



Royal Devon and Exeter
NHS Foundation Trust

Annual Report, Quality Report & Accounts 2018/19

Royal Devon & Exeter NHS Foundation Trust

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Royal Devon & Exeter NHS Foundation Trust
Annual Report & Accounts 2018/19

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CHAIRMAN'S INTRODUCTION

It is my pleasure to introduce our Annual Report, Quality Report and Accounts for 2018/19.

In my introduction last year, I outlined the challenges the NHS was facing in terms of growing demand for our services as our communities grow and age. In addition, as technology and treatments become ever more sophisticated, our ability to intervene to help people when they are unwell has also increased. The ongoing rise in demand comes at a time when the resources we require remain constrained. As expected, in 2018/19 demand continued to grow and to outpace our resources.

Despite the efforts of our staff - and along with most other Trusts - we failed to meet the majority of our access targets. The continuing challenges with diagnostics and the number of patients who had to wait more than 52 weeks for elective surgery - while reduced at the year-end - was particularly concerning. While we have plans in place to improve our attainment of both these targets in 2019/20, access targets will remain challenging.

We finished the year with a surplus of £19.6 million. This was, however, achieved through one-off profits including on the lease and lease-back of two non-clinical properties. The underlying financial position remains very challenging as we have had to absorb higher than forecast demand under our block contract and address the shortfall with non-recurrent gains. This shortfall is then added to an already challenging productivity improvement target for 2019/20.

On 5 July, 2018, the NHS celebrated its 70th birthday. It was a good opportunity to reflect on the positive impact that the NHS has had on the lives of so many British people, the support we receive from our communities and how our service remains the envy of other countries. It was also apparent, however, how significantly our population has changed over this period, as have the services we provide.

On 18 June 2018, in advance of the NHS's birthday, the Prime Minister announced a 5-year financial package for the NHS. This provided for a real terms increase over this period averaging 3.4% per annum so that the income to the NHS in 5 years' time will be £20.5 billion per annum higher than it is today. The increases are front-loaded slightly. It is true that independent think tanks have suggested that a minimum of 4% per annum increases are required to maintain services at their current levels. It is, however, a settlement that other parts of the public sector are understandably envious of and it gives us funding certainty over the next 5 years so that we can develop a 10-year plan for the NHS in England.

The Prime Minister acknowledged that this revenue funding package was only part of the solution. For this settlement to have a chance of success, it is critical that social care is appropriately funded (otherwise the burden falls back onto the NHS), that the NHS has sufficient capital to fund not only backlog maintenance but also transformational change, and that investment is made in training future generations of NHS staff. Given the focus of government and Parliament on Brexit, these matters remain outstanding.

As outlined in last year's report, we are very much a 'people business'. We have truly inspirational people working for us, driven by vocation and a desire to serve our communities to the best of their ability. But, as a country, we have been training too few clinicians and have become dependent on overseas and agency staff to fill the gap. Your Board is very grateful for the significant contribution that our overseas staff continue to make but it is critical that the UK trains the clinicians it needs. In March 2018, Health Education England (HEE) published a draft workforce strategy - 'Facing the Facts, Shaping the Future'. I welcome HEE's endeavours to plan for the scale of the challenge we face.

The pace of delivery, however, does not reflect the urgency that our situation deserves and we should not wait. In the South-West Peninsula we have two strong universities and, as a system, we need to work much more closely with them to deliver high quality education and fulfilling jobs for our communities. This should be one of the key priorities for our Sustainability and Transformation Partnership (STP), in my view.

In my last introduction, I mentioned the importance of transforming our services and the part that technology has to play. I mentioned that we had procured a new system from US-based company Epic to support our own transformation programme - 'MY CARE'. It is an expensive system and requires a significant amount of resource to implement (at the time of writing, we have 130 colleagues working on the MY CARE team and 452 colleagues acting as 'subject matter experts' for it - my thanks to all of you). Your Board remains confident, however, that following implementation in the summer of 2020, we will be able to further improve the quality and safety of our services and to do this at a reduced cost.

During the year we entered into a Collaborative Agreement with Northern Devon Healthcare Trust (NDHT). Under the terms of this Agreement the Trust has agreed to provide leadership and management support to NDHT with a joint Chairman and Chief Executive and now several other shared senior posts also. Your Board was conscious of the significant pressures that our Trust is facing and the demands which we had already placed on our leadership team. The Board decided, however, that it should support neighbouring trusts to ensure that the highest quality healthcare services possible are consistently provided across Devon. Moreover, if services in northern Devon struggle, the consequences would be felt at the RD&E. The relationship between the two trusts has developed strongly and we are confident that the services to the communities of northern Devon have materially improved.

During the year, we had a planned inspection from the Care Quality Commission (CQC). The CQC did not look at all our services. They reviewed six core services within acute and community; the first time

community services had been inspected under our ownership. They also reviewed our Use of Resources and Leadership. Our rating overall remained 'Good' but every aspect of every single domain reviewed either improved or remained the same. This is an incredible recognition of the fabulous work of our staff during a time when pressure has been so high. Particular congratulations must go to our renal services who were recognised as 'Outstanding' in their first review.

No Chairman's report would be complete without reference to Brexit! Clearly it is for Parliament and/or the electorate to determine whether/when/how we leave the European Union and on what terms. Our role is to do all we can to ensure that, whatever the outcome, we are as prepared as possible and that we support our EU colleagues during any transition. I would thank both my own colleagues, and those at NHSI/E and the Department of Health and Social Care, for all their hard work.

Our staff survey continued to show a very high level of engagement with continued positive results. Your Board remains focused on any areas of concern. Similarly, our patient surveys provide further reassurance. For example, the national cancer survey results ranked the Trust as third in the whole country, making it the only complex cancer centre in the top ten.

Finally, I would take this opportunity to thank our staff, our volunteers, my Governor and Board colleagues and colleagues across the health and care system for their massive endeavours over the last 12 months. The performance summarised in this annual report shows what a great team can deliver even in very challenging circumstances. Thank you.



James Brent
Chairman

PERFORMANCE REPORT: OVERVIEW

The purpose of the Overview is to provide a short summary that provides readers with sufficient information to understand the organisation, its purpose, the key risks to the achievement of its objectives and how it has performed during the year.

INTRODUCTION BY THE CHIEF EXECUTIVE

I am delighted to be introducing this year's Annual Report and Accounts, some three years after becoming the RD&E's Chief Executive.

The RD&E is a Foundation Trust and, as such, we are legally required to produce an Annual Report and Accounts. We are obliged, by our regulators, to follow a clear structure and to ensure we include certain mandated information that sets out how we have performed during the preceding financial year and how we have used the resources available to us. This is right and proper as an organisation that spends taxpayers' money and provides key healthcare services to the community as a Foundation Trust. Our focus in preparing this report has been to make sure we give a true and accurate account of our work over the year.

Aside from our legal obligations, for me this report is a great opportunity to highlight some of our key milestones over the past 12 months. Life at a major acute and community Trust is busy and challenging and as the months fly by, it can be all too easy to lose clear sight of the many steps we've taken towards improving our care and services. So this report is a good way to remind both ourselves and the people we serve of these.

At the outset I'd like to pay a heartfelt tribute to our staff. We have outstanding people here at the RD&E who put in extraordinary levels of skill, commitment and compassion day and night, all year round. Demand for our acute and community services remains high and we continue to face operational pressures. These can be intense at times, particularly during the winter months. We are well used to this and have robust plans to manage those pressures so we can continue to deliver the safe, high quality care our communities rightly expect of us. I am very aware that delivery of our plans is only achieved through our people. I was delighted to see the RD&E

was recognised in the top three Trust's nationally for staff engagement in this year's NHS Staff Survey, with nearly three-quarters of staff recommending the Trust as a place to work and 86% as a place to receive treatment. This year we also saw just how key all our staff groups are to the safe and smooth running of the Trust in a fascinating Channel 5 documentary filmed exclusively at the RD&E called 'The Secret Life of the Hospital: Revealed'. We will continue to work hard to support and empower all our staff groups and make sure they consistently feel engaged and positive about their work, despite the challenges they face.

I'm also very sensitive to the fact that behind our performance and financial statistics set out in this Annual Report, lie real people with real lives. Key Trust performance measures, such as national waiting time targets, are very important because they tell us, our regulators and our public if we are on the right track and hold us to account as a publicly-funded body.

On these measures, our operational performance continues to compare favourably with other NHS Trusts in the region and nationally. Levels of infection, such as MRSA and Clostridium Difficile, also remain very low thanks to continued vigilance. We've committed significant resource and taken a range of actions in the past year both at department level and jointly with our health and social care partners (such as Devon County Council) and, as a result, we continue to see and safely treat the majority of our patients within national target times. However, the picture remains challenging due to factors such as higher than planned demand for our services in the past year, staffing pressures in some key diagnostic services (supporting Cancer, for example) and complex systemic issues beyond our direct control which can impact on our performance.

For example, our Emergency Department (ED) teams have performed very strongly against the 95% four-hour target this year thanks to hard work and significant staffing investment in 2017/18. Despite this, their overall performance in 2018/19 remains just short of the 95% national target due to the combined effect of increased attendances; bed capacity pressures caused by high numbers of medical admissions and delayed discharges due to shortages in available domiciliary care; and high numbers of patients attending ED with mental health needs requiring inpatient psychiatric beds. Given this challenging picture and the importance of meeting the targets, our focus on maintaining and improving our strong overall performance will continue at pace in the coming year.

However, in order to truly transform our services and deliver ever higher standards of care, we must go further than this. As I said above, we must never lose sight of the fact that behind the targets we work with are real people with real lives, hopes and fears. We must not simply feel satisfied we have met a national target, important though that is. We need to go further and constantly ask ourselves: what matters to our patients and their families? Are we placing their needs first in our decision-making? At the RD&E our strategic goal is to develop a new, place-based model of care that delivers safer and more personalised services across a range of acute, community and home settings, not just in hospital. As well as asking 'what is the matter with you?', we are also now asking 'what matters to you?'. Asking this kind of question helps us and our health and social care Partners to individualise and join up the care we give and empower those we serve to recover quicker from illness or injury and stay happy and healthy at home for longer. By seeing the person not just the patient, we can improve clinical outcomes but also better meet the challenge of providing safe, high-quality and sustainable services to an ageing population with complex needs.

Much of our work now, as highlighted in this report, focuses on this goal. But in 2018 we took a major step towards it after securing funds and NHS Improvement approval to start our new 'MY CARE' Programme. Due for full operational launch in 2020, MY CARE is a hugely exciting clinical transformation programme that will change the way we deliver healthcare and services in the future moving away from inefficient paper-based processes and systems to make it easier for staff to provide even safer

and more compassionate, personalised care. The Programme will be supported by a state-of-the-art Electronic Patient Record - a single encrypted interactive digital care record which can be updated in real time by a broad range of health and care professionals. Patients, too, will also be able to see this information and connect with their clinicians online via a secure App or website portal. This revolutionary programme will give our clinicians a much more comprehensive and insightful picture of the people in their care in a fraction of the time it currently takes. It spells a welcome end to wasteful paper-chasing, fragmented care and patients having to repeat the same information to different people. Crucially, it will mean even safer and even higher quality care. I am very proud to report the RD&E is one of only a handful of NHS Trusts to receive approval and funding for this ground-breaking technology developed originally in the United States. Teams are now hard at work to prepare the Trust for MY CARE's operational launch in 2020 and I look forward to providing a full update on this programme in next year's Annual Report.

Another exciting focus for us this year has been our work in the community to prevent unnecessary hospital admissions and empower local communities to work together to improve health and well-being. Along with MY CARE, this is a central part of our strategy to create a more clinically and financially sustainable model of care for years to come, in line with the NHS' 10 Year Plan. Since 2017 we have been delivering services from 12 Eastern Devon community hospital sites in addition to our acute sites in Exeter. In addition we operate integrated and urgent-response health and social care teams comprising nurses, occupational therapists, physiotherapists and many other skilled workers. However, it's not just about delivering services effectively when and where these are needed. To achieve real, radical change, we also want to help create the right conditions for communities themselves to take the leading role in their own wellbeing.

To this end, throughout 2018 the Trust continued its 'Community Conversations' programme to engage and work differently with local communities in order to move towards a place-based system of care – working in collaboration with providers, commissioners, GPs, third sector organisations and communities themselves.

The aim of the Community Conversations, which now take place across ten market towns in East Devon, is to understand the needs of the local population and then work together to explore how best we can collectively meet those needs using the assets and strengths that already exist within that community. It is an opportunity for genuine dialogue between communities and professionals on the basis of each having something to offer. Importantly, the RD&E is just one of many Partners and we have been clear that this work should be led by the community not the Trust. As a result, the pace and progress can vary across localities, but the aim is to blend community-identified needs with good-quality data held by the NHS and local authorities to help determine priorities in specific places. This is an innovative and very positive change to the NHS' traditional 'top-down' relationship with communities and we will continue to develop this approach along with the quality of our community-based clinical services over the coming year.

We will also continue making positive progress in the north of the county thanks to our Collaborative Agreement with Northern Devon Healthcare Trust (NDHT). This began formally in 2018 and involves the RD&E providing leadership and management support to NDHT. The collaboration has already enhanced clinical standards – in maternity, for example – and improved community relations. Our focus now is to make sure we have a robust and future-proof way of working well together in place when the Collaborative Agreement is due to come to a formal end in 2020.

As many will know, this year was the NHS' 70th anniversary and to mark the occasion we held our first public Open Day for many years in September. Despite torrential rain, the day was very well received by all those who came and helped us to connect positively with a cross-section of people using our services. It's this kind of connection that will be so important going forward with our ambitious operational and strategic agenda. As we've done this year, we need go on listening to and connecting with the people we serve and then innovating our services to achieve ever better care, in the right place, for the people who need it. I am very proud of the significant steps we've taken towards this in 2018 and look forward to leading the RD&E through another year of improvement and opportunity.



Suzanne Tracey
Chief Executive

ABOUT THE RD&E

The Royal Devon and Exeter NHS Foundation Trust provides integrated health and care services across Exeter, East and Mid Devon. With more than 8,000 staff, it manages a large acute teaching hospital, twelve community hospitals and provides community services to a core population of over 450,000.

The Royal Devon and Exeter NHS Foundation Trust (RD&E) has a long and proud history dating back over 250 years. The Trust has earned an international reputation as a recognised provider of high quality healthcare services, innovation, research and education. The Trust is nationally and internationally recognised for excellence in a number of specialist fields including the Princess Elizabeth Orthopaedic Centre, the Centre for Women's Health (maternity, neonatology and gynaecology services), Cancer Services, Renal Services, Exeter Mobility Centre and Mardon Neuro-rehabilitation Centre.

As a teaching hospital, the RD&E delivers undergraduate education for a full range of clinical professions; is established as a leading centre for high quality research and development in the South West peninsula and is the lead centre for the University of Exeter Medical School. The RD&E became one of the first Foundation Trusts in 2004 and this status, together with accountability to local citizens through our membership and governors, is an important way of connecting with the people and communities we serve.

Our Corporate vision is to be a leader in transforming the health and care system, working in partnership to connect people, services, communities and voluntary groups to meet the needs of the communities we serve. In doing so we will continue to provide safe, high quality services delivered with courtesy and respect. This was reflected in the Care Quality Commission (CQC) inspection in November 2015 which praised the Trust's culture as "strongly focused on quality with patients being the absolute priority." Rated as good overall, the first in the South West, the CQC rated seven out of eight services at the Wonford site as either outstanding or good including outstanding for Caring Services (Trust wide), Urgent and Emergency Care and Critical Care.

The Trust has responsibility for Eastern Community Services and many of the services run in the

Community Hospitals in East Devon. By bringing acute and community services under one organisation in Eastern Devon, we are able to offer more efficient and joined up 'integrated' care. Working together with health and care Partners and local communities, we are better placed to meet people's needs to ensure a hospital stay happens only when acutely necessary and with more people kept well at home and supported within their community.

The integration of care services is part of a wider ambition to establish a place-based system of care which promotes independence, prevention and citizen wellbeing. This system places the needs of the individual firmly at the centre, supporting them to live the life they want to lead.

[NDHT and RD&E agree a new collaboration to maintain sustainability of clinical services in North Devon](#)

In May, the RD&E and the Northern Devon Healthcare NHS Trust (NDHT) reached agreement on a new collaboration between the two organisations. The aim of the collaboration is to support NDHT with challenges it faces in continuing to provide services and to ensure that the health needs of the population continue to be met.

The two organisations agreed that the RD&E will provide leadership and management support to NDHT for the next two years, with a dedicated senior management team based at each Trust location in Barnstaple and Exeter.

Following approval of both Trusts' Board of Directors, the Collaborative Agreement came in to effect in June 2018, with Suzanne Tracey, Chief Executive at the RD&E, becoming the Accountable Officer and Chief Executive of both organisations. James Brent became the Chair of both Trusts from July. During the year, a number of other joint appointments were also made at Executive level (see the remuneration report for more details).

NHS Improvement and the Devon Sustainability and Transformation Partnership (STP) have maintained oversight of the collaboration arrangements. NDHT will undertake work during the next year to consider options for the longer-term solutions to the challenges it faces.

OUR YEAR

Spring

RD&E rated highly in CQC's annual inpatient survey

Adult inpatients at the RD&E gave the Trust their stamp of approval in June, with survey results showing 8.4 out of 10 for patients overall experience of inpatient services.

The annual Care Quality Commission (CQC) Adult Inpatient Survey looked at the care of 597 patients who were discharged from the RD&E in July 2017. Patients assessed the hospital on a variety of topics, including the time taken to get to a bed on a ward, the care they received from clinical and non-clinical staff and their overall views of the care and services provided by the Trust.

The RD&E was rated as one of the best performing NHS Trusts in several areas, including: the privacy patients received when being examined or treated; how well staff explained how an operation or procedure had gone; whether their discharge was delayed and how long that delay was; and the support given by health or social care staff to help patients recover and manage their condition.

Adrian Harris, Medical Director at the RD&E, said: "We are very pleased with these results and proud of the staff here at the RD&E for providing such great care. The results of this survey are particularly important to us as it shows how our patients feel about the care and services we provide. As always, we are focused on maintaining these high standards of care and taking on board any additional learning from this important survey."

Exeter NHS champions recognised in Queen's Birthday Honours

A Devon community healthcare champion and an Exeter clinical scientist who have helped to transform the lives of thousands of patients worldwide were recognised by the Queen in her June Birthday Honours.

Professor Sian Ellard, the RD&E's Consultant Clinical Scientist and Professor of Genomic Medicine at the University of Exeter, received an OBE, while Steve

Hudson, the RD&E's former Divisional Director of Community Services at the RD&E, received an MBE.

Prof. Ellard has pioneered the use of diagnostic genetic testing in mainstream NHS clinical practice and now leads a ground-breaking genomics programme that has discovered 16 of the 26 new genetic subtypes of diabetes over the past 15 years.

On receiving her honour, Professor Ellard said: "I am delighted and honoured to receive this OBE. I would like to pay tribute to all of my colleagues who have done such a superb job from the initial research discoveries to changing clinical practice through new genomic testing. It's an enormously exciting time in Genomic research and I'm very proud to be part of it."

After studying chemistry and later qualifying as a nurse, Steve Hudson worked in the NHS for more than 30 years, initially specialising in learning disabilities, before later taking on a range of management posts across health and social care services in Devon. His last post before retiring this year was the RD&E's Divisional Director of Community Services.

Steve said: "I've been proud to work with so many fantastic teams of people over the years, both in the community and the NHS. I am deeply honoured and humbled to receive this honour."

RD&E gives "green light" for new patient-centred comprehensive health record system

In June, the RD&E received approval from NHS Improvement to proceed with a new clinical transformation programme. As well as fundamentally improving the way services and care are delivered to patients, the MY CARE Programme will see paper-based patient records at the RD&E becoming a thing of the past.

The Trust's Board approved the MY CARE Programme, including the go ahead for implementing a comprehensive electronic patient record (EPR) system supplied by Epic, a US-based healthcare technology company. It is already used by many of the world's top-ranked hospitals, health systems, and medical schools.

Epic is an integrated platform, meaning that there's just one record for each patient and providers have the full picture of each patient's story. For the first time ever at the RD&E, key aspects of a patient's care – their medical history, current medications and latest test results – will be available in a single encrypted interactive digital care record which can be updated in real time. The new MY CARE Programme will help RD&E staff deliver improved care to their patients, replacing the fragmented system in place today, which is largely still paper-based.

"Our teams across the Trust work very hard to consistently deliver great care to our patients and, as a result, our services are rated highly even at a time of unprecedented demand," said Tracey Cottam, Director of Transformation and Organisational Development. "But some of the ways we currently deliver services could be improved and some of the current processes and systems we use consume too much time and make it harder for staff to provide the level of compassionate, personalised care they aspire to. This transformation of our services will give all clinicians a much more comprehensive picture of their patients and their healthcare in a fraction of the time."

Adrian Harris, Medical Director, said, "This is a very exciting moment for the RD&E because the MY CARE Programme will help make the care we provide even better. Patients will have direct access to their care record whilst at home, providing the same control and convenience for managing their health that they've come to expect in other areas of their life. For my clinical colleagues, the Programme will help them do what matters most: deliver high-quality, compassionate care to the people who need it."

Summer

[Neonatal unit at the RD&E bounce their way to the top to win international Kangaroo-a-thon challenge](#)

The Neonatal team at the RD&E fought off competition from across the globe in July to win an international Kangaroo-a-thon.

The challenge saw the unit competing against 110 other hospitals around the world, including the USA, India and Australia. The team came out on top with an incredible 1,351 hours of Kangaroo care recorded over 15 days.

Kangaroo Care, named for the close physical contact kangaroos give their young, encourages skin to skin contact between parents and their premature or sick babies. Mounting evidence has shown that close contact helps to reduce the levels of stress hormones in sick or preterm babies, and can also help to stabilise the baby's temperature and heart rate, reduce oxygen requirements and support breastmilk production.

The annual challenge, arranged by Sunnybrook Health Sciences in Canada, asks hospitals to count the number of hours spent giving Kangaroo Care during a 15-day period. Exeter Neonatal unit has promoted the method for a number of years for sick and preterm babies and entering the challenge gave the team an opportunity to see how much skin contact parents could provide. The challenge, which had no prizes, was designed to raise awareness of Kangaroo Care and encourage hospitals to use it as much as possible.

[Success at the Hospital's Open Day](#)

The RD&E held its first Open Day in nine years in September and, despite torrential rain all day, it was a great success.

The rain forced the majority of activities into the RILD (Research, Innovation, Learning and Development) building but it didn't stop the hospital's Rhythm of Life choir from singing and dancing in the rain. The Upcrowd Band, JJ Wilde and hospital radio also all braved the rain to put on a great show.

Under the protection of the RILD, visitors were able to make their own smoothies on the Smoothie Bike, see how clean their hands really were and get a close look at how robotic surgery works.

One of the highlights of the day for many were the behind-the-scenes tours, where a total of thirteen departments, including the Centre for Women's Health, Laundry and Acute Medical Unit, volunteered their time to show members of the public around their departments.

Overall, it was a great day with a lot of positive feedback from those who attended.

A parent, whose teenage son was undecided about career prospects in the NHS, said: "After three tours, a demo on the robot and some very useful conversations with Recruitment and Learning and Development, he has gone away with a much clearer idea of what he would like to achieve and how to get there. I can't thank you enough".

Tracey Cottam, Director of Transformation & Stakeholder Engagement, said: "Despite torrential rain, our fantastic teams, volunteers and governors dug deep and brought to life the RD&E spirit of teamwork and a commitment for the 'the show to go on'. Thank you to everyone who worked so hard to make the day a success."

Autumn

The RD&E rates highly in national cancer patient survey

The RD&E was rated highly by cancer patients using its services, according to a national survey released in October.

The annual National Cancer Patient Experience Survey was completed by over 900 patients at the RD&E who received a cancer diagnosis and attended the hospital in April, May or June 2017. Questions asked included how involved they were with their care and treatment, the levels of respect and dignity they received while in hospital and the support they received after going home.

Overall, on a scale of zero to 10, the RD&E was rated 9.0 by patients. Some 29 areas were regarded as 'better than average' with the remaining 23 in line with national averages.

One patient commented: "Staff and consultant were great; caring, considerate and informative. They were a great support and answered any questions or queries I had. They are life savers and I am extremely grateful we have such caring and brilliant staff."

Em Wilkinson-Brice, Deputy Chief Executive and Chief Nurse at the RD&E, said: "We are extremely pleased with the results of the survey and very proud of the staff at the RD&E for providing such great care, which we always endeavour to maintain. The results provided in this survey are very important to us, as it shows us how our cancer patients feel about the care and services we provide."

RD&E and North Bristol NHS Trust join forces to deliver cutting-edge genomics testing for patients

In October, a new South West Genomic Laboratory Hub was announced as one of only seven hubs that will deliver genomic testing for patients with cancer or rare disease as part of a new national network.

The RD&E will work in partnership with North Bristol NHS Trust to provide potentially life-changing diagnosis and move towards a more personalised approach to treatment. The Exeter Genetics Laboratory is one of three designated providers of specialised endocrine tests for patients throughout England and is the national centre for monogenic diabetes and hyperinsulinism testing.

From early 2019, whole genome sequencing will be made available to seriously ill children with a suspected genetic disorder and people with specific types of cancer. The work will build on the 100,000 Genomes Project that is sequencing the genomes of around 70,000 people (100,000 patient samples) by the end of 2018.

Professor Sian Ellard, Head of the Exeter Genetics Laboratory, said: "We look forward to working with our colleagues in Bristol to provide cutting-edge genomic testing for patients throughout the South West and beyond. Now we are able to begin a true transformation that will support more personalised medicine for patients with cancer and rare diseases in the South West and beyond."

Cameras go behind the scenes at the RD&E for major Channel 5 documentary

The RD&E took centre-stage in a feature-length documentary on Channel 5 in October 2018.

The 90-minute programme, called 'Secret Life of the Hospital: Revealed', showed some of the unseen cogs in the vast complex machinery of a large Trust like the RD&E and shed light on the teamwork required to enable services working safely 24 hours a day, seven days a week.

It featured many services and departments rarely seen by the public, such as the laundry and sterilisation units, laboratories, equipment repair workshops, health record stores, and the super-fast 'pod' system for transporting bloods and other samples around the hospital in seconds. It also showed how the hospital 'deep cleans', prepares ultra-sterile chemotherapy drugs, and uses recycled hip bones in life-changing spinal surgery. A segment on the mortuary sensitively captured how teams respond when a patient sadly dies in hospital.

Many of the hospital's staff appeared, including porters, cleaners, emergency teams, together with the woman in charge of the busy operating theatres supply room and the man who has to figure out why a £500,000 CT scanner isn't firing up at 6.30am. It also featured several patients, including two brave teenagers undergoing major treatment, a premature baby, and a woman flown in by air ambulance after her heart stopped.

