 93.65%      |
| Q4 | 93.75% | 96.20%      |

- 6. Medicines Management** - this scheme involved the auditing of patient records to determine whether a medicines reconciliation is undertaken within 24 hours of admission for patients who have been admitted in an emergency to the emergency assessment unit.

|                         | Target  | Achievement |
|-------------------------|---|-------------|
| Q1 and Q2               | Provision of action plan, baseline audit and trajectory | Produced    |
| Q3 (October & November) | 60%   | 86%         |
| Q3 (December & January) | 75%   | 100%        |
| Q4 (February & March)   | 90% and achievement of data completeness measures       | 100%        |

- 7. Maternity** - this CQUIN scheme involved the implementation of an action plan to support vaginal birth, and the provision of evidence to support delivery of ten agreed outcomes.

- 8. Enhanced Recovery** - this CQUIN scheme involved the further roll out of enhanced recovery techniques to further surgical specialties including orthopaedics, urology, gynaecology, colorectal surgery, and plastic surgery.

- 9. Review of Patients with Severe Haemophilia** - this CQUIN scheme involved undertaking a pharmacokinetic study for adults with severe haemophilia, in order to determine whether there is a better clotting factor usage.

# Part Three - Safety

▶ How well have we done on our 2011/12 priorities?

## *Development of the dementia 'This is Me' passport*

Improving dementia care is very much a priority for the RD&E and locally by our service commissioners, NHS Devon to ensure this vulnerable adult patient group consistently receives compassionate, safe and effective care.

With this in mind, we have carried out a pilot study to evaluate two approaches to 'dementia passports'.

The passport is a document for each patient with a confirmed diagnosis of dementia, which sets out their individual needs and preferences so that staff know how best to

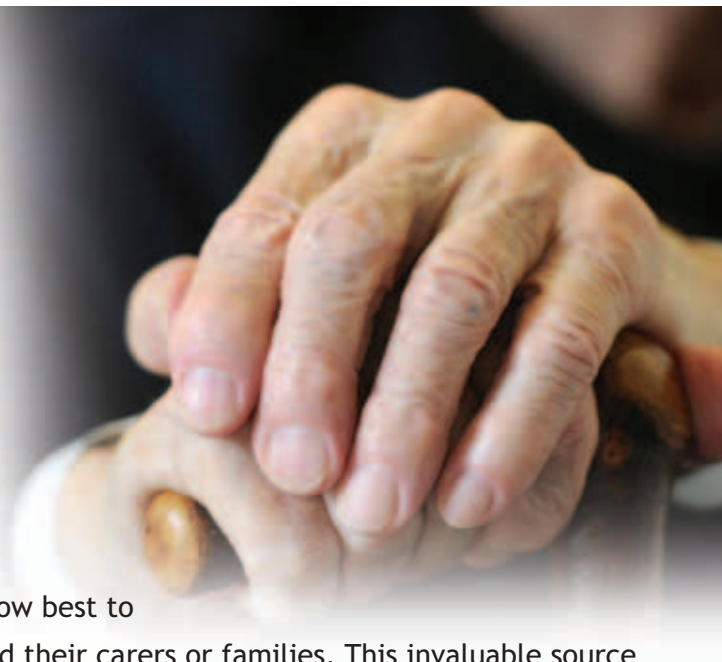
keep individuals safe and communicate with them and their carers or families. This invaluable source of information stays with the patient and is shared with any health or social care organisation or service the patient comes in contact with.

At the RD&E we trialled on two elderly care wards the 'Living Well' passport, which was developed in association with our local mental health trust; in the Acute Medical Unit we piloted the Alzheimer's Society 'This Is Me' passport. The passports were offered to patients and their carers who were invited to record this information and we have sought their views, as well as staff feedback. Our pilot study recommends use of the This Is Me passport and that it should be given to patients at an outpatient clinic appointment or when they are leaving the hospital, not whilst staying at the RD&E.

In May 2012 this recommendation will be considered with the study report by our commissioner NHS Devon.

## *Monitoring and Reporting*

Development of this initiative was overseen by the Dementia sub-group of the Trust's Integrated Safeguarding Committee, which in turn reported progress to the Governance Committee and thereby the Board.



► **RD&E delivers specialist training for keeping dementia patients safe in hospital care with a national first**

At the Royal Devon & Exeter we have seen a 25% increase over the past two years in the number of our inpatients with dementia symptoms (2009-2011). We are committed to providing safe, compassionate and effective care for this group of vulnerable adult patients.

Dementia is a group of related symptoms associated with a decline of the brain and its abilities including memory, thinking, language, understanding and judgement. People with dementia may also become apathetic, have difficulty controlling their emotions or behave inappropriately in social situations. Aspects of their personality may change or they may see or hear things that other people do not, or have false beliefs. Most cases of dementia are caused by damage to the structure of the brain.

This year our staff on the elderly care wards received what is thought to be the first bespoke training of its kind in the country so they know how best to look after dementia patients when confused or agitated during their hospital stay.

This training was developed by our own security service and Devon Partnership Trust mental healthcare professionals so that staff could improve their skills to prevent, diffuse and manage scenarios related to this health condition.



Matron Debbie Cheeseman said:  
*"Nursing and therapy staff work daily with very challenging patients who often have severe dementia. Our patients should be looked after by staff who understand their needs and will look after them and their families with kindness and consideration. To have our own training designed within our wards has been a fantastic development. We now have ward champions who support and teach their colleagues and ensure that this improvement in patient care goes from strength to strength."*

## *CQC inspection: dignity & nutrition of older people care standards results (2011)*

An unannounced inspection of Bovey and Bolham wards in April 2011 by the Care Quality Commission found that standards people expect for the dignity and nutrition of older people were being met. The CQC report concluded that the RD&E was compliant - “meeting the essential standards of quality and safety reviewed.”

Director of Nursing & Patient Care Em Wilkinson-Brice said: “The inspectors commented at the time that it was clear that staff enjoyed their work and this was reflected in the way they paid discreet, individual and skilled attention to assist patients with eating and ensured their dignity was respected at all times.”

In order to maintain these standards the Trust was asked to review documentation recording how a Do Not Attempt Resuscitation decision was made and the review process; to personalise and improve communication needs of a patient within care plans and look at promotion of patient experience at meal times.



## *Dr Foster award recognition - patient mortality*

***“The Trust of the Year award recognises excellence in the NHS. It is important to identify hospitals where the evidence points to outstanding achievement, both in outcomes and in how patients’ rate their experience of care.”***

*Chief Executive of Dr Foster Intelligence Tim Baker*

## How well have we done on our 2011/12 priorities?

Our Director of Nursing & Patient Care led a review of our Wonford hospital ward teams to ensure we have the right people doing the right job in the right place at the right time. The driver for this has been to improve patient experience and care on our wards.

The ward team re-design work is a two year project - the first year was focussed on non clinical care and the second year will look at the clinical teams. The intention is to put patients at the centre and wrap the right care team around them.

Ward housekeeping, cleaning and catering

provide essential support services to our patients and the ward team. After a thorough review of their duties and responsibilities, we carried out a pilot and in March introduced new roles on our wards - starting with the Ward Housekeepers who organise, supervise and where appropriate take part in delivery of non-clinical services. Their focus is on cleaning, food and hydration of patients, the general ward environment, auditing the quality of these services and meeting and greeting patients and their visitors on the ward. They deliberately do not work the same set hours throughout the week to ensure a true understanding and measure of what is happening at different times on their ward. Another key change was no longer having one role performing both cleaning and catering duties, with the introduction of the separate Domestic Assistant and Catering Assistant roles.



▶ Pictured is Taw Ward Housekeeper Suat Erten on his first day on duty in his new role

*“I have been here for three weeks and have seen first hand how the housekeeper has made a great contribution. She helps with the catering arrangements, goes through menus with those unable to complete them; and keeps an eye on the cleaning staff and lends them a hand when they need it. I have noticed she has even got repairs done.”*

*Patient feedback during our pilot*

# Clinical Effectiveness

## How well have we done on our 2011/12 priorities?

### **Nutrition & hydration - MUST (Malnutrition Universal Screening Tool) assessments to be completed on 85% adult inpatients within 24 hours of admission by April 2012.**

In August 2011 we launched a Trust-wide campaign called 'You Matter' promoting high quality nursing practice to ensure whilst in our hospital, patients will be safe, comfortable and cared for at all times. This on-going initiative focussed on nutrition (hydration and nourishment), pain (effective pain management) and skin care (to prevent and manage pressure ulcers).

#### **This is what we have achieved to date:**



**Your nutrition matters:** The focus of this campaign, launched in January 2012, was the promotion at ward level of the importance of good nutrition support for patients in our care. This was done through ward visits, posters and a specific reference folder for staff. A key aspect of this work raised awareness about MUST screening. Twelve months ago only 49% of our patients were nutritionally screened within 24 hours and only 70% were screened within the week. We can report that this position has improved with 88% of patients now being nutritionally screened within 24 hours and 97% of patients being screened within a week. We still have work to do to improve further and we will not be satisfied until over 95% of patients are screened within 24 hours.

We also introduced an electronic referral system with the aim of achieving an earlier patient referral by the ward team to the dietetic service.



**Your pain matters:** We are pleased to report that the Care Quality Commission inpatient survey last year found that 86% of our patients felt that staff had done all they could to manage their pain but we want to improve on this further. An internal audit we carried out this year compared favourably with 2004 and we intend to repeat the audit in early 2012.

| Year   | 2004 | 2011 |
|--|------|------|
| Number of patients in audit  | 491  | 430  |
| % asked about their pain at least once in 24 hours                 | 70   | 98   |
| % of patients with pain score documented at least once in 24 hours | 22   | 96   |



**Your skin matters:** In August 2011 we launched this initiative to raise awareness and reaffirm our commitment to identifying patients at risk of pressure ulcers and early intervention to prevent and effectively treat sores. To date we have seen a 35% reduction in total number of hospital acquired pressure ulcers in comparison to the previous year.

We are assessing 95% of our patients consistently that they may be at risk of developing pressure ulcers. Over 100 Trust-wide Skin Champions signed up to this campaign to encourage colleagues to understand what causes pressure ulcers, why it is unacceptable for our patients to have this painful skin condition and promote effective nursing care. A Matron's charter set out accountability among the ward team and each ward received an information folder to support nursing practice. We also revised our Pressure Ulcer Prevention Policy.

**Research at the Royal Devon & Exeter hospital has shown that trainee surgeons learn technical skills much more quickly and deal better with the stress of the operating theatre if they are taught to mimic eye movements of experienced surgeons.**

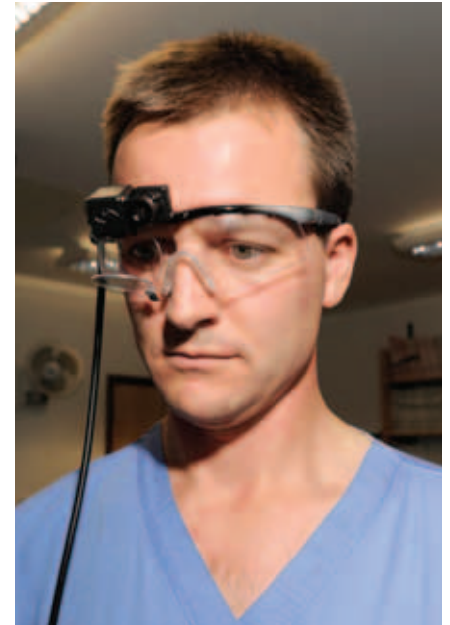
RD&E took part in research (published December 2011) which could transform the way in which surgeons are trained to be ready for working in theatres. They identified differences in eye movements of expert and novice surgeons and created a ‘gaze training’ programme which taught the novices the ‘expert’ visual control patterns.

RD&E consultant surgeon Mr John McGrath said: “This exciting collaboration with the universities of Exeter and Hong Kong and the Horizon training centre in Torbay enabled us to trial a very novel approach to surgical education, applying the team’s international expertise in the field of high performance athletes. Focussing on surgeons’ eye movements has resulted in a reduction in the time taken to learn specific procedures and, more importantly, demonstrated that their skills are less likely to break down under pressure. Our current work has now moved into the operating theatre to ensure that patients will benefit from the advances in surgical training and surgical safety.”

A wealth of clinical knowledge and research to improve the care of our surgical patients was brought together with the opening this year of a new dedicated unit at the Royal Devon & Exeter.

Creation and investment in the Exeter Surgical Health Services Research Unit reinforced the Trust’s collaborative approach and international reputation to improving surgical techniques and improvements in healthcare.

The unit includes a video link from a seminar room to theatres for teaching and a clinical consultation room. It supports work for the National Institute for Health Research and strengthens established links with partners including the University of Exeter and Peninsula College of Medicine & Dentistry.



▶ Pictured: Surgeon in training Mr Tom Dutton wearing the eye tracker technology

**“Collaborative working and sharing of knowledge and resources is essential to ensuring that research and improvement of health services goes from strength to strength.”**

*Professor Steve Thornton,  
Dean of Peninsula College of Medicine  
& Dentistry, congratulating the RD&E  
on the opening of the new research  
unit in April 2011.*

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# Patient Experience

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## ▶ How well have we done on our 2011/12 priorities?

*Customer care strategy for the whole Trust setting out what our patients and their carers and visitors can expect from our staff regarding our values and behaviours. This priority was identified by our Council of Governors in response to feedback from our membership survey.*

The overarching Trust Strategy for 2011-2016 sets out our vision for 'Safe, high quality, seamless services delivered with courtesy and respect' and this underpins our organisational values of honesty, fairness, inclusion, collaboration, respect and dignity. Essential to achieving our vision and embedding our values at the Royal Devon and Exeter, will be high levels of staff awareness, understanding and engagement of how this translates into real patient experience of quality healthcare.

### **Key work achieved this year has included:**

- ✓ Learning from staff and patient survey feedback and agreeing priorities for improvements. For our patients we will address staff attitude and communication; for our staff we want to improve their satisfaction with the quality of the services they provide and their motivation.
- ✓ We recognise that how staff and patients feel on these issues are inextricably linked and mutually beneficial so we are developing a joint plan, through our Engagement & Experience Committee and Workforce & Diversity Committee. These groups will explore staff-patient relationships and interaction and how staff responses influence patient experience.
- ✓ The Nursing Quality Assessment Tool (NQAT) is being enhanced with questions specifically related to staff behaviour and the impact on patient experience. This will enable us to have regular

opportunities to identify issues and take appropriate steps to support staff and reinforce our values. This work will help us define the key principles of a Customer Care or Patient Experience strategy but aligned with the wider Trust vision and values.

- ✓ About 80% of our staff have received equality and diversity training, which is also part of our corporate induction for all new employees joining us. In response to feedback from consultation, we have also developed specific training to raise awareness and understanding of issues related to the respect and dignity of older and ethnic minority patients. For example our open An Hour to Remember sessions (see page X of our Quality Account).

### ***Easy Read patient information - development of plain English, accessible information for those with reading difficulties.***

This was a priority identified by our Council of Governors in response to South West learning disability peer review and national inpatient survey results in 2010/11. The Disability Equality Action Group (DEAG) was tasked with this objective. Ten patient information leaflets were chosen on the basis they were most ordered across the Trust. Patient information available now in Easy Read includes the Bedside Comment Card and the Learning Disability Hospital Passport.

The RD&E was named as Trust of the Year (South region) by the independent health guide Dr Foster for 2011 for patient experience. The data was drawn from national patient satisfaction surveys about how they rated their care at the RD&E, involvement in decisions about their treatment and whether they felt looked after with respect and dignity.

## *Patient power*

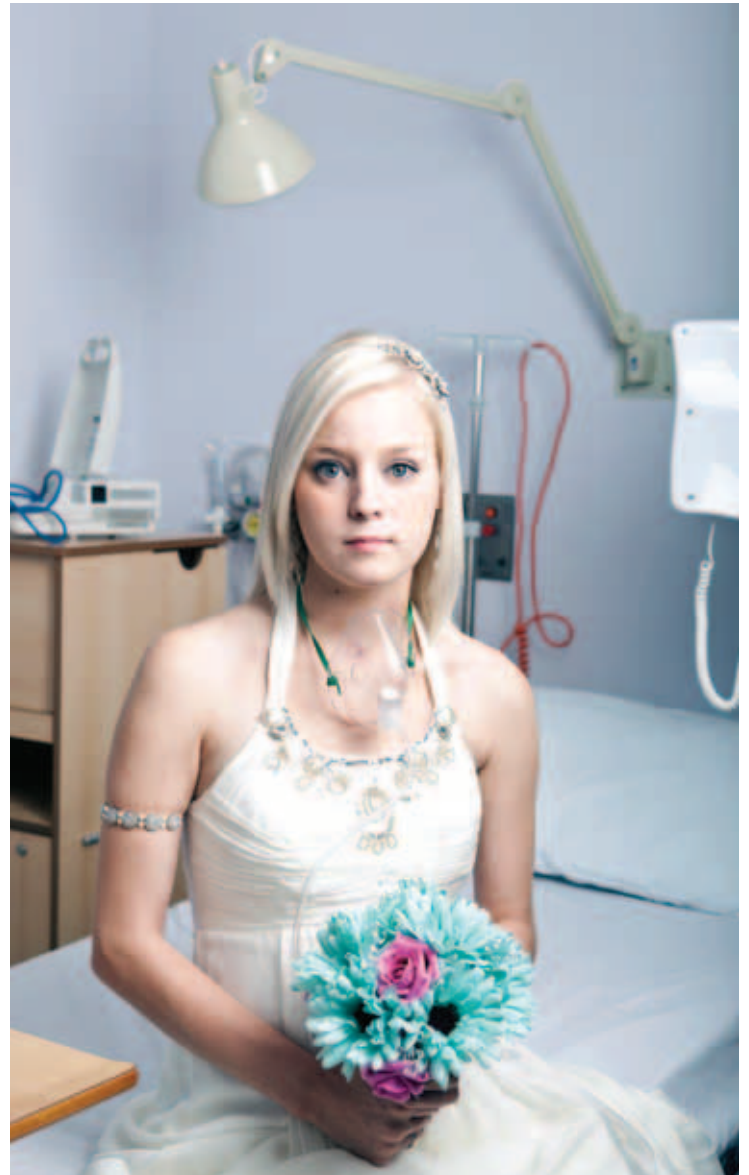
Hearing first hand from a patient can be immensely powerful when promoting complex or sensitive messages to inspire and educate the wider public about important health issues. Our patient Kirstie Mills (now Mrs Tancock) spearheaded a campaign the RD&E Organ Donation Committee launched with the city newspaper to raise awareness and encourage local people to register as an organ donor.

Kirstie shared her experience as a 21-year-old Cystic Fibrosis patient before and after having a successful lung transplant. The NHS Blood & Transplant Service reported 6,122 people living in the Exeter area signed up as an organ donor during the March-September campaign period - a significant increase on the 4,900 registrations for the same period in 2010.

***“With three people dying every day waiting for a transplant it is really important that more sign up to the NHS Organ Donor Register and tell their family their wishes.***

***The RD&E and Express & Echo have worked hard to highlight this issue and we thank them for raising awareness.”***

*Chris Chalker, NHS Blood & Transplant organ donation specialist nurse*



© Adrian Lourie

Television documentary picture of Kirstie who married whilst on the transplant list

# Monitor Dashboard - March 2012

| Indicator  | Trend | Position for Year | Target  |
|--|-------|-------------------|---|
| MON01<br>Clostridium Difficile <sup>1</sup>              |       | 85                | max. 74 annual                                    |
| MON02<br>MRSA  |       | 1                 | max. 3 annual                                     |
| MON03.I<br>Cancer 31 Day<br>Subsequent Surgery           |       | 98.0%             | min. 94%  |
| MON03.II<br>Cancer 31 Day<br>Subsequent Drug             |       | 99.8%             | min. 98%  |
| MON03.III<br>Cancer 31 Day<br>Subsequent<br>Radiotherapy |       | 99.0%             | min. 94%  |
| MON04.I<br>Cancer 62 Day<br>GP Urgent                    |       | 85.8%             | min. 85%  |
| MON04.II<br>Cancer 62 Day<br>Screening                   |       | 93.6%             | min. 90%  |
| MON05<br>RTT Admitted<br>95 <sup>th</sup> Percentile     |       | 19.6              | 95 <sup>th</sup> Percentile<br>max.<br>23 weeks   |
| MON06<br>RTT Non-Admitted<br>95 <sup>th</sup> Percentile |       | 14.9              | 95 <sup>th</sup> Percentile<br>max.<br>18.3 weeks |
| MON07<br>Cancer 31 Day<br>First Treatment                |       | 98.2%             | min. 96%  |



Indicates that the target has been achieved for the quarter  
 Indicates that the target has not been achieved for the quarter


The position for Cancer targets is subject to change when the data is uploaded to the National Cancer Waiting Times Database 6 weeks after month end.

<sup>1</sup> MON01 - Clostridium Difficile - Whilst the quarterly trajectory has been achieved for Q3 and currently Q4 the full year trajectory has already been exceeded and therefore both Q3 and Q4 will be judged by Monitor as not achieved.

# Monitor Dashboard - March 2012

| Indicator   | Trend           | Position for Year | Target  |
|---|-----------------|-------------------|---|
| MON08.I<br>Cancer 14 Day<br>GP Urgent                         |                 | 95.3%             | min. 93%  |
| MON08.II<br>Cancer 14 Day<br>Symptomatic Breast               |                 | 99.1%             | min. 93%  |
| MON09<br>A&E - 4 Hour Target                                  |                 | 95.6%             | min. 95%  |
| MON09.I<br>A&E - Total Time <sup>2</sup>                      |                 | 4.6               | 95 <sup>th</sup> Percentile<br>max.<br>4 hours    |
| MON09.II<br>A&E - Time to Initial<br>Assessment <sup>2</sup>  |                 | 22.0              | 95 <sup>th</sup> Percentile<br>max.<br>15 minutes |
| MON09.III<br>A&E - Time to Treatment<br>Decision <sup>2</sup> |                 | 42.0              | Median<br>max.<br>60 minutes                      |
| MON09.IV<br>A&E - Unplanned<br>Reattendance Rate <sup>2</sup> |                 | 7.6%              | max. 5%   |
| MON09.V<br>A&E - Left Without<br>Being Seen <sup>2</sup>      |                 | 2.6%              | max. 5%   |
| MON10<br>Stroke Indicator                                     | Not Yet Defined | n/a               | Not known   |
| MON11<br>Learning Disability<br>Compliance                    | Not applicable  | Compliant         | Compliant   |

Trend graphs run from April 2010 to current month

 Indicates that the target is not yet enforced

Approved by Trust Board April 2012.

<sup>2</sup> MON09.I to MON09.V - Following amendments to the 2011/12 Operating Framework Monitor sent a letter to Foundation Trusts on the 2nd August 2011 with the subject Changes to A&E indicator in the 2011/12 Compliance Framework which stated that the A&E performance will be assessed on the number of patients treated within 4 hours but unlike the previous A&E target this would become site specific. The 5 Clinical Indicators for A&E will still need to be monitored but are now no longer part of the Compliance Framework.

## Annexe A

### *Statements from PCT, Local Involvement Networks, Overview and Scrutiny*

#### Statement for The Royal Devon and Exeter NHS Foundation Trust Quality Account from NHS Devon

The Royal Devon and Exeter NHS Foundation Trust (RDEFT) has a long standing commitment to improving the quality and safety of the services they provide for the community they serve and NHS Devon as the lead commissioner are pleased to work in partnership with the Trust in support of this approach and welcomes the opportunity to provide commentary on the Trust's performance via the organisation's Quality Accounts.

NHS Devon acknowledges the hard work and commitment of staff at RDEFT and is happy to confirm that the Trust openly and willingly offers evidence and assurance to commissioners on the 3 domains of quality and safety of services, patient experience and effectiveness of care in the monthly Clinical Quality Review meetings (CQRM).

NHS Devon acknowledges the partnership working demonstrated by RDEFT with Devon Partnership Trust (DPT) to develop the 'This is Me' Dementia Documentation for Commissioning for Quality and Innovation (CQUIN) and would encourage other organisations to follow RDEFT's example in working in association with other providers in order that the patient has a safer and better experience.

The changed requirement to report all Grade 3 and 4 pressure sores has given RDEFT the opportunity to increase their focus on responsiveness to patients' needs and improving skin care, pressure relieving measures, nutrition and hydration and pain management in

2011/2012 with the introduction of the 'You Matter' campaign. RDEFT has utilised patient feedback effectively to influence improvement of these services which is to be commended. The Quality Account illustrates clearly that this will continue in 2012/2013, recognising the importance of the voice of the patients and carers in monitoring the quality of care delivered and identifying any areas for further improvement.

NHS Devon agrees with the hard work and developments reflected in the Quality Account. However we acknowledge that RDEFT continue to strive to improve their performance in order to create a better experience for the patient by ensuring that they are in the right place at the right time, that they do not experience delays at any point of their treatment and that the provision of early interventions ensures that early recovery is optimised. NHS Devon therefore supports the priorities for 2012/2013 with regards to improving patient flows, improving discharge delays and in particular the focus the Trust are giving to patients who are at the end of their life and who have made specific choices about where they wish to die.

RDEFT are working closely with their local commissioners and it is anticipated that this working relationship will strengthen further in 2012/2013 as Clinical Commissioning Groups evolve and that collectively the focus will continue to be the development of high quality, safe, cost effective services that improve the patient experience.

## Health and Wellbeing Scrutiny Committee

### *COMMENTARY ON THE ROYAL DEVON AND EXETER NHS FOUNDATION TRUST*

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 2011/12 which includes the priorities for 2012/13. All references in this commentary relate to the reporting period 1st April 2011 to 31st March 2012 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee believes that the Quality Report 2011-12 is a fair reflection and gives a comprehensive coverage of the services provided by the Trust, based on the Scrutiny Committee's knowledge.

The committee congratulate the trust on being awarded one of the four Dr Foster 'Trust of the year' this year. Progress against priorities over the last year seems good. Development of the dementia 'This is Me' passport was looked at by the task group into older people's mental health some years ago and the task group supported the wider application of the passport scheme. The committee is therefore pleased to see that the trust is developing this area. The committee also notes that the trust has met the CQC essential standards for quality and safety.

The Chief Executive of the Foundation Trust attended the Committee meeting on the 8th March and updated the committee on the implications of the difficult economic climate, political and demographic changes, strategic direction and implementation and implications for existing services.

The Scrutiny Committee is content with the level of patient involvement detailed in the Quality Report and welcomes the priorities for improvements 2012/13. The Committee fully supports the Trust's guiding principles for delivering quality healthcare and looks forward to continued partnership working.

## Commentary provided by LINK Devon for Royal Devon and Exeter NHS Foundation Trust's Quality Account 2011/12

LINK Devon's remit is to promote and support the involvement of people in the commissioning, provision and scrutiny of their local health and care services. To this end, LINK Devon welcomes the opportunity to respond to The Royal Devon and Exeter NHS Foundation Trust's (RDE) Quality Account for 2011/12. LINK Devon's response is set in the context of information LINK has gathered through engaging with patients and the public during the year 11/12 and of its involvement with and knowledge of the Trust to date.

Looking back at progress made, LINK Devon is particularly encouraged by the Trust's continued commitment to ensuring patients' nutrition and hydration needs are being met and that work is ongoing to ensure that the attention given to patients' nutrition, pain management and skin care continues to improve.

LINK Devon commends RDE's commitment to learning from patient experiences by responding and taking action to improve staff attitude and communication with patients on the ward. This is an area of concern that has been raised with the LINK and fed back to RDE, during the year and in previous years.

RDE's focus on gathering feedback through engagement that will lead to improvements in the way frail and elderly patients are cared for is to be commended. LINK Devon receives a high proportion of its feedback from older people and when focussing an engagement activity around 'leaving hospital' last year, the majority of the experiences we heard about were related to elderly patients, or those with complex care needs requiring extra support on discharge. In 2011, LINK Devon produced the 'Leaving Hospital' report which was welcomed by RDE. Recommendations made within that report referred to communicating information to patients, avoiding unnecessary delays and arranging aftercare or support that is both timely and well coordinated. During the last few months RDE has been fully committed to addressing the concerns raised within the LINK report through its Patient Experience Group. LINK Devon is represented on this group and the LINK Representative feeds back on how work is progressing on a regular basis. LINK Devon looks forward to receiving a formal progress report, outlining actions taken to address the recommendations, in due course.

LINK Devon is pleased to learn of RDE's plan to develop a patient discharge service, which would involve the voluntary sector to provide advocacy and support to patients with more complex needs. LINK Devon had initial input into this work and looks forward to finding out what progress has been made to improve coordination and continuity for transition for patients from ward to home.

Overall, RD&E's Quality Account highlights the Trusts ongoing efforts to improve the quality of the care it provides to its patients, their families and carers. LINK Devon will continue to engage with RDE through the Patient Experience Group and will continue to feed back comments relating to the RDE that are fed into the LINK on a regular basis.

