Annual Report 2006/07

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

& Summary Financial Statements
Chairman’s Statement

In my first year as Chairman of the Royal Devon & Exeter NHS Foundation Trust I am delighted to introduce you to the Annual Report 2006/07, the publication of which marks the completion of our third year as one of the first ten NHS Foundation Trusts (NHSFTs) in England. As a Foundation Trust, and therefore a public benefit corporation, the RD&E is accountable to the population we serve via our 13,588 public members; they elect the majority of our Governors who, together with the stakeholder Governors appointed by our partner organisations, form our Council of Governors.

2006/07 has been a successful year on many fronts. Thanks to the dedication and commitment of staff throughout the Trust, we’ve made good progress with the range of standards and targets we are required to meet by the Healthcare Commission, and on which our rating of ‘fair’ for quality of services and ‘excellent’ for managing resources was based - putting us among the region’s best-performing trusts. Good financial management is particularly important as an NHS Foundation Trust, as we must generate a surplus each year in order to reinvest in new developments and services. Achieving a surplus of £2.9 million in 2006/07 puts us in a strong position for the year ahead.

As a new Foundation Trust in 2004 we developed four strategic aims that form the cornerstone of our Service Development Strategy: improving access to the RD&E and its services; improving relationships with partners and stakeholders; developing new ways of delivering care; and responding to staff. Three years on it is now timely for the RD&E to review and refresh that strategy for the future. The Board of Directors, working closely with the Council of Governors, has commenced this process, taking account of the changing healthcare environment within which we work and national policy directives such as the need to provide care closer to home wherever possible.

With so many changes in the local healthcare environment, my Non-Executive colleagues and I have an important role in forging close and collaborative relationships with colleagues in partner organisations, to support the provision of the best possible care for local people. We will also work closely with the Executive Directors, to ensure that the RD&E Board of Directors remains fit for purpose and continues to provide effective leadership to the Trust.

With another successful year behind us, I would like to offer a personal message of thanks and congratulations to every member of staff at the RD&E. As I have come to know the Trust, and meet many of them personally, I have been impressed with their commitment to patient care, and to delivering consistently high standards.

I would also like to thank the people and organisations that have given us such wonderful support throughout the year - groups like the League of Friends and charities such as the Exeter Leukaemia Fund, Diabetes Direct, FORCE and the Princess Elizabeth Orthopaedic Centre Comforts Fund and the individual volunteers who give their time and support. We are grateful for their continuing efforts to improve services for our patients.

Angela Ballatti, Chairman

VIEWS OF THE GOVERNORS

The RD&E NHS Foundation Trust was founded on a sound base of clinical and corporate governance enabling staff to maintain and improve the quality of healthcare delivered.

The climate within the RD&E is one where patients and relatives are treated with care and consideration and in a manner that enables them to understand the information given to them. Governors are pleased to note the level of involvement that patients have in ward design, in particular in relation to considerations of privacy and safety. Recently, patients, including a number who are disabled, have been involved in the siting of ward and hospital notices. The ideas of groups of young people are also used to enable equal access to treatment and services.
In this Annual Report we profile the activities of the RD&E over the last 12 months and highlight the significant progress we have made in developing the range and scope of services we provide for people across Devon and the surrounding areas, to ensure patients receive the right treatment in the right place at the right time.

Throughout 2006/07 there has been a growing awareness of the financial and service challenges facing the PCTs who commission our services on behalf of local people, and the wider NHS. Despite this the RD&E has continued its programme of service redesign and improvement, and increased the overall number of staff it employs, particularly in medicine and nursing.

During the course of the year the RD&E has moved from having waiting times for routine MRI and CT scans of up to 50 weeks to the current longest waiting time of 13 weeks; we intend to reduce this further to 6 weeks, matching the best-performing NHS organisations across the country.

The Trust has previously faced the challenge of providing sufficient intensive care capacity to meet the increasing but fluctuating demand among our most critically ill patients. Building work to enable the creation of five additional ITU beds (a 50% increase) is now nearing completion and will significantly reduce the number of cancelled operations for our complex surgical patients.

Ten years ago the major strategic priority was to relocate maternity, gynaecology and neonatal services from the Heavitree site to the Wonford site. Whilst the case for relocation was well accepted, for many years it was not possible to identify the funding needed to support the scheme. In 2004 the contract was awarded, funded by a combination of Department of Health capital, and capital borrowed for investment by using our Foundation Trust freedoms; the service will relocate into excellent new facilities on the Wonford site in June 2007.

Partnership working with our primary care, social care and commissioning partners underpins the range and quality of care we offer local people who benefit from the ongoing strength and focus of the RD&E. Last year we reported a small surplus of £500,000. For 2006/07 the Board set a more challenging financial target of achieving a surplus of £2.4 million. During the year, in recognition of the financial challenges faced by our main PCT commissioner, and to support the RD&E’s commitment to partnership working and comprehensive healthcare within Devon, the Trust agreed to make a £2 million financial contribution to help resolve Devon PCT’s projected deficit. Despite this unplanned change, the RD&E has exceeded its target and generated a £2.9 million surplus.

None of these achievements could have been realised without the focus of all Trust staff on managing resources and driving quality improvement through innovation, service efficiency and effectiveness. Thanks to our staff, and their continuing efforts, we are now in a strong position to face the challenges of the year ahead.

Angela Pedder, Chief Executive

Taking into account the financial constraints placed on the service, the Trust makes every effort to balance value for money with the meeting of patient clinical need. By assessing research evidence the Trust ensures effective clinical outcomes. There are carefully devised systems to ensure not only the quality of care but also to enable an openness of ideas leading to innovation and changes in practice.

The Governors received regular reports from the Chief Executive, the Medical Directors, Director of Finance and other Directors, enabling us to question progress on a wide range of issues. We are pleased to recognise the positive outcome of last year’s financial statement and look forward to a continued improvement.

Overall, the Governors feel that the Royal Devon & Exeter NHS Foundation Trust has continued its exemplary service to its catchment area.
Infection control is championed right across the Trust. Building on the National Patient Safety Agency (NPSA) ‘Clean your hands’ campaign and on the Department of Health ‘Saving Lives’ initiative, our focus has been on infection control responsibilities at all levels. There are now infection control leads at board level, clinicians at directorate level and nurses at ward level.

Members of the public are playing their part as well by responding positively to the new visiting times. As part of the Cleaner Hospitals campaign, one of the reasons for introducing restricted visiting in most wards was to allow the housekeeping staff easier access to bed spaces for cleaning. We have also had a good response when visitors are requested to postpone non-essential visits at times when wards are experiencing outbreaks of infection, or if visitors themselves are feeling unwell.

On the clinical side, matrons and doctors have undertaken a thorough review using the Department of Health ‘Saving Lives’ assessment tools, of frequently performed invasive procedures where, by their very nature, there is a higher risk of infection. Policies, procedures and practice for urinary catheterisation, central and peripheral vein drips, surgical wounds and ventilator-assisted pneumonia have been checked.

Progress has also been made ‘behind the scenes’, with Trust laboratory technicians being able to swiftly confirm whether or not a patient has got Norovirus. Knowing this one way or the other at an early stage of admission allows us to take prompt action to minimise the spread of the virus if infection is confirmed or in the event of test results being negative, giving the all-clear for the reopening of a ward to admissions.

There is also a commitment to infection control in non-clinical areas, including food hygiene, portering and housekeeping services and waste management.

As well as good practice here and now, the Infection Control Team has been involved in the design and equipping of existing and new healthcare facilities to ensure the environment encourages effective infection control.

In new facilities, it is essential to ensure installation of washable surfaces, the right number of appropriately located hand-washing sinks and doors which can be opened or closed without having to touch knobs or handles; there must also be sufficient space between beds.

These are just some of the simple but effective decisions made, for example, with the new Centre for Women’s Health at Wonford.

The micro-organisms that cause infection move with patients from the community into hospital and out into the community again. It is therefore important to ensure good communication between primary and secondary care, between the RD&E and the community hospitals. Unlike many other areas, there is a joint Infection Control Team employed by this Trust which provides a service to the RD&E and also to the Exeter, East Devon and Mid Devon localities of the Devon Primary Care Trust as well as the whole of the Devon Partnership Trust. This team also works closely with the Devon Health Protection Unit which provides infection control advice to nursing and residential homes. This approach ensures good communication, uniformity of advice and a consistent approach to infection control practice.
A commitment to improving the quality of patient care drives innovation and new ways of working at the RD&E. Advances in technology and flexible staff who embrace change have achieved significant improvements in patient assessment and treatment worthy of national recognition and awards.

Outstanding Care for Our Youngest Patients

The first review of its kind of Children’s Hospital Services graded the RD&E in the top 20 per cent of UK hospitals and as the best in the peninsula. The Healthcare Commission gave the Trust a score of three out of a possible four when it looked at our Children’s Services against some of the Department of Health Children’s National Service Framework Standards. Areas covered by this review included Children’s Emergency Department care, outpatients, surgery, acute paediatrics, play therapy, nursing skill mix and training on child protection, communication and paediatric pain assessment tools.

‘Centre of Excellence’

The First Trimester Screening Clinic at the RD&E was designated as a ‘Centre of Excellence’ for Down’s Syndrome Antenatal Screening last autumn. The award was judged by the National Programme for Down’s Syndrome Screening Committee which applauded the screening programme as ‘the only one and the first in England to meet our 2007 standard.’ This screening clinic is a service available to all women in the first trimester (11–14 weeks) of their pregnancy who are booked to give birth at the RD&E or in midwife-led units in Tiverton, Honiton and Okehampton. This award is a fitting marker of strong cross-departmental working between a large number of staff drawn from Clinical Chemistry, Pathology, Ultrasonography and Midwifery.

Teamwork

Teamwork is second nature at the RD&E. This was recognised when Renal scooped the Medical Secretarial Team of the Year award for demonstrating that their vision, teamwork and enthusiasm contributed to improving the service offered to patients, their consultant, manager or Trust.

Tracey Herbert and student nurse Vicky Langley with a young patient.
PACS

Patients at the RD&E now have their x-rays, scans and other medical images captured and stored digitally and accessed electronically with a new system.

The Picture Archiving and Communications System (PACS) makes x-rays and scanned images available instantly to health professionals; and stores and transports them electronically. This minimises the chances of images being lost or misplaced and consultants can compare images to assess long-term conditions. In turn, patient exposure to radiation is decreased as fewer x-rays are necessary.

“I can’t praise the benefits of brachytherapy enough. There was nothing throughout the entire treatment that distressed me in any way whatsoever.”
Mr. Ralph Brown of Newton Abbot, who was the first patient to receive HDR brachytherapy at the RD&E.

I-Suite OR

International conference delegates watched live surgery beamed to them by state-of-the-art technology from Theatre 1 in the Princess Elizabeth Orthopaedic Centre (PEOC). The ‘I-Suite OR’ combines a computerised guidance system for surgery and a communication system for demonstrations and teaching.

Computer-aided orthopaedic surgery is becoming standard in leading orthopaedic centres around the world. The system is like a mapping device which assists surgeons and is mainly used for hip and knee replacements.

“This kit has given us a huge advantage in terms of teaching and is vital when it comes to continuing our tradition of attracting top-quality staff. PEOC boasts some of the leading hip surgeons in the UK.”
Peter Vickery, Directorate Manager, Trauma and Orthopaedics

EVAR

The RD&E is one of only three centres offering a life-saving procedure in the South West known as Endovascular Aneurysm Repair, or EVAR. The 50th patient was admitted in February for this non-invasive surgical procedure used on patients whose main abdominal blood vessel is enlarged.

The fantastic benefits of using EVAR are best summed up by one of the earliest patients to receive EVAR at the RD&E:

“The surgeon did a remarkable job and I have nothing but praise for the team. The scars were so minute I don’t think I could even see them! I have had open surgery in the past when a main artery burst so I know how that experience compares. With the EVAR I was up and about in a couple of days and had no ill effects whatsoever. The attention I received was first class!”
Robert Cooke, Axminster

High Dose Rate Brachytherapy

Patients are singing the praises of a new technique to treat prostate cancer. The RD&E is one of only three hospitals in the UK offering high dose rate brachytherapy. The difference between brachytherapy and other treatments is that instead of a radiation beam being directed at the prostate from outside the body, between 12 and 15 needles are inserted into the prostate and radiation is directed down each tube. This means that a higher dose of radiation is delivered direct to the prostate which makes it safer and more effective.
A new Patient Meals Service at the RD&E is generating positive feedback about the food being hotter with attractive presentation and portion sizes to suit individual appetites.

Advances in food and technology made it possible to introduce cook-freeze meals in April. Menu cards filled out by patients are scanned electronically to inform the catering service what frozen stock is needed.

“With the cook-freeze system, clinical staff on wards, especially nurses, are now more directly involved in mealtimes and monitoring patients. Food can be served in portion sizes appropriate for the individual because having a large plate of food in front of you when you don’t have an appetite can be very discouraging.”

