

# Annual report 2004/05

Presented to Parliament pursuant to schedule 1, paragraph 25(4)  
of the Health and Social Care (Community Health and Standards) Act 2003.

## & summary financial statements





**Ruth Hawker**  
chairman



**Angela Pedder**  
chief executive

## Reports by our chairman and chief executive

**Pass through Southernhay in the centre of Exeter and you'll see where the RD&E was established in 1741. Come to our main Wonford site today and you'll find a hospital with one of Europe's most advanced haematology centres and a new maternity, gynaecology and neonatology unit under construction.**

Ours is thus a history of change, growth and renewal and as the financial year 2004/05 began this unfolding process saw us become one of the country's first NHS Foundation Trusts (NHSFT).

We had the chance to become an NHSFT because our clinical and managerial performance ranks alongside the best. We seized the opportunity because we wanted to develop new ways of rising to the challenges our future will bring.

The NHSFT idea is new, but we felt it was in accord with our traditions of commitment to our community and to the highest clinical standards.

We remain part and parcel of the NHS and that's where we want to be. In this way we still have to hit our high-level year-end waiting time targets and meet our national service framework commitments. Thanks once more to a great team effort we did all of this.

We also continue to work closely with our partner organisations in the health and social care community and to enjoy the magnificent support of the League of Friends at our various centres, our dedicated volunteers and charities such as the Exeter Leukaemia Fund, DIRECT and FORCE.

There weren't obvious overnight changes as we became an NHSFT and in any case that's not the RD&E way. But things are different.

Our council of governors and our NHSFT members are already making their contribution, as discussed in this annual report. Through this and through other engagement work we're learning more about what the people we serve want of us. And we can now respond much more speedily to the demands we face, as demonstrated through our tenth operating theatre project (page 5).

Of course, it's been a challenging year. We get busier, the targets get tougher and as discussed in this report the financial situation has been significantly more demanding than first anticipated.

But with a 250 year history of service, achievement and success behind us and the benefit of a superb staff team, supportive partners and committed NHSFT governors and members, we've got what it takes.

**Professor Ruth Hawker, OBE** Chairman

**Three words come to mind as I look back on our first year as an NHSFT. Achievement, transition and challenge.**

Once more, despite being busier than ever, we hit our key NHS Plan targets and improved the range and quality of care we offer our patients.

Whilst the financial situation proved to be more challenging than anticipated we have continued to expand services and invest in key areas such as intensive care and emergency care.

Our board of management has been strengthened by the appointment of new non-executive directors, our council of governors is starting to play an important role in helping us plan for our future and we are starting to interact with our community in new ways.

This annual report shows how we are meeting the commitments we undertook in our service development strategy:

- Improving access to our services.
- Improving relationships with our community.
- Developing new ways of delivering care.
- Responding to our staff.

2004/05 has also been a year of transition and challenge. As an NHSFT, we've moved into a new funding system known as payment by results by which hospitals are paid for the actual work they do. This is welcome because it started to move us towards a situation where over four years we will receive the same level of payment for the work we do as any other NHS hospital.

Unfortunately the first year of the new system has not fully covered the consultants' contract and revised pension arrangements. These centrally imposed cost commitments gave us financial problems because the income to cover them was not made available. As a consequence of this and the need to invest to strengthen our services we are reporting a recorded deficit of £6.5 million at the end of the financial year (not including the impairment of £0.8m, a technical accounting adjustment that relates to the revaluation of the newly constructed Peninsula Medical School building but which does not have a cash impact on the year).

But whilst this overall result is disappointing, we have a robust plan in place to return to financial break even. If we had received the level of payment an average NHS hospital would get we would have generated a surplus in excess of £9 million. Our income position over the year remained broadly in line with our plan and we remain one of the leanest, most efficient hospitals in the land.

We will achieve parity with other NHS organisations by 2007/08, but in the meantime we know that we will need to contain costs and live within our means.

**Angela Pedder** Chief executive

# WORKING IN NEW WAYS

*“By extending the roles of experienced staff we can have trained practitioners giving patients the consistent care they need, when they need it.”*

## Advanced practitioners

**Our reputation for excellence was strengthened last year when we became the only trust in the country to pioneer simultaneously two projects looking at new ways of working in hospitals.**

These looked specifically at how the NHS can train experienced staff working in anaesthesia and critical care to become clinical practitioners and take on work previously done only by doctors.

“A predicted shortage of anaesthetists prompted the exploration of new ways of delivering anaesthetic services,” explains RD&E consultant anaesthetist, Paul Thomas.

“We became one of just five pilot sites to be involved in this project and our input has shaped the development of a two-year postgraduate diploma approved by the Royal College of Anaesthetists.”

The RD&E's first two anaesthetic practitioners are Hayley Lillie, formerly an intensive care nurse (foreground centre in the photo), and Dave Wilkinson (seated left), formerly a senior operating department practitioner. Both underwent the gruelling training programme to equip them to work as members of the anaesthetic team.

“We can support the consultant anaesthetist so they can run two surgical lists at the same time, increasing efficiency and theatre throughput,” says Hayley.

Dave adds a personal perspective: “We both see this as a superb opportunity to advance professionally whilst staying close to patients in a direct way.”

Similar concerns about a predicted shortage of intensive care doctors also explains the national pilot programme to train experienced NHS staff to become advanced critical care practitioners.

“Five pilot sites were chosen, including the RD&E, to look at how we can deliver good quality care differently,” says the RD&E's lead consultant for critical care, Chris Day.

“By extending the roles of experienced staff we can have trained practitioners giving patients the consistent care they need, when they need it.”

Intensive care nurse Carole Boulanger (standing right) was an early advocate for the role. She wanted to progress her career, but not to lose everyday patient contact.

Fellow intensive care nurse, Marie Toghil (sofa), soon joined her on the critical care practitioner training course.

“We're involved in the assessment and management of patients in intensive care and help to make their transfer to wards or other hospitals a smoother process for the patient, their family and other healthcare workers,” says Carole.

Marie was a bit daunted to be part of such a high profile national programme, but adds: “We see ourselves as ambassadors for the RD&E, and know we can make a real



difference and help consolidate this radical new approach to better patient care.”

Their experiences are now helping the national programme to establish the core competencies the critical care practitioners will need, whilst here at the RD&E we're looking to move the process forward by developing an additional role of assistant critical care practitioner.

## RD&E takes a clean hands lead

**National guidelines introduced last year to cut hospital-acquired infection rates were significantly shaped by the RD&E's experience as one of just six acute hospital trusts involved in an innovative pilot project that aimed to promote better hand hygiene.**

The guidelines are based upon the results of a 'clean your hands' campaign led by the National Patient Safety Agency (NPSA), the body set up to improve the safety of NHS patients.

Evidence from national and international studies shows that the bacteria that cause infections - including MRSA - are most commonly spread by hand contact. But they also show that for a range of reasons healthcare workers do not clean their hands often enough.

Two RD&E wards took part in the campaign: our Bramble children's unit and Clyst ward, where we care for stroke patients.

The aim of the project was to encourage patients, carers and staff to remind one another of the importance of good hand hygiene and to make it easier for everyone to keep their hands clean.

To do this we made disinfectant gel dispensers widely available and launched an awareness campaign emphasising the importance of good hand hygiene.

This was backed by our joint medical director, Dr Vaughan Pearce, who appeared on posters and leaflets to show that we meant business.

The pilot showed that the campaign could be highly successful. Hand hygiene compliance on the two wards increased to around 80 per cent and so far the increase has been maintained.

The enthusiasm of the staff played a key part and they must be congratulated for their commitment.



RD&E planning director Nigel Walsh (far left) alongside RD&E cancer services director Martin Cooper and other guests cutting the ribbon for the official opening in February 2005 of the superb new FORCE cancer support centre. FORCE is a local charity that raised the £900,000 needed to build the centre it runs at the RD&E main hospital site at Wonford.

## About the RD&E

**This annual report gives a summary of the work of the RD&E NHS Foundation Trust for the year 2004/05.**

The RD&E provides acute hospital services to the people of Exeter, East Devon and Mid Devon, a core population of around 350,000 people.

We also offer specialist services such as cancer care, plastic & reconstructive surgery, orthopaedic surgery, paediatric care and renal services to people living further afield in Devon, Cornwall & the Isles of Scilly, Somerset and Dorset.