The documentary, filmed and produced by Brinkworth Productions, was researched and filmed at the RD&E over a three-month period earlier in the year using a range of cutting-edge HD cameras and techniques.

Suzanne Tracey, RD&E Chief Executive, said: "Like many Trusts, what the public see when they come in for treatment or pay a visit to the RD&E is only half the story. There's also an incredible hidden network of supporting staff and services working hand-in-hand with the clinical frontline to keep the services safe and fully functioning round-the-clock, all year round.

"It's a real honour for me to see this amazing teamwork every day but it's very exciting to have a programme that shows this other vital side of our health service, particularly on the 70th anniversary of the NHS."

The RD&E is one of first NHS trusts awarded Veteran Aware accreditation

In November, as the nation marked the 100th anniversary of the end of the First World War, the Royal Devon and Exeter Hospital became one of 24 Trusts in the country to be accredited as a Veteran Aware hospital.

Trusts accredited by the Veterans Covenant Hospital Alliance (VCHA) will lead the way in improving NHS care for veterans and members of the armed forces community, providing training to staff to be aware of veterans' specific needs, making past and present servicemen and women aware of appropriate charities or NHS services beneficial to them and ensuring that the armed forces community is never disadvantaged compared to other patients.

The Trust will display posters in clinics and public waiting areas urging anyone who has served in the armed forces to make themselves known to staff.

The RD&E already has significant links with the armed forces and has previously pledged support by signing the Armed Forces covenant.

Dave Thomas, Deputy Chief Nurse at the RD&E and a Lieutenant Colonel with the Army Reserve, said: "We are really pleased to have gained recognition as a Veteran Aware Hospital. Over the last three years, we have worked hard to ensure we acknowledge the part that our armed forces and veterans play in our society and nation. This isn't the end for us, but rather recognition of the journey we are on to fulfil our commitment to the Armed Forces Covenant."

The VCHA was inspired by the heroism of Captain Noel Godfrey Chavasse VC, a doctor who gave his life rescuing men on the battlefields of the First World War.

Winter

Dementia patients at the RD&E benefit from MP3 players

From January, patients suffering from dementia at the RD&E now benefit from MP3 players filled with music from their youth, thanks to a new partnership with the Purple Angel Global Dementia campaign.

The scheme, which will initially be rolled out to patients on a selected number of wards across the acute and community hospitals, provides each ward with two MP3 players – one loaded with music for those over the age of 50 and the other for patients over the age of 70.

Evidence has found that music for patients with dementia can help to reduce anxiety and depression, help maintain speech and language and help patients to express feelings and ideas.

Norrmc McNamara, Founder of Global Purple Angel Dementia campaign, said: "We are so happy to announce we are working with the Royal Devon and Exeter Hospital and surrounding local hospitals in providing free Purple Angel MP3 music players to those who may need them. The MP3 players try to improve their lifestyle, wellbeing and general health via personalised music therapy which has proved hugely successful in other hospitals, care homes and private homes across the UK."

RD&E opens revamped Medical Triage Unit to reduce unnecessary admissions

A medical unit designed to assess patients quickly and avoid unnecessary admission into hospital was reopened in December, following a major £1million refit.

The RD&E's Medical Triage Unit (MTU) provides rapid diagnosis and care to emergency patients referred from their local GP or the RD&E's Emergency Department. The unit allows patients to be treated by expert clinical teams in a bed or seated in a treatment area if mobile, without being admitted to hospital. The unit's overall purpose is to minimise unnecessary hospital admissions, which can sometimes delay a patient's recovery and create extra pressure on inpatient beds around the hospital, especially during the busy winter season.

The improved layout allows patients to be assessed more rapidly and, where appropriate, be seen in private clinic rooms rather than automatically being admitted to a bed.

Key features include: a new ambulatory care suite with two triage rooms and two consultation rooms; two dedicated triage spaces for patients on trolleys or in beds; and an improved nurses and doctors station allowing clinicians to stay closer to patients.

The MTU is part of the RD&E's Acute Medical Unit, which has seen numbers of patients rise in recent years from around 40 patients a day a decade ago to currently 70-100 a day.

Dr Helen Lockett, Clinical Lead for Acute Medicine and Ambulatory Care, said: "Our new layout and extra space means we can assess and treat people more rapidly. This is good for patients because we can help get them on the correct treatment pathways and back to their own homes more quickly, and often on the same day. Now the unit has reopened, we can concentrate on giving our patients the best possible service."

The first of Devon's Nursing Associates complete their training

Celebrations took place at Devon hospitals in January, as some of the county's frontline nursing staff were among the first to qualify as Nursing Associates.

Introduced alongside other roles to bridge the gap between Healthcare Assistants and Registered Nurses, the Nursing Associate role offers a new entry point into a fully-registered nursing career. At the end of the two year course, staff can either continue studying to become fully-qualified registered nurses by taking a shortened nursing degree of two years rather than three, or continue to work as registered Nursing Associates within Devon organisations.

As one of 11 first-wave Nursing Associate pilot sites, funded by Health Education England, Devon is the only Sustainability and Transformation Partnership (STP) site selected.

The four Devon NHS trusts all held individual celebration events, where the newly qualified Nursing Associates were able to reflect on their roles, hear from senior nursing staff about the

difference the role has made in their area and to receive their certificates and organisational badges. Towards the end of the afternoon, Nursing Associates from across the STP joined together via Skype to hear from Samantha Donohue, Senior Nurse Manager of Transformation from Health Education England.

Out of Devon's 69 Trainee Nursing Associates who began their training in January 2017, 62 have completed the programme and are now able to apply to join the Nursing and Midwifery Council (NMC) register. Of the trainees who have completed the course, 20 are continuing in education to become registered nurses and a further 38 will be continuing to work as registered Nursing Associates across the Devon STP footprint.

[RD&E comes third nationally in latest NHS Staff Survey](#)

In February 2019, the RD&E achieved one of the highest scores in the country in the latest NHS Staff Survey.

When staff were asked if they would recommend the organisation as a place to work or receive treatment, 85.8% of staff recommending the RD&E – third in the country compared to similar NHS trusts.

The RD&E also came third on the survey's overall staff engagement indicator, scoring 7.32 out of 10 compared to the national average of 7.0. This was a significant improvement on last year's score and underlined a co-ordinated programme of activities to positively engage staff in change and transform the Trust's culture.

Over 4,200 RD&E staff members responded to the survey – 53% of its staff. This is up 11% over two years and placed the RD&E second place in the country for response rate compared to similar acute and community trusts. The Trust has improved its performance in a number of key areas, including whether the care of service users is seen as the organisation's top priority. There was a decline in other areas though, including the number of staff feeling they were able to manage conflicting demands on their time.

Tracey Cottam, RD&E Director of Transformation and Stakeholder Engagement said, "The survey results demonstrate that the RD&E has an incredibly dedicated and talented team who work hard to put patients and users first. I am pleased that the work we have done over the last few years in recognising the importance of engaged, motivated and empowered staff is really paying off. Over the next year we will continue to do more to listen to staff, connect with them and support innovative approaches to transforming how we design and deliver care to the communities we serve".

OUR STRATEGY

In the previous financial year, the Trust's Board of Directors (Board) reviewed and updated its corporate strategy to ensure that it captured the Trust's strategic ambitions in a fast changing external context.

The increase in demand seen over the last decade is associated with an ageing population and the increase in the number of people experiencing multiple long-term conditions. With affluent people enjoying 19 more years in good health than those who are poorer, carrying on as before is not an option and that is what the Trust's revised strategy sought to address.

The refreshed strategy highlighted the challenges facing the organisation and the wider NHS, but sought to identify the opportunities within the emerging context. In particular, the strategy placed emphasis on the need for a person-centred approach to help people to stay well and supported for longer, so they need the NHS less and later in life. In addition, it identified the need for people to do more to look after their own health and wellbeing and set out that, when people do become unwell, the Trust will work with its Partners to provide help so that they can remain independent in their own home for longer, avoiding hospital services wherever possible.

The strategy set out a radically new direction for the way in which health and care services need to be organised and delivered in Devon with much greater emphasis on striking a balance between a system focused on detecting and treating illnesses, with one that also predicts and prevents poor health. The strategy highlighted that the Trust would take a leading role within the county to make these changes happen. In particular, the Board wanted to underline the organisation's strategic intent: namely, that we want to be at the forefront of change, informed by the best research and evidence based practice, and working with and alongside our Partners to make the big changes that now need to happen.

The Board maintained its existing strategic intent:

"We will be a leader in transforming the health and care system, working in partnership to connect people, services, communities and voluntary groups to meet the needs of the communities we serve. In doing so, we will continue to provide safe, high quality, seamless services delivered with courtesy and respect."

As part of the refresh process, the Board also agreed that our values of fairness, honesty, openness & integrity, respect & dignity, and inclusion & collaboration should remain constant. The strategy positioned the Trust as a values-driven organisation with its values actively guiding what we do and how we do it, the way we work as a team, our recruitment, our decision-making and the way in which we treat each other and our patients. The strategy underlined that our values apply to all of us equally and underpin everything we do as we work together to provide care for our communities.

Our corporate objectives have remained the same:

We will: LISTEN to people and continually improve what we do. We will do this by building on our track record of providing safe, high quality services delivered with courtesy and respect. We will:

- Ensure we maintain high quality services for the people and communities we serve
- Make sure that our services are safe as well as clinically and financially sustainable
- Keep improving at all levels - from using the latest technological advances through to the small but important changes to improve patient experience
- Recognise our responsibility to the community, which includes listening and responding to the views of our Trust Members and Governors and the public.
- Engage with people to co-design and deliver sustainable services
- Listen to our staff and engage them to collectively influence, design, shape and test new ways of working and organising ourselves

We will: CONNECT people, communities and services so that we can work together to improve health and wellbeing for everyone We will do this by focusing on wellness, prevention and ill-health management, seeing patients as people and empowering them to be in control of their own care. We will:

- Work better to identify the current and future needs of our local communities
- Aim to minimise the length of stay in hospital and maximise the potential for rehabilitation
- Shift our focus from “patients” to “people”, and from “What is the matter with you?” to “What matters to you?”
- Increase delivery of outpatient and same-day services closer to where they are needed
- Work with social care and GPs to improve coordination and make services easier to navigate Help connect and support people, services, community initiatives and voluntary groups together within a local system of care

We will: INNOVATE so we can continue to grow our world-class specialisms, working with partners and our patients to push forward the best medical research. We know that patients have better outcomes by being involved in clinical trials. The Trust is already nationally and internationally recognised for excellence in a number of specialist fields such as Diabetes, Orthopaedics and Genomics. Thanks to our long-standing partnership with the University of Exeter and its Medical School (UEMS), we have developed first class training, research and development capabilities. These ensure we are able to embed and offer the latest clinical care, technologies and medicines to transform the lives of our patients and their families. We will meet this objective by:

- Building our research capability in order to enhance our clinical care as well as improve our reputation and our financial position
- Establishing academic departments where there is success in leading externally-funded research and develop staff to take part in research activities
- Increasing the numbers of patients taking part in clinical trials in all departments
- Strengthening our links between the Trust and the University of Exeter
- Using new technologies and practices to transform what we do

The Board is clear that whilst we need to continue to deliver first rate care in our acute and community settings, delivering hospital-based care is insufficient to meet the complex challenges we face.

Delivering our strategy will require both a sea change in our practices, our ways of working and our culture as well as a significant shift in the attitudes and expectations of the public. It will need to take into account that the causes of good and ill physical and mental health are often the result of wider issues concerning environment, housing, economic opportunities, underlining why the Trust cannot meet the challenges alone. Tackling the issues we face will involve working together in collaboration with, in particular, social services, local government, health organisations, GPs, the voluntary sector, as well as our people and communities.

That is why during the year, the Board took stock of its strategy by examining some critical areas that have changed or that were not as clear when the refreshed strategy was developed a year ago. In particular, this involved deepening the understanding of both the Board and the Council of Governors (COG) on the external issues that may impact, impede or provide opportunities for the delivery of the Trust’s strategy. The stock-taking process also allowed both bodies to ensure that the corporate strategy remained relevant and took into account the changes in our external context in advance of the planning cycle.

A joint Board/CoG received presentations on the Sustainability and Transformation Partnership strategy meeting, on the NHS ten year plan and the financial implications, on the key public health issues facing the communities we serve in Devon now and into the future, and on the plans for a Greater Exeter being led by Exeter City Council.

The discussions focused on the very real opportunity to change the health and wellbeing of the population as highlighted in the NHS ten year plan. This signalled a significant move from institution to system, with the STP and emerging Integrated Care Systems (ICS) being key in influencing distribution of new funding and capital investment.

There was an appreciation that the NHS ten year plan was driven by:

- Rising demand - people living longer but with more chronic conditions, rising expectations and new drugs/ technologies.
- Emergency Demand – 3% up nationally in 2018 and by 5% for the RD&E
- Referral growth 8% up for RD&E (cancer)
- Workforce shortages – 41,000 nurse vacancies nationally (12%)
- NHS Waiting List hits 4m – 10 year high
- A & E 95% standard – last achieved July 2015

At the same time as this growing demand, it was further recognised that the financial situation facing the NHS was still challenging despite recent announcements of new funding:

- Provider Sector £0.9bn overall deficit in 17/18 and, at the time of writing, this was predicted to deteriorate
- 90% of Trusts in deficit are Acute Trusts
- Underlying deficit reported at £1.85bn – an average deficit of £14m per Acute Trust. Some trusts are technically insolvent
- Nevertheless, the new funding formulae means that average real terms funding increases of 3.4% over next 5 years – front loaded 3.6% in years 1 and 2. The resources coming into the NHS are, however, lower than requested. NHS funding has grown on average by 3.7% since 1948

Other key drivers underpinning the 10 year plan, and that impact on the Trust's corporate strategy included the following:

- A need for a change in some long standing performance measures with the idea that clinicians should be more involved in determining what was most meaningful in the future
- Significant workforce pressures
- Technology – innovation and predictive modelling
- A recognition that the NHS works best when considered as local or regional systems rather than individual and autonomous units working separately or in competition.
- Integrated Care Systems with providers and commissioners aligned over population health
- Social care investment still unclear and Department of Health and Social Care, and in public health have been reduced in real terms

- Uncertainties over drug prices post Brexit
- Changes to staffing costs as a result of the uplift in pay
- There is a legacy to pay from years of austerity including underlying hospital deficits, longer waiting lists and estate backlog maintenance

At the same time, the Board and the CoG looked in more detail at some of the key challenges and priorities in Devon from a public health perspective. The key challenges included:

- Devon population projected to rise 13% by 2039
- Older population (65+) projected to rise 45% by 2039
- 1 in 3 people live with one or more long-term conditions
- 15 years' difference in life expectancy between some areas
- Highly skilled workforce with low earnings
- Mental health impact

These challenges mean:

- Increase in demand in secondary care
- Older people generally require more care and specialist care
- Nursing home sector could struggle to meet increasing demand and complexity
- Health and social care services will need to support the needs of those with multiple morbidities
- Preventable secondary care usage
- Difficulties in recruiting and retaining staff make it hard to provide comprehensive and high-quality services
- Increased burden of ill health and increased cost and demand

Discussions focused on the extent to which demand on acute services could be curtailed through improved interventions on lifestyle choices and other determinants of health. Devon's joint Health and Wellbeing Strategy (JHWS) sets health and wellbeing priorities for local organisations to tackle health issues "upstream" and sets out key priorities:

- Empowerment
- Focus on the individual, supported by families and friends within their local community
- All resources and assets in places must be used to support the wider determinants of health to improve population health and wellbeing
- Prevention and early intervention

How does Devon compare to the rest of England?

Better	Worse
<p>Starting Well</p> <ul style="list-style-type: none"> ▪ Early years foundation score ▪ Teenage conception <p>Living Well</p> <ul style="list-style-type: none"> ▪ Adult smoking prevalence ▪ Proportion of physically active adults ▪ Mortality rate from preventable causes ▪ Male and Female life expectancy gap <p>Ageing Well</p> <ul style="list-style-type: none"> ▪ Healthy life expectancy ▪ Deaths in usual place of residence ▪ Feel supported to manage condition ▪ Reablement service effectiveness <p>Strong and Supportive Communities</p> <ul style="list-style-type: none"> ▪ Reoffending rate <p>Lifelong Mental Health</p> <ul style="list-style-type: none"> ▪ Self-reported wellbeing ▪ Appropriate accommodation (MH) 	<p>Starting Well</p> <ul style="list-style-type: none"> ▪ Alcohol-specific admissions in under 18s <p>Ageing Well</p> <ul style="list-style-type: none"> ▪ Reablement service coverage <p>Strong and Supportive Communities</p> <ul style="list-style-type: none"> ▪ Fuel poverty ▪ Dwellings with category one hazards ▪ Rough sleeping <p>Lifelong Mental Health</p> <ul style="list-style-type: none"> ▪ Gap in employment rate (MH) ▪ Self-harm admissions ▪ Dementia diagnosis rate ▪ Social connectedness (social care clients) ▪ Mental health of looked after children

The Board and the CoG also looked in detail at the plans that Exeter City Council has developed for the Exeter city region and the implications for health demand:

- Exeter has seen a 29.1% increase in its workday population, and exerts a powerful employment pull and the largest proportionate increase in workday population after London, Crawley and Cambridge. Exeter was drawing in 37,000 commuters, equivalent to c.45% of its total employment, from across the county.
- Existing local plans suggest significant housing growth – 2,500 a year with a new town, urban extensions and other smaller sites.
- The Exeter region vision is for Exeter to be a leading knowledge economy and entrepreneurial city in the UK, raising productivity, attracting significant investment and raising income levels for the benefit of its residents and businesses.
- Exeter's plans to support the population's physical health in partnership with Sports England
- For Exeter to be the global leader for addressing the challenges of climate change and urbanisation, and the world-leading location for applied environmental science, health and data analytics.

In considering the changes in the external context, the Directors and Governors identified the key themes that were or were likely to impact on the delivery of the Trust's strategy. They were asked to consider the relevant threats and opportunities impacting on the Trust currently and over the next few years that could influence the achievement of the objectives and outcomes sought in the current corporate strategy.

Having considered the changes in the external context, there was general agreement that the current Corporate Strategy remained fit for purpose and the vision, corporate objectives, golden thread and values remain relevant and should continue to guide the Trust over coming years. No fundamental changes to the core approach outlined in the strategy document were therefore required.

SUSTAINABILITY AND TRANSFORMATION PARTNERSHIP

Three local authorities, seven NHS organisations and one Community Interest Company joined forces in October 2016 to create a single Devon Sustainability and Transformation Partnership (STP). Since the summer of 2018, Dame Suzi Leather has been the Devon STP independent chair.

The STP mission is to achieve the triple aim of improving:

1. Our population's health and wellbeing
 2. The experience of care
- The cost effectiveness of spending per head of population

In July 2018 it published a Two Year Report highlighting the significant progress that has been achieved through joint working.

It noted in particular:

- Improved performance against national NHS standards, putting Devon in the top 30% nationally on urgent care and mental health
- Reduced delays in transferring patients out of hospital, meaning Devon was on track to reach targets and to free 79 hospital beds for those needing them
- High quality social care, with 86% of adult social care providers rated as either Outstanding or Good by the Care Quality Commission
- Enhanced community services to support thousands more people to live independently at home, leading to 213 fewer acute and community hospital beds
- Clinically appropriate referrals into hospitals, reducing unnecessary visits and seeing a 5.37% reduction in planned procedures and treatments
- New clinical networks supporting "Best Care for Devon" standards in:
 - o Urgent and emergency care
 - o Stroke
 - o Maternity services
- Innovative mental health services including:
 - o Liaison psychiatry in each acute hospital
 - o Psychological support for people with long-term health conditions

- o Specialist support for women with postnatal depression

- More than 100 ambassadors trained to promote careers in health and social care in schools.
- Strengthening outcomes for children and young people, with children's community health services rated "Good" by the Care Quality Commission

In addition, historical overspending has been reduced from £95.4 million to £22.7 million in the past two years. This includes saving £25 million on agency staff. The Devon system is aiming to improve the financial position and although still in a deficit position, it is essential that organisations continue to work together to ensure financial balance in the future. During 2018/19, savings of £100m have been achieved in year, which has enabled the system deficit to be reduced to £43m.

However, real challenges remain. These include health inequalities, social isolation, disadvantage for people with mental health problems, an ageing population and meeting the needs of carers.

Recruitment of staff remains challenging, in primary care, in some medical specialties and in nursing and social care. Initiatives such as Proud to Care are showing the value of collaboration in this area. A campaign is under way with NHS England to promote the South West to prospective GPs, including those who have recently retired and those currently working abroad. Other initiatives will aim to make general practice more attractive to new doctors, in line with the Long Term Plan. NHS England workforce trajectories indicate a gap of 62 GPs in Devon by 2020. As at June 2017, 22% of GPs were aged over 55. This indicates the need for the action we are taking. A new academy of nursing was launched by four NHS Trusts in Devon and the University of Exeter so that local nurses are at the forefront of regional, national and international advances in care.

Services for children and young people with special educational needs and disabilities in the Devon County Council area also need improving. The CCGs and local authority have been working together to implement reforms, which will be co-designed with children, young people and their families.

The STP has proposed taking a more focused approach on fewer priorities for 2019/20, to deliver high impact transformational changes and make best use of system resources.

Over the next year, the STP focus will be on five areas:

- Accelerating the **digital opportunities** for the system to achieve integrated and interoperable care record systems, and improved access to care
- Developing an **acute care strategy** for Devon and Cornwall
- **Addressing inequalities** by moving resources to where they will be more effective in meeting need and improving outcomes
- **Integrating mental health services, alongside development of inpatient services**
- Promoting **prevention and self-care**, helping more people live healthy, well lives at home, with greater resilience in communities achieved through close working with charity and voluntary leaders.

These five priorities are accompanied by two other pieces of work that need to be accomplished:

- Implementation of the Integrated Care Model blueprint agreed in 2017
- Implementation of a system wide Workforce Strategy

We will continue to review our key hospital services across Devon, so that they deliver the same high standards of care. With the support of NHS Improvement, Northern Devon Healthcare NHS Trust and the Royal Devon and Exeter NHS Foundation Trust began work in April on securing the long-term sustainability of acute services for the people of North Devon. The collaboration is supporting Northern Devon to address the challenges it faces in continuing to provide acute services, ensuring that local people's health needs continue to be met.

The STP-led acute services review confirmed that our four acute hospitals in Exeter, Barnstaple, Plymouth and Torquay are key in the provision of NHS services. Clinical services are now approached in a more collaborative way. This includes a ground-breaking agreement on mutual clinical support among the four hospitals, which has proved invaluable in addressing short-term service challenges due to medical staffing problems.

New service providers for children's services

From 1 April 2019, following a procurement process, children's health and wellbeing services will be provided by NHS providers, working together and they will be provided by Devon Children and Families Alliance. This is led by Torbay and South Devon NHS Foundation Trust in partnership with Devon Partnership NHS Trust, Royal Devon and Exeter NHS Foundation Trust, University Hospitals Plymouth NHS Trust, Northern Devon Healthcare NHS Trust and Livewell Southwest. These services will transition from Virgin Care and all sides have been working to ensure a seamless transfer.

In Plymouth, children's health, wellbeing and special educational needs and disability services will be run by Livewell Southwest (the existing provider), in partnership with University Hospitals Plymouth NHS Trust, Plymouth City Council and a range of third sector organisations.

Also in Plymouth, Livewell Southwest is creating a new service - the Children, Young People and Families Service – bringing together for the first time all Child and Adolescent Mental Health Services, health visiting, school nursing, family nurse partnership and children's speech and language therapy.

Children, young people and families will be involved in the transformation of services across Devon in the months and years ahead. Partnerships with third sector organisations will create more seamless pathways, including for children with autism and neuro-disability, and every element will be focused on prevention and health promotion.

Visit by Secretary of State

The Secretary of State for Health, Matt Hancock, visited Devon STP in September. After working a night shift at Derriford Hospital in Plymouth, he toured Budleigh Health Hub and Ottery St Mary Hospital.

STP representatives explained how investment in digital technology is supporting new ways of providing care and outlined how community conversations were enabling local people to be involved in the development of new models of care.

The Budleigh Health Hub serves as an example of a community-led health project, being developed by Westbank Community Health, the League of Friends of Budleigh Salterton Hospital, Northern, Eastern

and Western CCG, the Royal Devon and Exeter NHS Foundation Trust, NHS Property Services and local GPs.

The Budleigh hub provides health, wellbeing, social care and voluntary sector services in one place, enabling collaboration and integration among them.

Maternity services

Hospitals in Torbay, Newton Abbot, Barnstaple, Exeter and Plymouth were highly rated in the Maternity Services Survey commissioned by the Care Quality Commission.

Their performance was rated by hundreds of women who had given birth in February 2018 either at home or in hospital and scored better than other Trusts in several areas, and similarly to other organisations in the remainder.

All the hospitals scored very highly for the care women received during labour and birth, and staff were rated very strongly across the board. Care in hospital following the birth was rated in line with other hospitals.

The survey included questions on the kindness shown, involvement in decision-making, the information received and consideration for emotional and post-natal health.

Digital strategy

The STP Digital Strategy underpins the system-wide endeavour to integrate care in Devon. It recognises that technology is vital in empowering patients to participate in their health and care.

During the year, STP colleagues agreed a Digital Blueprint for Devon, which envisages a fully integrated and interoperable clinical digital system, extending access to vital information across primary, secondary, community and social care and in to hospices and care homes.

With planned funding under the national Health System Led Investment in Provider Digitisation amounting to £8.8million over three years, Devon is pursuing this goal. Work is under way on a single electronic patient record (EPR) system for Devon hospices, system wide access to primary care information, and system-wide integration of the EPRs in Devon, as well as paperless working across the Torbay health and care community.

Winter

All parts of the system made detailed plans for responding to the increased demand on services that the NHS experiences every winter.

The 2017/18 winter had been particularly difficult, with demand significantly exceeding local and national predictions. Service capacity was challenged across health and care services. Gastric illness and influenza had a real impact.

This winter saw pressure once again on Devon's services, particularly in Torbay. The system-wide winter plan focussed on maintaining the flow of patients through our hospitals. This requires all Partners across health, social care and the voluntary sector working together to ensure that patients can be safely discharged from hospital at the appropriate time.

The four main hospitals were allocated national funding as follows:

- **Derriford Hospital, Plymouth:** £2.5million to press ahead with upgrading parts of the Emergency Department, in advance of a major rebuild.
- **Royal Devon and Exeter Hospital, Exeter:** £700,000 to improve the 'flow' of patients through the hospital and reduce demand on the Emergency Department
- **Torbay Hospital, Torquay:** £340,000 for key improvements to urgent and emergency care
- **North Devon District Hospital, Barnstaple:** £175,000 to provide increased bed capacity

To support this, an integrated communications approach included a drive to increase the uptake of flu vaccination in 2-3 year olds. The *#ThumbsUpForCoby* campaign worked closely with a Devon family who lost their 9-year-old son Coby to flu.