CATHY WEEKS, LEAD MATRON FOR OLDER PEOPLE

Did You Know?
The RD&E serves over 2,000 patient meals each day and roast beef is a firm favourite!

New purpose-built trolley ovens, crockery and non-slip trays are loaded with the meals which are then served directly to patients on the wards. The trolleys are taken from the kitchens out to the wards where the meals are cooked in time for lunch and supper. Housekeepers monitor food temperatures carefully and give the served meals to the ward nurses, who take the meals to the patients and collect them afterwards.

The majority of regular patient meals are served on blue trays but up to 30 per cent are on red trays to inform nursing staff that the patient has special nutritional or dietary needs.

The Trust nutritionists and dieticians worked closely with the catering service on the menu because it is recognised that patient meals are an important part of hospital care and central to the recovery process.

Special dietary meals, sandwiches, desserts, gravies and sauces continue to be made by the Trust catering department. Cook-freeze does not apply to the Oasis restaurant where over 400 freshly-cooked meals are served daily to staff, patients and visitors.

Ward housekeeper Sharon Clarke serving up hot food with nurse auxiliary David Mucklow ready to take meals to patients.
Capital Developments

The hospital landscape has changed a great deal over the past year - out went the landmark chimney when steam boilers were replaced with a new energy centre to supply steam for the laundry, though far more went up than came down!

- It’s the final countdown for the June opening of the Centre for Women’s Health – the new home for Gynaecology, Maternity and Neonatal services transferring across from Heavitree to Wonford. Covering 9,000 square feet, the Centre includes an atrium entrance with café and a range of rooms for labour, examination, assessment, recovery and counselling. There are en-suite bathroom facilities for patients and parents with babies in the Neonatal Unit, theatres, a water-birth pool, a conservatory rest room and gardens. This significant investment will help us to deliver high-quality healthcare services for women and children.

- Patient power lies at the very heart of the RD&E’s new Diabetes, Endocrinology and Vascular Health Centre which serves patients across Exeter, East and Mid Devon and is one of the UK’s leading diabetes facilities. There are very few centres where the whole gambit of specialist care, including research and education, are under one roof.

This new centre is better equipped to not only help medical management of the condition and its complications but also to empower patients to overcome their own individual difficulties.

The team can now offer an even more responsive service for patients with acute or complex challenges, including non-healing foot ulcers, disorders of limb circulation with risk of amputation, visual loss and kidney problems that can lead to kidney failure.

Local diabetes charity DIRECT raised £200,000 towards the overall project cost and has an office in the centre.

- An expansion of the Endoscopy Unit is currently under way, with plans to increase the number of procedure rooms from two to four. Endoscopy is the examination of the gastrointestinal tract with a flexible telescope (‘gastroscopy’ being the term used for investigation of the upper digestive tract and ‘colonoscopy’ being the investigation of conditions of the rectum). In a similar manner the lungs can also be examined (bronchoscopy) as can the urinary bladder (cystoscopy). As well as diagnosis, various treatments can be given via endoscopes, without the need for open surgery.

The project is due for completion by October 2007, and two new consultant gastroenterologists have already been recruited, as well as 12 nurses, and several support and administrative staff, to make efficient use of the new facilities.

The additional capacity will result in all patients in the urgent category receiving an appointment for their examination within two weeks and all other appointments being arranged within six weeks. It will also improve the detection of bowel cancer, with diagnosis being achieved at an earlier stage. The team also plans to have bowel cancer screening available, subject to national approval, within the year.

- The day-to-day work of the Intensive Treatment and High Dependency Units has continued, with building work to expand the bed capacity going on around them. By increasing the number of beds to 15 this should reduce, if not eliminate, cancellation of elective cases, and allow more flexibility to admit patients promptly and admit high-care surgical cases.

“We hope that this all-encompassing centre will support diabetes care for every patient in our locality wherever they are, and whatever problems they have.”

Dr Kenneth MacLeod, Consultant Physician (Diabetes and Endocrinology)
“The biggest part of my job is to put a patient at ease. Often patients don’t like to stop a nurse for a chinwag because the wards are so busy, so they seem to enjoy chatting with us as we move them around. You’d be surprised how much better a patient will feel for having a smile and a bit of friendly chit-chat to reassure or relax them. Meeting so many different people, often with amazing personal stories to tell, is the best part of my job.”

Alison Corley, X-Ray Porter
Cancers around the mouth, jaw and face are on the increase; in the last year 47 separate resections were carried out within the maxillofacial unit at the RD&E, 15 requiring complex reconstructions. Although cancer work takes precedence, consultant maxillofacial surgeon Andrew McLennan and his team also care for patients with major facial deformity, facial trauma and routine non-cancer work around the mouth, face and jaws.

Someone who has reason to thank the team for their expertise is Stuart Waine (above), who was diagnosed with cancer of the tongue aged 24. Says Andrew McLennan: “Stuart had several areas of invasive cancer, needing extensive surgery. The operation involved a tracheostomy to secure the airway, and major surgery to remove both the tumour and the surrounding lymph glands. We then carried out reconstructive surgery by taking a skin flap from Stuart’s arm, together with its artery and vein, to be reconnected to artery and veins in the neck. The operation took the whole day and Stuart spent 12 hours recovering in intensive care before returning to the ward. He then had to cope with a six-week course of radical radiotherapy.”

Five years on Stuart has made a fantastic recovery. He is an architectural stonemason and has raised hundreds of pounds for the Macmillan cancer fund, even travelling as far as Mount Everest!

Andrew concludes: “Although Stuart moved away we remain in contact and he has recently been giving invaluable counselling and support for another ‘youngster’ with a similar diagnosis and treatment plan. He’s an impressive guy.”

**Key to the success of the ‘maxfax’ team** is one of the RD&E’s many clinical nurse specialists, Claire Barber. Her role is to act as an expert resource, not just here at the RD&E, but across the whole healthcare community, offering support and specialist care for patients with head and neck related cancers. This involves the development of a co-ordinated and integrated approach between organisations and agencies and close workings with key members of other health-related specialities such as doctors, speech therapists, dieticians and radiographers.

“I care for patients with multiple health and social-care needs and carry out home visits for those who are too ill to travel or who are about to undergo major complex head and neck reconstructions. Some patients, due to the extensive nature of their surgery, have to rely on neck breathing (via a tracheostomy); others have complex nursing needs due to unhealed wounds and artificial feeding tubes. I also run a clinic jointly with the head and neck speech and language therapist, senior dietician and radiographer. Together we carry out a full assessment of every patient who has just completed a course of chemo or radiotherapy to the head and neck, and decide on treatments to encourage a more rapid recovery.

“It’s wonderful to be involved in the care of someone like Stuart. His determination to return to a normal life is a real inspiration to others.”

“Everyone in the maxillofacial department showed both professionalism and compassion in treating me and supporting my recovery. Whilst I can only guess at the huge workload of the department, I was – and continue to be – treated as if I were the most important person in the world. I am in their debt.”

Stuart Waine
There is a plethora of different roles and services at the RD&E which is reflected in the incredible skills mix of our clinical and non-clinical staff. The professionalism, commitment and motivation of staff and the huge benefits this brings for patients are immeasurable.

Inspector Morse has nothing on our Dr Lewis Jones. Relying on clinical skills alone to diagnose poisoning is what makes toxicology a particular interest of this Emergency Department consultant. It’s a bit like detective work using symptoms and patient history (which is not always available!) to work out what is making a patient ill rather than using tests such as blood samples.

Dr Jones, who has a postgraduate diploma in medical toxicology, said: “Only having clinical skills to work out what the poison is and being mindful of how every second counts is what makes this area of work interesting.”

The Emergency Department has seen over 1,000 cases of poisonings since 2006. Typical cases can range from excessive alcohol, street or ‘recreational’ drugs, and deliberate and accidental overdose of prescription medicine, to digesting harmful substances. The growing popularity of foraging for wild mushrooms, herbs and plants to eat means accidental poisoning is not unusual.

Specialist lung cancer nurse Sandra Collinson was shortlisted for the prestigious Nursing Times Awards 2006 for her outstanding work in setting up the Trust’s nurse-led clinic giving compassionate and practical support and advice to patients (and their families) diagnosed with lung cancer for as long as they need or want it.

Respiratory Medicine at the RD&E also has clinical nurse specialists for asthma, chronic obstructive pulmonary disease, cystic fibrosis and tuberculosis.

Sandra said: “I know I can make a difference because I can help sort out a lot of problems for patients, from symptom control and holiday insurance to what financial benefits they can claim and how best to inform family and friends.”

Mrs Patricia Adams (below) has come in from her Colyford home to the Exeter Kidney Unit for haemodialysis three times a week for the past two years. The retired pharmacist doesn’t underestimate how essential it is to heed the advice of Renal Dietitian Ruth Davies. “If I eat the wrong things it can poison me. There’s no pulling the wool over Ruth’s eyes. I’ve learnt that if I have some chocolate or a banana then the potassium in my blood test will give the game away!”

“Stroke comes out of nowhere like a thunderbolt so patients are often very scared and are in shock when they come to the acute stroke unit. They just want to get their lives back to normal. I work with stroke patients who have problems with mobility and movement. We take a multi-disciplinary approach, with medics, nurses, occupational, physio- and speech therapists and dieticians all working collaboratively together with the shared focus of the patient.”

Bridget Peace, Clinical Lead Physiotherapist

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The Royal Devon & Exeter became one of the first ten NHS Foundation Trusts in April 2004. As an FT the RD&E is now a public benefit corporation accountable to the population we serve via our members who elect the majority of our Governors. They, together with the stakeholder Governors appointed by our partner organisations, form our Council of Governors.

Our establishment as an NHS Foundation Trust followed a period of focussed engagement and consultation with both the public we serve and our own staff, who are key to ensuring we continue to offer timely, safe and effective healthcare - in other words ensuring people receive the right treatment in the right place at the right time. Arising out of that engagement process the four strategic aims that form the cornerstone of our Service Development Strategy emerged: improving access to the RD&E and its services; improving relationships with partners and stakeholders; developing new ways of delivering care; and responding to staff.

The RD&E provides acute hospital services to around 350,000 people in Exeter, East Devon and Mid Devon, and offers specialist services such as cancer care, plastic and reconstructive surgery, orthopaedic surgery, paediatric care and renal services to people further afield in Devon, Cornwall, Somerset and Dorset.

Most of the Trust’s services, including specialist units such as the West of England Eye Unit and the internationally-renowned Princess Elizabeth Orthopaedic Centre, are based at our main hospital at Wonford in Exeter. Maternity, neonatal and gynaecology services will relocate from the nearby Heavitree Hospital to a new, purpose-built centre at Wonford in June this year, to be called the Centre for Women’s Health.

The RD&E also runs:

- the Honeylands children’s centre, providing specialist assessment and support for children with special needs and their families;
- Exeter Mobility Centre, providing orthotics, prosthetics, wheelchairs and special seating;
- the Mardon Neuro-rehabilitation Centre.

Across these sites the Trust has around 850 inpatient beds and more than 60 daycase beds.

During 2006/07 the Trust spent around £275m, and employed more than 5,900 people to provide healthcare services for the communities it serves.

In planning and developing services to meet the healthcare needs of local people, the RD&E works closely with a number of local organisations including: NHS Southwest Strategic Health Authority; Devon Partnership Trust (mental health and learning disabilities); Northern Devon Healthcare NHS Trust; the South Western Ambulance Service NHS Trust (SWAST); Devon County Council Social Services.

The Trust will continue its close working relationship with the newly-formed Devon Primary Care Trust, to implement the national policy directive to increasingly provide care closer to home wherever possible. Whilst the RD&E already provides a wide range of services from community hospital settings, 2007/08 will see a further extension of this aspect of our service, with significant increases in the number of daycase operations we undertake away from the main hospital site.

The Trust is proud to be a partner in the Peninsula Medical School that links together the universities of Exeter and Plymouth with the local NHS.

The RD&E aims to include environmental management in every aspect of the Trust’s business, taking account of legislation, regulation and European Directives.

Sustainability is considered a priority throughout the Trust, including areas such as energy and water conservation, reducing the need to use private transport, responsible procurement and waste reduction.

The Trust’s Environmental Action Team considers how the policy is implemented, and the Trust has been actively involved in recycling items such as cardboard, scrap metal, glass and confidential waste for over ten years.
On Target

This year has been incredibly busy for the RD&E, with a record number of people visiting the Emergency Department (ED), and more patients being cared for across the board by dedicated staff throughout the Trust. As ever, everyone has risen to the challenge, and achievements for the year include:

- 98% of patients attending the ED were admitted, discharged or transferred within four hours;
- maximum 11-week wait for a first outpatient appointment;
- max. 20-week wait for inpatient and daycase treatment;
- all urgent GP referrals for suspected cancer were seen by an RD&E specialist within two weeks;
- we met the Trust target to provide a treatment decision for all new cancer patients within 31 days and achieved 94%, against a target of 95%, to treat all new cancer cases within 62 days of referral. We continue to work closely with PCTs and other hospitals to ensure that delays outside the Trust do not affect performance against targets;
- all breast cancer patients began treatment within a month of the appropriate treatment course being agreed;
- increasingly, patients have appointments to suit them.