Most of our services are based at our main hospital at Wonford in Exeter.

This hospital has been redeveloped over this past decade, bringing ophthalmic and orthopaedic services onto our main site to establish the West of England eye unit and the internationally renowned Princess Elizabeth orthopaedic centre.

This redevelopment programme will continue when maternity, neonatology and gynaecology services relocate from nearby Heavitree Hospital to a new, purpose built centre at Wonford in 2006.

The RD&E also runs:

- The Honeylands children's centre (specialist assessment and support for children with special needs and their families).
- The Exeter mobility centre (orthotics, prosthetics and wheelchairs & special seating).
- The Mardon centre (neuro-rehabilitation).

Across these sites we have around 850 inpatient beds and more than 60 daycase beds.

We spent around £225m to provide healthcare services in 2004/05 (£193 million in 2002/03) and at the end of the financial year we employed more than 5,800 people.

In planning and developing services to meet the healthcare needs of the people we serve we work closely with the:

- South West Peninsula Strategic Health Authority.
- The East Devon, Exeter and Mid Devon primary care trusts.
- The Devon Partnership NHS Trust (mental health and learning disabilities).
- Northern Devon Healthcare NHS Trust.
- The West of England Ambulance Service Trust.
- Devon County Council social services.

The RD&E is proud to be a partner in the Peninsula Medical School that links together the universities of Exeter and Plymouth with the local NHS to provide medical education and research.

## Activity increases, year on year

**The RD&E cared for more patients in 2004/05 than in the previous year. And the number of patients we saw as an emergency reached a new record high.**

Despite this level of activity we succeeded in hitting our March 2005 year-end targets for inpatient, outpatient and emergency department waiting times.

This meant that:

- 98 per cent of patients coming to our emergency department were admitted, discharged or transferred within four hours.
- No one was waiting more than 13 weeks for a first outpatient appointment.
- No one was waiting more than nine months for inpatient treatment.
- All patients referred as urgent by their GP with suspected cancer saw an RD&E specialist within two weeks.
- All patients with breast cancer started treatment within a month once the course of treatment was agreed.
- More and more of our patients have an appointment date and time that suits them.

**The numbers we see** (03/04 figures in brackets)

● Inpatients and day case:	112,960	(109,881)
● Outpatients:	256,932	(251,810)
● Emergency admissions:	27,577	(26,444)
● Emergency dept attendances:	62,772	(61,858)
● Babies born:	2,922	(2,852)



# THE CHANCE TO EAT IN PEACE

*“The NHS Plan urges us to offer patient-centred care and this means listening to patients and responding to what they say. We must never forget that they’re the experts when it comes to the experience of life on a ward.”*

## Calling time on lunchtime disruption

Over the year we’ve been phasing in what we call ‘protected mealtimes’ on our wards to give our patients the chance to eat their lunch in peace.

During these times we only do the most urgent clinical work and we ask family and friends to play their part by not visiting or phoning if they can avoid this.

The time of lunch varies from ward to ward, but our staff make sure that patients and visitors know when and where protected mealtimes apply.

“Research suggests that some patients don’t eat enough during a hospital stay,” explains our director of nursing & service improvement, Marie-Noelle Orzel.

“Sometimes they feel too poorly to eat. But they also tell us that disturbances on the ward – even visits by loved ones - can be a factor.

“The NHS Plan urges us to offer patient-centred care and this means listening to patients and responding to what they say. We must never forget that they’re the experts when it comes to the experience of life on a ward.

“Our aim is to ensure that patients can enjoy their meal – and as the first acute hospital trust in the country to launch the Better Hospital Food programme the reputation of our catering services is second to none.

“Protected mealtimes give patients time to eat in peace and get the best nutritional value from their food, whilst we’re able to focus on the patients who need our help the most.

“Of course, we always deal with an emergency on a ward as a top-priority in the usual way. And we try to be flexible with visiting times when we know that visitors face problems, for example because of the times of public transport from where they live.”



## Big lift delivers new theatre

**The biggest telescopic crane in the land came to the RD&E in January to help us construct a new operating theatre and extra space for our emergency department.**

The parts of the building were built off-site by a leading provider of modular operating theatres, PKL Healthcare.

They were then brought to Wonford by road and lifted over the top of our main hospital building and placed with meticulous care by crane into the courtyard next to our current operating theatres.

We are leasing the new building from PKL for five years at a cost of around £1m to give us much-needed extra operating theatre space whilst we develop our plan to construct a new £25m diagnostic and treatment centre at Wonford, including four new theatres for day-case surgery.

Work is also underway to expand our cardiology department, including the provision of a second cardiac catheterisation laboratory. We also plan to expand and improve the accommodation for our diabetes service, provide new intensive care beds and expand our endoscopy and central records facilities.

The £38m costs of our planned capital programme will be funded by a mix of internally-generated funds and long-term borrowing from the NHSFT financing facility.

# NEW LIFT FOR P&R

RD&E transport manager Bob Adams (right) with Kevin Busby from Dartline.

## Extra investment brings new buses

The demand for somewhere to park is one of the biggest headaches faced by hospitals everywhere, but as the first hospital trust in the southwest to set up a park & ride bus service, the RD&E has shown an imaginative response to the problem.

Providing more car parks is not an option. We have around 1,550 spaces already at our Wonford and Heavitree sites and the planning authorities want to keep it at this level because they quite rightly need to control traffic congestion in the city.

And even if we could provide more spaces, we'd never provide enough. We're the biggest employer in the area and hundreds of thousands of people come to the RD&E every year. We get busier all the time.

Our park & ride service was set up at the end of 2001, and new investment means that it has just got even better.

Last year, after retaining the contract after competitive tender, our service provider Dartline Coaches introduced new Optare Solo buses as a short-term trial. Passenger feedback was so positive that as the financial year closed they brought three of these superb new models into permanent use.

The Optare Solo can carry more passengers overall and is much easier for people with mobility problems to use because it has a low floor which can be lowered further to give wheelchair access.

"Passengers like the easy access and the RD&E thought the Optare Solo was well-suited to the many people with mobility problems who come to the hospital," says Dartline's manager Kevin Busby.

"Our drivers liked the good view through the deep windscreen and the comfortable driving position. And it is a cost-effective bus to operate and maintain.

"As a result of the positive outcome from our evaluation exercise, we bought three!"

So, if you plan to come to the hospital by car, please think about using our park & ride service. Buses run frequently from the park & ride site at Digby (near Tesco and junction 30 of the M5) weekdays until around about 7pm. The site is kept secure by SWS Secure Ltd.

Our main focus up until 9am is to get our staff to work, but we then encourage patients and visitors to use the service throughout the day. The service is quick and efficient and represents terrific value for money.

**For more details about our park & ride service see [www.rdehospital.nhs.uk](http://www.rdehospital.nhs.uk) or call (01392) 402358.**



## Maternity relocation moves closer

The construction of our superb new £27m maternity, gynaecology and neonatology centre at Wonford Hospital is now in full swing and will be completed in the summer of 2006.

By shifting these services from their current home at Heavitree Hospital we'll conclude the long-term redevelopment of our Wonford site and the concentration of all our acute services at a single location.

In this way we'll overcome the difficulties that can arise when hospital services are spread across two locations and will be able to improve significantly the quality of service we offer to women and their families.

It will bring closer to hand all the specialist support that a mother or her baby might need in an emergency. It will make it easier for us to call upon the full range of diagnostic services.

The new centre will contain:

- New wards for ante and post-natal care and for gynaecology.
- Day care facilities.
- Delivery rooms.
- A new neonatology unit.
- A gynaecology assessment area.
- Three new operating theatres (including maternity).
- A café for patients, visitors and staff.



Our project manager Mike Odgers (right) with Graham Holt, site manager for the construction contractors, HBG.



Some of our health records team, which was described as 'one of the best in the country' by the independent research and audit agency, CASPE.

CASPE renewed our health records accreditation for the maximum three-year period, making us one of only two NHS trusts nationwide to retain the award.

## Your views count

### We aim to work closely with the people we serve and to develop our services in the light of what they say they need and want from us.

This reflects the vision as expressed in the NHS Plan to put patients at the heart of our decision-making.

Our commitment has become stronger now we are an NHSFT. The principle of public accountability and community involvement is a vital expression of our status as a membership organisation (see page 9 for details).

