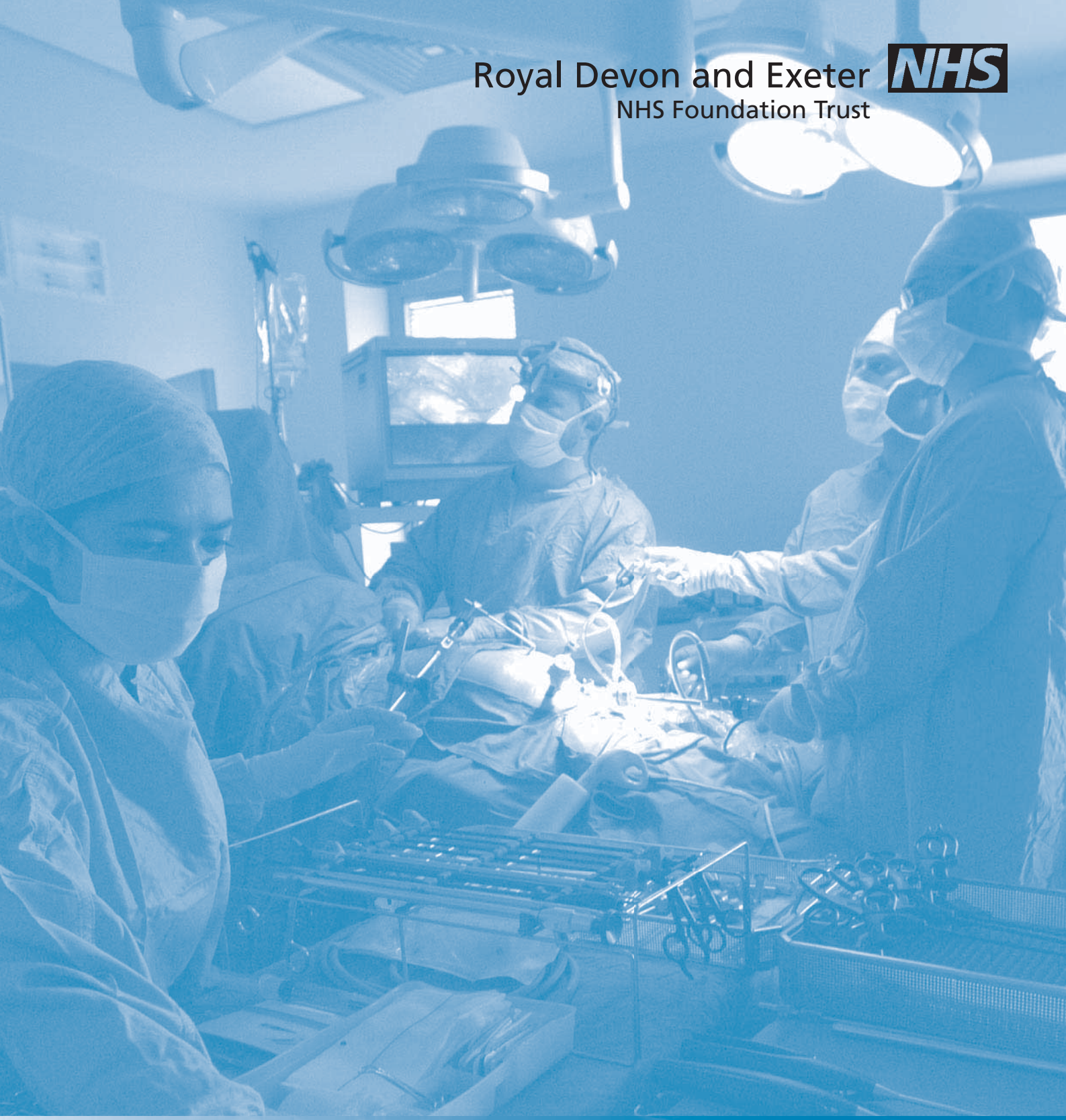


Royal Devon and Exeter NHS
NHS Foundation Trust

Annual Report 2005/06

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

& Summary Financial Statements

Celebrating

Chairman's statement

Authorisation as one of the first NHS foundation trusts on 1 April 2004 was the starting point for the RD&E on its journey to becoming a robust public benefit corporation capable of exploiting the associated mutual and financial benefits and freedoms, and during our second year as an NHSFT the RD&E has embraced the challenges created by this major transition.

When the RD&E first became an NHSFT we identified priorities for the next five years; improving access to services, improving relationships with our community, developing new ways of delivering care and responding to staff. This Annual Report shows how we continue to work to these priorities, and demonstrates how the Trust has met the challenges of targets, standards and good financial management, thanks to the consistent hard work and commitment of all our staff.

The focus on working with partner organisations within the local healthcare community also continues, and the Trust benefits greatly from the support of the League of Friends at our various centres and our volunteers and charities such as the Exeter Leukaemia Fund, DIRECT and FORCE.

During the year the Governors' role has further developed, as they undertook a review of Non Executive Director remuneration and completed the selection process for the appointment of myself as Chairman. I look forward to working closely with them, and developing membership and wider public involvement in the work of the Trust.

This Annual Report reflects on a year which also represents Professor Ruth Hawker's final year as Chairman. I would like to pay tribute to her leadership and skill in guiding the Board through many challenges and successes during her ten-year tenure. We wish her well in her continuing involvement in the NHS locally.

It is a great privilege to have been appointed as Chairman of this Trust. During my induction, staff have expressed a justifiable sense of pride in their considerable achievements to date; their enthusiasm for continuously improving patient care is tangible. Similarly, the Board must continuously review its fitness for purpose as we face new opportunities and challenges. Building on the successes of the past, I speak for all Board members in saying that we look forward to these challenges.

Angela Ballatti
Chairman

Chief Executive's statement

During 2005/06 the RD&E has applied the lessons learned in the first year as an NHS foundation trust, and is now well placed to rise to the significant challenges associated with ongoing system reform in the NHS.

The Trust has met or exceeded all the objectives set in the 2005/06 Annual Plan. Good progress has been made across the broad range of NHS standards and targets. A number of targets have been exceeded, underlining an excellent overall performance, with a particularly pleasing 33% reduction in the number of hospital-acquired MRSA bacteraemias.

The previous year was particularly challenging financially, so it is with considerable pleasure that I am able to report an excellent financial performance during 2005/06, closing the year £3.3 million better than plan with a small surplus of £0.5 million.

For the fifth consecutive year, the RD&E was awarded three stars in the NHS annual performance league tables — a continuous period of achievement shared by very few NHS organisations. This external validation of quality is only made possible by the ongoing dedication and commitment of all our staff, whose teamwork ensures we provide comprehensive care for our patients.

We have made further improvements to patient care with significant expansion of facilities and services. Among these, our second cardiac catheter laboratory and new modular operating theatre opened and work started on the much-needed expansion of our intensive care unit. These schemes will provide significant benefits to many patients and represent major steps forward in improving the range of the facilities and services offered at the RD&E.

There are still many challenges ahead but the RD&E is well placed to remain strong through the period of turbulence and volatility that will occur as the wider NHS system reforms are implemented over the next 12 months.

Angela Pedder
Chief Executive

Emergency waiting times are down and, for our youngest patients, becoming a lot less stressful thanks to a new children's waiting room, equipped using £10,000 raised by local people and businesses for the Smile appeal launched by the local paper, the Express & Echo.

Award-winning perfo

The past year has seen the Royal Devon & Exeter NHS Foundation Trust enjoying an impressive array of awards and other markers of achievement spanning all directorates.

In February 2005 the RD&E began work on a National Pathology Improvement Programme, along with five other hand-picked test-bed sites throughout the UK.

The work involved four disciplines: clinical chemistry, histology, microbiology and molecular genetics, as well as looking at whole-service issues.

The project:

- encouraged Trust-wide perspective and a greater understanding of how Pathology interacts with the whole organisation;
- established a more regular communication with service users;
- embedded the Pathology service into the Trust-wide culture of service development;
- highlighted the importance of executive and clinical leadership in service improvements;
- re-affirmed the constant need to ensure that the 'patient journey' is at the centre of service improvement.

The Access Team celebrate their HSJ Award. Left to right: Mark Paver (Operations Support), Fred Cock (Access Team Manager), Bernadette George (Lead Nurse for Medicine) and John Keast (Service Improvement Manager for East Devon PCT).

IN SPRING 2006 the Government once again hand picked the RD&E, this time to serve as one of eight national pioneer sites in delivery of the 18-week referral-to-treatment pathway, which is a national target for December 2008. The successful bid from the RD&E was put forward in conjunction with the Trust's three main PCT commissioners comprising the health economy for the study. This success typically describes the onus given to joined-up thinking in improving patient services.

"a genuinely learning organisation" *Health Service Journal*

LAST DECEMBER the RD&E's entry to the coveted *Health Service Journal* awards was noted in the same light, with judges dubbing the Trust "a genuinely learning organisation". Being awarded a 'Highly Commended' for the category of Improving Patient Access, the RD&E stood out from the crowd with its reduction in avoidable admissions and planning of discharges.

The Service Development Department submitted the entry, highlighting several areas of key improvement, including the development of an Access Team in collaboration with Exeter Primary Care Trust, and the use of a predictor tool, which accurately predicts numbers of patients requiring emergency admission to the hospital.

The Access Team, comprising two occupational therapists and two community care workers, worked in the Emergency Department and Emergency Medical Unit to directly commission alternative care for patients who arrive at the RD&E but do not require admission. The joint working arrangement between the Trust and the PCT impressed the *HSJ*, who commented: "This was all about cultural system redesign and it had a strong focus on whole-system working. There was obviously strong leadership from the top as well as staff empowerment at all levels."

Use of the predictor tool has eliminated inappropriate admissions which means an end to cancelled operations due to bed unavailability. It has also played a large part in helping us hit our ED target and over £1m has been saved.

Within the Trust the greatest sense of achievement has been derived from the successful development of a culture across our health and social-care community that promotes a truly patient-centred approach to care and delivery at all levels.

rmance

CASE NOTES: JACK'S MUM, EMMA FROM ESSEX, EXPLAINS THE DIFFERENCE WHICH EXETER RESEARCH HAS MADE TO HER SON'S DIABETES AND FAMILY LIFE.

"Jack's life is completely changed, it's fantastic. He's in a main-stream school, he's talking in fragmented sentences, he can count up to 20, he's reading basic words. He's sleeping better (he used to wake with hypoglycaemic episodes). Our whole lives used to be controlled by Jack's diabetes, it's just not an issue any more. It's beyond my wildest dreams."

THE MOLECULAR GENETICS LABORATORY, a world leader in diabetes research, clearly examples the profound benefits of both a joined-up approach and whole-system working. The laboratory, which is a joint venture between the Trust and Peninsula Medical School, has been the site of award-winning research which has impacted almost immediately on patient care thanks to an outstanding scientist and her team.

The Queen's Anniversary Prize 2005 recognised the world-class work of our team of scientists who have transformed the lives of hundreds of diabetes sufferers. They have identified new forms of the disease, developed new treatments and trained frontline staff to use them.

Their work has meant that hundreds of patients — many of them children or babies — have been able to come off insulin injections and transfer to tablets. This has made it much easier for patients to control their blood-sugar levels and dramatically improve quality of life.

Included in the research team is Sian Ellard, a Consultant Clinical Molecular Geneticist and Head of the Molecular Genetics Laboratory. At the Healthcare Science Awards 2005 Sian was named Healthcare Scientist of the Year by the Department of Health.