Annual Health Check

In April 2005 the Healthcare Commission introduced a new system for measuring performance for all healthcare organisations, called the Annual Health Check, to replace star ratings.

The Annual Health Check assesses a wider broad range of issues to help decide whether trusts are getting the basics right, like meeting national standards and targets and using resources wisely, and making and sustaining progress, which relates to meeting new targets and achieving good results in improvement reviews. It relies on gathering information from a wide variety of sources, and takes account of patients’ views. As part of this assessment the RD&E also goes through a rigorous self-assessment process, measuring progress against 44 core standards, of which we met 42 for the year 2005/06.

In October 2006 we received the top rating of ‘excellent’ (4 out of 4) for managing resources, and a rating of ‘fair’ (2 out of 4) for quality of services. This total rating (6 out of 8) puts us among the region’s best-performing trusts. Our finance score puts us in a strong position to deliver plans to improve services and provide new and better clinical environments, like the new Centre for Women’s Health and the expansion of the Intensive Care Unit. For quality of services, although the RD&E was assessed as having achieved a ‘good’ standard for the vast majority of indicators, the rating of ‘fair’ for achievement of a small number of new national targets affected our overall rating.

During the past year we have made significant progress. Having met 42 of the 44 core standards, with work to achieve the remaining two having been completed by September 2006, we are confident that in 2006/07 we are meeting all 44 standards, and look forward to the HCC assessment in October.

Finance

As a Foundation Trust we continue to reap the benefits of having greater financial freedom; we must also respond to the greater responsibilities. As an FT, the RD&E must generate a surplus so that we are able to fund new building projects, develop and expand services, and respond to NHS changes.

In 2006/07 the Trust has exceeded its financial target, achieving a surplus of £2.9m, giving us the continued flexibility to plan and deliver services to meet local need. This is entirely down to the staff’s hard work, and their continued efforts to ensure no opportunity for good financial management or service improvement is missed. They deserve sincere congratulations.

MRSA

Only 20 patients acquired MRSA bacteraemia whilst at the RD&E. Although this is more than we would like, when compared with the 117,080 patients admitted to the Trust in a year, this works out as a tiny proportion of patients. We must still take account of the fact that the target, our overall measure of success, relates to MRSA bacteraemia acquired within the whole healthcare community, and therefore tested in our laboratory, not just those patients who acquire MRSA here. We will continue to be vigilant within the RD&E, and work closely with community colleagues to ensure that a reduction in infection rates continues to be a top priority.

2006/07 Activity (2005/06 in brackets)

<table>
<thead>
<tr>
<th>Category</th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients and day case</td>
<td>117,080</td>
<td>(112,460)</td>
</tr>
<tr>
<td>Outpatients</td>
<td>257,853</td>
<td>(253,502)</td>
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<tr>
<td>Emergency admissions</td>
<td>28,804</td>
<td>(28,434)</td>
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<td>Emergency dept attendances</td>
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</tr>
<tr>
<td>Babies born</td>
<td>2,988</td>
<td>(2,972)</td>
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</table>
Behind the Scenes: HSDU

Technology alone is not enough when it comes to the essential work of the Hospital Sterilisation and Decontamination Unit (HSDU). The fully-trained technicians must be conscientious and highly motivated to process and turn around 11,000 packs a week which come into the specialist unit for decontamination and sterilisation.

This is a far cry from the pre-Second World War approach when nurses were expected to ‘sterilise’ their own instruments, needles and syringes in boiling water!

Today the HSDU technicians provide hospital wards and departments with all of the equipment and materials needed to carry out clean and sterile procedures.

The trained eye of technicians enables them to spot damaged items, and they have an unrivalled knowledge of thousands of instruments across the whole gambit of clinical fields. A theatre nurse will know the instruments specific to the specialism they work in, such as cardiology, oral surgery or orthopaedics, but an HSDU technician knows all of the instruments - what they are, where they belong and what they should look like.

All of the technicians rotate weekly between the different stages of the decontamination and sterilisation process.

HSDU staff clean, sterilise and pack around 450 theatre instrument sets a day - totalling 11,000 per week!

There’s a doctor with a difference at HSDU playing a crucial role in tracking the journey of every instrument or item used on a patient; Total Documentation, or ‘T-Doc’, is a computerised bar-coding system which gives each soiled or contaminated item coming into HSDU a unique number containing information on who packed, sterilised, despatched and returned the item and where it went when it left HSDU. This system is the first of its kind to be installed in this country.

Layers of safeguard measures exist to help ensure that what leaves HSDU is ready to re-use, and an independent regulatory body makes six-monthly checks to ensure procedures are followed to the letter. Every three years the HSDU has to re-qualify for its quality accreditation ISO-9001/2000.

Purpose-built for its specialist role at the RD&E in 1996, HSDU provides a round-the-clock service to the 19 operating theatres at the Wonford hospital site (including the Princess Elizabeth Orthopaedic Centre) and four theatres at Heavitree. It also serves the RD&E Emergency Department, outpatients departments and wards in Exeter and the community hospital theatres, as well as health centres including Axminster, Exmouth, Sidmouth, Tiverton, Honiton, Ottery St Mary, Crediton, Chagford and Okehampton.

“We are serving the patients. You have to be eagle-eyed and never cut corners. It’s about taking pride in what you do and knowing that it is helping others – that’s what gives job satisfaction.”

Clive Westney, Manager, HSDU
Rachel Ciolino and Alwi Hassan working for haematology and immunology in the Clinical Chemistry department. Rachel is a medical laboratory assistant training to become a biomedical scientist. Undergraduate biomedical scientist Alwi is spending his one-year industrial placement with the RD&E approved training laboratory.
As a Foundation Trust the RD&E continues to develop greater links with the people we serve by offering membership throughout the local community, and by giving members the opportunity to find out more about what goes on at the Trust, share their views with us, and get involved in a range of activities to help us plan and deliver better healthcare.

Membership Constituencies

Thanks to the interest of local people our membership continues to increase, and now stands at 13,588 public members. 5,931 staff are also members of the Trust. Anyone aged 12 or over who lives in the area we serve, or who works for the Trust, has the right to become a member of the RD&E NHS Foundation Trust.

The three public constituencies, with membership numbers on 31 March, are: Exeter and South Devon: 5,218; East Devon, Dorset and Somerset: 5,084; Mid, North, West Devon & Cornwall: 3,286.

These constituency areas follow local council boundaries, and take account of the fact that, although the RD&E mainly serves people living in Exeter, East Devon and Mid Devon, we also provide specialist services to a much wider population, so membership is available to all.

Our fourth constituency, for staff, is subdivided to take account of the five major staff groups - nurses and midwives, doctors and dentists, allied health professionals, hotel services and estates, and managers and administrative staff.

Membership Involvement

Members themselves decide how much involvement they want to have at the RD&E, so we offer a range of opportunities. For many, receiving the quarterly newsletter fulfils a desire to have more information about the Trust, so we have regular features about new developments, the special achievements of staff, and how we work with partner organisations in the community. For those who want a more active role, we have regular constituency meetings, with senior staff coming along to talk about the work of their departments. We consider these meetings to give us, and your Governors, a great opportunity to hear about what’s concerning you, and your ideas and suggestions about how make improvements.

Some members are happy to take part in surveys when we need information about your experience of specific services. For those who want a much greater level of involvement, members can nominate themselves for election to the Council of Governors.

When we asked members to join the Research & Development Steering Group, the team were delighted to hear from 30 local people who wanted to get involved - the Trust now has two members as part of the group. The Governance Support Unit told members they needed help putting questionnaires together, to make sure they are user-friendly and easily understood. They now have a panel of 29 members who can be called upon to give their views.

Membership Strategy

Because our members influence how we plan future healthcare, it’s important that they come from all parts of our community; we work hard to ensure that our local population is properly reflected in our membership. We review membership annually and take account of areas where we might need to make greater efforts to recruit new members. We have the greatest success recruiting members who have been patients at the Trust, and continue to offer membership by keeping in touch with a range of local organisations, and advertising membership in places like local libraries.

If you are already a member, we’d like to thank you for your continuing interest and support. If not, and 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.
At the RD&E we want to give each individual patient the best possible experience of care. To help us get it right we rely on patients and visitors telling us what went well and what we could do better. We also work closely with volunteers who are prepared to give their valuable time to represent the needs of local people.

**National Role for PALS**

The Patient Advice & Liaison Service (PALS) acts as a central point of contact for patients, family or friends who need information or help because they have a particular problem or concern; it also highlights areas where changes and improvements may be necessary.

In 2006/07 the team dealt with 1,109 cases (1,104 in 2005/06). 94% were resolved needing no further action; the remainder required advice or information. When PALS sent questionnaires to service users, 96% of people told us they were completely satisfied with the outcome after contacting PALS, and everyone said that PALS team members had listened to and understood their concerns, keeping them informed of progress.

96% of complaints were acknowledged within just two working days (92% in 2005/06). From April to August 2006 we provided a full response to 87% of complainants within 20 working days and, following a change to the NHS complaints regulations from September 2006, 98% of people received their response within 25 working days for the remainder of the year.

- When a patient pointed out that she was not provided with continuous care from the same midwives, the rotation of midwives was changed to six-weekly to minimise disruption.
- Following a complaint received from a patient regarding missed medication, plans to introduce a computerised diary system for timely administration of medication in the Oncology Department are being explored.

For more information please call (01392) 403915 or e-mail Complaints.Department@rdeft.nhs.uk

**Patient Surveys**

Improving the experience of each individual patient is one of the key priorities in our Patient and Public Involvement Strategy. One method of obtaining patient feedback is to undertake patient satisfaction surveys, from local surveys within departments to large-scale national surveys conducted throughout the Trust.

The 2006 National Survey of Inpatients was conducted independently, using the survey devised by the Healthcare Commission. Results were extremely positive, with 92% of patients rating the RD&E on a par with, or significantly better than, other acute trusts, and a high score for patients being treated with respect and dignity, and patients saying they would recommend the hospital to family and friends.

Patients also said we could do better in a number of areas, for example in how we provide information to patients, particularly on discharge, and by improving patients’ involvement in decisions about their care. Improvement action plans are now being developed and progress against these will be monitored every quarter.

For more information about local surveys please call Patient Liaison Services on (01392) 406050 or e-mail PLS.Administrator@rdeft.nhs.uk. See also: www.healthcarecommission.org.uk for details of our national survey results.

Our success in meeting users’ needs recently drew some special attention from the Department of Health, when we were chosen to share our experience to help develop and improve PALS across the country. Researchers from the University of the West of England were particularly interested in hearing about our approach to applying the learning from PALS cases throughout the Trust.

For information about PALS call (01392) 402093 or e-mail PALS@rdeft.nhs.uk

**Compliments & Complaints**

Last year the Trust treated close to 477,000 people and we received 7,770 letters of commendation from patients, carers and relatives (8,115 in 2005/06) and 311 written complaints (13 down from the previous year) - one complaint for every 1,453 patient episodes, and 25 letters of commendation for every letter of complaint.
User Groups

Patient & Public Involvement Forum for the RD&E

The Patient and Public Involvement (PPI) Forum is an independent organisation (supported by the Commission for Patient and Public Involvement in Health – CPPIH) that promotes public involvement, encourages others to get involved, and discovers what local people think about health services. The Trust works closely with, and supports the work of, the PPI Forum.

The Forum sets its own work plan, and some of the topics concentrated on this year included engaging with the public to obtain feedback on RD&E services, carers’ support and services, and hospital hygiene.

In July 2006 Forum members carried out hygiene inspections on two wards, forming the overall impression of the Trust being clean and tidy with a calm atmosphere, and reported that patients appeared content with the treatment they were receiving.

For information about the PPI Forum for the RD&E call the Forum Development Officer on (01404 549210) or see www.cppih.org

Disability Equality Action Group (DEAG)

Progress has been achieved in helping to identify particular needs of patients with a disability so that their time in hospital is as straightforward as possible. The following changes were driven by a sub-group of the Disability Equality Action Group (DEAG), with 50:50 local community and staff membership:

- ordering of coloured jugs and glasses to assist people with visual impairment by the Trust, supported by the League of Friends;
- using a flagging system with at-a-glance symbols (below) which can be put on medical notes and at the bedside so that staff know of specific patient needs;
- using an easy-read version of a patient comment card for people with a learning disability to feed back their personal views of their hospital experience.