The campaign reached more than a million people across the country and was picked up by other NHS organisations and local authorities. Before Christmas, the campaign focussed on promoting the national Improving Access to GPs service and reminding patients that additional appointments were available over the holiday period.

Early indications from flu vaccination uptake data suggest there was an increase in flu vaccination for 2-3 year olds this winter and that the two Devon CCGs have some of the highest performance in the country.

Integrated Care System/Devon Long Term Plan

The creation of one CCG for Devon is an important step in the journey to create a single strategic Commissioner for the county, as Partners in the Sustainability and Transformation Partnership design a new, more integrated care system.

Work has been progressing on how this Integrated Care System (ICS) for Devon should operate and improve outcomes for our population.

Over the coming months we will:

- Develop a Devon five-year plan in response to the national NHS Long Term Plan, showing how we will work together across the NHS, local authorities and other partners to improve outcomes for our population. System leaders have agreed that a key priority in Devon will be to address inequalities by ensuring resources are used in line with strategic ambitions, population needs and outcomes
- Design the most effective ways of working together both in local communities and places as well as across the wider Devon system, with the right system governance that allows for transparent and responsive decision making
- Engage with stakeholders and local communities in developing the plan and system working
- Publish the Devon Strategy in the Autumn, 2019

MAKING PROGRESS TOWARDS A NEW MODEL OF CARE

Over five years ago we started out on a journey at the RD&E. In common with the rest of the NHS and our partners in the region, we could see that the pace of development in healthcare was failing to keep up with demand or with what was best for people. So we challenged ourselves to think differently – without losing our focus on the things that matter most to the people in our care or the great things that we currently do.

Everyone is familiar with the principles that came out of that. Our new service model takes us from a narrow focus on ill-health and hospital-based care to basing services on a collaboration with individuals, families and communities. We talk about people as partners in their care and we often sum up the thinking as a shift from asking “What’s the matter with you?” to “What matters to you?”

The strategy that follows from that thinking was set out in the comprehensive Five Year Plan which we published in the summer of 2018. Now the task is to spell out the practical implications.

What does our thinking mean for real people with different care needs? How are we putting our principles to work?

Here is how things are changing

Our new approach places greater emphasis on:

- Preventing ill health, keeping people well for longer and focusing on independence and wellbeing - always making sure we draw on the best evidence-based practice and research
- Supporting people to manage their own care needs in the community and at home and providing more individualised support
- Working with communities and volunteers to support people where they live – what we call “place based care”
- Harnessing technology, including a new care record system, that empowers people by giving them access to their own information
- Understanding the needs and goals people have and working with them to support them appropriately

- Helping to prevent people from becoming acutely unwell by focusing on their health and wellbeing, including their mental health
- Working with partner organisations - either voluntary or statutory – to address the wider determinants of ill-health.

What does this mean in practice for people who need care?

Most people will continue to access health care as they do now – seeing a GP or other primary care professional as appropriate. When they become unwell, they will see their GP, get advice from a pharmacy or use the 111 service.

For people who are frail or have numerous health conditions, we are working differently with GPs and other stakeholders. The idea is to develop an individualised care plan that begins by defining the person’s needs and goals and involves care professionals who – depending on the person’s requirements - could be based in the community, in hospital or in social care. This group of professionals will then work regularly together with the individual to assess needs and administer care as appropriate, primarily at home. As we move to an electronic patient record, the care plan will be held on secure devices that will be available to the individual and to the people dealing with their care. This means that anyone requiring care will be better supported at home in a more joined up and individualised way.

Above all, the idea is to avoid hospital admissions whenever possible because we know that in most cases bed-based care is the least beneficial option. Where appropriate the person will be supported in other ways through community groups, voluntary sector organisations or volunteers. If they require ways to keep them mentally and physically healthy, then the GP might offer social prescribing to tackle issues such as loneliness or to encourage people to exercise.

The approach also means fewer trips to hospitals. Cancer and dementia specialists will hold clinics in local surgeries. There will be one point of call for family doctors, community nurses, social and mental health services. Access to blood tests, dialysis or even chemotherapy will all be available closer to home. Of course, whenever it’s necessary, GPs will be able to access specialist advice from hospital-based

consultants and in some instances the individual may need to attend a clinic in the hospital for further assessment.

What happens when someone's health deteriorates or they need access to a specialist in an outpatients' clinic?

When there is deterioration in a person's health, there are three different routes they could follow depending on the relative immediacy of the issue they are managing:

Elective: If, after a consultation with a GP or other primary care professional, there is a shared view with the individual that follow up is required, a GP will seek further advice and guidance from hospital-based consultants on what needs to happen next. When that involves referring the individual for further tests or to be seen by a hospital consultant, they will be referred through outpatients and, on the basis of the diagnostic test and consultation, a decision will be made to continue to further treatment. The preferred course of action at this point, provided they can access support, is to manage their condition at home. For those that require elective care, the future model will involve bringing people into an admissions lounge. Following their procedure or operation, the aim, where possible, will be to get them home without a stay in a hospital bed. Alternatively they might be moved into a ward where the emphasis will be on reablement and, again, getting them home as soon as it is safe to do so.

Urgent conditions: When a person's health deteriorates to the extent that they require urgent (though not emergency) treatment, they will either be triaged through the 111 service or through primary care. If they then require further assistance, they will usually be seen in an urgent care centre or at home where they are able to access short term support from our urgent community response team. Alternatively, their GP (or other primary care professional) together with hospital consultants may decide to admit them to an urgent care centre or to an ambulatory unit in the main hospital where their health status can be assessed and treated. Depending on their condition, some people may be seen by newly established "hot clinics" set up to treat urgent cases in a number of specialities. If their condition can be managed effectively, they may be able to return home at this stage. If they require further tests or treatments, they may need to be admitted onto a ward.

Emergencies: If a person needs immediate or emergency treatment, they are likely to require ambulance transport direct into the Emergency Department. The person will be triaged and assessed early by a consultant and, depending on their condition, may require resus or major intervention.

What's changing for people in hospital?

For people who require hospital-based care, we will ensure that we continue to provide a first class service providing compassionate and safe care in collaboration with patients. As always, we will seek to offer the latest treatments and innovations based on world class research.

What's changing is our effort to ensure that people requiring hospital-based care only remain in a bed that is not their own for as long as it is beneficial to them. This means developing new ways of working together across teams and services, enhanced by technology, to ensure that care is streamlined, timely, and avoids delay and duplication.

In particular we are putting in place new ways of working designed to treat people on the day or to redirect them to other places to receive their treatment. Within the hospital, it is now well understood that long periods of recovery in a hospital bed can result in harm to the patients, so when it is clinically safe, the emphasis will be on helping people to recover quickly. We are encouraging people to remain active, to get up and dress normally and to take the initiative in getting home as and when they are ready. Patients who have had a stroke or who have urology or gynaecological diagnoses or who need assistance at home to recover will be helped appropriately across East Devon.

Helping someone get back home relies on a system-wide approach. Once again the care model requires stakeholders in health, social care and the third sector to work together with the individual as the starting point for social prescribing, coordination of home based care with the GP and planning for future needs. The approach also requires a change our culture and approach in the hospital. For the majority of people in our care, we are striving to move away from the traditional model of caring for them in a way that increases their dependency. Our emphasis will be on enabling them to do what they can to live full and independent lives.

The key to unlocking these changes is the clinical transformation enabled by an electronic patient

record system introduced through MY CARE and based on the work clinicians have done together to streamline our processes. The system will provide clinicians with the right information at the right time, allowing them to make speedier and more accurate diagnoses and treatment plans. Enabling the care model with technology will also put even more control in the hands of the people in our care, encouraging and supporting self-management and patient activation.

So what specific initiatives have we taken or are in train to make the new service model happen?

- Listening to people's views – drawing on initiatives such as the CCG's Devon "I" statements where people emphasised issues such as "no place like my own bed" and the need for a seamless, joined up NHS.
- Conducting community conversations - working in collaboration with providers, commissioners, GPs, third sector organisations and communities themselves to talk among communities and help them create the right conditions to take the leading role in their own wellbeing.
- Changing outpatients – reducing the need for people to come in to Exeter with separate conditions on different days, eliminating unnecessary follow-up visits and finding alternative ways for people to access assessment or ongoing treatment.
- Enhancing services in the community – such as enabling hospital-based elderly care consultants to work with GPs to support elderly people with multiple conditions and an improved advice and guidance service for local GPs to make it easier to work together to assess the needs of individual patients.
- A single point of access - providing a single dedicated telephone number or online form for health and social care professionals to enable a clinical conversation at the point of referral about the most appropriate interim plan for an individual. Urgent Community Response Community health and social care teams receive the referrals and take appropriate action within 2 hours.
- Investing in the MY CARE programme - using technology to enable transformations in the way we work, focused on the implementation of a comprehensive patient record system.
- Making the most of community hospitals – including offering people intermediate care and rehabilitation and providing more specialist or acute care closer to patients' homes
- Encouraging people in hospital to recover well – including dedicated rehabilitation wards and education campaigns to encourage people to get up and about and prepare for going home.
- Rapid triage for patients coming into the emergency department
- Establishment of an urgent day-case unit – so that people can access ambulatory care without the need for a stay in hospital overnight.
- Changing medical practices and culture – by raising the importance of recognising and reporting on practice through our governance programmes, by introducing more challenge and practice coaching and by new training initiatives such as the Learning from Excellence programme.
- More joined up working on domiciliary care with our partners.

So what happens next?

The RD&E is a high performing Trust. But even if we get better at what we do, it won't be enough to tackle the issues that we and the wider NHS system are facing. That's why we have set out on a journey to reimagine and reshape health and care services in Devon. The extent of this transformation needs to be more radical and far reaching than at any moment since the NHS started in 1948. Some of the approaches described in this short paper are already under way: many are just beginning to make themselves felt. We will only succeed in continuing to provide excellent care to the communities we serve if we keep up the momentum. That means working comprehensively with our Partners to change the rules across the whole health and care system and, for the first time, enlisting individuals – the people we care for - as Partners in promoting and managing their own health.

KEY ISSUES AND RISKS

The Trust's key strategic risks are captured in its comprehensive Board Assurance Framework (BAF) which is regularly updated and reviewed by the Board as part of its deliberations. The BAF identifies key risks to the Trust's three strategic objectives and what the organisation is doing to manage or mitigate the risks.

Operational

Whilst the demand and capacity planning process is undertaken with the intention of delivering on all key national standards, there remain significant risks to the delivery originating from other areas. These include but are not limited to:

- Changes to service provision at local acute trusts which could result in increased demand on clinical services
- Unanticipated increases in General Practitioner or other referrals, particularly in Cancer specialties requiring urgent 2-week outpatient appointments and subsequent diagnostics
- Changes in the urgent care landscape, such as the provision of 111 services, Minor Injury Units (MIU), Walk-in Centres (WIC), access to primary care and support for patients with urgent mental health issues
- Severe adverse weather affecting capacity
- Major infection control outbreaks, such as the high levels of flu experienced in 2014/15 and 2017/18
- Unplanned workforce availability such as the junior doctors' industrial action during 2014/15 and 2015/16

In the event of events such as those listed above, further discussions with commissioners, providers and regulators will take place to minimise the risk to performance.

Quality

Continued financial constraints and the delivery of CIP have the potential risk of impacting on the quality of services. The risk mitigation centres on the robust quality assurance framework which is in place, incorporating a balance of hard, empiric data and soft intelligence which alerts relevant levels of clinicians and managers throughout the Trust to any deterioration in quality.

Finance

The Trust's 2019/20 plan has been established in the context of the wider plan established for the whole Devon population, driven by the Devon Sustainability and Transformation Plan (STP). The STP for Devon seeks to respond to some of the key challenges facing the county, primarily the ability to continue to deliver financially and clinically sustainable services in the face of increasing demand from a growing and ageing population. The Devon STP aims to address the financial challenge whilst improving health outcomes for people in an equitable way through shifting our model of care to provide more effective joined up services in, or closer to, people's homes and thereby reducing reliance on bed-based care.

The inability to access government borrowing and the competing STP priorities for Public Dividend Capital when making strategic capital investments in critical acute services such as Accident & Emergency, cancer and vascular surgery is a key risk. This therefore puts more emphasis on achievement of Provider Sustainability Funding (PSF) and property disposals in order to fund future developments.

During 2018/19 the Trust achieved cost improvement savings of £20.5m (against a target of £23.3m). Although the requirement for 2019/20 is set at a similar level to 2018/19 (£21.2m), around £5m of savings have yet to be identified, and therefore this represents a risk to achievement of the Trusts £7.4m planned surplus for 2019/20. Once savings schemes have been identified, a Quality Impact Assessment is carried out to determine whether it is appropriate to proceed with the scheme, to ensure patient safety is maintained.

Included in the planned £7.4m surplus for 2019/20 is £6.4m of PSF from NHSI which is dependent on achieving the financial control total on a quarterly basis. Failure to achieve these targets will result in the loss of up to £6.4m of funding.

The Trust is planning on a fixed financial contract with Devon CCG with assumed levels of patient referrals and activity growth. If the level of patient growth is higher than those planned levels, this could give rise to both operational and financial pressures.

Going Concern statement

After making enquiries, the directors have a reasonable expectation that the NHS foundation trust has adequate resources to continue in operational existence for the foreseeable future.

For this reason, they continue to adopt the going concern basis in preparing the accounts.

For further details, please see Note 1 to the Accounts.

PERFORMANCE ANALYSIS

Performance Management and Assurance

The Trust Performance Assurance Framework (PAF) enables assurance to be provided that performance, including safety and quality indicators, is effectively monitored and reported, thereby supporting managers and clinicians to deliver the required targets. Monthly PAF meetings, chaired by the Deputy Chief Operating Officer, with support from the Deputy Chief Nurse, Director of Operational Finance, and Deputy Director of Workforce & Organisational Development, take place with each of the four Clinical Divisions. At the meetings, divisional and specialty level dashboards are reviewed, covering a detailed set of indicators across safety and quality, performance, operational efficiency, workforce, finance and a wide array of supplementary information. The reports prepared for the meeting also support the Clinical Divisions to undertake their own assessments of performance, as well as providing an outline of actions to address any key issues. This is tested and challenged in the meetings.

At the heart of the Trust's PAF is the alignment of monitoring and performance from service line and ward level through to Board. The monthly Integrated Performance Report (IPR) to Board includes a wide range of national and local performance indicators grouped under the following themes:

- Quality & Safety
- Activity & Flow
- Operational Performance
- Patient Experience
- Our People
- Finance

These are accompanied by narrative detailing the contributory issues, the actions planned to restore performance, the timeframes in which the actions are to be undertaken, and identification of any key risks. The integration of these indicators within a single report provides an opportunity for triangulation of indicators and themes that is made explicit within the accompanying narrative and overview to the report.

A selection of key indicators from the Trust's "Ward to Board" dashboard are included within the Quality & Safety section of the Integrated Performance Report each month. This dashboard, which has also been refreshed in 2018/19, incorporates indicators relating to process and outcome measures which underpin the delivery of safe, high quality care, including pressure ulceration, falls, patient nutrition, complaints, venous thromboembolism and staffing levels. A detailed analysis of performance against each of these metrics at divisional level alongside indicators specific to the provision of Community Services, is provided to the Board on a quarterly basis, with narrative provided where necessary at ward level in the event of any outliers. This approach thereby provides triangulation at a more granular level, minimising the risk that Trustwide performance could mask individual areas of concern.

The Trust continues to use the Connecting Care methodology to support the delivery of good performance. Connecting Care enables teams to work together in a more joined-up approach, supporting staff to find new and better ways of working, from making small changes that make a difference to much larger scale improvements. Connecting Care also provides a systematic way of working together using a set of continuous improvement tools and techniques that has been rolled out across the Trust over the last 3 years and is now used in all divisions.

NHS Improvement Single Oversight Framework

A performance framework has been established by NHS Improvement to help ensure that Trusts meet NHS Constitutional Standards, with a particular focus on each of

- the 4-hour Emergency Department Waiting Time Standard,
- the 62-day Waiting Time Standard for patients referred by a GP or a cancer screening service with suspected cancer,
- the 18-week Referral to Treatment Waiting Time Standard, and
- the 6 –week Diagnostic Waiting Time Standard

The Single Oversight Framework is closely aligned to the Care Quality Commission's (CQC) standards, and replaces Monitor's Risk Assessment Framework and the Trust Development Authority (TDA) Accountability Framework. It applies to both NHS Trusts and NHS Foundation trusts irrespective of their legal form, and in 2018/19 was extended to cover NHS-controlled providers. The Single Oversight Framework is based on the principle of earned autonomy.

The Framework is designed to help NHS providers attain, and maintain, Care Quality Commission ratings of 'Good' or 'Outstanding' and NHSI segment providers based on the level of support each provider needs across the five themes of quality of care, finance and use of resources, operational performance, strategic change and leadership and improvement capability.

Each trust is segmented into one of the following four categories:

Segment 1 Providers with maximum autonomy: no potential support needs identified. Lowest level of oversight; segmentation decisions taken quarterly in the absence of any significant deterioration in performance.

Segment 2 Providers offered targeted support: there are concerns in relation to one or more of the themes. We've identified targeted support that the provider can access to address these concerns, but which they are not obliged to take up. For some providers in segment 2, more evidence may need to be gathered to identify appropriate support.

Segment 3 Providers receiving mandated support for significant concerns: there is actual or suspected breach of licence, and a Regional Support Group has agreed to seek formal undertakings from the provider or the Provider Regulation Committee has agreed to impose regulatory requirements.

Segment 4 Providers in special measures: there is actual or suspected breach of licence with very serious and/or complex issues. The Provider Regulation Committee has agreed it meets the criteria to go into special measures.

The current assessment for the RD&E is segment 2 (Providers offered targeted support).

The Single Oversight Framework in 2018/19 retains an emphasis on the importance of leadership and improvement capability within NHS organisations, and an expectation that providers will engage constructively with local partners to build shared understanding of local challenges and patient needs, and to design solutions that will drive improvements in the care of the local population.

As outlined above, in 2018/19 the Framework retained its focus on core performance metrics relating to access to services. Performance improvement trajectories were agreed between providers, commissioners and regulators for 2018/19. Delivery of each of the performance improvement trajectories has been monitored closely throughout the course of the year, with delivery of the Emergency Department Waiting Time Standard securing a significant proportion of the Trust's Provider Sustainability Funding in the year.

Financial measures also play a key part in the Single Oversight Framework, and focus on sustainability, efficiency and control. The RD&E's Use of Resources rating as at quarter 4 2018/19 is a 1 out of a possible 4, 1 being the best rating that can be achieved. See detailed assessment on next page:

Area	Metric	2018/19 scores				2017/18 scores			
		Q4	Q3	Q2	Q1	Q4	Q3	Q2	Q1
Financial sustainability	Capital service capacity	1	1	2	2	1	2	2	1
	Liquidity	1	1	1	1	1	1	1	1
Financial efficiency	I&E margin	1	2	3	3	1	3	2	2
Financial controls	Distance from financial plan	1	1	1	1	1	1	1	1
	Agency spend	3	3	3	2	1	1	1	1
Overall scoring		1	2	2	2	1	2	1	1

Overview of Performance in 2018/19

Although the Trust performance continues to compare favourably with other Trusts in the region, 2018/19 has remained challenging with regards to achieving performance targets, as demand has remained high, and in some areas continued to grow more quickly than the availability of resources.

Indicator	Measure	Standard target /	2017/18	2018/19
Infection Control	Meet the C.Diff objective	30 (2018/19) 31 (2017/18)	22 (20 of which were agreed with the CCG as being unavoidable)	15 (13 of which were agreed to be unavoidable)
Infection Control	Meet the MRSA objective	0 (2017/18) 0 (2016/17)	2	2
18-week RTT	% admission – incomplete pathways	92%	88.0%	81.8% (March 19)
18-week RTT	Total number of open pathways	30,251	30,251	34,278
Cancer Access	Urgent GP referrals seen within 2 weeks – all cases	93%	93.7%	83.2%
Cancer Access	Breast cancer symptomatic referrals seen within 2 weeks	93%	96.3%	95.0%
Cancer Access	Cancer treatment started within one month of diagnosis	96%	98.0%	94.6%
Cancer Access	Cancer treatments started within 2 months of urgent GP referral	85%	81.5%	73.5%
Waiting Times	A&E max waiting times of 4 hours (Trust)	95%	90.9%	91.7%
Waiting Times	A&E max waiting times of 4 hours (Eastern Devon)	95%	92.8%	93.11%
DTOC	Delayed Transfers of Care	N/A	50.8	39.1

Infection Control: Clostridium difficile

The number of cases of Clostridium difficile for 2017-18 was 15 hospital onset cases (i.e. cases identified on or after day 4 of admission where the day of admission is day 1) against an objective of no more than 30 cases. All 15 cases were investigated and thirteen cases were deemed unavoidable i.e. no contributory lapses in care were identified. In two cases inappropriate antimicrobial prescribing was identified as the key issue that may have contributed to acquisition of infection. These two cases were associated with different specialties and different prescribers both of whom have received feedback to reduce risk of similar lapses in future.

Infection control: MRSA

Both cases identified were associated with admissions to the same specialty ward. Post infection reviews were undertaken for both cases and no contributory lapses in care were identified. However, this was the same ward where an MRSA blood stream infection was identified in 2017/18 thus making three cases associated with one specialty ward over an 18 month period. None of the patients had any contact with each other or were indeed hospital patients at the same time and the antibiotic sensitivity patterns were not the same, therefore it was not immediately apparent that this was actually an outbreak with a common source. However, a thorough outbreak investigation was undertaken, which included screening every member of staff, and it was found that the outbreak was associated with a staff carrier. This has been addressed and there have not been any subsequent cases.

ED Maximum Waiting Time of Four Hours from Arrival to Admission, Transfer or Discharge (excluding Walk in Centre activity), and Ambulance Handover Delays

In line with providers nationally, the Trust remained challenged throughout the year to deliver the ED maximum waiting time of 4 hours target. This was due to a number of factors including:

- Increased ED attendances
- Bed capacity pressures caused by increased levels of emergency medical admissions and delays in discharging patients due to shortfalls in domiciliary care

- Continued pressure from high levels of patients attending ED with mental health needs requiring inpatient psychiatric beds

The Trust invested significantly in ED staffing resource in 2017/18, with the addition of two consultants and a further six nursing staff. Other improvements included the provision of a senior nurse to cover all night shifts and the introduction of a senior physiotherapy role into the ED to help triage and treat patients. This has supported the department to manage increased demand during 2018/19.

A performance trajectory was agreed with commissioners and regulators, to support delivery of the national performance standard of 95% and achieve an improved performance in March 2019 compared to March 2018 within the Eastern Devon urgent care system. Comprehensive plans were developed and implemented, which were integrated with the Eastern Devon A&E Delivery Board and the Devon STP plans in order to optimise performance against this target. Although the national target of 95% was not achieved, the Eastern Devon system exceeded the planned performance trajectory throughout 2018/19, which secured 100% of the £3.7m of income associated with performance against the 4-hour target.

62 –Day Wait for First Treatment (All Cancers)

Performance against the key performance indicators relating to cancer patients has been challenging in 2018/19 due to two significant issues. Within the Endoscopy Unit, challenges with nursing and medical staff availability due to unplanned absence led to reduced capacity throughout much of the year. The team responded well to the challenges and provided many extra weekend sessions to reduce the shortfall. The team were also successful in appointing 3 gastroenterologists, who commenced towards the end of the year, restoring the department to full workforce establishment. Consequently endoscopy waiting times are improving and expected to make a full recovery in 2019/20.

The second issue has been high levels of demand for cancer services, with referral increases of as much as 30% in some key services such as Urology, which has put pressure on the delivery of the national standards. Plans are in place across all areas to improve performance as the Trust moves into 2019/20.

Average Number of Patients reportable as a Delayed Transfer of Care (DTOC)

DTOCs are a significant pressure on NHS acute services and reducing their levels has been a significant focus of the Trust throughout 18/19. Good progress has been made for much of the year, with a particular focus on increasing the market provision for domiciliary care, as well as enhancing our community services. There was good progress in tackling this towards the end of the year however, with levels of DTOC being among the lowest levels for several years, and a marked improvement from 2017/18.

18 weeks Referral to Treatment (RTT) Incomplete Pathways

In common with all local Trusts, overall compliance with the 18-week target deteriorated over 18/19, with Trust performance falling from 83.9% in April 2018 to 81.9% in March 2019. Challenges to delivering the 18-week RTT target increased markedly in 2018/19 as a result of a significant growth above planned levels. Total growth across the Trust was 5.9% compared to a plan of approximately 1.5%, which was consistent with previous years. This equated to more than 10,000 additional referrals, which exceed the Trust's capacity in a number of areas.

The planning process for 2019/20 has allocated additional significant resources, in excess of £10m, to front line services to ensure that the Trust can meet patient demand in 2019/20.

Financial Performance

The Trust has achieved a £19.6m surplus for 2018/19, a significant improvement compared to the planned £6.3m surplus. As with 2017/18 this position has benefited from a non-recurring gain relating to the disposal of non-clinical property and associated PSF funding, which if removed would have resulted in a surplus of £2.0m.

Although non-recurring in nature, the sale of assets gives an important boost to cash reserves which will enable the Trust to make much needed investment in its estate and equipment which will benefit both patients and staff.

Nationally and locally there continues to be a focus on improving the underlying deficit of NHS organisations. In 2018/19 the underlying deficit of £15.0m has remained broadly static compared to 2017/18. In part this is a reflection of the fact that recurring efficiency savings are becoming more difficult to identify, leading to a need to deliver one off non-recurring schemes. For 2019/20, an element of provider sustainability funding will be paid to the Trust on a recurring basis, giving more certainty to income, and improving the underlying deficit further from £14.2m to £8.7m.

	2019/20 Plan	2018/19	2017/18
	(£m)	(£m)	(£m)
Surplus prior to impairments	7.4	19.8	13.0
Less non-recurring Income / profit	0.0	-7.3	-4.5
Less non-recurring PSF / STF above plan	0.0	-10.5	-8.1
Less non-recurring Winter funding allocation	0.0	0.0	-0.9
Surplus / (Deficit) after non-recurring benefits	7.4	2.0	-0.5
Less Planned Sustainability funding	-6.3	-12.2	-8.7
Add 19/20 Income relating to 18/19 activity	0.0	5.0	0.0
Less recurrent Cost improvement shortfall C/Fwd	-9.8	-9.8	-5.0
Underlying deficit	-8.7	-15.0	-14.2

During 2018/19 the Trust experienced a significant increase in patient referrals. This combined with a number of vacancies in nursing and the medical workforce has led to an increase in agency costs which breached the expenditure limit set by NHSI. Although this is expected to improve marginally in 2019/20, given the expected increase in vacancies nationally, the Trust is planning to over-spend the agency cap in 2019/20. The Trust continues to implement new staffing models to ensure a sustainable workforce for the future.