## Statement from Council of Governors

### **GOVERNORS' RESPONSE TO THE RDEFT QUALITY REPORT 2011-12**

This report has been compiled by the Patient Safety and Quality Group, one of the newly-formed sub-groups of the Council of Governors (COG). In reviewing this year's quality report, the group was looking for evidence to assure COG that the Board has continued to scrutinize the quality of care provided by the Trust and to check that actions to improve care have been implemented effectively. This group has direct links with the Trust's newly-formed Engagement and Experience Committee through its three governor members.

#### ***Matters arising from the quality report for 2010-11***

Based on feedback from members at 'Members Say' Events, the governors had agreed two key priorities for 2010-11:

##### **1. Customer Care**

As well as the roll-out of the equality and diversity training across the Trust, this report contains good evidence of the willingness of the Trust to understand and respond to concerns raised by staff, patients and carers. The additional questions in the Nursing Quality Assessment Tool about staff behaviour should be helpful in identifying issues around attitude and communication. The governor membership of the Engagement and Experience Committee will help COG to keep in close touch with future work around this topic.

##### **2. Easy Read Patient Information**

The Disability Equality Action Group led this work which has resulted in the production of Easy Read versions of some of the most ordered information leaflets, including the bedside

information leaflet.

#### ***Governors' views of quality activities during 2011-12***

Governors have been pleased to see that in spite of the current financial pressures and organisational changes in the NHS, the Trust has been able to maintain and improve the quality of its services. Confirmation of this can be seen by the excellent results achieved in the national inpatient and outpatient surveys, the Dr Foster award as one of the four 'hospitals of the year' and achieving the CNST level 2 (best risk rating) for maternity services.

The 'ward to Board' system has allowed the Board to see how well individual areas are performing in essential criteria such as nutritional and pressure damage screening, hand washing and thrombo-embolism prophylaxis, and to see evidence of early intervention when improvements are needed. The COG receives regular feedback on performance against these criteria.

Governors have been impressed with the amount of quality improvement activity that has taken place during the past year, such as staff training on end of life care by Hospice nurses. The introduction of the ADAstra computer system across the health community will improve the sharing of key information for staff caring for patients at the end of their lives.

The most recent 'Members Say' Event highlighted the need for improvements in discharge processes, and the governors look forward to positive outcomes from the Trust's adoption of the 100 days initiative on all aspects of discharge.

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A governor representative was part of the team reviewing ward services which has resulted in the redesign of the ward housekeeper role and the reduction of nursing time spent on non-clinical duties. Governors look forward with interest to seeing the results from the next phase of this work, aimed at strengthening the leadership role of ward matrons.

Improving the care of patients suffering from dementia was a key Trust priority. Governors were pleased to see the introduction of a Trust-wide programme of training for staff in this very important aspect of care, as well as the pilot of the 'This is Me' patient passports.

### ***Trust initiative on delayed leaving hospital***

The winter of 2011-12 saw a huge increase in the number of very elderly patients admitted to the Trust with complex care needs. As well as the Patient Experience Group work on discharge, the Trust has opened a rehabilitation ward, led by an occupational therapist, to improve the ability of patients to be returned to care in the community as soon as they are fit to do so. Trust staff have also played a key role in the development of the 'Hospital at Home' project which is currently being piloted. Governors welcome these examples of the Trust's clinicians working in conjunction with their community colleagues to improve patient pathways of care.

The Trust continues to be involved in high numbers of research and clinical audit projects and it is good to see the changes and improvements being put in place in response to findings from these projects.

## ***Governor priorities for 2012-13***

### **Dignity**

Following a survey of all governors, the following priorities were identified for the coming year:

- a focus on all aspects of dignity, with particular emphasis around the care of frail elderly patients and those nearing the end of life.
- Continuation of work to eliminate any unnecessary delays in the discharge process, including the provision of take-home medication.
- Improvements in communication, especially written communication from the Trust to patients, such as the quality of appointment letters.

Governors are aware that the uncertainties around the introduction of the new Health and Social Care Bill, together with the ongoing financial constraints and the increasing demands on elderly care are just some of the difficult challenges facing the Trust in this coming year. As representatives of the members, governors will continue to work to ensure that the Trust remains focused on enabling its staff to respond to and deliver the best possible care for all its patients.

Jill Gladstone, Chair of Patient Safety and Quality Group

15th May 2012

### **Members of the Patient Safety and Quality Group**

Kate Caldwell; David Giles; Peter Hull; Rachel Jackson; Linda Vijeh; Alison Wootton.

## Statement of Directors' responsibilities in respect of quality report

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 as amended 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 foundation trust boards should put in place to support the data quality for the preparation of the Quality Report.

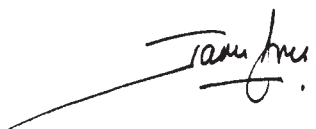
In preparing the Quality Report, Directors are required to take steps to satisfy themselves that:


- the content of the Quality Report meets the requirements set out in the NHS Foundation Trust Annual Reporting Manual;
- 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 2011 to June 2012;
  - Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
  - Feedback from the commissioners April 2012;
  - Feedback from Governors April 2012;
  - Feedback from LINKs dated April 2012;
  - The Trust's Complaints Report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, reported quarterly to the Board - Q1 and 2 30/11/11 and Q3 and 4 25/4/12;
  - The national inpatient survey 24/4/12;
  - The national staff survey March 2012
  - The Head of Internal Audit's annual opinion over the Trust's control environment 28/05/2012;
  - Care Quality Commission quality and risk profiles were reported on the following dates; 21/4/11, 16/6/11, 20/7/11, 17/8/11, 20/10/11, 17/11/11, 8/12/11, 9/2/12, 6/3/12

- the Quality Report presents a balanced picture of the NHS foundation Trust's performance over the period covered;
- the performance information reported 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 reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, and 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) (published at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual)) as well as the standards to support data quality for the preparation of the Quality Report (available at [www.monitor-nhsft.gov.uk/annualreportingmanual](http://www.monitor-nhsft.gov.uk/annualreportingmanual)).

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

 Mr James Brent, Chairman  
30 May 12

 Angela Pedder, Chief Executive  
30 May 12

# Annex C

During 2011-12, 44 national clinical audits and 4 national confidential enquiries covered NHS Services that the Royal Devon and Exeter NHS Foundation Trust provides.

During that period, the Royal Devon and Exeter NHS Foundation Trust participated in 98% national clinical audits and 100% national confidential enquiries of the national clinical audits and national confidential enquiries in which it was eligible to participate.

The national clinical audits and national confidential enquiries that the Royal Devon and Exeter NHS Foundation Trust participated in and for which data collection was completed during 2011/12 are listed below, alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry.

| National Clinical Audit / Confidential Enquiry Enquiry Title      | Eligible? | Participated 2011/12   | % Participation Rate                                 |
|---|-----------|--|--|
| Perinatal Mortality   | Yes       | Procurement for this audit stopped in March, not yet re-procured | N/A  |
| Neonatal intensive and special care (NNAP)                        | Yes       | Yes  | 100%   |
| BTS Paediatric Pneumonia  | Yes       | Yes  | 26.9%  |
| BTS Paediatric Asthma   | Yes       | Yes  | 100%   |
| Paediatric Pain Management  | Yes       | Yes  | 100%   |
| Childhood Epilepsy (RCPH National Childhood Epilepsy Audit)       | Yes       | Yes  | 100%   |
| Paediatric Intensive Care (PICANet)                               | No        | No   | N/A  |
| Paediatric Cardiac Surgery (NICOR Congenital Heart Disease Audit) | No        | No   | N/A  |
| Diabetes (RCPH National Paediatric Diabetes Audit)                | Yes       | Yes  | 158 cases submitted (denominator data not available) |
| BTS Emergency Use of Oxygen                                       | Yes       | Yes  | 100%   |
| BTS Adult Community Acquired Pneumonia                            | Yes       | Yes  | 100%   |
| BTS Non-Invasive Ventilation - Adults                             | Yes       | Yes  | Data collection in progress (to be completed 31 May) |
| BTS Pleural Procedures  | Yes       | Yes  | 100%   |
| Cardiac Arrest (National Cardiac Arrest Audit)                    | Yes       | Yes  | 100%   |
| Severe Sepsis & Septic Shock                                      | Yes       | Yes  | 97%  |
| Adult Critical Care (ICNARC CMPD)                                 | Yes       | Yes  | 95.4%  |
| Potential Donor Audit   | Yes       | Yes  | 95.8%  |
| Seizure Management (National Audit of Seizure Management)         | Yes       | Yes  | 100%   |
| Diabetes (National Adult Diabetes Audit)                          | Yes       | Yes  | 888 cases submitted (denominator data unavailable)   |

| National Clinical Audit / Confidential Enquiry<br>Enquiry Title   | Eligible? | Participated<br>2011/12 | % Participation<br>Rate   |
|---|-----------|-------------------------|---|
| Heavy Menstrual Bleeding  | Yes       | Yes                     | 153 cases submitted<br>(denominator<br>unavailable<br>retrospectively)                                  |
| Chronic Pain (National Pain Audit)                                | Yes       | Yes                     | 45%   |
| Ulcerative Colitis & Crohn's Disease (UK IBD Audit)               | Yes       | Yes                     | 100%  |
| Parkinson's Disease (National Parkinson's Audit)                  | Yes       | Yes                     | 100%  |
| BTS Adult Asthma  | Yes       | Yes                     | 13.1%   |
| BTS Bronchiectasis  | Yes       | Yes                     | 100%  |
| Hip, Knee and Ankle Replacements<br>(National Joint Registry)     | Yes       | Yes                     | 94%   |
| Elective Surgery (National PROMs Programme)                       |           |                         |   |
| Hernia  |           |                         | 32%   |
| Hip   | Yes       | Yes                     | 99%   |
| Knee  |           |                         | 100%  |
| Vein  |           |                         | 22%   |
| Intra-Thoracic Transplantation                                    | No        | No                      | N/A   |
| Liver Transplantation   | No        | No                      | N/A   |
| Coronary Angioplasty (NICOR Adult Cardiac<br>Interventions Audit) | Yes       | Yes                     | 100%  |
| Peripheral Vascular Surgery                                       | Yes       | Yes                     | 93.18%  |
| Carotid Interventions   | Yes       | Yes                     | 93.48%  |
| CABG and Valvular Surgery (Adult Cardiac<br>Surgery Audit)        | No        | No                      | N/A   |
| Acute Myocardial Infarction & Other ACS (MINAP)                   | Yes       | Yes                     | 43%*<br>to date - submission<br>taking place to the end<br>of May anticipate it will<br>be 100% by then |
| Heart Failure (Heart Failure Audit)                               | Yes       | Yes                     | 47%   |
| Acute Stroke (SINAP)  | Yes       | Yes                     | 100%  |
| Cardiac Arrhythmia (Cardiac Rhythm<br>Management Audit)           | Yes       | Yes                     | 100%  |
| Renal Replacement Therapy (Renal Registry)                        | Yes       | Yes                     | 100%<br>(*estimated figures only)   |
| Renal Transplantation   | Yes       | Yes                     | 100%  |
| Lung Cancer (National Lung Cancer Audit)                          | Yes       | Yes                     | 100%  |
| Bowel Cancer (National Bowel Cancer Audit<br>Programme)           | Yes       | Yes                     | 100%  |

# Annex D

| National Clinical Audit / Confidential Enquiry<br>Enquiry Title           | Eligible? | Participated<br>2011/12 | % Participation<br>Rate  |
|---|-----------|-------------------------|--|
| Head & Neck Cancer (DAHNO)  | Yes       | Yes                     | 100%   |
| Oesophago-Gastric Cancer (National O-G<br>Cancer Audit)                   | Yes       | Yes                     | 100%   |
| Hip Fracture (National Hip Fracture Database)                             | Yes       | Yes                     | 100%   |
| Severe Trauma (Trauma Audit & Research Network)                           | Yes       | Yes                     | 100%   |
| Prescribing in Mental Health Services (POMH)                              | No        | No                      | N/A  |
| Schizophrenia (National Schizophrenia Audit)                              | No        | No                      | N/A  |
| Bedside Transfusion (National Comparative<br>Audit of Blood Transfusion)  | Yes       | Yes                     | 100%   |
| Medical Use of Blood (National Comparative<br>Audit of Blood Transfusion) | Yes       | Yes                     | 9%   |
| Risk Factors (National Health Promotion in<br>Hospitals Audit)            | Yes       | No                      | 0%   |
| Care of Dying in Hospital (NCDHAH)  | Yes       | Yes                     | 100%   |
| NCEPOD - Bariatric Surgery  | Yes       | Yes                     | 100%<br>*only eligible to<br>participate in the<br>organisational<br>questionnaire |
| NCEPOD - Cardiac Arrest Procedures  | Yes       | Yes                     | 100%   |
| NCEPOD - Peri-Operative Care  | Yes       | Yes                     | 100%   |
| NCEPOD - Surgery in Children  | Yes       | Yes                     | 100%<br>*only eligible to<br>participate in the<br>organisational<br>questionnaire |

The reports of 13 national clinical audits were reviewed by the provider in 2011/12 and the Royal Devon and Exeter NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

| National Clinical Audit / Confidential Enquiry Title                                   | Actions  |
|--|--|
| Adult Critical Care (ICNARC)   | <ul style="list-style-type: none"> <li>• Out of hours discharges to be reduced to a minimum, i.e. the Trust will only discharge patients between the hours of 22:01 - 06:59 when they have no other options (bed or staff shortages).</li> </ul>   |
| National Audit of Falls and Bone Health  | <p><b>Falls Service</b></p> <ul style="list-style-type: none"> <li>• Joint planning with commissioners via Clinician 2 Clinician (C2C) meetings</li> <li>• Integrated falls service to be improved</li> <li>• Evidence-based physiotherapy programmes after a fragility fracture to be improved</li> <li>• Routine occupational therapy for home hazards assessment after a fragility fracture to be improved</li> <li>• Screening for falls risk from Emergency Department (ED) to be improved</li> <li>• Introduce "flagging" system from fracture clinics and ED to encourage appropriate bone health and falls assessment in primary care.</li> </ul> <p><b>Hip Fracture Care</b></p> <ul style="list-style-type: none"> <li>• Assessment of pain and administration of adequate analgesia on arrival to hospital to be reviewed</li> <li>• Cognitive assessment during initial admission assessment to be improved with the introduction of a new trauma. admissions proforma.</li> </ul> <p><b>Non-hip Fragility Fracture Care</b></p> <ul style="list-style-type: none"> <li>• Improvement of the multifactorial falls risk assessment and prevention and osteoporosis assessment and treatment.</li> </ul> |
| National Audit of Adult Asthma   | <ul style="list-style-type: none"> <li>• Further education of the respiratory ward nurses to improve the peak flow measurement and inhaler technique review</li> <li>• Education of junior doctors to improve arterial blood gases in asthma with sats &lt; 92%.</li> </ul>  |
| National Audit of Depression Screening & Management of NHS Staff on Long Term Sickness | <ul style="list-style-type: none"> <li>• In-house Occupational Health Physiotherapy Service established; this is having a positive impact on sickness absence costs due to musculoskeletal disorders</li> <li>• Business case in progress for provision of a continued Physiotherapy Service.</li> </ul>   |

| National Clinical Audit / Confidential Enquiry Title   | Actions  |
|--|--|
| <p><b>National Audit of Depression Screening &amp; Management of NHS Staff on Long Term Sickness</b></p> | <ul style="list-style-type: none"> <li>Improved identification of depression for staff with high 'Hospital Anxiety and Depression Scale' scores through supplementary enquiries about omitted cardinal symptoms (e.g. appetite/sleep) and suicide. Occupational Health clinical staff to receive education and training to achieve this</li> <li>Re-education for staff re enquiring about the use of recreational drugs</li> <li>Data re timing of OH assessments to be shared with Health and Wellbeing Groups to ensure compliance with referral times in accordance with the Trust's Sickness Absence Policy.</li> </ul> |
| <p><b>National Re-audit of Bedside Transfusion</b></p>   | <ul style="list-style-type: none"> <li>Education of clinical staff around importance of baseline observations on all patients prior to receiving a blood transfusion.</li> </ul>   |
| <p><b>National Audit of Care of the Dying</b></p>  | <ul style="list-style-type: none"> <li>Each ward to have supplies of Liverpool Care Pathway (LCP) leaflets in the "LCP Box".</li> </ul>  |
| <p><b>Stroke Improvement National Audit Programme (SINAP)</b></p>  | <ul style="list-style-type: none"> <li>Direct admissions to Acute Stroke Unit of all Face, Arms, Speech, Time (FAST)-positive patients at triage in the Emergency Department</li> <li>Time to brain imaging for acute stroke reduced through the introduction of Nurse Practitioner-led CT requests and weekend imaging.</li> </ul>  |
| <p><b>National Confidential Enquiry: Surgery in Children 'Are We There Yet?'</b></p>                     | <ul style="list-style-type: none"> <li>Enhancement of surgical network to ensure standards of care are safe, consistent, and have parity across the peninsula</li> <li>Less urgent surgical transfers to be audited by the Clinical Network</li> <li>A Paediatric Surgery Morbidity and Mortality Forum will be developed to take place 3 times a year, which will include surgeons, anaesthetists and paediatricians</li> <li>Compliance with Paediatric Early Warning Tool to be assessed through clinical audit.</li> </ul>   |
| <p><b>National Confidential Enquiry: Peri-Operative Care 'Knowing the Risk'</b></p>                      | <ul style="list-style-type: none"> <li>Mortality risk for high-risk surgeries to be given to patients and documented clearly on the consent forms.</li> <li>An analysis of the volume of critical care requirements for high risk patients to be undertaken on an annual basis to aid planning for provision of facilities and presented to the Clinical Effectiveness Committee</li> <li>Business case in progress to fund the extension of the high-risk pre-operative assessment clinic.</li> </ul>   |
| <p><b>National Emergency Oxygen Audit</b></p>  | <ul style="list-style-type: none"> <li>Prescribing of oxygen to be part of e-learning package at induction</li> <li>Education of nursing staff re importance of signatures on drug charts</li> <li>Further audit to take place on doctor and nursing staff knowledge of guidelines.</li> </ul>   |

The reports of 69 local clinical audits were reviewed by the provider in 2011/12 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   | Actions   |
|--|---|
| Post-operative Discharge Analgesia for Day-Case Gynaecology Patients | <ul style="list-style-type: none"> <li>• Patient information leaflets explaining the self-supply system of analgesia to be produced</li> <li>• A stamp for use on the front of a patient's anaesthetic chart to be implemented to ensure patients are asked pre-operatively if they have appropriate self-supply analgesia.</li> </ul>  |
| Pre-surgery Pregnancy Risk Assessment                                | <ul style="list-style-type: none"> <li>• Further education for clinical staff involved in pre-operative assessment around pregnancy checks</li> <li>• The completion of the pregnancy check section on surgical consent form to be enforced.</li> </ul>   |
| Monitoring of Patients Receiving Epidural and PCA Analgesia          | <ul style="list-style-type: none"> <li>• Introduction of a new pain monitoring chart for patient controlled analgesia and epidural.</li> </ul>  |
| Pain Audit   | <ul style="list-style-type: none"> <li>• Pain Team to work with elderly care and trauma teams to improve and formalise the assessment of pain in cognitively impaired older adults</li> <li>• Profile of pain management to be raised through the 'You Matter' advertising campaign.</li> </ul>   |
| Pre-op Starvation Times in Elective Patients                         | <ul style="list-style-type: none"> <li>• Improvement of patient information re pre-op starvation</li> <li>• Increase use of carbohydrate drinks 2 hours pre-op for enhanced recovery</li> <li>• Improve Theatre list organisation.</li> </ul>   |
| Cannula Phlebitis Re-Audit   | <ul style="list-style-type: none"> <li>• Improve documentation of daily review of cannulae</li> <li>• Education of staff to remove cannula when not indicated, especially if patient has more than one.</li> </ul>  |
| Central Line Audit   | <ul style="list-style-type: none"> <li>• Improve documentation of daily review of central venous catheter.</li> <li>• All CVC lines to be tracked</li> <li>• Improve the documentation of ultrasound scanning as part of the process of inserting central lines.</li> </ul>   |
| Adherence to Venous Thromboembolism (VTE) Policy in ICU              | <ul style="list-style-type: none"> <li>• New Department Of Health VTE risk assessment charts introduced.</li> </ul>   |
| Adherence to ICU Feeding Protocol                                    | <ul style="list-style-type: none"> <li>• Improve use of new protocol for Naso Gastric feeding of patients on ICU through staff education.</li> </ul>  |
| Audit of Adherence to Streptococcus Guidelines                       | <ul style="list-style-type: none"> <li>• Improve awareness of guidelines through posters on the door of every labour suite</li> <li>• Improve compliance with guidelines through simplification of the algorithm</li> <li>• Improve identification of patients through use of a sticker once it is diagnosed (when patient in labour, sticker on drugs chart).</li> <li>• Education of mothers on their treatment so they can remind their Midwives.</li> </ul> |

# Annex F

| Local Clinical Audit Title   | Actions  |
|--|--|
| <b>Audit of Vaginal Hysterectomy - Variation in Length of Stay</b>   | <ul style="list-style-type: none"> <li>Planned length of stay for each procedure agreed</li> <li>Agreement to use Enhanced Recovery as the normal model of care for all patients undergoing major gynaecological surgery.</li> </ul>   |
| <b>Audit of NICE TAG 131 - Inhaled Corticosteroids (ICS) for the Treatment of Chronic Asthma in Children Under the Age of 12</b> | <ul style="list-style-type: none"> <li>Education of nursing and medical staff of the necessity of advising patients and carers about how to reduce side effects of ICS and documenting this</li> <li>Ensure that all patients receive a self-management plan prior to discharge and that this is communicated to their GP</li> <li>Ensure that children who have a severe enough exacerbation are admitted, and those who have a good response to short acting beta 2 agonist and oral steroid therapy receive appropriate preventer therapy on discharge.</li> </ul>  |
| <b>Audit of NICE CG 33 - Tuberculosis</b>  | <ul style="list-style-type: none"> <li>All patients <math>\leq 1</math>yr old to have TB vaccination prior to leaving the post-natal ward</li> <li>Respiratory nurses to conduct training sessions at doctors' induction day to raise awareness and give practical training on how to deliver the vaccination</li> <li>Contact numbers to be collected at time of referral. Discuss with the Health Protection Unit at Heathrow airport about best practice for documenting a contact number for every referral made.</li> </ul>   |
| <b>Referral Patterns and Indication for Testicular Ultrasounds</b>   | <ul style="list-style-type: none"> <li>Update of guidelines for referral for scrotal/testicular ultrasound following issue of the Royal College of Radiologists guidelines.</li> <li>'Testicular Swelling' pathway to be incorporated into the Trust's Map of Medicine and circulated to GPs.</li> </ul>   |
| <b>Management of Diabetic Ketoacidosis (DKA)</b>   | <ul style="list-style-type: none"> <li>Introduction of new DKA management prescription form.</li> <li>Prescription charts re-designed Trust-wide in response to Government targets</li> <li>Enhancement of the morning report system</li> <li>Introduction of Patient First on Acute Medical Unit.</li> </ul>  |
| <b>ED Record Keeping (Doctors)</b>   | <ul style="list-style-type: none"> <li>Education and awareness-raising of doctors re the importance of good record keeping and specific areas in need of improvement through training sessions and posters.</li> </ul>   |
| <b>Re-audit of the Management of Transient Ischaemic Attack (TIA) in the Emergency Department (ED)</b>                           | <ul style="list-style-type: none"> <li>Education of ED Doctors on the administration of aspirin by the ED consultants through training sessions</li> <li>Transient Ischaemic Attack (TIA) management flowchart to be amended to include driving advice on the 'Tree of Knowledge' electronic system in ED.</li> </ul>  |
| <b>Acute Urinary Retention - Time to Catheterisation</b>   | <ul style="list-style-type: none"> <li>Catheter insertion to be made the first priority</li> <li>Ensure that catheter trolleys are well stocked</li> <li>Patients requiring catheterisation to be prioritised in a more urgent triage category</li> <li>Improve staff awareness of the importance of reducing the time to catheterisation through education/posters</li> <li>Improve documentation of catheter insertion through education.</li> <li>Improve communication with Emergency Department (ED) nursing staff to reiterate to them the importance of the documentation of catheterisation</li> <li>Analgesia to be given in a timely fashion so as not to delay catheter insertion.</li> </ul> |

| Local Clinical Audit Title  | Actions  |
|---|--|
| <b>ATMIST Pre-alert information</b>   | <ul style="list-style-type: none"> <li>• Documentation to be improved</li> <li>• Education and feedback to South Western Ambulance Service Trust (SWAST)</li> <li>• Pre-alert information to be integrated into trauma calls / trauma network by education and reviewing trauma call criteria.</li> </ul>  |
| <b>NICE CG35 Warfarin use in Atrial Fibrillation in prevention of Stroke and Transient Ischaemic Attack (TIA)</b> | <ul style="list-style-type: none"> <li>• Opportunistic pulse checks to be increased within primary care</li> <li>• Improve accuracy of risk assessments for consideration of anticoagulation in patients identified with atrial fibrillation.</li> </ul>   |
| <b>NICE CG100 Management of Alcohol withdrawal on Acute Medical Unit (AMU) and Okement Ward</b>                   | <ul style="list-style-type: none"> <li>• Education package to be designed and rolled out Trust-wide.</li> </ul>  |
| <b>Parkinson's Medicine Management</b>  | <ul style="list-style-type: none"> <li>• Electronic flagging system developed to highlight Parkinsons Disease (PD) patients</li> <li>• Awareness raising education amongst staff of PD guidelines e.g. the 'Get it on time' campaign with posters and wash bags</li> <li>• 'Get it on time' stickers developed to go on medication charts to raise awareness amongst nursing staff</li> <li>• Self-medication of patients to be encouraged</li> <li>• Business case for hospital-based PD nurse to be developed.</li> </ul>  |
| <b>An audit of Colonoscopic Indications and outcome in Patients over 89 in accordance to BSG Guidelines</b>       | <ul style="list-style-type: none"> <li>• The need for colonoscopy to be questioned in elderly patients in whom colonoscopy findings will not significantly affect management and where alternative methods of imaging may be more appropriate.</li> </ul>  |
| <b>An audit of colorectal Cancer in Irritable Bowel Disease (IBD) Patients</b>                                    | <p>Development of a colorectal cancer surveillance system:</p> <ul style="list-style-type: none"> <li>• A new surveillance page on the existing IBD database to be developed</li> <li>• An electronic link with the endoscopy reporting tool (Unisoft) to be produced</li> <li>• Date of diagnosis for 600 patients on database to be established to determine disease duration and eligibility for surveillance.</li> <li>• Patient information sheet relating to surveillance to be composed</li> <li>• A review of hospital notes, (+/- clinic review) of all patients identified from secondary care records as being eligible for surveillance to be undertaken. Patients identified as being eligible for surveillance to be identified and offered a colonoscopy with chromoscopy. The potential demand will be identified and then solutions will be sought to increase capacity to deliver this additional work.</li> </ul> |
| <b>Upper GI Bleed Audit</b>   | <ul style="list-style-type: none"> <li>• Staff to be informed that combinations of endoscopic therapy rather than single modalities should be used</li> <li>• Staff to be informed that serology or stool test should be thought about when clo tests results are negative for peptic ulcers.</li> </ul>   |