Children’s Coming into Hospital Booklet

Children and young people say it as it is and their refreshing honesty has resulted in our brightly-coloured and very child-friendly Children’s Coming into Hospital Booklet. This is aimed at giving children an idea of the kind of people they might meet in hospital and where they are going to stay.

Interactive pages encourage children to tick off the things they need to bring with them when they come to Bramble Ward and to add their own drawings.

From start to finish the creative process included input from younger members of the community - including comments, photographs, drawings and a review of the final product which got the thumbs up!

Bone-Anchored Hearing Aids

Our patients sometimes want to give something back by channelling their energy and goodwill into user groups so that newer patients can gain from their experience. Staff also continue to have a role in supporting and advising user groups.

Users of Bone-Anchored Hearing Aids (BAHA) recently set up one such group. About 200 local people have been fitted with the BAHA (an implant fitted in the skull directly behind the ear) and are cared for jointly at the RD&E Ear, Nose and Throat department and Devon PCT Audiology Department.  

“My bone-anchored hearing aid has changed my life in a way I hadn’t envisaged. I only now realise what I was missing… I feel it is my mission to spread the good word. It will be great to hear other people’s experiences and help new users who might feel it’s daunting.”

WENDY EVANS, BAHA USER
Patients and hospitals across the South West will be taking part in a new research initiative into stroke being led by the RD&E Stroke Unit.

RD&E Stroke specialist Dr Martin James said: “Stroke is the third biggest killer in the UK after heart disease and cancer, and it ruins lives when it causes paralysis and disability. The South West has a particular problem with stroke because our population is older than elsewhere in the country.

“This new research network is an exciting opportunity to push forward medical progress in the prevention and treatment of stroke, so that we’re not waiting another ten years for the next major advances to become available.

“Members of the research team will be running a whole range of different projects from studying the role of vitamins in the prevention of stroke, to testing the latest ‘clot-busting’ treatments for acute stroke, and searching for the genes that cause certain inherited types.”

The Peninsula Stroke Research Network, bringing together NHS acute and primary care trusts and academic partners in Devon, Cornwall and Somerset, successfully bid for £1.9 million for up to five years as part of a national drive to speed up the progress of stroke research projects. The research will involve hospitals in Taunton, Yeovil, Barnstaple, Plymouth and Truro.

The RD&E is one of the few hospitals in the country which has been chosen to take part in all of the recently introduced disease-specific research networks. In addition to the Peninsula Stroke Research Network, the RD&E hosts the Peninsula Diabetes Research Network, and the Medicines for Children Research Network (together with United Bristol Healthcare Trust).

Patients are actively involved in research at the RD&E. Through involvement in the Research Networks, the R&D Committee and other service-user forums, patients are involved in the planning, selecting and commissioning of research projects. In addition to our partnership with patients and service users, the Trust collaborates with scientists in the Peninsula Medical School to undertake world-class research. This success has been recognised with a £4.5m grant to establish a Clinical Research Facility in Exeter.

Did You Know?

The RD&E is the largest recruiter for national studies to find the best treatment for Parkinson’s Disease.

Staff from the RD&E Stroke Unit with Dr Martin James had good reason to jump for joy on the launch of the new research project.
In the past few months the RD&E has been undertaking a review of strategic plans for the future. When we were originally preparing to become a Foundation Trust, we put together a Service Development Strategy, with the involvement of local people, staff and partner organisations, to map out our plans. Three years on we need to update that strategy to take account of recent or impending changes in the NHS, like the formation of the Devon-wide Primary Care Trust or the new GP commissioning arrangements.

This work is being led by the Trust’s Board of Directors, in collaboration with the Council of Governors, and also we’ve relied on the involvement of members and staff to help us put our plans together. Via the RD&Express, our membership newsletter, we asked 5,000 members to complete a questionnaire, picking their top five priorities for the Trust. The response was excellent, with 2,138 members getting back to us with their views. A similar questionnaire was completed by members of staff, and when the analysis was complete it showed that both groups agreed that our top five priorities should be: controlling/reducing hospital infection; continuing to meet targets; a clean and tidy hospital; ensuring patients get the food and nutrition they need; less time waiting once at the hospital (e.g. to see the doctor).

The next step is to ask members to attend a series of meetings, one for each of the top five priorities, to help us get further suggestions, so that we can better understand what improvements matter most to patients and visitors. In a similar way, groups of staff have been invited to a series of meetings, so that people from all areas and professional groups can get involved in this important work.

As well as their vital role in the review of the Trust’s strategic directions, the Governors have been involved in several significant pieces of work in the past year, among them a revision of the Constitution, the appointment of a new Non-Executive Director, and approving the appointment of the Senior Independent Director. As national guidance and greater understanding of the Governor’s role continues to develop, so healthcare have increased. Many Governors now attend well over 20 meetings a year, and the Trust relies heavily on their commitment and goodwill, as they give their time voluntarily.

Governors have been involved in the procedure for choosing a supplier for the new system of food preparation and distribution for the Trust (see page 7); a Governor took part in the Patient Environment Action Team inspection, another has represented the Council of Governors at the Trust’s Audit Committee. Governors were also able to offer their collective opinion of the Trust’s performance in the past year to the Healthcare Commission, as part of the Annual Health Check.
Consultation & Involvement

There have been several major consultation exercises over the past year, including the introduction of a new patient meals service and the redesign of midwifery services.

Changes to the patient meals service (described on page 7) involved catering and housekeeping staff, managers and the HR lead working closely with trade unions to ensure that full and appropriate consultation with staff was undertaken. Despite being a complex service redesign involving large numbers of staff over several months, no redundancies were made; some staff were successfully re-deployed into alternative vacancies within the Trust.

In the maternity unit a service redesign was undertaken to implement a new integrated model of care, aiming to provide antenatal continuity and one-to-one care in labour.

Employment of the Disabled

The Trust’s Equal Opportunities policy ensures that job applications from disabled people are given the same professional consideration as any other candidates who apply to work for us. Our policy states clearly that anyone who declares that they have a disability on their initial application form is guaranteed an interview for the position which is of interest to them, subject to them meeting the minimum essential criteria.

Prior to the interview taking place, applicants are asked to advise us if they have any special needs we should be aware of, to ensure the interview process goes smoothly. If offered a position, individual needs or adjustments are discussed on a one-to-one basis with the line manager, supported by Human Resources and Occupational Health departments.

We have procedures in place, reviewed annually, which satisfy all Government legislation and best-practice relating to the employment of disabled people. Our Trust website gives further details of all such policies.

In the unfortunate event that someone becomes disabled during their time of employment with us, we ensure that, from the outset, all relevant and necessary support is offered by the Occupational Health Department and Human Resources, working in conjunction with the individual’s line manager. If the individual is unable to return to their substantive job, our re-deployment policy is instigated to enable them to be redeployed elsewhere within the Trust. An initial assessment provides information about the individual capabilities, reflecting personal preferences where possible. Over the past year we have had two such cases, both of which have successfully resulted in re-deployment within the Trust.

Each year the Trust offers extensive learning and development opportunities for all staff, given that both the retention and skills development of all our people is fundamental to the continued success of the Trust in delivering excellent patient care. Specific initiatives relating to disabled staff include the following: an annual performance appraisal; review of any special needs in relation to carrying out their work; identification of any key learning and development needs as part of ongoing career development.
Trade Union Activity

The Trust has very constructive working relationships with a number of trades unions who represent Staff Side issues relating to their employment with the Trust. There are a number of key meetings which take place across any one calendar year, for example bi-monthly meetings with Directors and staff representatives where all key issues relating to the day-to-day management of the Trust are discussed. Staff Side are involved in the creation of all policies which are used by the Trust in the course of normal day-to-day activity, including areas such as governance, health and safety, and employment policy.

Each year a staff survey is conducted to give staff the opportunity to raise their views about a number of issues relating to their employment with the Trust, covering, for example, areas such as working hours, work-life balance, appraisal and staff development. In 2006/07 we also conducted a survey of all staff in the Trust seeking their views on strategy and the key issues that they see as being important when setting our direction for the future. Staff have really welcomed this initiative.

During the year staff received several updates on the overall financial position of the Trust, with a detailed explanation of the key issues and risks affecting the organisation, giving them a better understanding of the current wider NHS financial environment.

Communication with Staff

The RD&E has an extensive range of communication channels through which we stay in touch with staff to ensure that they are fully informed of the key issues facing the Trust at any given point in time. Our in-house website (ComEx) is widely available to all staff. We also have facilities for those who do not have access, or find it difficult to use a computer. Other communication channels include the monthly (paper-based), newsletter where staff have the opportunity to read updates on key matters relating to the Trust such as Board meeting summaries, service developments and new policies. Staff Side representatives also have the opportunity to communicate with staff through this newsletter, as do all staff if there is a particular feature that they wish to communicate. The newsletter provides the forum for both formal and informal matters to be highlighted.

Other communication avenues include team meetings, quarterly departmental reviews, and face-to-face meetings. Noticeboards and emails are also effective communication channels.

Occupational Health

The Trust offers confidential and professional occupational health services to all staff, as and when required. In addition to servicing the Trust, we also provide services to other providers within the Peninsula. Over the past year, in collaboration with NHS Plus, we have extended our services to small and medium enterprises in line with the Government’s agenda on ‘Health, Wellbeing and Work’.

Other key achievements include renegotiation and retention of contracts with both Devon Partnership Trust and Devon PCT.

In line with Health & Safety Executive best practice, we have also established a ‘Stress Action Group’ to build on our current work based around proactively managing this vital issue.

"The new manual-handling training room is excellent. Staff will be able to use the equipment available to them away from the distractions and pressures of their work areas. It also confirms that the Trust treats the issue seriously and are committed to improving the training and competence of their staff.”

Health & Safety Executive

Trainee biomedical scientist Tasneem Hassanali happy in her work at the RD&E.
Dr Vaughan Pearce, a consultant in care of the elderly and general medicine, and Dr Iain Wilson, a consultant anaesthetist, share the role of Medical Director for the RD&E and sit on the Board of Directors.
The Executive Directors are appointed in accordance with the Trust’s constitution. An Appointments Committee comprising the Chairman and Non-Executive Directors select the Chief Executive and the appointment is ratified by the Council of Governors (CoG). An Appointments Committee of the Chairman, Non-Executive Directors and Chief Executive appoint the Executive Directors. It is the Trust’s normal practice to appoint a professional assessor to advise the Appointments Committee.

All appointments within the Trust are based on merit and follow human-resource management best practice to ensure compliance with all statutory responsibilities in this field. A new Human Resources Director was appointed in accordance with this process in July 2006. All Executive Directors have an annual appraisal, the outcome of which is discussed by the Executive Director Remuneration Committee. The Executive Directors all hold permanent pensionable contracts and notice periods are set out below:

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<th>POST</th>
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<td>Chief Executive</td>
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<td>Director of HR</td>
<td>6 months</td>
</tr>
<tr>
<td>Medical Director *</td>
<td>3 months</td>
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</table>

* The Medical Directors have permanent clinical contracts with the Trust. This notice period relates to the Medical Director appointment.

None of the Executive Directors hold a Non-Executive Director portfolio in another organisation.

The Nominations Committee has met three times this year, to shortlist candidates and select a new NED to replace Mr John Evans who resigned in February 2006. Mr John Rackstraw was appointed for an initial period of three years from 1 September 2006. Other work has included a review of the committee’s composition and terms of reference, and consideration of a process for Chairman and NED appraisal. Apart from Professor Kay who missed one meeting, there was full attendance at meetings of the committee.

The Chairman and Non-Executive Directors (NEDs) are appointed by the Council of Governors acting on the recommendation of the Nominations Committee (NC), which is a committee of the Council of Governors (CoG). The Chairman is selected by the Nominations Committee, with advice from external advisors and the Chief Executive. The recommendation of the NC is presented to the Council of Governors who confirms an offer of appointment can be made. The same process is followed for the appointment of Non-Executive Directors with the addition of the Chairman participating fully in the selection process. Prior to the appointment of a Non-Executive Director, the Board and the CoG will undertake a review of the ‘Policy for the Composition of NED on the Board’ to ensure the necessary experience mix on the Board is achieved. Membership of the committee can be found in the Governors section of this report on pages 27-28.

The Chairman and Non-Executive Directors are all appointed for initial three-year terms (as approved by the Council of Governors) and are re-appointable subject to satisfactory appraisal and approval of the Governors to a further three-year term. Consideration of extension beyond six years would be subject to vigorous review. NED employment may be terminated on performance grounds or for contravention of the qualification criteria in our Constitution, by a three-quarters majority of the Governors voting at a Governors’ meeting, or by mutual consent for other reasons.
The Board of Directors

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

As a public-benefit corporation, the Trust - and the Board of Directors - are accountable to the membership via the Council of Governors (CoG). The Board comprises seven Non-Executive Directors and six Executive Directors and works on a unitary basis. The operating 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 or on request from the Board Secretary.