We also learn a great deal from our commendations and complaints, our patient advice and liaison service (PALS), our patient and public involvement (PPI) work and our inpatient and outpatient surveys.

### Commendations and complaints

In 2004/05 we received 9,241 letters of commendation from patients and carers (10,180 in 03/04) and 309 written complaints, plus 66 requests for compensation (a total of 375, down from 402 the previous year).

The number of complaints represents less than 0.08 per cent of our work and we got 28 letters of commendation for each letter of complaint.

All complaints were acknowledged within five working days (100 per cent 03/04): 91.5 per cent within just two working days (95.5 per cent in 03/04).

We gave our full response within 20 working days to 70 per cent of complaints (67 per cent in 03/04) and within 25 working days to 78.5 per cent of complaints (81 per cent in 03/04).

During the year we appointed a new complaints manager, revised our complaints policy and continued to review services in the light of complaints and improve them where appropriate.

**For more information about our complaints service please call (01392) 403915.**

### Patient advice and liaison (PALS)

Our PALS service can help to resolve matters of concern and guide patients and carers to the service they need.

PALS activity continues to grow significantly and in 2004/05 there were 781 cases (577 in 03/04). The number of cases dealt with by our PALS service has nearly doubled in two years.

Well over half involved concerns or issues and 86 per cent were resolved so that no further action was needed. The rest mostly required advice or information although PALS also provides an informal way to give feedback.

Our PALS service was rated 'green' by the South West Peninsula Strategic Health Authority in February 2005, meaning it was on track to deliver all the goals agreed as part of the PALS annual reporting framework.

PALS is also involved in our disability and diversity work and in work associated with our maternity services, medicines governance and transport.

Feedback shows high levels of satisfaction with the service. Users said PALS had listened to and understood their concerns and kept them informed of progress.

**For more information about PALS at the RD&E please call (01392) 402093.**

### Patient & public involvement (PPI)

Hospitals are required to consult with patients and the public and involve them in decisions about the future. The RD&E is keen to do so because we feel this is the right thing to do.

We work closely with and support the work of the patient & public Involvement (PPI) forum for the RD&E. PPI forums aim to:

- Promote better public involvement.
- Encourage others to get involved.
- Discover what local people really think about health.
- Help shape decisions which impact on health.

You can also let us know what you think by becoming a member of the RD&E NHS Foundation Trust (see page 9).

**For more information about our NHS Foundation Trust arrangements or the RD&E's PPI forum please call (01392) 402187.**

### National patient surveys

Patients spoke highly about us in the 2004 national opinion surveys of patients using acute trust emergency departments and outpatient departments, conducted by the independent Healthcare Commission.

We were ranked 'as good as' the other trusts in two-thirds of the outpatient survey questions and 'significantly better' in the other third.

We also did 'significantly better' than the other trusts in just under half of the emergency department survey questions and 'as well as' the other trusts in most of the rest.

Patients said we needed to do better in areas such as car parking, seating and patient information. Improvement action plans are in hand.

**For details of these surveys please visit the Healthcare Commission's website [www.healthcarecommission.org.uk](http://www.healthcarecommission.org.uk)**



Members of our breast care team, seen left, was the only team nomination to proceed to join the eleven individual members of staff who received the annual chairman's award at a ceremony in January 2005. The award recognises the commitment and professionalism of RD&E staff.

## At the heart of our services

**A total of 5,822 people worked for us full or part time at the end of March 2005 (409 more than 2003/4) and we remain the biggest employer in the Exeter area.**

During the year we started to implement Agenda for Change, the biggest change to staff pay and terms & conditions since the birth of the NHS. This will carry on until the end of 2005/6. Workforce Modernisation is now a major strategic initiative for the RD&E.

We are committed to fairness and respect for all patients and staff. As part of this commitment progress against our Race Equality Scheme and Action Plan will be reported in the Trust annual report in future. We have also published our Equality and Diversity Statement. This includes:

- employing a workforce that is representative of the local community
- implementing recruitment and selection processes which are non-discriminatory and encourage applications from all groups in the community
- ensuring that all employees have fair access to learning and development opportunities
- providing a safe and accessible working environment that values and respects the identity and culture of each individual
- ensuring that access to information is as open and transparent as possible

- ensuring a culture and working environment free from discrimination, harassment and violence
- encouraging and supporting all staff to reach their full potential

We have policies in place to be fair in all aspects of a staff member's experience of employment with us. We have a Diversity Steering Group to promote understanding and training to ensure that staff both experience respect in the workplace and are fully able to meet the needs of the patients we serve.

We consult with staff formally through the Joint Staff Forum and the Health and Safety Committee.

We know that for staff to enjoy their work and provide a first class service they need to be involved in decisions that affect them. We have continued to develop this area of our work through the Improving Working Lives initiative and we will seek Practice Plus accreditation in 2005/6. We have also improved childcare facilities this year and have ambitious plans to make further improvements in the future.

All staff have confidential self-referral access to the trust's in-house occupational health and staff support and counselling service.

We now recruit to many posts by means of the internet as e-recruitment became a reality in 2004/5. We aim to promote job opportunities with the RD&E in this way further. All our job vacancies can be found via [www.rdehospital.nhs.uk](http://www.rdehospital.nhs.uk)

### At the forefront of knowledge

There is considerable external recognition of the high quality of the RD&E's research and development (R&D) work and in 2004/05 we received over £800,000 NHS R&D funding and external grant income of over £2m. Trust staff wrote 109 research papers on a wide range of topics and four members of the diabetes research team won national and international research awards.

#### Testing treatments

Clinical trials help us to know if new treatments are better for patients. Trials benefit not only the patients in the trials but also improve our knowledge of when new medicines should be used. Exeter has led the way nationally in the recruitment of trials in cancer, leukaemia, diabetes and Parkinson's Disease.

#### Teenage teachers

Dr John Tripp and his Exeter based team have pioneered the development of peer-led sex education. The approach has had an impact on reducing teenage pregnancy rates and sexually transmitted diseases and is now being implemented throughout the UK and Europe.

#### Diet dilemmas

Despite the controversy about low carbohydrate diets such as the Atkins' diet, researchers in Exeter observed that many patients with diabetes could do extremely well with these. With grant funding from Diabetes UK, Mark Daly has set up the largest long-term study in the UK to see whether low carbohydrate diets can help patients reduce weight and control their diabetes. This approach will be compared with conventional dietary advice to see if it represents a real step forward.

#### No needles

The genetics laboratory led by Sian Ellard discovered that most patients diagnosed with diabetes within the first six months of life had a change in the Kir6.2 gene. This has revolutionised the lives of these patients because we have gone on to show that these patients, who previously took insulin injections four times daily, can have good blood sugar control by taking tablets. News of this test has spread rapidly and samples have been received in Exeter from patients from 30 countries.

## Helping to make the RD&E better

**We became one of the country's first NHSFTs because this gave us an opportunity to forge new links with the people we serve and to develop new ways of meeting their needs and wants.**

To drive this process forward we asked local people to become members of the RD&E – in effect, to register their support for our NHSFT bid and their desire to be involved in our future – and we were delighted when 8,995 people responded to our first appeals.

Membership has since become one of the cornerstones of the RD&E as an NHSFT and our total now exceeds 15,100.

### Our NHSFT constituencies

Anyone who uses our services, or who lives in the area we serve, has the right to become a member of the RD&E.

We have created three NHSFT membership constituencies to follow the local council boundaries in the area where our core population lives. NHS services in this area are commissioned by three local primary care trusts – Exeter, East Devon and Mid Devon.

We also provide specialist services to a wider population in Devon and beyond into Cornwall & the Isles of Scilly, Somerset and Dorset. So we have set up a fourth NHSFT constituency for this larger area.

All our staff are classed as NHSFT members, so this becomes a fifth constituency.

### Involvement to suit you

You decide as an NHSFT member the level of involvement that's right for you. But whatever you choose – from telling us what you think at meetings or via surveys to electing your representative on the council of governors (see next column) – you play a key role in shaping our future.

We hold membership meetings every three months in each constituency area. These are open to all but members are specifically invited.

A variety of topics are discussed at the meetings: transport, for example, or infection control. Members also hear about the previous meeting of the council of governors and can ask about the RD&E's general strategy. Issues of concern are fed into the RD&E and a quarterly membership newsletter is also produced.