# Annex F

| Local Clinical Audit Title   | Actions   |
|--|---|
| Endoscopic Retrograde Cholangiopancreatography (ERCP) Audit                        | <ul style="list-style-type: none"> <li>Protocol to be changed so that after two attempts at big stone clearance the case should be reviewed at the multidisciplinary team (MDT) along with the X-ray</li> <li>Laparoscopic clearance and a clear pathway to be explored.</li> </ul>   |
| Endoscopy 30 Day Mortality Review  | <ul style="list-style-type: none"> <li>Staff to be informed that decisions for further endoscopic intervention should be clearly documented.</li> </ul>   |
| Audit of the First Six Months of the Multi-disciplinary Renal Low Clearance Clinic | <ul style="list-style-type: none"> <li>Access Nurse to attend review of blood meetings to improve links between staff</li> <li>Dieticians to see all patients for nutritional assessment and commence phosphate education at initial meeting to improve assessments and phosphate levels.</li> </ul>  |
| Audit of Compliance with the Malnutrition Universal Screening Tool (MUST)          | <ul style="list-style-type: none"> <li>Training sessions to be improved to include the importance of knowing 'usual' weight as well as 'actual' weight</li> <li>Assess barriers to completion of Food Record Chart and formulate ideas for improving compliance</li> <li>Include importance of weekly re-assessment of MUST in training sessions</li> <li>Possibility of an alert system on the ward to be explored</li> <li>Include clear referral criteria to dieticians in training sessions</li> <li>Discuss how ward staff communicate malnutrition risk to auxiliary staff and look into how this could be improved</li> <li>Train ward staff on using high energy stickers. Get information on increased nutrient content to illustrate this.</li> </ul> |
| Audit of Patient Knowledge of Haemodialysis Patients                               | <ul style="list-style-type: none"> <li>To raise the awareness of foods high in phosphate the Renal Team will undertake a health promotion project and repeat the questionnaire in 6 months</li> <li>More detailed questioning and documentation in clinics, posters sourced externally and student projects to raise awareness of phosphate binders, dose and timing</li> <li>Access to PowerPoint Presentation on Phosphate and renal disease via Trust intranet site to increase knowledge of nursing staff to facilitate better patient understanding.</li> </ul>  |
| Audit of Compliance with Supplementary Prescribing                                 | <ul style="list-style-type: none"> <li>Medics to be informed of the correct procedure for prescribing Oral Nutritional Supplements (ONS) to decrease the number of ONS prescribed by Doctors</li> <li>Implement ward-based supplements to improve flavour selection and availability and increase the frequency of ONS being given to the patient</li> <li>Nursing staff to be trained to identify the barriers to ONS tolerance and the importance of improved nutritional intake.</li> </ul>  |
| Dietetic Reviews of Patients on Peritoneal Dialysis                                | <ul style="list-style-type: none"> <li>A review of all patients who Do Not Attend (DNA) appointments to be undertaken to establish how we can decrease the number of patients who DNA and who are potentially not being reviewed within 6 months</li> <li>A Dietician to attend South Devon Peritoneal Dialysis Clinic to ensure patients are reviewed within 6 months.</li> </ul>  |

| Local Clinical Audit Title  | Actions   |
|---|---|
| <b>CQUIN Medicines Reconciliation Audit</b>   | <ul style="list-style-type: none"> <li>• The use of the clerking pro-forma to be promoted amongst all medical staff on the ward with the support of all consultants working in the area in order to increase the percentage of patients with a well-documented medication history</li> <li>• Discussion to take place with the ED to decide what should happen to any list generated in the Department to minimise duplication</li> <li>• Clerking doctors to be encouraged to clearly document if they think that the drug history requires further checking (e.g. during the next working day) as part of the care planning</li> <li>• Introduction of electronic prescribing (will facilitate the electronic recording of drug histories and also facilitate accurate prescribing from that drug history thereby minimising transcription errors)</li> <li>• Development of electronic 'Summary Care Records' - will allow hospital staff to access relevant medication histories directly from the General Practitioner records.</li> </ul> |
| <b>NICE TAG 1 - Audit of the Extraction of Wisdom Teeth</b>   | <ul style="list-style-type: none"> <li>• All staff to be issued with a copy of the NICE guidelines to assist in reducing the number of extractions that take place without proper documentation of the indication</li> <li>• In future the audit to be carried out prospectively, with a copy of the proforma either as a sheet or sticker in the notes to be filled in at the patient's assessment appointment. This will require the clinician to document which wisdom teeth are to be extracted and the indication, and thus reduce any failures of record keeping.</li> </ul>  |
| <b>Audit of the Diagnostic Quality of Head &amp; Neck Fine Needle Aspiration (FNA)</b>  | <ul style="list-style-type: none"> <li>• Implementation of a standard protocol for FNA among clinicians.</li> </ul>   |
| <b>Audit of Infantile Squints to Improve Timeliness of Corrective Surgery</b>   | <ul style="list-style-type: none"> <li>• All healthcare professionals including GP, ophthalmologists and optometrists to be involved in referrals to reduce time delays from early referral to earlier surgery.</li> </ul>  |
| <b>Re-audit of Orthoptist Reports</b>   | <ul style="list-style-type: none"> <li>• Orthoptists to be encouraged to be more diligent in ensuring that a date is written on every page of the patient records.</li> </ul>   |
| <b>On-going Audit of Cataract Complications 2010-2011</b>   | <ul style="list-style-type: none"> <li>• Current Vitreous Loss Documentation Forms to be discontinued and replaced with vitreous loss books where patient label, side of operated eye, date and name of operating surgeon only needs to be entered.</li> </ul>  |
| <b>NICE IPG 196 - CJD Policy Adherence Audit</b>  | <ul style="list-style-type: none"> <li>• Awareness-raising of guidelines amongst Ophthalmology department.</li> </ul>   |
| <b>Audit of Canine Care Pathway</b>   | <ul style="list-style-type: none"> <li>• Day Case Unit lists to be increased to reduce waiting times</li> <li>• Patients to be seen on ad-hoc basis during orthodontic W/P clinics to reduce waiting list for joint clinic.</li> </ul>  |
| <b>NICE CG 92 - Audit of Completion of VTE Risk Assessment for Adult Patients within the Department of Plastic &amp; Reconstructive Surgery</b> | <ul style="list-style-type: none"> <li>• Morning ward, all inpatient admissions and appropriate patients to be checked for assessment of VTE prophylaxis in Wonford admissions on Abbey ward to improve compliance with documentation standards in clinical notes and drug charts</li> <li>• Education of staff involved in pre-assessment on the over investigation of patients pre-operatively.</li> </ul>  |

# Annex F

| Local Clinical Audit Title  | Actions   |
|---|---|
| <b>NICE CG3 - Audit of pre-operative assessment in Breast Surgery</b>   | <ul style="list-style-type: none"> <li>• Education of staff involved in pre-assessment on the over investigation of patients pre-operatively.</li> </ul>  |
| <b>Compliance with UK Guidelines for the Management of Acute Pancreatitis</b>                                 | <ul style="list-style-type: none"> <li>• Teaching sessions and e-learning modules to be developed for junior staff regarding the importance of early gallbladder ultrasound</li> <li>• Inpatient cholecystectomy service to be planned.</li> </ul>  |
| <b>Audit of Surgical Ward IV Fluid Management</b>   | <ul style="list-style-type: none"> <li>• Education of nursing staff through posters displayed to ensure weight and fluid balance charts are completed</li> <li>• Introduction of small prompt cards to reduce prescribing of normal saline, increase prescription of potassium and ensure volumes of fluid are prescribed appropriately</li> <li>• Education of junior doctors to reiterate which team should be prescribing maintenance fluids.</li> </ul>   |
| <b>Audit of Quality Antibiotic Prescribing</b>  | <ul style="list-style-type: none"> <li>• Antibiotic Aide Memoire Card to be updated to include up-to-date Trust guidelines for antimicrobial treatment of intra-abdominal infections.</li> </ul>  |
| <b>Audit of the Management of Epididymo-orchitis</b>  | <ul style="list-style-type: none"> <li>• Guidelines to be amended to include sexual history risk factors to encourage accurate sexual history</li> <li>• Essential microbiological investigations to be suggested on guidelines to address the low rate of microbial investigation</li> <li>• Suitable antibiotics suggested on guideline according to Sexually Transmitted Infection (STI) risk to minimise the wide variation in antibiotics given and duration of antibiotics</li> <li>• To improve the rate of referral to Genitourinary Medicine (GUM) clinic and reduce overnight admissions there has been a suggested follow-up procedure to be stated within the guidelines. The proposed suggestion was to include: GP to follow-up likely non-STI related, referral to GUM clinic for likely STI related and patients to be discharged on same day unless clinically indicated.</li> </ul> |
| <b>Audit of pre-operative assessment of patients undergoing elective Total Hip Replacement in August 2010</b> | <ul style="list-style-type: none"> <li>• Patients to be assessed in an allocated hip slot</li> <li>• ECG to have a documented analysis written in the notes.</li> </ul>   |
| <b>Audit of pre-op starvation for patient on the trauma list</b>  | <ul style="list-style-type: none"> <li>• Patients on trauma list to be given a pre-operative nutritional drink</li> <li>• Repeat drink for patients on afternoon list</li> <li>• IV fluid to be written up for all patients on the trauma list and this includes the pre-op checklist.</li> </ul>   |

## Safety measures reported

| Measure   | 2008/09   | 2009/10   | 2010/11  | 2011/12 | Data Source                        | Notes  |
|---|-----------|-----------|----------|---------|------------------------------------|--|
| Hospital Standardised Mortality Ratio             | 97.4      | 95.1      | 82.9     | 0.89    | Dr Foster / NHS Information Centre | For financial years 2008/09-2010/11 data source is Dr Foster HSMR *. For 2011/12 this has been replaced with the Summary Hospital Mortality Indicator (SHMI)** |
| Adverse Events (Adverse Events per 1000 bed days) | 54.8      | 51.6      | 32.3     | 33.4    | Local System                       | Figures are subject to change as the current data is to January 2012.  |
| 'Never Events' that occur within the Trust        | 0         | 0         | 1        | 1       | Datix                              |  |
| Patients with <i>C.difficile</i> infection        | 145 (230) | 100 (183) | 93 (162) | 85 (74) | National HPA MESS                  | Health Protection Agency MRSA Enhanced Surveillance System (HPA MESS).   |
| Patients with MRSA (bacteraemia) infection        | 15 (18)   | 7 (17)    | 2 (4)    | 1 (3)   | National HPA MESS                  | This indicator is all Trust apportioned infections, calculated as infections found in specimens received at least 2 days after admission.                      |

\*HSMR is a ratio against the expected national level of 100, a figure lower than 100 indicates fewer deaths than expected whilst a figure higher than 100 indicates more deaths than expected. It should also be noted that the current year value can change significantly as Dr Foster re-base the data when the entire year's data is available.

\*\*The SHMI value is the ratio of observed deaths in a Trust over a period of time divided by the expected number given the characteristics of patients treated by that Trust (where 1.0 represents the national average).

## Clinical outcome measures reported

| Measure   | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Data Source     | Notes  |
|---|---------|---------|---------|---------|-----------------|--|
| Stroke: % of stroke patients with a LOS >3 days who spend 90% of their time in hospital in the Acute Stroke Unit  | 55.0%   | 56.0%   | 66.9%   | 76.7%   | Local System    |  |
| Stroke: Patients who suffer a stroke & NICE Guidance suggest should have an urgent CT imaging to receive CT scan within 30 mins of arrival in hospital. | -       | -       | 97.8%   | 97.4%   | Local System    |  |
| Stroke: Proportion of high risk TIA patients who are treated within 24 hrs.   | -       | -       | -       | 30.6%   | Vital signs     |  |
| Proportion of those requiring surgery for fracture of the neck of femur who are operated on within 48hrs (of becoming fit for surgery)                  | 66.1%   | 77.0%   | 79.3%   | 95.9%   | Local data      | This priority will be reported in the 2012/13 Quality Account with the standard amended to 36 hours. |
| % of (elective) in-patients who have a pre-assessment prior to their procedure  | 66.0%   | 76.0%   | 76.0%   | 80.9%   | Local data      |  |
| % of (elective) day case patients who have a pre-assessment prior to their procedure  | 57.0%   | 72.0%   | 78.9%   | 79.3%   | Local data      |  |
| % of patients given enough privacy when discussing treatment  | 77.0%   | 74.0%   | 75.0%   | 75.0%   | National survey |  |

## Clinical outcome measures reported

| Measure   | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Data Source     | Notes   |
|---|---------|---------|---------|---------|-----------------|---|
| % of patients who felt they were treated with dignity/respect throughout their stay | 83.0%   | 84.0%   | 86.0%   | 86%     | National survey | H73 (People who answered yes always - overall did you feel you were treated with respect and dignity whilst you were in hospital?)<br>2011 CQC National inpatients Survey |
| % of patients who rated care received as very good/excellent                        | 83.0%   | 85.0%   | 85.0%   | 96%     | National survey |   |
| % of patients who rate their hospital as very clean                                 | 69.0%   | 74.0%   | 72.0%   | 75%     | National survey |   |
| Rate of grade 2 and above pressure ulcers per 1000 bed days                         | 0.49    | 0.89    | 0.7     | 0.6     | Datix           | Patient Experience measures   |

## Patient Experience measures

| Measure   | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Data Source | Notes  |
|---|---------|---------|---------|---------|-------------|--|
| % of patients felt safe                                       | -       | 99.0%   | 99.0%   | 99.0%   | NQAT        | Nursing Quality Assessment Tool (NQAT) is an assessment of patient experience, observations of care and a document audit which provides an overall score on the quality of care. |
| % of patients who felt cared for                              | -       | 97.4%   | 98.0%   | 99.0%   | NQAT        |  |
| % of patients who would recommend hospital to relative/friend | -       | 97.9%   | 98.0%   | 98.0%   | NQAT        |  |

# Annex G

## Previous Years National Targets & Regulatory Requirements which will be replaced by those listed at Table 1

| Measure   | 2008/09   | 2009/10   | 2010/11  | 2011/12 | Data Source                              | Notes  |
|---|-----------|-----------|----------|---------|--|--|
| <i>Clostridium difficile</i> year on year reduction (target)  | 145 (230) | 100 (183) | 93 (162) | 85 (74) | National HPA MESS                        |  |
| MRSA - maintaining the annual number of MRSA bloodstream infections at less than half the 2003/04 level (target)                  | 15 (18)   | 7 (17)    | 2 (4)    | 1 (3)   | National HPA MESS                        |  |
| Maximum waiting time of 31 days from decision to treat to start of treatment extended to cover all cancer treatments              | 94.3%     | 96.0%     | 97.3%    | 98.2%   | Local data submitted to National systems |  |
| 62 day wait for first treatment from GP urgent referral for suspected cancer  | -         | -         |          | 85.8    |  | Quarter 3 data this refers to the 62 day wait between initial "urgent 2 week wait GP referral" and "First definitive Cancer treatment" |
| 62 day wait for first treatment from NHS screening service referral   |           |           |          | 93.6%   |  |  |
| Maximum waiting time of two weeks from urgent GP referral to first outpatient appointment for all urgent suspect cancer referrals | 99.3%     | 98.5%     | 97.8%    | 95.4%   |  |  |
| 18-week maximum wait from point of referral to treatment (admitted patients)  | 91.3%     | 91.7%     | 94.7%    | 93.5%   |  |  |
| 18-week maximum wait from point of referral to treatment (non-admitted patients)  | 96.6%     | 96.4%     | 98.0%    | 97.8%   |  |  |

Previous Years National Targets & Regulatory Requirements which will be replaced by those listed at Table 1

| Measure  | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Data Source                              | Notes |
|--|---------|---------|---------|---------|--|-------|
| Maximum waiting time of 4hrs in A&E from arrival to admission, transfer or discharge | 98.8%   | 98.6%   | 97.9%   | 95.6%   | Local data submitted to National systems |       |

Key process indicators

| Measure  | 2008/09 | 2009/10 | 2010/11 | 2011/12 | Data Source           | Notes  |
|--|---------|---------|---------|---------|-----------------------|--|
| Patients treated for 90% of stay in Stroke Unit            | 68%     | -       | 69%     | -       | Sentinel Stroke Audit | The Sentinel Audit is undertaken every 2 years |
| Screened for swallowing disorders within first 24hrs       | 64%     | -       | 91%     | -       |                       |  |
| Brain scan within 24hrs of stroke                          | 72%     | -       | 68%     | -       |                       |  |
| Commenced aspirin by 48hrs after stroke                    | 92%     | -       | 92%     | -       |                       |  |
| Physiotherapy assessment within first 72hrs of admission   | 96%     | -       | 98%     | -       |                       |  |
| Assessment by Occupational Therapist within 4 days         | 78%     | -       | 98%     | -       |                       |  |
| Weighed at least once during admission                     | 87%     | -       | 90%     | -       |                       |  |
| Mood assessed by discharge                                 | 94%     | -       | 100%    | -       |                       |  |
| Rehabilitation goals agreed by the multi-disciplinary team | 95%     | -       | 98%     | -       |                       |  |

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Production of our Quality Report  
is a statutory requirement.

To view and download: [www.rdehospital.nhs.uk](http://www.rdehospital.nhs.uk)

### Independent Auditors' Report on the Annual Quality Report

#### Independent Auditor's Limited Assurance Report to the Council of Governors of Royal Devon and Exeter NHS Foundation Trust on the Annual 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 (the 'Quality Report') and specified performance indicators contained therein.

#### Scope and subject matter

The indicators in the Quality Report that have been subject to limited assurance consist of the national priority indicators as mandated by Monitor. We refer to these national priority indicators collectively as the "specified indicators".

#### 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 assessment criteria referred to on page 29 of the Quality Report (the "Criteria"). The Directors are also responsible for their assertion and the conformity of their Criteria with the assessment criteria set out in the NHS Foundation Trust Annual Reporting Manual ("FT ARM") issued by the Independent Regulator of NHS Foundation Trusts ("Monitor"). In particular, the Directors are responsible for the declarations they have made in their Statement of Directors' Responsibilities.

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 does not incorporate the matters required to be reported on as specified in Annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources specified below; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.

We read the Quality Report and consider whether it addresses the content requirements of the FT ARM, 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 2011 to June 2012;
- Papers relating to Quality reported to the Board over the period April 2011 to June 2012;
- Feedback from the Commissioners dated May 2012;
- Feedback from LINKS dated May 2012;
- The Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated November 2011;
- The latest national patient survey;

- The latest national staff survey;
- Care Quality Commission quality and risk profiles dated February 2012; and
- The Head of Internal Audit's annual opinion over the Trust's control environment dated February 2012.

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 Royal Devon and Exeter 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 2012, to enable the Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicators. 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 save 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 ‘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;
- Limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- Comparing the content requirements of the FT ARM to the categories reported in the Quality Report; and
- Reading the documents.

A limited assurance engagement is less 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.

## Limitations

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 impact 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 thereof, may change over time. It is important to read the Quality Report in the context of the assessment criteria set out in the FT ARM and the Directors' interpretation of the criteria of the Quality Report.

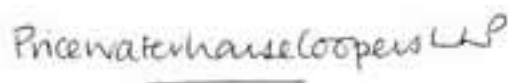
The nature, form and content required of Quality Reports are determined by Monitor. This may result in the omission of information relevant to other users, for example for the purpose of comparing the results of different entities. In addition, the scope of our assurance work has not included governance over quality or non-mandated indicators in the Quality Report, which have been determined locally by Royal Devon and Exeter NHS Foundation Trust.

The maintenance and integrity of the Royal Devon and Exeter NHS Foundation Trust's website is the responsibility of the directors; the work carried out by the assurance providers does not involve consideration of these matters and, accordingly, the assurance providers accept no responsibility for any changes that may have occurred to the reported performance indicators or criteria since they were initially presented on the website.

## Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that,

- The Quality Report does not incorporate the matters required to be reported on as specified in annex 2 to Chapter 7 of the FT ARM;
- The Quality Report is materially inconsistent with the sources documents reviewed; and
- The specified indicators have not been prepared in all material respects in accordance with the Criteria.



PricewaterhouseCoopers LLP

Chartered Accountants

Plymouth

30 May 2012

### About the Board of Directors

The Royal Devon and Exeter NHS Foundation Trust (RD&E) has a governance structure based on a constitution approved by its regulators, Monitor, that defines how it will operate from a governance perspective. Although its constitution is unique, it incorporates the legal requirements that apply to all Foundation Trusts which are set out in a model constitution developed by the regulator. The RD&E must also comply with a Code of Governance that sets out in detail the governance structures of Foundation Trusts.

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

- the membership
- the Council of Governors
- the Board of Directors.

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

The Council of Governors consists of elected public governors, staff governors and appointed individuals from key stakeholders. Governors help bind the Trust to its patients, service users, staff and stakeholders. The Chairman is both chair of the Council of Governors and the Board of Directors. The Council of Governors is responsible for:

- representing the interests of members and partner organisations in the governance of the RD&E Foundation Trust
- holding the Board of Directors collectively to account for the performance of the RD&E including ensuring that the Trust does not breach its terms of authorisation (the conditions under which an FT is required to operate as set by its regulator, Monitor)
- feeding back information about the Trust to members and stakeholder organisations
- having an input into the Trust's forward plans

- various roles on appointments and remuneration including appointing the Chairman, Non-Executive Directors, auditors.

The Board of Directors of the RD&E is ultimately and collectively responsible for all aspects of the performance of the Trust. The RD&E's Board of Directors' role is to provide active leadership of the Trust within a framework of prudent and effective controls which enables risk to be properly assessed and managed. The Board of Directors has both Executive and Non-Executive Directors 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 to offer appropriate advice to the Board on all matters of financial propriety and regularity.

### **The Board is responsible for:**

- Ensuring the quality and safety of healthcare services, education, training and research delivered by the Trust and applying the principles and standards of clinical governance set out by the Department of Health, the Care Quality Commission, and other relevant NHS bodies
- Ensuring compliance with the Trust's terms of authorisation, its constitution, mandatory guidance issued by Monitor, relevant statutory requirements and contractual obligations
- The Trust's strategic aims, taking into consideration the views of the Board of Governors, ensuring that the necessary financial and human resources are in place for the NHS Foundation Trust

to meet its objectives and review management performance

- Ensuring the Trust exercises its functions effectively, efficiently and economically
- Setting the Trust's values and standards of conduct and ensuring that its obligations to its Members, patients and other stakeholders are understood and met.

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 interests 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, integrity, objectivity, accountability, 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, led by the non-executive Chairman, is made up of both Executive and Non-Executive Directors (NEDs). There are six Non-Executive Directors who, together with the Chairman, form a majority on the Board. The six 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.

## 4. Our Governance

The Board normally meets at least ten times a year and takes strategic decisions and monitors the operational performance of the Trust, holding the Executive Directors to account for the Trust's achievements. The papers for the monthly Part 1 Board meeting and the approved minutes of the previous meeting are published on the Trust's website in advance of the Board meeting. Items of a confidential nature are discussed by the Board in private on a monthly 'Part 2' agenda. Ten formal Board meetings and three development meetings were held during the year alongside additional briefing meetings and seminars.

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](http://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 Terms of Authorisation.

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 timely and pertinent information to ensure that members can exercise their responsibilities and make well-grounded decisions. The Chief Executive is responsible for running all aspects of the Trust's business, assisted by the team of Executive Directors.

Collectively, the Board of Directors is accountable to the membership via the Council of Governors. The Chairman and other Directors inform the Council of Governors about the work and effectiveness of the Board at each Council Meeting, providing the necessary assurance for the Council to effectively hold the Board accountable.

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 twelve months in advance.

The Chairman and all Non-Executive Directors meet the independence criteria laid down in Monitor's Code of Governance (Provision A.3.1). The Chairman has no other outside interests. 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' Interests which is available upon request from the Foundation Trust Secretary. Directors and Governors may appoint advisors to provide additional expertise on particular subjects if required.

### Board Effectiveness and Evaluation

The Board recognises that it has a pivotal leadership role, a responsibility to set the strategic direction of the Trust, and that it oversees the performance of the organisation. In exercising these duties, the Board is aware that it needs to regularly assess its capabilities and development needs, make full use of opportunities and resources for developing its leadership and operational capabilities, and to foster a "whole Board" unitary approach.

Over the year, the Board made considerable progress on a number of fronts. The development of the organisational strategy helped to provide clarity of purpose for the organisation, which had previously been identified by the Board as a key issue for the Board to address. In addition, the development and implementation of the Trust's review of its governance structures gave the Board significant assurance and confidence in its abilities to oversee the performance of the Trust. The Board also

received regular "drill downs" on specific issues identified in the new Ward to Board reporting which enabled Board members to understand aspects of the Trust's business in more detail. The changes made to the functioning of both the Audit and Governance Committees were also a key aspect of the improvements and development of the Board over the last year.

During the year the Board completed a self assessment process to identify its development priorities for the coming financial year. The assessment encouraged Directors to assess and rate the relative progress made by the Board in its development thus far towards the ideal of being an exemplar. The assessment model was based on good practice on Board development which was developed from similar exercises undertaken by other Foundation Trusts. The assessment process was viewed as an interim step towards defining Board development needs in advance of a more substantive and in-depth analysis during 2012.

The main issues identified in the self assessment were:

- Continuing to develop the relationship with Governors
- Maintaining a unitary Board and addressing Board dynamics
- Continuing to develop the performance information to the Board.

The Board held a seminar in January on how it could develop its ongoing role with Governors particularly taking into account the growing role of Governors that was being signalled in the Health & Social Care Act.

## 4. Our Governance

In February, the Board discussed how effectively it managed the issue of maintaining a unitary Board whilst allowing for robust challenge. It was agreed that the Board is ably managing these tensions in a constructive way. It resolved at a Board development day in March to remind individual Directors of some work carried out two years ago on behavioural dynamics to ensure that all members of the Board remained conscious of the need to strive towards maximum Board effectiveness both individually and collectively.

Performance information has continued to evolve over the course of the year, reflecting changes in the governance structures, greater clarity about what information was useful to the Board (particularly in triangulating data and making connections between financial information and quality of service) and in some of the detail presented to the Board (particularly on the Ward to Board reporting) and subsequent “drill downs.” Over the next year the Board will continue to develop and refine the performance information it receives.

The Chairman met regularly with individual NEDs to discuss their personal development and performance issues. These discussions focussed on issues such as continuing professional development and capacity building to enhance personal performance. A new appraisal process was agreed during the year by the Appraisals Working Group made up of Governors, the Senior Independent Director and the Chairman and implemented for the year’s Director appraisals.

The new approach, which was developed on the basis of best practice elsewhere, helped to more rigorously focus on performance and add real value to appraisals discussions. As well as a more robust system, the new approach to appraisals included a considerable level of 360 degree engagement from other Directors and Governors. The new system has been a success and, with some modifications, this will be the basis for all future appraisals of Directors. The outcomes of Non-Executive Director appraisals (carried out by the Chairman) were reported to the Nominations Committee when considering re-appointment, and were reported annually to the Governors.

The Chief Executive undertook a similar process with the Executive Directors and these discussions were enhanced by seeking the views of the NEDs in examining performance and identifying future development needs. The outcome of the appraisals is fed back to the Executive Director Remuneration Committee (EDRC). The Chief Executive was appraised by the Chairman, with the outcome reported to the EDRC. The process for the appraisal of the Chairman is led by the Senior Independent Director and is also reported to the Nominations Committee and then to the Council of Governors.

The Board is satisfied that it has the right balance, completeness and appropriateness to meet the requirements of the Royal Devon & Exeter NHS Foundation Trust.

### The Board of Directors

Brief details of each director and their record of attendance at Board meetings are shown below:

#### Angela Ballatti, Chairman

Joined the Trust as Chairman in May 2006, and was previously the Chair of County Durham and Darlington Acute Hospitals Trust since 1997. She has an extensive background in business management and governance, having worked, among others, as a senior consultant for Coopers Deloitte and been a senior tutor at the University of Durham Business School. The Chairman has had no other significant external commitments over the course of the year.

#### Brian Aird, Vice-Chairman

Brian joined the Trust in April 2008. He has considerable previous NHS experience as a Chief Executive of an NHS Trust and a Health Authority. He was previously a Non-Executive Director of Trent SHA and more recently has run his own company offering organisational development and executive coaching services. He is also a Trustee of United Response, a national charity providing services to people with learning difficulties and mental health needs. Appointed Vice-Chairman in May 2010.

#### John Rackstraw, Non-Executive Director

A Board member since August 2006, he has spent his career in the construction industry and is accustomed to dealing with contract law from an industry perspective. He is a Chartered Director and past Chief Executive and Deputy Chairman of Pearce Group Ltd. He has lived in Somerset for 34 years and has extensive knowledge of the local community and a range of both local and national contacts.

#### 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 20 years, prior to which he was with KPMG for 14 years. He is also a Trustee of South West Lakes Trust, a regional environment charity.

### **Andrew Willis, Non-Executive Director**

Joined the Board in February 2011. Previous board experience includes service on two NHS acute provider boards and in the housing sector. 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 Kings Fund focusing on corporate governance and NHS board / director development.

### **David Wright, Non-Executive Director, Senior Independent Director**

David joined the Trust in April 2008 and is now retired but spent the majority of his career with Save the Children UK where he was a Country Programme Director for various areas both in the UK and abroad. He was also Chairman of Swindon PCT and a Non-Executive Director with Wiltshire NHS Community Trust. David became the Senior Independent Director in February 2011.

### **Non-Executive Directors not in post at year end:**

#### **James Gaisford, Non-Executive Director**

James joined the Board in May 2010 and has a Chartered Accountant background having trained with Ernst & Young in London. He has spent most of his career in director roles within the retail and publishing industries. He has lived near Exeter for the last 22 years and is also a School Governor and Chairman of an Almshouse Charity. James left the Board in September 2011.

### **Executive Directors**

#### **Angela Pedder, OBE, Chief Executive**

Joined the NHS in 1975. Angela 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 Lists 2007 for services to the NHS.

#### **Mr Martin Cooper, Joint 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 Senior Lecturer in Bristol and spent 18 months at the University of Chicago. In addition to his clinical role Martin has a major interest in the management of cancer, acting as the Clinical Director of Cancer Services from 1995 until taking up his current position in 2009. Regionally, he was the Medical Director of the Peninsula Cancer Network from 2000 to 2007.

#### **Elaine Hobson, Chief Operating Officer**

Elaine is a trained nurse and has held a number of positions at the RD&E, becoming Director of Operations in December 2000 and Chief Operating Officer in 2008. Elaine Hobson is a Governor at Exeter College. Since January, Elaine has been seconded to a new post of Joint Agency Director of Delivery and System Redesign for Frail Elderly People with effect from 16th January 2012. This is a three month post and will have the authority to deliver the changes necessary to improve the pathway for this category of patients. As a result of this secondment, Elaine's key roles were allocated to other Directors with Em Wilkinson-Brice taking on the majority of the Chief Operating Officer role.