During 2006/07 11 formal Board meetings were held, plus two development meetings. The Board of Directors and Council of Governors also held joint development meetings during the year to ensure effective joint working particularly in relation to the review of the Trust’s strategic direction. Board members attend Council of Governors meetings to keep abreast of Governors’ views.

The composition of the Board is in accordance with both the Trust’s Constitution and the Policy for the Composition of Non-Executive Directors 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.

Directors’ details and their record of attendance at Board meetings are shown below. 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 declared outside interests. The Directors’ Register of Interests is available for inspection via the Board Secretary on 01392 402993 or via the Trust website.

Members of our Board of Directors

**ANGELA BALLATTI, CHAIRMAN * (10/10)**
Angela was appointed Chairman on 1 May 2006, and has considerable previous NHS experience as Chairman of County Durham & Darlington Priority Services NHS Trust (97-01), North Durham Healthcare NHS Trust (01-02) and County Durham & Darlington Acute Hospitals NHS Trust (02-05). Until joining the RD&E she was also a senior tutor in executive education at University of Durham Business School. She also chairs the Nominations Committee and Executive Director Remuneration Committee (EDRC).

**PROFESSOR RUTH HAWKER OBE, CHAIRMAN * (1/1)**
Ruth retired as Chairman on 30 April 2006, having served in the post since 1995 after 50 years’ service in the NHS.

**GERALD STURTRIDGE, NED & VICE CHAIRMAN * # (11/11)**
Gerald joined the Board in November 1998, taking over as Vice Chairman in June 2004, and will serve until October 2009. He retired from accountancy practice in 1997 to develop other business interests and is also involved with voluntary agencies working with disabled and disadvantaged people. He is Chair of the Audit Committee and was, until 1 February, the Chair of the Governance Committee. He is also a member of the Foundation Trust Financing Facility Committee and the Treasurer of Exeter University.

**MAUREEN DE VIELL OBE, NED * # + (10/11)**
Maureen joined the Board in May 2001 and will serve until March 2008. She is a retired civil servant with experience of social policy and equality issues and was awarded the OBE for her services to the Department of Employment.

**RICK WALKER, NED * # + (11/11)**
Rick joined the Board in 2001 and will serve until March 2008. He is a retired senior police officer.

**BOB BATY OBE, NED * # + (8/11)**
Bob joined the Board in September 2004 and will serve until August 2007. He is a chartered civil engineer who has worked all his life in the water industry and was until recently CEO of South West Water Ltd. He assumed the Chair of the Governance Committee from Mr Sturtridge on 1 February 2007. He was awarded the OBE in 2002 for services to the water industry.
DAVID BISHOP, SENIOR INDEPENDENT NON-EXECUTIVE DIRECTOR (SID) * # (10/11)
David joined the Board in February 2005 and will serve until January 2008. He is a retired senior partner of KPMG and led the strategic financial management and governance areas of the practice. He has also served on Government working parties. He was appointed Senior Independent Director on 31 January 2007.

JOHN RACKSTRAW, NED * # + (5/6)
John joined the Board on 1 September 2006 and will serve until August 2009. He spent a lifetime career in the construction industry, with which he retains strong links. He also has considerable experience of contract law relating to major construction projects.

Executive Directors

ANGELA PEDDER OBE, Chief Executive (10/11)
Angela joined the NHS in 1975 and was Chief Executive of St Albans’ & Hemel Hempstead NHS Trust before becoming 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.

MIKE STEVENS, DIRECTOR OF FINANCE & INFORMATION (10/11)
Mike joined the RD&E in April 2005 and was previously Director of Finance at the Queen’s Medical Centre Nottingham.

ELAINE HOBSON, DIRECTOR OF OPERATIONS (9/11)
Elaine qualified as a nurse and held a number of positions at the RD&E previous to becoming Director of Operations in December 2000.

STEVE JUPP, DIRECTOR OF HUMAN RESOURCES UNTIL 3 JULY THEN JOINT DIRECTOR OF HUMAN RESOURCES WITH LYNN LANE UNTIL 31 OCTOBER 2006 (7/8)
Steve joined the RD&E in 1993 and became Director of HR in 1997, having previously worked in the private sector and the NHS. He retired from the Trust for personal reasons on 31 December 2006.

LYNN LANE, JOINT DIRECTOR OF HUMAN RESOURCES WITH MR STEVE JUPP FROM 3 JULY TO 31 OCTOBER AND DIRECTOR OF HUMAN RESOURCES FROM 1 NOVEMBER 2006 (8/9)
Lynn 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 the NHS in Oxford.

MARIE-NOELLE ORZEL OBE, DIRECTOR OF NURSING & SERVICE IMPROVEMENT (10/11)
Marie-Noelle joined the RD&E in 2002. Her professional background is in A&E and children’s nursing. She has worked in both clinical and educational roles in London, Portsmouth and Oxford and is a qualified aeromedical nurse and a part-time member of the Royal Auxiliary Air Force. Marie-Noelle was awarded the OBE in the Queen’s Birthday Honours List 2006 for Services to Nursing and the NHS.

DR VAUGHAN PEARCE & DR IAIN WILSON, JOINT MEDICAL DIRECTORS (11/11)
Vaughan is a consultant in the care of the elderly and general medicine. His special interests include Parkinson’s disease and dystonia. Iain is a consultant anaesthetist, and is a Director of the Association of Anaesthetists of GB and Ireland.

LINDA HALL, DIRECTOR OF FACILITIES (8/11)
Linda is a qualified occupational therapist and held a number of positions at the RD&E before becoming Director of Facilities in January 2001. As a corporate director Linda sits on the Board of Directors but is not a voting member.

Key

* member of Executive Director Remuneration Committee
# member of the Audit Committee
+ member of the Governance Committee
(n/n) indicates the number of Board meetings attended out of a possible total

Directors’ Interests

The registers of both Directors’ and Governors’ interests may be viewed on the Trust’s website www.rdehospital.nhs.uk or by calling the Foundation Trust Secretary on 01392 402993.
The Council of Governors (CoG) has continued to flourish over the year. Governors are elected by the members to represent a public constituency, elected by the staff to represent a particular staff group, or appointed by one of the stakeholder organisations listed in our Constitution. In addition to their constitutional responsibilities, they act as a conduit between the Board, members and stakeholders, to ensure their interests are upheld.

The Governors held four general meetings this year, four development days and a meeting with the Board of Directors, in addition to the Annual Members’ Meeting. These events provide an opportunity for Governors to receive information on Trust performance throughout the year and to contribute to the formation of strategic directions and forward planning. Governors are also presented with the Annual Report and Accounts each year to aid in this process. Public constituency meetings enable members to meet the Governors, be updated on the Trust’s progress and convey their views on local healthcare provision.

This year saw the culmination of a governor-led constitutional review, resulting in a number of significant changes. These include reorganisation of the public constituencies, changes in the stakeholder representation, mainly to complement changes in the NHS regional organisation, and, after consultation, authorising Governors to approve any future changes to the Constitution on behalf of members. The changes were approved at September’s Annual Members’ Meeting and approved by Monitor shortly thereafter.

For more information about the Governors’ work please see page 20.

No Governor holds directorship in a firm that does business with the Trust. A register of Governors’ interests is available from the Trust Secretary (01392 402993) or at www.rdehospital.nhs.uk/trust/ft/documents.html. Public constituency areas in the Governor listing are co-terminous with local authority areas. To contact your Governor either call 01392 403977 or see www.rdehospital.nhs.uk/trust/ft/governors2.html.

East Devon, Dorset & Somerset

MARGARET GREEN (Oct 09) 4/4 
Deputy Chairman of the Council of Governors. Lives in Ebford near Exeter. Retired nurse teacher with a career in nursing/health work. Vice-Chair Hospiscare Exeter and Mid Devon.

LINDA FRYER (Oct 08) 3/4 **
Lives in Sidmouth. 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.

GAIL NUNAN (Oct 07) 4/4
Lives near Axminster. Gained over 40 years’ nursing experience in the UK and overseas.

BOB DOY (Oct 07) 3/4 *
Lives in Exmouth. Retired doctor who has worked in the NHS and abroad.

STANLEY WHITE (Oct 09) 3/4 *
Lives in Honiton. Financial controller and executive administrator of a West German charity working in India before retirement.

TRICIA MCKENZIE (Oct 08) 3/4
Lives in Exmouth. Works with the community in various roles as a Magistrate, Special Constable, Samaritan and with the WRVS.

CHRISTOPHER D’OYL (Oct 08) 4/4 *
Lives in Somerset but was brought up in Exeter and Topsham. Commanded a regiment in the Army and worked in the City of London before returning to work in Exeter.

Mid, North, West Devon & Cornwall

GORDON DAVIES (Oct 07) 3/4
Lives in Tiverton. Former ICI senior manager, then a management consultant and businessman. Active for Tiverton Hospital League of Friends.

REUBEN MILES (Oct 07) 3/4
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.
Elections

The following Governors were elected at the annual elections in June 2006:

Staff
- Medical & Dental: Dr. Paul Marshall, returned unopposed
- Hotel Services & Estates: Brian Croft, returned unopposed

Public
- Exeter: Rachel Jackson and Miles Kinchin, returned unopposed
- Mid Devon: Roger Smith, returned unopposed
- East Devon: Margaret Green and Stan White, both re-elected; 51% turnout
- Other Parts: Martin Perry, elected; 46% turnout

Appointed Governors

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

- Cllr David Cox, East Devon District Council (Nov 07) (2/4)
- Cllr Alan Griffiths, Mid Devon District Council (Jan 09) (4/4)
- Cllr Sally Morgan, Devon County Council (May 09) (3/4)
- Cllr John Shepherd, Exeter City Council (Apr 07) (1/4)
- Professor Janice Kay, Peninsula Medical School (Apr 09) (2/4) #

Dates after names in brackets indicate term of office in years
(n/n) indicates the number of general meetings attended out of a possible total
# membership of Nominations Committee
* membership of NED Remuneration Committee
** membership of the Attendance Committee.
There are two vacancies for appointed Governors:
- North Devon, Teignbridge and Torridge District Councils (combined post) and Devon PCT.

Staff Governors

- Tony Cox, Allied Health Professionals (Oct 07) 3/4 *
  Clinical Director for Professional Services and Directorate Manager for Diagnostics.
- Paul Marshall, Medical and Dental (Oct 09) 3/4 #
  Consultant anaesthetist in Exeter since 1982.
- Monica Overy, Nursing and Midwifery (Oct 07) 4/4
  Worked as a nurse at the RD&E for 15 years and now works in the Health Information Centre.
- Sue Greenall, Managerial, Administrative and Clerical (Oct 08) 4/4
  Has worked at the RD&E for over 15 years. Sue is Learning and Development Tutor in the Widening Participation Team based at Heavitree.
- Andrew Webber (Oct 08) 2/2
  Lives in Exeter. A Police Inspector managing Exeter Custody Unit; over 20 years’ experience.
- Miles Kinchin (Oct 09) 3/3
  Lives in Alphington. Served for 30 years in the Devon & Cornwall Constabulary, retiring as Superintendent in Middlemoor’s personnel department. Involved with various voluntary groups.

Exeter & South Devon

- Rachel Jackson (Oct 09) 4/4 *
  Lives in Stoke Hill. Mother of five and cares for elderly relatives. Recently retired as superintendent of a physiotherapy service with 40 years’ clinical experience.
- Imran Jhetam (Oct 07) 3/4#
  Lives in Exeter. A GP for 18 years and a police surgeon for the last six years.
- Margaret Read (Oct 08) 1/4
  Lives in Exeter. Retired teacher of health and social policy. Active in local-interest groups and a member of St Leonard’s Church for 25 years.
- Andrew Webber (Oct 08) 4/4**
  Lives in Exeter. A Police Inspector managing Exeter Custody Unit; over 20 years’ experience.
- Miles Kinchin (Oct 09) 3/3
  Lives in Alphington. Served for 30 years in the Devon & Cornwall Constabulary, retiring as Superintendent in Middlemoor’s personnel department. Involved with various voluntary groups.

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Royal Devon & Exeter NHS Foundation Trust Annual Report 2006/07

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### Financial & Operational Reporting

The Board of Directors meets formally on a scheduled basis 11 times per year. An Annual Plan is approved in May in accordance with the guidance issued by Monitor. Operational and financial performance against the plan is reviewed on a monthly basis, together with a detailed financial and operational performance report.

The report includes detailed commentary of performance against the Trust’s agreed service and financial plans for the year. Areas of current concern or potential concerns for future performance are highlighted in the report and action plans put in place when milestone progress has not been achieved.

In addition to this routine reporting, on a quarterly basis the Board of Directors reviews the Trust’s current authorisation which governs its operation as an NHS Foundation Trust. A declaration is submitted to Monitor declaring the level of compliance the Board can provide against Monitor’s Compliance Framework. In due course the Board reviews the Trust’s compliance with the NHS Foundation Trust’s rules of authorisation and assesses the effectiveness of the Trust’s management procedures and control processes.