### Our membership strategy

Our members help us to identify and prioritise the needs and wants of our community.

So it's essential that we do all we can to ensure that our local population is properly reflected in our membership. With this in mind, we want to recruit additional younger members, for example, because older people are over-represented. And we'll focus on recruiting members from under-represented geographical areas, especially in the more remote rural areas.

**If you would like more information about getting involved with the work of the RD&E – and about NHSFT membership – please call us on (01392) 403977.**

Our NHSFT team: company secretary Tony Taylor, head of membership Pauline McCluskey (centre) and admin manager Tori Paterson.



## What's the CoG?

**The RD&E's council of governors - or the CoG as we call it - was established as we became an NHSFT and is made up of governors who are either:**

- Elected by members of the RD&E NHSFT living in each of our constituencies.
- Elected by our staff.
- Appointed by our local partners including the local primary care trusts (PCTs), local councils, Exeter University and voluntary organisations.

The first CoG elections were held in March 2004 as our NHSFT bid was about to be approved and the turnout for the ballot was 56 per cent.

The CoG meets four times a year, bringing together the governors to represent their community and to help shape the development of the RD&E as an NHSFT.

The governors discuss new service developments, review how NHSFT members are recruited and kept informed and look at the annual report and accounts.

They can also:

- Appoint or remove the trust chairman and non-executive directors.
- Approve the appointment of the trust's chief executive.
- Decide the remuneration, allowances and other terms and conditions of office of the non-executive directors.

No governor holds a directorship in a firm that does business with the trust. However, one governor is involved in NHS contracts with the South West Peninsula Statagic Health Authority. For further information please contact the RD&E's company secretary on (01392) 402993.

Governors also meet with people in their local community (or in the case of staff governors with staff at the RD&E) four times a year to report on what happens at the CoG and to collect new ideas and opinions.

Elections to the council of governors take place every spring and governors generally serve a three-year term beginning at our annual members' meeting in October.

**However, because these arrangements have only been in place since we became an NHSFT in April 2004 the current situation is a little different.**

In June 2005 the following governors are standing for re-election: Linda Fryer, Margaret Read and Ivor Watts.

Two new staff governors will also be chosen to replace Robert Flint and Shirley Stunnell, who have both stood down.

The following governors will be due for re-election in June 2006: Victor Bloom, Tony Cox (staff), Gordon Davies, Margaret Green, Rachel Jackson, Roger Smith, Stanley White and Rosemary Whitehurst.

A governor does not need to have special skills or qualifications but they should be enthusiastic and willing to represent the views of others.

They also need to be an RD&E NHSFT member and are expected to attend training events to learn more about being a governor and to keep them up to date with what's happening in the NHS.

## The view of the governors

**The RD&E's success in becoming one of the first NHSFTs is something we celebrate, writes Margaret Green, vice chair of the council of governors.**

We recognise, of course, that this is something new, that the NHSFT concept is still at an embryonic stage and that we are all feeling our way forward.

So the idea that we're in at the start and that we all have our part to play is one of the reasons why being a governor feels so worthwhile.

We've been on a steep learning curve over this first year, but we believe that we've got off to a good start in terms of commenting, reporting and informing the public about what we're doing and have achieved.

We played a key part in the appointment of the auditor and the new non-executive directors (see opposite page).

We're very aware, though, that true engagement with constituents to ensure a representative view is not easy to

achieve and that how we relate to our constituents through our constituency meetings is a big issue. There's a lot for us to do, but we are excited about the prospects.

We agree with the idea that as one of the country's leading hospital trusts the RD&E has earned the right to have more freedom to develop its healthcare services to meet the needs and wants of local people. As governors, we can help with this process in our constituencies.

This doesn't mean that the trust shouldn't strive to meet nationally set targets and standards. It should. And we congratulate the RD&E's superb staff team for hitting and in some cases going beyond these.

But it does mean that in the uncertain world in which the RD&E operates, especially with a tough financial outlook, with targets that are becoming ever more demanding and with uncertainties about the way the NHS is organised in our region, the trust must strive to maintain the high standards of patient care for which is so well known.

### Get to know your governors

#### Public constituency area: East Devon

##### Margaret Green<sup>2</sup>

Lives in Ebford near Exeter. Retired nurse teacher with a career in nursing or health work. Vice-chair Hospiscare Exeter and Mid Devon.

##### Linda Fryer<sup>1</sup>

Lives in Newton Poppleford. Was a manager in education and social care and has represented patients on the Peninsula Cancer Network and the RD&E cancer/carer user group.

##### Ruth Kelly<sup>1</sup>

Worked as a cytologist at the RD&E's pathology laboratory for 43 years. Involved in the Girls' Brigade nationally and internationally.

##### Gail Nunan<sup>3</sup>

Lives near Axminster. Gained over forty years' nursing experience in the UK and overseas.

##### Dr Bob Doy<sup>3</sup>

Lives in Exmouth. Retired doctor who has worked in the NHS and abroad.

##### Dr Stanley White<sup>2</sup>

Lives in Honiton. Financial controller and executive administrator of a West German charity working in India before retirement.

#### Public constituency area: Mid Devon

##### Gordon Davies<sup>2</sup>

Lives in Tiverton. Former ICI senior manager, then a management consultant & businessman. Active for Tiverton Hospital League of Friends.

##### Reuben Miles<sup>3</sup>

Lives in Crediton. Semi-retired pharmacist, previously community pharmacist then regional manager of a group of pharmacies. Active for the RD&E League of Friends.

##### Roger Smith<sup>2</sup>

Lives in Black Dog, Crediton. Held senior positions in industry. Currently volunteer advisor with the Citizens Advice Bureau and trustee on the management board of Teignbridge CAB.

##### Ivor Watts<sup>1</sup>

Lives in Tiverton. Career in education. Worked for 25 years with the British Council, with managerial responsibility overseas.

#### Public constituency area: Exeter City

##### Margaret Cushing<sup>1</sup>

Lives in Exeter. Recently retired, experience of teaching and further education management.

##### Peter Davey<sup>3</sup>

Lives in Exeter. Active member of local church council and trustee of the Clyst Caring Friends. Volunteer for the Stroke Association.

##### Rachel Jackson<sup>2</sup>

Lives in Stoke Cannon. Mother of five who cares as well for elderly relatives. Recently retired as superintendent of a physiotherapy service with 40 years' clinical experience.

##### Dr Imraan Jhetam<sup>3</sup>

Lives in Exeter. A GP for eighteen years and a police surgeon for the last six years.

##### Margaret Read<sup>1</sup>

Lives in Exeter. Retired teacher of health & social policy. Active in local interest groups and a member of St Leonard's church for 25 years.

##### Rosemary Whitehurst<sup>2</sup>

Lives in Topsham. Interest in healthcare of older people and carers. Vicechair of Carers UK (Exeter). Member of the RD&E's PPI Steering Group and Exeter PCT Patients' Forum.

#### Public constituency area: other parts of Devon, Cornwall & the Isles of Scilly, Dorset, Somerset

##### Dr Brian Perriss<sup>3</sup>

Lives in Chudleigh. Retired consultant anaesthetist, worked at the RD&E until 2002.

##### Prof Ian Mercer<sup>1</sup>

Lives in Moretonhampstead. Held senior positions in a national park authority and a government agency. Governor of the University of Plymouth and of Stover school.

##### Dr Victor Bloom<sup>2</sup>

Lives near Ashburton. A registered medical practitioner with experience as a specialist in general medicine and occupational medicine.

#### Staff governors

##### Tony Cox<sup>3</sup> allied health professionals

Clinical director for professional services and directorate manager for diagnostics.

##### Robert Flint<sup>2</sup> hotel services and estates

Porter in the patient portering services dept.

##### Dr Paul Marshall<sup>2</sup> medical and dental

Consultant anaesthetist in Exeter since 1982.

##### Cheryl Vidall<sup>3</sup> nursing and midwifery

Colo-rectal nurse specialist.

##### Shirley Stunnell<sup>1</sup> managerial, administrative & clerical

PA to the chief executive. Seven years' experience of work in the NHS.

#### Appointed governors

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

**Cllr Alan Connett**, district councils of North Devon, Teignbridge and Torridge. Replaced on the CoG in January 2005 by **Cllr Marguerite Shapland**.