Sian set up the laboratory which, within a decade, has become a world-renowned diagnostic centre. Its research programme to investigate the genetics of diabetes has generated over £2m in research grant income, garnered international acclaim and produced over 100 publications.

Sian has moved her research rapidly into patient care and set up diagnostic molecular genetic testing for patients in the UK and worldwide. As most healthcare professionals have had little or no training in genetics, Sian and colleagues have also launched a variety of educational initiatives.

Sian's dedication to ensuring that her ideas become part of routine care was judged "exceptional" by the DoH, as were her "outstanding contributions to other research fields such a leukaemia and spinal disease."

Exeter diabetes sufferer Tracey Davies is one patient who has benefited from this work. She has been able to transfer to tablets after 17 years of injections: "It's made an amazing change. When I was first diagnosed no-one knew about monogenic diabetes so the Exeter research has really made a difference to people like me."

AWARDS FOR THE RD&E KITCHEN: Scott and Mike 'Chalky' White, who competed for the title of National Hospital Chef of the Year at Hotelympia in February 2006. The father-and-son team brought home a Gold Medal for food hygiene and Silver for their two-course meal. Four months earlier Scott scooped Gold with chef Matt Warren for the 'Live' event at the HCA Wessex Branch Salon Culiniere competition sponsored by the Hospital Caterers Association. At the same event Mike White received Gold for 'Patients' Afternoon Tea' and Ron Hedicker completed the trio of top prizes for his 'Plated Main Course'.

Valuing & involving

A total of 5,782 people worked for us at the end of March 2006 (40 fewer than at March 2005) and we remain Exeter city's largest employer.

During the year we successfully implemented Agenda for Change, the biggest change to staff pay, terms and conditions since the creation of the NHS. The Trust was also in the first wave of introducing the Electronic Staff Record — a national web-based human resource management and payroll system. Workforce Redesign is a major strategic initiative for the RD&E.

We are committed to fairness and respect for every patient and staff member. As part of this commitment we have published our Race Equality Scheme and Action Plan which is overseen by the Diversity Steering Group. For the first time, Diversity and Equality is part of everyone's job as it is a core dimension in the Knowledge and Skills Framework.

We have also produced our Equality and Diversity Statement. This includes:

- employing a workforce that is representative of the local community;
- implementing non-discriminatory recruitment and selection processes which encourage applications from all groups in the community;
- ensuring that all employees have fair access to learning and development opportunities;
- providing a safe and accessible working environment that values and respects the identity and culture of each individual;
- ensuring that access to information is as open and transparent as possible;
- ensuring a culture and working environment free from discrimination, harassment and violence;
- encouraging and supporting all staff to reach their full potential.

The 'two ticks' disability framework gives full and fair consideration to applications for employment, arranging appropriate training and providing career development and promotion opportunities for disabled persons.

We consult with staff formally through the Joint Staff Forum and the Health and Safety Committee. Both sides agree that partnership working has been improved considerably through the Agenda for Change process.

We know that for staff to be committed to their work and provide an excellent service they need to be involved in decisions that affect them. We have responded to the results of the annual Staff Survey and will be introducing a new Internal Communication Strategy which includes best practice in staff engagement and ensures that employees receive information systematically.

We have improved childcare facilities again this year and many staff benefit from our salary sacrifice scheme.

All staff have confidential self-referral access to the Trust's in-house Occupational Health and Staff Support and Counselling Service.

We now recruit to all posts by means of the internet as e-recruitment was fully implemented during 2005/06. All our job vacancies can be found via www.rdehospital.nhs.uk

CASE NOTES: STAFF IDEAS

WITHIN THE TRUST EVERYONE'S IDEAS COUNT, WHETHER THAT BE IN FLAGGING UP AREAS OF DUPLICATION OR IDENTIFYING POSSIBILITIES FOR IMPROVED PATIENT CARE.

In Spring 2005 Orthopaedic Registrar Christoph McAllen and Technician Neil Tarn returned from a visit to the Netherlands to see Softcast modern functional fracture management in use. Softcast can be applied alone or as a combi cast with a slab of fibreglass between Softcast layers for extra stability.

Impressed by the atmosphere in the Dutch plaster room, Christoph and Neil were keen to implement change here at the RD&E.

We have now been using Softcast for one year with many benefits:

- reduced clinic numbers as many patients with minor injuries can remove their own casts;
- less cast changes required with Softcast;
- a more patient- and staff-friendly environment without the noisy cast saw which can upset children and babies;
- patients can bathe, shower and swim in their Softcast;
- patients enjoy increased freedom and comfort, and a quicker return to normal activities.

Stroke patient Sister Kathleen Herlihy is assisted by Senior Occupational Therapist Rachel Johns (left) and Senior Physiotherapist Jenny Chidley (right).

About the RD&E

This Annual Report gives a brief summary of the work of the Royal Devon & Exeter NHS Foundation Trust for the year 2005/06.

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 and the Isles of Scilly, Somerset and Dorset.

Most of the RD&E'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, neonatology and gynaecology services will relocate from the nearby Heavitree Hospital to a new, purpose-built centre at Wonford later this year. The RD&E also runs:

- the Honeylands Children's Centre (specialist assessment and support for children with special needs and their families);
- the Exeter Mobility Centre (orthotics, prosthetics, 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 2005/06 the Trust spent around £250m, and employed more than 5,700 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 the following:

- South West Peninsula Strategic Health Authority;
- East Devon, Exeter and Mid Devon Primary Care Trusts;
- Devon Partnership Trust (mental health and learning disabilities);
- Northern Devon Healthcare NHS Trust;
- The West of England Ambulance Service Trust (WAST);
- Devon County Council Social Services.

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

VIEWS OF THE GOVERNORS:

IN THE RD&E'S SECOND YEAR AS A FOUNDATION TRUST, THE GOVERNORS ARE REALLY GETTING TO GRIPS WITH HOW FOUNDATION TRUSTS CAN INFLUENCE HEALTHCARE NATIONALLY, WITH SOME OF US PARTICIPATING IN NATIONAL CONFERENCES, GIVING US A WIDER UNDERSTANDING OF OUR ROLE.

Throughout the year we've been impressed by the frank and honest approach of senior managers, who've shown enthusiasm, commitment and a real grasp of their area. This has enhanced our confidence in the Trust and accelerated our understanding and effectiveness, and we appreciate the easily accessible information and support we are given. Governors have received regular reports on the Service Development Strategy, progress towards meeting targets, measures taken to improve the services, and financial management. We commend all staff for their hard work throughout the year.

The RD&E has risen to some tough challenges, particularly during the outbreak of clostridium difficile last summer. We recognise that despite every effort to maintain excellent standards of cleanliness and infection control, some patients are prone to infection, and appreciate the Trust's continued emphasis on hospital cleanliness.

Governors have been involved in a number of vital roles in 2005/06. We've appointed a new Chairman to replace Professor Ruth Hawker on her retirement in April 2006. We have been involved in a review of the constitution and have revised the Governors' Code of Conduct and Rules of Procedure. Governors continue to meet regularly with members at constituency meetings. We'd like to thank those people who have contributed their ideas and we'd be delighted to see more of you at these meetings. Finally, we would like to thank Ruth Hawker for her very real contribution to the ongoing success of the RD&E. As Governors we have appreciated her personal leadership skills, her friendly guidance and her dedication to the Trust.

Modernising

Providing the right environment for patients and staff is a high priority at the RD&E. Most of the Wonford site was redeveloped in the 1990s with many additions in the intervening years, but even for a relatively new building, wear and tear takes its toll, so we regularly renovate departments to ensure we have the most up-to-date services possible.

Last August an upgrade of the Emergency Department (ED) was completed, under the watchful eye of Melanie Holley, Deputy Directorate Manager, Critical Care. "Some parts of the department had started to look a bit tired," says Melanie, "not surprising when you realise that on an average day we see 180 patients. So we used the refurbishment plans to take a look at how the whole department worked, and make improvements of benefit to patients and ensure staff could work comfortably and efficiently."

Adrian Harris, Emergency Department Director, worked closely with the team to agree the main priorities in developing the department:

- provide a more patient-centred service;
- increase capacity, whilst improving security;
- modernise the department;
- provide space for services like the access and liaison psychiatry teams, whose staff work closely with the ED;
- comply with Disability Discrimination Act.

ED FACTS: Sprains, strains and fractures are the most common presenting conditions. Monday is the busiest day and August the busiest month, with over 60,000 patients being seen annually.

In 2005/06 there were 1,753 trauma patients. Of 62,591 patients coming through the door, 15,748 were admitted — around 25%.

The staff include 6 consultants, 20 doctors, 82 nurses, 4 support workers, 30 clerical staff, housekeepers, porters and others.

After the inevitable disruption, patiently endured by staff and patients, the unit has been transformed as a result of significant building work creating separate treatment areas for children and adults as well as for those with minor and major injuries.

A new reception area was created, with better access for disabled people and a larger, brighter waiting room. To take account of the differing mobility needs of patients, the new chairs come in several styles and heights. In addition, a new children's playroom, fitted out with toys and books as a result of the highly successful *Express & Echo* appeal, has proved an enormous asset.

The upgraded computer system, with its 'virtual' whiteboard on the screen, enables patient names and details to be shown, and with a 'click-and-move' option staff can update the treatment progress which is then time-checked as it happens. In an instant, all staff can access details about numbers of patients waiting, where they are in the department, how long they have been waiting, if a specialist has been called and so much more. This has improved communication with patients, their families, and staff elsewhere in the Trust.

The computer system is an 'off-the-peg' solution which has been used in other hospitals but there are 'bespoke' elements built into it for the RD&E, and ED consultant Tony Hudson has worked very closely with the Trust's IT department and the suppliers to ensure the system meets the needs of staff.

Concludes Melanie: "The way we work has been revolutionised. In the past year we have met the target that 98% of patients should be seen, treated and discharged or moved to a ward within four hours. We're really moving the department forward so that it is more welcoming for patients, a much improved working environment and able to help us meet the challenging treatment and performance targets we face."

"We were delighted when the Express & Echo *approached us; the Smile appeal raised £10,000 which would not have been possible without the local people and businesses of Exeter and around. The new children's waiting area has made a huge difference and is a hit with children and staff alike. I was in there last night and the children were saying how much they love it — one even got upset when they had to leave to be admitted for their treatment!"*
MELANIE HOLLEY

Specialising

Our well-established specialist units – Mardon Neuro-rehabilitation Centre, Exeter Mobility Centre and Honeylands Children's Centre – are just the tip of the iceberg when it comes to specialising at the RD&E. The workforce includes a myriad of highly specialist roles across all directorates. In January 2006, for example, we appointed a Lupas UK Nurse, who is using her musculoskeletal nursing experience to meet the complex needs of Lupas patients. In radiotherapy and nuclear medicine the nature of the equipment means that we employ specially-trained housekeepers to clean in these areas. Specialist dieticians work with specific disease processes and clinical pharmacists *(like Libby Hardy, left)* are assigned to every speciality in the hospital, from cardiology to vascular medicine. Libby, for example, is the Trust's Senior Cancer Services Pharmacist and also Lead Pharmacist for the Peninsula Cancer Network.

"As oncology becomes more complex with time and more expensive drugs emerge it is not surprising that a high emphasis has to be placed on oncology pharmacy management. I have been in this role for 16 years now and I would envisage the need for it to grow year on year as modern medicines continue to move forward."
LIBBY HARDY

CASE NOTES: RESPIRATORY PHYSIOTHERAPY TEAM

AT THE RD&E OUR TEN RESPIRATORY PHYSIOS SEE 4,000 NEW PATIENTS PER YEAR AND PROVIDE 21,000 TREATMENTS. WE ARE THE REGIONAL CENTRE FOR CYSTIC FIBROSIS PATIENTS AND CHILDREN RECEIVING SCOLIOSIS CORRECTIVE SURGERY, ALL OF WHOM REQUIRE SPECIALIST RESPIRATORY PHYSIO INPUT.