A Finance and Performance Report is presented to the Council of Governors at each quarterly general meeting and progress against the Annual Plan is reported on a six-monthly basis.

The Trust operates a rigorous system of internal control which is designed to provide ongoing assurance that risk is managed to a reasonable level. By identifying and prioritising risks, they are managed effectively and their impact on the Trust’s objectives are minimised. The Chief Executive’s Statement on Internal Control is included on pages 41-42 of this report.

As far as the Directors are aware, there is no relevant audit information of which the auditors are unaware, and that the Directors have taken all of the steps that they ought to have taken as Directors in order to make themselves aware of any relevant audit information and to establish that the auditors are aware of that information.

### Audit Committee

The Audit Committee is a formally-constituted committee of the Board and consists of at least three Non-Executive Directors (NEDs) and is chaired by a NED with a financial background.

This year the Audit Committee has met three times. Apart from Mrs De Viell who missed one meeting, there was full attendance at the committee meetings. Its main tasks are to examine: whether the management of the Trust’s activities is in accordance with laws and regulations; whether the Trust establishes and maintains a system of internal control designed to give reasonable assurance that assets are safeguarded, waste and inefficiency are avoided and reliable information is produced; and whether the Trust establishes and maintains a system of risk management designed to give reasonable assurance that risks are appropriately managed.

The work of the Audit Committee is reported to the full Board on a regular basis.

During the year under review the committee has paid particular attention to the following issues: review of the Acute Hospital Portfolio; review of Counter Fraud procedures; review of the results of an internal audit review of Child Services; and review of Capital Programme Management.

The Trust’s external auditors, Pricewaterhouse-Coopers (PwC), are appointed by the Council of Governors. PwC work closely with, and review the quality of the Trust’s extensive system of internal audit, which monitors various aspects of the Trust’s operation in accordance with an agreed programme and assesses the effectiveness of internal control.

The external auditors provide an independent opinion on the Trust’s accounts and also audit the overall state 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 2006/07, 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.
Information & Development

Induction programmes are arranged for all newly-appointed Directors and Governors which include the provision of information necessary to the performance of their function. An annual programme of events to facilitate Director and Governor development is in place and joint Board of Directors and Council of Governors development events are scheduled twice yearly. These programmes are supplemented by individual, externally-facilitated development opportunities linked to Directors’ personal development plans and achieving their objectives.

The business of the Trust is conducted in an open manner and an annual schedule of meetings for both the meetings of the Board of Directors and Council of Governors are published 12 months in advance. To ensure that timely and accurate information regarding the performance of the Trust is available, a schedule of routine reports to be presented throughout each year is maintained. The appropriateness of its content is reviewed annually to ensure that information needs are met on an ongoing basis.

The Trust has a publication scheme contained within its website which provides access to a wide range of information, and both Directors and Governors may appoint advisors to provide additional expertise on particular subjects.

Performance Evaluation

Appropriate arrangements are in place to ensure the appraisal of the Executive Directors and the Non-Executive Directors (NED). The Chief Executive is appraised by the Chairman and the outcome is reported to the Executive Director Remuneration Committee (EDRC). The Chief Executive appraises the Executive Directors and the outcome is also reported to the EDRC. Personal development plans are used for all Executive Directors.

The Chairman appraises the Non-Executive Directors and the outcome is reported to the Nominations Committee when considering re-appointment of a NED. The process for the appraisal of the Chairman will be led by the Senior Independent Director and the process through which this will occur is being developed together with the process for whole Board and Council of Governors’ appraisal to ensure compliance with the Code of Governance. The Trust has formed a working group consisting of the Chairman, the Senior Independent Director and the Nominations Committee to develop this work.

The Council of Governors has established an Attendance Committee which monitors Governor attendance at general meetings, development days and constituency meetings. The Attendance Committee would also consider any situation where a Governor may have acted contrary to their Code of Conduct.

Director Remuneration

The Trust believes that to attract and motivate Directors of the required quality and to run the Foundation Trust successfully, their remuneration must be fair and sufficient to achieve this.

A full explanation of the way in which the Trust decides upon Directors’ remuneration and information on terms of office and contracts may be found in both the Appointments section above and the Remuneration Report later in this document (see page 33). Actual remuneration figures may be found on page 40 in the Accounts section of the Annual Report.
Relationships with Stakeholders

Both the Board of Directors and Council of Governors have taken steps to safeguard that satisfactory systems are in place to ensure effective dialogue with members, the public, patients and the local community. These include active involvement and participation in the following activities:

- Patient and Public Information Forums;
- Devon County Council Overview and Scrutiny Committee;
- quarterly General Meetings of the Council of Governors;
- Annual Members’ Meeting;
- quarterly Public Constituency Meetings;
- Disability and Equality Action Group;
- engagement with the voluntary and charitable sector including our Leagues of Friends, ELF, FORCE and DIRECT;
- Joint Staff Consultative Forums.

The Trust has a statutory duty to collaborate with partners in health and social care to ensure that services provided to the public are well co-ordinated and effective. Good working relationships are in place with Devon Primary Care Trust, Devon Partnership Trust, North Devon District Hospital, Devon County Council Social Services Department and local City and District Councils.

Public engagement is key to the ongoing development of the Royal Devon & Exeter as a public benefit corporation. To ensure the continued development of the membership base and the engagement of members in the forward thinking about the ongoing development of our services, the Council of Governors leads the work of the Trust’s membership development strategy. This work is supported internally within the hospital by the activities of the Patient Advice and Liaison Service in developing public and patient involvement.

The Board of Directors and Council of Governors work effectively together to secure the ongoing success of the Trust. Board members attend Council of Governor meetings, and joint Board of Director and Council of Governor development sessions are held each year to ensure all parties maintain a sound understanding of the views and aspirations of the Trust and its members and contribute to the forward thinking for the organisation’s future development.

Code of Governance Compliance

Monitor published the Code of Governance in September 2006. The Code requires foundation trusts to achieve full compliance with the code or to explain non compliance by the end of the financial year 2007/08. The Board of Directors has decided to report as fully as possible against the requirements of the Code in this Annual Report. The Code of Governance may be viewed on Monitor’s website at www.monitor-nhsft.gov.uk/publications.php?id=930.

The Board considers that, with the exception of the following, the Trust has, throughout the 2006/07 reporting year, applied the principles and met the requirements of the Code of Governance. Non Compliance or limited compliance is reported as follows:

Code Provision A.1.3 (The Chairman should hold meetings with the Non-Executive Directors without the Executives present. Led by the Senior Independent Director, the Non-Executive Directors should meet without the Chairman present at least annually to appraise the Chairman’s performance, as part of a process which should be agreed with the Governors for appraising the Chair and on such other occasions as are deemed appropriate.)

Explanation: Whilst an appraisal process is in place for the NEDs, the Board, in co-operation with the Governors, is reviewing its current system of appraisal of the whole Board, Chair and Non-Executive Directors (NEDs) which will incorporate the role of the Senior Independent
Director in the appraisal of the Chairman. This work will be complete by the autumn of 2007.

Code Provision C.2.1 (Approval by the Council of Governors of the appointment of a Chief Executive should be a subject of the first General Meeting after the appointment by a committee of the Chairman and Non-Executive Directors. Re-appointment by the Non-Executive Directors followed by re-approval by the Board of Governors thereafter should be made at intervals of no more than five years. All other Executive Directors should be appointed by a committee of the Chief Executive, the Chairman and Non-Executive Directors and subject to re-appointment at intervals of no more than five years.)

Explanation: All Executive Directors are on permanent pensionable contracts and subject to annual performance appraisal. The Board will review whether it wishes to alter these arrangements during 2007/08.

Code Provision D.2.2 (Led by the Chairman, the CoG should periodically assess their collective performance and they should regularly communicate to members details on how they have discharged their responsibilities, including their impact and effectiveness on:

- advising the Board on the forward plans of the NHS Foundation Trust;
- communicating with their member constituencies and transmitting their views to the Board of Directors.

The Board of Governors should use this process to review its roles, structure, composition and procedures, taking into account emerging best practice.)

Explanation: The Council of Governors is currently developing a system for assessing its collective performance. This will be in force by the end of the 2007/08 reporting year.

Code Provision E.1.1 (Any performance-related elements of the remuneration of Executive Directors should be designed to align their interests with those of patients, service users and tax-payers and to give these Directors keen incentives to perform at the highest levels. In designing schemes of performance-related remuneration, the Remuneration Committee should follow the following provisions:

(i) The Remuneration Committee should consider whether the Directors should be eligible for annual bonuses. If so, performance conditions should be relevant, stretching and designed to match the long-term interests of the public.

(ii) Payouts or grants under all incentive schemes should be subject to challenging performance criteria reflecting the objectives of the NHS Foundation Trust. Consideration should be given to criteria which reflect the performance of the NHS Foundation Trust relative to a group of comparator trusts in some key indicators.

(iii) In general, only basic salary should be pensionable.

(iv) The Remuneration Committee should consider the pension consequences and associated costs to the NHS Foundation Trust of basic salary increases and any other changes in pensionable remuneration, especially for Directors close to retirement.)

Explanation: The Trust does not operate a system of performance-related pay or bonuses.

Code Provision E.2.2 (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’ for this purpose should be determined by the Board but should normally include the first layer of management below Board level.)

Explanation: The Board has determined that the definition of ‘senior management’ should be limited to Board members only. All other staff remuneration is covered by the NHS Agenda for Change pay structure.

Did You Know?

The RD&E is the leading patient recruiter for cancer trials in the South West Peninsula.
Remuneration

This report contains information required by Monitor’s Financial Reporting Manual (Chapter 4). Where such information is already contained within the Annual Accounts the information is not duplicated, and reference is made to the relevant tables/notes in the accounts. The term ‘Non-Executive Director’ is used collectively to describe the Chairman and the Non-Executive Directors (NEDs). The term ‘senior manager’ is used to describe the executive members of the Board of Directors.

INTRODUCTION

Only Board-level Directors have locally agreed remuneration packages. For all other staff, remuneration is set in accordance with NHS Agenda for Change terms and conditions of service. The Trust operates two Remuneration Committees as described below and membership of both committees can be ascertained from the Director and Governor sections of the Corporate Governance Report.

NON-EXECUTIVE DIRECTOR REMUNERATION COMMITTEE

The NEDRC is chaired by the Deputy Chairman of the Council of Governors and consists of Governors. Periodically, the NEDRC will commission a benchmarking review of the NED remuneration packages against those offered by NHS Foundation Trusts of a similar size, turnover and complexity, to ensure the reward packages remain competitive. The Committee recommends levels of remuneration and conditions of service for the Chairman and NEDs which are submitted to the Council of Governors for approval. In 2006/07 the Chairman and NEDs were awarded a salary uplift of 2.2%. All NEDs receive the same basic level of remuneration. An additional payment is made for the role of Vice Chairman and the Chairman of the Audit Committee. Full details of Chairman and NED remuneration are set out in the accounts on page 40 of this Annual Report.

NEDs are appointed for an initial three-year term which may be renewed for a further three years, subject to satisfactory appraisal, and approval by the CoG. In exceptional circumstances reappointment for a further three-year term may be considered but would be subject to close scrutiny to ensure the NED continued to fulfil the independence criteria set out in Monitor’s Compliance Code.

Salary, Pension & 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 related lump sum at age 60 and cash equivalent transfer values are stated in full on pages 39–40. The total of salaries, allowances and non-cash benefits in kind paid to NEDs and senior managers for this and the previous year are:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Remuneration</th>
</tr>
</thead>
<tbody>
<tr>
<td>2005/06</td>
<td>£1,095k</td>
</tr>
<tr>
<td>2006/07</td>
<td>£1,091k</td>
</tr>
</tbody>
</table>

Compensation in the form of an agreed voluntary early retirement package was approved in respect of a senior manager as detailed on page 40. There have been no payments to third parties for the services of a senior manager.

Angela Pedder, Chief Executive, 31 May 2007

Expiry dates of current terms are as follows:

<table>
<thead>
<tr>
<th>Name</th>
<th>Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ms Ballatti</td>
<td>30 April 2009</td>
</tr>
<tr>
<td>Mr Sturtridge</td>
<td>31 October 2009</td>
</tr>
<tr>
<td>Mrs De Viell</td>
<td>31 March 2008</td>
</tr>
<tr>
<td>Mr Walker</td>
<td>31 March 2008</td>
</tr>
<tr>
<td>Mr Baty</td>
<td>31 August 2007</td>
</tr>
<tr>
<td>Mr Bishop</td>
<td>31 January 2008</td>
</tr>
<tr>
<td>Mr Rackstraw</td>
<td>31 August 2009</td>
</tr>
</tbody>
</table>
The Royal Devon & Exeter NHS Foundation Trust has now completed its third year of operation as an NHS Foundation Trust. During the year, the Trust continued to improve its overall financial position from a surplus of £0.5m achieved in 2005/06 to a surplus of £2.9m in 2006/07.