**Cllr David Cox**, East Devon District Council.

**Ann Crawford**, voluntary sector.

**John Dowell**, director of finance, Exeter PCT.

**Denise Fardon**, voluntary sector.

**Ann Mattock**, Mid Devon PCT. Replaced on the CoG in March 2005 by **Neil Gilmour**, chair of the Patients' Forum, Mid Devon PCT.

**David Johnstone**, director of social services, Devon County Council.

**Cllr Dennis Knowles**, Mid Devon District Council.

**Dr Ali Round**, director of public health, East Devon PCT. Replaced on the CoG in April 2005 by **Liz Smith**, head of nursing and human resources, East Devon PCT.

**Cllr John Shepherd**, Exeter City Council.

**Kate Tomkins**, chief executive North Devon PCT (also represented Teignbridge PCT). Replaced on the CoG by **Jac Kelly**, the new chief executive at North Devon PCT.

**Professor Paul Webley**, Peninsula Medical School.

Figures after names indicate term of office in years. The Register of Governors' Interests may be viewed at [www.rdehospital.nhs.uk](http://www.rdehospital.nhs.uk)

**Our board of directors is responsible for the management of the RD&E and is accountable to the membership (see page 9) via the council of governors (see pages 9 & 10) for its overall performance.**

The board of directors is made up of executive directors who work at the RD&E as part of the senior management team, and non-executive directors, who will bring independent judgement and scrutiny to the board to ensure that sound and well-informed decisions are made.

Non-executive director appointments may be terminated on performance grounds or for contravention of the qualification criteria in our NHSFT constitution by a three quarters majority of the council of governors voting at a governors' meeting, or by mutual consent for other reasons.

For the purposes of this report the disclosure of remuneration to senior managers is limited to executive directors.

## Our board of directors

### Non-executive directors

#### **Professor Ruth Hawker OBE** *chairman\**

Ruth has been chairman since 1995. When the RD&E became an NHSFT in 2004 she agreed to remain in post transitionally until May 2006. After a nursing career that started in Exeter in 1956, she became chief executive of the Tor & South West College of Health Studies, then responsible for all nurse and radiographer training in the region.

#### **Gerald Sturtridge\***

*non-executive director and vice-chairman*  
Gerald joined the board in November 1998 and his appointment runs until October 2006. He retired from accountancy practice in 1997 to develop other business interests and is involved with voluntary agencies working with disabled and disadvantaged people.

#### **Bob Baty OBE** *non-executive director\**

Bob joined the board in September 2004 and his appointment runs until August 2007. He is a chartered civil engineer who has worked all his life in the water industry and is now chief executive of South West Water Ltd.

#### **David Bishop** *non-executive director\**

David joined the board in February 2005 and his appointment runs until January 2008. He is a retired senior partner with KPMG who was involved with major projects such as the Thames barrier and the channel tunnel and has served on government working parties.

#### **Maureen De Viell OBE\***

*non-executive director*  
Maureen joined the board May 2001 and was reappointed following a competitive process until March 2008. She is a retired civil servant with experience of social policy and equality issues who received an OBE for her services to the Employment Department.

#### **John Evans** *non-executive director\**

John joined the board in September 2004 and his appointment runs until August 2007. He is a partner in the international law firm of Coudert Brothers where he specialises in employment law. He has a background in commercial litigation and arbitration and has represented many NHS trusts.

#### **Rick Walker** *non-executive director\**

Rick joined the board in May 2001 and was reappointed following a competitive process until March 2008. He is a retired senior police officer.

**Richard Smith retired as a non-executive director in June 2004 after serving on the board with distinction for eight years, including six years as vice-chairman.**

### Executive directors

#### **Angela Pedder** *chief executive*

Angela joined the NHS in 1975 and was chief executive of St Alban's & Hemel Hempstead NHS Trust before becoming chief executive at the RD&E in 1996.

#### **Steve Astbury**

*director of finance and IM&T*  
Steve worked in the private sector before joining the NHS in 1984, becoming director of finance and information at the RD&E in 1985. He retired from the RD&E in March 2005.

#### **Mike Stevens joined the RD&E as director of finance and IM&T in April 2005.**

#### **Elaine Hobson** *director of operations*

Elaine is a qualified nurse who has held a number of positions at the RD&E, becoming director of operations in December 2000.

#### **Steve Jupp** *director of human resources*

Steve joined the RD&E as HR director in 1995 having previously worked in the private sector and the NHS.

#### **Marie-Noelle Orzel**

*director of nursing & service improvement*  
Marie-Noelle joined the RD&E as director of nursing in January 2002 after working as a nurse in A&E and paediatrics in London, Oxford and Portsmouth.

#### **Dr Vaughan Pearce and Dr Iain Wilson**

##### *joint medical directors*

Dr Pearce is as a consultant in the care of the elderly and general medicine. His special interests include Parkinson's disease and dystonia.

Dr Wilson is a consultant anaesthetist. He was the RD&E's director of medical education from 2001-3 and is a council member of the Association of Anaesthetists of GB & Ireland and a committee member of the World Federation of Societies of Anaesthesiologists.

### Other board members

#### **Linda Hall** *director of facilities*

Linda is a qualified occupational therapist who has worked in the NHS since 1980. She has held a variety of posts at the RD&E, becoming director of facilities in January 2001.

#### **Nigel Walsh** *director of planning*

Nigel was the general administrator for the RD&E Hospitals before becoming development manager and then planning director of the RD&E's redevelopment programme.

### Other key RD&E committees

**The audit committee** is made up of non-executive directors, not including the chairman. It meets regularly to review the work of the internal and external auditors.

#### **The executive director remuneration committee**

is made up of all non-executive directors. It meets to review the performance and set the pay of the chief executive and other executive directors.

**The governance committee** is made up of a number of non-executive and executive directors. It manages the RD&E's compliance with clinical governance arrangements.

### Directors' interests

**You can arrange to see the register of directors' interests during normal office hours by contacting the RD&E NHS Foundation Trust secretary on (01392) 402993. You can also view this in the RD&E's website [www.rdehospital.nhs.uk](http://www.rdehospital.nhs.uk)**

The RD&E follows government guidance on corporate governance and a director with interests outside the NHS that may conflict with their role is excluded from discussions and decisions on matters affecting those interests. Under that guidance the interests of the following board members are declared:

#### **Professor Ruth Hawker**

Pro-chancellor the University of Exeter; trustee St Loye's College, Exeter.

#### **Gerald Sturtridge**

director of County Environmental Services Ltd, County Environmental Trust, Witchwood Media Ltd and University of Exeter in Cornwall Enterprises Ltd; advisor Leander Developments; chairman Island Trust; secretary Transit International Group Ltd; treasurer University of Exeter.

#### **Bob Baty**

executive director Pennon Group plc; chief executive South West Water Ltd.

#### **David Bishop**

senior advisor KPMG; chairman of Compass Group Pension Fund Ltd; non-executive director Cornwall Community Foundation Ltd, Trewane Property Holdings Ltd and Diocesan Board of Finance Ltd; council member International Chamber of Commerce.

#### **Maureen De Viell**

chair Budleigh Salterton medical centre patient participation group; member Budleigh Salterton health & social care team; member Budleigh Salterton Hospital consultation group.

**John Evans** partner Coudert Brothers.

#### **Elaine Hobson**

partner works for Exeter Nuffield Hospital.

#### **Marie-Noelle Orzel**

director/trustee Injury Minimisation Programme for Schools.

#### **Dr Iain Wilson**

council member Association of Anaesthetists of GB & Ireland; committee member World Federation of Societies of Anaesthesiologists.

# Operating and financial review for the financial year 2004/05

The Royal Devon and Exeter NHSFT was formed on the 1st of April 2004 adopting a financial strategy based on addressing its underlying financial deficit and delivering a small surplus which would largely be achieved through early adoption of the national Payment by Results regime which would result in the Trust's income increasing to match the average level of spend per patient nationally over a four year period.

The Trust achieved its operational income expectation as planned, achieved all the required waiting times targets for outpatients, inpatients and A&E and benefited from the first phase of movement towards the national average income.

However, it became apparent early in the year that although the Trust had addressed its underlying deficit, the first year's movement towards national tariff would be insufficient to address the shortfall in funding that would result from new unavoidable external cost pressures largely resulting from the most significant reforms of national staff pay arrangements that the NHS has ever experienced and additionally the costs incurred in meeting the national four hour waiting time target in emergency departments.