Respiratory physiotherapy has many functions:

- aids airway clearance in acute patients;
- facilitates early recognition and prevention of potential respiratory deterioration in post-op and post-trauma patients;
- empowers patients in disease management;
- increases function and quality of life for those with chronic disease.

Respiratory physiotherapy takes place across all clinical areas, although most of the team's work stems from the ITU, surgical wards, respiratory medicine and outpatient respiratory patients. In addition, 24-hour cover provides treatment to the acutely unwell respiratory patients. Our outpatient physio service includes treatment of patients with dysfunctional breathing patterns. The Trust also runs four pulmonary rehabilitation programmes for 60 patients per year – an exercise and education programme for those with chronic respiratory disease to increase stamina, exercise tolerance and quality of life.

CASE NOTES: NURSE CONSULTANT SAFEGUARDING CHILDREN

LIAISING CLOSELY WITH THE NAMED CHILD-PROTECTION DOCTORS, CLAIRE MITCHELL'S POST INVOLVES JOINED-UP WORKING WITH EMPLOYEES OF THE RD&E AND EXETER PCT TO ENSURE THAT SAFEGUARDING CHILDREN AND PROMOTING THEIR WELFARE IS FIRMLY EMBEDDED WITHIN THE CULTURE OF BOTH ORGANISATIONS. BY JOINT FUNDING THE POST, THE MANAGERS OF BOTH TRUSTS HAVE RECOGNISED THE IMPORTANCE OF CROSS-BOUNDARY WORKING TO SAFEGUARD CHILDREN.

Among her many other tasks, Claire Mitchell teaches, advises and provides consultation for all employees, supports staff when attending child-protection meetings, produces reports and, in rare cases, attends court. In serious cases, she is involved in completing the organisation's report to the Devon Local Safeguarding Children's Board serious case review.

"Combining the role of named nurse for child protection with nurse consultant role is unusual, there being only two such posts in the South West. The combination emphasises the importance placed on provision of expert advice and consultation grounded in evidence-based research and practice. It also recognises the role of nursing in providing leadership to develop and empower all staff to provide a proactive, preventative approach in this difficult and sensitive area of work. Ensuring effective training, backed up by robust procedures and organisational support systems, can enable staff to be alert to the early signs of significant harm to children and be an initial catalyst for a responsive multi-agency approach to support parents and prevent further harm to a child."

Age matters

Age Matters was the title of our recent two-year project, aimed to improve the experience of hospital care for older people. A Department of Health grant enabled us to employ two older person's nurses for the Trust, whose role it was to identify any knowledge gaps and skills deficits concerning elderly care within our workforce. These were then made a priority and the older person's nurses were subsequently able to get out on the wards, working with older people, ward and other hospital staff, carers and relatives, to act as role models and educators in the delivery of good care for older people.

"Thank you for the care at the RD&E. One hears so much that is wrong with the NHS and the way senior citizens are treated in hospital by staff, etc. During my recent stay at the Royal Devon & Exeter Hospital I was treated with great care and affection by all the staff of Dart Ward and cannot thank all the nurses and other staff enough."

Michael Dunk, patient, 75, writing to the *Express & Echo*

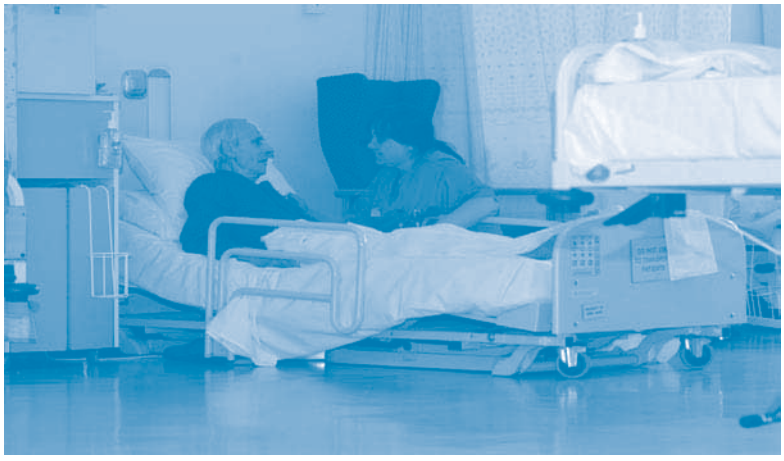
The nurses set up an older person's link nurse group which included representatives from each ward and department. Monthly meetings were held and guest speakers taught the link nurses about various important aspects of older people's healthcare such as hearing aids and footcare. The link nurses then acted as a source of expertise in older people's care in their workplace, spreading good practice and acting as champions in their area for older people.

Cathy Weeks, project lead and Matron for Older People, was delighted with the project's impact:

"The knowledge and skills scoping exercise showed that whilst a number of staff felt that they had a knowledge gap concerning the health needs of older people, they were keen to learn and wanted to give the best care possible to older patients. Consequently, increased awareness of older people's health-care needs and a growing recognition that older people dominate the RD&E hospital population is now apparent within the workforce."

The project has also served as a catalyst for two major developments: we now have a new Falls Management Policy which takes a multi-disciplinary approach to falls. Its main aim is to reduce the risk to patients by undertaking a comprehensive falls assessment. Community practitioners can then be better informed if a patient is at a high risk of falls on discharge by using simple documentation and a clear, straightforward protocol. In turn patients can be supported to remain independent, empowered and safe.

The RD&E is also testing the newly developed care pathway for adults on our elderly-care wards. The pathway is based on the principles of the Single Assessment Process, which advocates a multi-professional, shared health record to be used between agencies and healthcare settings. The overall benefit of the Age Matters project will have a positive impact for all patients in the RD&E — because if we get it right for older patients, we get it right for everyone.



Healthcare Assistant Linda Powter attending to an elderly patient in one of our new lower beds which we use for those who have been identified as being at risk from a fall.

CASE NOTES: SHEILA EDGECOMBE

OLDER PERSON'S HEALTHCARE ASSISTANT SHEILA RECENTLY ATTAINED A CERTIFICATE IN FOOTCARE AND NOW OFFERS PATIENTS A SPECIALISED, DEDICATED SERVICE.

"Offering footcare makes a valuable contribution to the quality of the older person's care. It can be very difficult for them to cut their nails and they may have missed a chiropody appointment due to illness or may simply be struggling at home. I am rostered to do footcare several afternoons a month where I assess the patient and offer them what is appropriate and that which I am qualified to do. I keep an audit of the patients I am working with and draw up a care plan for them. If they have additional foot problems I can feed that through to the doctor on the ward. Often the patient response is tremendous and this gives me great pleasure — I get a lot out of it! Patients are so surprised to receive the service that they usually ask whether they have to pay for it!"

Innovating

Innovation has always been a key part of our philosophy at the RD&E. In many cases we are leading the field in the delivery of new and exciting treatments. For example, we are one of just three centres in the UK to be offering brachytherapy treatment for sufferers of prostate cancer, and the Trust has become recognised as the UK leader in the implementation of the DONOR™ Autologous Reinfusion System. Sufferers of severe rheumatoid arthritis, meanwhile, have had their lives transformed after treatment with TNFalpha, a new Biologic drug for this debilitating condition.

CASE NOTES: MINIMALLY INVASIVE OESOPHAGECTOMY

SURGEONS AT THE RD&E HAVE BEEN INTRODUCING A MINIMALLY INVASIVE (KEYHOLE) APPROACH TO ONE OF THE MOST MAJOR OPERATIONS WHICH CANCER PATIENTS HAVE TO UNDERGO – THE OESOPHAGECTOMY.

Richard Berrisford, thoracic surgeon, was the first UK surgeon to visit Jim Luketich in Pittsburgh, Pennsylvania, who has pioneered this approach. Richard and Saj Wajed, upper GI surgeon, have now performed over 60 of these operations with excellent results. They have presented the first UK series of 34 operations at the Association of Upper GI Surgeons in 2005 and the Society of Cardiothoracic Surgeons in 2006 and are currently publishing the largest UK series of 60 patients.

Richard Berrisford and Saj Wajed

The traditional open operation involves a thoracotomy (cut on the side of the chest) and laparotomy (cut on the abdomen), after which patients take an average of six months to recover. Patients who have had the keyhole operation are recovering much more quickly, and are finding the operation far easier to cope with. The oesophagus and its cancer can be more thoroughly removed with a greater number of surrounding lymph nodes than before, blood loss is much lower than with open surgery and post-operative pain is reduced.

The upper GI team in Exeter are also at the forefront of research into investigating patients with oesophageal cancer. Keith Mitchell, our upper GI cancer nurse, has been researching the faster recovery of quality of life in our patients, and the team have been working together with the Oesophageal Patients Association to encourage patient support groups.

CASE NOTES: RADIOFREQUENCY ABLATION OF RENAL TUMOURS

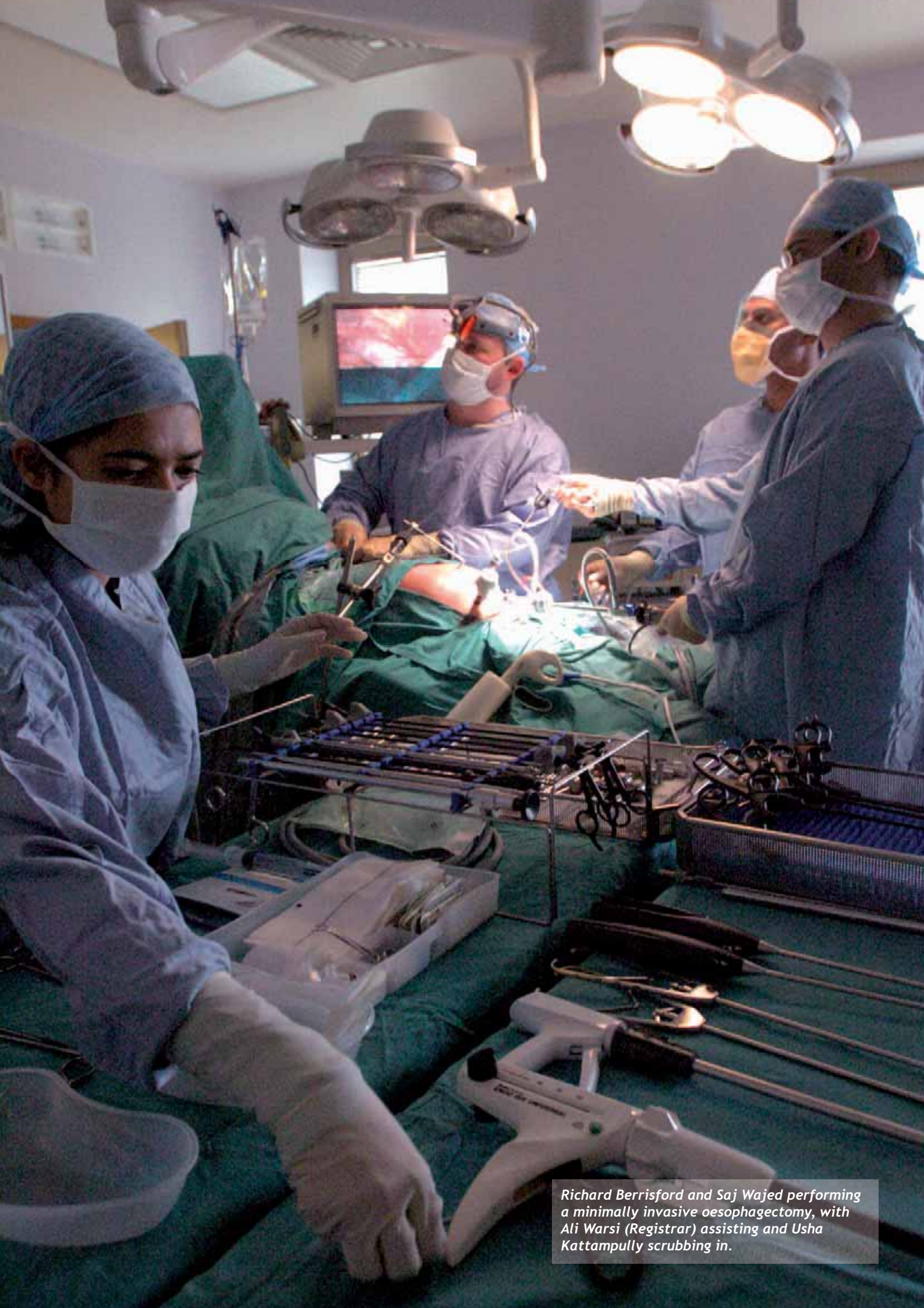
UNTIL RECENTLY, TREATING INCIDENTAL RENAL CELL CARCINOMAS (WHICH HAVE A SPREAD RATE OF 30%) HAS EITHER INVOLVED KIDNEY REMOVAL OR SURGERY, LEADING TO RISKS OF MORBIDITY AND MORTALITY IN THE (COMMONLY) ELDERLY PATIENTS AND SIGNIFICANT FINANCIAL COSTS.