The achievement of this outturn is set against a background of great financial uncertainty including changes in the methodology of funding, reductions in central allocations from the Department of Health and significant financial pressures across the local health community. In spite of these challenges the Trust has delivered all of its key targets and retained an overall financial risk rating of 4 (set by Monitor, range of 1 to 5). The Trust’s three-year financial plan provided for an improvement in the overall position from a surplus of £0.5m in 2005/06 to a surplus of £2.4m in 2006/07. At the year-end the Trust achieved a surplus of £2.9m.

The financial regime requires NHS Foundation Trusts to plan for a financial surplus in order to maintain the ability to respond to unforeseen changes as, unlike traditional NHS trusts, NHS Foundation Trusts cannot obtain external financial support when faced with a deteriorating financial position. Any surplus generated in-year is retained by the Trust and may be reinvested in improvements to services and/or additional capital spending, or retained to offset future potential deficits.

The Trust has continued to implement the four-point financial strategy established in 2005, and the drive to improve efficiency through a programme of work targeted at areas where improvements can be achieved despite the overall efficiency of the Trust (17% below average national cost). This programme identified £16m of potential savings over a three-year period. The first phase of this programme has been delivered, with the initial £3m being achieved in-year, and further savings coming on-stream in future years. This programme will continue to be rolled out with a target of delivering at least £5m of savings each year. The Trust has continued to develop this process by identifying further financial benefits to be obtained throughout all areas of operation. This approach will not only guarantee the delivery of short-term financial targets, but will also ensure a sustainable programme of change into the future to deliver long-term financial stability beyond 2007/08. By integrating the programme into the daily operation of the Trust’s workings it is now seen as essential ongoing work, rather than merely as a short-term fix to meet current requirements.

During the year the Trust completed work on the new Diabetes, Endocrinology and Vascular Health Centre and made significant progress in expanding Critical Care facilities. The building and commissioning of the new state-of-the-art Centre for Women’s Health, which will replace the Neonatal, Maternity and Gynaecology facilities currently housed at Heavitree Hospital, is now almost complete and work has commenced on other new developments including an expansion of radiotherapy facilities, the endoscopy department and mortuary facilities.

Future Outlook

The Payment by Results funding system introduced into the NHS in 2001 has undergone extensive and continuous development, resulting in significant changes to levels of funding received on a year-by-year basis. This has led to great uncertainty, making any sort of medium-term planning difficult. The national tariff, or ‘price list’, has frequently been published late and contained significant errors, making it very difficult for both commissioners and providers to reach agreement on work to be undertaken in any given year. In recognition of this, the Department of Health committed itself to publishing the new tariff well in advance of the new financial year, and limiting the changes taking place year to year in order that a greater element of stability could be achieved. The tariff price list for 2007/08 has largely been restricted to increasing the tariff rates from 2006/07 by 2.5%, with only marginal changes to the scope of the system overall. For the first time since 2004, the combination of early publication with minimal changes in scope has led to the negotiation of the Trust’s contract with the new Devon PCT in the first week of April 2007, giving both organisations the confidence of starting the new year knowing exactly what commitments they are entering into.

2007/08 will see significant growth in the number of patients requiring treatment as the Trust heads towards achieving the Government’s target of ensuring that all patients do not wait any longer than 18 weeks from the time they are referred by their GP to when their treatment...
commences. This increase in capacity will bring in over £10m of additional income in 2007/08 alone. This will be a great challenge for the Trust on three counts - delivering such a significant increase in activity compared to the previous year; being able to increase capacity for the next two years to achieve the waiting-time target; and thereafter potentially reducing capacity again when the target has been met.

Financial targets for the next three years will see the delivery of a surplus of £6.5m in 2007/08 rising to a surplus of £10m by 2008/09.

The transfer of services from Heavitree Hospital to the Wonford site is now nearing completion and will see the first patients being treated in the new building in the summer. Work will be completed on an expanded endoscopy unit providing essential diagnosis and care for the treatment of patients with a variety of conditions. Expanded ITU facilities are nearing completion, meeting the needs of some of our sickest patients, and better radiotherapy provision will bring improvements in the treatment of cancer patients. 2007/08 will also see the development of plans for the hospital’s new ‘Emergency Hub’ for consideration by the Board of Directors, with the intention that the Trust will reorganise the way emergency cases are treated within the hospital, once again providing significant benefits for patients.
With thanks to all of the staff, patients and governors who have contributed to this year’s Annual Report.
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 below address:

Royal Devon and Exeter NHS Foundation Trust, Barrack Road, Exeter, EX2 5DW. Telephone (01392) 411611.

These Summary Financial Statements have been approved by the Board of the Royal Devon & Exeter NHS Foundation Trust.

Angela Pedder, Chief Executive, 7 June 2007

INDEPENDENT AUDITORS’ STATEMENT TO THE BOARD OF GOVERNORS OF ROYAL DEVON & EXETER NHS FOUNDATION TRUST

We have examined the summary financial statements for the year ended 31 March 2007 which comprise the Income and Expenditure Account, the Balance Sheet, the Statement of Total Recognised Gains and Losses, the Cashflow Statement and the related notes.

This report, including the opinion, is made solely to the Board of Governors of Royal Devon & 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 within the Annual Report and with the statutory financial statements. We also read the other information contained in the Annual Report and consider the implications for our statement if we become aware of any apparent misstatements or material inconsistencies with the Summary Financial Statements.

BASIS OF OPINION

We conducted our work in accordance with Bulletin 1999/6 ‘The auditors’ statement on the summary financial statement’ issued by the Auditing Practices Board. Our report on the statutory financial statements describes the basis of our audit opinion on those financial statements.

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2007

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income from activities</td>
<td>207,887</td>
<td>195,273</td>
</tr>
<tr>
<td>Other operating income</td>
<td>45,802</td>
<td>46,448</td>
</tr>
<tr>
<td>Operating expenses</td>
<td>(242,649)</td>
<td>(233,554)</td>
</tr>
<tr>
<td>OPERATING SURPLUS</td>
<td>11,040</td>
<td>8,167</td>
</tr>
<tr>
<td>Loss on disposal of fixed assets</td>
<td>(611)</td>
<td>(27)</td>
</tr>
<tr>
<td>SURPLUS BEFORE NET FINANCING COSTS</td>
<td>10,429</td>
<td>8,140</td>
</tr>
<tr>
<td>Net Financing Income</td>
<td>939</td>
<td>1,033</td>
</tr>
<tr>
<td>SURPLUS FOR THE FINANCIAL YEAR</td>
<td>11,368</td>
<td>9,173</td>
</tr>
<tr>
<td>Public Dividend Capital dividends payable</td>
<td>(8,466)</td>
<td>(8,699)</td>
</tr>
<tr>
<td>RECORDED SURPLUS FOR THE YEAR</td>
<td>2,902</td>
<td>474</td>
</tr>
</tbody>
</table>

All activities are classed as continuing.

STATEMENT OF TOTAL RECOGNISED GAINS AND LOSSES FOR THE YEAR ENDED 31 MARCH 2007

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surplus for the financial year before dividend payments</td>
<td>11,368</td>
<td>9,173</td>
</tr>
<tr>
<td>Unrealised surplus on fixed asset revaluations/indexation</td>
<td>404</td>
<td>273</td>
</tr>
<tr>
<td>Increases in the donated asset reserve due to receipt of donated assets</td>
<td>410</td>
<td>921</td>
</tr>
<tr>
<td>Reductions in the donated asset reserve due to the depreciation, impairment and disposal of donated assets</td>
<td>(329)</td>
<td>(223)</td>
</tr>
<tr>
<td>Total recognised gains and losses for the financial year</td>
<td>11,853</td>
<td>10,144</td>
</tr>
<tr>
<td>Prior period adjustments</td>
<td>-</td>
<td>286</td>
</tr>
<tr>
<td>Total recognised gains and losses since last annual report</td>
<td>11,853</td>
<td>10,430</td>
</tr>
</tbody>
</table>

In our opinion the summary financial statements are consistent with the statutory financial statements of the Trust for the year ended 31 March 2007.

PricewaterhouseCoopers LLP
31 Great George Street, Bristol, BS1 5QD
8 June 2007
BALANCE SHEET AS AT 31 MARCH 2007

<table>
<thead>
<tr>
<th></th>
<th>31 March 2007</th>
<th>31 March 2006</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>FIXED ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intangible assets</td>
<td>466</td>
<td>491</td>
</tr>
<tr>
<td>Tangible assets</td>
<td>261,697</td>
<td>248,684</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td>262,163</td>
<td>249,175</td>
</tr>
<tr>
<td><strong>CURRENT ASSETS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Stocks and work in progress</td>
<td>4,147</td>
<td>2,596</td>
</tr>
<tr>
<td>Debtors</td>
<td>16,520</td>
<td>15,246</td>
</tr>
<tr>
<td>Cash at bank and in hand</td>
<td>15,797</td>
<td>12,870</td>
</tr>
<tr>
<td><strong>CREDITORs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due within one year</td>
<td>(21,005)</td>
<td>(20,335)</td>
</tr>
<tr>
<td><strong>NET CURRENT ASSETS</strong></td>
<td>15,459</td>
<td>11,377</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS LESS CURRENT LIABILITIES</strong></td>
<td>277,622</td>
<td>260,552</td>
</tr>
<tr>
<td><strong>CREDITORs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amounts falling due after more than one year</td>
<td>(26,102)</td>
<td>(12,733)</td>
</tr>
<tr>
<td><strong>PROVISIONS FOR LIABILITIES &amp; CHARGES</strong></td>
<td>(399)</td>
<td>(464)</td>
</tr>
<tr>
<td><strong>TOTAL ASSETS EMPLOYED</strong></td>
<td>251,121</td>
<td>247,355</td>
</tr>
</tbody>
</table>

FINANCED BY:

**TAXPAYERS’ EQUITY**

Public dividend capital | 146,532 | 146,153 |
Revaluation reserve | 90,374 | 92,819 |
Donated asset reserve | 2,530 | 2,426 |
Income and expenditure reserve | 11,685 | 9,964 |
**TOTAL TAXPAYERS EQUITY** | 251,121 | 247,355 |

The Annual Accounts were formally approved by the Board on 7 June 2007 and were signed on its behalf by:

Angela Pedder, Chief Executive

PUBLIC SECTOR PAYMENT POLICY BETTER PAYMENT PRACTICE CODE - MEASURE OF COMPLIANCE

<table>
<thead>
<tr>
<th>Number</th>
<th>£000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Non-NHS trade invoices paid in the year</td>
<td>74,729</td>
</tr>
<tr>
<td>Total Non-NHS trade invoices paid within target</td>
<td>64,766</td>
</tr>
<tr>
<td>Percentage of Non-NHS trade invoices paid within target</td>
<td>86.67%</td>
</tr>
<tr>
<td>Total NHS trade invoices paid in the year</td>
<td>1,942</td>
</tr>
<tr>
<td>Total NHS trade invoices paid within target</td>
<td>1,460</td>
</tr>
<tr>
<td>Percentage of NHS trade invoices paid within target</td>
<td>75.18%</td>
</tr>
</tbody>
</table>

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.

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 (2005/06 - £nil).
Royal Devon & Exeter NHS Foundation Trust Annual Report 2006/07

INCOME FROM ACTIVITIES

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective income</td>
<td>60,248</td>
<td>53,938</td>
</tr>
<tr>
<td>Non-elective income</td>
<td>74,459</td>
<td>71,300</td>
</tr>
<tr>
<td>Outpatient income</td>
<td>33,827</td>
<td>34,472</td>
</tr>
<tr>
<td>Other types of activity income</td>
<td>36,167</td>
<td>41,509</td>
</tr>
<tr>
<td>A &amp; E income</td>
<td>6,230</td>
<td>5,550</td>
</tr>
<tr>
<td>PbR clawback</td>
<td>(4,762)</td>
<td>(13,371)</td>
</tr>
<tr>
<td>Private patient Income</td>
<td>1,718</td>
<td>1,875</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>207,887</td>
<td>195,273</td>
</tr>
</tbody>
</table>

Income from mandatory services 206,124 193,356
Income from non-mandatory services 1,763 1,917

**Total** 207,887 195,273

The 2005/06 comparatives have been amended to show 'Other types of activity income'; this was previously stated within 'Outpatient income'.

Road Traffic Act income is subject to a provision for doubtful debts of 7.7% to reflect expected rates of collection.