Without these additional cost pressures the Trust would have been reporting a surplus had it been funded at the full national tariff rates in its first year. As a result of these changes, which the Trust had been forecasting since May 2004, the final end of year results show a deficit of £7.3m deficit (including a technical adjustment in respect of the valuation of buildings of £0.8m). The trust did not take out any borrowing against its approved £17.1m prudential borrowing limit in its first year as an NHSFT and did not require to make any use of its working capital facility of £4m. The Trust is seeing a reducing amount of private patient activity consistent with that expected from reducing waiting times and so is well within its private patient cap of 1.2%.

In terms of service developments during the year, the Trust opened the Peninsula Medical School building in September 2004 taking in its first set of student doctors. Other significant developments commenced during the year include the

redevelopment of child & women's health services on the main hospital site at Wonford, a new MRI scanner and improvements in facilities for patients with coronary heart disease. In conjunction with Exeter PCT the trust commenced improvement to A&E facilities and the development of an onsite walk in centre.

The charts below show where the Trust derived its income from in 2004/5 and the delivery of patient activity against plan.

### Future outlook

Significant change continues to be made to the national tariff system which determines the level of income that the Trust receives for the patients it treats which for 2005/6 will reduce the level of income by £4m from that which the Trust was previously anticipating. This together with further anticipated cost pressures over the coming years has resulted in the need for the Trust to put in place a challenging cost reduction programme which will release savings of about £5m in each of the next three years in spite of the fact that the Trust remains one of the most cost effective in the country. This programme will ensure that the Trust returns to a revenue surplus position by 2006/7. The Trust is assuming it will need to treat growing numbers of patients which has been agreed with local primary care trusts although PCTs do propose to transfer the treatment of certain patients to a more local setting during the course of the financial year. The Trust continues to treat an ever-growing number of emergency patients seeing record numbers of patients in the final quarter of 2004/05.

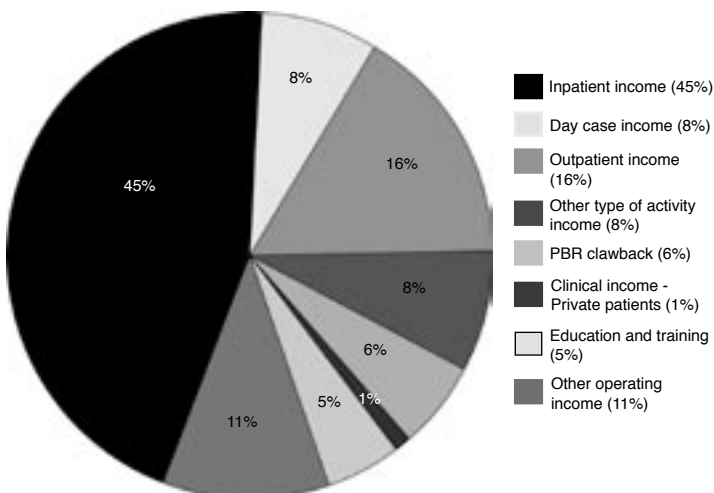
To meet predicted increases in demand the Trust is looking to reconfigure parts of the hospital to achieve improved efficiency and better quality care, increase intensive care facilities and build a new treatment centre. In order to achieve this the Trust is expecting to make use of its new freedoms as an NHSFT to borrow between £15m and £20m over the next two years to ensure these new patient facilities can be brought into use earlier than would otherwise be the case. In order to reduce the risk of operational cash flow difficulties the Trust is also increasing its working capital facility to £18m.

### Mike Stevens

Director of Finance and IM&T

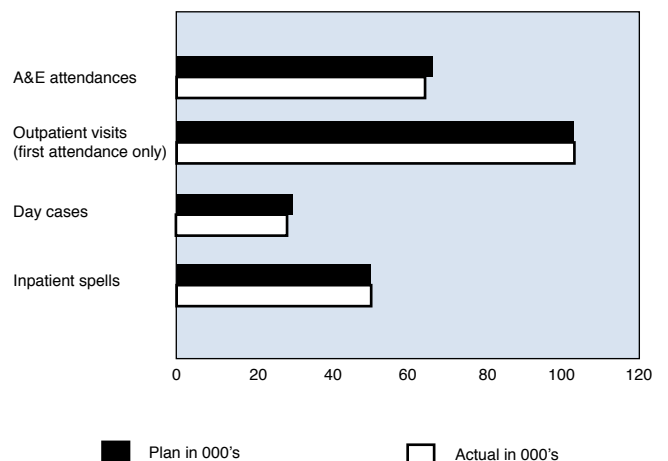
### Sources of income in 2004/05

Where the income came from



### Comparison of actual patient activity against plan

Summary of actiity for 2004/05



# Summary financial statements

The summary financial statements are merely a summary of the information in the full accounts that are available on request from the Director of Finance at the: Royal Devon and Exeter NHS Foundation Trust, Barrack Road, Exeter EX2 5DW. Telephone (01392) 411611.

## ACCOUNTING POLICIES

Monitor has directed that the financial statements of NHS Foundations Trusts shall meet the accounting requirements of the NHS Foundation Trusts Manual for Accounts which has been agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 12/04/2005 NHS Foundations Trusts Manual for Accounts issued by Monitor. The accounting policies contained in the manual follow UK generally accepted accounting practice for companies (UK GAAP) and HM Treasury's Resource Manual to the extent that they are meaningful and appropriate to the NHS. The accounting policies have been applied consistently in dealing with items considered material in relation to the accounts. Details of the Foundation Trust's individual accounting policies are disclosed in the full accounts.

## CASH FLOW STATEMENT

For the year ended 31 March 2005

	2004/05 £000
<b>OPERATING ACTIVITIES</b>	
Net cash inflow from operating activities	8,454
<b>RETURNS ON INVESTMENTS AND SERVICING OF FINANCE</b>	
Interest received	1,215
Interest paid	(7)
<b>Net cash inflow from returns on investments and servicing of finance</b>	<u>1,208</u>
<b>CAPITAL EXPENDITURE AND FINANCIAL INVESTMENT</b>	
Payments to acquire tangible fixed assets	(18,500)
Receipts from sale of tangible fixed assets	915
Payments to acquire intangible assets	(72)
<b>Net cash outflow from capital expenditure</b>	<u>(17,657)</u>
<b>DIVIDENDS PAID</b>	<u>(7,372)</u>
<b>Net cash outflow before financing</b>	<u>(15,367)</u>
<b>FINANCING</b>	
Public dividend capital received	14,262
Other capital receipts	1,384
<b>Net cash inflow from financing</b>	<u>15,646</u>
<b>Increase in cash</b>	<u>279</u>

## PRIVATE PATIENT INCOME

	2004/05 £000	2002/03 £000
Private patient income	1,561	1,806
Total patient related income	180,570	145,349
Proportion (as a percentage)	0.9%	1.2%

Section 15 of the 2003 Act requires that the proportion of private income to the total patient related income of NHS Foundations Trusts should not exceed its proportion whilst the body was an NHS Trust in 2002/03 or the base year.

## EXCEPTIONAL ITEM

Included within operating expenditure is an impairment of £779,000. This relates to the revaluation of the newly constructed Peninsula Medical School building. It has been charged to the Income and Expenditure account due to the valuation provided by the District Valuer being lower than the actual cost of the newly constructed building. The District Valuer has valued the building at depreciated replacement cost which involves the valuer using standard assumptions about the new building which may not be the case in the particular circumstances here. The impairment charge follows the accounting treatment required in the NHSFT Manual for Accounts which is in line with Financial Reporting Standard 11: Impairment of Fixed Assets and Goodwill. Previously, under NHS Trust accounting rules, this charge would have been made to the revaluation reserve and would not have any impact on the Income and Expenditure account. The retained deficit under the previous NHS Trust accounting rules would therefore have been £6,543,000 rather than the current deficit of £7,322,000 using the NHSFT accounting rules. The impairment charge, and the resultant change in the reported Income and Expenditure account, is the result of following FRS 11 and professional valuation rules, rather than the operational decisions of the Board of the NHSFT. This technical accounting adjustment does not have a cash impact on the year.