## 4. Our Governance

### **Dr Vaughan Lewis, Joint Medical Director**

Dr Lewis joined the Board as Joint Medical Director on 1 April 2011. Dr Lewis joined the RD&E in February 2002 as Paediatrician with interest in Neonatology and Paediatric Nephrology. He served as Lead Clinician in Child Health from 2004 and was promoted to Clinical Director of Child & Women's Health in 2009.

### **Lynn Lane, Human Resources Director**

Joined the RD&E in July 2006 as HR Director with over 20 years HR experience having held senior management positions at both the BBC and NHS in Oxford.

### **Suzanne Tracey, Director of Finance and Business Development**

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.

### **Em Wilkinson-Brice, Director of Nursing & Patient Care**

Em joined the RD&E as Director of Nursing & Patient Care in July 2010. After qualifying from nursing in Exeter she subsequently worked in Oxford specialising in critical care. She was Director of Nursing at Derby Hospital before joining the RD&E.

The Directors' Register of Interests is available for inspection from the Foundation Trust Secretary (01392-402993) or on the Trust website

<http://www.rdehospital.nhs.uk/trust/ft/documents.html>

Directors can be contacted via email at [rde-tr.foundationtrust@nhs.net](mailto:rde-tr.foundationtrust@nhs.net)

## Attendance

Board Attendance for 2011/12 was as follows:

| NAME              | Apr | May | Jun | Jul | Sep | Oct | Nov | Jan | Feb | Mar |
|-------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|
| A Ballatti        | *   | *   | A   | *   | *   | *   | *   | *   | A   | *   |
| B Aird            | *   | *   | *   | *   | *   | *   | *   | *   | *   | *   |
| J Gaisford        | *   | A   | *   | *   |     |     |     |     |     |     |
| J Rackstraw       | A   | *   | *   | A   | A   | *   | *   | *   | *   | *   |
| D Robertson       | *   | *   | *   | *   | *   | *   | *   | *   | *   | *   |
| A Willis          | *   | *   | *   | A   | *   | *   | *   | *   | *   | *   |
| D Wright          | *   | *   | *   | *   | *   | *   | *   | *   | *   | A   |
| A Pedder          | *   | *   | *   | *   | *   | *   | *   | *   | *   | *   |
| Mr M Cooper       | *   | *   | *   | *   | A   | A   | *   | *   | *   | *   |
| E Hobson          | *   | *   | *   | *   | *   | *   | *   | A   | A   | A   |
| L Lane            | *   | *   | *   | *   | *   | *   | A   | *   | *   | *   |
| Dr V Lewis        | *   | *   | *   | *   | *   | *   | *   | *   | *   | *   |
| S Tracey          | *   | *   | A   | *   | *   | *   | A   | *   | *   | *   |
| E Wilkinson-Brice | *   | *   | *   | *   | *   | *   | *   | *   | *   | *   |

KEY: \* - Present A - Absent

Members wishing to contact Directors or Governors should email the Trust:

[Rde-tr.foundationtrust@nhs.net](mailto:Rde-tr.foundationtrust@nhs.net) or telephone 01392 403977

### 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 page nn. The Chairman and Non-Executive Directors are initially appointed for 3-year terms, as approved by the COG. Reappointment for a further 3-year term can be made, subject to satisfactory appraisal and the approval of the Governors. Consideration of extension beyond 6 years is subject to rigorous review, in line with the agreed processes.

One Non-Executive Director - James Gaisford - stood down from the Board during the financial year. The Board acknowledged the contribution made by Mr Gaisford in his time with the Trust. The Nominations Committee have begun the process of appointing a replacement for Mr Gaisford and it is expected that this will come to a conclusion in May/June. In advance of this process, the Board and the COG undertook a review of the 'Policy for the Composition of NED on the Board' to ensure the necessary mix of skills and experience on the Board is achieved. The Board remains satisfied that it maintains an appropriate balance regarding Board membership and that it has the necessary skills and experience to provide sound stewardship.

The Nominations Committee has spent considerable effort during the year on recruiting a new Chairman to replace Angela Ballatti who leaves the Trust at the end of April 2012 when her second term comes to an end. The Committee, led by the lead Governor Richard May, undertook a thorough search and selection process using an external recruitment specialist. This search identified a range of high calibre candidates which the Nominations Committee then reviewed and shortlisted. Prior to the interviews, the shortlisted candidates met informally with a range of Governors and Directors to give them an opportunity to learn more about the Trust and the role. On the basis of the recruitment and selection process, the Nominations Committee identified a preferred candidate - Mr James Brent - who they then proposed to the Council of Governors in January. The Council endorsed the nomination and Mr Brent will begin his tenure as Chairman from the beginning of May 2012.

**Expiry dates of current terms of office are as follows:**

|              |                 |
|--------------|-----------------|
| Ms Ballatti  | 30 April 2012   |
| Mr Aird      | 31 March 2014   |
| Mr Rackstraw | 31 July 2012    |
| Mr Wright    | 31 March 2014   |
| Mr Robertson | 31 October 2013 |
| Mr Willis    | 31 January 2014 |

### Remuneration Report

The Executive Director Remuneration Committee (EDRC) comprises of the Chairman and all the Non-Executive Directors. The Chief Executive and Director of Human Resources are invited to attend the meetings in an advisory role and are excluded on issues directly relevant to them by the Chairman of the Committee. The Committee is chaired by David Wright, the Senior Independent Director, since the beginning of the financial year. The Committee is supported by the Trust Secretary.

The Committee's main purpose is to set rates of remuneration, terms and conditions of service for the Chief Executive and Executive Directors, i.e. those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS Foundation Trust.

During the previous financial year, the Committee successfully completed the development of a policy framework for Executive remuneration and conditions. The policy sets out a framework by which the EDRC will manage the remuneration and terms of service of the Chief Executive and Executive Directors. The policy details the approach that the Committee will take to executive remuneration, how the policy will be applied, and the duties and responsibilities of key staff. The policy allows a reasonable level of flexibility on which the members of the Committee will apply their best judgements in reaching conclusions about the remunerations of Executive Directors. Further details on the policy were included in last year's Annual Report.

Although the policy provides a framework for determining remuneration for Executive Directors, and demonstrates levels of remuneration below the comparator group, once again this year, the Committee have, in effect, suspended the application of the policy on the basis that the political and economic context meant that it was not possible to improve the remuneration packages of the Directors.

The EDRC met three times during the year and:

- Received feedback from the Chief Executive and Chairman on the appraisals undertaken for the Executive Directors and Chief Executive and reviewed the remuneration of the Executive Directors against the benchmarked comparator group. Sought and received legal advice on the implications of the Executive Director Remuneration policy.
- Considered the changes being made to pensions arrangements and decided that it would seek specific advice on request when necessary.
- Discussed the current situation on car allowances for Executive Directors. It was agreed that discussions on car allowances should be kept separate from that concerning core remuneration. The Committee may return to this issue in the next year.

NHS Pension Scheme provisions apply to all Executive Director posts, with the level of employer contribution determined nationally. Executive Directors are on permanent pensionable contracts, subject to standard NHS terms and conditions of service and their current notice periods are:

|  |           |
|--|-----------|
| Chief Executive                              | 12 months |
| Chief Operating Officer                      | 3 months  |
| Director of Finance and Business Development | 6 months  |
| Director of Human Resources                  | 6 months  |
| Director of Nursing & Patient Care           | 6 months  |
| Medical Directors*                           | 3 months  |

\*The Medical Directors are on permanent clinical contracts with the Trust. This period relates to the Medical Director appointment only.

The EDRC has determined that, over time on appointment, it will move all EDs onto a uniform notice period.

### Attendance at the EDRC meetings 2011/12

| NAME        | June 11 | Oct 11 | Jan 12 |
|-------------|---------|--------|--------|
| A Ballatti  |         | *      | *      |
| B Aird      | *       | *      | *      |
| J Gaisford  | *       | -      | -      |
| J Rackstraw | *       | *      | *      |
| D Robertson | *       | *      | *      |
| A Willis    | *       | *      | *      |
| D Wright    | *       | *      | *      |

### Non-Executive Director Remuneration Committee (NEDRC)

The Non-Executive Director Remuneration Committee (NEDRC) comprises five elected Governors and is chaired by the Lead Governor, Council of Governors. 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. NEDRC held a meeting in Spring 2011 to review the levels of remuneration. They decided not to recommend any change to the basic level of remuneration for Non-Executive Directors and consequently, in line with the policy agreed by the Council of Governors in April 2010, increases in remuneration to the Chairman and Non-Executive Directors were limited to reflect increases in the cost of living only.

#### Membership and attendance at the NEDRC

##### Richard May

(Deputy Chair of COG, Lead Governor and Chairman of the NEDRC) - 1/1

##### Monica Overy

(Staff Governor) - 1/1

##### Kate Caldwell

(Exeter & South Devon) - 1/1

##### Cynthia Thornton

(Mid, North, West Devon & Cornwall) - 1/1

##### Christopher D'Oyly

(East Devon, Dorset & Somerset) - 1/1

## Salary, Pension and Other Information

A full declaration of salary, benefits in kind, real increase in pension and related lump sum at age 60, total accrued pension and cash equivalent transfer values are stated in full on page 58. The accounting policy for pensions and other retirement benefits is set out in a note 1.9 to the accounts.

The total of salaries, allowances and non-cash benefits in kind paid to Non-Executive Directors and senior managers for this and the previous year are:

| 2010/11    | 2011/12    |
|------------|------------|
| £1,133,000 | £1,097,000 |

There have been no significant awards or compensation to past senior managers, nor any payments to third parties for the services of a senior manager.

Signed:



Angela Pedder, OBE, Chief Executive

30 May 2012

## 4. Our Governance

### Director' remuneration Salary and pension entitlement of senior managers

#### Remuneration

| Name and Title    |   | Salary           |
|-------------------|---|------------------|
|                   |   | (bands of £5000) |
|                   |   | £000             |
| 2011/12           |   |                  |
| A Ballatti        | Chairman  | 45 - 50          |
| B Aird            | Non-Executive Director                          | 10 - 15          |
| J Gaisford        | Non-Executive Director (resigned 6 Sept 2011)   | 5 - 10           |
| J Rackstraw       | Non-Executive Director                          | 10 - 15          |
| D Robertson       | Non-Executive Director                          | 10 - 15          |
| A Willis          | Non-Executive Director                          | 10 - 15          |
| D Wright          | Non-Executive Director                          | 10 - 15          |
| A Pedder          | Chief Executive                                 | 170 - 175        |
| M Cooper          | Joint Medical Director                          | 70 - 75          |
| E Hobson          | Chief Operating Officer                         | 125 - 130        |
| L Lane            | Director of Human Resources                     | 85 - 90          |
| V Lewis           | Joint Medical Director (Appointed 1 April 2011) | 65 - 70          |
| S Tracey          | Director of Finance & Business Development      | 125 - 130        |
| E Wilkinson-Brice | Director of Nursing & Patient Care              | 110 - 115        |

Other Remuneration shows the salary that is attributable to clinical duties.

The contractual hours of L Lane are 0.8 of a whole time equivalent.

The benefit in kind for A Pedder relates to the provision of a lease car.

The remaining benefits in kind relates to the mileage allowance paid over and above the HM Revenue Customs and Excise allowance.

**Ratio between highest paid director and median remuneration received by employees of the Trust**

|  |           |
|--|-----------|
| Band of highest paid Director - as above                   | 170 - 175 |
| Median remuneration received by employees within the Trust | 28.2      |
| Ratio  | 6.1       |

| Other Remuneration | Golden Hello/ compensation for loss of office | Benefits in Kind              |
|--------------------|---|-------------------------------|
| (bands of £5000)   | (bands of £5000)                              | (rounded to the nearest £100) |
| £000               | £000  | £                             |
| -                  | -   | 3,000                         |
| -                  | -   | 200                           |
| -                  | -   | -                             |
| -                  | -   | 1,700                         |
| -                  | -   | 100                           |
| -                  | -   | 500                           |
| -                  | -   | 500                           |
| -                  | -   | 8,200                         |
| 140 - 145          | -   | -                             |
| -                  | -   | 100                           |
| -                  | -   | 300                           |
| 90 - 95            | -   | -                             |
| -                  | -   | -                             |
| -                  | -   | -                             |

The Trust is required to disclose the relationship between the highest paid director and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director, excluding remuneration attributable to clinical duties, was £170,000 to £175,000. This was 6.1 times the median remuneration of the workforce which was £28,200.

Total remuneration includes salary, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer value of pensions.

## 4. Our Governance

### 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) |
|-------------------|--|---|---|
|                   |  | £000  | £000  |
| A Pedder          | Chief Executive                            | (0.0 - 2.5)                                       | (0.0 - 2.5)   |
| M Cooper          | Joint Medical Director                     | (2.5 - 5.0)                                       | (7.5 - 10.0)  |
| E Hobson          | Chief Operating Officer                    | 5.0 - 7.5   | 20.0 - 22.5   |
| L Lane            | Director of Human Resources                | 0.0 - 2.5   | 2.5 - 5.0   |
| V Lewis           | Joint Medical Director                     | 0.0 - 2.5   | 2.5 - 5.0   |
| S Tracey          | Director of Finance & Business Development | 0.0 - 2.5   | 2.5 - 5.0   |
| E Wilkinson-Brice | Director of Nursing & Patient Care         | 0.0 - 2.5   | 2.5 - 5.0   |

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

A Cash Equivalent Transfer Value (CETV) is the actually assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the members's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV 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 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.

Cast 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. No CETV is therefore available, as at 31 March 2011 and 31 March, for M Cooper.

| Total accrued pension at age 60 at 31 March 2012 (bands £5,000) | Total accrued related lump sum at age 60 at 31 March 2012 (bands £5,000) | Cash Equivalent Transfer Value at 31 March 2012 | Cash Equivalent Transfer Value at 31 March 2011 | Real Increase in Cash Equivalent Transfer Value at 31 March 2012 |
|---|--|---|---|--|
| £000  | £000   | £000  | £000  | £000   |
| 75.0 - 80.0   | 230.0 - 235.0  | 1,590   | 1,475   | 69   |
| 60.0 - 65.0   | 180.0 - 185.0  | -   | -   | -  |
| 50.0 - 55.0   | 160.0 - 165.0  | 1,069   | 844   | 199  |
| 5.0 - 10.0  | 25.0 - 30.0  | 176   | 139   | 33   |
| 20.0 - 25.0   | 70.0 - 75.0  | 359   | 278   | 72   |
| 15.0 - 20.0   | 55.0 - 60.0  | 286   | 215   | 64   |
| 30.0 - 35.0   | 95.0 - 100.0   | 455   | 350   | 94   |

### Audit Committee

The Audit Committee is a formally constituted committee of the Board of Directors, chaired by David Robertson (a Non-Executive with a financial background). While membership of the Committee changed during the year, a further three Non-Executives constituted the Committee which is also attended by representatives of the External Auditors PricewaterhouseCoopers (PwC); Internal Audit and the Counterfraud Service.

The Audit Committee met four times during 2011/12. The names of Members and their attendance at 2011/12 meetings is as follows:

| Date of committee | David Roberston | James Gaisford (until 9/11) | John Rackstraw | David Wright |
|-------------------|-----------------|-----------------------------|----------------|--------------|
| 27 April 2011     | Y               | Y                           | N              | Y            |
| 3 June 2011       | Y               | Y                           | N              | N            |
| 26 October 2011   | Y               | N/A                         | Y              | Y            |
| 25 January 2012   | Y               | N/A                         | Y              | Y            |

A full description of the duties and responsibilities of the Audit Committee can be found on the Trust website. Some of the Committee's key areas of responsibility are to:

- Review the systems of integrated governance across Trust activities (both clinical and non-clinical), which support the achievement of the Trust's objectives
- Utilise the work of Internal Audit, External Audit and other assurance functions to assess the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness
- Oversee the monitoring and management of those risks seen to be fundamental to the strategy and sustainability of the Trust
- Ensure the existence of an effective internal audit function and to review the work and findings of the external auditor
- Review the annual report and financial statements and ensure that systems for financial reporting to the Board are subject to review.

The work of the Audit Committee is reported to the full Board of Directors. During 2011/12 the work of the Committee included:

- Reviewing the findings and recommendations arising from the work of External and Internal Audit and the Counterfraud Service and assessing the impact of these findings on the overall system of internal control
- Receiving the Head of Internal Audit opinion which stated that the Trust assurance and controls amounted to “significant assurance.” The Committee understood that this meant that Internal Audit believed that the Trust’s internal controls were managed effectively
- Receiving assurance on the quality of the data underpinning the Trust Quality Report
- Recommending to the Council of Governors that the Trust’s external auditors, PricewaterhouseCoopers, have their term extended for a further year from November 2012, a recommendation accepted by the Council of Governors.

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 included with the accounts in this report and the Annual Management Letter to the Board. For the year under report, the External Auditor provided an unqualified opinion on the Trust’s accounts and expressed themselves satisfied with the Trust’s management procedures and control processes.

### Compliance with the NHS Foundation Trust Code of Governance

The Code of Governance published in September 2006 (last updated April 1, 2010) contains recommended best practice to be followed by FTs in areas of corporate governance. The Code contains main and supporting principles, which are subject to ‘comply’ or ‘explain’ reporting procedures. Any provisions with which the Trust does not comply must be disclosed in the Annual Report.

In the 2010/11 Annual Report, the following provisions were reported under the ‘explain’ category:

E.2.2 Definition of senior management - which states that “the Remuneration Committee should have delegated responsibility for setting remuneration for all Executive Directors, including pension rights and any compensation payments. The Committee should also recommend and monitor the level and structure of remuneration for senior management. The definition of ‘senior management’ should be determined by the Board but should normally include the first layer of management below Board level.”

The Trust’s explanation for non-compliance with this provision is that the Board has defined ‘senior management’ to be limited to Board members only. All other staff to be covered by the Agenda for Change scheme of nationally agreed terms and conditions.

It was reported to the Board in March 2012 that the Trust had maintained compliance with all provisions of the Code except E2.2 and the Board again decided to declare under the ‘explain’ category for the same reasons as in 2010/11.

### Quality Governance

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 - which is a sub-section within the main Annual Report as well as in the Annual Governance Statement (see page 65).

In March, our Audit Committee confirmed that it is satisfied with the governance arrangements in place regarding quality. At a Board Development Day in December 2011 the Board considered Monitor's Quality Governance Framework and the approach the Board wanted to take to the collation of evidence to support future Monitor declarations. It was also agreed that the Governance Committee would consider the evidence collated with a view to making a recommendation to the Board as to whether sufficient assurance existed to justify the Board agreeing to make Declaration 1 for the Q4 Quality Declaration to Monitor. The evidence base considered by the Board's sub-committees provided evidence of how the Trust has used internally generated metrics, evidence from external visits and regulatory reports, internal audit reports and recommendations and evidence compiled to support CQC registration to satisfy the Board of Directors that due regard has been given to the requirements of the Quality Governance Framework.

There are no material inconsistencies between the Annual Governance Statement, Board statements required by the Compliance Framework, the Quality Report and Annual Report. The Board, through its sub-committees, regularly reviews the effectiveness of the Trust's system of internal controls.

### Annual Governance Statement

#### 1. 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.

#### 2. 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 ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal Devon & Exeter NHS Foundation, 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 2012 and up to the date of approval of the annual report and accounts.

#### 3. Capacity to handle risk

**3.1** During 2010/11 the Board of Directors commissioned a review of the Trust's governance framework and agreed a development plan which resulted in a revised governance architecture with effect from October 2011. An interim review undertaken by Internal Audit will take place in April 2012 with a full evaluation in October 2012.

**3.2** The Audit Committee monitors and oversees both internal control issues and the process for risk management. Audit Southwest (internal audit) and PWC (external auditors) attend all Audit Committee meetings. The Audit Committee receives all reports of the Internal and External Auditors and reports regularly to the Board.

**3.3** 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. All directorates have Governance Groups which meet regularly. There are established Governance Coordinator posts to support the directorates in implementing robust risk and governance processes. Directorate Governance Groups report and escalate concerns to the five Governance sub committees.

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

## 4. Our Governance

**3.5** 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 Intranet.

**3.6** In June 2011 the Trust implemented Datix web, an electronic Governance System, which has the ability to record and monitor incidents, complaints and risks. Since its implementation the reporting and management of incidents has improved. The complaints and risk register module were implemented in December 2011 and January 2012.

**3.7** Senior clinical staff and Governance Co-ordinators are trained to conduct Serious Incidents Requiring Investigation (SIRI). The Risk Management Team co-ordinates SIRI's and adverse incidents which are reported and managed through the Incident Review Group (a sub group of the Safety and Risk Committee) and learning points are made available to all relevant staff. All SIRI's and action plans are shared with the Trust's lead commissioner, NHS Devon.

### 4. The risk and control framework

**4.1** The Board of Directors is responsible for the strategic direction of the Trust. The Board of Directors has reviewed and approved a revised Risk Strategy and 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 revised 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 when setting Internal Audit's annual work plan.

**4.2** Any gaps in controls of assurance are highlighted and reported to the Board of Directors. Risks to the Trust's strategic objectives that cannot be immediately eliminated are placed on the corporate register and action plans put in place to address any gaps. The Board of Director's 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.

**4.3** The Audit Committee is a Non-Executive committee of the Board of Directors and reviews the establishment and maintenance of an effective system of integrated governance across the whole of the Trust's activities that supports the achievement of the Trust's objectives. The Committee provides assurance to the Board of Directors that the governance system is functioning in accordance with the framework agreed by the Board.

**Specifically, the committee reviews the adequacy of:**

- All risk and control related disclosure statements together with the Head of Internal Audit Opinion and external audit opinion (ISA 260 report) prior to endorsement by the Board.
- Reviews and approves the annual audit plans.
- Reviews the data assurance process underpinning the Trust's Quality Report.
- The underlying assurance processes that indicate management of risks that may impact the degree to which achievement of the corporate objectives is secured, together with the effectiveness of the management of principal risks and the appropriateness of disclosure statements

- The policies and procedures for all work related to fraud and corruption as required by the counter fraud and security management service.
- The Trust's self assessment process for assessing compliance with Care Quality Commission Regulations for the period April 2011 to March 2012.

**4.4** The chairs of the Audit Committee and the Governance Committee meet no less than three times per year to ensure that the agendas of the two committees are aligned and there are no gaps in assurance.

**4.5** The Governance Committee is chaired by a Non-Executive Director and provides leadership to 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
- Workforce and Diversity Committee
- Safety and Risk Committee
- Engagement and Experience Committee

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

**4.6** The Significant Events Forum is chaired by a consultant clinical lead and reviews all adverse incidents, Clinical Audits and Mortality and Morbidity Reviews. The Incident Review Group is chaired by the Deputy Director of Nursing and Patient Care and reviews all Serious Incidents Requiring Investigation (SIRI) and action plans.

## 4. Our Governance

Other specialist Groups led by a Director or senior clinician include:

- Clinical Audit and Guidelines Group
- Medical Devices Group
- Medicines Management Group
- Medical Gases Group
- Patient Safety Programme Group
- Radiation Safety Group
- Trust Infection Control and Decontamination Assurance Group
- Drugs and Therapeutics Committee

### 5. Risk Identification and evaluation

**5.1** The Trust has a risk management strategy which has been approved by the Board of Directors and clearly sets out the process for identifying and managing risk. 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 strategy also includes the governance reporting structure and the terms of reference of the Governance Committee and all the committees reporting to the Governance Committee.

**5.2** The Trust maintains a comprehensive Corporate Risk Register covering both clinical and organisational risk. There are 20 current risks on the Corporate Risk Register all identified risks have clear mitigation plans in place. Of the Trust's six highest scoring risks, two relate to operational clinical capacity and the risk of non availability, two relate to medical records storage and two relate to the implementation of a diagnostic test ordering and result communication system. 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, this 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 Committee each time they meet.

**5.3** The Trust has directorate level risk registers which feed into the Corporate Risk Register. At directorate level, the risk registers contain lower level localised risks which can be managed by the relevant directorate. 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.

**5.4** Other methods 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
- LiNKs and Health Scrutiny Committee reports
- Incident reports and trend analysis (via Datix software, identification of hot spots)
- Internal and external audit reports
- Quarterly Performance Reviews
- Feedback from Governors and Members
- Ward to Board Framework, Nursing Quality Assessment Tool (NQUAT)

**5.5** 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. Information Asset Owners for critical systems have been identified; system risk assessments and Information Risk Management training is undertaken annually.

**5.6** 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 Tool Kit assessment and the Audit Committee and the Board of Directors has received a report regarding its system for control of Information Governance.

**5.7** The Trust is green rated on the Information Governance Toolkit, achieving a level 2 on all 45 requirements.

**5.8** Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with. As a public sector organisation, the Trust has legal obligations as regards equality and diversity through both the Equality Act and the Public Sector Duty.

**5.9** The Board of Directors receive assurance that we are meeting our legal obligations with regard to equality and diversity, 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.

## 4. Our Governance

The Trust uses an NHS-designed tool, the Equality Delivery System (EDS), to ensure compliance with legal obligations and enable continuous improvement.

**5.10** 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.

**5.11** The Trust has undertaken risk assessment 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.

### 6. Quality Report

**6.1** The Trust is fully registered with the Care Quality Commission and remains compliant with the requirements of registration.

**6.2** 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.

**6.3** The Content of the Trust's Quality Account for 2011/12 builds on the 2010/11 report. It has been agreed by the Board of Directors and incorporates the views and priorities of Governors and the views of approximately 500 Trust Members in setting priorities for improvement in 2012/13. The development of the report is led by the Director of Nursing and Patient Care. The views of NHS Devon, as lead commissioner, LiNKs Devon and Devon County Council Health Scrutiny Committee have been sought.

**6.4** The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Account as it does for other clinical quality and performance information. The data is subject to regular review and challenge at speciality, directorate 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 Account and through this process and other review of data, the Board of Directors are assured that the Quality Account represents a balanced view.

**6.5** 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 Accounts.

### **7. Review of economy, efficiency and effectiveness of the use of resources**

**7.1** The Trusts Annual Plan, including financial, performance, quality and governance targets was approved by the Board of Directors in May 2011. Overall performance is monitored via an integrated performance report at the monthly meetings of the Board of Directors. This includes trend data on a number of measures of efficiency and use of resources such as sickness absence rates. Operational management and the coordination of Trust services are delivered by the Executive Directors and Trust Management Committee, which comprises the Executive Directors, Clinical Directors

and Divisional Managers. Performance of individual clinical and support directorates is monitored informally on a monthly basis and formally on a quarterly basis via the quarterly review process.

**7.2** The Trust's Internal Audit Plan and External Audit Management Letter include commentary on the economical, effective and efficient use of resources. The findings of internal and external audit are reported to the Board via the Audit Committee.

**7.3** 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.

**7.4** 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.

### **8. Review of effectiveness**

**8.1** 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 and the Executive Managers 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 external audit management letter and other report. I have been advised on the implications of the results of my review of the effectiveness of the

system of internal control by the Board, the Audit Committee, Internal Audit, the Divisional Manager of Corporate Affairs and External Audit. The system of internal control is regularly reviewed and plans to address any identified weaknesses and ensure continuous improvement are put in place.

**8.2** 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 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 Board's 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
- 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 Monitors Governance Framework
- CNST level 2 accreditation for its maternity services
- NHSLA level 1 accreditation for all other services
- 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
- Completion of the health and safety action plan
- The Trust's compliance with the Hygiene Code
- The Trust's unconditional registration with the CQC.

**8.3** 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. The assurance framework includes plans to address any gaps in control of assurance in order to ensure that continuous improvement of the system is in place.

### 9. Conclusion

There is no significant internal control issues (i.e. issues where the risk could not be effectively controlled) I wish to report in respect of 2011/12. I am satisfied all internal control issues raised have been, or are being, addressed by the Trust through appropriate action plans and that implementation of these plans is monitored.

Signed



Angela Pedder OBE

Chief Executive

30 May 2012

## 4. Our Governance

### Board Assurance Framework

Following the agreement of the Trust's new Strategy in September 2011 the Board instituted a review of the Board Assurance Framework with a view to ensuring that the revised Assurance Framework captured the key risks to the new strategy and the extent to which the Trust had in place plans to control those risks and provide assurance to the Board. The Board agreed the revised Assurance Framework in January 2012.

### Regulatory Ratings/CQC Reports and Response

Monitor assesses the performance of the Trust using Key Performance Indicators, designated as Regulatory Ratings. There are two risk ratings:

- Financial Risk Rating assessed on a scale from 1 (high risk) to 5 (low risk).
- Governance assessed on a scale of green/amber-green/amber red/red.