The Trust received income from NHS Devon CCG (57% of total patient income) on a block contract basis for 2018/19 rather than on a variable payment by results (PbR) basis. This gives certainty of income for both the Trust and Devon CCG, and also helps to reduce transaction costs between the organisations. Due to an increase in emergency patients and elective patient referrals during the year however, increases in both pay and non-pay have been experienced by the Trust, and it will be necessary to increase the Devon CCG contract in 2019/20 to reflect this increased cost.

The Trust continues to work closely with other organisations within the Devon STP across a number of work programmes to develop sustainable services over the STP footprint. The seven priority work programmes include:-

- Prevention
- Integrated Care Model
- Mental Health
- Children & Young People
- Acute Services Review
- Productivity (inc. Elective Care & Corporate Support Services)
- Enablers (including estates & IM&T)

Progress continues to be made across the Devon STP to improve the financial position, and although still in a deficit position, it is essential that organisations continue to work together to ensure financial balance in the future. During 2018/19, savings of £100m have been achieved in year, which has enabled the system deficit to be reduced to £43m.

Of the £100m of STP savings, the Trust has contributed £20.5m through a combination of increased efficiency and transformational change. This equates to circa 4% of overall running costs.

Capital expenditure for the year was £27.4m, £8.2m lower than planned in part due to slippage of a number of strategic schemes into 2019/20.

Capital expenditure by scheme in 2018/19 is set out below:

- Clinical Pathway transformation programme (MY CARE) £12.4m
- Estates Infrastructure £4.5m
- Linear Accelerator and bunker (for radiotherapy treatments) £2.5m
- Other schemes and equipment replacement £8.0m

During the year, the Trust secured a commercial loan of £42.0m which will be used to invest in the MY CARE programme.

An NHS Finance and Use of Resources score of 1 (out of 4, with 1 being the best) has been achieved for 2018/19 against a planned rating of 1.

For 2019/20, the Trust is planning for an operational income and expenditure surplus of £7.4m in line with the revised control total identified by NHS Improvement. In order to achieve the control total the Trust will need to achieve a challenging CIP target of £21.2m for 2019/20 (3.9% of patient income, excluding STF).

Workforce Performance

Nationally there has been considerable focus on the workforce over the last 12 months much of it driven by the aptly named 'Facing the Facts, Shaping the Future' draft health and care workforce strategy for England. Reassuringly the national document reiterated many of the same issues that were highlighted in our 'People Strategy 2018-21 – Working Together' that was approved by the Board in May 2018. With the stated purpose **"To be recognised as an organisation that inspires and develops the potential of its people, creating a great place to work"** the strategy is driven by six core workstreams that aim to address the medium and longer term issues whilst providing the flexibility to respond to the immediate needs arising from the annual workforce planning exercise.

- **Professional Development:** To establish and develop our clinical staff group ensuring it is fit for purpose now and in the future.
- **Medical Education:** To maintain high quality postgraduate medical training programmes which will continue to attract and retain doctors.

- **Attraction & Resourcing:** To engage with STP Partners to build a strong Devon brand – ‘Proud to Care’ in order to attract new staff and aid retention of existing staff.
- **Environment & Staff Support:** To create the conditions and ways of working which celebrate difference and which recognise the needs of individuals and teams, ensuring support is in place for them.
- **Continuous Learning & Development:** To work collaboratively with STP Partners to establish a continuous learning and development approach that nurtures talent now and in the future.
- **Staff Engagement in Quality Improvement:** To develop and embed a comprehensive quality improvement approach which engages our community (public, patients, carers and staff) in delivering our future care model.

To address the short term workforce needs during 2018-19, the Trust has continued to operate the annual workforce planning process that is aligned to the Trust’s operational plans. Operational plans are derived from commissioning discussions, demand and capacity review and projections and to meet the needs of the corporate strategy. The workforce planning process, consistently adopted across the whole Trust in both acute and community settings, is service line driven, completed by the service line cluster teams led by a Clinical Lead, Senior Nurse and Operational Manager. Each Cluster team submits a workforce plan, which is then collated into a divisional workforce plan for first level approval by the Divisional Leadership Team. This goes through a support and challenge process involving senior Finance, Operations and HR managers. This is designed so that the workforce plans are well-modelled and integrated with both financial, quality and activity plans to ensure the proposed workforce levels are sustainable and able to deliver effective and safe care to patients.

Once approved, the divisional workforce plans are consolidated to generate the overall Trust workforce plan, which receives second level support and challenge by the Executive Team prior to approval and finally submission.

The Clinical Resource Management System (CRMS) is used to maintain consultant job plans with job plans being signed off on an annual basis. Nurses, midwives and healthcare assistants are rostered using the Allocate HealthRoster system with rosters being agreed six weeks in advance. It is the intention to roster other AHPs including therapists and

pharmacists using Healthroster in the near future. The Allocate Safecare module will be introduced in 2019 and this will provide ‘real time’ indications of actual patient acuity allowing for even better allocation of staff across the wards and reducing demand for agency shifts.

Recruitment and retention of staff continued to challenge the Trust during 2018-19. Already tested by significant national shortages the situation was made difficult with the uncertainty around the EU Exit. This has seen a reduction in applications from European nurses coming to the UK and, whilst we have had significant success recruiting from the Philippines in particular the lead time and costs of recruitment are significantly higher.

The government has announced changes to the immigration rules which includes an extension to the salary exemption for nurses, paramedics and medical radiographers recruited from overseas which was due to expire in July 2019. Critically this means that when recruiting nurses and medical radiographers from overseas we will need to meet a lower minimum income rate compared to the normal minimum salary threshold for other professions making it possible to recruit at entry level in these areas.

The RD&E is a great place to work, we have the 3rd highest staff survey score nationally on overall staff engagement, and this is reflected in the higher than average staff retention figure of 89.1% compared to a national median of 85.8% (July 2018). Over the last few years significant resources have been applied to support staff and aid retention including our 3-Step Prevention, Intervention and Protection health and wellbeing strategy. The Health and Wellbeing team were shortlisted for a national award for the breadth and depth of campaigns including mental health, musculo-skeletal health, inactivity and lack of fitness, smoking cessation, alcohol and drug abuse, menopause and obesity and weight management programmes run during the year

Staff development has also been identified as a driver for staff recruitment and retention and it is satisfying to note that the Trust has solid plans in place that commit the whole of the Apprenticeship Levy fund over the next three years.

A crucial factor in recruitment and retention of staff is the remuneration package available to staff. During the year the NHS Staff Council reached agreement on a refresh of the NHS Terms and Conditions of Service (Agenda for Change), and

following a consultation exercise, trade union members accepted the proposed changes. There will now be a three-year pay deal, reform of the pay structure and changes to terms and conditions. Significantly more generous to lower paid staff it is hoped that by increasing starting salaries, reducing the number of pay points and the time it takes to get to the top of the pay band the new pay structure will aid recruitment and retention of staff.

Emphasising the Trust's commitment to working with and supporting our staff we are pleased to report that we have jointly agreed a new Partnership Agreement with our Staffside representatives that will enable even closer working together in the future.

Capital Programme

The Trust's capital programme has been limited to investment in essential capital assets to help support the Trust's cash liquidity. The value of capital expenditure continues to remain lower than the value of depreciation. A robust capital planning process has been undertaken, capital requests have been risk assessed and checked for consistency, linked to the Trust's strategy, with procurement and lead times being duly considered for equipment and larger schemes, to help support the Trust's cash liquidity. Capital funding has been focused on replacing existing equipment and IM&T and for re-investment in the Trust's current estate.

Carbon/Sustainability update

2018-19 has been a successful year for RD&E sustainability improvements. Various projects over a range of themes and sizes have jumped forward.

The RD&E spent £3.6 million on energy during 2018-19 and a significant milestone has been reached for a major project aimed at reducing this cost. In March, an Energy Performance Contract (EPC) between the RD&E and Centrica Business Solutions (CBS) was signed. Over the next 18 months this project will see £7 million invested by the RD&E in energy and water efficiency measures across Wonford, Heavitree, Mardon House and the Sowton warehouse. CBS will deliver the project and have guaranteed that a minimum level of £800,000 per year of energy savings will be achieved. This will also reduce RD&E annual carbon dioxide (CO₂) building energy emissions by 1,900 tonnes per year. The projects include:

- Replacing the current Combined Heat and Power engine at Wonford, this will result in more efficient and economical generation of heat and electricity across the site
- Installing high efficiency LED lighting across Wonford and Heavitree. Estates now fit LED lighting in refurbishments and new builds as standard practice; however this project will up the ante with the replacement of around 14,000 light fittings
- Additional solar photovoltaic (PV) arrays at Wonford, Heavitree and Mardon House will contribute to the existing PV arrays, with an increase in electrical generation sufficient to power over 100 homes for a year*.
- Installing mechanical services insulation across Heavitree and Wonford will prevent heat from being lost from exposed pipework
- Water saving measures, including automatic taps and flushing controls
- Boiler improvements at Heavitree and Mardon House
- Various improvements to the way that the heating and cooling systems operate across the estate

*based on Ofgem typical consumption value of Profile Class 1meter, Medium size house

Last year the Estates department invested in monitoring software to automatically analyse over 280 utility meters from around the estate, this is currently being commissioned and in future will allow greater analysis of consumption patterns and help to identify opportunities to reduce consumption of energy and water.

The RD&E is continuing to work with partners in the City of Exeter to develop a district heating network to provide low carbon heating across the City.

The RD&E has completed a successful first year of sustainability engagement work. This was aimed at providing staff with information and encouragement to make sustainability themed improvements to the way that they work. Each month saw a new area of focus with RD&E focused environmental information and suggestions published on Hub and online via the RD&E's @sustainableRDE Twitter feed. Posters supporting each month's theme are available to staff on request and a sustainability representative from the Estates Department visits departments each month to update them on the topic of the month.

The RD&E spends £385 an hour on energy

If the RD&E reduced energy consumption by 3%, the cost would fund 3 nurses



For more information visit the sustainability hub page.

#RDESustainability

This poster contains pulp recycled from coffee cups

For more information please see The Sustainability Hub page.

[Twitter](#) : @sustainableRDE

[Email](mailto:rde-tr.sustainability@nhs.net) : rde-tr.sustainability@nhs.net

Royal Devon and Exeter **NHS**
NHS Foundation Trust

Stopping three leaking taps pays for one ultrasound scan

Just one dripping tap can waste 9,500 litres of water every year. That's £32 a year down the drain!

Stopping three leaking taps saves the RD&E enough money for an expectant mother to have an ultrasound scan.

Please help us spend our resources as best we can. If you spot a leaky tap, or other obvious energy wastage please contact Estates.



Keep an eye on the Sustainability Hub page over the coming months to find out how you can help reduce energy consumption.

#RDESustainability

For more information please see The Sustainability Hub page.

[Twitter](#) : @sustainableRDE

[Email](mailto:rde-tr.sustainability@nhs.net) : rde-tr.sustainability@nhs.net

Royal Devon and Exeter **NHS**
NHS Foundation Trust

A central part of the engagement campaign was the Green Team competition. This saw entrants from all parts of the RD&E developing projects that would directly improve the sustainability of their departments, measured across the three sustainability pillars:

- Environmental
- Social
- Economic

Amongst other benefits, these projects achieved the following headline successes:

- Annual reduction in emissions of 1.5 tonnes of CO₂
- 59% reduction in patients cannulated in the Emergency Department
- Annual savings of £39,000

Two of the teams have since been nominated for national awards, the Housekeepers for reducing waste and use of disposable catering items and the Emergency Department Team for changing practice to reduce unnecessary cannulation.

The RD&E recognises that one of the ways to continue to deliver sustainability improvements is to have a Board of Directors approved Sustainable Development Management Plan (SDMP). Work is underway to deliver a SDMP this year.

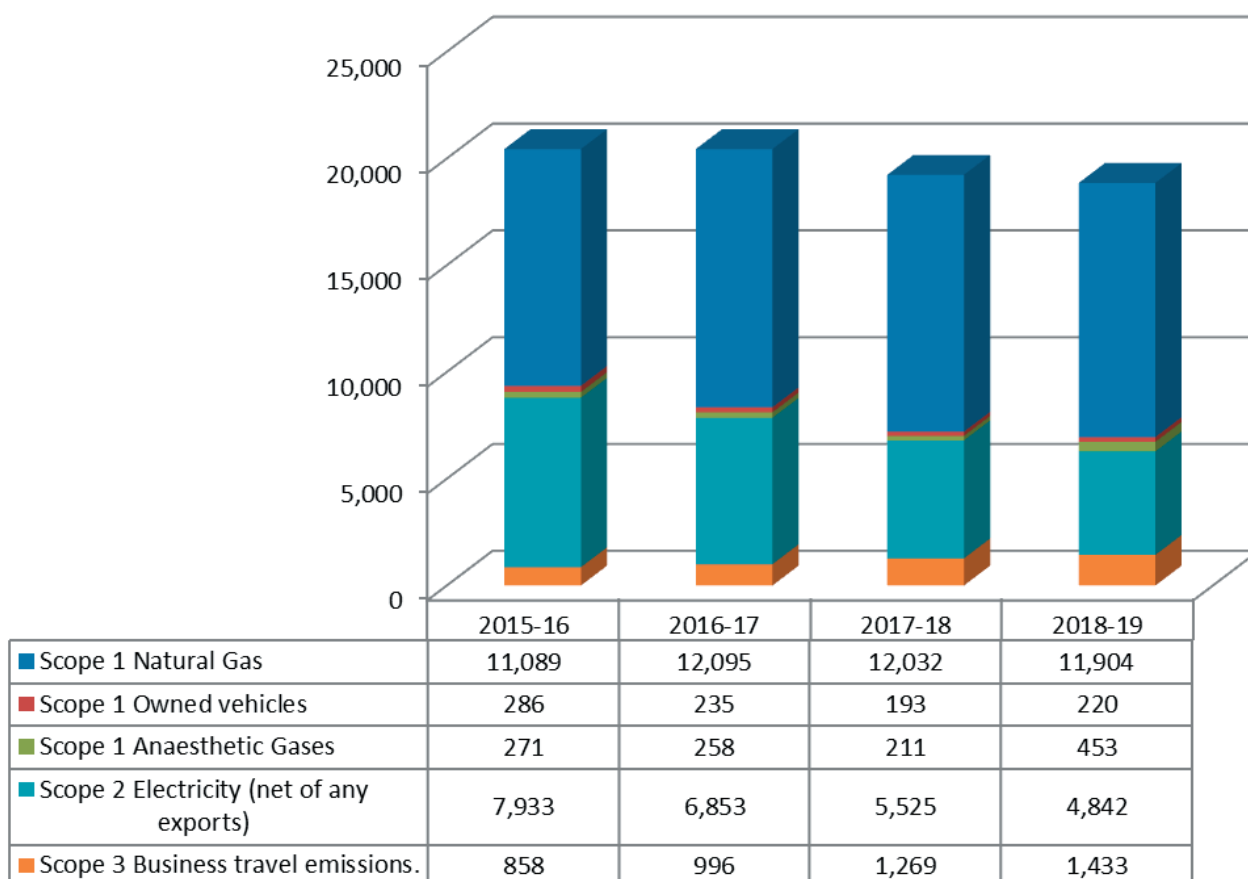
Carbon and utilities performance:

The figures below are calculated from RD&E consumption and financial information using the NHS Sustainable Development Units Sustainability reporting tool and meet HMRC requirements for reporting on greenhouse gas emissions. The emissions reported on are limited to:

- Scope 1 - Energy direct emissions: natural gas, fuel oil, anaesthetic gas and owned vehicles
- Scope 2 - Energy indirect emissions: electricity
- Scope 3 - Business transport emissions: grey fleet / personal cars claiming business mileage.

To simplify greenhouse gas reporting, emissions are reported in tonnes of CO₂ equivalent (t/CO₂e), this is in line with guidance.

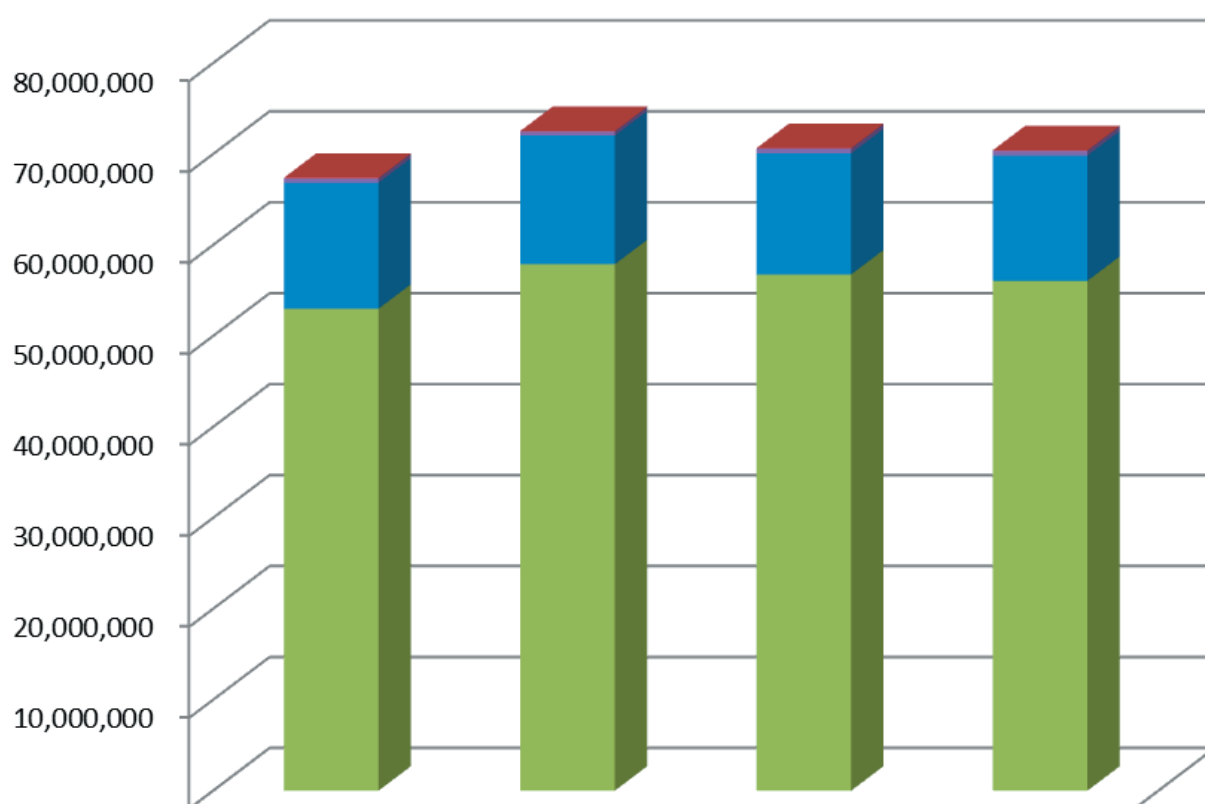
Emissions Breakdown (t/CO₂e)



The noticeable reduction in t/CO₂e is primarily due to decarbonisation of the electricity grid. The rise in transport emissions is due to the RD&E staff base increasing through Total Community Services. The cost of RD&E business travel in 2018-19 was £2.5m.

Water		2014/15	2015/16	2016/17	2017/18
Water	m ³	244,089	225,480	218,598	220,245
	tCO ₂ e	229	212	205	207
Water & Sewage Spend		£ 1,018,482	£ 901,425	£ 905,268	£ 946,151

Annual Building Energy Consumption (kWh)



	2015-16	2016-17	2017-18	2018-19
Electricity (Solar PV)	59,388	55,023	53,189	53,291
Oil Consumed	494,308	453,814	533,889	534,667
Electricity (Grid)	13,857,241	14,144,756	13,308,153	13,780,009
Gas Consumed	52,984,297	57,875,056	56,752,987	56,046,481

Waste disposal (tonnes)	2015/16	2016/17	2017/18	2018/19
Incineration (with energy recovery)	32	332	450	30
Incineration (no energy recovery)	816	840	805	795
Landfill Disposal	882	420	428	475
Waste Recycling weight	462	449	330	618

ENVIRONMENT, EMPLOYEE MATTERS, SOCIAL, COMMUNITY AND HUMAN RIGHTS ISSUES

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

- Meet the acute health needs of the population we serve as safely, effectively and efficiently as possible
- Ensure that in designing and delivering health services we fully take into account, and are influenced by, the views and opinions of our patients and patients to be. Our Members' Say events/Open Day are a good example of where we listen and engage with members – who broadly correspond to the profile of the wider community – on important healthcare matters. In addition we undertake formal and informal consultation with patients when we need to redesign or improve services
- Take into account the impact we have on the environment because this will ultimately have an effect on the communities we serve. As we set out in the sustainability report section of this Report, we are committed to reducing our environmental impact
- Take into account our status as the largest employer in Exeter and surrounding area. This means that decisions we make may well have an impact on the local economy and the health and wellbeing not only of our staff but their families and communities as well
- Take into consideration our responsibilities, as an ethical organisation, to respect human rights and to ensure that our actions or decisions do not have an adverse impact on upholding human rights
- Uphold the tenets of the NHS Constitution which brings together in one place details of what staff, patients and the public can expect from the NHS
- Uphold the legal framework that exists to promote equality and diversity
- Take very seriously our commitment to ensuring that staff feel motivated, empowered and are clear about the difference they are making to patient care and the pursuit of our strategic objectives. The section in this Report on "Our Staff" sets out some of the work we have done to improve staff engagement and motivation
- Ensure that the Trust is a positive place to work and that staff are supported appropriately. The Trust has a positive staff programme – engaging working lives – that brings together our approach to equality and diversity, support for health and wellbeing, staff benefits, staff engagement and training and development.
- Uphold the legal framework in terms of the Bribery Act 2010 by providing staff with a robust and detailed "Standards of Business Conduct" policy and on-going engagement, support and monitoring by Audit South West (Internal Audit, Counter Fraud and Consultancy Services).

Signed:



Suzanne Tracey
Chief Executive

Date: 22 May 2019

ACCOUNTABILITY REPORT

DIRECTORS' REPORT

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

Essentially, there are three basic components to the RD&E's governance structure:

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

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

Members elect Governors and can stand for election themselves.

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

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

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

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

The Board of Directors has both Executive and Non-Executive Directors (NEDs). All Non-Executive Directors are independent. It is a unitary Board which means that both Executive and Non-executive Directors share the same liabilities and joint responsibility for every decision of the Board. In so doing, Board members bear full legal liability for the operational and financial performance of the Trust. The Chief Executive is the nominated Accounting Officer and is responsible for the overall organisation, management and staffing of the NHS Foundation Trust, for its procedures in financial and other matters, and for offering appropriate advice to the Board on all matters of financial propriety and regularity.

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

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

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

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

Board Meetings

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

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

The composition of the Board is in accordance with the Trust's Constitution and the Policy for the Composition of NEDs on the Board. The Board considers it is appropriately composed in order to fulfil its statutory and constitutional function and remain within the NHS's Licence. In consultation with Governors, it has, through its recruitment of NEDs, been able to maintain a good quality and effective Board that is appropriately balanced and complete.

There is a clear division of responsibility between the Chairman and the Chief Executive. The Chairman heads the Board, providing leadership and ensuring its effectiveness in all aspects of its role, and sets the Board agenda. The Chairman ensures the Board receives appropriate information to ensure that Board members can exercise their responsibilities and make well-grounded decisions.

The Chief Executive is responsible for running all operational aspects of the Trust's business, assisted by the team of Executive Directors.

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

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

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

Board Focus

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

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

- Operational Performance
- Corporate Strategy
- Strategic discussions
- Devon Sustainability and Transformation Plan (STP)
- Collaborative Agreement with Northern Devon Healthcare Trust (NDHT)
- Board Assurance Framework
- Brexit
- Clinical Pathway Transformation enabled by Electronic Patient Record (EPR) (MY CARE Programme)
- Care Quality Commission (CQC) inspection

- Governance
- Operational Capacity
- Workforce
- Learning from deaths
- Inclusion
- Research and Development
- Infection Prevention and Control
- Staff and Patient Survey results
- Cancer performance
- Cardiology performance
- Board Development
- Emergency Preparedness, Resilience and Response

Outside Interests

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

Board Effectiveness and Evaluation

The Board continued to develop its effectiveness during the year primarily through its programme of 'development days.' Development days are seminar sessions that allow the whole Board to explore a range of issues and topics and develop and discuss ideas outside the formal setting of the Board. In addition, the Board held seminar and development sessions on the days in which the formal Board sessions took place.

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

- Corporate Strategy
- Mental Health
- Emergency Department collaborative working
- Integration
- New model of care
- MY CARE Programme
- CQC inspection
- A reflection after each Board meeting to ensure the Board considered and upheld the Trust's vision and values

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

Feedback on the performance of the NEDs was considered by the Chairman and fed back to the NEDs in appraisal meetings. Feedback on the performance appraisals was provided in written form and verbally to the Nominations Committee and an overview of the appraisals was discussed with the COG. All the appraisals undertaken were favourable with all NEDs performing at or above the expected level. In the event of concerns being identified through the appraisal process, this would be managed in line with the appropriate Human Resource policy.

A similar process was undertaken for the Chairman. In this case the process was led by the Senior Independent Director. Feedback on the appraisals was provided by the Chief Executive to the Remuneration Committee (RC). The Chairman undertook an appraisal of the Chief Executive and the results of this were fed back to the RC.

Quality Governance Reporting

We have put in place a rigorous approach to governing the quality of our services. More details about these arrangements are included in our Quality Report as well as in the Annual Governance Statement (from page 97 of this report).

Well Led

The Trust's approach to Well Led is outlined within the Accountability Report (page 41) and also within the Annual Governance Statement (from page 97)

The last independent review of the Trust's Well Led Framework was undertaken by the Care Quality Commission as part of a full routine inspection in January, 2019. The Trust received a 'Good' rating for Well Led and an overall rating of 'Good' for the full inspection.

The Board of Directors undertook an assessment using the Well Led Framework guidance in September, 2018, and concluded that the Trust has a robust Well Led framework.