The RD&E is now one of a small handful of trusts offering radiofrequency ablation of these tumours, up to 5cm in size. Professor Tony Watkinson, Consultant Interventional Radiologist at the RD&E and President of the British Society of Interventional Radiology, explains: "An image-guided probe inserted into the centre of the tumour, connected to a radiofrequency generator, dissipates an alternating current which destroys the tumour.

The probe in its extended state

The treatment takes ten minutes to an hour, can usually be completed as a day-case or involving an overnight stay and patients walk away with just a small plaster to cover the 1–2mm incision. Complication rates are less than 1% and effective tumour destruction rates lie between 96–100%. At the RD&E all patients have been treated successfully, with no failures and no tumour recurrence so far."

For patients who before faced surgery and up to a week in hospital, the new technique is very welcome. 80-year-old Frances comments: "I bumped into someone in a charity shop and they advised me to go the RD&E and it was the best thing ever. The day after the procedure I was as right as rain, it was fantastic and I was thrilled to bits." For those unfit for anaesthetic, or with only one kidney, impaired renal function or bilateral tumours, radiofrequency ablation offers an alternative to a life of dialysis with the associated health risks and high annual costs. The same treatment is now being applied to small liver tumours and in the palliation of malignant bone lesions.



Richard Berrisford and Saj Wajed performing a minimally invasive oesophagectomy, with Ali Warsi (Registrar) assisting and Usha Kattampully scrubbing in.

On target

Three stars five years running

In 2005/06 the RD&E retained its prestigious three-star rating for the fifth consecutive year, making it one of only a few trusts in the country to have achieved this. In rating the performance of trusts the Healthcare Commission looks at:

- meeting key Government performance targets;
- effectiveness of clinical treatment;
- the way the Trust is organised;
- the views of the patients.

Annual Health Check

In April 2005 the Healthcare Commission introduced a new system of measuring performance, called the Annual Health Check, which takes over from star ratings and looks at a much broader range of issues. As part of this process the Trust has gone through a rigorous self-assessment, measuring progress against 44 core standards. For 2005/06 the Trust has been able to declare that it has met 42 of these 44 core standards. The Healthcare Commission will now undertake its own assessment, making use of national data, and the judgements and expertise of others, as well as the information provided by the Trust, and publish its first annual assessment of all NHS organisations in October 2006.

A surplus of £0.5m

Having the financial freedom granted to foundation trusts has given us the flexibility to plan service developments that otherwise would have taken years to bring about. Furthermore, against a background of large-scale change throughout the NHS, the RD&E has succeeded not only in tackling its deficit, whilst at the same time maintaining or improving patient services, but also of achieving a surplus of £0.5m at year end. This is rewarding testimony to our approach which ensures that no opportunity for financial recovery or service improvement is wasted.

MRSA rates down by 33%

This year held great news in relation to MRSA rates. The Healthcare Commission recognised that assessment should only be measured against the bacteraemia cases proved to have been acquired at the RD&E (as opposed to all those acquired within the healthcare community as a whole but tested at our laboratory). Thus in the past year improvements became easier to demonstrate. We achieved a 33% reduction in the number of MRSA bacteraemia cases, putting us firmly on track to meet the target set by the Healthcare Commission – great news for all the staff making such a huge effort to ensure that infection is kept to a minimum.

Once again, the RD&E has had a busy year with significant inpatient, outpatient and ED activity in 2005/06. Despite the level of activity the continued hard work of all members of staff meant we succeeded in hitting our March 2006 year-end targets for inpatient, outpatient and Emergency Department waiting times.

Activity achievements for the year included:

- 98% of patients coming to our Emergency Department were admitted, discharged or transferred within four hours;
- no-one was waiting more than 13 weeks for a first outpatient appointment;
- no-one was waiting more than nine months for inpatient treatment;
- all patients referred as urgent by their GP with suspected cancer saw an RD&E specialist within two weeks;
- the Trust met the target to provide a treatment decision for all new cancer patients within 31 days, and achieved 94%, against a target of 95%, for treatment of all new cancer patients within 62 days of urgent GP referral. In 2006/07 we will work closely with PCTs and other hospitals, so that delays in the patient pathway outside the Trust do not affect our target achievement;
- all patients with breast cancer started their treatment within a month once the appropriate course of treatment was agreed;
- more and more of our patients have appointment dates and times that suit them.

Activity	05/06
Inpatients & daycase:	112,445
Outpatients:	253,502
Overall emergency admissions:	28,429
Emergency attendances:	62,591
Babies born:	2,972

NOTE: Inpatient, daycase and outpatients data shows apparent reduction as work carried out in 'community hospitals' is now counted for PCTs as providers.

Listening

We aim to put patients, carers, relatives and members of the community we serve at the heart of decision-making. As an NHSFT, we work with our users, developing services in light of their needs and wants.

We have worked closely with the Patient and Public Involvement Steering Group (PPI) and the Disability Equality Action Group (DEAG) to oversee implementation of our involvement strategy, agree annual action plans and report our progress to the Governance and Diversity Committee. We liaise with the DEAG to consider how we can improve services for, and better involve, disabled people. Around half of both groups are staff and half are representatives of the local community.

For information call (01392) 402187.

Commendations and complaints

In addition to feedback from user groups, we also learn a great deal from commendations and complaints, our Patient Advice and Liaison Service (PALS), other day-to-day community involvement work, and our in-patient surveys. In 2005/06, we received 8,046 letters of commendation (9,241 in 04/05) and 324 written complaints (up 15 from 309 in 04/05). We received 55 requests for compensation (66 last year). We receive one complaint for every 1,342 patient episodes and 25 letters of commendation for each complaint. We acknowledged 92% of complaints within just two working days (91.5% in 04/05), the remainder being acknowledged within five. We responded fully within 20 working days to 80% of complaints (70% in 04/05) and within 25 working days to 81% of complaints (78.5% in 04/05).

Patient Advice and Liaison Service (PALS)

Our PALS service aims to resolve patient and carer concerns and guide people to the services they need. In 2005/06, there were 1,104 cases (781 in 04/05). Activity has almost doubled in two years. 86% of cases were resolved so that no further action was needed. The rest mostly required advice or information, although PALS also serves as an informal way for people to give feedback. PALS also sent questionnaires to service users which showed that 91% of people were completely satisfied with the outcome after contacting PALS; 96% said PALS had listened to and understood their concerns, keeping them informed of progress.

For more information please call (01392) 402093.

> ***"The lady responding to my query was kind, calm, helpful, practical, professional and listened patiently... she quickly called me back."***

National inpatient surveys

Patients spoke very highly of us in the 2005 survey of inpatients. This was conducted for us by an independent organisation, and used the national survey devised by the Healthcare Commission. The results were extremely positive with 94% of patients rating the RD&E on a par with, or significantly better than, other acute trusts. The results also demonstrate improvements in areas such as waiting times for admission, communication with medical staff, and privacy and dignity. Patients said we needed to do better in areas like providing information for patients, and the movement of patients between wards. Improvement action plans are now being devised and progress against these will be monitored every quarter.

See also: www.healthcarecommission.org.uk

CASE NOTES: EVOLVING IN RESPONSE TO FEEDBACK

DURING THE YEAR WE CONTINUED TO REVIEW SERVICES IN THE LIGHT OF COMPLAINTS AND IMPROVE THEM WHERE APPROPRIATE

- A concern was raised on behalf of two wheelchair users who attended the Walk-in Centre and were booked in from behind a tall desk. Although there was a lower desk, the booking system for the Walk-in Centre was behind the higher desk. A bell and notice have been fitted to the lower desk to allow wheelchair users to attract the receptionist's attention and the booking system is now available at both desks.
- The Trust booklet on information to help people following bereavement has been revised following feedback. It now includes more information about other useful publications available, and a revised map showing the location of the Exeter Register Office.

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

Clean !

Cleanliness consistently rates at the top of patients' concerns when it comes to hospital admission. In the Healthcare Commission Inpatient Survey 2005, the RD&E scored in the top 20% of UK trusts for every question relating to cleanliness. This covered clinical areas, toilets and bathrooms and frequency of handwashing by doctors and nurses.

> *"I can only give the Royal Devon & Exeter Hospital 10 out of 10. What a superb hospital we have here. Now that visiting hours are 2.30pm until 8pm it… gives the nurses more time to tend to their patients, the cleaning staff more time to give the wards an even more thorough clean, and more privacy for the doctors to speak to their patients on their ward rounds."* ***Rob Brereton, patient, writing to the Express & Echo.***

Over the year the Infection Control Team has continued the full roll-out of the NPSA 'Cleanyourhands' campaign, with four main components: point-of-care alcohol hand rub, awareness and role-model posters, patient involvement and audit of practice and feedback to wards/departments using run charts. The Hand Hygiene Policy has been updated to incorporate these measures.

The emphasis in the second half of this year has been to ensure that directorates and wards take responsibility for improving compliance. To this end clinical directorates have been encouraged to make infection control a standing agenda item at their governance group meetings and identify a directorate lead with responsibility for infection control. New senior nursing roles have also seen the inclusion of infection control responsibilities.

The roll-out continues of the new, modern scrubs-style uniforms for all nursing staff across the Trust. The new uniforms are more comfortable, unisex and practical, thinner, cooler and sturdier, but more importantly there is a benefit for cleanliness and infection control: every nurse will have five different sets of uniform, making it easier for them to have a fresh change for every shift.

On 1 July 2005 the Trust launched the new visiting times as part of the Cleaner Hospitals Campaign. The measure was put in place:

- to allow staff to clean wards more thoroughly;
- to make provision of care easier;
- to ensure patients get the necessary rest.

The new visiting times are 2.30pm until 8pm, with no more than two visitors per patient being recommended at any one time. This applies across almost all wards, although exceptions are made in some areas such as paediatrics.