#### Deriving the financial risk rating

| Financial criteria     | Weight (%) | Metric to be scored                      | Rating categories |    |    |    |     |
|------------------------|------------|--|-------------------|----|----|----|-----|
|                        |            |  | 5                 | 4  | 3  | 2  | 1   |
| Achievement of plan    | 10         | • EBITDA* achieved (% of plan)           | 100               | 85 | 70 | 50 | <50 |
| Underlying performance | 25         | • EBITDA* margin (%)                     | 11                | 9  | 5  | 1  | <1  |
| Financial efficiency   | 40         | • Return on Capital Employed** (%)       | 6                 | 5  | 3  | -2 | <-2 |
|                        |            | • I&E surplus margin net of dividend (%) | 3                 | 2  | 1  | -2 | <-2 |
| Liquidity              | 25         | • Liquidity ratio*** (days)              | 60                | 25 | 15 | 10 | <10 |

**Financial risk rating is weighted average of financial criteria scores**

\* EBITDA: Earnings before interest, taxes, depreciation and amortisation. EBITDA (and other financial metrics) may be adjusted by Monitor for any 'one-off' non-recurring revenue, costs or investment adjustments'.

\*\* Defined as EBIT divided by (fixed assets plus current assets less current liabilities). Denominator includes PFI liabilities and finance leases.

\*\*\* The liquidity ratio is defined as cash plus trade debtors (including accrued income) minus (trade creditors plus other creditors plus accruals) plus unused committed working capital facility (up to a maximum of 30 days and excluding overdraft agreements) expressed as the number of days operating expenses (excluding depreciation) that could be covered.

### Deriving the governance risk rating

Monitor includes five elements within the governance risk rating.

1. Service performance against nationally prescribed indicators.
2. Third parties' views (such as the Care Quality Commission and the NHS Litigation Authority).
3. The expectation that the Trust will be able to continue to provide mandatory services set out in its terms of authorisation.
4. Other certification failures: where NHS Foundation Trust boards have failed to meet Monitor's reporting requirements.
5. Other factors where Trusts are not meeting statutory requirements of other bodies.

More detail on Monitor's regulatory approach during 2011/12 is set out in its Compliance Framework which is available at : <http://www.monitor-nhsft.gov.uk/home/our-publications/browse-category/guidance-foundation-trusts/mandatory-guidance/compliance-frame-0>

### Analysis

In our Annual Plan, we declared that our governance risk rating for the year would be amber-red. This was because of:

- a. *Clostridium Difficile*: A more sensitive test was introduced on 11th October 2010 for *C. Difficile* allowing us to identify and treat patients more quickly for it. The Board agreed that whilst this may have repercussions with regard to breaching Monitor's target, the new test was in our patients' best interests. Measures were put in place to keep numbers as low as possible and have proved to be effective in delivering reductions year-on-year. *C. Difficile* numbers were monitored for both the old and new test to pick up any underlying increase in cases.
- b. A&E Target: Total time in A&E (within 4 hours): The revised target no longer allowed the RD&E to include minor injury unit activity in measurement of the 95% performance. This, combined with 2010/11 Q4 increases in attendances, makes target achievement more challenging. In its Annual Plan submission, the Board identified a range of mitigating actions including:
  - i. Joint work with the PCT, GPs and Ambulance Trust via the Urgent Care Group to understand recently increased levels of attendance at the Emergency Department and to agree interventions to address this.
  - ii. Set or formalise internal standards for response times within the hospital for main specialties interfacing with Emergency Department. Formalise and monitor response standards within the department itself.

## 4. Our Governance

**c.** 62 day cancer urgent GP: Target not achieved in Q1 and Q4 2011/12, but achieved for the year as a whole. Complex pathways can make this target more difficult to deliver than others. In addition, increased numbers of patients being referred for endoscopy as a result of bowel cancer screening campaign may result in additional referrals for surgery and oncology. The potential impact of the lung awareness campaign on referrals; lessons learnt from the bowel cancer screening would indicate an increase in fast-track referrals with the consequent diagnostic and treatment pathways referral to treatment target. As part of the Annual Plan, the Board agreed a range of actions to mitigate these risks including:

- i.** Review of capacity and demand in endoscopy, surgery and oncology and additional capacity to be identified.
- ii.** Liaison with Peninsula Cancer Network regarding commencement of lung awareness campaign.
- iii.** Sub-specialty completing initial draft response plans.
- iv.** Weekly Cancer Waiting Times (CWT) predictors will continue to be sent out to Directorates in addition to standard weekly breach reports.
- v.** Additional MDT meetings rescheduled to avoid delays in case presentation and clinical decision making.
- vi.** Review of clinical pathways of high volume 62 day cancer subspecialties (including lung) with the support of the Service Development Team.
- vii.** The Trust is working closely with the Peninsula Cancer Network (PCN) to review patient pathways from neighbouring Trusts, to understand specialty specific issues around tertiary referrals and address any concerns

**Quarter 1:** The Trust did not achieve one Monitor target for *C. Difficile* resulting in an Amber-Green governance risk rating for the reasons set out above.

**Quarter 2:** The Trust did not achieve one Monitor target for *C. Difficile* resulting in an Amber-Green governance risk rating. As a result of the enhanced *C. Difficile* testing there were 26 cases against a plan of 18 for Q2. Of the 26 cases only 10 would have

been reported under the previous testing regime, which would mean the Trust would have achieved the target for the quarter.

**Quarter 3:** Two of the Monitor targets were not met for Quarter 3.

- The *Clostridium Difficile* target was achieved during Quarter 3 with a total of 17 cases (10 toxin positive) against a trajectory of 19 for the quarter, but failure to meet the target in the previous two quarters means that the cumulative target is still not being met, with a total of 70 cases (30 toxin positive) against a target of 55 for the first three quarters. A supplementary analysis of the action that had been taken to provide assurance that the Trust's action was appropriate in regard to *C.Difficile* was provided to Monitor with the Q3 reporting.
- In addition the A&E 4 Hour Target was not met with the combined position of the RD&E and the Wonford Walk-In-Centre for the quarter being at 93.7% against a target of 95%. The failure was linked to the increase in emergency admissions.

**Quarter 4:** One of the Monitor targets assessed on a quarterly basis is currently not being met for Quarter 4.

*Clostridium Difficile* target. The Trust achieved the target during Quarter 4 with a total of 15 cases (of which 5 were toxin positives and would have been reportable under the previous testing regime) against a target of 19 but the cumulative positive for the year was 85 cases (of which 35 were toxin positive and would have been reported under the previous testing regime) against a target of 74.

Non-achievement of the RTT 95th Percentile Admitted Patients target was reported. The Trust achieved the target in January, February and for the quarter overall with 95th percentile waits of 18.9, 21.4 and 22.3 respectively but failed to meet target in March with a 95th percentile of 25.7, failure of any one month in the quarter means that the quarterly position is also considered to have been failed.

## Table of analysis

|                        | Annual Plan 2010/11 | Q1 2010/11  | Q2 2010/11 | Q3 2010/11 | Q4 2010/11  |
|------------------------|---------------------|-------------|------------|------------|-------------|
| Financial risk rating  | 3                   | 3           | 3          | 3          | 4           |
| Governance risk rating | amber-green         | amber-green | green      | green      | amber-green |

|                        | Annual Plan 2011/12 | Q1 2011/12  | Q2 2011/12  | Q3 2011/12 | Q4 2011/12 |
|------------------------|---------------------|-------------|-------------|------------|------------|
| Financial risk rating  | 3                   | 3           | 4           | 3          | 3          |
| Governance risk rating | amber-red           | amber-green | amber-green | amber-red  | amber-red  |

## 5. Our Governors and Members

### Council of Governors

The Council of Governors (CoG) continued to play a key role in the governance of the Trust during the year.

Over the last few years a number of improvements have been made to the way the CoG conducts its business. These changes - most of which took place as a result of the Fundamental Review of Governors that concluded in July 2010 - included:

- Altering the format of the CoG meetings to align it to the core role of Governors
- Changes to the Governors performance report to enable the Governors to carry out their accountability and assurance role effectively
- Governors' representatives on a new key Committee that reports to the Governance Committee - the Experience and Engagement committee
- Clarification of annual CoG objectives and a detailed business plan
- Significant progress made in understanding and engaging with members through Members' Say and surveys.

### New Constitution

A subset of Governors and Directors worked together during the year on developing a revised constitution for the Trust. The new constitution, which updated and modified the Trust's existing constitution, was approved by Monitor in June 2011. The percentage of public governors on the Council has been increased to 70%. This will mean a stronger connection with our members by increasing the strength of their voice within the Trust. The number of Staff Governors remains at five but with a new 'Non-Clinical' constituency created which incorporates Admin, Clerical & Managers and Hotel Services & Estates. This keeps us in line with many other Trusts and will hopefully make recruitment of staff governors more straightforward in future.

During the last year, on the back of the changes made and the clarification on defining their core role, Governors were able to focus on making progress in a number of key areas. At the start of the year, Governors developed some key priorities and linked this to a business plan which helped drive and focus their work programme. The business plan was overseen by a coordinating group which sought to track progress and ensure that there was sufficient momentum on the delivery of Governor priorities.

#### **In constructing its first business plan, Governors took into account:**

- The need to link the forthcoming agenda and work plan of the CoG to the RD&E's Board and wider expectations from the Trust's regulators
- The understanding that ongoing developments mean that not all aspects of the plan can be pinned down at this stage and that there needs, therefore, to be some flexibility going forward
- The clarification on the distinct role of governors that has emerged from the fundamental review of Governors, Monitor guidance and other guidance
- The need to enhance the effectiveness, impact and added value of the Governors to the Trust
- Ensuring that in challenging times, the Governors will continue to act in the best interests of the Trust first and foremost
- Capacity limitations of both the Governors and the Trust secretariat to support the work of the CoG.

#### **The business plan established the following aims:**

- To continue to clarify and strengthen the role of Governors as a core component of the RD&E's governance structures
- To contribute to the effectiveness of the Trust by appropriately undertaking its statutory powers, holding the Board to account and ensuring that the Board takes into account the views of the Trust's stakeholders.

#### **It also set out its main priorities for 2011/12:**

- 1 Stakeholder views:** Make progress on developing the CoG's capacity to better understand and represent stakeholder opinion to the Trust.
- 2 Membership:** Develop the role of Members and membership as part of the Trust's overall approach to stakeholder engagement.
- 3 Quality matters:** Make effective contributions to Trust work on quality and patient experience.
- 4 Effectiveness:** Enhance the effectiveness of the CoG by ensuring that its knowledge base, processes and operations are fit for purpose.
- 5 Holding to account:** Continuing to work closely with the Board whilst at the same time developing processes to hold the Board to account.

An action plan detailing the CoG's work programme was set out and underpinned the issues that the CoG focused on during the last year. The following overview provides a summary of some of the issues Governors were involved in during the year linked to the priorities set out above.

## 5. Our Governors and Members



### Main priorities for 2011/12

#### 1. Stakeholder views

Over the last year the new approach developed to build relationships with Members - our Members' Say events - continued to thrive. Members' Say events were held in March and October and were attended by close to 500 Members. These events provided a prime opportunity for Members to relate to Governors and Directors, for Governors to hear Members' views at first hand (both through the interactive sessions and discussion groups) and to represent these views back to the Trust. More detail on these events is included in the membership section of this report.

One important development that helped to give a platform for Governors on stakeholder and Member engagement was in the establishment of a new Committee that reported to the Board's Governance Committee - the Engagement and Experience Committee. This new Committee brought together three Governors and three Non-Executives (including the Chairman) to discuss and agree the development and implementation of the Trust's stakeholder engagement strategy in relation to two key audiences: patients and Members/public. The new Committee helps to knit together the engagement work the Trust undertakes with patients with the engagement work it has in place for Members/wider public in order to improve the intelligence that the Trust has on its key stakeholders and to improve services in line with the views expressed. Governors are now actively contributing to the work of this committee and bringing to bear the views of Governors and their wider membership on the discussions taking place in this forum.

At a different level, Governors are able to seek improvements in the way that the Trust engages with some of its stakeholders based on issues that are brought to their attention by Members. There have been a number of issues brought to the attention of the Trust by Governors over the course of the year. One specific example during the year was the way the Trust handled bereavement office advice and support out of office hours. As a result of questions raised by Governors, the previous practice was changed to better enable appropriate support to be offered to relatives dealing with bereavement out of hours.

## 2. Membership

Governors' engagement with Members is a two way process. The Members' Say events and surveys we undertake during the year help the Trust to better understand the views of its Members and the Trust has placed considerable emphasis on this approach over the last few years. However, one of the important issues for Foundation Trusts, such as the RD&E, and one of the issues that our regulator, Monitor, is keen to track, is to recruit and manage a sufficient number of Members to represent the wider community serviced by the Trust.

Over the last few years the Trust has broadly maintained numbers of Members (both public and staff Members). The last few years has seen a small deterioration in overall numbers reflecting an earlier decision not to mail shot all patients who came into the Trust during the course of a year. Although this helped to keep overall numbers of Members consistent (i.e. recruiting as many new Members over the year compared to those that stopped being a Member) the cost per new Member made this unsustainable. A number of new methods of recruiting new Members have taken place over the last few years; some of these methods have worked well while others have not resulted in the desired outcome of increased numbers of Members. Based on the different approaches we have tried out, the most successful is the face to face recruiting undertaken by Governors themselves in the Trust's restaurant. The ability to meet with people and to explain membership to them has helped to keep overall levels broadly consistent. Recruiting by Governors of new Members will continue in the next financial year alongside a revamp of the Trust's website and its membership area which we hope will attract new Members.

The profile of the Trust's Members has remained broadly the same during the year. On the whole the Trust's membership generally reflects the socio-demographic groups within the local area. Our membership is for the most part comfortably off and, as is generally the case with Foundation Trust membership, the average age of our members is higher than that of the local population with 75+ age group especially over represented.

On the basis that there is a good alignment between the wider population and our membership, there is a high degree of overlap which means that in the engagement work undertaken by the Trust, we can be confident that when we "take the temperature" of our Members in focus groups and surveys we are getting a reasonably accurate insight into the views of the broader public.

Although Governors did not have the capacity during the year to begin to address any specific areas of underrepresentation, Governors remain keen to address this issue in innovative ways and will prioritise targeted recruitment activities over the next financial year.

The Trust continued to produce its newsletter for Members during the year. Through savings made elsewhere and income generation linked to placing adverts in our staff newsletter, we were able to produce the newsletter in full colour.

This move enhanced the impact of the newsletter and helped to underpin both Governors' and Members' ability to act as ambassadors for the Trust in the areas served by the Trust.

## 5. Our Governors and Members

### 3. Quality matters

Over the course of the year patient quality and safety were recurrent themes. Patient safety was the subject of a joint session with the Board in September. This discussion focused on answering some of the key questions on patient safety that all Governors need to be taking into account in their work.

Quality issues are central to the revised performance data received by Governors at CoG meetings. The performance data shines a light on some of the key quality indicators of relevance and the narrative in the revised performance report outlines the issues taken up by the Board to assure themselves on relevant quality and safety matters. This approach, which is based on an accountability relationship that seeks to ensure that the Board is paying sufficient attention to quality and safety and, when necessary, seeking further assurance, is entirely consistent with the model the Trust has developed over the last few years. In this model Governors provide a secondary tier of assurance - a “double lock” - that the Board is properly overseeing patient quality and safety issues. The accountability relationship between the Board and the CoG provides a level of confidence both to the Governors and, through them, the Trust’s membership, that overall performance on critical quality and safety issues is being properly governed by the Board.

A sub-set of Governors worked together on contributing narrative to the Quality Report. This group has also evolved into a task group on patient quality and safety and is currently developing its ideas on how it can best contribute a Governor perspective on ongoing Trust work in these areas.

## 4. Effectiveness

Governors have continued to innovate and identify new ways of working that reflected the changing external context, their own development, as well as maximising their effective contribution to the governance of the Trust. As a result, Governors agreed to change existing governance and operational structures based on the following principles:

- Improving the coordination and oversight of the CoG's business plan
- Better integrating the involvement of Governors in the Experience & Engagement Committee with the wider CoG
- Better aligning the structure of the CoG to the business plan and to the priorities of the Trust as a whole
- Promoting greater inclusivity and the participation of Governors in core activities
- Making it clearer how the involvement of Governors contributes to the Trust
- Enhancing the mutual accountability of Governors (i.e. that Governors are accountable to the CoG)
- Developing the structure in a way that is broadly consistent with the direction of travel set out in the Health & Social Care Act as it applies to Governors.

In line with these principles the Governors established three new task groups on:

- a. CoG effectiveness
- b. Patient safety and quality aligned to the E&E Committee work programme
- c. Member and public engagement.

These groups are responsible for identified elements of the agreed 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 convenor and a core group but are open to any member of CoG that wishes to participate. The task groups' convenors are the three Governors who currently represent the CoG on the Experience & Engagement Committee providing an essential link between this part of the Trust's governance structure and the Governors.

In light of this new architecture, Governors decided to remove the Business Management Group and replace it with a Coordinating Group overseen by the Chairman and involving the Lead Governor (and Deputy), the convenors of the three task groups, a staff governor representative and FT secretariat staff. The new Committee meets every two months and focuses on coordinating the work of the CoG and ensuring that progress is being made against the plan.

## 5. Our Governors and Members

One innovation that has helped Governors access information to enable them to carry out their role was the introduction of a secure website that allowed Governors to access relevant papers and other information.

Governors agreed that they would conduct a self-assessment based review and have undertaken a survey of both Governors and Directors. As Governors have spent a lot of time reviewing their role, it was agreed that the formal process would focus on specific areas, namely:

- Holding to account
- Engagement and direction
- CoG dynamics
- Training and development.

The results of the survey were being analysed by Governors and a report was scheduled for the April 2012 CoG meeting.

### 5. Holding to account

Another issue that the Governors worked on during the year was improving the performance information provided to the CoG. On the basis of greater clarity on their role, Governors were able to work with the Trust to better define the level and extent of information they required to enable them to carry out their job effectively. A number of versions were tried out during the year until Governors were comfortable with the new approach. The new style performance information focused on providing the assurance to the CoG that the Directors were effectively performance managing the Trust. This meant that Governors were able to focus on holding the Board accountable for their own performance rather than trying to double up the work of the Board by seeking to separately performance manage the organisation.

### Governor Profiles

**Governor Kate Caldwell is a member of our Nomination Committee, which appoints Non-Executive Directors and, this year, our new Trust Chairman. Kate explains why she doesn't underestimate the significance of this responsibility:**

“The role of Chairman of the Board of Directors and the Council of Governors is crucial to the staff of the hospital as well as patients and the wider community. The Chairman is more than a figurehead, they must help us keep the RD&E on the right course and realise the aspirations and expectations we have for our hospital services. That means we have to have the right person and it is the task of the Governors on the Nomination Committee to meet the short listed candidates and say who we think would be best suited to the appointment. The Committee members come from a wide range of backgrounds but what we have in common is a commitment to wanting the RD&E to thrive. Although scary, I think the responsibility which comes with this involvement in the decision making process is also a privilege.”

**Governor Martin Perry has served for the past four years as a member of our Patient Environment Action Team (PEAT) alongside colleagues from infection control, housekeeping, estates and dieticians. Martin explains what PEAT inspections involve and his verdict on our standards:**

“We arrive unannounced on wards to check for cleanliness, safety, meals and the general tidiness of the hospital surroundings. I enjoy having the opportunity to talk to patients to find out what they think because, in effect, it is their home until they leave. We look at a range of criteria including car parks, pavements, signage, stairwells, toilets and

## 5. Our Governors and Members

bathrooms and give scores which are verified by someone from another NHS Trust to ensure we are not cheating or being too hard on ourselves. We also sample the patient meals on the day. I am also a verification officer when other hospitals are having PEAT inspections and can honestly say that we have every reason to be very proud of the standards maintained at the Royal Devon & Exeter.”

**Governor Keith Broderick explains as a member of our project steering group which looked at ward cleaning and hospitality services what this work involved:**

“My main interest in becoming a Governor was patient care in its widest sense, mostly the non-clinical support before, during and after the clinical care that the Trust delivers to a high standard. Initially it was a steep learning curve to understand the project scope and aims, as well as internal structures and responsibilities, but they soon became clear and I felt I was able to contribute. Although the key objectives evolved, the main project focus was to maintain good practice and improve patient care. For the pilot, following feedback from Ward Nurses, the staff roles for catering and cleaning duties were separated and supervised by the new Housekeeper.

I worked alongside Governor Martin Perry and two patient representatives on a survey of patients to find out what they thought about the changes to inform the pilot evaluation. The ward redesign has reaffirmed the whole ward team is managed by the Matron with duties re-allocated to support service staff so that nurses spend more time for direct patient care. It was a privilege to have been involved, and the project's positive results persuaded the Strategic Redesign Board to roll out the model across the Trust.”



Kate



Martin



Keith

## 5. Our Governors and Members

### Elections results

The following Governors were elected at the annual elections in June 2011:

#### Public Governors

##### East Devon, Dorset & Somerset

Jill Gladstone re-elected. Vivian Dibling elected. The turnout was 44.2%.

##### Exeter and South Devon

Keith Broderick re-elected. Rachel Jackson and Terry Roberts elected. The turnout was 39%.

##### Mid, North West Devon & Cornwall

Cynthia Thornton re-elected unopposed. Andrew Green elected unopposed (Andrew chose not to take up his seat for health reasons).

#### Staff Governors

##### Allied Health Professionals

Tony Cox re-elected unopposed.

##### Nurses and Midwives

Alison Wootton elected unopposed.

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](mailto:rde-tr.foundationtrust@nhs.net)

The Governors' Register of Interests is available for inspection from the FT Secretary (01392 402993) or on the Trust website.

## Council of Governors 2011-12

### East Devon, Dorset & Somerset

#### Vivien Dibling (Sep 2014)

Vivien lives in Axminster. She trained as a nurse and has also worked as a medical secretary and care assistant. Vivien was elected for a three year term in 2011.

#### Jill Gladstone (Sep 2014)

Jill enjoyed a nursing career mainly in acute and emergency medicine. She has an MSc in healthcare and has published research into drug administration errors. More recently she established the team that supports clinical audit in the district hospital. Prior to retirement she worked as a nursing adviser to the Health Service Ombudsman and was a member of the local Research Ethics Committee. Jill was re-elected for a second term in 2011.

#### Peter Hull (Sep 2013)

Peter qualified as a Master Mariner and spent most of his working life in the Shipping Industry. After extensive treatment at the RD&E, Peter is keen to support the Trust and help it maintain its reputation as a place of excellence, and indeed one of the best hospitals in the country.

#### Andrew Kyle (Sep 2013)

Andrew lives in Exmouth and is a retired teacher. During his career he was involved in teacher education and one of his responsibilities was helping NHS staff improve their teaching skills. He has long-standing family connections with the NHS and is committed to community involvement in decision making. He has a special interest in communication.

#### Nicholas Morse (Sep 2013)

Nicholas lives on the edge of Exmoor near Dulverton and is retired from a 40 year career in communications, advertising and marketing, working on many well known accounts at London West End advertising agencies and in the media with the Guardian Newspaper and House & Garden.

#### Linda Vijeh (Sep 2012) #

Linda has lived and worked in South Somerset for over 20 years. She has extensive experience in the media and hospitality industries both in the public and private sectors, with a particular emphasis on customer service, and social responsibility within the licensing trade. Linda also holds a number of positions within the voluntary sector, including her role as District Councillor, Publicity Officer for Samaritans, Ilminster Town Councillor and Chairman of Somerset Schools Forum, Governor of two local schools and Trustee for the local museum, with responsibility for fund raising.

#### Lynne Wright (Sep 2013)

Lynne trained as a secretary. After working at executive level within industry, for barristers and senior partners in legal firms she moved into office management and financial control, and has over thirty years commercial experience. She was a long term member and secretary of the League of Friends of a South Warwickshire cottage hospital, and is now retired and living in Budleigh Salterton. She is on the Board of Trustees of a Warwickshire charity.

# indicates membership of Nominations Committee

\* indicates membership of NED Remuneration Committee

## 5. Our Governors and Members

### Exeter & South Devon

#### **Keith Broderick (Sep 2014)**

Keith is an accountant who took early retirement from the public sector in 2005. Keith lives in Exeter and is Committee Chairman for the City of Exeter Division of St John Ambulance. Keith was re-elected in 2011.

#### **Janice Cackett (Sep 2013)**

Janice worked in the Health Service for 35 years, as a ward Sister and then in nurse education. She moved to Devon in 1988 to amalgamate three Schools of Nursing, retiring in 1993. Janice was ordained a Deacon in the Church of England in 1999 and a Priest in 2000. She was appointed part time Priest in Charge of the Parishes of East Budleigh and Otterton in 2003 and retired from this position in 2010. She lives in Topsham.

#### **Kate Caldwell OBE (Sep 2013) # \***

Kate was Director of Midwifery and Deputy Director of Nursing at the RD&E until 2002. She was a Non-Executive Director of Exeter PCT until 2006 and was Treasurer of the Royal College of Midwives. She is Chairman of Exeter Municipal Charities.

#### **Rachel Jackson (Sep 2014)**

Rachel was an NHS clinical physiotherapist for 42 years and managed a large

physiotherapy service. Previously a Governor for six years, Rachel was elected again in 2011 after a year's break.

#### **Richard May (Sep 2012) # \***

Richard, who lives in Exeter, is a chartered civil engineer and latterly ran a waste management company providing a range of services within Exeter and the surrounding areas. Richard is the Lead Governor on the Council of Governors.

#### **Terry Roberts (Sept 2013)**

Terry is a retired Police Chief Inspector who lives in Exeter. He has been involved in working with Social Services, his local Alzheimer's Society and with the Peninsula College of Medicine and Dentistry's doctor selection panel. Terry was previously a Governor between 2006-07 and was elected again in 2011.

## Mid North West Devon & Cornwall

### David Giles (Sep 2013)

Following spells in the Royal Navy and in hospitals in the South East, David was a GP for 30 years in North Cornwall. With a keen interest in healthcare quality, David was Chairman of the Healthcare Accreditation Programme for three years. David lives in Bude.

### Martin Perry CBE (Sep 2012) #

Martin is a political consultant living in Northlew, outside Okehampton. He is widowed with three children, Chairman of the Friends of Okehampton Hospital, Treasurer of St Boniface RC Church, and was awarded the CBE in 1994.

### Dianah Pritchett-Farrell (Sep 2013)

Dianah is a retired University Lecturer, Examiner, Quality Standards Assessor in social care and Senior Probation Officer, with a research background in doctor-patient communication, criminal justice, child protection and mental health. She is currently an International Assessor for the Social Care Council. Dianah was elected Chairman of the Foundation Trust Governors Association in August 2011.

### Cynthia Thornton (Sep 2014) \*

Cynthia lives in Willand. She has had wide nursing experience, including ten years as a district nursing sister. She has a PGCEA and a MSc. in Care, Policy and Management and held University teaching and research posts in London and Reading. Published work focused upon Primary Health Care for People with Learning Disabilities and Innovation and Change in Healthcare Practice.

## Staff Governors

### Tony Cox, Allied Health Professional (Sep 2014)

Tony joined the Trust in 1992 as Head of Physiotherapy. His current role is as

Directorate Manager for Professional Services and Diagnostics.

### Mike Jeffreys, Medical and Dental (Sep 2012) #

Mike is Lead Clinician for Elderly Care Medicine and has been a Consultant

Physician in Exeter since 1994. During this time he was a member of the Executive Committee of the Exeter Primary Care Trust. Previous medical training was carried out at Guy's Hospital London, Western Australia, Southampton, Manchester and Cardiff.

### Alison Wootton, Nursing and Midwifery (Sep 2014)

Alison is Senior Matron in Respiratory Medicine at the RD&E, with 25 years of nursing experience behind her.

### Loveday Varian, Admin, Clerical & Managers (Sep 2012)

Loveday has worked for the NHS as a hospital-based medical secretary for the past thirty years. She joined the RD&E over five years ago and is a medical secretary within the Renal team.