Foundation Trust Code of Governance

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

Signed:



Suzanne Tracey
Chief Executive
Date: 22 May 2019

SUMMARY BOARD ATTENDANCE 2018/19

	Apr-18			May-18		Extraordinary meeting 12/06/18	Jun-18		Jul-18		Sep-18		Oct-18	
	Public	Confidential		Public	Confidential	Confidential	Public	Confidential	Public	Confidential	Public	Confidential	Public	Confidential
Mr J Brent	P	P		P	P	P	P	P	P	P	P	P	P	P
Mr P Adey	P	P		P	P	P	P	P	A	A	P	P	P	P
Mrs J Ashman	P	P		P	P	A	P	P	P	P	P	P	P	P
Mrs J Cooper											P	P	P	P
Ms T Cottam	P	P		P	P	P	P	P	P	P	P	P		
Mr P Dillon	P	P		P	P	P	P	P	P	P	P	P	P	P
Prof A Harris	P	P		P	P	P	P	P	P	P	P	P	P	P
Prof J Kay	P	P		A	A	A	P	P	P	P	A	P	P	P
Mr S Kirby	P	P		P	P	P	P	P	A	A	P	P	P	P
Dr S Knowles	A	A		P	P	P	P	P	A	A	P	P	P	P
Mr A Matthews													P	P
Mrs J McCloskey													P	P
Ms M Romaine	P	P		P	P	P	P	P	P	P				
Mr C Tidman	P	P		P	P	P	P	P	P	P	P	P	P	P
Mrs S Tracey	A	A		P	P	P	P	P	P	P	P	P	P	P
Prof E Wilkinson-Brice	P	P		P	P	P	P	P	P	P	A	P	P	P

	Nov-18		Dec-18	Jan-19			Feb-19		Mar-19	
	Public	Confidential	Confidential	Public	Confidential		Public	Confidential	Public	Confidential
Mr J Brent	P	P	P	P	P		P	P	P	P
Mr P Adey	P	P	P	P	P		P	P	P	P
Mrs J Ashman	P	P	P	P	P		P	P	P	P
Mrs J Cooper	P	P	P	P	P		A	A	P	P
Ms T Cottam										
Mr P Dillon	P	P	P	P	P		P	P	P	P
Prof A Harris	P	P	P	P	P		A	A	P	P
Prof J Kay	P	P	P	A	A		P	P	A	A
Mr S Kirby	P	P	P	P	P		P	P	P	P
Dr S Knowles	P	P	P	P	P		P	P	A	A
Mr A Matthews	P	P	P	P	P		P	P	P	P
Mrs J McCloskey	A	A	A							
Ms M Romaine										
Mr C Tidman	P	P	P	P	P		P	P	P	P
Mrs S Tracey	P	P	P	P	P		P	P	P	P
Prof E Wilkinson-Brice	P	P	P	P	P		P	P	P	P

BOARD OF DIRECTORS

Non-Executive Directors

James Brent, Chair

James joined the Trust in May 2012 and is Chairman of both the Board of Directors and the Council of Governors. He was an investment banker for twenty-five years and established Akkeron Group which has key business activities in hotels, urban regeneration and leisure (including Plymouth Argyle Football Club). He is also Non-Executive Chairman of Hawksmoor Group Limited, an investment and fund management business. He has combined his commercial ventures with a desire to contribute in a range of public sector settings as well, for example previously as Chairman of Plymouth City Development Company and Plymouth University. James was appointed as Chair of Northern Devon Healthcare NHS Trust on 1st July 2018.

Jane Ashman, Non-Executive Director

Jane joined the Trust in April 2014. A Social Worker by profession for the last 34 years and a passionate believer in the integration of Health and Social Care, Jane was a Director of Social Services for nine years until 2009. Jane is the Chair of the Trust's Organ Donation Group and the Patient Experience Committee and is a member of the Governance Committees.

Peter Dillon, Non-Executive Director, Vice Chair (October 2018 – date)

Peter joined the Trust in July 2013 and was appointed Vice Chair in October 2018. First with Deloitte then in his own business, he advises on stabilisation, cash management, turnaround and interim finance. Peter has worked locally in what is now Liverty, a social and affordable housing provider, and is finance director at The Rivers Trust, the umbrella organisation for a charity working to protect and enhance freshwater ecosystems around the UK and Ireland. Peter has chaired the Patient Experience Committee at the Trust and now chairs the Audit Committee and the Trust's Charity Sub Committee. He is also a member of the MY CARE Programme Board.

Janice Kay, Non-Executive Director, Senior Independent Director

Janice joined the Trust in April 2014. She is Provost of the University of Exeter and Deputy to the Vice Chancellor. She line manages the University of Exeter

Medical School among other key roles. She holds a number of national positions in Higher Education, including the HEFCE Strategic Advisory Committee on Quality, Accountability and Regulation. Janice was appointed as Senior Independent Director (SID) in May 2017.

Steve Kirby, Non-Executive Director

Steve joined the Trust in September 2017. Following a period in the NHS, Steve worked internationally in health, running hospitals before moving into consulting. As a Partner at KPMG and then Ernst & Young, he has consulted on a wide range of Government and health organisations both in the UK and overseas. He has worked at all levels on a wide variety of health projects and programmes including large system reorganisations, regulatory issues for Development Banks lending into country wide programmes and "at the coal face" helping to develop services or dealing with failing organisations. He was one of the two EY partners who undertook the administration of Mid Staffs NHS FT. Steve was appointed as Chair of the Governance Committee in September 2018 and is a member of the Audit and Patient Experience Committees.

Simon Knowles, Non-Executive Director

Simon joined the Trust in September 2017. He has wide experience as a clinician and director in the UK and Australia, working in the public, academic and commercial sectors. Until recently he was a non-executive director to a Clinical Commissioning Group and a specialist advisor to the Care Quality Commission. He has a particular interest in using innovation and improvement science to help deliver "joined up" health and social care. Simon is a member of the Audit Committee and Governance Committee.

Jane McCloskey, Non-Executive Director (October 2018 – January 2019)

Alastair Matthews, Associate Non-Executive Director (October 2018 – date)

Alastair joined the Trust in October 2018. He has broad strategic financial and commercial experience gained in both the private and public sectors. He is currently Chief Financial Officer at the University of Plymouth. Prior to that he spent 8 years as Finance Director and Deputy CEO at the University of Southampton NHS Foundation Trust. He has been Finance Director at Ordnance Survey, including

being a member of HMT's Financial Reporting Advisory Board, and spent 6 years as VP Finance and Administration at Computer Sciences Corporation. He qualified and worked with Price Waterhouse in Bristol and then Southampton on a broad range of assignments across many sectors. Alastair is a member of the Trust's Audit Committee.

Michele Romaine, Non-Executive Director, Vice Chair (April 2018 – August 2018)

Michele joined the Trust in September 2012. She has held a number of senior roles in public sector organisations, including the BBC as its Director of Production. Ten years ago Michele helped steer the course for the BBC in a time of significant change setting the vision for the technology, people and the process change necessary to modernise the BBC's production capabilities. Michele has more recently served for three years as a Non-Executive Director on the Board of Salisbury NHS Foundation Trust. She continues to travel internationally through her consultancy business. Michele took over the role as Chair of Governance Committee in September 2014, and is a member of the Audit Committee. Michele was appointed as Vice Chair in May 2017. Michele completed her term of office in August 2018 and is now the of Chair of North Bristol NHS Trust.

Executive Directors

Suzanne Tracey, Chief Executive

Suzanne Tracey joined the NHS in 1993 having qualified as an accountant with Price Waterhouse. She held the post of Director of Finance/Deputy Chief Executive at Yeovil District Hospital NHS Foundation Trust since 2002 before joining the Trust to take up the role of Director of Finance in 2008, subsequently progressing to Deputy CEO/Chief Financial Officer. She was appointed Chief Executive in 2016 (Acting from July 2016 and substantively appointed in November 2016). She is the Chair of the Provider Faculty Healthcare Financial Management Association (HFMA) and past President of the HFMA. Suzanne was appointed as Chief Executive of Northern Devon Healthcare NHS Trust on 18 June 2018.

Pete Adey, Chief Operating Officer

Pete qualified as a nurse in 1988, subsequently working at Hammersmith Hospital on a number of medical speciality wards prior to progressing to Senior Nurse. He joined the Trust in 1995 and undertook roles as Divisional Manager in a number

of services including Child and Women's Health, Cancer Services, Radiology and Pathology prior to his appointment as Deputy Chief Operating Officer in 2012. Pete was appointed as Executive Director of Operations in 2016, formally took up his position on the Board in March 2016 and from March 2017 has assumed the role of Chief Operating Officer.

Julie Cooper, Interim Director of People (September 2018 – date)

Julie joined the NHS in 1990, working in community trusts in the midlands before becoming Director of HR in 2003 at the Walsall provider of community and mental health services. During her time there, the Trust rose to the top ten of the NHS league table for staff survey results and finished first in the region for the Improving Working Lives initiative. As Director of Workforce and OD in a Birmingham PCT, she saw the Trust win the HSJ Workforce Development Award in 2010 for its apprenticeship scheme. A spell at the Department of Health followed, where she contributed to the development of the governance framework and role outlines for the governing body of CCGs. In recent years, Julie has worked as an independent consultant, managing a portfolio of assignments and supporting numerous NHS organisations in senior interim roles and with specialist consultancy services throughout the country including Gloucestershire, Liverpool, Manchester and Leeds.

Tracey Cottam, Executive Director of Transformation & Organisational Development (April 2018 – August 2018)

Tracey joined the Trust in 2013, having worked in industry for over 30 years in a variety of senior leadership and consulting roles. Since joining the Trust, Tracey has led the Trust wide Transformation Programme as part of the Trust's overall corporate strategy. Tracey works alongside her teams from Human Resources, the Programme Management Office, Service Development and Communication & Engagement to ensure the appropriate support is provided to the Trust to enable successful delivery of our strategic plans. Tracey stepped down from her position on the Board in August 2018 to take up the position of MY CARE Programme Senior Responsible Officer and Director of Transformation & Stakeholder Engagement.

Adrian Harris, Executive Medical Director

Adrian has been the Executive Medical Director since April 2015. Prior to his appointment, Adrian served as Associate Medical Director for the Surgical Services Division and previously held the role of Director of the Emergency Department, spanning 12 years. Adrian has seen healthcare from both a primary and secondary care perspective, having trained as a GP before spending the last 22 years as a consultant Emergency Physician. He is an Honorary Associate Professor in Healthcare Leadership and Management at the University of Exeter Medical School.

Adrian was appointed as Interim Medical Director at Northern Devon Healthcare NHS Trust from July 2018 and was substantially appointed from December 2018. In his spare time, Adrian is a practicing sports physician and is the Head of Sports Medicine for the Exeter Chiefs Rugby Football Club and intermittently works for the English Rugby Football Union (RFU).

Chris Tidman, Chief Financial Officer

Chris joined the Trust in September 2017 as an experienced Chief Financial Officer, having worked in a number of senior NHS roles in the West Midlands across Acute, Mental Health and Commissioning sectors and as Director of Delivery and Improvement for NHSI. After graduating in 1991, Chris took his first CFO position in 2005 at South Birmingham Primary Care Trust before joining Birmingham and Solihull Mental Health Foundation Trust as Director of Resources and leading them to FT status in 2008. Chris joined Worcestershire Acute in 2011 as Director of Resources / Deputy CEO. Chris has taken on strategic change projects, including major PFI hospital moves, EPR and IT change programmes, and developing strategic clinical partnerships with neighbouring providers. Chris has been part of the NHS Top Leaders programme and was also HFMA Chair for the West Midlands in 2015.

Em Wilkinson-Brice, Deputy Chief Executive / Chief Nurse

Em joined the RD&E in July 2010 after qualifying as a nurse in 1992 in Exeter. She subsequently worked in Oxford specialising in Cardiology and high dependency care. A firm interest in facilities management alongside nursing resulted in Em taking the post of Director of Nursing and Facilities at Derby Hospitals NHS Foundation Trust prior to coming back to Exeter. During her time at the RD&E, Em has undertaken numerous roles as well as the role of Chief Nurse, including Chief Operating Officer for a time and lead for the Trust's five year Transformation Programme focused on delivering, in partnership with local agencies, a new model of care to facilitate population health and wellbeing. In recognition of the close working partnership between the Trust and Plymouth University, Em was appointed Associate Professor Faculty of Health and Human Sciences. She is also an Honorary Associate Professor in Healthcare Leadership and Management at the University of Exeter Medical School. Em was in the first cohort of the national NHS Leadership Academy Aspiring Chief Executive programme, completing it in February 2017.

NON-EXECUTIVE DIRECTOR APPOINTMENTS

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

The Chairman chairs the Committee when appointing Non-Executive Directors. Membership of the Committee can be found below.

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

During 2018 one NED, Michele Romaine, reached the end of her term of office. A decision was taken to over recruit in order to succession plan for the next NED vacancy. Therefore two appointments were made, Jane McCloskey and Alastair Matthews.

Membership of Nominations Committee (as at 31 March 2019)

- Chairman of the Trust – James Brent (Chair)
- Lead Governor - Peta Foxall
- Tony Ducker (Exeter & South Devon)
- Vacancy (Exeter & South Devon)
- Vacancy (East Devon, Dorset & Somerset & Rest of England)
- Kay Foster (East Devon, Dorset & Somerset & Rest of England)
- Chris Wilde (Mid, North, West Devon & Cornwall)
- Cynthia Thornton (Mid, North, West Devon & Cornwall)
- Hazel Hedicker (Staff)
- Angela Short (Appointed)

NON-EXECUTIVE DIRECTOR REMUNERATION COMMITTEE

The Non-Executive Director Remuneration Committee (NEDRC) comprises five elected Governors and is chaired by the Lead Governor. The Committee is supported by the Deputy Director of People.

Recommendations for any changes to remuneration for the Chairman and other Non-Executive Directors are made by the NEDRC for consideration by the Council of Governors at a general meeting. The Committee met in February 2018. The decisions set out that the NEDs would receive the National Pay Award for 2018/19 to be applied with effect from 1 April 2018.

Membership of NEDRC (as at 31 March 2019)

- Peta Foxall (Lead Governor and Chair of the NEDRC)
- Hazel Hedicker (Staff Governor)
- Vacancy (East Devon, Dorset, Somerset and the Rest of England)
- Vacancy (Exeter and South Devon)
- Cynthia Thornton (Mid, North, West Devon and Cornwall)
- Vacancy (Appointed Governor)

ENHANCED QUALITY GOVERNANCE REPORTING

Patient Care

The Trust is a public benefit corporation which is inextricably linked, through the Council of Governors, to our members. The demographic information we hold about our members suggests that there is a reasonable correlation with the demographics of our wider population. To this end, we have sought to involve and engage our members to seek their views on strategic direction, on service improvements or changes and on improving patient experience as a reasonable proxy for the broader population served by the Trust.

The Governors and Members contribute to the quality agenda as described on pages 4, 15 and 46 of the Quality Report. Contributions come in a variety of ways, including:

- Three Governors as members of the Patient Experience Committee (PEC)
- Governors participating in the patient-led assessments of care environment
- All Governors identifying yearly priorities with a quality perspective

Performance Against Key Healthcare Targets

The Trust has continued to work towards delivering the key national health care targets relating to quality throughout 2018/19.

The Trust is monitored against a wider suite of metrics through its internally developed Ward to Board Framework adapted now to reflect the integrated Trust; Home, Community, Hospital framework is fully embedded. This incorporates process and outcome metrics across a range of domains relating to quality of care including pressure ulcerations, nutrition, infection control, falls, and delivery of harm free care.

On average, in 2018 /19 the Trust:

- Delivered harm free care within the hospital on 97.3% of occasions
- Achieved hand hygiene compliance rate of 89.9%
- Undertook risk assessments for the likelihood of:
 - Developing pressure ulcers for 96.1% of patients
 - Falls for 92.8% of patients
 - VTE for 95.7% of patients and
 - Nutritional needs for 91.5% of patients

Monitoring Improvement in Quality

The Trust approach adopts a balanced scorecard, presented through the Board's Integrated Performance Report (IPR). Governance and Performance are managed via the Governance Operations and Performance System, overseen by the Governance Committee which takes a comprehensive oversight of the quality and safety of care including all inpatient, outpatient areas and community services.

The Trusts' Clinical Quality Assessment Tool (CQAT) forms part of the monthly Home, Community, Hospital framework where key quality and safety indicators are reported and monitored. Furthermore a quarterly drill down report is also presented to the Board of Directors where Divisions report by exception any ward/ department/service area that flags on the framework.

The Trust also uses the Performance Assurance Framework (PAF) to provide assurance that performance including safety and quality indicators are effectively monitored and reported to support managers and clinicians in delivering the required targets. Observations of care are secured through Chief Executive "back to floor" sessions, Deputy Chief Executive/Chief Nurse clinical work/presence, "Observe and Support" by Senior Leadership Team and Non-Executive Directors attendance on Safety Thermometer Day and CQAT assessments.

Service Improvements

Home

Place based care

Seaton, Axminster and Sidmouth (SAS) Cluster has developed a system of care that has been extremely successful at maintaining people's independence, health and wellbeing at home and therefore decreasing unnecessary visits to the RD&E hospital. As such, we have the lowest 'Standardised Admission Ratio' in Devon and one of the lowest in the country. SAS has the fewest patients waiting for discharge from the RD&E and they wait for the shortest length of time to be discharged. So we keep people safe and well at home and if they need admitting to hospital, we then get people back home faster than any other cluster and maybe anywhere else in the country.

How do we achieve this? Firstly by recruiting innovative, positive and happy staff! We then organise our staff around the needs of the community in each town base, i.e. 'place-based' working. We have helped Voluntary and Community Services (VCS) in each town to develop, e.g. Sid Valley Help. These teams of volunteers work with us very closely and are able to help put in services such as befriending, as well as to signpost people to other voluntary groups to help meet people's needs. Once a week in each town we have a Wellbeing Group meeting which involves nurses, therapists, social workers, GPs and these VCS teams. We look at everybody who is most vulnerable in the community and ensure that we work together to enable them to carry on living at home and to prevent unnecessary hospital admissions. This work is overseen by the Community Matrons we have in each town. Their main job is to work with people with complex and long-term conditions to help them to stay living at home and prevent the need to go to hospital or into a care home.

Working alongside these town based Wellbeing teams, we have a Dementia Matron, an Admiral Nurse (working with people who are carers for loved ones who have dementia), Rehabilitation Nurses (who help people who are at risk of falls), our Community Nurse Teams and Rehabilitation Therapists. Social Care is fully integrated into these teams as well, so there is a seamless service between the NHS and Social Care.

We also go looking for patients to find those who we might be able to keep at home before a crisis develops. As such, we have Associate Matrons in each team who visit GP surgeries every morning to see who they have on their home visit lists. It is often these patients who have a crisis or carer breakdown late in the afternoon who then get admitted to hospital. By seeing them early in the day, we can put things in place to keep them safe at home.

When people need to be discharged following a spell in the RD&E we have a fabulous team to help people get back home rapidly and safely. For example, we now have 17 Urgent Care Response Workers, who are carers that will visit people when they first get back home from hospital to ensure that they are safe and well and have all that they need to settle back in. We also have therapists and workers who do 're-ablement' with patients who might need some help in moving around the house with confidence again, or help with preparing meals

or having a wash. We have a team of nurses and social workers based in the RD&E that communicate with us hour by hour, minute by minute to ensure that we are all working together as one unit. Therefore at any one time, we know where all the patients from the SAS Cluster are, and where they next need to go. We can also offer night sits for patients who need that extra reassurance and help for the first few days after being in hospital.

We are now even working to prevent people's mental and physical health deteriorating in the first place. We have health coaches based in each town who work with community teams and GPs, in conjunction with Leisure East Devon. They work for a few weeks at a time with people who would like to get fitter, eat better, feel better about themselves and maybe connect more with other people and groups.

So we don't leave any stone unturned here in SAS to do whatever we can to help people to live better lives and to do so in their own homes, spending less time in hospital wherever possible.

Community

The Bed based intermediate care model is based around assessments and interventions that are provided in a bed-setting (community Hospital Wards).

The model has been rolled out across the three community in-patient sites, Tiverton, Exmouth and Sidmouth where there is a focus on moving away from the traditional nurse led-approach to a therapy led "enabling" approach to care, providing a 7 day multidisciplinary service approach to recovery, rehabilitation and reablement. It recognises shared skills across the team to ensure an enabling approach with every patient contact, with increased non-registered workforce including an activities co-ordinator.

Equipment across the three sites has been altered/amended where necessary to support each individual's need and this will replicate what will be available in their own home.

The aim of the model is to prevent unnecessary acute hospital admissions, prevent premature admissions to long-term care/premature dependency on high packages of care and to optimise independence

Hospital

The Wynard Ambulatory Care Unit opened in November 2016. Now, more than 2 years on, the unit provides a comfortable environment for patients who are mobile and medically stable to receive a range of procedures and treatments. Patients who attend the unit would otherwise have required a hospital bed, either as an inpatient or day case. Patients now have their treatment and can then return to their own home, coming each day as required. This has improved the pathway for the patient, ensuring quality of care and an improved experience of our services. The original range of procedures and pathways included:

- Day-Case blood transfusions, drug infusions, interventional radiology, lumbar punctures, pleural and ascetic taps
- Urgent clinic review of patients to avoid admissions or facilitate early discharge
- Urgent tests and investigations
- Intra Venous (IV) antibiotics – for patients who are well enough to be at home, but require a prolonged course of IV antibiotics that cannot be delivered in the community

Over the past 2 years further pathways and treatments have been developed on the unit, including lung biopsies, treatment of renal colic, diabetic foot ulcer and a range of additional infusions. Use of the unit has increased from 570 attendances in March 2018 to over 900 in December 2018. Further expansion of ambulatory services is also happening in our community setting too, to bring care closer to home for our patients. Feedback from patients about this service has been positive, with 100% of patient's surveyed saying that they would recommend to a friend, and more than one person commenting that it is life-changing, not having to be confined to a hospital bed.

PATIENT SURVEYS

Over the last year, a number of surveys have been reported, which demonstrate the effectiveness of our services. These include:

- National Inpatient Survey Results
- National Maternity Survey Results
- National Cancer Survey Results

National Inpatient Survey Results

The survey results were received in March (for 2018) and will be reviewed through the Patient Experience Committee. There was an overall response rate of 58% which compares well to last year (53%). We were in the top 20% of trusts nationally (benchmarked against the Trusts surveyed by Quality Health and not full national data) for 31 of the 72 questions.

What went well?

- Patients reported that when they had important questions to ask a nurse they received answers they could understand
- Patients felt there were enough nurses on duty to care for them and they had confidence and trust in them
- Patients reported that on the day they left hospital, their discharge was not delayed for any reason

Even Better if?

- Patients felt that on discharge they had not received written or printed information about what they should or should not do after leaving hospital or any additional equipment/adaptions that may be required at home.
- Patients reported that before the operation or procedure, staff did not explain how they could expect to feel after they had the operation or procedure
- Patients reported being bothered by noise at night from other patients

National Maternity Survey Results

The National Maternity Survey results were published in January 2019 and presented to the Trust's Patient Experience Committee in February 2019. The survey is part of a national survey programme run by the Care Quality Commission (CQC) to collect feedback on the experiences of women using NHS maternity services across England. The survey looks at five periods of care:

- Care while you were pregnant
- Your labour and the birth of your baby
- Care in hospital after the birth
- Feeding your baby
- Care at home after birth

304 questionnaires were sent out and 157 completed and returned. This gives a response rate of 52% which is above the national average.

What went well?

- 'During your antenatal check-ups, did a midwife ask you how you were feeling emotionally?' - 82% of women said 'Yes Definitely' (national average 66%)
- 50% of women felt they were offered a choice about where to have their baby (national average 37%)
- 86% of women answered yes to 'If, during evenings, nights or weekends, you needed support or advice about feeding your baby, were you able to get this?' (national average 74%)
- 84% of women answered yes to 'Did the midwife or midwives that you saw appear to be aware of the medical history of you and your baby?' (national average 74%)

What could be better?

- 70% of women responded yes to 'Since your baby's birth have you been visited at home by a midwife?' which is 24% less than the national average. However women currently have a choice of clinic or home and although it appears that we are below average – consideration should be given that this may have been the woman's choice of not being seen at home but to come into a birth centre/clinic instead. The Better Births prevention work stream of the Devon Local Maternity System (LMS) is looking at postnatal pathways. This piece of work will include in which environment postnatal care is offered.

- 49% of women responded yes to 'Thinking about your stay in hospital, if your partner or someone else close to you was involved in your care, were they able to stay with you as much as you wanted?', which is 20% below the national average. More camp beds have been purchased to enable partners to stay alongside the birthing mother following fundraising by a midwife. Additional beds and further initiatives for postnatal patients are being considered.

National Cancer Survey

The National Cancer Patient Experience Survey results were published in September 2018 and presented to the Trust's Patient Experience Committee in November 2018. Overall the Trust performed extremely well, and was within the top 10% of hospitals nationally, with 29 questions in the top quartile and an overall score rating of 9.

What went well?

- 83% of respondents said they were involved as much as they wanted to be in decisions about their treatment and care.
- 92% were given the name of the Clinical Nurse Specialist who would support them through their treatment, and 89% confirmed that they found it easy or very easy to make contact with them.
- 93% of respondents said that overall, they were always treated with dignity and respect while they were in hospital.
- 97% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.

What could be better?

- Progress continues to be made against the Living With and Beyond Cancer (LWBC) agenda, introduced in 2014.
- The lead nurses are working with the national team to explore a collective approach to the rarer tumours to gain views across the Peninsula. To ensure we gain patients views while we are reviewing with the national team, local surveys are in development.
- Continue to work with the clinical trials team to ensure we offer patients the opportunity to access trials.

Learning From Patient Feedback

The "Demonstrating Difference" approach is one method used, where learning from patient and carer feedback is captured and used to demonstrate the changes that have been made in response to feedback. The information is reviewed in the monthly Divisional Performance Assurance Framework meetings, Patient Experience Committee (PEC) and Board of Director reports. The following examples demonstrate how the Trust has learnt from and improved patient experience based on feedback received.

Cardiology Department/Taw Ward

Following a number of complaints, Taw Ward has identified an ongoing issue with Cardiology patients waiting for procedure who no longer require or want the procedure or who have symptom changes. A test of change has been undertaken whereby an Elective Co-ordinator contacts all patients following their booking. The co-ordinator discusses the patients' needs in order to highlight special requirements for the ward and advice about post procedural requirements. The coordinator also ensures the day case environment has the correct skills, safety and specialised equipment required for the elective activity. All patients are greeted on the day of their procedure by the co-ordinator, someone they have already been speaking with and who understands their needs. The aim of the role is to prevent cancellation on the day of any patient and to improve patient satisfaction. This has been received positively by patients, Consultants and the booking teams.

Ashburn Ward

The Division would like to share the positive impact that Collaborative Learning in Practice (CLiP) students has had on patients, ward staff and the students themselves. The CLiP student model has been introduced into the Hospital as part of a pilot study monitored by the Clinical Practice Facilitator (CPF) team.

The students have been very proactive on the ward and importantly are keen to give caring and compassionate care to the patients. They have been allocated their own patients (with supervision) and have spent time getting to know their patients individually.

Feedback from students shows they feel that CLiP has enhanced their chance as students to interact and find out further information about our patients. There is more time with patients to communicate and also to support the relatives and explain any discharge details and answer any questions they may have.