Trust cleaning standards are subject to rigorous daily, weekly, monthly, quarterly and annual checks. These take place both internally and externally. Staff work very hard to ensure that we do well whatever the level of checking. For example, the quarterly internal management audits involve infection control, nursing, housekeeping and estates and here the RD&E scored an average of 88.5% for the year. Meanwhile, in the external National Standards of Cleanliness, the Trust score for April 2005 was 89.6% (against a national average of 75%).

CASE NOTES: PETER HEMSTOCK

PETER JOINED THE HOUSEKEEPING TEAM AT THE RD&E IN FEBRUARY 2005. ALTHOUGH HE CAME FROM ANOTHER NHS JOB TO JOIN THE TRUST, PETER'S WORKING LIFE HAS ALSO INCLUDED 17 YEARS IN THE PRINT TRADE, AS WELL AS HOTEL AND TRANSPORT WORK.

Peter works as a relief housekeeper, which means he has to be flexible, moving to different departments depending on staffing requirements. His typical day starts at 7.15am, and he often works in the Emergency Department.

"I try to do resus. first, then majors. I need to be flexible and plan the work around the patients, so that no-one gets disturbed. I know the routine, so if someone goes to X-ray, that's when I can nip in," says Peter. As well as working his way around all the clinical areas Peter fits in offices, the doctors' room and the relatives' room, all by 3.15pm when his shift ends.

"Sometimes when you're older looking for a new job is difficult, but not here. When I applied, nobody worried about my age, that's just not an issue – it's being able to do the job. We get training and staff meetings to keep us up to date, and working in the NHS means the holidays are good. I like the job because it's different, it's challenging. It's nice to know that the work I do means that wards and departments are clean. Because I've done an NVQ in infection-control cleaning, I always work to that standard, and I even get people stopping to say I can come and clean in their house anytime!"

Peter Hemstock, cleaning here in the Emergency Department, has done an NVQ in infection-control cleaning and ensures that he always works to that standard. He delights in the fact that he even gets people stopping to say he can come and clean their house anytime! Danny Marks, Peter's boss, agrees: "People like Peter are worth their weight in gold — we're lucky to have him at the RD&E."

Evolving

The RD&E is constantly evolving its day-to-day organisation, working practices, facilities and services to improve life for its users and staff and to reflect changes on a wider level.

Smoke-free at the RD&E

In the Spring of 2006 we began an awareness campaign relating to September 2006 when all buildings and grounds will become smoke-free, in line with Government directives. In the run-up to this move, a full communication strategy has been set in motion, a smoking cessation officer is available to help staff and patients wishing to quit and Nicotine Replacement Therapy has been made available through the hospital shop.

Expanded services

Numerous services have been expanded, including cardiology, with the opening of a brand new second cardiac catheterisation lab, a move which comes after two years of planning and hard work by the project delivery team. The opening of a second lab has also made possible a complete refurbishment of the original lab.

Senior Matron Anita Irwin

The nursing and midwifery restructure

During the year the Trust started to implement a new nursing and midwifery structure, in response to feedback that differences in the role and range of responsibilities for senior nursing staff varied too much between directorates. This was backed up by an Audit Commission report, so when the new pay system Agenda for Change presented the opportunity to look at the roles of nurses and midwives at all levels in the Trust, we were keen to consider the possibilities. The restructure aims to ensure consistency throughout the Trust, good career structures and opportunities for staff development. Most importantly, the changes will help patients to understand who has responsibility for their care, as clinical roles are more clearly defined.

Anita Irwin explains what the restructure means to her. She became a matron in 2001, with responsibility for ensuring clincial standards, nursing care quality and good teamwork, as well as cleanliness and upkeep of the environment in various surgical wards. Initially Anita had reservations "I completely understood the principles, but wasn't sure that a different structure would achieve the changes we nurses and midwives wanted."

She was soon convinced though:

"I believe we've always given excellent care, but once I got to grips with how the plans would work I really appreciated that senior nurses and midwives need to step away from the traditional roles we had in the past. Now, staff with greater experience will spend more time offering support and supervision to junior colleagues, and use their experience and knowledge effectively to improve patient care."

Capital developments

Work has continued through 2005/06 on Phase 4, our new maternity, gynaecology and neonatology unit at the main site. The architects have involved many clinical staff in the design and layout of the building and staff at the present unit at Heavitree have been asked to help choose a name for the new unit.

Part of the space left at Heavitree will be occupied by the Exeter arm of the new Peninsula Dental School which the Government announced its backing for in February 2006.

In February work also began on the new Diabetes and Endocrine Centre, due to open in September. Most of the centre is Trust funded and will provide local patients with improved care, education, support and research services. Amenities will include: eight consulting rooms; dedicated educational facilities; a focus for clinical trials; a retinal screening hub; diabetes dieticians and foot service; endocrinology; and the DIRECT charity office.

CASE NOTES: PODS

THE ROLL-OUT OF PODS (PATIENTS' OWN DRUGS SCHEME) CONTINUES, WHEREBY PATIENTS ARE ENCOURAGED TO BRING THEIR PRESCRIPTIONS WITH THEM INTO HOSPITAL

The Scheme is considered to be good practice by the Healthcare Commission and Audit Commission and has many benefits:

- facilitates checking of discrepancies between medications mentioned in the GP referral letter and patient testimonial;
- patient familiarity with their drugs;
- drugs issued by the GP are not wasted and unnecessary Trust prescribing is avoided;
- reduced risk of drug administration errors;
- saves nurse time for drug administration and discharge process.

Membership

The RD&E has been a foundation trust for two years now, and we continue to build on the opportunities this has given us – developing greater links with the people we serve so that we are more able to focus on meeting their healthcare needs and better at providing information about what we do.

These links are forged principally through membership of the RD&E NHS Foundation Trust. People who live in the large area we serve are encouraged to become members of the RD&E, because they want to register their support for our Trust, they want to contribute to our plans for the future, or they want to know more about how we deliver the hospital services they need. Thanks to the interest of local people and staff, our membership continues to increase, standing at 15,600 at the end of March 2006.

> *"Looking forward to being of service to the Trust (rather than just a patient)!"*

Our NHSFT constituencies

Anyone aged 12 or over who lives in the area we serve, or who works for the Trust, can become a member of the RD&E NHS Foundation Trust.

The four public membership constituencies are:

- Exeter;
- East Devon;
- Mid Devon;
- Other Parts of Devon, Dorset, Somerset, Cornwall & the Isles of Scilly.

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

> *"We are new residents in Devon and enjoyed the meeting very much. We hope to continue to be involved."*

Our partnership with members

We see our members as partners – joining us in the debate about what local people want from their hospital. As a member of the RD&E, you decide how far you want to take this involvement. You may join because you want more information about the Trust, so you'll receive our quarterly newsletter, the *RD&Express*, posted to you at home. But if you want a more active role, you may choose to come to meetings, voice your opinions and give us your ideas, or you may be happy to take part in surveys when we need information about your experience of specific services.

For those of you who want a much greater level of involvement, you can put yourself forward for election to the Council of Governors and represent the views of people in your area.

Our membership strategy

Because our members influence how we plan healthcare for the future, it's important that they come from all parts of our local community and that everyone has an opportunity to have a say. So 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 know that we have many members in the older age group, mainly because they have used the hospital, so we will continue to encourage young adults to become members. We will also continue to focus on areas where membership numbers are smaller, perhaps because they are remote, or rural.

A Council of Governors meeting

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 Bernadette on (01392) 403977.

The Governors

Public constituency area: East Devon

Margaret Green from Ebford (Oct 06) 4/4 # •
Ret'd nurse teacher with nursing/health work career. Vice-Chair Hospiscare Exeter and Mid Devon.

Linda Fryer from Newton Poppleford (Oct 08) 4/4 #
Former manager in education and social care. Has represented patients on the Peninsula Cancer Network and the RD&E cancer/carer user group.

Gail Nunan from Axminster (Oct 07) 4/4
Has 40-plus years' nursing experience in UK/overseas.

Bob Doy from Exmouth (Oct 07) 4/4 •
Ret'd doctor who has worked in the NHS and abroad.

Stanley White from Honiton (Oct 06) 4/4 •
Ret'd former financial controller and executive administrator of a German charity working in India.

Tricia McKenzie from Exmouth (Oct 08) 1/1
Worked with the community as a Magistrate, Special Constable, Samaritan and with the WRVS.

Public constituency area: Mid Devon

Gordon Davies from Tiverton (Oct 07) 3/4
Former ICI senior manager, then a management consultant and businessman. Active for Tiverton Hospital League of Friends.

Reuben Miles from Crediton (Oct 07) 3/4
Semi-retired pharmacist, previously community pharmacist then regional manager of a group of pharmacies. Active for the RD&E League of Friends.

Roger Smith from Black Dog, Crediton (Oct 06) 3/4 #
Held senior positions in industry. Volunteer advisor with the Citizens Advice Bureau and trustee on the management board of Teignbridge CAB.

Ivor Watts from Tiverton (Oct 08) 3/4
Career in education. Worked for 25 years with British Council in areas of managerial responsibility overseas.

Public constituency area: Exeter

Rachel Jackson from Stoke Hill (Oct 06) 2/4 •
Mother of five who also cares for elderly relatives. Recently retired as superintendent of a physiotherapy service with 40 years' clinical experience.

Imraan Jhetam from Exeter (Oct 07) 3/4 #
A GP for 18 years and a police surgeon for the last six.

Margaret Read from Exeter (Oct 08) 0/4
Ret'd teacher of health and social policy. Active in local-interest groups and a member of St Leonard's Church for 25 years.

Andrew Webber from Exeter (Oct 08) 1/2
A Police Inspector who manages the Exeter Custody Unit and has over 20 years' policing experience.

Miles Kinchin from Alphington (Oct 06) 0/0
Served for 30 years in the Devon & Cornwall Constabulary and retired as Superintendent in Personnel at Middlemoor. Since then he has been involved with a variety of voluntary groups.

Terry Roberts from Exeter (Oct 07) 0/0
Ret'd Police Chief Inspector and since retirement has been involved with the Exeter Community Health Council, Social Services, the local Alzheimer's society and the Peninsula Medical School.

Public constituency area: Other Parts of Devon, Somerset, Cornwall & the Isles of Scilly

Brian Perriss from Chudleigh (Oct 07) 3/4 #
Former consultant anaesthetist at RD&E, ret'd 2002.

Victor Bloom from Ashburton (Oct 06) 1/4
Registered medical practitioner with experience as a specialist in general medicine/occupational medicine.

Christopher D'Oyly from Somerset (Oct 08) 1/1 •
Was brought up in Exeter and Topsham. Commanded a regiment in the Army and worked in the City of London before retiring to work in Exeter.

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 06) 4/4 #
Consultant anaesthetist in Exeter since 1982.

Monica Overy, Nursing and Midwifery (Oct 07) 1/1
A nurse at the RD&E for the past 15 years and now working in the Health Information Centre.

Sue Greenall, Managerial/Admin/Clerical (Oct 08) 1/2
An RD&E employee for over 15 years. Works as a Learning and Development Tutor in the Widening Participation team based at Heavitree.

Brian Croft, Hotel Services and Estates (Oct 06) 0/0
Has worked in the NHS for 20 years and is a supervisor in the RD&E Portering Department.