## OPERATING EXPENSES

	2004/05 £000
Services from other NHS Foundation Trusts	70
Services from NHS Trusts	1,626
Services from other NHS bodies	3,392
Purchase of healthcare from non NHS bodies	112
Director's costs	716
Staff costs	133,762
Drug costs	22,287
Supplies and services (excluding drug costs)	
- clinical	26,652
- general	3,552
Establishment	3,539
Transport	408
Premises	8,112
Bad debts	551
Depreciation and amortisation	9,269
Fixed asset impairments and reversals	779
Audit fees	93
Other auditor's remuneration	3
Clinical negligence	2,239
Other	8,284
<b>Total</b>	<u>225,446</u>

## BETTER PAYMENT PRACTICE CODE

### measure of compliance

	Number	£000
Total bills paid in the year	81,568	97,591
Total bills paid within target	75,068	90,888
Percentage of bills paid within target	92.03%	93.13%

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.

## SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS

### Remuneration 2004/05

Name and title	Salary (bands of £5,000)	Other remuneration (bands of £5,000)	Golden hello/ compensation for loss of office (bands of £5,000)	Benefits in kind (rounded to the nearest £100)
	£000	£000	£000	£000
R Hawker Chairman	20 - 25			0
G Sturtridge Non-Executive Director	5 - 10			100
R Walker Non-Executive Director	5 - 10			0
M De Viell Non-Executive Director	5 - 10			300
B Baty Non-Executive Director	0 - 5			0
J Evans Non-Executive Director	0 - 5			0
D Bishop Non-Executive Director	0 - 5			0
R Smith Non-Executive Director	0 - 5			0
A Pedder Chief Executive	125 - 130			7,900
V Pearce Joint Medical Director	110 - 115	90 - 95		200
I Wilson Joint Medical Director	70 - 75	70 - 75		0
S Astbury Director of Finance	100 - 105			100
S Jupp Director of Human Resources	85 - 90			300
M N Orzel Director of Nursing & Service Imp.	80 - 85			100
R Muskett Acting Director of Finance	0 - 5			0
E Hobson Director of Operations	85 - 90			100
L Hall Director of Facilities	65 - 70			100
N Walsh Director of Planning	60 - 65			0

R Smith resigned 30/6/04.

B Baty was appointed 1/9/04.

J Evans was appointed 1/9/04.

D Bishop was appointed 1/2/05.

R Muskett was Acting Director Finance from 17/3/05.

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

V Pearce's salary and I Wilson's salary include arrears, relating to the year ending 31/3/04 of £35,000 and £7,000 respectively.

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

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 Inland Revenue allowances.

### Pension Benefits 2004/05

Name and Title	Real increase in pension & related lump sum at age 60 (bands £2,500)	Total accrued pension & related lump sum at age 60 at 31 March 2005 (bands of £5,000)	Cash equivalent transfer value at 31 March 2005	Cash equivalent transfer value at 31 March 2004	Real increase in cash equivalent transfer value
	£000	£000	£000	£000	£000
A Pedder Chief Executive	27.5 - 30.0	180 - 185	663	532	117
V Pearce Joint Medical Director	22.5 - 25.0	195 - 200	896	746	129
I Wilson Joint Medical Director	10.0 - 12.5	120 - 125	443	394	34
S Astbury Director of Finance	15.0 - 17.5	90 - 95	352	270	74
S Jupp Director of Human Resources	10.0 - 12.5	65 - 70	268	210	53
M N Orzel Dir of Nursing & Service Imp.	12.5 - 15.0	70 - 75	237	180	52
R Muskett Acting Director of Finance	2.5 - 5.0	40 - 45	123	105	15
E Hobson Director of Operations	20.0 - 22.5	120 - 125	426	328	89
L Hall Director of Facilities	15.0 - 17.5	80 - 85	283	215	62
N Walsh Director of Planning	10.0 - 12.5	90 - 95	395	331	55

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 actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 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.

## Royal Devon and Exeter NHS Foundation Trust General Charity

The Royal Devon and Exeter NHS Foundation Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity (Registered Charity No 1061384). The Foundation Trust has received during the year £43,000 revenue and £84,000 capital payments from the charity. The Charity is registered with the Charity Commission.

## STAFF COSTS

	2004/05 £000
Salaries and wages	108,102
Social Security Costs	8,609
Employer contributions to NHSPA	13,399
Agency and contract staff	4,313
	<u>134,423</u>

### THE LATE PAYMENT OF COMMERCIAL DEBTS (INTEREST) ACT 1998

There were no amounts included within interest payable arising from claims made by businesses under this legislation.

### PRUDENTIAL BORROWING LIMIT

	Total £000
Prudential borrowing limit set by Monitor	17,100
Actual borrowing in the year	<u>Nil</u>

The Trust has a £4,000,000 approved working capital facility in place although this was unused during the year. In line with Monitor's working capital facility guidance the Trust has agreed a Working Capital Facility of £18,000,000 and is awaiting Monitor's approval.

# Statement on internal control

## 1.0 Scope of responsibility

1.1 The Board is accountable for internal control. As Accounting Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accounting Officer Memorandum.

1.2 The Trust is an NHS Foundation Trust and as such has a three-year strategy which it consulted on widely during the Foundation consultation. This strategy was subsequently taken to the council of governors which is made up of partner organisations, staff and public members. The council of governors meets regularly during the year and holds constituency meetings between the main meetings so that the membership can be engaged in the development of the organisation.

At an operational level the Trust performance against contract is reviewed at the monthly contract review meetings with the purchasers. The north and east Devon meeting is lead by the Exeter PCT, with representatives from each of the other three north and east Devon PCTs, plus the nominated contract managers of the RD&E. There are regular meetings with all PCT purchaser leads in this format.

1.3 Internally, overall performance is monitored at the monthly meetings of the board of directors. Operational management and coordination of the Trust services is delivered via the trust executive, which comprises executive directors and clinical directors. Performance of individual clinical and non-clinical directorates is monitored informally on a monthly basis and formally on a quarterly basis via the Quarterly Review process.

1.4 Responsibility for the risk management process is divided between executive directors. The medical director is responsible for clinical risk management, the director of finance and information for financial risk management and the director of human resources is the nominated lead for health & safety.

1.5 A governance committee, which is a sub committee of the board of directors, manages the whole risk management agenda. A non-executive director chairs this committee with appropriate membership from executive directors and senior clinical staff. The Trust risk management strategy details the terms of reference of this committee.

## 2.0 The purpose of the system of internal control

2.1 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 organisation's policies, aims and objectives.
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2.2 The system of internal control has been in place in the RD&E NHS Foundation Trust for the whole year ended 31 March 2005 and is ongoing including the period to the date of approval of the annual report and accounts.

## 3.0 Capacity to handle risk

3.1 The governance committee provides leadership to the risk management process. This committee deals with all types of risk, both clinical and organisational. The risk management department offers advice and teaching to the Trust on all matters of risk management. Specialist functions also exist within the Trust to manage various agendas. These include:

- Governance & risk manager.
- Fire, infection control and radiation advisors.
- Occupational health physician and advisors.
- Governance support unit.
- Trust solicitor.
- Complaints department.
- Patient Advice & Liaison Service.

3.2 Guidance and training is provided to staff through induction, update, specific risk management training, policies and procedures, information on the Trust intranet and feedback from audits, inspections and incidents. Included within all of this is sharing of good practice and learning from incidents.

3.3 Risk management training courses are run on a regular basis to teach the necessary skills needed to undertake risk management duties. Courses are also run in incident investigation to enable the Trust to learn from incidents.

3.4 Policies and procedures are ratified on a regular basis to offer guidance to the Trust and information to a wider audience on how the Trust manages risk. These include: risk management strategy; incident reporting and investigation policy and procedure; risk assessment policy and procedure.

## 4.0 The risk and control framework

4.1 A key element of the risk management strategy is a standard methodology in which risk is evaluated. This is via a likelihood-consequence matrix. The roles and responsibilities of key players and all members of staff within the organisation are also detailed. The terms of reference of the governance committee and the governance structure is also highlighted along with the terms of reference of all committees reporting to the governance committee.

4.2 Directorate governance groups undertake risk management activities within their own sphere of responsibility.

4.3 The Trust utilises a risk register in order to manage both the higher level and Trust wide risks that are faced by the Trust. Directorate based risk registers have also been developed to enable directorates to manage the risk assessment process.