Student's comments included:

"Taking the time to know the person behind the patient makes a difference in the life of that person. Supporting the patient and their family impacts upon their lives in a positive way and it defines how they see the health care system. As a student I want to make a difference to the people who I come in contact with, I want them to feel that I care and their thoughts and feeling are being listened to and understood. I have had many a 'thank you' from patients/relatives and each time I am thanked I think; I made a difference today."

Macleod Diabetes and Endocrine Centre (MDEC)

Patients with diabetes test their blood glucose levels regularly and use meters to do this which record and store their blood glucose levels. These meters are then downloaded in the waiting room and are used during the patient consultations.

Patients were experiencing difficulty in following the manufacturer's instructions on how to download the meters and pumps which meant clinical staff were having to do this. The Inpatient Diabetes Specialist Nurse and Health Care Assistant printed and laminated various pictures of different meters and pumps and placed them in the waiting room thus enabling patients to be able to complete the task themselves, before their appointment. Clinical information is now readily available for the consultation and has reduced the amount of staff time used for this process.

Staff have received feedback from the patients saying that the picture guides are useful and more user/patient friendly and it has given them a sense of ownership.

Otter and Abbey Ward

Otter and Abbey Ward patients and staff had commented on the lack of recycling facilities available. The Ward Housekeeper has worked to improve recycling and reduce waste in the ward environments. Otter ward has been able to demonstrate that up to 75% of their waste can be recycled. In addition to this the wards have stopped using plastic spoons and are using reusable cups. These initiatives are being fed back to look at Trust wide adoption.

Stoma Department

Over the last 2 years a number of clinics have been set up to run in the community to provide a review service which ensures that patients are receiving the optimum products and prescription for their stoma. In addition, reviews are taking place at GP surgeries to ensure that patients are not using too many products associated with their stoma that do not add value and can be costly.

Working within the primary and secondary care setting the stoma care nurse specialists are well placed to develop a cohesive pathway to support patients from hospital to home. The recent service development demonstrates that the stoma care team have patients at the heart of the service they deliver with the aim of providing cost effective, quality care.

Patient feedback is that they have real confidence in the service and it has made a real difference to them.

Elective Orthopaedics

The Senior Nurse & Practice Educator have designed an elective orthopaedic nursing module (University Partnership Adult Elective Orthopaedic Nursing Module) with the aim of developing competent orthopaedic practitioners skilled in assessing, planning, implementing and evaluating nursing care for elective orthopaedic patients. The course has been accredited with Plymouth University at 20 credits BSc level.

Anticipated benefits

- Provide skilled competent orthopaedic nurses to maintain patient safety
- Improved patient experience through knowledgeable staff
- Attract and retain staff
- Maintain PEOC reputation as a centre for excellence
- Improve MDT working as the module has been designed to incorporate teaching and facilitated learning from the whole MDT

We aim to commence the module in April 2019. Following evaluation of the module we plan to design and accredit a trauma nurse module.

Yarty Ward – Chevithorn Suite

This room is used for End of Life (EoL) and Teenage and Young Adults (TYA) patients as well as young families enabling family life to continue. A new family suite has been designed and built with the full support of ELF (Exeter Leukaemia Fund). Fundraising from the community and donations from businesses obtained to help raise required funds.

The suite has been furnished with a large flat screen TV in the patient's room, family accommodation and shower room, a family sitting room with additional sofa bed and TV with basic kitchen facilities to allow relatives to stay with patients comfortably. A covered garden area is also available where a bed can be pushed outside, with garden chairs and flowers provided and maintained by a local garden centre. This enables nurses to provide care for patients in a less clinical environment within the safety of the ward area, allowing family to be present in a more comfortable and dignified space.

Benefits are being seen across the patients groups, but especially EoL care and the TYA group allowing for family and friends support.

Maternity - Antenatal/Postnatal Ward (ANPW)

Following feedback regarding the bathrooms, which are felt to be clinical, cold and not conducive to a warm, relaxing environment, a positive birth study day was held in May 2018. This was arranged by midwives from the birth centre and was attended by 120 people from across the region.

Subsequently, subdued lighting, some furnishings and wall decoration have been added to the room creating a homely environment that allows women to have a relaxing bath whilst in early labour. This was launched in mid-November 2018. Feedback from patients has been very positive and included comments as below:

"This has been a godsend the last few days thank you "

"This is gorgeous and was much needed"

Community Nursing

Cognitive Stimulation therapy (CST) is a recognised therapy by National Institute for Clinical Excellence (NICE) for people with dementia. To enable implementation, a training day was organised for the whole team to attend. Work has now commenced on embedding the theory into our practice.

Staff are being supported to create activity plans for a library of activities. This might include a word game, looking at maps of the world and talking about travel which everyone is able to enjoy regardless of the severity of the dementia with which they are living.

It is clear that those who are trying these new activities are happy in our care, with regular comments from them about how much they enjoy their day with us and how much they look forward to coming to us.

Tiverton – Doris Heard ward

Feedback was received from patients and staff that there was no area on the ward for private conversations or a place to undertake assessments, which made it difficult to maintain privacy and dignity.

A store room adjacent to the ward was cleared and comfortable seating and a table provided to enable a better area for use by any professional to facilitate meaningful conversations or for families to sit quietly together away from the ward activity.

Exmouth Community Rehabilitation - Physiotherapy

The Physiotherapy Clinical Lead noted an on-going issue regarding excessive waiting times for community physiotherapy. A review was undertaken of the community physiotherapy pathway and the following actions were taken:

- A short term waiting list initiative was introduced to clear the backlog and reduce waiting times
- Introduction of a new daily referral triage process
- Telephone re-screening of patients waiting longer than 4 weeks
- Administrative support staff booked new patient slots into physio diaries
- Clinicians booked into additional new patient slots if they had capacity

This resulted in the reduction of the waiting list for routine referrals with the telephone re-screening re-allocating patients, who no longer required input, to more appropriate services,

The capacity of the service is currently under review so that it meets demand. Currently the service is accessed via different referral routes that are both paper based and electronic. MY CARE has the capability to simplify the referral route and reduce inefficiencies.

Complaints Handling

The complaints and concerns performance shows an overall increase in the number of complaints and concerns by 30.1%. The number of acknowledgements sent within the target time remained the same as for 2016/17. The Royal Devon & Exeter (RD&E) figures during the same period (1 April 2017 to 31 March 2018), showed there were 288 complaints which is similar to the 285 received for 2016/17. The number of concerns received (848) increased by 44.5% from 587 received for 2016/17. The increase is due to a large number of concerns being raised with regard to waiting times and communication of delays in the Cardiology, Orthopaedics and Surgical Outpatient departments.

However, the number of complaints and concerns received is low when compared to the number of contacts with patients. Of the 862,192 patients interactions of either being admitted or attending the hospital during 2017/18, 1136 (0.13%) registered a complaint or concern with the Trust.

All feedback from patients and their families is used to help us to further improve our services. On a quarterly basis a detailed analysis on patient experience including complaints is reviewed by our Patient Experience Committee which has Governors as part of its membership. This committee ensures that learning from complaints and Demonstrating Difference examples are shared.

The top complaint and concern themes were:

Communication Issues

Complaints featuring communication often link with other themes such as providing and receiving of information, attitude of staff and length of wait for appointments. All complaints and concerns logged under this heading are reviewed and are often spread across a number of specialities. Any actions and/or learning from complaints featuring communication are shared with the clinical teams concerned so that they can reflect upon the experience of patients or their families/carers in order to improve the care of patients in the future. Where appropriate, the member(s) of staff involved in a complaint are invited to meet with the respondent and the complainant's comments are explored. Where there is learning this is shared with the team through Communication cells and newsletters. Examples of actions that have been taken include:

- A Cluster Manager has implemented an action plan with the administrative team to ensure that communication with patients is improved within the Cardiology Department.
- One case has been used for education and training; reiterating the difficulties of the presentation of abdominal pain in older patients, specifically pointing out that the diagnosis of small bowel infarction can be very difficult. Ensuring the importance of documenting follow up examination and decision making in the notes was reiterated to the medical and nursing team.
- In response to a complaint in Radiology, the department will now, where possible, be telephoning patients to advise them when their appointments are being moved, and to provide an explanation of this.
- The Fertility department has seen several complaints on the issue of communication specifically around appointment timing, test results, inconsistent information (including treatment cost) and appointment content. A new streamlined pathway of care is being embedded which should help address this type of complaint. Open evenings have also been held to inform prospective couples of treatments and costs to help manage patient expectations. The Fertility Exeter website has also been updated.
- A concern was also received in radiology around an ultrasound examination and the patient information leaflet not accurately describing the procedure, particularly relating to the application of local anaesthetic which had led to increased anxiety. The patient leaflet is now being reviewed.
- In Maternity Services a concern was received around communication given when waiting for induction of labour, the subsequent need for caesarean section and the receiving of a test result. A Senior Midwife met with the couple on the ward to apologise and listen to their concerns and suggestions to improve care. Work is ongoing around improving communication including the use of social media, updating leaflets, increasing user involvement and communication feedback to staff.

Length of wait for review/treatment

This theme is often linked with the lack of communication. Some examples of actions taken following issues being raised are:

- A patient was concerned with the wait for an annual Ophthalmology review appointment. It is acknowledged that this is a national problem at present. In order to alleviate the concern of patients waiting for appointments, a system has been implemented whereby if a patient is worried about their condition, the administration/booking team will print the last 4 clinic letters for the patient and give these to the relevant Consultant for review. If the Consultant indicates that the patient needs to be seen urgently, then an appointment can be arranged for them, and if there is no urgency then reassurance can be provided to the patient.
- A patient is concerned with the waiting time for knee replacement surgery. An Administration Line Manager has explained the current situation, provided assurance that the patient is on the waiting list, and also confirmed that the patient is on the separate cancellation list.
- A patient under the fertility team raised a concern over the wait to commence treatment. The Cluster Manager apologised to the patient and explained the implementation of a new referral system. This development should ensure that there is minimal time lapse between decision making and the provision of date for procedure. It is regrettable that the patient fell between the two processes.

STAKEHOLDER RELATIONS

The Trust has continued to develop its partnership working with key local, regional and national stakeholders during the year. As outlined in our corporate strategy, there is a clear recognition that the Trust alone cannot fulfil its strategic aims without partnering with key players. An institutional stakeholder survey undertaken during the year demonstrated that the RD&E has a positive reputation with this group of stakeholders.

In addition, and as outlined elsewhere in this report, the Trust is doing ever more to develop a new relationship with the communities that it serves. Across East and Mid Devon we're working to join rather than dictate community engagement. We've started by bringing together all the different groups in what we call 'community conversations', which aims to pass leadership on engagement to local communities, and better connect GPs and other health professionals, local government, social services, the voluntary sector and local people, in ways that work for them.

Our focus on this area is very much reflected in the emerging national policy direction, which sees a growth in joint working, for example through primary care networks and integrated care systems – underpinned by strong community engagement – as the way forward.

Striking up a different conversation

As a Trust, our work on transforming Community engagement started back in 2016, when we added the delivery of community services across eastern Devon to our acute hospital services portfolio. At the time, a legacy of difficult public consultations meant that we had a huge amount of work to do to establish trust and understanding with local people, and we promised to strike up a different conversation with our communities.

From our wider engagement work in previous years, we knew that people in our area tended to identify themselves centred around the market towns, so we approached the natural community leaders in those hubs, and asked them to work with us to gather people together. Finding just one or two people in each place proved to be a real springboard for community conversations, bringing together statutory organisations with citizens, voluntary sector organisations, local authorities, police and ambulance trusts, fire services, and local community leaders to look at health and wellbeing.

From the start it seemed that while lots of engagement had been happening, it hadn't been joined up; many working in the third sector didn't even know each other. However, we did discover that communities and individuals were already doing great things to make the most of their local assets and that there was a real appetite for local leadership.

The approach to the conversations has been different in each community, and we've been careful to lead from behind, offering support and information to support decision-making but not dictating the agenda or running the discussions. Connections are being forged through face to face meetings, phone conversations and virtual membership on social media, as just a few examples.

What's key is that each conversation is bringing professionals, organisations and communities together in ways that make it easy for them to talk to each other and deliver a joined up response to the needs of local people.

The feedback and progress so far have been incredibly positive and some of the groups have already pulled together their own priority plans, based on what they see as the strengths of the local area, what everyone has to offer, and what matters most to them.

A shift is underway in our engagement; we are now just one of many Partners and our communities are starting to take the leading role in their own wellbeing. Maximising the coordination of current resources and strengthening the connections that support people in their communities have become the drivers rather than the engagement of old which too often focused on service 'losses'.

There are now ten community conversations underway, growing organically and reaching varying levels of maturity, and we continue to offer admin support and some financial assistance to those that need it.

What is key now is to remember that we cannot over-manage this type of engagement and we have to become ever more comfortable with communities, rather than health professionals, leading the way in wellbeing.

DISCLOSURES

Statement as to disclosure to auditors

The Annual Report, Quality Report and Annual Accounts have been approved by each individual who is a Director at the time.

Disclosure to Auditors and Further Disclosures

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

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

If management wishes to use the services of the Trust's external auditor for any non-audit purposes, we demonstrate why this is appropriate. The Deputy Chief Executive/Chief Financial Officer will provide professional advice on the appropriateness of such an arrangement and the Audit Committee keep under review the level of non-audit services provided by the External Auditor taking into account relevant guidance. The safeguard is in place to ensure independence.

Income disclosures required by Section 43 (2a) of the NHS Act 2006

The Trust has complied with Section 43 (2a) of the NHS Act 2006 (as amended by the Health and Social Care Act 2012). The Trust's income from the provision of goods and services for the purposes of the health service in England is greater than its income from the provision of goods and services for any other purposes.

Income generated from the provision of goods and services for any other purposes is used by the Trust to provide healthcare services.

RENUNERATION REPORT

The membership of the Remuneration Committee (RC) consists of the Chairman and all the Non-Executive Directors. During the year, the Committee was chaired by Professor Janice Kay as the Senior Independent Director and Mr Steve Kirby was appointed as Deputy Chair of the RC. The Chief Executive and, as necessary, other Executive Directors are invited to attend the meetings in an advisory role but are excluded on issues directly relevant to them by the Chair of the Committee. The Committee is supported by Peter Oliver, Deputy Director of People.

There have been a number of changes to membership of the RC during 2018-19. Michele Romaine resigned as a Non-Executive Director on 31 August 2018 having reached the end of her term of office and her last meeting as a member of the Committee was on 20 July 2018. Following the appointment of Mrs Jane McCloskey and Mr Alastair Matthews as Non-Executive Directors from 1 October 2018, they joined the Committee with effect from the meeting on 13 October 2018. Mrs McCloskey subsequently resigned on 14 January 2019.

The Committee's main purpose is to set rates of remuneration, terms and conditions of service for the Chief Executive and Executive Directors i.e. those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. Since completion of the Senior Management Review in 2014 the role of the Committee has extended to also include direct reports to the Executive Directors who moved to 'spot' salaries outside national terms and conditions within the review of the Trust's senior management arrangements.

Non-Executive Director and Chairman Remuneration is dealt with by the Non-Executive Director Remuneration Committee (NEDRC).

In-year remuneration decisions

The RC, taking into account the three-year pay deal awarded to staff on Agenda for Change (AfC) terms and conditions of employment, undertook a review of all salaries subject to RC review.

Decisions were made in accordance with the Remuneration Principles as set out below and took into account the results of an extensive benchmarking exercise of comparator trusts, national median data provided by NHSI and individual performance data provided by the Chairman for Chief Executive and the CEO for the executive team. The decision was made to consider awards for all Executive roles purely in the context of their respective roles within the Trust with consideration for additional responsibilities arising from the management contract with North Devon Hospital Trust being considered separately. Approval was sought and gained from NHSI and the Department of Health and Social Care for all recommended salaries that exceeded the £150k threshold.

This review resulted in changes to the salaries of three executives: the Chief Executive Officer, Medical Director and the Chief Operating Officer. In all of these cases an element of the total award made included a specific payment in recognition of the additional responsibilities arising out of their respective NDHT Board responsibilities and accountabilities.

In accordance with HM Treasury guidance the Chief Executive Officer's contract includes a clause permitting 10% of salary to be clawed back if performance is not considered to be satisfactory.

As a consequence of the three-year pay deal for AfC staff no annual cost of living figure was available for comparison purposes this year and the annual VSM guidance letters had not been issued at the time of the RC's deliberations.

Attendance at RC meetings in 2018/19

NAME	18 May 2018	23 May 2018	12 June 2018	15 June 2018	27 June 2018	20 July 2018	11 Jan 2019
J Brent	P	P	P	P	P	P	P
J Ashman	A	P	A	A	P	P	P
P Dillon	P	P	P	P	P	P	A
J Kay	P	P	A	A	P	P	P
S Kirby	P	P	P	P	P	A	P
S Knowles	P	P	P	P	P	A	P
A Matthews							P
J McCloskey							A
M Romaine	A	P	P	P	P	P	

Senior Managers Remuneration Policy

The RC completed the review of the Remuneration Principles and Application 2018 at the July 2018 meeting. These are:

Key principles

1. The Committee understands that its approach must strike an appropriate balance with its duty to ensure the effective stewardship of public resources. The Committee understands that senior level positions in the Trust operate in a regional/national context and that remuneration for these positions is primarily determined by the market. In order to remain competitive and attract and retain high calibre staff, the salaries of senior staff must be regularly reviewed to ensure that they remain broadly competitive and that the salaries offered to incumbents do not degrade over time so that they are out of line with comparable Trusts. Nevertheless, the Committee will avoid paying more than is necessary to recruit, retain and motivate high calibre Executive Directors and Very Senior Managers* and will take positions that are publicly defensible.

2. The Committee's approach to remuneration will seek to position the Trust in a way that it is able to attract, retain and motivate Executive Directors and Very Senior Managers of sufficient calibre to maintain high quality, patient-centred healthcare and effective management of the Trust's resources.

3. In reaching its determinations, the Committee will take proper account of National Agreements, for example Agenda for Change, and guidance issued by the Government, the Department of Health and the NHS market rates for comparable roles in comparable organisations.

4. The Committee will treat all people with equality and fairness when determining remuneration.

5. The Committee will be rigorous in ensuring that potential conflicts of interest are recognised and avoided. Executive Directors and Very Senior Managers will not be involved in deciding their own remuneration package.

6. On an annual basis, the Committee will consider the remuneration packages of all Executive Directors and Very Senior Managers bearing in mind the performance of the Executive Directors and Very Senior Managers in fulfilling their duties and in regard to the overall performance of the Trust (as set out in Appendix A). The objectives set for the Executive Directors at appraisal and the progress against these will be shared with the Committee.

7. The Committee will consider external benchmark comparison data on the pay and conditions of EDs and Very Senior Managers in comparator FTs annually. This work will be undertaken on behalf of the RC by the Deputy Director of People. The process followed for benchmarking can be found at Appendix A. The Committee will make judgements on where it wants to position its relative remuneration package for Executive Directors and Very Senior Managers. The RC will treat comparator data with caution not least so as to avoid undue pay inflation.

8. The Committee will seek to apply the principles fairly and transparently and on the basis of data and advice from competent external bodies/consultants or senior HR advisor as necessary. The Committee understands that it will use the data it gathers and the framework set out in the principles to exercise the necessary judgment on pay and reward issues. The Committee will ensure that remuneration reflects the extent of the role and responsibilities of individual posts and their contribution to the organisation and will be based on judgements relating to:

- Market rates for comparable roles in comparable organisations
- Interpretation of the data from an agreed comparator group
- The size and scope of the role in question
- Advice from the Chairman of the Trust in relation to the Chief Executive
- Information from the Chief Executive in relation to the Executive Directors and Very Senior Managers
- Affordability
- Other NHS pay settlements
- Wider implications that may arise from setting the remuneration packages of Executive Directors and Very Senior Managers in relation to pay levels determined through national agreements within the NHS
- Performance against set objectives
- Any other factors deemed appropriate.

9. The Committee will seek to achieve broadly standardised terms and conditions for example on notice periods for all posts which fall within the scope of the principles. RC has resolved to move towards a situation in which there is a higher degree of conformity (a notice period of six months).

10. The Committee will be transparent in the application of its remuneration principles. It is a requirement that details of the remuneration package for Board Directors are recorded in the Trust's Annual Report

11. The Trust recognises that the RC has the authorised responsibility to apply its independent judgement on matters within its remit within the wording and the spirit of the agreed principles. However, there may be times when a different approach is required which steps outside the scope of the principles and in these cases, particular care must be taken and clear justification must be given and recorded. Some circumstances which may require flexibility include temporary promotions; atypical employment conditions; specific issues related to individuals etc. The Committee will reserve the right to recruit an Executive Director or Very Senior Manager on a salary below the market value in cases where a development plan would enable the employee to reach the minimum standards to undertake the role at a satisfactory level. The Committee also reserves the right to pay additional payments to Executive Directors and Very Senior Managers when deemed necessary because of exceptional circumstances. The occasions when additional payments are required will be limited. When considering using additional payments, the RC will need to be able to fully justify and explain why it has opted to take this course of action. It would only normally consider such action on the basis of a clear business case. Special care must be taken to ensure that the use of additional payments is completely transparent and that consideration has been given to the impact on pay inflation among Executive Directors and Very Senior Managers as well as to guard against accusations of bias or arbitrary practice.

12. The Committee will on an annual basis (in line with the Committee's work plan) ensure effective succession planning is in place for the Executive Directors and receive assurance from the Chief Executive that effective succession planning is in place for Very Senior Managers.

* Very Senior Managers = anyone grade 8D and above who is not on Agenda for Change or on a Consultant pay grade.

Scope

1. The principles will apply to the pay, awards and terms of employment of the Trust's Chief Executive and Executive Directors and Very Senior Managers and include the following components:

- the core salary
- any supplementary payments to the Director over and above the core salary in recognition of extraordinary factors such as matching market forces in recruitment; exceptional performance etc.;
- additional non-pay benefits over and above the core salary including pensions, vehicle/lease car issues, mobile phones and other such benefits;
- the terms and conditions in regards to issues (such as notice periods, conditions attached at recruitment stage for professional development for example) etc.;
- arrangements for termination of employment and other contractual terms.

2. On an annual basis the Committee will consider whether any issues have emerged which require consideration of any adjustments to existing remuneration packages such as:

- at the beginning of a process to recruit a replacement Executive Director or Very Senior Manager ;
- when issues concerning national inflationary uplifts within the NHS need to be considered – on an annual basis;
- when changes are made to the size and scope of Executive Director or Very Senior Manager portfolios.

Remuneration Principles and Application 2018

Process for benchmarking Executive Director salaries

Each year the Committee will agree a number of trusts, typically 10-12, of a similar type, turnover, FTE, CQC rating and any other factor considered appropriate at that time and will establish the salary data for comparable executive director roles within those trusts as a primary source of benchmark data. In addition this will be completed for neighbouring trusts as directed by the Committee.

Each year NHS Providers complete a survey of remuneration paid to executive and non-executive directors of all trusts and foundation trusts operating in the UK. Typically between 140 and 150 trusts complete the return and data is collated into the annual dashboards. The data is sorted by trust size based on FTE and the largest group, median FTE, will be used to provide an additional source of benchmark data for comparison purposes.

The final set of data is that used by NHSI as benchmark data for very large trusts, i.e. those with a turnover of over £500m. NHSI provide median, upper and lower quartile data when publishing this data.

The Deputy Director of People will also provide some analysis of the benchmarking data, history of individuals pay awards and any other data regarding current or planned NHS pay awards to inform the Committee.

The Committee will use these sources of benchmark data to inform the discussion to decide remuneration for all Executive Director positions.

Process for benchmarking Very Senior Manager salaries

Benchmarking data for Very Senior Managers as defined in these principles is significantly more difficult to establish.

In advance of Very Senior Manager remuneration reviews, the Deputy Director of People will write to each of the benchmark trusts identified as the peer group for Executive Director remuneration reviews seek benchmark comparators. It must be recognised that different trusts may have significantly different management and leadership structures and direct comparison of roles is often very difficult. Trusts operating within the peninsula will also be approached irrespective of relative size to provide a local benchmark. The Deputy Director of People will also provide some analysis of the benchmarking data, recent history of individual pay awards, current Executive Director remuneration and any other data regarding current or planned NHS pay awards to inform the Committee during the review of Very Senior Manager packages.

The Chief Executive completes a formal annual performance review for all Executive Directors and the Chairman reviews the performance of the Chief Executive. These reviews are reported to RC and, whilst the Trust does not currently operate a performance related pay scheme, these reviews are considered as a part of the review of remuneration.

The Executive Directors are appointed on permanent contracts and have a six-month notice period.

The Trust follows Agenda for Change (AfC) principles in calculating severance packages for redundancy. The redundancy payment will take the form of a lump sum, dependent on the employee's reckonable service at the date of termination of employment. The lump sum will be calculated on the basis of one month's pay for each complete year of reckonable service, subject to a minimum of two years' continuous service and a maximum of 24 years' reckonable service being counted. Fractions of a year of reckonable service will not be taken into account. For those earning over £80,000 per year (full time equivalent) the redundancy payment will be calculated using notional full-time annual earnings of £80,000, prorated for employees working less than full time. No redundancy payment will exceed £160,000 (pro-rata).

In accordance with the Agenda for Change Terms and Conditions of Employment Executive Directors shall not be entitled to redundancy payments or early retirement on grounds of redundancy if:

- they are dismissed for reasons of misconduct, with or without notice; or
- at the date of the termination of the contract have obtained without a break, or with a break not exceeding four weeks, suitable alternative employment with the same or another NHS employer; or
- unreasonably refuse to accept or apply for suitable alternative employment with the same or another NHS employer; or
- leave their employment before expiry of notice, except if they are being released early; or

- they are offered a renewal of contract (with the substitution of the new employer for the previous NHS one); or
- where their employment is transferred to another public service employer who is not an NHS employer.

There was only one new component to the remuneration package introduced during the year and this applies only to the three executives that have specific board roles at NDHT arising as a result of the management agreement. The payments of between £10k and £19k are to recognise the increased responsibility that is created by holding accountable office roles on the NDHT board as well as the Board. This pays a fixed amount per annum for the duration of the agreement and this is reported in the remuneration tables below.