Appointed Governors

David Cox, East Devon District Council (Nov 07) 3/4
John Dowell, Exeter PCT (Apr 07) 2/4
Alan Griffiths, Mid Devon District Council (Jan 09) 1/1
David Johnstone, Director of Social Services, Devon County Council (Apr 07) 2/4
Marguerite Shapland, North Devon District Council (Apr 08) 0/3
John Shepherd, Exeter City Council (Apr 07) 3/4
Liz Smith, Head of Nursing & HR, East Devon PCT (Apr 08) 2/4
Paul Webley, Peninsula Medical School (Apr 07) 1/4 #
(Professor Janice Kay replaced Professor Webley as the PMS Appointed Governor on 1 April 06)

There are four vacancies for appointed governors:
North Devon, Teignbridge and Torridge PCT (no longer wish to retain seat);

Exeter Council for Voluntary Services (2) (awaiting outcome of constitution review);

Mid Devon-PCT (awaiting outcome of PCT re-organisation).

NOTES:

(date)	term of office in years
Ret'd	retired
n/n	no. of governor meetings attended in year (e.g. 3/4 means 3 out of 4 meetings attended).
#	membership of Nominations Committee
•	membership of NED Remuneration Committee

The public constituency areas are co-terminous with the local authority areas

CoG Update

Our Council of Governors (CoG) has continued to develop over the year. Governors are either elected by the members to represent a public constituency, elected by the staff to represent a particular staff class, or appointed by one of our partner organisations, such as local primary care trusts, councils, the Peninsula Medical School, and voluntary organisations. Governors have met formally in total on six occasions this year, and also held four development days, two in conjunction with the Board of Directors. They have also attended the quarterly constituency meetings and some voluntary sector meetings in the local community.

The Governors are kept updated by means of regular briefings at meetings, are presented with the Annual Report and Accounts each year and contribute to the annual service development planning process. In addition their opinion is sought on any sensitive matters facing the Board. During the year, as part of their constitutional role, the Governors have appointed a new Chairman, and agreed new levels of remuneration for the Chairman and NEDs (see more detail under **The Nominations Committee** and **The NED Remuneration Committee** sections below).

No Governor holds a directorship in a firm that does business with the Trust. A register of Governors' interests can be obtained from the Foundation Trust Secretary (01392) 402993 or from the website at www.rdehospital.nhs.uk/rde/foundation/documents. A full list of our Governors is shown on page 19, together with a brief description of their backgrounds and length of office. If you would like to contact your governor then either call (01392) 403977 and ask for details, or go to www.rdehospital.nhs uk/docs/nhsft/governorcontactdetails.doc

The Nominations Committee, which consists of the Chairman and Governors, has met 14 times this year, its main task being to appoint a new Chairman to replace Professor Ruth Hawker OBE who retired on 30 April 2006. Ms Angela Ballatti, previously the Chairman of Durham & Darlington Acute Hospitals NHS Trust, took over as Chairman on 1 May 06. The recruitment process used both external search consultancy and open advertising. The Committee has also developed a good practice guide for the appointment of a Foundation Trust Chairman for future use.

The Non Executive Directors Remuneration Committee, which also consists of Governors, has met three times to consider remuneration of the Chairman and NEDs. New levels of remuneration were recommended, following a survey by the Foundation Trust Network on behalf of foundation trusts, and latterly approved by Governors.

The Constitution Review Working Group, consisting of six governors and one NED, has met regularly to review the Constitution; its recommendations will be put to the members for approval at the Annual Members Meeting in September 2006, following agreement by the Board of Directors and CoG this summer.

Elections were held on three occasions during the year. The following people were elected in the annual election in June 2005:

- Margaret Read, re-elected, Exeter;
- Andrew Webber, Exeter;
- Sue Greenall, staff (Admin, Clerical and Managers);
- Linda Fryer, re-elected, East Devon (uncontested);
- Ivor Watts, re-elected, Mid Devon.

The vacant position for Other Parts of Devon, Dorset, Somerset, Cornwall & the Isles of Scilly was not filled. The second vacant position for East Devon was not filled.

Two by-elections were held during the year. The first was to fill the positions that remained vacant from the annual elections and a vacant staff position, following Cheryl Vidall's resignation.

Results were as follows:

- Christopher D'Oyly, Other Parts of Devon, Dorset, Somerset, Cornwall & the Isles of Scilly;
- Tricia McKenzie, East Devon;
- Monica Overy, Staff (Nursing and Midwifery) (uncontested).

Another by-election was held because of the resignation of Peter Davey (Exeter), Rosemary Whitehurst (Exeter) and Robert Flint (Staff - Hotel Services & Estates). Results as follows:

- Terry Roberts, Exeter;
- Miles Kinchin, Exeter;
- Brian Croft, Hotel Services & Estates (uncontested).

The Directors

About the Board

The Board of Directors is responsible for the management of the RD&E and is accountable to the membership via the Council of Governors (CoG) for its overall performance. It consists of both executive and non-executive directors (NEDs) and met 11 times in 2005/06. Among many other things, the Board will always decide upon matters concerning strategic capital development, operational performance, Trust-wide policies, complaints, risk assurance and governance.

The composition of the Board is in accordance with both the Trust's Constitution and the Governors' Policy for the Composition of NEDs on the Board. NEDs attend CoG meetings when available and joint Director/ Governor meetings are also held to discuss strategic planning matters.

Statement by the Board: The Board collectively considers that it is appropriately composed in order to fulfil its function and remain within Monitor's Terms of Authorisation. Brief details of each Director, their declared interests 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 the Combined Code (Section A.3.1). The performance of Executive Directors is evaluated by the CEO, and that of the CEO and Non Executives by the Chairman, on an annual basis. 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.

Our Board of Directors

Professor Ruth Hawker OBE Chairman * (11/11)
Ruth became Chairman in 1995 and retired on 30 April 2006 after 50 years' service in the NHS. After her nursing career, which started here in Exeter in 1956, she became CEO of the Tor & SW College of Health Studies, which was then responsible for all nurse and radiographer training in the region.

Gerald Sturtridge NED & Vice-Chairman * # + (10/11)
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 involved with voluntary agencies working with disabled and disadvantaged people.

Maureen De Viell OBE NED * # + (11/11)
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 * # + (10/11)
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 is now CEO of South West Water Ltd.

David Bishop NED * # (8/11)
David joined the Board in February 2005 and will serve until January 2008. He is a retired senior partner with KPMG and led the strategic financial management and governance parts of the practice. He has also served on Government working parties.

John Evans resigned as a NED in February 2006 for work commitment reasons. A recruitment campaign to appoint a replacement is under way.

NOTES:

*	indicates member of the Executive Director Remuneration and Executive Nominations Committees
#	indicates member of the Audit Committee
+	indicates member of the Governance Committee
(n/n)	indicates number of Board meetings attended
NED	Non Executive Director

Executive Directors

Angela Pedder Chief Executive (11/11)
Angela joined the NHS in 1975 and was Chief Executive of St Alban's & Hemel Hempstead NHS Trust before becoming Chief Executive at the RD&E in 1996.

Mike Stevens Director of Finance & Information (11/11)
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 is a qualified nurse who has held a number of positions at the RD&E, becoming Director of Operations in December 2000.

Steve Jupp Director of Human Resources (11/11)
Steve joined the RD&E in 1993 and became Director of HR in 1997 having previously worked in the private sector and NHS.

Marie-Noelle Orzel OBE Director of Nursing & Service Improvement (9/11)
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 addition, as a qualified aeromedical nurse and a part-time member of the RAuxAF, Marie-Noelle has evacuated casualties from around the world both in peacetime and conflict situations.

Drs Vaughan Pearce and Iain Wilson
Joint Medical Directors (10/11) since April 2003.
Dr Pearce is a consultant in the care of the elderly and general medicine. His special interests include Parkinson's disease and dystonia. Dr Wilson is a consultant anaesthetist and a Director of the Association of Anaesthetists of Great Britain and Ireland.

Non-voting Board members

Linda Hall Director of Facilities (11/11)
Linda is a qualified occupational therapist and has worked in the NHS since 1980. She has held a variety of posts at the RD&E and became Director of Facilities in January 2001.

Nigel Walsh Director of Planning (9/11)
Nigel was the general administrator for the RD&E before becoming development manager and then planning director of our redevelopment programme.

Other key RD&E committees

The Audit Committee consists of NEDs, not including the Chairman, and has met four times this year. Its main business is to consider any matter relating to the financial affairs of the Trust, and to the Trust's internal and external audit functions.

The Executive Director Remuneration Committee consists of all NEDs. It met three times this year and, among other business, reviewed CEO and Executive Directors' performance and remuneration. Details appear in the accounts section of this report.

The Governance Committee consists of a number of Executive and Non Executive Directors, senior clinicians and managers and met nine times this year. It manages the RD&E's compliance with clinical and corporate governance requirements.

Directors' interests are declared below, none of which conflict with their responsibilities as Trust directors. 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

Prof. Ruth Hawker OBE (ret'd April 2006)	1. Pro-Chancellor of the University of Exeter 2. Trustee St Loye's College 3. Trustee Peninsula Medical School Foundation
Dr Iain Wilson	Director of the Association of Anaesthetists of GB & Ireland
Ms Marie-Noelle Orzel OBE	Director: Injury Minimisation Programme for Schools (Charity 1084113)
Ms Elaine Hobson	Partner works for Nuffield Hospitals Group
Mr Gerald Sturtridge	1. Director of County Environmental Trust 2. Director of Witchwood Media Ltd 3. Advisor to Leander Developments 4. Chairman of the Island Trust and Exeter Cathedral Music Foundation Trust (Charities) 5. Secretary Transit International Group Ltd 6. Treasurer of University of Exeter 7. Director of University of Exeter in Cornwall Enterprises Ltd
Mrs Maureen De Viell OBE	1. Chair Budleigh Salterton Medical Centre Patient Group 2. Member Budleigh Salterton Health & Social Care Team 3. Member Budleigh Salterton Hospital Consultation Board
Mr Bob Baty OBE	Chief Executive South West Water Ltd
Mr David Bishop	1. Senior Advisor to KPMG 2. Chairman Compass Group Pension Scheme Ltd 3. Director of: Cornwall Community Foundation Ltd Trewane Property Holdings Ltd Truro Diocesan Board of Finance Ltd

No other Directors have declared interests.

Remuneration

This report contains information required by Monitor's Financial Reporting Manual (Chapter 4) where it is applicable. Where such information is already contained within the Summary Financial Statements (SFS) the information is not duplicated and, instead, reference is made to the relevant tables/notes. 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

In accordance with the requirements of good governance and the Constitution, the Trust operates two separate Remuneration Committees called the Non Executive Director Remuneration Committee (NEDRC), which considers remuneration for NED, and the Executive Director Remuneration Committee (EDRC), which considers remuneration for Senior Managers. These committees are described further below.

Non Executive Director Remuneration Committee (NEDRC)

Membership The NEDRC consists of the Chairman and six Governors as detailed in the section of the Annual Report entitled 'The Governors' and meets two or three times a year.

Remuneration Policy for NEDs The NEDRC function is to set levels of remuneration for the roles of Chairman and Non Executive Director, and will review these annually. Periodically, comparative external data, drawn from other foundation trusts and the public sector, will be used to ensure these levels remain competetive, fair and appropriate.

Contracts/Notice NEDs serve for three years, renewable up to a maximum of six, subject to appraisal. Expiry dates of current terms are as follows:

Ms Angela Ballatti	30 April 2009
Mr Bob Baty	31 August 2007
Mr David Bishop	31 January 2008
Mrs Maureen De Viell	31 March 2008
Mr Gerald Sturtridge	31 October 2009
Mr Rick Walker	31 March 2008

Executive Director Remuneration Committee (EDRC)

Membership The EDRC consists of the Chairman and NEDs as detailed in the section of the Annual Report entitled 'The Directors' and usually meets quarterly.