# indicates membership of Nominations Committee

\* indicates membership of NED Remuneration Committee

## 5. Our Governors and Members

### Appointed Governors

The following people have been appointed by the organisations listed to serve as governors:

**Mrs Rebecca Harriott**, NHS Devon (Primary Care Trust) (Jul 2013)

**Professor Mark Overton**, Peninsula School of Medicine & Dentistry # (Apr 2014)

**Cllr Andrew Leadbetter**, Devon County Council (Jan 2015)

# indicates membership of Nominations Committee

\* indicates membership of NED Remuneration Committee

#### Nominations Committee attendance

| Name          | 22.7.11 | 2.8.11 | 5.9.11 | 21.9.11 | 12.10.11 | 9.11.11 | 22.2.12 |
|---------------|---------|--------|--------|---------|----------|---------|---------|
| Mike Jeffreys | Y       | Y      | Y      | Y       | Y        | Y       | Y       |
| Kate Caldwell | Y       | Y      | Y      | Y       | Y        | Y       | Y       |
| Linda Vijeh   | Y       | Y      | Y      | Y       | Y        | Y       | Y       |
| Martin Perry  | Y       | Y      | Y      | Y       | Y        | Y       | Y       |
| Richard May   | Y       | Y      | Y      | Y       | Y        | Y       | Y       |
| Mark Overton  | A       | Y      | Y      | Y       | Y        | Y       | Y       |

The following people were also members of the Council of Governors during 2011/12:

#### Public constituency area: East Devon, Dorset & Somerset

Christopher D'Oyly (until Sep 11) 0/2

#### Public constituency area: Exeter & South Devon

Ed Pitman (until Dec 11) 3/3

#### Staff Governors

Monica Overy, Nurses & Midwives (until Sept 11) 0/2

#### Appointed Governors

Stuart Barker, Devon County Council (until Aug 11) 1/2

John Gill, North Devon District Council (until Jul 11) 0/2

Alan Griffiths, Mid Devon District Council (until Jul 11) 1/1

Peter Halse, East Devon District Council (until Jul 11) 0/2

Norman Shiel, Exeter City Council (until Jul 11) 0/2

(n/n) indicates the number of Governor meetings attended in year (e.g. 3/4 means 3 out of 4 meetings attended)

## 5. Our Governors and Members

| Governors' attendance<br>April 11 onwards for<br>Governors currently in post | Council of Governors |        |        |        |     |        |        |        |        |  |
|--|----------------------|--------|--------|--------|-----|--------|--------|--------|--------|--|
|  | Apr-11               |        | Jul-11 |        | AMM | Oct-11 |        | Jan-12 |        |  |
|  | Part 1               | Part 2 | Part 1 | Part 2 |     | Part 1 | Part 2 | Part 1 | Part 2 |  |
| Mr Keith Broderick   | Y                    | Y      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Miss Janice Cackett  | Y                    | Y      | Y      | Y      | A   | A      | A      | Y      | Y      |  |
| Ms Kate Caldwell   | Y                    | A      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mr Tony Cox  | Y                    | Y      | A      | A      | A   | Y      | A      | Y      | Y      |  |
| Mrs Vivien Dibling   |                      |        |        |        | A   | A      | A      | Y      | Y      |  |
| Dr David Giles   | Y                    | Y      | Y      | Y      | A   | A      | A      | Y      | Y      |  |
| Mrs Jill Gladstone   | Y                    | Y      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Rebecca Harriott   | A                    | A      | A      | A      | A   | A      | A      | A      | A      |  |
| Mr Peter Hull  | Y                    | Y      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Rachel Jackson   |                      |        |        |        | Y   | Y      | Y      | Y      | Y      |  |
| Dr Mike Jeffreys   | Y                    | A      | Y      | A      | A   | DNA    | DNA    | Y      | Y      |  |
| Mr Andrew Kyle   | Y                    | Y      | Y      | Y      | A   | A      | A      | Y      | Y      |  |
| Cllr Andrew Leadbetter   |                      |        |        |        |     |        |        | Y      | Y      |  |
| Mr Richard May   | Y                    | Y      | Y      | Y      | A   | Y      | Y      | Y      | Y      |  |
| Mr Nicholas Morse  | Y                    | A      | Y      | Y      | A   | A      | A      | Y      | Y      |  |
| Professor Mark Overton   | A                    | A      | A      | A      | A   | A      | A      | Y      | Y      |  |
| Mr Martin Perry  | Y                    | Y      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Dianah Pritchett-Farrell   | Y                    | Y      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mr Terry Roberts   |                      |        |        |        | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Cynthia Thornton   | Y                    | A      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Loveday Varian   | Y                    | Y      | Y      | Y      | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Linda Vijeh  | Y                    | Y      | A      | A      | A   | Y      | Y      | Y      | Y      |  |
| Mrs Alison Wootton   |                      |        |        |        | Y   | Y      | Y      | Y      | Y      |  |
| Mrs Lynne Wright   | Y                    | Y      | A      | A      | A   | A      | A      | A      | A      |  |

Members wishing to contact Governors should email the Trust:  
[Rde-tr.foundationtrust@nhs.net](mailto:Rde-tr.foundationtrust@nhs.net) or telephone 01392 403977

## 5. Our Governors and Members

### Membership Overview

Our membership now stands at 18,300, made up of 12,811 public Members and 5,489 staff Members.

Anyone aged 12 or over who lives in the area we service, or who works for the Trust on a permanent contract or one of 12 months or more, has the right to become a Member of the Trust.

**The three public constituencies, with membership numbers as at 31 March 2012, are:**

East Devon, Dorset & Somerset - 4,953  
Exeter & South Devon - 4,605  
Mid, North, West Devon & Cornwall - 3,253

The boundaries of the Trust's public membership include Cornwall, Devon, Somerset and Dorset.

### The Apprentice: Work Experience Week

Students from a number of local schools took part in the RD&E's Work Experience week in July this year. As part of the week's activities, students took part in an Apprentice-style exercise where they were set a group task of marketing the RD&E to 12-16 year olds through creating a brand and designing a poster. The groups then pitched their ideas to a panel of RD&E staff and each other.

The enthusiasm and creativity of the students involved was exemplary and the ideas generated in these sessions were used to develop a poster inspired by their ideas to advertise membership of the RD&E Foundation Trust to schools and young people. This promotional material was a direct result of the material gathered in work experience week and is testament to how much the students' contributions and their creativity were valued.

Over the next year, the RD&E is keen to get more young people involved in membership in order to be fully representative of the local community. Membership would be particularly beneficial to any young people considering a future career in the NHS as it offers them an extra insight into their local hospital and the issues affecting healthcare.

## Members' Say

We continued with our highly successful Members' Say events during the year, hosting nearly 400 members at day-long interactive events. Members who came along to our events were able to hear talks on a range of issues such as stroke care, diabetes, dermatology and dementia; browse the stalls covering a variety of different issues such as infection control, nutrition, child and women's health and respiratory problems; and take part in a number of different activities designed to give members a chance to have their say. The events were also attended by a number of the Trust's Governors and Directors. In October, we brought together our Members' Say event and the Trust's Annual Members' Meeting which enabled a larger number of Members to attend than in previous years.

Feedback from the events was very positive - nine out of ten people who filled in the evaluation form felt the event was worthwhile.

**“Thank you all for putting together such a very interesting and informative day”**

**“Keep up the good work in difficult times!”**

### Members' Say activities

#### Environment

- Members were asked to estimate how far you could travel in a Ford Mondeo to emit the level of carbon dioxide equivalent to the average carbon cost of an inpatient in hospital.

Various answers were given ranging from 25 miles to 25,000 miles with the average of 5,100 miles.

**The actual answer is: 1,200 miles or the equivalent of travelling by car between Exeter and London and back again three times.**

- Members were also asked to say which country has the same carbon emissions as the whole of the NHS.

**The answer is Portugal - both produce around 21 million tonnes of CO2 annually.**

- Members were asked how many miles the Trust's fleet of laundry trucks travels every year.

Answers ranged from 5,200 miles to 1,500,000 miles with the average of 386,000 miles.

**The actual answer is: 216,000 miles a year.**

The NHS accounts for 25% of public sector emissions in the UK. So reducing the NHS's carbon footprint will make a big dent in the UK's carbon footprint. The RD&E along with the rest of the NHS is committed to reducing its carbon footprint. The Trust aims to meet the NHS target of reducing its 2007 carbon emissions by 10% by 2015.

### Smoking

Members were asked their views about possible changes to our smoking policy. By and large those who responded preferred the idea of establishing smoking shelters although this was closely followed by providing additional support for helping people give up smoking.

These views have been taken into account in the revision of our smoking policy.

### Hospital gowns

We asked Members for their views on the gowns that the Trust provides for patients who are often admitted as emergencies and without their own nightwear or suitable clothing. Often the nightgown provided by the Trust does not get returned and it costs the local NHS £30,000 a year to replace them. As the Trust is considering replacing the current cloth nightgown with a disposable alternative, we asked the members for their views. Of the Members who gave us their views, 60% selected the disposable alternative telling us that they understood the need to make some financial savings whilst still providing a gown that protected a patient's dignity.

## 5. Our Governors and Members

### Travelling to Members' Say

We want to make sure our events are accessible to as many of our Members as possible. So we asked them to let us know how far they had travelled to get to the event and how they had travelled. As well as several Exeter-based Members, people travelled from Paignton, South Molton and Wilmington amongst others. A majority (77%) of those who answered travelled to the event by car.

### Medicine for Members

Our Members' Say events always include lectures from our Medicine for Members series. We asked our Members for topics they would be interested in. These included: the Emergency Department, radiotherapy, neurology and infection control. We will be looking at all the suggestions made and we hope to build as many as possible into our Medicine for Members series.

### Priorities

Members were asked to identify their priorities by spending fake money. The priorities identified in March were:

| Priority  | How much?     | % of total money spent |
|---|---------------|------------------------|
| Time spent whilst waiting at the hospital                           | £490          | 10                     |
| Cleanliness of the hospital   | £970          | 20                     |
| Time between being referred by GP and being seen by hospital doctor | £1,010        | 21                     |
| Reducing hospital infections  | £1,070        | 22                     |
| Being treated with respect  | £650          | 13                     |
| Being informed  | £730          | 15                     |
| <b>Total spent</b>  | <b>£4,920</b> |                        |

In October the priorities were:

| Priority  | How much?     | % of total money spent |
|---|---------------|------------------------|
| Time spent whilst waiting at the hospital                           | £280          | 12                     |
| Cleanliness of the hospital   | £400          | 18                     |
| Time between being referred by GP and being seen by hospital doctor | £530          | 24                     |
| Reducing hospital infections  | £350          | 16                     |
| Being treated with respect  | £280          | 12                     |
| Being informed  | £410          | 18                     |
| <b>Total spent</b>  | <b>£2,250</b> |                        |

## Focus groups

In March, the Focus Groups looked at issues of patient choice, patient experience and the RD&E brand. The groups considered what information was available to underpin choice, the role of the GP, the differences between private and public healthcare providers, what more could be done to improve patient experience from referral through to discharge, and some of the specific issues people faced as patients in navigating their way through the NHS system and bureaucracy.

These Focus Groups helped the Board and Governors consider what changes might be made to the Trust's strategy and plans to make sure it is offering the very best healthcare in a way that strives hard to meet patient expectations.

The Focus Groups also looked at the RD&E brand. The Board was keen to understand what our members think about the Trust and the extent to which they recognise and value our brand. The majority view compared the RD&E to Waitrose or M&S with one particular attendee suggesting the Trust was most like British Rail.

In October the Focus Groups helped provide evidence for the Trust's review of our Outpatients Departments. 11 Focus Groups were held to give members the chance to have their say about what are the key elements of a good Outpatient experience. The feedback from the Focus Groups, together with the results of other patient surveys will be used as a central part of our planning for Outpatients in the future.

Members were generally very positive about the service they receive at the RD&E and many of their ideas about what a good service for the future would look like were based on the best aspects of what we do currently. Members ideas of what a good Outpatients service would look like included:

- ✓ Being treated as an individual with respect and courtesy
- ✓ Consistency of care to develop positive relationship with staff
- ✓ Timely and accurate information
- ✓ Use of technology, for example emails, texts and phones, for reminders to maximise attendance
- ✓ Coordinated appointments where possible to avoid multiple journeys
- ✓ Use of the Hospital Volunteers to provide help and guidance
- ✓ Being kept informed of any delays in a consistent manner across all outpatients departments.

### Business review/management commentary

2011/12 has been another busy but successful year for the Trust, both financially and operationally. At the start of the year, the Trust agreed QIPP (Quality, Innovation, Productivity and Prevention) plans with its Commissioners, NHS Devon. We aim to work together in partnership with the intention of increasing the numbers of patients treated close to home. The expected impact of these plans during 2011/12 and in future years is to stabilise the number of patients being treated in the acute hospital setting.

Although the plans did deliver some benefits, particularly around the number of elective patients referred by GPs to the hospital, the Trust experienced a higher level of complex elderly patients during the winter months. This affected the number of beds available to admit patients scheduled for elective treatment. As a result, the Trust has a small backlog of patients to treat in order to maintain its Referral to Treatment (RTT) target of 18 weeks. The Trust has developed robust plans to address this backlog but, during the first two quarters of 2012/13, whilst additional patients are treated, there will be a deterioration of the Trust's RTT performance.

Despite these pressures the Trust has continued to perform well; operationally all targets have been achieved with the exception of Referral to Treatment as highlighted above, the A&E target of treating/admitting or discharging all patients within 4 hours (this was also breached in Qtr 3). In addition, against national targets, the Trust is reported as being higher than expected in relation to *C. Difficile* testing.

However, this is because the Trust has adopted, earlier than most other hospitals, a more sensitive form of testing. The decision to do this, even though it would appear to impact upon the Trust's reported performance, was taken by the Board of Directors, as it was considered to be in the best interests of patient care. Going forward, the Trust's performance against this target will improve, as monitoring of performance will accommodate the more sensitive testing. Overall the Trust achieved its planned Governance rating (assessed by the regulator monitor) of Amber-Red.

During the year, the Trust achieved a surplus of £3m, against a plan of £3.5m. This surplus, together with performance against other financial indicators, ensured the Trust achieved a financial risk rating (FRR) of 3 against Monitor's compliance framework. This benchmarks comparatively with other hospitals licensed as Foundation Trusts (FTs).

As at the end of Qtr 3, 2011/12, approximately 50% of FTs were rated at an FRR of 3. The Trust's Earnings Before Interest, Tax, Depreciation and Amortisation (EBITDA) margin for 2011/12 was 6.6%. Again this benchmarks favourably against other FTs who in aggregate at Qtr 3 had an EBITDA margin of 6.1%.

The Trust is required to achieve a surplus, not only to meet its financial duties against its Terms of Authorisation but also importantly in order to fund the Trust's capital programme to provide new and replacement buildings and equipment.

To achieve these financial results, the Trust met its plan to generate approximately £17m of increased productivity and cost improvements during the year. Looking forward to 2012/13, the Trust is currently planning to achieve a similar level of savings and increased productivity.

During 2011/12, the Trust invested approximately £14m in building schemes and equipment and over the next three years it plans to invest a further approximately £51.5m to maintain and improve the patient environment. Key schemes undertaken during 2011/12, including the re-provision of the Trust's Aseptic Facilities (for drugs manufacture) and the implementation of an order communications and e-prescribing system.

Given significant changes, within the environment for NHS hospitals, the Trust is focussed on identifying and managing the risks it faces. The key strategic risks identified for the organisation are detailed on the Board's Assurance Framework and include the risk of not delivering the required level of cost savings; the risk of the Trust not adapting to change effectively; the risk of continued bed pressures (as experienced in 2011/12) and the constraints this places on treatment of all our patients, both elective and emergency; failure to respond flexibly and with sufficient pace to the changes in the external context which leads to the Trust becoming reactive rather than proactive. The Trust will continue to manage these risks and work with others in the local health economy to ensure their impact is minimised.

### Disclosure to Auditors and Further Disclosures

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.

After making enquiries, the Directors have a reasonable expectation that the RD&E has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

Serious Untoward Incidents (SUI) confidentiality breaches: There were no Serious Untoward Incidents relating to data losses or breaches in patient confidentiality during the course of the financial year.

If management wishes to use the services of the Trust's external auditor for any non-audit purposes, we demonstrate why this is appropriate. The Director of Finance and Business Development will provide professional advice on the appropriateness of such an arrangement and the Audit Committee develop, implement policy and review the engagement of the External Auditor to supply non-audit services, taking into account relevant ethical guidance regarding the provision of non-audit services by the external audit firm.

This safeguard is in place to ensure independence. PwC also need to confirm that they would be able to carry out any non-audit work without impacting on their independence.

The Counter Fraud Service for Royal Devon & Exeter NHS Foundation Trust (RDEFT) is provided by Audit South West (ASW) and the Local Counter Fraud Specialist (LCFS) team. LCFS time during 2011/12 was predominantly spent on: promoting an Anti Fraud Culture; intelligence gathering; raising awareness of current fraud scams; giving advice in respect of fraud risks, attempted scams, procedures and policies and potential conflicts of interest; conducting local proactive exercises; and dealing with case referrals. The Trust also participated in the Audit Commission's National Fraud Initiative data matching exercise.

## 7. Our Finances

### **Full Financial Accounts 2011/12 including Accounting officer responsibilities**

**ROYAL DEVON AND EXETER NHS FOUNDATION TRUST**

**ANNUAL ACCOUNTS**

**YEAR ENDED 31 MARCH 2012**

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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 Royal Devon and Exeter NHS Foundation Trust ("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 the Independent Regulator of NHS Foundation Trusts ("Monitor").

Under the 2006 Act, Monitor has directed the 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; 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: 30 May 2012

**Independent Auditors' Report to the Council of Governors of Royal Devon and Exeter NHS Foundation Trust**

We have audited the financial statements of Royal Devon and Exeter NHS Foundation Trust for the year ended 31 March 2012 which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Cash Flows, the Statement of Changes in Taxpayers' Equity and the related notes. The financial reporting framework that has been applied in their preparation is the NHS Foundation Trust Annual Reporting Manual 2011/12 issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

**Respective responsibilities of directors and auditors**

As explained more fully in the Statement of the Chief Executive's responsibilities as the Accounting Officer of Royal Devon and Exeter NHS Foundation Trust set out on page 2 the accounting officer is responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12. Our responsibility is to audit and express an opinion on the financial statements in accordance with the NHS Act 2006, the Audit Code for NHS Foundation Trusts issued by Monitor and International Standards on Auditing (ISAs) (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

This report, including the opinions, has been prepared for and only for the Council of Governors of Royal Devon and Exeter NHS Foundation Trust in accordance with paragraph 24 of Schedule 7 of the National Health Service Act 2006 and for no other purpose. We do not, in giving these opinions, accept or assume responsibility for any other purpose or to any other person to whom this report is shown or into whose hands it may come save where expressly agreed by our prior consent in writing.

The maintenance and integrity of the Royal Devon and Exeter NHS Foundation Trust website is the responsibility of the directors; the work carried out by the auditors does not involve consideration of these matters and, accordingly, the auditors accept no responsibility for any changes that may have occurred to the financial statements since they were initially presented on the website.

Legislation in the United Kingdom governing the preparation and dissemination of financial statements may differ from legislation in other jurisdictions.

**Scope of the audit of the financial statements**

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the NHS Foundation Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the NHS Foundation Trust; and the overall presentation of the financial statements. In addition, we read all the financial and non-financial information in the Annual Report and Accounts to identify material inconsistencies with the audited financial statements. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

**Opinion on financial statements**

In our opinion the financial statements:

- give a true and fair view, in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12, of the state of the NHS Foundation Trust's affairs as at 31 March 2012 and of its income and expenditure and cash flows for the year then ended; and
- have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2011/12.

**Independent Auditors' Report to the Council of Governors of Royal Devon and Exeter NHS Foundation Trust**

**Opinion on other matters prescribed by the Audit Code for NHS Foundation Trusts**

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 2011/12; and
- the information given in the Directors' Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

**Matters on which we are required to report by exception**

We have nothing to report in respect of the following matters where the Audit Code for NHS Foundation Trusts requires us to report to you if:

- in our opinion the Annual Governance Statement does not meet the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2011/12 or is misleading or inconsistent with information of which we are aware from our audit. We are not required to consider, nor have we considered, whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls;
- we have not been able to satisfy ourselves that the NHS Foundation Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources; or
- we have qualified our report on any aspects of the Quality Report.

**Certificate**

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

*Heather Ancient*

Heather Ancient (Senior Statutory Auditor)  
For and on behalf of PricewaterhouseCoopers LLP  
Chartered Accountants and Statutory Auditors  
Plymouth

30 May 2012

**FOREWORD TO THE ACCOUNTS**

These accounts for the year ended 31 March 2012 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: 30 May 2012

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED  
31 MARCH 2012

|  | Note | 2011/12<br>£000 | 2010/11<br>£000<br>(restated) |
|--|------|-----------------|-------------------------------|
| Income from activities                                     | 3    | 287,244         | 288,333                       |
| Other operating income                                     | 4    | 63,350          | 62,008                        |
| <b>Operating income</b>                                    |      | <b>350,594</b>  | 350,341                       |
| Operating expenses   | 5    | (339,647)       | (338,741)                     |
| <b>Operating surplus</b>                                   |      | <b>10,947</b>   | 11,600                        |
| <b>Finance costs</b>                                       |      |                 |                               |
| Finance income   | 10   | 279             | 247                           |
| Finance expense  | 11   | (1,018)         | (1,072)                       |
| PDC dividends payable                                      | 14   | (7,178)         | (7,048)                       |
| <b>Net finance costs</b>                                   |      | <b>(7,917)</b>  | (7,873)                       |
| <b>Surplus for the year</b>                                |      | <b>3,030</b>    | 3,727                         |
| <b>Other comprehensive income</b>                          |      |                 |                               |
| Revaluation gains on property, plant and equipment         |      | -               | 15,397                        |
| <b>Total comprehensive income and expense for the year</b> |      | <b>3,030</b>    | 19,124                        |

STATEMENT OF FINANCIAL POSITION AS AT  
31 MARCH 2012

|  | Note | 31 March 2012<br>£000 | 31 March 2011<br>£000<br>(restated) | 01 April 2010<br>£000<br>(restated) |
|--|------|-----------------------|-------------------------------------|-------------------------------------|
| <b>Non-current assets</b>                    |      |                       |                                     |                                     |
| Intangible assets                            | 15   | 1,190                 | 544                                 | 716                                 |
| Property, plant and equipment                | 16   | 240,055               | 238,779                             | 224,225                             |
| Trade and other receivables                  | 18   | 960                   | 966                                 | 838                                 |
| <b>Total non-current assets</b>              |      | <b>242,205</b>        | <b>240,289</b>                      | <b>225,779</b>                      |
| <b>Current assets</b>                        |      |                       |                                     |                                     |
| Inventories                                  | 17   | 4,081                 | 4,592                               | 4,607                               |
| Trade and other receivables                  | 18   | 13,950                | 11,009                              | 13,116                              |
| Cash and cash equivalents                    | 24   | 49,621                | 53,583                              | 41,498                              |
|  |      | <b>67,652</b>         | <b>69,184</b>                       | <b>59,221</b>                       |
| Non-current assets held for sale             | 19   | -                     | -                                   | 6,000                               |
| <b>Total current assets</b>                  |      | <b>67,652</b>         | <b>69,184</b>                       | <b>65,221</b>                       |
| <b>Current liabilities</b>                   |      |                       |                                     |                                     |
| Trade and other payables                     | 20   | (23,456)              | (26,238)                            | (26,271)                            |
| Borrowings                                   | 21   | (1,270)               | (1,270)                             | (1,271)                             |
| Provisions                                   | 22   | (1,392)               | (1,368)                             | (130)                               |
| Other liabilities                            | 20   | (2,835)               | (1,475)                             | (2,110)                             |
| <b>Total current liabilities</b>             |      | <b>(28,953)</b>       | <b>(30,351)</b>                     | <b>(29,782)</b>                     |
| <b>Total assets less current liabilities</b> |      | <b>280,904</b>        | <b>279,122</b>                      | <b>261,218</b>                      |
| <b>Non-current liabilities</b>               |      |                       |                                     |                                     |
| Borrowings                                   | 21   | (18,943)              | (20,213)                            | (21,483)                            |
| Provisions                                   | 22   | (347)                 | (346)                               | (296)                               |
| <b>Total non-current liabilities</b>         |      | <b>(19,290)</b>       | <b>(20,559)</b>                     | <b>(21,779)</b>                     |
| <b>Total assets employed</b>                 |      | <b>261,614</b>        | <b>258,563</b>                      | <b>239,439</b>                      |
| <b>Financed by taxpayers' equity</b>         |      |                       |                                     |                                     |
| Public dividend capital                      |      | 149,736               | 149,715                             | 149,715                             |
| Revaluation reserve                          |      | 58,953                | 60,772                              | 50,272                              |
| Income and expenditure reserve               |      | 52,925                | 48,076                              | 39,452                              |
| <b>Total taxpayers' equity</b>               |      | <b>261,614</b>        | <b>258,563</b>                      | <b>239,439</b>                      |

The notes on pages 10 to 32 form part of these accounts.

The Annual Accounts were formally approved by the Board of Directors and were signed on its behalf by:



Angela Pedder - Chief Executive

Date: 30 May 2012

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2012

|   | Public dividend<br>capital<br>£000 | Revaluation<br>reserve<br>£000 | Income and<br>expenditure<br>reserve<br>£000 | Total<br>£000  |
|---|------------------------------------|--------------------------------|--|----------------|
| <b>Taxpayers' equity at 1 April 2010 (restated)</b>   | 149,715                            | 50,272                         | 39,452                                       | <b>239,439</b> |
| Surplus for the year  | -                                  | -                              | 3,727  | <b>3,727</b>   |
| Revaluation property, plant and equipment   | -                                  | 15,397                         | -  | <b>15,397</b>  |
| Impairments property, plant and equipment   | -                                  | (1,171)                        | 1,171  | -              |
| Transfers to the income and expenditure account in respect of assets disposed of  | -                                  | (2,132)                        | 2,132  | -              |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve | -                                  | (1,594)                        | 1,594  | -              |
| <b>Taxpayers' equity at 31 March and 1 April 2011</b>   | <b>149,715</b>                     | <b>60,772</b>                  | <b>48,076</b>                                | <b>258,563</b> |
| Surplus for the year  | -                                  | -                              | 3,030  | <b>3,030</b>   |
| Transfers to the income and expenditure account in respect of assets disposed of  | -                                  | (15)                           | 15   | -              |
| Public Dividend Capital received  | 21                                 | -                              | -  | <b>21</b>      |
| Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve | -                                  | (1,804)                        | 1,804  | -              |
| <b>Taxpayers' equity at 31 March 2012</b>   | <b>149,736</b>                     | <b>58,953</b>                  | <b>52,925</b>                                | <b>261,614</b> |

**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 2012

|   | Note | 2011/12<br>£000 | 2010/11<br>£000<br>(restated) |
|---|------|-----------------|-------------------------------|
| <b>Cash flows from operating activities</b>               |      |                 |                               |
| Operating surplus   |      | 10,947          | 11,600                        |
| <b>Non-cash income and expense</b>                        |      |                 |                               |
| Depreciation and amortisation                             |      | 12,015          | 10,499                        |
| Impairments   |      | -               | 2,806                         |
| (Increase) / decrease in trade and other receivables      |      | (2,921)         | 1,695                         |
| Decrease in inventories                                   |      | 511             | 15                            |
| Decrease in trade and other payables                      |      | (1,510)         | (1,088)                       |
| Increase / (decrease) in other liabilities                |      | 1,360           | (635)                         |
| Increase in provisions                                    |      | 25              | 1,288                         |
| (Decrease) / increase in tax liability payable            |      | (704)           | 1,035                         |
| Other movements in operating cash flows                   |      | 103             | 35                            |
| <b>Net cash generated from operations</b>                 |      | <b>19,826</b>   | <b>27,250</b>                 |
| <b>Cash flows from investing activities</b>               |      |                 |                               |
| Interest received   |      | 279             | 247                           |
| Purchase of intangible assets                             |      | (888)           | (95)                          |
| Purchase of property, plant and equipment                 |      | (13,472)        | (12,553)                      |
| Sale of property, plant and equipment                     |      | 14              | 6,081                         |
| <b>Net cash used in investing activities</b>              |      | <b>(14,067)</b> | <b>(6,320)</b>                |
| <b>Cash flows from financing activities</b>               |      |                 |                               |
| PDC received  |      | 21              | -                             |
| Loans repaid  |      | (1,270)         | (1,271)                       |
| Interest paid   |      | (1,018)         | (1,072)                       |
| PDC dividend paid   |      | (7,454)         | (6,502)                       |
| <b>Net cash used in financing activities</b>              |      | <b>(9,721)</b>  | <b>(8,845)</b>                |
| <b>(Decrease) / increase in cash and cash equivalents</b> |      | <b>(3,962)</b>  | <b>12,085</b>                 |
| Cash and cash equivalents at 1 April                      |      | 53,583          | 41,498                        |
| <b>Cash and cash equivalents at 31 March</b>              | 24   | <b>49,621</b>   | <b>53,583</b>                 |

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

Monitor has directed that the financial statements 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 financial statements have been prepared in accordance with the 2011/12 NHS Foundation Trust Annual Reporting Manual issued by Monitor. The accounting policies contained in that manual follow International Financial Reporting Standards (IFRS), EU endorsed, 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.

The financial statements have been prepared under the historical cost convention modified to account for the revaluation of non current assets at their value to the business by reference to their fair value.

The directors have a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they continue to adopt the going concern basis in preparing the accounts.

1.1 Change of accounting policy

HM Treasury has introduced a new accounting approach for donated assets and has also changed its interpretation of IAS 20 to align the accounting for government grants and grant funded assets with the new basis of accounting for donations and donated assets.

The change means that donated and government granted assets are no longer recognised in the donated asset reserve / deferred income with an amount equal to the depreciation charge being released to the Statement of Comprehensive Income. Instead, the donated / government grant amount is recognised as income to the extent that conditions have been met.

This change in accounting for donated and government grant assets is considered a change in accounting policy under IAS 8: Accounting policies, changes in accounting estimate and errors. The Trust is therefore required to apply this change retrospectively. The effect on the Trust's current and previous statements of financial position and statements of comprehensive income are disclosed below.