OTHER OPERATING INCOME

<table>
<thead>
<tr>
<th></th>
<th>2006/07</th>
<th>2005/06</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research and development</td>
<td>2,182</td>
<td>1,655</td>
</tr>
<tr>
<td>Education and training</td>
<td>15,137</td>
<td>15,955</td>
</tr>
<tr>
<td>Transfers from donated asset reserve</td>
<td>329</td>
<td>223</td>
</tr>
<tr>
<td>Transfers from deferred income</td>
<td>- Government grant</td>
<td>212</td>
</tr>
<tr>
<td>Non-patient care services to other bodies</td>
<td>22,127</td>
<td>22,747</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>5,815</td>
<td>5,695</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>45,802</td>
<td>46,448</td>
</tr>
</tbody>
</table>

Include within 'Non-patient care services to other bodies' are drug sales, laundry services, financial services, IT services and estates services totalling £13.8 million (2005/06 - £15.2 million).

Include within 'Other income' above is catering income of £1.6 million, (2005/06 - £1.6 million), merit awards of £0.9 million (2005/06 - £0.9 million) and car parking income of £1 million (2005/06 - £0.9 million).

AVERAGE NUMBER OF PERSONS EMPLOYED

<table>
<thead>
<tr>
<th></th>
<th>Number</th>
<th>Number</th>
<th>Number</th>
<th>Number</th>
<th>Number</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and dental</td>
<td>508</td>
<td>1</td>
<td>501</td>
<td>6</td>
<td>-</td>
<td>479</td>
</tr>
<tr>
<td>Administration and estates</td>
<td>1,048</td>
<td>7</td>
<td>1,038</td>
<td>3</td>
<td>-</td>
<td>1,057</td>
</tr>
<tr>
<td>Healthcare assistants &amp; other support staff</td>
<td>555</td>
<td>-</td>
<td>555</td>
<td>-</td>
<td>-</td>
<td>597</td>
</tr>
<tr>
<td>Nursing, midwifery &amp; health-visiting staff</td>
<td>1,470</td>
<td>-</td>
<td>1,463</td>
<td>7</td>
<td>-</td>
<td>1,464</td>
</tr>
<tr>
<td>Scientific, therapeutic &amp; technical staff</td>
<td>624</td>
<td>-</td>
<td>621</td>
<td>3</td>
<td>-</td>
<td>634</td>
</tr>
<tr>
<td>Bank &amp; agency staff</td>
<td>178</td>
<td>-</td>
<td>-</td>
<td>178</td>
<td>200</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>4,383</td>
<td>8</td>
<td>4,178</td>
<td>19</td>
<td>178</td>
<td>4,431</td>
</tr>
</tbody>
</table>

PENSION ENTITLEMENTS OF SENIOR MANAGERS 2006/07

Name and Title | Real increase in pension at age 60 (bands £2,500) | Real increase in pension-related sum at age 60 (bands £2,500) | Total accrued pension at age 60 at 31 March 2007 (bands £2,500)

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Real increase in pension at age 60</th>
<th>Real increase in pension-related sum at age 60</th>
<th>Total accrued pension at age 60 at 31 March 2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Pedder Chief Executive</td>
<td>0.0 - 2.5</td>
<td>2.5 - 5.0</td>
<td>57.5 - 60.0</td>
</tr>
<tr>
<td>L Hall Director of Facilities</td>
<td>0.0 - 2.5</td>
<td>2.5 - 5.0</td>
<td>22.5 - 25.0</td>
</tr>
<tr>
<td>E Hobson Director of Operations</td>
<td>2.5 - 5.0</td>
<td>7.5 - 10.0</td>
<td>35.0 - 37.5</td>
</tr>
<tr>
<td>S Jupp Director of Human Resources</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>17.5 - 20.0</td>
</tr>
<tr>
<td>L Lane Director of Human Resources</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
<td>0.0 - 2.5</td>
</tr>
<tr>
<td>M-N Orzel Director of Nursing &amp; Service Improvement</td>
<td>0.0 - 2.5</td>
<td>2.5 - 5.0</td>
<td>20.0 - 22.5</td>
</tr>
<tr>
<td>V Pearce Joint Medical Director</td>
<td>2.5 - 5.0</td>
<td>10.0 - 12.5</td>
<td>57.5 - 60.0</td>
</tr>
<tr>
<td>M Stevens Director of Finance &amp; Information</td>
<td>0.0 - 2.5</td>
<td>2.5 - 5.0</td>
<td>45.0 - 47.5</td>
</tr>
<tr>
<td>N Walsh Director of Planning</td>
<td>-</td>
<td>-</td>
<td>25.0 - 27.5</td>
</tr>
<tr>
<td>I Wilson Joint Medical Director</td>
<td>2.5 - 5.0</td>
<td>10.0 - 12.5</td>
<td>37.5 - 40.0</td>
</tr>
</tbody>
</table>

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.
### SALARY ENTITLEMENTS OF SENIOR MANAGERS - 2006/07

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>Salary (bands of £5,000)</th>
<th>Other Remuneration (bands of £5,000)</th>
<th>Golden hello/ compensation for loss of office (bands of £5,000)</th>
<th>Benefits in kind (rounded to nearest £100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Ballatti Chairman</td>
<td>35 - 40</td>
<td></td>
<td></td>
<td>800</td>
</tr>
<tr>
<td>R Hawker Chairman</td>
<td>0 - 5</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B Baty Non-Executive Director</td>
<td>10 - 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D Bishop Non-Executive Director</td>
<td>10 - 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M De Viell Non-Executive Director</td>
<td>10 - 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J Rackstraw Non-Executive Director</td>
<td>5 - 10</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>G Sturtridge Non-Executive Director</td>
<td>15 - 20</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>R Walker Non-Executive Director</td>
<td>10 - 15</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A Pedder Chief Executive</td>
<td>145 - 150</td>
<td></td>
<td></td>
<td>7,900</td>
</tr>
<tr>
<td>L Hall Director of Facilities</td>
<td>70 - 75</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E Hobson Director of Operations</td>
<td>90 - 95</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>S Jupp Director of Human Resources</td>
<td>40 - 45</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>L Lane Director of Human Resources</td>
<td>45 - 50</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>M N Orzel Director of Nursing &amp; Service Improvement</td>
<td>80 - 85</td>
<td></td>
<td></td>
<td>100</td>
</tr>
<tr>
<td>V Pearce Joint Medical Director</td>
<td>80 - 85</td>
<td>105 - 110</td>
<td></td>
<td></td>
</tr>
<tr>
<td>M Stevens Director of Finance &amp; Information</td>
<td>120 - 125</td>
<td></td>
<td></td>
<td>500</td>
</tr>
<tr>
<td>N Walsh Director of Planning</td>
<td>15 - 20</td>
<td>See below</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I Wilson Joint Medical Director</td>
<td>60 - 65</td>
<td>90 - 95</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


- Other Remuneration shows the salary that is attributable to clinical duties.
- During the year N Walsh received compensation for agreed voluntary early retirement under the terms of an approved compensation scheme.
- 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 allowance.

<table>
<thead>
<tr>
<th>Total accrued related lump sum at age 60 at 31 March 2007 (bands £2,500)</th>
<th>Cash equivalent transfer value at 31 March 2007 £'000</th>
<th>Cash equivalent transfer value at 31 March 2006 £'000</th>
<th>Real increase in cash equivalent transfer value at 31 March 2007 £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>172.5 - 175.0</td>
<td>868</td>
<td>823</td>
<td>17</td>
</tr>
<tr>
<td>70.0 - 72.5</td>
<td>343</td>
<td>314</td>
<td>14</td>
</tr>
<tr>
<td>105.0 - 107.5</td>
<td>516</td>
<td>452</td>
<td>37</td>
</tr>
<tr>
<td>57.5 - 60.0</td>
<td>320</td>
<td>297</td>
<td>6</td>
</tr>
<tr>
<td>2.5 - 5.0</td>
<td>22</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>62.5 - 65.0</td>
<td>295</td>
<td>267</td>
<td>15</td>
</tr>
<tr>
<td>172.5 - 175.0</td>
<td>-</td>
<td>981</td>
<td>-</td>
</tr>
<tr>
<td>137.5 - 140.0</td>
<td>750</td>
<td>700</td>
<td>23</td>
</tr>
<tr>
<td>75.0 - 77.5</td>
<td>-</td>
<td>430</td>
<td>-</td>
</tr>
<tr>
<td>112.5 - 115.0</td>
<td>606</td>
<td>523</td>
<td>49</td>
</tr>
</tbody>
</table>

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 2007, for V Pearce and N Walsh.
The Trust had an £18,000,000 approved working capital facility in place although this was unused during the year. The renewal date of this facility is July 2007.

### Financial Ratios

<table>
<thead>
<tr>
<th>Ratio</th>
<th>2006/07 Actual Ratios</th>
<th>2006/07 Approved PBL Ratios</th>
<th>2005/06 Actual Ratios</th>
<th>2005/06 Approved PBL Ratios</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Debt/Capital Ratio</td>
<td>9%</td>
<td>9%</td>
<td>4%</td>
<td>25%*</td>
</tr>
<tr>
<td>Minimum Dividend Cover</td>
<td>2.5x</td>
<td>2.5x</td>
<td>2.2x</td>
<td>&gt;1x</td>
</tr>
<tr>
<td>Minimum Interest Cover</td>
<td>31.8x</td>
<td>26.7x</td>
<td>470x</td>
<td>&gt;3x</td>
</tr>
<tr>
<td>Minimum Debt Service Cover</td>
<td>19.4x</td>
<td>15.9x</td>
<td>470x</td>
<td>&gt;2x</td>
</tr>
<tr>
<td>Maximum Debt Service to Revenue</td>
<td>0.4%</td>
<td>0.6%</td>
<td>0%</td>
<td>3%</td>
</tr>
</tbody>
</table>

* The maximum debt/capital ratio is based upon the Prudential Borrowing code risk rating of 4.

The Trust is required to comply and remain within a prudential borrowing limit. This is made up of two elements:
- The maximum cumulative amount of long-term borrowing. (This is set by reference to the five ratio tests set out in Monitor’s Prudential Borrowing Code. The financial risk rating set under Monitor’s Compliance Framework determines one of the ratios and therefore can impact on the long-term borrowing limit.)
- The amount of working capital facility approved by Monitor.

### Statement of Internal Control

#### 1.0 Scope of responsibility

1.1 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; 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 Trust;
- evaluate the likelihood of those risks being realised and the impact they should be realised, and to manage them efficiently, effectively and economically.

2.2 The system of internal control has been in place in The Royal Devon & Exeter NHS Foundation Trust for the year ended 31 March 2007 and up to the date of approval of the Annual Report and Accounts.

#### 3.0 Capacity to handle risk

3.1 The Governance Committee (committee of the Board of Directors) 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 to manage various agendas. These include:
- governance and risk manager;
- fire, infection control and radiation advisors;
- occupational health physician and health advisors;
- governance support unit providing clinical audit and research ethics advice;
- Trust solicitor;
- complaints department;
- Patient Advice and Liaison Service (PALS).

3.2 Guidance and training is provided to staff through both corporate and local induction, update training, specific risk management training, policies and procedures and feedback from audits, inspections and incident reporting. Included within this is the 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. Root-cause analysis training has also been undertaken to equip the organisation with the necessary skills to investigate and learn from more serious incidents.

3.4 Policies and procedures are updated on a regular basis to offer a benchmark to the Trust on how to manage risk. Some of these policies, specifically the risk management strategy, risk assessment policy and procedure and the incident and investigation policy and procedure, also inform external stakeholders on the Trust position in these areas.

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

4.3 Directorates undertake risk management activities within their own sphere of responsibility by holding regular directorate governance groups meetings.

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. Action plans have been put in place to address any gaps.

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

- Monitor;
- healthcare standards;
- service development strategy;
- local delivery plan.

4.6 Primary Care Trust consultations on the wider aspects of risk (for example, access risk issues) are undertaken through regular meetings on the local delivery plan and monthly contract management meetings.

4.7 Planning risk issues are discussed with the local authorities via Overview and 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.

4.8 Quarterly Council of Governor meetings are also held to discuss all aspects of Trust business, including risks, in meeting national targets.

5.0 Pensions

5.1 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.

6.0 Review of economy, efficiency and effectiveness of the use of resources

6.1 Internally, overall performance is monitored at the monthly meetings of the Board of Directors. Operational management and the co-ordination of Trust services is delivered by the Trust Executive, which comprises the Executive Directors and Clinical Directors. 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.

7.0 Review of effectiveness

7.1 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, and comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit Committee and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

7.2 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.

7.3 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 quarterly basis and regular reports are given to the Audit and Governance Committees. The Trust position against the core healthcare standards has been reported to the Board and the Healthcare Commission via the Annual Healthcheck.

7.4 No significant internal control issues (i.e. issues where the risk could not be effectively controlled) have been identified in respect of 2006/07.

Angela Pedder, Chief Executive, 25 April 2007
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We can give you this information in larger text. Please ask us on (01392) 402833.