Future Policy Table

Element of pay (Component)	How component supports short and long term strategic objective/goal of the Trust	Operation of the component	Performance metric used and time period
<ul style="list-style-type: none"> Basic salary 	<p>Provides a stable basis for recruitment and retention, taking into account the Trust's position in the labour market and a need for a consistent approach to leadership.</p> <p>Stability, experience, reputation and widespread knowledge of local needs and requirements supports the Trust's short term strategic objectives outlined in its annual priorities and its long term strategic goals</p>	<p>Following market testing (undertaken every year) which seeks to identify salary paid for similar role, individuals are remunerated by spot salary on a case by case basis. There is no predefined upper limit.</p> <p>In accordance with the NHSI Guidance on pay for very senior managers in NHS trusts and Foundation Trusts the Chief Executive Officer contract includes a clause permitting 10% of salary to be clawed back if performance is not considered to be satisfactory.</p>	<p>Pay is reviewed annually in relation to individual performance based on agreed objectives set out prior to the start of that financial year which runs between 1 April and 31 March. Increases are ordinarily in line with the wider NHS workforce as recommended by the NHS Pay Review Body.</p>
<ul style="list-style-type: none"> Benefits 	N/A	N/A	N/A
<ul style="list-style-type: none"> Pension 	<p>Provides a solid basis for recruitment and retention of top leaders in sector.</p>	<p>Contributions within the relevant NHS pension scheme. Details of the schemes currently in place can be found at: http://www.nhsbsa.nhs.uk/Pensions.aspx</p>	<p>Contribution rates are set by the NHS Pension Scheme.</p>
<ul style="list-style-type: none"> Bonus 	N/A	N/A	N/A
<ul style="list-style-type: none"> Fees 	N/A	N/A	N/A

Directors' Remuneration 2018/19

Name and Title		Salary and Fees (bands of £5000)	Taxable Benefits (Rounded to the nearest £100)	Pension related Benefits (bands of £2500)	Other Remuneration (bands of £5000)	Golden hello / compensation for loss of office (bands of £5000)	Gross Total (bands of £5000)	Recharges to Northern Devon Healthcare NHS Trust (bands of £5000)	Net Total (bands of £5000)
J Brent	Chairman	45 - 50	-	-	-	-	45 - 50	15 - 20	25 - 30
J Ashman	Non-Executive Director	10 - 15	3,800	-	-	-	15 - 20	-	15 - 20
P Dillon	Non-Executive Director	15 - 20	1,200	-	-	-	15 - 20	-	15 - 20
J Kay	Non-Executive Director	10 - 15	-	-	-	-	10 - 15	-	10 - 15
S Kirby	Non-Executive Director	10 - 15	300	-	-	-	10 - 15	-	10 - 15
S Knowles	Non-Executive Director	10 - 15	-	-	-	-	10 - 15	-	10 - 15
A Matthews	Non-Executive Director (appointed 1 October 2018)	5 - 10	700	-	-	-	5 - 10	-	5 - 10
J McCloskey	Non-Executive Director (appointed 1 October 2018, resigned 14 January 2019)	0 - 5	-	-	-	-	0 - 5	-	0 - 5
M Romaine	Non-Executive Director (resigned 31 August 2018)	5 - 10	2,400	-	-	-	5 - 10	-	5 - 10
P Adey	Chief Operating Officer	135 - 140	-	85.0 - 87.5	-	-	225 - 230	85 - 90	135 - 140
J Cooper	Director of People (appointed 17 September 2018)	120 - 125	-	-	-	-	120 - 125	50 - 55	65 - 70
T Cottam	Executive Director Transformation and Organisational Development (stood down as Executive Director 1 September 2018)	50 - 55	-	40.0 - 42.5	-	-	90 - 95	-	90 - 95
A Harris	Executive Medical Director	200 - 205	100	130.0 - 132.5	-	-	330 - 335	125 - 130	200 - 205
C Tidman	Chief Financial Officer	145 - 150	100	-	5 - 10	-	150 - 155	-	150 - 155
S Tracey	Chief Executive	210 - 215	100	45.0 - 47.5	20 - 25	-	280 - 285	105 - 110	170 - 175
E Wilkinson - Brice	Deputy Chief Executive / Chief Nurse	145 - 150	100	-	-	-	145 - 150	-	145 - 150

There were no annual performance-related bonuses or long-term performance-related bonuses paid to any individual in the financial year.

The benefits in kind relate to the mileage allowance paid over and above the HM Revenue & Customs allowance for Executive Directors. For Non-Executive Directors official mileage is paid under a Payment Settlement Agreement (PSA) with HMRC, and the Trust makes payments for Tax and NI based on grossed up figures. Other remuneration for C Tidman relates to HMRC scheme approved relocation costs and for S Tracey a compensatory payment for expenses incurred.

The remuneration shown in the 'Recharges to Northern Devon Healthcare NHS Trust' column for J Brent, P Adey, J Cooper, A Harris and S Tracey relates to their roles as Directors under a collaborative agreement with Northern Devon Healthcare NHS Trust (NDHT), which commenced on 18 June 2018. The final column discloses the net total remuneration for each Director in respect of their duties for the Royal Devon & Exeter NHS Foundation Trust.

Directors' Remuneration 2017/18

Name and Title		Salary and Fees (bands of £5000)	Taxable Benefits (Rounded to the nearest £100)	Pension related Benefits (bands of £2500)	Other Remuneration (bands of £5000)	Golden hello / compensation for loss of office (bands of £5000)	Total (bands of £5000)
J Brent	Chairman	45-50	0	-	-	-	45-50
J Ashman	Non-Executive Director	10-15	4,600	-	-	-	15-20
P Dillon	Non-Executive Director	10-15	1,400	-	-	-	15-20
J Kay	Non-Executive Director	10-15	0	-	-	-	10-15
S Kirby	Non-Executive Director (appointed 1 September 2017)	5-10	400	-	-	-	5-10
S Knowles	Non-Executive Director (appointed 1 September 2017)	5-10	0	-	-	-	5-10
D Robertson	Non-Executive Director (resigned 31 October 2017)	5-10	0	-	-	-	5-10
M Romaine	Non-Executive Director	15-20	3,200	-	-	-	15-20
A Willis	Non-Executive Director (resigned 31 March 2017)	0	900	-	-	-	0-5
P Adey	Chief Operating Officer	120-125	100	70.0-72.5	-	-	190-195
T Cottam	Executive Director Transformation and Organisational Development	115-120	-	27.5-30.0	-	-	145-150
A Harris	Executive Medical Director	175-180	300	12.5-15.0	-	-	190-195
P Southard	Acting Chief Financial Officer (resigned 17 September 2017)	55-60	-	77.5-80.0	-	-	135-140
C Tidman	Chief Financial Officer (appointed 18 September 2017)	75-80	-	-	-	-	75-80
S Tracey	Chief Executive	185-190	200	157.5-160.0	-	-	340-345
E Wilkinson - Brice	Deputy Chief Executive / Chief Nurse	160-165	100	42.5-45.0	-	-	205-210

There were no annual performance-related bonuses or long-term performance-related bonuses paid to any individual in the financial year. E Wilkinson-Brice's salary includes an additional payment for her role as Senior Responsible Officer for the STP.

The benefits in kind relate to the mileage allowance paid over and above the HM Revenue & Customs allowance for Executive Directors. For Non-Executive Directors official mileage is paid under a Payment Settlement Agreement (PSA) with HMRC, and the Trust makes payments for Tax and NI based on grossed up figures.

Pension related benefits for defined benefit schemes:

The amount included is the annual increase (expressed in £2,500 bands) in pension entitlement determined in accordance with the 'HMRC' method. The HMRC method derives from s229 of the Finance Act 2004, but is modified for the purpose of this calculation. In summary the increase in value is calculated as follows:

$((20 \times PE) + LSE) - ((20 \times PB) + LSB)$ - employee contributions.

- PE is the annual rate of pension that would be payable to the director if they became entitled to it at the end of the financial year;
- PB is the annual rate of pension, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year;
- LSE is the amount of lump sum that would be payable to the director if they became entitled to it at the end of the financial year;
- and LSB is the amount of lump sum, adjusted for inflation, that would be payable to the director if they became entitled to it at the beginning of the financial year.

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

Reporting bodies are required to disclose the relationship between the remuneration of the highest paid director in their organisation and the median remuneration of the organisation's workforce.

The banded remuneration of the highest paid director in the organisation in the financial year 2018-19 was £145k- £150k (2017-18, £185k - £190k). This was 5.1 times (2017-18, 6.8 times) the median remuneration of the workforce, which was £28.7k (2017-18, £27.6k).

In 2018-19, 76 (2017-18, 8) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £150k to £242k (2017-18, £187k to £247k).

Total remuneration includes salary, non-consolidated performance-related pay and benefits-in-kind. It does not include severance payments, employer pension contributions and the cash equivalent transfer value of pensions. The calculation is based on the full-time equivalent staff of the Trust at the reporting period end date on an annualised basis. Where there is a sharing arrangement, it is cost to the entity of an individual that identifies them as "highest paid" and not the total of that individual's remuneration. A proportion of the remuneration for the Chief Executive, Medical Director and Chief Operating Officer are recovered from Northern Devon Healthcare Trust under the terms of the Management Contract and as a result E Wilkinson-Brice is the highest paid Director for the purposes of the calculation accounting for the significant change in Director pay since last year. The three-year national pay deal is responsible for the change in median pay for employees.

	2018-19	2017-18
	£000	£000
<i>Band of highest paid Director – as above</i>	<i>145-150</i>	<i>185-190</i>
<i>Median remuneration received by employees within the Trust</i>	<i>28.7</i>	<i>27.6</i>
<i>Ratio</i>	<i>5.1</i>	<i>6.8</i>

Pension Benefits 2018/19

Name and Title		Real increase in pension at age 60 (bands £2,500)	Real increase in pension related sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2019 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2019 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2019 (£'000)	Cash Equivalent Transfer Value at 31 March 2018 (£'000)	Real Increase in Cash Equivalent Transfer Value at 31 March 2019 (£'000)
P Adey	Chief Operating Officer	5-7.5	5-7.5	55-60	140-145	1136	914	194
J Cooper	Director of People (appointed 17 September 2018)	-	-	-	-	-	-	-
T Cottam	Executive Director Transformation and Organisational Development (stood down as Executive Director 1 October 2018)	2.5-5	0-2.5	10-15	0-5	200	134	63
A Harris	Executive Medical Director	5-7.5	20-22.5	65-70	195-200	1513	1194	284
C Tidman	Chief Financial Officer	-	-	-	-	-	-	-
S Tracey	Chief Executive	2.5-5	0-2.5	45-50	95-100	821	669	131
E Wilkinson-Brice	Deputy Chief Executive / Chief Nurse	-	-	-	-	-	-	-

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

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

or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

Cash Equivalent Transfer Values (CETV) are not available for members that have reached the normal retirement age or who have commenced drawing their pension or are a deferred member.

Pension Benefits 2017/18

Name and Title		Real increase in pension at age 60 (bands £2,500)	Real increase in pension related sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2018 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018 (£'000)	Cash Equivalent Transfer Value at 31 March 2017 (£'000)	Real Increase in Cash Equivalent Transfer Value at 31 March 2018 (£'000)
P Adey	Chief Operating Officer	2.5-5	5-7.5	50-55	130-135	914	828	86
T Cottam	Executive Director Transformation and Organisational Development	0-2.5	0-2.5	10-15	0-5	133	100	32
A Harris	Executive Medical Director	0-2.5	5-7.5	55-60	170-175	1193	1087	96
P Southard	Acting Chief Financial Officer (appointed 1 July 2016)	0-2.5	2.5-5	45-50	120-125	802	709	87
S Tracey	Chief Executive	7.5-10	7.5-10	40-45	90-95	669	531	133
C Tidman	Chief Financial Officer (appointed 18 September 2017)	0.00	0.00	0.00	0.00	0	0	0
E Wilkinson-Brice	Deputy Chief Executive / Chief Nurse	0-2.5	0-2.5	55-60	145-150	890	801	82

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

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

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

Cash Equivalent Transfer Values (CETV) are not available for members that have reached the normal retirement age or who have commenced drawing their pension or are a deferred member.

Signed:



Suzanne Tracey

Chief Executive

Date: 22 May 2019

STAFF REPORT

The Trust recognises the exceptional work of all our staff and the Trust has created an environment and a range of ways through which the commitment and hard work of our dedicated workforce is recognised and supported through these challenging times. In addition to an increasingly comprehensive range of mental and physical health support for our staff we have also introduced an external Employee Assistance Programme that provides access to support 24 hours a day, 365 days a year.

Staff Numbers

Note 4.3 Average number of employees (WTE basis)	A09CY01	A09CY01P	A09CY01O	A09PY01	A09PY01P	A09PY01O	Maincode
	Total 2018/19 No.	Permanent 2018/19 No.	Other 2018/19 No.	Total 2017/18 No.	Permanent 2017/18 No.	Other 2017/18 No.	Subcode
Medical and dental	835	816	19	779	760	19	STA0370
Ambulance staff	0			0	0		STA0380
Administration and estates	1,428	1,309	119	1,531	1,447	84	STA0390
Healthcare assistants and other support staff	2,504	2,380	124	2,041	1,945	96	STA0400
Nursing, midwifery and health visiting staff	1,915	1,826	89	1,954	1,849	105	STA0410
Nursing, midwifery and health visiting learners	15	15		11	11		STA0420
Scientific, therapeutic and technical staff	721	704	17	681	670	11	STA0430
Healthcare science staff	197	197		194	194		STA0440
Social care staff	0			0			STA0450
Agency and contract staff				0			STA0460
Bank staff				0			STA0470
Other	0			0			STA0480
Total average numbers	7,615	7,247	368	7,191	6,876	315	STA0490
Of which:							
Number of employees (WTE) engaged on capital projects	75	75		0			STA0500

Staff numbers have increased again this year primarily as a result of transfers into the Trust. For example, the increase in Medical and Dental staffing is almost exclusively related to the transfer of GP Trainees from HEE to the Trust.

Staff Costs

Staff costs for 2018/19 and 2017/18 are summarised in the table below.

Note 4.2 Employee Expenses (Group after consolidation of charity)	A09CY01	A09CY01P	A09CY01O	A09PY01	A09PY01P	A09PY01O
	Total 2018/19 £000	Permanent 2018/19 £000	Other 2018/19 £000	Total 2017/18 £000	Permanent 2017/18 £000	Other 2017/18 £000
Salaries and wages	261,112	259,697	1,415	243,265	242,046	1,219
Social security costs	23,600	23,600	0	21,880	21,880	0
Apprenticeship levy	1,288	1,288	0	1,191	1,191	0
Pension cost - defined contribution plans (employer's contributions to NHS pensions)	31,706	31,706	0	29,531	29,531	0
Pension cost - other	117	117	0	30	30	0
Other post-employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	172	172	0	856	856	0
Temporary staff - external bank	0	0	0	0	0	0
Temporary staff - agency/contract staff	11,627	0	11,627	7,641	0	7,641
NHS charitable funds staff	0	0	0	0	0	0
TOTAL GROSS STAFF COSTS	329,622	316,580	13,042	304,394	295,534	8,860
Recoveries from DHSC Group bodies in respect of staff cost netted off expenditure	0	0	0	0	0	0
Recoveries from other bodies in respect of staff cost netted off expenditure	0	0	0	0	0	0
TOTAL STAFF COSTS	329,622	316,580	13,042	304,394	295,534	8,860

Note 6.1 Reporting of other compensation schemes - exit packages 2018/19			A09CY17	A09CY18	A09CY19	A09CY20	A09CY21	A09CY22	A09CY23	A09CY24	Maincode
		Expected sign	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages	
			2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	2018/19	
			No.	£000	No.	£000	No.	£000	No.	£000	Subcode
Exit package cost band (including any special payment element)											
<£10,000		+	3	6	18	55	21	61			STA0560
£10,000 - £25,000		+			5	83	5	83			STA0570
£25,001 - £50,000		+			1	26	1	26			STA0580
£50,001 - £100,000		+					0	0			STA0590
£100,001 - £150,000		+					0	0			STA0600
£150,001 - £200,000		+					0	0			STA0610
>£200,000		+					0	0			STA0620
Total		+	3	6	24	164	27	170	0	0	STA0630

FTs refer to annex 1 to chapter 2 of the FT Annual Reporting Manual 2018/19. NHS Trusts refer to paragraph 3.57(h) and annex 3 to chapter 3 of the Group Accounting Manual 2018/19. Note that all exit packages must be disclosed in the above note including those also disclosed in the Directors' Remuneration Report.

Note 6.2 Reporting of other compensation schemes - exit packages 2017/18			A09PY17	A09PY18	A09PY19	A09PY20	A09PY21	A09PY22	A09PY23	A09PY24	Maincode
		Expected sign	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages	
			2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	2017/18	
Note that columns G, I and M are entered in £000 NHS Trusts - note that the GAM advises local accounts should be in £			No.	£000	No.	£000	No.	£000	No.	£000	Subcode
Exit package cost band (including any special payment element)											
<£10,000		+	50	229	16	47	66	276			STA0560
£10,000 - £25,000		+	18	279	1	20	19	299			STA0570
£25,001 - £50,000		+	6	243	1	38	7	281			STA0580
£50,001 - £100,000		+					0	0			STA0590
£100,001 - £150,000		+					0	0			STA0600
£150,001 - £200,000		+					0	0			STA0610
>£200,000		+					0	0			STA0620
Total		+	74	751	18	105	92	856	0	0	STA0630

Note 6.3 Exit packages: other (non-compulsory) departure payment		Expected sign	A09CY25	A09CY26	A09PY25	A09PY26	Maincode
			Payments agreed	Total value of agreements	Payments agreed	Total value of agreements	
			2018/19	2018/19	2017/18	2017/18	
			No.	£000	No.	£000	Subcode
Voluntary redundancies including early retirement contractual costs		+					STA0720
Mutually agreed resignations (MARS) contractual costs		+					STA0730
Early retirements in the efficiency of the service contractual costs		+					STA0740
Contractual payments in lieu of notice		+	18	89	13	37	STA0750
Exit payments following employment tribunals or court orders		+	6	75	5	68	STA0760
Non-contractual payments requiring HMT approval (special severance payments)*	<i>i</i>	+					STA0770
Total**		+	24	164	18	105	STA0780
of which:							
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary		+					STA0790

* Includes any non-contractual severance payment made following judicial mediation, and non-contractual payments in lieu of notice [please note additional footnote disclosure required in accounts by Group Accounting Manual Annex 3 to Chapter 3]

** As individual exit packages can be made up of several components, each of which listed in this note, the total number of payments listed in this note may exceed the total number of other departures agreed in Note 6.1 and Note 6.2, which will be the number of individuals.

Gender Equality

The Trust is committed to achieving equality and diversity in all that we do, for our staff and in the services they provide. The numbers of male and female employees at 31 March 2019 is reported in the table below.

	Female	Male	Total
Directors	5	8	13
Other Senior Managers	0	0	0
Employees*	6,516	1,733	8,249

*The figure for employees is the total number of employees as opposed to the whole time equivalent reported in the staff number section above.

Sickness Absence

The total number of days lost to sickness in 2018/19 has increased compared to 2017/18. While there has been an increase in staff numbers over the same period, the number of days lost to sickness has increased above and above the increase in staff numbers, with the average number of working days lost per whole time equivalent increasing from nine to 10.

Staff Sickness Absence	2018/19	2017/18
Total days lost	72,473	64,577
Total staff years	7,067	6,872
Average working days lost (per WTE)	10	9

Disability

The Equality Act 2010 defines disability and makes it clear that a person is disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to do normal daily activities. The Board has reviewed our approach to inclusion as described in the Equality, Diversity and Inclusion section of the Annual Report. The Trust is already taking a variety of actions to support both existing staff and applicants wishing to join the Trust.

The Director of People is personally responsible for ensuring that the Trust complies with equality law and any relevant NHS standards for the promotion and assessment of equality. This reflects the importance placed by the Trust on the proper and equitable treatment of all applicants, workers and service users regardless of disability. All staff undergo equality and diversity training, raising awareness of personal and Trust responsibilities to

those with any protected characteristic including disability, and through the Towards Inclusion Plan this training will be expanded in the future. The Director of People will lead implementation of the workforce disability equality standard (WDES) later this year.

The core Trust Policy that applied during the financial year is the Equality and Diversity Policy. This policy gives full and fair consideration to applications for employment made by disabled persons relating to their particular aptitudes and abilities, for continuing the employment and arranging appropriate training for employees who have become disabled persons during the period and for the training and for career development and promotion of disabled employees. This policy was subject to periodic review and was ratified by the Workforce and Governance Committee in May 2015.

The ultimate aim of the policy is to harness the individuality of every employee, so everyone is fully engaged in the work of the Trust and to protect all workers and service users from all forms of discrimination, harassment and victimisation on the basis of any protected characteristic.

We have been recognised as Positive about Disabled People, for our work supporting employees with disabilities and hold a number of accreditations demonstrating our supportive approach towards staff and applicants with both physical and mental health issues. Following funding changes the educational needs assessment provider that the Trust had been using has ceased trading and we are currently negotiating with a local education college to provide this support going forwards.

Recruitment

The Recruitment and Selection Policy is designed to ensure that recruitment is carried out in accordance with the Equality Act 2010. Its aim is to ensure that applicants feel that they have been dealt with professionally, fairly and that they feel that the Trust values its staff.

The Trust is accredited by Jobcentre Plus to use the 'Positive about Disabled People' symbol. This means that the Trust will:

- Interview all applicants with a disability who meet the minimum criteria for a position and consider them on their abilities
- Consult with employees with a disability about how the Trust can help develop their abilities

- Make every effort when employees acquire a disability to make sure they stay in employment
- Take action to ensure that all employees develop sufficient awareness of disability to make these commitments work
- Review these commitments and plan on ways to improve them.

All applicants for employment with the Trust complete a Health Questionnaire that is reviewed by the Occupational Health Service (OHS) as a part of the recruitment process. If issues are identified, the individual will be invited to attend the OHS where an assessment is completed and recommendations made so that whenever possible the person may be employed safely. Experts from both the Occupational Health Service and Human Resources are available to provide reasonable adjustment advice and guidance to managers during and after the recruitment process.

Staff Who Become Disabled

Whenever possible we support staff to either prevent or minimise the impact of any disability on the ability to work. Early referrals to the Occupational Health Service are encouraged so that action can be taken to aid rehabilitation and return to work following illness or injury, making any reasonable adjustments that can assist. Actions taken to assist staff who develop disability include provision of additional software, specially adapted hardware or larger screen to facilitate use of technology, adjustments to desks or chairs through to job redesign to enable a person to continue working. Over the last 12 months Sixteen Mental Health Champions have been appointed and have received two-day training in Mental Health First Aid. This is in addition to the mental health awareness briefings delivered for managers and two other Mental Health First Aid programmes for other staff.

The Stress Management: Prevention, Recognition and Support Policy is supported with an extensive Manager's Toolkit to help managers have a positive impact on the health and wellbeing of employees. A Health and Wellbeing Improvement Practitioner was appointed in 2017 and a significant part of her remit is to aid in the prevention of injury through an extensive programme of information, education and engagement events.

Mindful Employer

The Trust holds the Mindful Employer accreditation for the way we promote good mental health among our employees. The Mindful Employer scheme delivers against the following aims:

- Show a positive and enabling attitude to employees and job applicants with mental health issues. This will include positive statements in local recruitment literature.
- Ensure that all staff involved in recruitment and selection are briefed on mental health issues and the Disability Discrimination Act, and given appropriate interview skills.
- Make it clear in any recruitment or occupational health check that people who have experienced mental health issues will not be discriminated against and that disclosure of a mental health issue will enable both employee and employer to assess and provide the right level of support or adjustment.
- Not make assumptions that a person with a mental health issue will be more vulnerable to workplace stress or take more time off than any other employee or job applicant.
- Provide non-judgemental and proactive support to individual staff who experience mental health issues.
- Ensure all line managers have information and training about managing mental health in the workplace.

Career Development and Promotion

The Trust is committed to the support and development of all our staff, irrespective of any disability, and this is supported by managers creating Personal Development Plans (PDPs) with their staff in order to identify any areas for them to learn and develop within their roles. These are then used in conjunction with our comprehensive Learning and Development Department and Professional Development Team who can offer a range of training from clinical skills and management skills training to customer care. Many of our training and development programmes are accessible through a range of training approaches including both face to face and e-learning giving staff the opportunity to learn through the methodology best suited to their learning preferences and needs.

The key policy that guides all staff is the Recruitment and Selection Policy. It is designed to ensure that selection and promotion is carried out in accordance with the Equality Act 2010. A range of policies including Staff Development, Essential Learning, e-Learning and Study and Professional Leave are all designed to support staff equitably in their career development.

Countering Fraud and Corruption

The Trust is committed to countering fraud and corruption and achieves this by maintaining a close working relationship with the South West Counter Fraud Team and by raising awareness of fraud through both the internal intranet (HUB) and face to face presentations delivered to staff at both Divisional and Speciality Level.

The Trust has a number of policies to guide and support staff such as the Standards of Business Conduct and the Trust's Whistleblowing Policy. Staff access Trust policies via HUB and are encouraged to seek clarification direct from the policy author or through the Head of Governance.

The South West Counter Fraud Team monitor and report fraud to the Board through the Audit Committee.

Expenditure on consultancy

The total expenditure on consultancy for the 2018-19 financial year was £895k.

Trade Union Facility Time

As part of the Trade Union (Facilities Time Publication Requirements) Regulations 2017, information has been collated regarding the facilities time activities of our recognised Trade Union officials during the relevant period of 1 April 2018 to 31 March 2019. The following calculations have been undertaken and the results are detailed in the tables below:

- Number of employees who were relevant union officials during the relevant period
- Full-time equivalent employee number
- Percentage of time spent on facility time
- Percentage of pay bill spent on facility time
- Paid trade union activities

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
33	30.55

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	6
1-50%	25
51-99%	1
100%	1

Percentage of pay bill spent on facility time

	Figures
Provide the total cost of facility time	£95,129
Provide the total pay bill	£261,062,000
Provide the percentage of the total pay bill spent on facility time, calculated as: (total cost of facility time ÷ total pay bill) x 100	$(95,129/261,062,000)100 = 0.036\%$

Paid trade union activities

Time spent on paid trade union activities as a percentage of total paid facility time hours calculated as: (total hours spent on paid trade union activities by relevant trade union officials during the relevant period ÷ total paid facility time hours) x 100	9.16%
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STAFF SURVEY

The RD&E employs over 8,000 people all of whom perform a range of different roles, working together to achieve the best and safest outcomes for people who require acute care and working with communities (and other stakeholders) to support people to stay healthy and well at home. While staff at the RD&E share a common purpose, there is a great deal of diversity in their backgrounds and experiences. In developing effective communications, inclusion and engagement strategies for our people, we recognise and celebrate those differences and design a blended approach to ensure that all voices are heard and that everyone can learn about what is going on across the Trust and participate as they choose.

Over the last six years, the Trust has consciously sought to improve staff engagement as part of a broader organisational development and culture change agenda. Based on overwhelming academic evidence that demonstrates a clear link between committed and motivated staff, improved patient outcomes and patient experience; the Trust has committed to an objective to build a culture in which staff engagement is viewed as mission critical.