Effect of change of accounting policy on total assets employed and taxpayers equity

|  | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--|-----------------------|-----------------------|-----------------------|
| Total assets employed based on previous accounting policy    | 261,491               | 258,395               | 239,210               |
| Decrease in current liabilities                              | 45                    | 45                    | 140                   |
| Decrease in non-current liabilities                          | 78                    | 123                   | 89                    |
| <b>Total assets employed per revised accounting policy</b>   | <b><u>261,614</u></b> | <b><u>258,563</u></b> | <b><u>239,439</u></b> |
| Total taxpayers' equity based on previous accounting policy  | 261,491               | 258,395               | 239,210               |
| Increase in income and expenditure reserve                   | 3,773                 | 4,127                 | 4,461                 |
| Decrease in donated asset reserve                            | (3,370)               | (3,531)               | (3,524)               |
| Decrease in revaluation reserve                              | (280)                 | (428)                 | (708)                 |
| <b>Total taxpayers' equity per revised accounting policy</b> | <b><u>261,614</u></b> | <b><u>258,563</u></b> | <b><u>239,439</u></b> |

Effect of change of accounting policy on statement of comprehensive income

|   | 2011/12<br>£000     | 2010/11<br>£000     |
|---|---------------------|---------------------|
| Surplus for the year based on previous accounting policy            | 3,233               | 4,061               |
| Decrease in release of income from donated asset reserve            | (281)               | (336)               |
| Decrease in release of income from deferred government grant income | (45)                | (61)                |
| Increase in income from donations                                   | 123                 | 63                  |
| <b>Surplus for the year per revised accounting policy</b>           | <b><u>3,030</u></b> | <b><u>3,727</u></b> |

Effect of change of accounting policy on cash and cash equivalents

The change in accounting policy did not alter the cash or cash equivalents position for the Trust.

1.2 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.3 Expenditure

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 they 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 which 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 which 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</u><br><u>(years)</u> |
|-----------------------|--------------------------------------|
| Software licences     | 4 - 7                                |

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<br/>(years)</u> |
|------------------------------------|--------------------------------|
| Freehold property - buildings      | 11 - 43                        |
| Freehold property - dwellings      | 33 - 48                        |
| Plant and machinery                | 5 - 10                         |
| Equipment - transport              | 5 - 7                          |
| Equipment - information technology | 3 - 5                          |
| 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 2.9%, 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 22. 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 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 financial statements 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.

**1.10 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.

**1.11 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 benefits in respect of legal claims is possible the Trust discloses the estimated value as a contingent liability in note 26.

**1.12 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 29, to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

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 the Trust's Wonford site.

**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 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.

**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'.

## NOTES TO THE ACCOUNTS

### 1. ACCOUNTING POLICIES (CONTINUED)

#### 1.16 Financial instruments and financial liabilities (continued)

##### 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.

##### 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 Non-current assets held for sale

Non-current assets are classified as assets held for sale when their carrying amount is to be recovered principally through a sale transaction and a sale is considered highly probable. They are stated at the lower of carrying amount and fair value.

#### 1.19 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 HM Treasury has granted a dispensation to the application of IAS 27 in relation to the consolidation of NHS charitable funds for 2011/12. Further information relating to transactions between the Trust and the Charity is disclosed in note 27.

NOTES TO THE ACCOUNTS

**2. Segmental analysis**

Operating segments are reported in a manner consistent with the internal reporting provided to the chief operating decision maker. The chief operating decision maker, who is responsible for allocating resources and assessing performance of the operating segments, has been identified as the Trust's Board of Directors.

The Trust's income and activities are for the provision of health and health related services within the United Kingdom. The services provided by the Trust are designated between directorates. Details of the services provided within each of the Trust's main clinical directorates are included below. The information is a summary of activity by directorate level, similar information is provided to the Trust's Board of Directors each month.

Segmental information for 2011/12 has been prepared on a different basis to that shown for 2010/11, leading to some significant movements by Directorate. 2011/12 has been prepared using a detailed service line costing system at patient level, whereas 2010/11 was prepared by using a simple system of recharging directorates a fixed charge for direct and indirect costs.

Segmental information by assets and liabilities has not been disclosed as this information is not reported to the chief operating decision maker.

**2.1 Segmental analysis - explanation of the services provided by directorates**

| <b>Directorates</b>               | <b>Examples of services provided within each directorate: -</b>  |
|-----------------------------------|--|
| Medicine (Specialist and General) | Dermatology, diabetes, medical outpatients, renal services, acute medicine, cardiology, elderly care, lymphoedema, neurology, neurophysiology, respiratory medicine, stroke and rehabilitation and emergency department.                                       |
| Critical Care                     | Anaesthetics, day care unit, fracture clinic, intensive therapy unit / high dependency unit, pain services, resuscitation training and theatres.   |
| Orthopaedics                      | Fracture clinic, orthopaedic day surgery, orthopaedic inpatient surgery, orthopaedic outpatients, rheumatology day cases, rheumatology outpatients and trauma inpatient surgery.   |
| Surgery 1                         | Breast surgery, colorectal surgery, general surgery, surgical outpatients, thoracic and upper gastrointestinal surgery, urology and vascular surgery.  |
| Specialist Surgery                | Ophthalmology, oral surgery, orthodontics, orthoptics, otolaryngology and plastic and reconstructive surgery.  |
| Women & Child Health              | Child health, clinical genetics, gynaecology, fertility services, maternity, midwifery, neonatology, obstetrics and paediatrics.   |
| Cancer Services                   | Clinical haematology, oncology and breast care unit.   |
| Diagnostics                       | Blood transfusion, cellular pathology, clinical chemistry, computerised tomography scanning, cytopathology, haematology, histopathology, immunology, infection control, microbiology, magnetic resonance imaging services, mortuary, pathology and ultrasound. |
| Professional Services             | Includes Exeter mobility centre and elements of dietetics, occupational therapy, physiotherapy.  |
| Other                             | Included within the "Other" heading is the Patient Transport Service and other financial adjustments such as non payment for emergency readmissions.   |

## NOTES TO THE ACCOUNTS

## 2. Segmental analysis (continued)

## 2.2 Segmental analysis 2011/12

|                                | Medicine<br>£'000 | Critical Care<br>£'000 | Orthopaedics<br>£'000 | Surgery 1<br>£'000 | Specialist<br>Surgery<br>£'000 | Women &<br>Child Health<br>£'000 | Cancer<br>Services<br>£'000 | Diagnostics<br>£'000 | Professional<br>Services<br>£'000 | Other<br>£'000 | Trust<br>£'000 | Difference<br>£000                | Total<br>£000 |
|--------------------------------|-------------------|------------------------|-----------------------|--------------------|--------------------------------|----------------------------------|-----------------------------|----------------------|-----------------------------------|----------------|----------------|-----------------------------------|---------------|
| Patient Income -PbR            | 64,006            | 1,465                  | 31,911                | 31,070             | 24,957                         | 28,618                           | 6,634                       | 75                   | 2                                 | -              | 188,737        |                                   |               |
| Patient Income - Non PbR       | 27,747            | 7,805                  | 2,204                 | 1,216              | 4,276                          | 14,990                           | 18,199                      | 9,057                | 10,995                            | 1,202          | 97,690         |                                   |               |
| Total Clinical Income          | <b>91,753</b>     | <b>9,270</b>           | <b>34,115</b>         | <b>32,286</b>      | <b>29,233</b>                  | <b>43,608</b>                    | <b>24,832</b>               | <b>9,132</b>         | <b>10,996</b>                     | <b>1,202</b>   | <b>286,426</b> | Note 1                            | 818           |
| Admin Secretarial Support      | 2,827             | 79                     | 1,012                 | 1,280              | 916                            | 1,725                            | 640                         | -                    | -                                 | -              | 8,479          |                                   |               |
| Anaesthetics                   | 216               | -                      | 1,915                 | 2,078              | 1,783                          | 1,103                            | 18                          | -                    | -                                 | -              | 7,112          |                                   |               |
| Devices                        | 4,620             | 471                    | 3,402                 | 287                | 467                            | 123                              | -                           | -                    | -                                 | -              | 9,370          |                                   |               |
| Other Departments              | 4,859             | 447                    | 954                   | 783                | 1,285                          | 5,378                            | 918                         | 426                  | 773                               | 814            | 16,638         |                                   |               |
| Diabetes services              | 1,110             | -                      | -                     | -                  | -                              | -                                | -                           | -                    | -                                 | -              | 1,110          |                                   |               |
| Dialysis                       | 5,984             | 5                      | -                     | -                  | -                              | -                                | -                           | -                    | -                                 | -              | 5,989          |                                   |               |
| Medical Staffing               | 14,123            | 1,216                  | 4,777                 | 4,896              | 6,514                          | 8,504                            | 2,471                       | -                    | -                                 | -              | 42,500         |                                   |               |
| Mobility Centre                | -                 | -                      | -                     | -                  | -                              | -                                | -                           | -                    | 8,032                             | -              | 8,032          |                                   |               |
| Nuclear Medicine               | 107               | 1                      | 55                    | 290                | 56                             | 31                               | 174                         | 24                   | 38                                | -              | 776            |                                   |               |
| Oncology Centre                | -                 | -                      | -                     | -                  | -                              | -                                | 2,978                       | -                    | -                                 | -              | 2,978          |                                   |               |
| Professions Allied to Medicine | 2,764             | 175                    | 617                   | 695                | 437                            | 351                              | 129                         | -                    | 1,459                             | -              | 6,628          |                                   |               |
| Pathology                      | 3,513             | 376                    | 474                   | 1,761              | 507                            | 1,841                            | 1,967                       | 6,293                | 33                                | -              | 16,765         |                                   |               |
| Pharmacy                       | 7,233             | 464                    | 1,856                 | 1,232              | 3,293                          | 909                              | 8,358                       | 2                    | 239                               | -              | 23,584         |                                   |               |
| Radiology                      | 4,529             | 266                    | 947                   | 1,652              | 744                            | 551                              | 1,392                       | 511                  | 229                               | -              | 10,821         |                                   |               |
| Health Records                 | 688               | 24                     | 764                   | 181                | 311                            | 264                              | 178                         | -                    | 101                               | -              | 2,509          |                                   |               |
| R.T. Physics                   | -                 | -                      | -                     | -                  | -                              | -                                | 1,278                       | -                    | -                                 | -              | 1,278          |                                   |               |
| Theatres                       | 5,932             | 478                    | 9,258                 | 8,186              | 7,376                          | 3,070                            | 183                         | -                    | -                                 | -              | 34,483         |                                   |               |
| Wards / Nursing                | 36,108            | 4,179                  | 6,127                 | 9,904              | 5,277                          | 18,940                           | 3,804                       | 6                    | -                                 | -              | 84,344         |                                   |               |
| Total Expense                  | <b>94,614</b>     | <b>8,178</b>           | <b>32,158</b>         | <b>33,223</b>      | <b>28,965</b>                  | <b>42,791</b>                    | <b>24,488</b>               | <b>7,262</b>         | <b>10,903</b>                     | <b>814</b>     | <b>283,396</b> | Note 2                            |               |
| Surplus / (Deficit)            | <b>(2,861)</b>    | <b>1,091</b>           | <b>1,957</b>          | <b>(937)</b>       | <b>268</b>                     | <b>817</b>                       | <b>345</b>                  | <b>1,870</b>         | <b>93</b>                         | <b>387</b>     | <b>3,030</b>   | Agrees to surplus reported in the |               |
| Margin %                       | (3%)              | 12%                    | 6%                    | (3%)               | 1%                             | 2%                               | 1%                          | 20%                  | 1%                                | 32%            | 1%             | Statement of Comprehensive Income |               |

## Notes:

1 - Total clinical income recorded in the Accounts is £817,000 higher than the value reported on the Service Line Report (SLR), the difference relates to road traffic accident income netted against expenditure reported in the SLR.

2 - Expenditure reported in the Service Line Report document nets other operating income and RTA income against expenditure.

## NOTES TO THE ACCOUNTS

## 2. Segmental analysis (continued)

## 2.3 Segmental analysis 2010/11

|  | Cancer           | Critical Care | Diagnostics    | Medicine       | Orthopaedics  | Professional     | Specialist      | Surgery 1     | Women and Children's | Other         | Total          | Reconciliation to figures reported on the Statement of Comprehensive Income see explanation below |                |
|--|------------------|---------------|----------------|----------------|---------------|------------------|-----------------|---------------|----------------------|---------------|----------------|---|----------------|
|  | Services<br>£000 | £000          | £000           | £000           | £000          | Services<br>£000 | Surgery<br>£000 | £000          | Health<br>£000       | £000          | £000           | £000  | £000           |
| Patient income                               | 25,062           | 9,444         | 10,116         | 89,441         | 35,927        | 11,091           | 28,444          | 30,944        | 43,653               | 3,164         | <b>287,286</b> |   |                |
| Road traffic accident income                 | -                | -             | -              | -              | -             | 16               | 12              | -             | -                    | 1,017         | <b>1,045</b>   |   |                |
| Education income                             | 457              | 1,032         | 650            | 3,886          | 650           | 230              | 900             | 1,129         | 1,529                | 3,769         | <b>14,232</b>  |   |                |
| Research & development income                | -                | -             | -              | -              | -             | -                | -               | -             | -                    | 13,071        | <b>13,071</b>  |   |                |
| Commercial income                            | 1,739            | 465           | 3,597          | 2,372          | 442           | 2,632            | 714             | 409           | 2,693                | 19,972        | <b>35,035</b>  |   |                |
| <b>Total operating income</b>                | <b>27,258</b>    | <b>10,941</b> | <b>14,363</b>  | <b>95,699</b>  | <b>37,019</b> | <b>13,969</b>    | <b>30,070</b>   | <b>32,482</b> | <b>47,875</b>        | <b>40,993</b> | <b>350,669</b> | <b>(328)</b>  | <b>350,341</b> |
| Pay  | 8,786            | 20,656        | 16,605         | 46,400         | 12,479        | 12,001           | 12,161          | 11,249        | 26,773               | 36,310        | <b>203,420</b> |   |                |
| Drugs  | 7,571            | 976           | 3,019          | 7,187          | 2,575         | 2,232            | 2,389           | 696           | 1,061                | 72            | <b>27,778</b>  |   |                |
| Clinical supplies                            | 612              | 5,618         | 6,948          | 8,535          | 6,235         | 7,993            | 1,331           | 787           | 1,587                | 607           | <b>40,253</b>  |   |                |
| Non-clinical supplies                        | 36               | 401           | 34             | 388            | 188           | 48               | 74              | 55            | 166                  | 3,043         | <b>4,433</b>   |   |                |
| Research & development expenditure           | -                | -             | -              | -              | -             | -                | -               | -             | -                    | 13,009        | <b>13,009</b>  |   |                |
| Other non-pay                                | 233              | 1,221         | 1,072          | 1,684          | 262           | 898              | 438             | 164           | 2,919                | 27,612        | <b>36,503</b>  |   |                |
| Depreciation and amortisation*               | -                | -             | -              | -              | -             | -                | -               | -             | -                    | 10,499        | <b>10,499</b>  |   |                |
| Net recharges between directorates           | 10,662           | (19,472)      | (11,510)       | 32,825         | 15,336        | (7,916)          | 13,906          | 18,203        | 16,233               | (68,267)      | -              |   |                |
| <b>Total operating expenditure</b>           | <b>27,900</b>    | <b>9,400</b>  | <b>16,168</b>  | <b>97,019</b>  | <b>37,075</b> | <b>15,256</b>    | <b>30,299</b>   | <b>31,154</b> | <b>48,739</b>        | <b>22,885</b> | <b>335,895</b> | <b>2,846</b>  | <b>338,741</b> |
| <b>Total operating surplus / (deficit)</b>   | <b>(642)</b>     | <b>1,541</b>  | <b>(1,805)</b> | <b>(1,320)</b> | <b>(56)</b>   | <b>(1,287)</b>   | <b>(229)</b>    | <b>1,328</b>  | <b>(864)</b>         | <b>18,108</b> | <b>14,774</b>  | <b>(3,174)</b>  | <b>11,600</b>  |
| Net loss on disposal of assets               | -                | -             | -              | -              | -             | -                | -               | -             | -                    | (35)          | <b>(35)</b>    | (35)  | -              |
| Impairment                                   | -                | -             | -              | -              | -             | -                | -               | -             | -                    | (2,806)       | <b>(2,806)</b> | (2,806)   | -              |
| Interest receivable*                         | -                | -             | -              | -              | -             | -                | -               | -             | -                    | 247           | <b>247</b>     | -   | <b>247</b>     |
| Interest payable*                            | -                | -             | -              | -              | -             | -                | -               | -             | -                    | (1,071)       | <b>(1,071)</b> | 1   | <b>(1,072)</b> |
| Dividends on public dividend capital         | -                | -             | -              | -              | -             | -                | -               | -             | -                    | (7,048)       | <b>(7,048)</b> | -   | <b>(7,048)</b> |
| <b>Retained surplus / (deficit) for year</b> | <b>(642)</b>     | <b>1,541</b>  | <b>(1,805)</b> | <b>(1,320)</b> | <b>(56)</b>   | <b>(1,287)</b>   | <b>(229)</b>    | <b>1,328</b>  | <b>(864)</b>         | <b>7,395</b>  | <b>4,061</b>   | <b>(334)</b>  | <b>3,727</b>   |

Income received from English primary care trusts in 2010/11 totalled £285,694,000 (2009/10 - £284,256,000) and is included in all the segments above.

Explanations for reconciling items between figures reported in the segmental analysis information and the Statement of Comprehensive Income:

- Prior period adjustment - surplus reduced by £334,000. Previously reported a surplus of £4,061,000 after prior period adjustment reduced to £3,727,000, see change of accounting policy note 1.1 for further details.

- Profits / losses on disposal of non-current assets and impairments are included within income and operating expenditure headings in the accounts but disclosed separately within the segmental analysis.

\* Depreciation and amortisation, interest receivable, interest payable, gains and (losses) on disposal of assets and dividends on public dividend capital are included within recharges between directorates.

NOTES TO THE ACCOUNTS

**3. Income from activities**

|                                     | 2011/12<br>£000 | 2010/11<br>£000 |
|-------------------------------------|-----------------|-----------------|
| Elective income                     | 76,585          | 82,655          |
| Non-elective income                 | 89,805          | 88,073          |
| Outpatient income                   | 55,232          | 55,993          |
| Other NHS clinical income           | 54,618          | 50,663          |
| A & E income                        | 10,009          | 9,778           |
| Private patient income              | 970             | 1,142           |
| Other non-protected clinical income | 25              | 29              |
|                                     | <u>287,244</u>  | <u>288,333</u>  |
| Income from mandatory services      | 286,249         | 287,162         |
| Income from non-mandatory services  | 995             | 1,171           |
|                                     | <u>287,244</u>  | <u>288,333</u>  |

NHS Injury Scheme income is subject to a provision for doubtful debts of 10% to reflect expected rates of collection based upon historical experience.

**3.1 Income from activities - by source**

|  | 2011/12<br>£000 | 2010/11<br>£000<br>(restated) |
|--|-----------------|-------------------------------|
| NHS foundation trusts                        | 25              | 49                            |
| NHS trusts                                   | 37              | 47                            |
| Primary care trusts                          | 285,301         | 285,694                       |
| NHS - other                                  | -               | 199                           |
| Non-NHS - private patients                   | 970             | 1,142                         |
| Non-NHS - overseas patients (non-reciprocal) | 94              | 157                           |
| NHS injury scheme                            | 792             | 1,016                         |
| Non-NHS - other                              | 25              | 29                            |
|  | <u>287,244</u>  | <u>288,333</u>                |

**3.2 Private patient income**

|                              | 2011/12<br>£000 | 2010/11<br>£000 | Base year<br>2002/03<br>£000 |
|------------------------------|-----------------|-----------------|------------------------------|
| Private patient income       | 970             | 1,142           | 1,806                        |
| Total patient related income | <u>287,244</u>  | <u>288,333</u>  | <u>145,349</u>               |
| Proportion (as a percentage) | <u>0.3%</u>     | <u>0.4%</u>     | <u>1.2%</u>                  |

Section 44 of the 2006 Act requires that the proportion of private patient income to the total patient related income of NHS foundation trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 or the base year.

**4. Other operating income**

|   | 2011/12<br>£000 | 2010/11<br>£000<br>(restated) |
|---|-----------------|-------------------------------|
| Research and development                          | 12,936          | 13,071                        |
| Education and training                            | 13,901          | 14,231                        |
| Charitable and other contributions to expenditure | 123             | 63                            |
| Non-patient care services to other bodies         | 22,722          | 22,298                        |
| Staff recharges                                   | 6,070           | 5,451                         |
| Profit on disposal of plant and equipment         | 10              | 5                             |
| Other   | 7,588           | 6,889                         |
|   | <u>63,350</u>   | <u>62,008</u>                 |

Included within "Non-patient care services to other bodies" are laundry services, transport services, payroll services, procurement services, IT services, estates services, pathology services, pharmacy services and drug sales totalling £14.4 million (2010/11 - £14.3 million).

Included within "Other income" above is catering income of £2 million, (2010/11 - £2 million), car parking income of £1.5 million (2010/11 - £1.3 million), nursery/creche income of £0.9 million (2010/11 - £0.6 million), staff accommodation £0.6 million (2010/11 - £0.5 million).

NOTES TO THE ACCOUNTS

5. Operating expenses

|  | 2011/12<br>£000 | 2010/11<br>£000 |
|--|-----------------|-----------------|
| Services from other NHS foundation trusts                  | 1,807           | 559             |
| Services from NHS trusts                                   | 1,394           | 1,947           |
| Services from other NHS bodies                             | 2,627           | 4,346           |
| Employee expenses - executive directors (see note 5.1)     | 957             | 956             |
| Employee expenses - non-executive directors (see note 5.1) | 140             | 177             |
| Employee expenses - staff                                  | 202,659         | 202,287         |
| Drug costs   | 30,090          | 27,777          |
| Supplies and services - clinical (excluding drug costs)    | 37,148          | 40,253          |
| Supplies and services - general                            | 5,107           | 4,432           |
| Establishment  | 2,973           | 3,409           |
| Research and development                                   | 12,144          | 13,009          |
| Transport  | 633             | 487             |
| Premises   | 15,258          | 13,862          |
| Increase in bad debt provision                             | 94              | 70              |
| Depreciation   | 11,773          | 10,269          |
| Amortisation of intangible assets                          | 242             | 230             |
| Impairments  | -               | 2,806           |
| Audit fees - statutory audit                               | 79              | 91              |
| Other auditors' remuneration                               | 48              | 14              |
| Clinical negligence  | 5,667           | 4,516           |
| Losses, ex gratia and special payments                     | 206             | 161             |
| Loss on disposal of intangible non-current assets          | -               | 13              |
| Loss on disposal of plant and equipment                    | 113             | 27              |
| Other  | 8,488           | 7,043           |
|  | <b>339,647</b>  | <b>338,741</b>  |

Included within "Other expenditure" above is £1 million consultancy costs, which includes £0.4 million relating to consultancy costs of the Peninsula Procurement Supplies Alliance (PPSA) hosted by the Trust (2010/11 - £1.4 million, includes £0.9 million relating to PPSA), patient travel £1.1 million (2010/11 - £1.3 million), training courses and conferences £0.8 million (2010/11 - £0.9 million), Fetal anomaly screening £0.6 million (2010/11 £0.4 million), property rental £0.5 million (2010/11 £0.5 million).

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

Staff costs reported in note 6.1 is higher than the employee expenditure reported above. The difference is due to some employee expenditure being reported within the above research and development expenditure heading.

5.1 Directors' remuneration and other benefits

|   | 2011/12<br>£000 | 2010/11<br>£000 |
|---|-----------------|-----------------|
| Aggregate directors' remuneration         | 992             | 1,038           |
| Employer's contribution to pension scheme | 105             | 95              |
| Total                                     | <b>1,097</b>    | <b>1,133</b>    |

In the year ended 31 March 2012 seven (2011 - eight) directors accrued benefits under defined benefit pension schemes.

5.2 Other auditors' remuneration

The audit fee for the statutory audit including quality accounts in 2011/12 was £79,000 (2010/11 - £91,000 included quality accounts for two years) and including VAT not recoverable. This was the fee for an audit in accordance with the Audit Code issued by Monitor in October 2007. In addition to this, payments made to the auditors for non audit work in 2011/12 amounting to £48,000, excluding VAT, £47,000 relating to providing support and advice in connection with the back-office productivity review and £1,000 for technical accounting advice. Non audit fees in 2010/11 were £14,000, excluding VAT, for a CRES review.

5.3 Auditors' liability

The Board of Governors appointed PricewaterhouseCoopers LLP (PwC) as external auditors for the financial year ending 31 March 2012. The engagement letter signed on 30 September 2011, states that the liability of PwC, 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 (2010/11 - £1 million).

5.4 Operating leases

|   | 2011/12<br>£000 | 2010/11<br>£000 |
|---|-----------------|-----------------|
| Operating lease payments recognised in expenses | <b>1,757</b>    | <b>1,767</b>    |

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:

|   | 2011/12                    |               |               | 2010/11                    |               |               |
|---|----------------------------|---------------|---------------|----------------------------|---------------|---------------|
|   | Land and buildings<br>£000 | Other<br>£000 | Total<br>£000 | Land and buildings<br>£000 | Other<br>£000 | Total<br>£000 |
| No later than 1 year                        | 517                        | 478           | 995           | 515                        | 1,149         | 1,664         |
| Later than 1 year and no later than 5 years | 1,101                      | 108           | 1,209         | 1,360                      | 2,407         | 3,767         |
| Later than 5 years                          | 3,374                      | -             | 3,374         | 3,528                      | 1,429         | 4,957         |
|   | <b>4,992</b>               | <b>586</b>    | <b>5,578</b>  | <b>5,403</b>               | <b>4,985</b>  | <b>10,388</b> |

## NOTES TO THE ACCOUNTS

**6. Staff costs and numbers**

| <b>6.1 Staff costs</b>          | <b>2011/12</b> | <b>2010/11</b> |
|---------------------------------|----------------|----------------|
|                                 | <b>£000</b>    | <b>£000</b>    |
| Salaries and wages              | 168,910        | 169,736        |
| Social security costs           | 12,699         | 12,367         |
| Employer contributions to NHSPA | 20,291         | 20,297         |
| Termination benefits            | 706            | 822            |
| Agency and contract staff       | 4,822          | 3,857          |
|                                 | <b>207,428</b> | <b>207,079</b> |

**6.2 Average number of persons employed including directors**

|   | Permanent employees | Other employees | <b>2011/12</b> | <b>2010/11</b> |
|---|---------------------|-----------------|----------------|----------------|
|   | Number              | Number          | <b>total</b>   | <b>total</b>   |
|   |                     |                 | <b>Number</b>  | <b>Number</b>  |
| Medical and dental                            | 608                 | 8               | 616            | 597            |
| Administration and estates                    | 1,238               | 3               | 1,241          | 1,283          |
| Healthcare assistants and other support staff | 495                 | -               | 495            | 532            |
| Nursing, midwifery and health visiting staff  | 1,931               | 4               | 1,935          | 1,943          |
| Scientific, therapeutic and technical staff   | 673                 | -               | 673            | 693            |
| Bank and agency staff                         | 219                 | -               | 219            | 195            |
| <b>Total</b>                                  | <b>5,164</b>        | <b>15</b>       | <b>5,179</b>   | <b>5,243</b>   |

**6.3 Staff exit packages**

| <b>Exit package cost</b> | <b>2011/12</b> | <b>2010/11</b> |
|--------------------------|----------------|----------------|
|                          | <b>Number</b>  | <b>Number</b>  |
| Less than £10,000        | 15             | 9              |
| £10,000 to £25,000       | 4              | 8              |
| £25,001 to £50,000       | 13             | 12             |
| £50,001 to £100,000      | 2              | -              |
| £100,001 to £150,000     | -              | 2              |
| <b>Total number</b>      | <b>34</b>      | <b>31</b>      |

| <b>Total exit package expense</b> | <b>2011/12</b> | <b>2010/11</b> |
|-----------------------------------|----------------|----------------|
|                                   | <b>£000</b>    | <b>£000</b>    |
|                                   | <b>706</b>     | <b>822</b>     |

All exit packages relate to staff that left the employment of the Trust under a Department of Health mutually agreed voluntary scheme. The exit package expense includes 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, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to run in a way that would enable the Trust to identify its share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as if it were a defined contribution scheme; the cost to the Trust is taken as equal to the contributions payable to the scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation the FReM requires that the period between formal valuations shall be four years.

**Full actuarial (funding) valuation**

The purpose of the valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience) and to recommend the contribution.