4.4 The board has approved an assurance framework, which covers the key priorities of the Trust. Where gaps in control or assurance have been highlighted to the board, these have been placed on the risk register. A board approved action plan is in place to address the gaps where the board considers the risks require action.

4.5 The assurance framework is split into a number of areas that includes the regulatory, national, local and commissioner issues. These are:

- Monitor.
- Healthcare Standards.
- Service development strategy.
- Local delivery plan.

4.6 A database of information regarding external sources of assurance that the organisation uses has also been produced.

4.7 PCT consultation on the wider aspects of risk (eg on access risk issues) is undertaken through regular meetings on the local delivery plan and monthly contract management meetings.

4.8 Planning risk issues are discussed with the local authorities via scrutiny committees. The Trust also involves the media in matters relating to communication with the public. An example would be in managing the risks around infection outbreaks.

## 5.0 Review of effectiveness

5.1 As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The head of internal audit provides me with an opinion on the overall arrangements for gaining assurance through the assurance framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The assurance framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review has also been informed by the Clinical Negligence Scheme for Trusts and the Risk Pooling Scheme for Trusts external reviews together with external audit review and internal clinical audits.

5.2 My review of the effectiveness of the system of internal control has been presented and approved by the board. The board and the governance committee have been kept informed of progress against action plans throughout the year. The assurance framework includes plans to address any gaps in control or assurance in order to ensure that continuous improvement of the system is in place.

5.3 Internal Audit has examined the assurance framework for the Trust and has agreed that it is satisfactory. The board will review the process on a six monthly basis and regular reports are given to the audit and governance committees. The Trust position against the Healthcare Commission standards has been reported to the board and the governance committee monitors actions.

5.4 No significant internal control issues (i.e. issues where the risk could not be effectively controlled) have been identified in respect of 2004/05.



**Angela Pedder** Chief Executive  
(on behalf of the board)  
Wednesday, 25 May 2005.

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

The Health and Social Care (Community Health and Standards) Act 2003 states that the Chief Executive is the Accounting Officer of the NHS Foundation Trust. The relevant responsibilities of the Accounting Officer, including their responsibility for the propriety and regularity of public finances for which they are answerable, and for the keeping of proper accounts, are set out in the Accounting Officers' Memorandum issued by the Independent Regulator of NHS Foundation Trusts ("Monitor").

The Accounting Officer is responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the NHS Foundation Trust and to enable him/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 NHS Foundation 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.



Angela Pedder, Chief Executive

Date: 29 June 2005

### Statement of directors' responsibilities in respect of the accounts

The directors are required under the Health and Social Care (Community Health and Standards) Act 2003 to prepare accounts for each financial year. The Independent Regulator of NHS Foundation Trusts ("Monitor"), with the approval of the Treasury, directs that these accounts give a true and fair view of the Foundation Trust's gains and losses, cash flows and financial state at the end of the financial year. In preparing those accounts, the directors are required to:

- Apply on a consistent basis accounting policies developed using methods and principles laid down by Monitor with the approval of the Treasury.
- Make disclosure of information as required by Monitor with the approval of the Treasury.
- Make judgements and estimates which are reasonable and prudent.
- State whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors confirm to the best of their knowledge and belief they have complied with the above requirements in preparing the accounts.

#### By order of the board



Angela Pedder, Chief Executive  
Mike Stevens, Director of Finance

Date: 29 June 2005

Date: 29 June 2005

### Independent auditors' report to the council of governors of the Royal Devon and Exeter NHS Foundation Trust on the summary financial statements

We have examined the summary financial statements set out on pages 14 and 15. This report is made solely to the council of the Royal Devon and Exeter NHS Foundation Trust in accordance with paragraph 24(5) of Schedule 1 of the Health and Social Care (Community Health and Standards) Act 2003 (the Act) and for no other purpose. We do not, in giving this opinion, 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.

#### Respective responsibilities of directors and auditors

The directors are responsible for preparing the annual report. Our responsibility is to report to you our opinion on the consistency of the summary financial statements with the statutory financial statements. We also read the other information contained in the annual report and consider the implications for our report if we become aware of any misstatements or material inconsistencies with the summary financial statements.

#### Basis of opinion

We conducted our work in accordance with Bulletin 1999/6 'The auditor's statement on the summary financial statements' issued by the Auditing Practices Board for use in the United Kingdom.

#### Opinion

In our opinion the summary financial statements are consistent with the statutory financial statements of the NHS Foundation Trust for the year ended 31 March 2005 on which we have issued an unqualified opinion and certificate.

Signature:  
PricewaterhouseCoopers LLP

Date: 30 June 2005  
31 Great George Street  
Bristol BS1 5QD.

## INCOME AND EXPENDITURE ACCOUNT

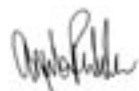
For the year ended 31 March 2005

	2004/05 £000
Income from activities	180,570
Other operating income	43,710
Operating expenses - (including exceptional item)	<u>(225,446)</u>
Operating deficit - before exceptional item	(387)
Exceptional item	<u>(779)</u>
OPERATING DEFICIT	(1,166)
Profit on disposal of fixed assets	<u>8</u>
DEFICIT BEFORE NET FINANCING COSTS	(1,158)
Net financing income	<u>1,208</u>
SURPLUS FOR THE FINANCIAL YEAR	50
Public Dividend Capital dividends payable	<u>(7,372)</u>
RECORDED DEFICIT FOR THE YEAR	<u><u>(7,322)</u></u>

All activities are classed as continuing

## BALANCE SHEET as at 31 March 2005

	31 March 05 £000
<b>FIXED ASSETS</b>	
Intangible assets	444
Tangible assets	<u>238,903</u>
	<u>239,347</u>
<b>CURRENT ASSETS</b>	
Stocks and work in progress	3,685
Debtors	11,319
Cash at bank and in hand	862
	<u>15,866</u>
<b>CREDITORS:</b> Amounts falling due within one year	<u>(16,951)</u>
<b>NET CURRENT LIABILITIES</b>	(1,085)
<b>TOTAL ASSETS LESS CURRENT LIABILITIES</b>	238,262
<b>PROVISIONS FOR LIABILITIES AND CHARGES</b>	(370)
<b>TOTAL ASSETS EMPLOYED</b>	<u><u>237,892</u></u>
<b>FINANCED BY:</b>	
<b>TAXPAYERS' EQUITY</b>	
Public dividend capital	138,421
Revaluation reserve	94,555
Donated asset reserve	1,715
Government grant reserve	1,239
Income and expenditure reserve	1,962
	<u>237,892</u>



Angela Pedder  
chief executive  
Date: 29 June 2005

## STATEMENT OF TOTAL RECOGNISED GAINS & LOSSES for the year ended 31 March 2005

	2004/05 £000
Surplus for the financial year before dividend payments	50
Unrealised surplus on fixed asset revaluations/indexation	29,280
Increases in the donated asset reserve and government grant reserve due to receipt of donated and government grant financed assets	1,384
Reductions in the donated asset reserve due to depreciation, impairment and disposal of donated assets	(262)
Reductions in the government grant reserve due to the depreciation, impairment and disposal of government grant financed assets	(61)
<b>Total recognised gains and losses in the financial year</b>	<u><u>30,391</u></u>

**The RD&E has a number of specific strategic goals. These are to:**

- Provide services of consistently high quality.
- Be a leading centre for acute medical care.
- Provide exemplary cancer services.
- Continue to develop partnership with primary care.
- Develop the capital and service infrastructure.
- Have patient-centred management systems.
- Have committed staff achieving their full potential.
- Work in partnership with the Peninsula Medical School.
- Implement the NHS Plan.

**In achieving our goals we will adhere to a set of principles. In this way we will:**

- Always put the interest of patients and their families and carers first.
- Recognise that all staff are important, are committed, and deserve real respect for their contribution to the team.
- Be open in our dealings and will not undermine each other.
- Always do things in an exemplary way and will not fear to innovate.
- Celebrate our successes and learn from our failures.
- Invest, within our ability and needs, in the well-being and competence of each staff member.
- Recognise our responsibility to look after each other as well as our patients, and that staff have lives outside the work place.

**For a version of this report in large print  
please contact Julia Bond at the  
RD&E on (01392) 402419.**

**[www. rdehospital.nhs.uk](http://www.rdehospital.nhs.uk)**

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