Remuneration Policy for Senior Managers
Periodically the EDRC considers comparative external data which looks across other foundation trusts, private and public bodies to assess whether the remuneration for senior managers is competitive, fair and appropriate. Each year the EDRC will consider appraisal reports on each Senior Manager provided by the Chairman and Chief Executive and is asked to approve an annual uplift in line with that awarded to all NHS staff to reflect the annual cost of living increase. The Trust does not operate a system of performance related pay for senior managers.

Contracts/Notice Senior managers are on permanent contracts and subject to normal NHS terms and conditions of service, including the Code of Conduct for Senior Managers. Notice periods are three months, except for the CEO for whom it is one year, and the Finance Director for whom it is six months.

Provision for compensation for early termination would be decided on a case-by-case basis.

Salary, pension and other information

All other details required for inclusion in the Remuneration Report may be found in the tables and/or notes to the SFS accompanying this report as shown in the table below. NEDs do not receive pensionable remuneration:

Salary, allowances, benefits in kind:	See Summary Financial Statements *Salary & Pension Entitlement of Senior Managers (and notes thereto)
Real increase in pension and related lump sum at 60:	
Total accrued pension & related lump sum at age 60:	
Cash equivalent transfer values:	

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

2004 / 05	2005 / 06
£1,031k	£1,095k

There have been no significant awards or compensation to past senior managers. There have been no payments to third parties for the services of a senior manager.

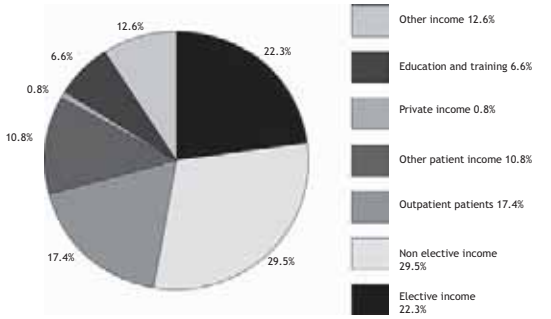
Angela Pedder
Chief Executive
31 May 2006

Operating & Financial Review

The Royal Devon & Exeter NHSFT has now completed its second year of operation as an NHS Foundation Trust. At the beginning of 2005/06 the Trust adopted a revised financial strategy in response to the deficit of £7.3m* incurred in the previous financial year, placing greater emphasis on increasing the overall efficiency of the Trust and receiving additional income in moving towards the full adoption of Payment by Results (PBR), thus ensuring the Trust returned to its original future financial plans as quickly as possible.

In re-setting its future targets, the Trust planned to reduce the £7.3m* deficit incurred in 2004/05 to £2.8m in 2005/06 before returning to a surplus position of £0.9m in 2006/07. This target was exceeded as the Trust returned to a surplus position of £0.5m by March 2006, a year ahead of schedule. The Trust also delivered all of its key waiting-time targets in respect of inpatients, outpatients and the ED.

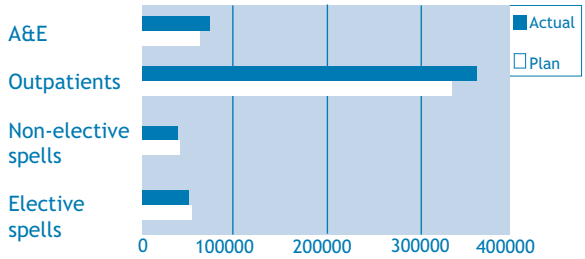
Sources of income 2005/06



In response to the disappointing financial outturn in 2004/05, a revised four-point financial strategy was adopted, based on a combination of plans to ensure the Trust received all income due in respect of services provided, and that this income represented the full cost of delivering those services. The Trust continued to deliver services in the most cost-effective way possible by increasing efficiency whilst maintaining the highest standards of quality possible, and ceased work that did not deliver real value in terms of patient outcomes, through a comprehensive programme of service improvement. In 2005/06, it became increasingly clear that the Trust could no longer rely on the more traditional approaches to cost reduction but needed a radical approach to ensuring the delivery of short-term financial targets, whilst still delivering long-term sustainable financial health. In-year the Trust worked through an intensive programme of financial recovery to realise the required level of financial benefits that would facilitate the delivery of financial targets into the future. This identified the potential to realise up to £16m in financial benefits over that time period, as well as further financial benefits throughout all areas of operation to ensure a sustainable programme of change into the future, and long-term financial stability beyond 2007/08.

In spite of increases in income received through the PbR system the Trust has been able to retain its historical level of efficiency when compared to the average cost nationally of delivering a similar range of services as delivered locally. The 'Reference Cost Index' published annually shows that the cost of delivering services at the RD&E is still 17% below the national average.

Comparison of actual patient activity compared to plan 2005/06



During the year the Trust completed work on building a new cardiac catheter laboratory equipped with state of the art diagnostic and treatment equipment funded by the National Lottery, opened the newly developed Walk in Centre and Primary Care Out of Hours Centre adjacent to the hospital's ED and also a new office block which will enable more prime accommodation in the main hospital building to be devoted to front-line patient services.

Future outlook

In readiness for the new financial year we saw further major changes to the national PbR system which determines the level of payment that the Trust receives for treating patients. Nationally a major 're-baselining' process was undertaken to reset the financial relationship between Trusts as providers and PCTs as commissioners across the entire NHS and this has led to a reduction in the level of income received by the RD&E for delivering the same volume of services. There have also been significant changes in the national system in an attempt to maintain stability during this transition phase but which impact on the level of income the Trust receives, most notably relating to the level of income the Trust receives for any increased numbers of emergency patients. Rather than the Trust being paid the full cost for each new additional patient seen, it will now receive a proportion ranging from 10% to 50% of the full average cost.

Locally, cost pressures mean that the Trust must improve its efficiency by some £7m in 2006/07 and a further £9m over the subsequent two years. The financial recovery work undertaken in the past year puts the Trust in a good position to deliver these requirements, and its future financial targets.

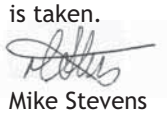
**The stated deficit of £7.3m in 2004/05 has subsequently been restated as £5.8m as a result of a prior period adjustment emanating from production of the 2005/06 annual accounts.*

Operating & Financial Review

It is anticipated that the number of patients requiring treatment at the RD&E will continue to grow but probably at a much lower rate that has been the case in previous years as PCTs establish alternative ways for patients to receive treatment in the community.

Financial targets for the next three years will see the delivery of a financial surplus of £2.4m in 2006/07 rising to a surplus of £10m by 2008/09, which the Trust will invest in new hospital buildings and equipment (NHS Foundation Trusts have to 'borrow' capital money to fund new equipment and buildings) and improving the quality of services for patients.

Work is ongoing on a number of new developments. The transfer of obstetric and gynaecology services from Heavitree Hospital to the Wonford site is due to take place early in 2007. Work has started on providing a new upgraded Diabetes Centre, a second cardiac catherisation laboratory and an expanded radiotherapy department at the hospital. The RD&E is expanding its facilities for renal patients and its endoscopy services. The Trust has deferred a decision on building a new Treatment Centre on the Wonford hospital site for 12 months until there is greater clarity on the delivery of outpatient and day-case services. In the meantime day-case facilities will be expanded at Heavitree hospital to meet demand until a longer term decision is taken.



Mike Stevens
Director of Finance & Information

Summary Financial Statements

The Summary Financial Statements are merely a summary of the information in the full accounts that are available on request from the Director of Finance at the below address:

Royal Devon & 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
13 June 2006

Independent auditors' report to the Council of Governors of the Royal Devon & Exeter NHS Foundation Trust on the Summary Financial Statements

We have examined the summary financial statements for the year ended 31 March 2006 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 Council of Governors of the 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 the preparing the 'Annual Report 2005/06'. Our responsibility is to report to you our opinion on the consistency of the summary financial statements within the 'Annual Report' with the statutory financial statements. We also read the other information contained in the 'Annual Report' and consider whether it is consistent with the audited summary financial statements. This other information comprises only the Operating and Financial Review and the remuneration section. We consider the implications for our report if we become aware of any mis-statements or material inconsistencies with the summary financial statements. Our responsibilities do not extend to any other information.

Basis of opinion

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

Opinion

In our opinion the summary financial statements are consistent with the statutory financial statements of the NHS Foundation Trust for the year ended 31 March 2006 on which we have issued an unqualified opinion and certificate.

PricewaterhouseCoopers LLP
31 Great George Street, Bristol, BS1 5QD.

16 June 2006

Summary Financial Statements

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 MARCH 2006

	2005/06 £000	Restated 2004/05 £000
Income from activities	195,273	182,095
Other operating income	46,448	43,710
Operating expenses	(233,554)	(225,446)
OPERATING SURPLUS	8,167	359
(Loss) profit on disposal of fixed assets	(27)	8
SURPLUS BEFORE NET FINANCING COSTS	8,140	367
Net Financing Income	1,033	1,208
SURPLUS FOR THE FINANCIAL YEAR	9,173	1,575
Public Dividend Capital dividends payable	(8,699)	(7,372)
RECORDED SURPLUS (DEFICIT) FOR THE YEAR	474	(5,797)

All activities are classed as continuing

STATEMENT OF TOTAL RECOGNISED GAINS & LOSSES FOR THE YEAR ENDED 31 MARCH 2006

	2005/06 £000	Restated 2004/05 £000
Surplus for the financial year before dividend payments	9,173	1,575
Unrealised surplus on fixed asset revaluations/indexation	273	29,280
Increases in the donated asset reserve due to receipt of donated assets	921	84
Reductions in the donated asset reserve due to depreciation, impairment and disposal of donated assets	(223)	(262)
Total recognised gains and losses for the financial year	10,144	30,677
Prior period adjustments	286	-
Total recognised gains and losses since last annual report	10,430	30,677

CASH FLOW STATEMENT FOR THE YEAR ENDED 31 MARCH 2006

	2005/06 £000	Restated 2004/05 £000
OPERATING ACTIVITIES		
Net cash inflow from operating activities	17,021	9,754
RETURNS ON INVESTMENTS AND SERVICING OF FINANCE:		
Interest received	1,073	1,215
Interest paid	(40)	(7)
Net cash inflow from returns on investments and servicing of finance	1,033	1,208
CAPITAL EXPENDITURE AND FINANCIAL INVESTMENT		
Payments to acquire tangible fixed assets	(17,856)	(18,500)
Receipts from sale of tangible fixed assets	16	915
Payments to acquire intangible assets	(160)	(72)
Net cash outflow from capital expenditure	(18,000)	(17,657)
DIVIDENDS PAID	(8,699)	(7,372)
Net cash outflow before financing	(8,645)	(14,067)
FINANCING		
Public dividend capital received	7,732	14,262
Foundation Trust Financing Facility loans received	12,000	-
Other capital receipts	921	84
Net cash inflow from financing	20,653	14,346
Increase in cash	12,008	279

BALANCE SHEET AS AT 31 MARCH 2006

	31 March 2006 £000	Restated 31 March 2005 £000
FIXED ASSETS		
Intangible assets	491	444
Tangible assets	248,684	238,903
	249,175	239,347
CURRENT ASSETS		
Stocks and work in progress	3,596	3,685
Debtors	15,246	12,844
Cash at bank and in hand	12,870	862
	31,712	17,391
CREDITORS:		
Amounts falling due within one year	(20,335)	(17,114)
NET CURRENT ASSETS	11,377	277
TOTAL ASSETS LESS CURRENT LIABILITIES	260,552	239,624
CREDITORS:		
Amounts falling due after more than one year	(12,733)	(1,076)
PROVISIONS FOR LIABILITIES AND CHARGES	(464)	(370)
TOTAL ASSETS EMPLOYED	247,355	238,178
FINANCED BY:		
TAXPAYERS' EQUITY		
Public dividend capital	146,153	138,421
Revaluation reserve	92,812	94,555
Donated asset reserve	2,426	1,715
Income and expenditure reserve	5,964	3,487
TOTAL TAXPAYERS' EQUITY	247,355	238,178

Angela Pedder
Chief Executive
13 June 2006

OPERATING EXPENSES

	2005/06 £000	2004/05 £000
Services from other NHS Foundation Trusts	311	70
Services from NHS Trusts	1,807	1,626
Services from other NHS bodies	2,178	3,392
Purchase of healthcare from non NHS bodies	7	112
Directors' costs	1,102	1,051
Staff costs	141,687	132,676
Drug costs	22,742	22,287
Supplies and services (excluding drug costs)		
- clinical	26,231	26,638
- general	3,268	3,552
Establishment	3,002	3,499
Research and development	1,083	975
Transport	393	408
Premises	8,854	8,112
Bad debts	30	551
Depreciation and amortisation	9,559	9,269
Exceptional item - fixed asset impairments and reversals	-	779
Audit fees	106	93
Other auditor's remuneration	35	3
Clinical negligence	2,419	2,239
Other	8,740	8,114
	233,554	225,446

Included within "Other expenditure" above is £4.2 million (2004/05 - £4 million) being the Trust's share of PMS expenditure, training and education costs of £0.7 million (2004/05 - £0.8 million), patients travel costs of £0.7 million (2004/05 - £0.6 million).