**Accounting valuation**

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, at the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

**8. Retirements due to ill-health**

During 2011/12 there were 8 (2010/11 - 11) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £466,000 (2010/11 - £1,089,000). 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 2011/12 the Trust did not incur expenditure (2010/11 - £nil) arising from claims made under this legislation.

| <b>10. Finance income</b>             | <b>2011/12</b> | <b>2010/11</b> |
|---------------------------------------|----------------|----------------|
|                                       | <b>£000</b>    | <b>£000</b>    |
| Interest on cash and cash equivalents | 279            | 247            |

## NOTES TO THE ACCOUNTS

| <b>11. Finance expense</b>                         | <b>2011/12</b>      | 2010/11      |
|--|---------------------|--------------|
|  | <b>£000</b>         | £000         |
| Loans from the Foundation Trust Financing Facility | <b>1,007</b>        | 1,065        |
| Unwinding of discount on provisions                | <b>11</b>           | 7            |
| <b>Total</b>                                       | <b><u>1,018</u></b> | <u>1,072</u> |

**12. Better Payment Practice Code**

|   | <b>2011/12</b> | <b>2011/12</b> | 2010/11 | 2010/11 |
|---|----------------|----------------|---------|---------|
|   | <b>Number</b>  | <b>£000</b>    | Number  | £000    |
| Total non-NHS trade invoices paid in the year           | <b>92,381</b>  | <b>120,249</b> | 89,715  | 109,534 |
| Total non-NHS trade invoices paid within target         | <b>84,433</b>  | <b>108,360</b> | 84,284  | 101,810 |
| Percentage of non-NHS trade invoices paid within target | <b>91.40%</b>  | <b>90.11%</b>  | 93.95%  | 92.95%  |
| <br>  |                |                |         |         |
| Total NHS trade invoices paid in the year               | <b>3,087</b>   | <b>28,806</b>  | 3,101   | 35,023  |
| Total NHS trade invoices paid within target             | <b>2,576</b>   | <b>24,759</b>  | 2,612   | 31,191  |
| Percentage of NHS trade invoices paid within target     | <b>83.45%</b>  | <b>85.95%</b>  | 84.23%  | 89.06%  |

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.

| <b>13. Losses and special payments</b>   | <b>2011/12</b>    | <b>2011/12</b>    | 2010/11    | 2010/11    |
|--|-------------------|-------------------|------------|------------|
|  | <b>Number</b>     | <b>Value</b>      | Number     | Value      |
|  |                   | <b>£000</b>       |            | £000       |
| Losses                                   | <b>104</b>        | <b>77</b>         | 88         | 119        |
| Special payments                         | <b>66</b>         | <b>129</b>        | 71         | 42         |
| <b>Total losses and special payments</b> | <b><u>170</u></b> | <b><u>206</u></b> | <u>159</u> | <u>161</u> |

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 NHS trusts not been bearing their 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.

**14. Public dividend capital**

A charge, reflecting the cost of capital utilised by the Trust, is payable 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 during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and cash held with the Government Banking Service.

**15. Intangible assets**
**15.1 Intangible assets at 31 March 2011**

|  | <b>Software</b>     |
|--|---------------------|
|  | <b>licences</b>     |
|  | <b>£000</b>         |
| Fair value at 1 April 2010                       | 1,388               |
| Additions - purchased                            | 95                  |
| Impairment                                       | (24)                |
| Disposals  | (62)                |
| <b>Fair value at 31 March 2011</b>               | <b><u>1,397</u></b> |
| <br>   |                     |
| Accumulated amortisation at 1 April 2010         | 672                 |
| Provided during the year                         | 230                 |
| Eliminated on disposals                          | (49)                |
| <b>Accumulated amortisation at 31 March 2011</b> | <b><u>853</u></b>   |
| <br>   |                     |
| <b>Net book value</b>                            |                     |
| Purchased at 1 April 2010                        | 689                 |
| Donated at 1 April 2010                          | 27                  |
| <b>Total at 1 April 2010</b>                     | <b><u>716</u></b>   |
| <br>   |                     |
| <b>Net book value</b>                            |                     |
| Purchased at 31 March 2011                       | 531                 |
| Donated at 31 March 2011                         | 13                  |
| <b>Total at 31 March 2011</b>                    | <b><u>544</u></b>   |

**15.2 Intangible assets at 31 March 2012**

|  |                     |
|--|---------------------|
| Fair value at 1 April 2011                       | 1,397               |
| Additions - purchased                            | 888                 |
| <b>Fair value at 31 March 2012</b>               | <b><u>2,285</u></b> |
| <br>   |                     |
| Accumulated amortisation at 1 April 2011         | 853                 |
| Provided during the year                         | 242                 |
| <b>Accumulated amortisation at 31 March 2012</b> | <b><u>1,095</u></b> |
| <br>   |                     |
| <b>Net book value</b>                            |                     |
| Purchased at 31 March 2012                       | 1,183               |
| Donated at 31 March 2012                         | 7                   |
| <b>Total at 31 March 2012</b>                    | <b><u>1,190</u></b> |

## NOTES TO THE ACCOUNTS

## 16. Property, plant and equipment

16.1 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 2011                     | 32,780        | 173,214                                | 2,400              | 11,421  | 35,914              | 988                 | 6,587                  | 51                     | 263,355        |
| Additions - purchased                                 | -             | 627                                    | -                  | 12,035  | 295                 | 14                  | 72                     | -                      | 13,043         |
| Additions - donated                                   | -             | -                                      | -                  | 123   | -                   | -                   | -                      | -                      | 123            |
| Reclassifications                                     | -             | 7,795                                  | -                  | (12,595)  | 3,447               | 153                 | 1,200                  | -                      | -              |
| Disposals   | -             | -                                      | -                  | -   | (2,230)             | (79)                | -                      | (6)                    | (2,315)        |
| <b>Total at 31 March 2012</b>                         | <b>32,780</b> | <b>181,636</b>                         | <b>2,400</b>       | <b>10,984</b>                                     | <b>37,426</b>       | <b>1,076</b>        | <b>7,859</b>           | <b>45</b>              | <b>274,206</b> |
| Accumulated depreciation at 1 April 2011              | -             | -                                      | -                  | -   | 20,018              | 425                 | 4,092                  | 41                     | 24,576         |
| Provided during the year                              | -             | 6,901                                  | 51                 | -   | 3,480               | 106                 | 1,228                  | 7                      | 11,773         |
| Eliminated on disposals                               | -             | -                                      | -                  | -   | (2,113)             | (79)                | -                      | (6)                    | (2,198)        |
| <b>Accumulated depreciation at 31 March 2012</b>      | <b>-</b>      | <b>6,901</b>                           | <b>51</b>          | <b>-</b>  | <b>21,385</b>       | <b>452</b>          | <b>5,320</b>           | <b>42</b>              | <b>34,151</b>  |
| Purchased at 31 March 2012                            | 32,780        | 171,932                                | 2,349              | 10,934  | 15,550              | 610                 | 2,534                  | 3                      | 236,692        |
| Donated at 31 March 2012                              | -             | 2,803                                  | -                  | 50  | 491                 | 14                  | 5                      | -                      | 3,363          |
| <b>Total at 31 March 2012</b>                         | <b>32,780</b> | <b>174,735</b>                         | <b>2,349</b>       | <b>10,984</b>                                     | <b>16,041</b>       | <b>624</b>          | <b>2,539</b>           | <b>3</b>               | <b>240,055</b> |
| <b>16.2 Analysis of property, plant and equipment</b> |               |  |                    |   |                     |                     |                        |                        |                |
| Protected assets at 31 March 2012                     | 30,975        | 166,451                                | -                  | -   | -                   | -                   | -                      | -                      | 197,426        |
| Unprotected assets at 31 March 2012                   | 1,805         | 8,284                                  | 2,349              | 10,984  | 16,041              | 624                 | 2,539                  | 3                      | 42,629         |
| <b>Net book value</b>                                 | <b>32,780</b> | <b>174,735</b>                         | <b>2,349</b>       | <b>10,984</b>                                     | <b>16,041</b>       | <b>624</b>          | <b>2,539</b>           | <b>3</b>               | <b>240,055</b> |

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

Protected assets are designated as protected in the Trust's Terms of Authorisation ("ToA"). Condition 9 of the ToA defines property as protected if it is required for the purposes of providing mandatory goods and services. Protected assets are limited to land and buildings owned by the Trust, assets such as equipment are not regarded as protected assets.

The Trust's land, buildings and dwellings were revalued as at 31 March 2011, the valuation is considered to be still appropriate as at 31 March 2012. 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.

## NOTES TO THE ACCOUNTS

## 16. Property, plant and equipment (continued)

## 16.3 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 2010                | 33,490        | 156,904                                | 2,400              | 13,574  | 32,887              | 764                 | 6,910                  | 74                     | 247,003        |
| Additions - purchased                            | -             | 683                                    | -                  | 10,445  | 757                 | 219                 | 144                    | -                      | 12,248         |
| Additions - donated                              | -             | -                                      | -                  | 45  | 18                  | -                   | -                      | -                      | 63             |
| Reclassifications                                | -             | 8,105                                  | -                  | (12,333)  | 3,558               | 113                 | 542                    | 15                     | -              |
| Impairment                                       | (710)         | (1,921)                                | -                  | (237)   | -                   | -                   | -                      | -                      | (2,868)        |
| Revaluation                                      | -             | 9,443                                  | -                  | -   | -                   | -                   | -                      | -                      | 9,443          |
| Disposals  | -             | -                                      | -                  | (73)  | (1,306)             | (108)               | (1,009)                | (38)                   | (2,534)        |
| <b>Total at 31 March 2011</b>                    | <b>32,780</b> | <b>173,214</b>                         | <b>2,400</b>       | <b>11,421</b>                                     | <b>35,914</b>       | <b>988</b>          | <b>6,587</b>           | <b>51</b>              | <b>263,355</b> |
| Accumulated depreciation at 1 April 2010         | -             | -                                      | -                  | -   | 18,187              | 441                 | 4,085                  | 65                     | 22,778         |
| Provided during the year                         | -             | 5,990                                  | 50                 | -   | 3,133               | 91                  | 1,002                  | 3                      | 10,269         |
| Revaluation                                      | -             | (5,904)                                | (50)               | -   | -                   | -                   | -                      | -                      | (5,954)        |
| Impairment                                       | -             | (86)                                   | -                  | -   | -                   | -                   | -                      | -                      | (86)           |
| Eliminated on disposals                          | -             | -                                      | -                  | -   | (1,302)             | (107)               | (995)                  | (27)                   | (2,431)        |
| <b>Accumulated depreciation at 31 March 2011</b> | <b>-</b>      | <b>-</b>                               | <b>-</b>           | <b>-</b>  | <b>20,018</b>       | <b>425</b>          | <b>4,092</b>           | <b>41</b>              | <b>24,576</b>  |
| Purchased at 1 April 2010                        | 33,490        | 154,177                                | 2,400              | 13,574  | 13,996              | 301                 | 2,781                  | 9                      | 220,728        |
| Donated at 1 April 2010                          | -             | 2,727                                  | -                  | -   | 704                 | 22                  | 44                     | -                      | 3,497          |
| <b>Total at 1 April 2010</b>                     | <b>33,490</b> | <b>156,904</b>                         | <b>2,400</b>       | <b>13,574</b>                                     | <b>14,700</b>       | <b>323</b>          | <b>2,825</b>           | <b>9</b>               | <b>224,225</b> |
| Purchased at 31 March 2011                       | 32,780        | 170,316                                | 2,400              | 11,421  | 15,303              | 545                 | 2,486                  | 10                     | 235,261        |
| Donated at 31 March 2011                         | -             | 2,898                                  | -                  | -   | 593                 | 18                  | 9                      | -                      | 3,518          |
| <b>Total at 31 March 2011</b>                    | <b>32,780</b> | <b>173,214</b>                         | <b>2,400</b>       | <b>11,421</b>                                     | <b>15,896</b>       | <b>563</b>          | <b>2,495</b>           | <b>10</b>              | <b>238,779</b> |

## 16.4 Analysis of property, plant and equipment

|                                     |               |                |              |               |               |            |              |           |                |
|-------------------------------------|---------------|----------------|--------------|---------------|---------------|------------|--------------|-----------|----------------|
| Protected assets at 31 March 2011   | 30,975        | 164,770        | -            | -             | -             | -          | -            | -         | 195,745        |
| Unprotected assets at 31 March 2011 | 1,805         | 8,444          | 2,400        | 11,421        | 15,896        | 563        | 2,495        | 10        | 43,034         |
| <b>Net book value</b>               | <b>32,780</b> | <b>173,214</b> | <b>2,400</b> | <b>11,421</b> | <b>15,896</b> | <b>563</b> | <b>2,495</b> | <b>10</b> | <b>238,779</b> |

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

Protected assets are designated as protected in the Trust's Terms of Authorisation ("ToA"). Condition 9 of the ToA defines property as protected if it is required for the purposes of providing mandatory goods and services. Protected assets are limited to land and buildings owned by the Trust, assets such as equipment are not regarded as protected assets.

## NOTES TO THE ACCOUNTS

## 17. Inventories

## 17.1 Inventories held at year end

|  | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--|-----------------------|-----------------------|-----------------------|
| Drugs  | 1,282                 | 1,220                 | 1,330                 |
| Work in progress                                     | 55                    | 40                    | 8                     |
| Consumables  | 1,863                 | 2,638                 | 2,427                 |
| Energy   | 304                   | 219                   | 177                   |
| Inventories carried at fair value less costs to sell | 577                   | 475                   | 665                   |
| <b>Total inventories</b>                             | <b>4,081</b>          | <b>4,592</b>          | <b>4,607</b>          |

## 17.2 Inventories recognised in expenses

|  | 2011/12<br>£000 | 2010/11<br>£000 |
|--|-----------------|-----------------|
| Inventories recognised in expenses               | 43,029          | 40,640          |
| Write-down of inventories recognised in expenses | 68              | 103             |
| <b>Total inventories recognised in expenses</b>  | <b>43,097</b>   | <b>40,743</b>   |

## 18. Trade and other receivables

|  | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--|-----------------------|-----------------------|-----------------------|
| <b>Current</b>                                   |                       |                       |                       |
| NHS receivables                                  | 8,277                 | 7,238                 | 8,496                 |
| Non-NHS receivables                              | 1,847                 | 1,256                 | 1,392                 |
| Provision for impaired receivables               | (68)                  | (27)                  | (25)                  |
| Prepayments                                      | 2,318                 | 1,726                 | 1,476                 |
| Accrued income                                   | 942                   | 714                   | 901                   |
| Other receivables                                | 241                   | 102                   | 204                   |
| PDC dividend receivable                          | 14                    | -                     | 284                   |
| VAT receivable                                   | 379                   | -                     | 388                   |
| <b>Total current trade and other receivables</b> | <b>13,950</b>         | <b>11,009</b>         | <b>13,116</b>         |
| <b>Non-current</b>                               |                       |                       |                       |
| Accrued income                                   | 960                   | 966                   | 838                   |
| <b>Total trade and other receivables</b>         | <b>14,910</b>         | <b>11,975</b>         | <b>13,954</b>         |
| <b>Provision for impairment of receivables</b>   |                       |                       |                       |
| At 1 April                                       | 27                    | 25                    | 91                    |
| Increase in provision                            | 94                    | 70                    | -                     |
| Unused amounts reversed                          | (53)                  | (68)                  | (52)                  |
| Amounts utilised                                 | -                     | -                     | (14)                  |
| <b>At 31 March</b>                               | <b>68</b>             | <b>27</b>             | <b>25</b>             |

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

## 18.1 Analysis of impaired receivables

|                                | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--------------------------------|-----------------------|-----------------------|-----------------------|
| Ageing of impaired receivables |                       |                       |                       |
| In three to six months         | 56                    | 84                    | 78                    |
| Over six months                | 117                   | 94                    | 177                   |
|                                | <b>173</b>            | <b>178</b>            | <b>255</b>            |

## 18.2 Ageing of non-impaired receivables

|                    |              |              |              |
|--------------------|--------------|--------------|--------------|
| Up to three months | <b>1,674</b> | <b>1,078</b> | <b>1,137</b> |
|--------------------|--------------|--------------|--------------|

## 19. Non-current assets held for sale

|  | Property, plant<br>and equipment<br>£000 |
|--|--|
| <b>Net book value of non-current assets held for sale at 1 April 2010</b>                    | <b>6,000</b>                             |
| NBV of non-current assets for sale at 1 April 2010   | 6,000                                    |
| Assets sold in year  | (6,000)                                  |
| <b>Net book value of non-current assets held for sale at 31 March 2011 and 31 March 2012</b> | <b>-</b>                                 |

All non-current assets held for sale were property assets that were no longer used by the Trust and declared surplus to requirements in 2008/09. The sale of these assets was completed in the 2010/11 financial year.

NOTES TO THE ACCOUNTS

20. Current trade and other payables

|                          | 31 March 2012<br>£000 | 31 March 2011<br>£000<br>(restated) | 01 April 2010<br>£000<br>(restated) |
|--------------------------|-----------------------|-------------------------------------|-------------------------------------|
| NHS payables             | 1,661                 | 3,053                               | 3,503                               |
| Trade payables - capital | 1,476                 | 1,782                               | 2,024                               |
| Other trade payables     | 2,384                 | 2,771                               | 2,460                               |
| VAT payable              | -                     | 697                                 | -                                   |
| Other taxes payable      | 4,379                 | 4,386                               | 4,048                               |
| Other payables           | 2,688                 | 2,656                               | 2,568                               |
| Accruals                 | 10,868                | 10,631                              | 11,668                              |
| PDC dividend payable     | -                     | 262                                 | -                                   |
|                          | <u>23,456</u>         | <u>26,238</u>                       | <u>26,271</u>                       |
| <b>Other liabilities</b> |                       |                                     |                                     |
| Other deferred income    | <u>2,835</u>          | <u>1,475</u>                        | <u>2,110</u>                        |

21. Borrowings

|  | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--|-----------------------|-----------------------|-----------------------|
| <b>Current</b>                                 |                       |                       |                       |
| Loans from Foundation Trust Financing Facility | <u>1,270</u>          | <u>1,270</u>          | <u>1,271</u>          |
| <b>Non-current</b>                             |                       |                       |                       |
| Loans from Foundation Trust Financing Facility | <u>18,943</u>         | <u>20,213</u>         | <u>21,483</u>         |
| Total borrowings                               | <u>20,213</u>         | <u>21,483</u>         | <u>22,754</u>         |
| Amounts falling due within: -                  |                       |                       |                       |
| In one year or less by instalments             | 1,270                 | 1,270                 | 1,271                 |
| Between one and five years by instalments      | 5,084                 | 5,082                 | 5,082                 |
| Over five years by instalments                 | 13,859                | 15,131                | 16,401                |
|  | <u>20,213</u>         | <u>21,483</u>         | <u>22,754</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.

22. Provisions

|                          | Early<br>retirements<br>£000 | Legal<br>claims<br>£000 | Other<br>£000 | Total<br>£000 |
|--------------------------|------------------------------|-------------------------|---------------|---------------|
| At 1 April 2010          | 128                          | 111                     | 187           | 426           |
| Change in discount rate  | (6)                          | -                       | (21)          | (27)          |
| Arising during the year  | 2                            | 141                     | 1,273         | 1,416         |
| Utilised during the year | (11)                         | (31)                    | (14)          | (56)          |
| Reversed unused          | -                            | (52)                    | -             | (52)          |
| Unwinding of discount    | 3                            | -                       | 4             | 7             |
| <b>At 31 March 2011</b>  | <u>116</u>                   | <u>169</u>              | <u>1,429</u>  | <u>1,714</u>  |
| At 1 April 2011          | 116                          | 169                     | 1,429         | 1,714         |
| Arising during the year  | 11                           | 180                     | 6             | 197           |
| Utilised during the year | (11)                         | (88)                    | (14)          | (113)         |
| Reversed unused          | -                            | (50)                    | (20)          | (70)          |
| Unwinding of discount    | 4                            | -                       | 7             | 11            |
| <b>At 31 March 2012</b>  | <u>120</u>                   | <u>211</u>              | <u>1,408</u>  | <u>1,739</u>  |

Expected timing of cash flows:

|                            | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 1 April 2010<br>£000 |
|----------------------------|-----------------------|-----------------------|----------------------|
| In one year or less        | 1,392                 | 1,368                 | 130                  |
| Between one and five years | 92                    | 90                    | 75                   |
| Over five years            | 255                   | 256                   | 221                  |
|                            | <u>1,739</u>          | <u>1,714</u>          | <u>426</u>           |

Legal claims relate to employee and public liability claims.

The "Other" category relates to injury benefit claims against the Trust and a provision to terminate a contract.

Contingent liabilities relating to legal claims are shown in note 26.

The NHS Litigation Authority is carrying provisions as at 31 March 2012 in relation to Existing Liabilities Scheme and in relation to Clinical Negligence Scheme on behalf of the Trust of £24,329,000 (2011 - £24,354,000).

NOTES TO THE ACCOUNTS

23. Prudential Borrowing Limit

|  | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--|-----------------------|-----------------------|-----------------------|
| Total long term borrowing limit set by Monitor | 66,700                | 65,300                | 70,000                |
| Working capital facility agreed by Monitor     | 18,000                | 18,000                | 18,000                |
| Total Prudential Borrowing Limit               | <u>84,700</u>         | <u>83,300</u>         | <u>88,000</u>         |
| Long term borrowing at beginning of year       | 21,483                | 22,754                | 24,024                |
| Repayment in year                              | (1,270)               | (1,271)               | (1,270)               |
| Long term borrowing at the end of year         | <u>20,213</u>         | <u>21,483</u>         | <u>22,754</u>         |

During the year the Board decided that the working capital facility was not considered necessary.

Financial ratios

|                         | 2011/12<br>Actual<br>ratios | 2011/12<br>Minimum<br>PBL | 2010/11<br>Actual<br>ratios<br>(restated) | 2010/11<br>Minimum<br>PBL |
|-------------------------|-----------------------------|---------------------------|---|---------------------------|
| Dividend cover          | 3.0x                        | >1x                       | 3.3x                                      | >1x                       |
| Interest cover          | 22.0x                       | >3x                       | 22.2x                                     | >3x                       |
| Debt service cover      | 9.6x                        | >2x                       | 10.6x                                     | >2x                       |
| Debt service to revenue | 0.7%                        | <2.5%                     | 0.7%                                      | <2.5%                     |

The Trust is required to comply and remain within a prudential borrowing limit.

The maximum cumulative amount of long-term borrowing this is set by reference to the four ratio tests set out in Monitor's Prudential Borrowing Code.

24. Cash and cash equivalents

|                        | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|------------------------|-----------------------|-----------------------|-----------------------|
| At 1 April             | 53,583                | 41,498                | 38,359                |
| Net change in the year | (3,962)               | 12,085                | 3,139                 |
| At 31 March            | <u>49,621</u>         | <u>53,583</u>         | <u>41,498</u>         |

Broken down into:

|  |               |               |               |
|--|---------------|---------------|---------------|
| Cash at commercial banks and in hand                         | 18            | 26            | 38            |
| Cash with Government Banking Service                         | 49,603        | 53,557        | 41,460        |
| Cash and cash equivalents as in SoFP and Cash Flow Statement | <u>49,621</u> | <u>53,583</u> | <u>41,498</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.

25. Capital commitments

Commitments under capital expenditure contracts, which relate to property, plant and equipment, at the balance sheet date were £27,479,000 (2011 - £2,315,500). The increase is mainly due to the Trust entering into a construction contract to construct a new Research, Innovation, Learning and Development building. Approximately 70% of the cost of this building will be funded by contributions from the University of Exeter.

26. Contingent liabilities

|                                | 31 March 2012<br>£000 | 31 March 2011<br>£000 | 01 April 2010<br>£000 |
|--------------------------------|-----------------------|-----------------------|-----------------------|
| Contingent NHSLA legal claims. | <u>-</u>              | <u>-</u>              | <u>3</u>              |

27. 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

**27. 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 Trust has received during the year £57,000 (2010/11 - £57,000) revenue income and £123,000 (2010/11 - £63,000) capital contributions from the Charity. At 31 March 2012 the Trust was due £119,000 (2011 - £7,000) from the Charity. The Charity's most recent audited accounts were the year ended 31 March 2011. The charity reported a surplus of £99,000 and held aggregated reserves of £1,807,000.

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<br>£000 | Expenditure<br>£000 | Receivables<br>£000 | Payables<br>£000 |
|--|----------------|---------------------|---------------------|------------------|
| <b>2011/12</b>                               |                |                     |                     |                  |
| Bristol Primary Care Trust                   | 21,028         | -                   | 906                 | -                |
| Department of Health (excludes PDC dividend) | 11,135         | -                   | 264                 | -                |
| NHS Devon Primary Care Trust                 | 249,123        | 2,297               | 1,940               | (21)             |
| Northern Devon Healthcare NHS Trust          | 9,201          | 1,183               | 2,426               | 227              |
| Somerset Primary Care Trust                  | 7,276          | 40                  | (29)                | 39               |
| South West Strategic Health Authority        | 14,271         | 14                  | 2                   | -                |
| Torbay Primary Care Trust                    | 5,308          | 3                   | 168                 | -                |
| <b>2010/11</b>                               |                |                     |                     |                  |
| Bristol Primary Care Trust                   | 18,709         | -                   | 1,804               | -                |
| Department of Health (excludes PDC dividend) | 11,960         | -                   | 10                  | -                |
| NHS Devon Primary Care Trust                 | 258,964        | 4,417               | 678                 | 993              |
| Northern Devon Healthcare NHS Trust          | 1,787          | 563                 | 368                 | 61               |
| Somerset Primary Care Trust                  | 7,908          | 11                  | -                   | 25               |
| South West Strategic Health Authority        | 14,445         | 100                 | -                   | 41               |
| Torbay Primary Care Trust                    | 4,530          | 9                   | -                   | 86               |

The Trust has entered into a contract with NHS Devon PCT, on 30 March 2012, to provide it with patient services for 2012/13. This contract also includes services that will be provided to Plymouth PCT, Torbay PCT, NHS Somerset and NHS Cornwall. Income from this contract is expected to be comparable with 2010/11.

**28. 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 primary care trusts 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 primary care trusts pose 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. Cash balances are regularly transferred to a commercial bank, from deposit with the Government Banking Service, in order to make payments. Whilst lodged with the commercial bank said deposits pose a credit risk if the commercial bank were to become insolvent during the period from receipt of monies to subsequent payment of suppliers. However as payments are structured to minimise the period of credit risk exposure, the Trust considers that it has reduced the credit risk to an acceptable level.

**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 local primary care trusts, 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 primary care trusts is 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

28. 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.

28.1 Financial assets by category

|                               | <b>Loans and<br/>receivables<br/>£000</b> |
|-------------------------------|---|
| NHS receivables               | 8,496                                     |
| Accrued income                | 1,739                                     |
| Other receivables             | 1,571                                     |
| Cash at bank and in hand      | 41,498                                    |
| <b>Total at 1 April 2010</b>  | <b>53,304</b>                             |
| NHS receivables               | 7,238                                     |
| Accrued income                | 1,680                                     |
| Other receivables             | 1,331                                     |
| Cash at bank and in hand      | 53,583                                    |
| <b>Total at 31 March 2011</b> | <b>63,832</b>                             |
| NHS receivables               | <b>8,277</b>                              |
| Accrued income                | <b>1,902</b>                              |
| Other receivables             | <b>2,020</b>                              |
| Cash at bank and in hand      | <b>49,621</b>                             |
| <b>Total at 31 March 2012</b> | <b>61,820</b>                             |

An analysis of any impairment of receivables is provided in note 18.1.

28.2 Financial liabilities by category

|                               | <b>Other<br/>financial<br/>liabilities<br/>£000</b> |
|-------------------------------|---|
| Borrowings                    | 22,754  |
| NHS payables                  | 3,503   |
| Other payables                | 5,028   |
| Accruals                      | 11,668  |
| Capital payables              | 2,024   |
| Provisions under contracts    | 426   |
| <b>Total at 1 April 2010</b>  | <b>45,403</b>                                       |
| Borrowings                    | 21,483  |
| NHS payables                  | 3,053   |
| Other payables                | 5,427   |
| Accruals                      | 10,631  |
| Capital payables              | 1,782   |
| Provisions under contracts    | 1,714   |
| <b>Total at 31 March 2011</b> | <b>44,090</b>                                       |
| Borrowings                    | <b>20,213</b>                                       |
| NHS payables                  | <b>1,661</b>  |
| Other payables                | <b>5,072</b>  |
| Accruals                      | <b>10,868</b>                                       |
| Capital payables              | <b>1,476</b>  |
| Provisions under contracts    | <b>1,739</b>  |
| <b>Total at 31 March 2012</b> | <b>41,029</b>                                       |

28.3 Fair value

For all of the financial assets and liabilities at 31 March 2012 and 31 March 2011 the fair value is equal to book value.

29. Third party assets

The Trust held £nil cash at bank and in hand at 31 March 2012 (2011 - £nil) relating to monies held on behalf of patients.

**NOTES TO THE ACCOUNTS**

**30. Accounting standards issued and not adopted**

The financial statements have been prepared in accordance with the 2011/12 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 7 - Financial Instruments: Disclosures**

**IFRS 9 - Financial Instruments**

**IFRS 10 - Consolidated Financial Statements**

**IFRS 11 - Joint Arrangement**

**IFRS 12 - Disclosure of Interests in Other Entities**

**IFRS 13 - Fair Value Measurement**

**IAS 12 - Income Taxes amendment**

**IAS 1 - Presentation of financial statements, on other comprehensive income (OCI)**

**IAS 27 - Separate Financial Statements**

**IAS 28 - Associates and joint ventures**