Summary Financial Statements

INCOME FROM ACTIVITIES

	2005/06 £000	Restated 2004/05 £000
Elective income	53,938	57,741
Non-elective income	71,300	76,925
Outpatient income	42,171	38,985
Other types of activity income	33,810	25,627
A&E income	5,550	4,162
PbR clawback	(13,371)	(22,906)
Private patient income	1,875	1,561
	195,273	182,095
Income from mandatory services	193,356	180,479
Income from non-mandatory services	1,917	1,616
	195,273	182,095

Due to a change in Tariff "Other types of activity income" includes £7.5million of income in respect of drugs and devices. Previously, this income was included in elective and non-elective income. The comparative figures have not been reclassified as it is not considered practicable due to the change in the method of receiving income.

OTHER OPERATING INCOME

	2005/06 £000	2004/05 £000
Research and development	1,655	1,075
Education and training	15,955	13,423
Transfers from donated asset reserve	223	262
Transfers from deferred income - government grant	173	61
Non patient care services to other bodies	22,747	25,037
Other	5,695	3,852
	46,448	43,710

Included within "Non-patient care services to other bodies" are drug sales, laundry services, financial services, IT services and estates services totalling £15.2 million (2004/05 - £14.5 million).

Included within "Other income" above is catering income of £1.6 million, (2004/05 - £1.4 million), merit awards of £0.9 million (2004/05 - £0.9 million) and car parking income of £0.3million (2004/05 - £0.3 million).

SALARY AND PENSION ENTITLEMENTS OF SENIOR MANAGERS - Remuneration 2005/06

Name and title		Salary (bands of £5,000) £000	Other remuneration (bands of £5,000) £000	Golden hello/ compensation for loss of office (bands of £5,000) £000	Benefits in kind (rounded to the nearest £100) £
R Hawker	Chairman	40 - 45	-	-	-
B Baty	Non-Executive Director	10 - 15	-	-	-
D Bishop	Non-Executive Director	10 - 15	-	-	200
M De Viell	Non-Executive Director	10 - 15	-	-	100
J Evans	Non-Executive Director	5 - 10	-	-	-
G Sturtridge	Non-Executive Director	15 - 20	-	-	100
R Walker	Non-Executive Director	10 - 15	-	-	-
A Pedder	Chief Executive	140 - 145	-	-	8,200
L Hall	Director of Facilities	70 - 75	-	-	100
E Hobson	Director of Operations	85 - 90	-	-	100
S Jupp	Director of Human Resources	85 - 90	-	-	300
R Muskett	Acting Director of Finance	0 - 5	-	-	100
M N Orzel	Director of Nursing & Service Imp.	85 - 90	-	-	100
V Pearce	Joint Medical Director	80 - 85	90 - 95	-	100
M Stevens	Director of Finance & Information	100 - 105	-	-	200
N Walsh	Director of Planning	60 - 65	-	-	-
I Wilson	Joint Medical Director	50 - 55	85 - 90	-	-

R Muskett was Acting Director Finance until 17/4/2005, M Stevens was appinted 18/04/2005, J Evans resigned 28/02/2006, R Hawker retired 30/04/2006, A Ballatti was appointed as Chairman 1/05/2006.

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

The benefit in kind for A Pedder relates to the provision of a lease car. The remaining benefits in kind relates to the mileage allowance paid over and above the Inland Revenue allowances.

Pension Benefits 2005/06

Name and title		Real increase in pension & related lump sum at age 60 (bands £2,500) £000	Total accrued pension & related lump sum at age 60 at 31 March 2006 (bands of £2,500) £000	Cash equivalent transfer value at 31 March 2006 £000	Real increase in cash equivalent transfer value £000
A Pedder	Chief Executive	30.0 - 32.5	220.0 - 222.5	823	100
L Hall	Director of Facilities	2.5 - 5.0	87.5 - 90.0	314	17
E Hobson	Director of Operations	0.0 - 2.5	125.0 - 127.5	452	10
S Jupp	Director of Human Resources	2.5 - 5.0	75.0 - 77.5	297	15
R Muskett	Acting Director of Finance	0.0 - 2.5	50.0 - 52.5	145	1
M N Orzel	Director of Nursing & Service Imp.	2.5 - 5.0	80.0 - 82.5	267	16
V Pearce	Joint Medical Director	10.0 - 12.5	212.5 - 215.0	981	44
M Stevens	Director of Finance & Information	5.0 - 7.5	175.0 - 177.5	700	30
N Walsh	Director of Planning	2.5 - 5.0	100.0 - 102.5	430	17
I Wilson	Joint Medical Director	10.0 - 12.5	132.5 - 135.0	523	48

Summary Financial Statements

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

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

AVERAGE NUMBER OF PERSONS EMPLOYED

	Total	Senior Managers	Others	Staff on inward secondment	Agency, temporary and contract staff	2004/05
	Number	Number	Number	Number	Number	Number
Medical and dental	479	1	469	9	-	450
Administration and estates	1,057	8	1,046	3	-	1,020
Healthcare assistants & other support staff	597	-	597	-	-	665
Nursing, midwifery & health visiting staff	1,464	-	1,461	3	-	1,383
Scientific. therapuetic and technical staff	634	-	632	2	-	617
Bank and agency staff	200	-	-	-	200	244
Total	4,431	9	4,205	17	200	4,379

PUBLIC SECTOR PAYMENT POLICY
Better Payment Practice Code - measure of compliance

	Number	£000
Total Non-NHS trade invoices paid in the year	74,596	88,304
Total Non-NHS trade invoices paid within target	60,692	70,892
Percentage of Non-NHS trade invoices paid within target	81.36%	80.28%
Total NHS trade invoices paid in the year	1,980	27,615
Total NHS trade invoices paid within target	1,422	18,776
Percentage of NHS trade invoices paid within target	71.82%	67.99%

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 (2004/05 - £Nil).

PRUDENTIAL BORROWING LIMIT

	31 March 2006	31 March 2005
	£000	£000
Prudential borrowing limit set by Monitor	29,900	17,100
Actual borrowing in the year	12,000	Nil

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 2006.

The Trust has complied and remained within the prudential borrowing limit. The PBL 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.

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST GENERAL CHARITY

The Royal Devon and Exeter NHS Foundation Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity. The Trust has received during the year £45,000 revenue income, £1,000,000 deferred income and £921,000 capital contributions from the Charity.

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 Trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring that the Trust is administered prudently and economically and that resources are applied efficiently and effectively. In addition, I also acknowledge my responsibilities as set out in the NHS Foundation Trust Accounting Officer Memorandum.

2.0 Purpose of the system of internal control

2.1 The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to:

- identify and prioritise the risks to the achievement of the policies, aims and objectives of the Trust;
- evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

2.2 The system of internal control has been in place in the Trust for the year ended 31 March 2006 and up to the date of approval of the Annual Report and Accounts.

3.0 Capacity to handle risk

3.1 The Governance Committee (sub 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 are 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 frequent 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 frequent 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 of 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, using a likelihood consequence matrix. The roles and responsibilities of key players and all members of staff within the organisation are also detailed. The terms of reference of the Governance Committee and the governance structure are also highlighted along with the terms of reference of all committees reporting to the Governance Committee.

4.2 The Trust uses a risk register to manage both the higher level and trustwide 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 frequent meetings on the local delivery plan and monthly contract management meetings.

4.7 Planning risk issues are discussed with local authority 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 particular in meeting national targets.

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

5.1 Internally, overall performance is monitored at the monthly meetings of the Board of Directors. Operational management and the coordination of Trust services are 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.

5.2 During 2005/06, the Trust, working with a team of consultants, identified a number of areas where savings could be made by avoiding duplication or introducing new technology as well as generating more income by increasing capacity. A number of projects have been developed, each led by an Executive Director that will further improve the financial position of the Trust over the coming years.

6.0 Review of effectiveness

6.1 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.

6.2 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.

6.3 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 frequent reports are given to the Audit and Governance Committees. The Trust's position against the core healthcare standards has been reported to the Board and the Healthcare Commission via the Annual Healthcheck.

6.4 No significant internal control issues (i.e. issues where the risk could not be effectively controlled) have been identified in respect of 2005/06.

Signed:

Angela Pedder
Chief Executive
13 June 2006

We can arrange language translation if you do not speak English. We can also arrange British Sign Language translation. Please ask us on (01392) 402093.

We can give you this information in larger text. Please ask us on (01392) 402833.

ما برای کمك شما ترجمهٔ زبان بمنظور استفاده از خدمات که شما نیاز دارید فراهم کرده میتوانیم. لطفاً به بخش روغتون بر نمرهٔ تلفون رابطه کنید که در نامهٔ شما داده شده است.	Dari
અમે તમને જરૂરી સેવાઓ મેળવવા મદદ માટે ભાષાંતરની વ્યવસ્થા કરી આપીશું. કૃપા કરીને પત્રમાં તમને આપવામાં આવેલ નંબર ઉપર ઇસ્પીતાલ વોર્ડને ટેલિફોન કરો.	Gujarati
ہم آپ کی مطلوبہ خدمات کو پانے میں آپ کی مدد کے لئے زبان کے ترجمہ کا انتظام کر سکتے ہیں۔ برائے مہربانی آپ کے خط میں دئے ہوئے نمبر پر اسپتال کے وارڈ کو فون کریں۔	Urdu
我們能夠爲您安排語言翻譯，以協助您獲得需要的服務。請撥打信中提供的電話號碼以便與醫院病房聯絡。	Chinese
ما قادر هستیم برای شما امور مربوط به ترجمه را انجام دهیم تا خدمات مورد نیاز خود را بدست آورید. لطفا با بیمارستانی که شماره تلفن آن در نامه ذکر شده تماس حاصل نمایید.	Farsi

Designed and compiled by Naomi Cudmore, Communications Department, RD&E;
Photographs by Graham Slocombe, Medical Photography, RD&E.

Royal Devon and Exeter NHS Foundation Trust, Barrack Road, Exeter, Devon EX2 5DW
Telephone: 01392 411611 Website: www.rdehospital.nhs.uk

This document cost 42p per copy to produce