Research on staff-reported experience was carried out by Kings Fund and Picker (2018), and this confirmed a correlation with patient feedback, notably between staff perceptions of care quality and patient experience. Unsurprisingly their research also established that patient experience was negatively associated with workforce factors: higher spend on agency staff, fewer doctors and especially fewer nurses per bed and bed occupancy. A 2018 report by NHS Employers established:

“many factors of staff experience are important in predicting patient experience. High work pressure for staff, staff perceptions of unequal treatment, and discrimination against staff were all damaging for patient satisfaction, as was physical violence between staff. However, having the right conditions to deliver patient care is about more than the absence of negative experiences: it is about being able to work effectively together in effective teams, with well-designed jobs.”

Our approach focuses on:

- creating the necessary conditions and environment to improve staff engagement
- using every opportunity to bring our values to life, embedding them into our DNA
- enabling all managers and leaders to continuously improve engagement of their people
- promoting and facilitating two-way conversations with staff
- ensuring that our staff have consistent messaging and the right information to do their jobs
- setting out a clear expectation of behaviour changes incorporated into the Trust’s culture.

Our stakeholders are also our people – the people who work tirelessly every day to deliver great care for the people who require it. There are many definitions of engagement however employee engagement essentially describes what happens when people act and think in a positive way about the work they do, the people they work with and the organisation they work in. From the health service perspective the following definition is useful: “Employee engagement describes the involvement of people at all levels in positive two-way dialogue and action to deliver the highest quality patient care and create great places to work – where people find their work meaningful and are willing to work together for patients, their colleagues and the future success of their organisation” (Huggett et al, 2008).

- In addition to the reputational benefits brought about by employee engagement there is compelling evidence that employee engagement in healthcare has significant benefits for organisations, staff and patients, notably:
- It improves patient care outcomes and experiences. West and Dawson (2012) put forward compelling evidence that organisations with a strong culture of employee engagement report lower patient mortality rates and lower infection rates, as well as higher patient satisfaction scores and suggest it is when organisations care for their staff, staff can fulfil their roles of caring for their patients.
- It helps to deliver continued improvements and programmes of change – The King’s Fund Report (2012) proposes that engaged staff are likely to exert more influence over the use of standard processes, teamwork and the degree to which there is a culture of improvement.
- It helps connect clinicians with the organisation as well as the professional agenda and take on leadership roles.
- It can improve sickness absence.

Staff engagement cannot be achieved through internal communications alone. There are a range of influential factors including reward, recognition and leadership contributing to staff engagement levels, all of which are set out in the People Strategy developed in early 2018.

Building on our achievements to date the Trust’s staff engagement and communications approach

is central to a comprehensive transformational organisational development approach. By integrating elements of our People, Quality Improvement and Stakeholder Engagement strategies, we have built a comprehensive approach to cultural change and transformation which has staff engagement at its heart.

Our methodology is one that encompasses the whole organisation and is based on the understanding that all staff have a role to play in staff engagement and that engagement is a two-way process.

It is essential to enable staff to develop the necessary skills and behaviours required to manage the level and scale of change required to deliver health and care differently into the future. Our integrated organisation aims to deliver more joined-up care for people out of hospital and this will only be realised if the culture and outlook of staff right across the organisation rapidly adapts. Our staff need to be at the heart of these changes as we lead the way in helping to innovate and transform services, to ensure that our current health system is fit for the future.

In the context of the changes required, there is a need to address the entrenched cultural norms and ways of working in order to facilitate the new ways in which care will need to be delivered differently, now and into the future. We have already begun this process through cross learning between the acute and the community elements of our organisation.

We will continue to build better integration across acute and community settings to enable better care and services to be delivered. In addition, we have started to improve integration of physical and mental health provision by working with our mental health partner, Devon partnership Trust. Together we have:

- Psychiatric liaison team with our Emergency Department, enabling more effective triage and care to be delivered to people attending with mental health needs (often in association with physical health needs)
- As a joint partnership we formed the Devon Flow Coaching Academy (FCA), the first combined physical and mental health FCA in the country. Led by clinical and non-clinical staff, this has engaged patients and staff in delivering quality improvements across three pathways since April 2018. The success of this approach has resulted in a further nine pathways to be added with our partners from Torbay and South Devon Trust joining the FCA.
- Since 2014, the Trust has embedded Connecting Care – one of our key ways of engaging staff in

quality and performance improvement. Every team across the acute, community and corporate settings are involved in daily/weekly conversations around how they can improve delivery of care and services.

Approach and Key Activities

As noted above, the Trust takes an integrated and holistic approach to improving staff engagement. This section highlights some of our core activities designed to boost staff engagement levels.

Values and behaviours

Over the next year we will continue to embed our values with a focus on quality improvement and inclusion as well as continuing with ongoing activities including within our:

- induction and orientation day for new staff
- attraction and recruitment approach
- learning and development programmes
- PDR approach.

Staff engagement activities

- The Trust has continued to engage each Division and Department in developing and implementing a bespoke engagement plan, based on the evidence collated from the staff survey and other local/ anecdotal evidence for their area. Supporting Divisional Directors and Managers, we developed and launched the Everyday Engagement Toolkit, guiding managers through their engagement planning. This approach has helped drive improvements in staff engagement and other relevant indicators. The sharing of the plans and support from the Communications and Engagement team to all parts of the Trust has enabled best practice and cross fertilisation to take place. It has also enabled bespoke support to be provided to those people that have specific issues to tackle or where there is underperformance. Communication Cells continue to play a key role in cascading messages and engaging staff to identify and solve problems at their level.
- During the year we have continued to use Executive webinars (WebExecs) to give an opportunity for staff to keep up to date with issues of strategic and operational importance in brief video messages by the Chief Executive. This is a two-way channel with staff able to put forward questions and receive a response from the Executive team in real time. Staff unable to attend the live session can watch the recorded session at a later stage at a time at their convenience. The blog sits alongside our existing communication products: Staff Briefing is a two-

sided A4 summary of key issues that all staff need to be aware of. Both products support the cascading of information at the Connecting Care communications cells, i.e. team or ward meetings.

- Our intranet (HUB) is the main way in which staff find out key information about the Trust, keep up-to-date with news, access vital policies and comment on key issues. A round-up of the weekly news on the HUB, 'HUB bites', is a popular way for staff to easily get an overview of the latest stories and updates. Internal surveys show that the intranet is the main way in which staff find out information and is the preferential way of receiving information for the majority of staff.
- Our award scheme – Extraordinary People – has continued to be a success during the year. The scheme, which is run three times a year, culminating in an end-of-year Winner of Winners event, regularly attracts on average over 80 nominations each time it is run and is highly valued by staff. Patients, carers, relatives and staff are able to submit nominations across a range of categories recognising individuals and teams who have gone the "extra mile".
- We also undertake regular "Staff Say" meetings. These meetings provide a safe environment for staff to openly discuss issues of concern or anxiety and, through this process, anonymously raise issues with leaders. The topics discussed with staff then inform actions within our delivery plans and we keep staff updated through our communications channels.

Engaging with Community Colleagues

Across East and Mid Devon we've been continuing to work on changing the dynamic into one where we as statutory agencies join rather than dictate community engagement. This work started by bringing together all the different groups in what we call 'Community Conversations', in an initiative which aims to pass leadership on engagement to local communities, and better connect GPs and other health professionals, local government, social services, the voluntary sector and local people, in ways that work for them.

The Community Conversations, which now take place in ten market towns, have evolved in different ways, with different contributors and at different paces. None have conformed to a single standard blue print but have developed in line with how those leading the initiatives have taken them. For a number of places, the output from these ongoing conversations has been the development of community-led, co-owned and co-produced plans to develop the right mix of bespoke interventions targeted at the specific needs of local citizens (and which seek to address the wider determinants of health and wellbeing), and the coordination of existing assets and connections that currently support people in their communities.

The approaches and formats have been different in each community but what matters most is that a self-selected group of people have an opportunity to come together to work on things that matter to them and the wider community and are able to effect real change.

Staff survey results in summary

In 2018, the Trust, as part of its staff engagement strategy, undertook a full census survey of its staff. The response rate was 52.8% which was 11.8 per cent higher than the national average for Combined Acute and Community (A&C) Trusts.

Key findings on staff sentiment

In terms of staff sentiment against four key indicators the trust has continued to improve and is rated above average by our people. We will continue to have a focus on all four indicators over the next year.

Staff sentiment indicator	Acute & Community Trust 2018		RD&E outcome 2017	RD&E outcome 2018	Trajectory
	Average	Best			
Staff recommending the organisation as a place to work	61%	77%	70%	73%	↑
Staff recommending that if a friend or relative needed treatment would be happy with the standard of care provided	70%	90%	84%	86%	↑
Staff feeling care if patients/service users is organisations top priority	76%	89%	81%	85%	↑
Staff think the organisation acts on concerns raised by patients/users	73%	84%	76%	77%	↑

The overall 'staff engagement' indicator, assessed by combining the answers to nine key questions increased significantly at 7.3 (out of 10) comparing to 7.0 nationally for Acute & Community Trusts and places the RD&E in joint third position nationally in the combined category. Other areas in which the Trust does well and scores 0.1 point lower than the best Trust nationally in the A&C category include:

- Equality, diversity & inclusion
- Health and wellbeing
- Morale

While the survey highlights key achievements it also identifies a number of areas with room for improvement, with the following areas identified as our key improvement areas:

- Quality of appraisals
- Effective use of patient / service user feedback
- Pockets of the Trust with low engagement scores

Work has commenced to engage with staff, patients and service users to drive improvements in all three areas.

Summary of Results: Overall staff survey response

	2017/18	2018/19		Trust improvement/deterioration
Response rate	RD&E	RD&E	Combined Acute & Community Trusts	
	50%	53%	41%	3% increase

Summary of Results: Selected indicators

	2018/19		2017/18	
	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.4	9.2	9.3	9.5
Health and wellbeing	6.3	6.4	6.4	6.0
Immediate managers	6.9	6.8	7.0	6.8
Morale	6.4	6.5	-	-
Quality of appraisals	5.1	5.4	5.2	5.3
Quality of care	7.4	7.4	7.4	7.5
Safe environment – bullying and harassment	8.4	8.1	8.4	8.1
Safe environment – violence	9.5	9.5	9.5	9.5
Safety culture	6.9	6.7	6.8	6.7
Staff engagement	7.3	7.4	7.3	7.0

2018 Action Plan, Priorities and Targets

Over the past year the Trust has prioritised addressing the areas highlighted by staff in the previous year's (2017) NHS staff survey. Spanning a range of topics, the summary below provides an update on the work undertaken by the Trust:

Operational Demands

Staff said: "I love my job, unfortunately due to staffing levels, I feel I am unable to carry out my role to the best of my ability."

In response: At the start of 2018 the Trust invested significantly in increasing staffing to ensure we have enough staff to provide high quality care for our patients. In addition the Trust has invested further funds in increasing staffing levels to give ourselves the best possible chance of managing winter pressures to support high quality patient care and to minimise the pressure faced by staff at times when demand for emergency care is at its peak. In the meantime, we continue to look at new roles and overseas recruitment to support staff.

Improve the Appraisal Process

Staff said: "Improve our appraisal and PDR process, including providing support about my work and discussing organisational values".

In response: A PDR task team formed and our new PDR approach will be called "Valuing YOU". The Board have agreed an approach to identifying talent and to recognise and value what all our people do every day. This approach has already been built into existing PDR skills training, supporting our leaders to start to have conversations about individual's aspirations and how we can retain and develop all our people and identify our future potential talent.

Developing the potential of people

Staff said: "I enjoy working here but would like to be able to access career progression more easily"

In response: Clear career pathways for clinical staff have been established to ensure visibility of developmental opportunities. The Trust has developed a full suite of pathways for leaders and managers. An in-house accredited coaching service is available, a systems leadership programme, a range of masterclasses from PDR skills to courageous conversations. Development of our managers and leaders will remain a priority over the next year.

Staff Engagement

Staff said: "We rate the Trust as top 4th A&C Trust in 2017, though across the Trust the engagement score vary".

In response: Our Divisions (and some Departments) have been supported to develop local staff engagement plans in response to local findings in the 2017 staff survey. In addition, the Trust is piloting a scheme working with Junior Doctors/Doctors in Training to create an engagement plan for this staff group. A staff engagement steering team with wide representation acted to spread best practice. The Engagement Team continually researches external best practice to inform action plans for improving staff engagement further within the Trust.

Effective use of Patient / Service User feedback

Staff said: "We don't collect and use patient/service user feedback sufficiently across the Trust."

In response: Patient Experience Leads and Associate Directors of Nursing are proactively sharing Patient Experience Committee reports within their division for wider learning and are working with a central team to develop a consistent approach to complaints reviews which will allow for easier feedback and wider sharing. The Trust is recruiting a volunteer coordinator role in 2019, capturing real-time feedback will form a core part of our future approach to use patient/service user feedback.

Car Parking

Staff said: "Parking and commuting options not sufficient, causes stress worrying about how to get to work."

In response: The Trust has improved Park & Ride capacity by some 250 spaces. A bus subsidy is in place for all staff, with over 1100 staff members already on board. Cycle to work salary sacrifice scheme is in place and extra bike storage/racks now in place. We continue to work with our wider Devon partners to identify other creative solutions.

Health and Wellbeing

Staff said: "Rating the Trust above the average for prioritising health and wellbeing, though in the free text comments, stress is still a concern for many colleagues."

In response: The Trust has continued to focus on increasing support and training for mental health. Nearly 600 staff have attended a Stress Self-Management Workshop and a further 126 managers have had additional training on how to manage stress and support those with mental health problems. The Trust now has 70 Mental Health Champions and 78 Health and Wellbeing Champions across the Trust supporting colleagues locally to improve their health and wellbeing.

Additionally, in March 2018, the Trust conducted a Health and Wellbeing Survey with our staff. Over 2000 staff completed this survey which provided further insight into the health needs of staff, as per below:

Summary of overall health needs of our staff

- Overall Health: 71% rated their health as good or very good (only 4.5% rated their health as poor or very poor)
- Physical Activity: 30% of staff are achieving 4+ days a week of exercise, however 32% of staff were achieving only 30 minutes or less of exercise per week (Inactive).
- Active Travel: 21% walk to work; 6% cycle
- Musculoskeletal problems: 49% of those that have suffered from MSK problems felt supported.
- Diet: 67% of staff do not achieve their 5+ a day; 43% of staff regularly go longer than 4 hours between meals/snacks; 37% drink 4 glasses of fluid or less in a typical working day.
- Weight: 44% of staff are overweight
- Alcohol: 9% of staff reported drinking on 4+ days per week.
- Smoking: 6% of staff smoke (daily) and another 3% smoke e-cigarettes
- Menopause: 26% of those staff that have gone/going through the menopause did NOT feel supported at work during this time.
- Summary of mental health needs of our staff:
 - 28% of staff would describe their job as very or extremely stressful in the past year
 - 57% report work demands as the main cause of stress
 - Other key causes of stress include: Personal Circumstances (19%); Not feeling valued (18%); Poor leadership (17%); Organisational Change (17%)
- To further support with mental wellbeing staff would like to see:
 - Relaxation sessions (49%)
 - Mindfulness courses (33%)
 - Stress management workshops (32%)
- Clinical staff also wanted better support after an incident/emotional shift and community staff were interested in Resilience Sessions
- 70% of managers reported they were only somewhat to not very confident in providing support/advice on mental health issues

In response to the results from the health and wellbeing survey, some key initiatives which the Trust has implemented include:

- Management Essentials Training Course
- Stress Self-Management Workshops
- Building Resilience Course
- Mental Health First Aid Training for Mental Health Champions
- Increased access and opportunities for community based staff

Future Staff Engagement Priorities and Targets

The Trust's 2019 engagement priorities are being developed in partnership with representative from across the trust and the Engagement Team, with discussions informed by results from the 2018 staff survey findings.

Areas the Trust is considering:

- Promote and support the implementation of a new appraisal/PDR system
- Implementing a plan for how we better make use of patient/service user feedback
- Embedding Values and Behaviours – within for example appraisal/PDRs, and the newly adopted Towards Inclusion strategy
- Promoting and sharing good practice of quality of care across the Trust
- Engagement planning and deep dive Divisional/departmental, to continue supporting the development and implementation of localised engagement plans
- Seeking to continue the successful delivery of the Health and Wellbeing programme, having just launched the second annual survey to all Trust staff

We will continue the conscious effort to improve on the Trust staff experience, with the aim to maintain our position within the top five Trusts among the 43 Acute and Community Trusts, in terms of engagement score in the NHS staff survey.

OFF PAYROLL PAYMENTS

There were no off-payroll engagements as of 31 March 2019, for more than £245 per day and that lasted for longer than six months.

Table 1: For all off-payroll engagements as of 31 March 2019, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2019	0
Of which...	0
No. that have existed for less than one year at time of reporting.	0
No. that have existed for between one and two years at time of reporting.	0
No. that have existed for between two and three years at time of reporting.	0
No. that have existed for between three and four years at time of reporting.	0
No. that have existed for four or more years at time of reporting.	0

There were no new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that lasted for longer than six months.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, for more than £245 per day and that last for longer than six months

Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	0
Of which:	0
Number assessed as within the scope of IR35	0
Number assessed as not within the scope of IR35	0
Number engaged directly (via PSC contracted to trust) and are on the trust's payroll	0
Number of engagements reassessed for consistency/assurance purposes during the year	0
Number of engagements that saw a change to IR35 status following the consistency review	0

There were no off-payroll engagements of board members, and/or, senior officials with significant financial responsibility during the financial year.

Table 3: For any off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, between 1 April 2018 and 31 March 2019

Number of off-payroll engagements of board members, and/or, senior officials with significant financial responsibility, during the financial year.	0
Number of individuals that have been deemed 'board members and/or senior officials with significant financial responsibility' during the financial year. This figure must include both off-payroll and on-payroll engagements.	16

BOARD ASSURANCE FRAMEWORK (BAF)

The Board Assurance Framework (BAF) is a Board-owned document whose primary role is to inform the Board about the totality of risks or obstacles that may impede the Trust from achieving its strategic objectives, as outlined in the Trust's long-term Strategy document. The BAF also provides assurances that adequate controls are operating to reduce these risks to acceptable levels.

In line with the newly developed Corporate Strategy and priorities, the BAF underwent a refresh during 2018 with the Board approving the new BAF in September 2018.

A review of the BAF by Internal Audit, undertaken in February 2019, was rated as "significant".

AUDIT COMMITTEE

Audit Committee

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

The primary role of the Audit Committee is to conclude upon the adequacy and effective operation of the organisation's overall internal control system.

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

The Audit Committee is also attended by representatives of KPMG LLP the Trust's External Auditors; Internal Audit, Counter Fraud Service, and the Trust's Chief Operating Officer, Director of Operational Finance, Head of Governance and a Trust Governor.

As part of the external audit plan for 2018/19, KPMG highlighted four significant audit opinion risks which have been considered by the Audit Committee.

Revaluation of property and land

The Trust's accounting policies require a land and buildings revaluation to be undertaken at least every five years, dependent upon the changes in the fair value of the property. Where assets are subject to significant volatility, annual revaluations may be required. Conversely, where changes in asset values are insignificant then a revaluation may be necessary only every 3 or 5 years. In 2015/16 it was agreed by the Trust's management that changes in fair values that exceed 10% since the last valuation may

provide an indication that the change in value may be moving towards being significant, and therefore the need for a revaluation should be considered.

In 2016/17 as a result of building indices indicating a rise of 12.9%, a full revaluation of the Trust's land and buildings was undertaken by a professionally qualified valuer, in accordance with the Royal Institution of Chartered Surveyors valuation manual and was included within the Trust's audited accounts.

For 2018/19, an assessment of the change in building indices and the local index factor has been undertaken, and advice sought from the District Valuer (DV), who specialises in providing property valuations for NHS Trusts.

This assessment has identified that the latest indices that are now being applied by the DV, for valuations dated the 31st March 2019, have indicated a material movement in fair value since the last valuation. The Trust's buildings and dwellings have therefore been increased in value by £17.6m, circa 11.1%. The value of land has also been increased by £0.5m, a rise of 5% and is in accordance with the information supplied by the DV.

KPMG have not identified any issues arising from the work performed relating to the revaluation of property and land.

Recognition of income

Around 95% of the Trust's income is received from other NHS organisations, with the majority (60%) being receivable from NHS Devon CCG. The Trust participates in the Department of Health's agreement of balances exercise. This exercise seeks to identify all income and expenditure transactions as well as payable and receivable balances that arise from whole government accounting (WGA) bodies. The Audit Committee is satisfied that by participating in this exercise it helps to provide further assurance that the vast majority of income and expenditure with WGA bodies has been properly recognised and WGA receivable and payable balances are appropriately recorded. The Trust's external auditors have reviewed the outcome of the exercise, along with non WGA income and reported their findings to the Audit Committee.

KPMG have not identified any issues arising from the work performed relating to the recognition of income.

Management Override of controls

Professional standards require KPMG to communicate the fraud risk from management override of controls as significant. Management is typically in a unique position to perpetrate fraud because of its ability to manipulate accounting records and prepare fraudulent financial statements by overriding controls that otherwise appear to be operating effectively.

KPMG have carried out appropriate controls testing and substantive procedures, including testing of journal entries, accounting estimates and significant transactions that are outside the normal course of business, or are otherwise unusual. No specific instances of management override were identified relating to this audit.

Non-Pay Expenditure Recognition

This has been highlighted as an additional significant risk for 2018/19, and applies to all NHS Trusts. In the public sector auditors consider the risk that material misstatements due to fraudulent financial reporting may arise from the manipulation of expenditure recognition (for example deferring expenditure to a later period). This may arise due to the organisation manipulating expenditure to meet externally set targets.

KPMG have designed the audit to carry out a range of testing, including:

- Sampling invoices for material expenditure after 31 March 2019 to determine whether expenditure is recognised in the correct accounting period
- Considering the completeness and judgements made within the expenditure balance, specifically surrounding accrued expenditure
- Assessing the outcome of the agreement of balances exercise with CCGs and other NHS Providers
- KPMG have not identified any issues with the work carried out in connection with Non-pay expenditure recognition

Other Issues considered by the Audit Committee

NHS Counter Fraud Authority (NHSCFA) – Quality Assessment Report

The NHSCFA conducts periodical assessments in line with the requirements of their Fraud, Bribery and Corruption standards for Providers. The assessments examine the annual Self Review Tool (SRT) the Trust completed earlier in 2018.

The assessment focused on two (out of four) parts of the standard: "Inform and Involve" and "Hold to Account". For "Inform and Involve" the Trust was assessed as amber as per the self-review rating, however for "Hold to account", the Trust was assessed as a red rather than a self-assessment of green.

The red rating was due primarily to two issues:

1. The Trust had not documented process for recovering losses due to fraud. The Audit Committee was reassured that recoveries are still maximised.
2. The use of the NHSCFA system for recording older cases. It was recognised that for newer cases recording was in line with the standard.

The Trust has produced an action plan which has been acknowledged by the NHSCFA, to be monitored by the Audit Committee. In addition, the Audit Committee has recently approved an updated Counter Fraud, Bribery and Corruption policy which reflected feedback from the Committee, key stakeholders, the Governance Managers group, Operations Board and the Policy Expert Panel. The policy will help all employees who reasonably suspect or become aware of fraud, bribery / corruption or abuse of position, will be promoted at Trust Induction, included as a must read on the Trust intranet, and highlighted to employees as part of awareness sessions run by the Counter Fraud lead.

Effectiveness of the external auditors

KPMG LLP were appointed as external auditors to the Trust from 2014/15 for a five-year period under a competitive tender process. As the five year contract term ends on 31 October 2019, a procurement tender exercise has commenced to appoint an external auditor for the period commencing from 1 November 2019.

The Audit Committee assessed the effectiveness of the external auditors, in particular the timeliness of reporting, the quality of work and whether audit fees provided value for money. The Audit Committee provided the Council of Governors (CoG) with positive feedback and provided assurance to the CoG that the external auditors provided a quality, timely and cost effective external audit service.

The external auditors provided non-audit services to the Trust in relation to technical data support during 2018/19 for which the charge for this service was £2,000, along with audit assurance of the Quality Accounts (£7,687). Due to the low value of this work, the Audit Committee consider that there is no risk to auditor objectivity or independence.

Meeting schedule

The Audit Committee met five times during 2018/19. The names of members and their attendance at 2018/19 meetings are as follows:

NAME	April 2018	May 2018	July 2018	Nov 2018	Feb 2019
P Dillon	P	P	P	P	P
S Kirby	P	P	A	P	A
S Knowles	P	P	A	P	P
M Romaine*	P	A	P		
A Matthews*				P	P
Professor J Kay*					P

*Ms Romaine resigned from the Audit Committee in August 2018. Mr Matthews joined the Audit Committee in November 2018 and Professor Kay re-joined in February 2019 respectively.

P – Present

A – Apologies

Duties and Responsibilities of the Audit Committee

Governance, risk management and internal control

The Audit Committee reviews the establishment and maintenance of an effective system of integrated governance across the whole of the Trust's activities (both financial and non-financial), that supports the achievement of the Trust's objectives.

In particular, the Audit Committee reviews:

- all risk and control related disclosure statements together with any accompanying Head of Internal Audit statement, external audit opinion or other appropriate independent assurances, prior to endorsement by the board
- the assurance processes that underpin the achievement of the Trust's objectives, the effectiveness of the management of principal risks and the appropriateness of the above disclosure statements
- the policies and procedures for all work related to fraud and corruption as set out in the NHS England standard contract and as required by the NHS Counter Fraud Authority.
- The annual ISA260 report and Letter of Representation produced by External Audit in relation to the Annual report, Quality report and Accounts.

In carrying out this work the Audit Committee primarily utilises the work of internal audit, local counter fraud specialists, external audit and other assurance functions, but is not limited to these functions. It will also seek reports and assurances from the Governance Committee, Directors and Managers as appropriate, concentrating on the overarching systems of integrated governance, risk management and internal control, together with indicators of their effectiveness.

Internal Audit

The internal audit function is provided by Audit South West (ASW). The Audit Committee ensures that there is an effective internal audit function, including the Counter Fraud function, established by management that meets mandatory Public Sector Internal Audit Standards and provides appropriate independent assurance to the Audit Committee, Chief Executive and Board. This is achieved by:

- consideration of the provision of the internal audit service, the cost of the audit and any questions of resignation and dismissal
- review and approval of the annual internal audit plan, ensuring that this is consistent with the audit needs of the Trust as identified in the assurance framework
- consideration of the major findings of internal audit work (and management's response), and ensuring co-ordination between the internal and external auditors to optimise audit resources
- consideration of the annual Head of Internal Audit's Opinion
- follow-up by the Governance Committee, or one of its sub-committees, where internal audit's work is an area covered by that committee, as set out in internal audit's plan
- ensuring that the internal audit function is adequately resourced and has appropriate standing within the Trust, and
- an annual review of the effectiveness of internal audit.

External Audit

The Audit Committee:

- reviews and monitors the external auditor's independence and objectivity and the effectiveness of the audit process, taking into consideration relevant UK professional and regulatory requirements
- keeps under review the level of non-audit services provided by the external auditor, taking into account relevant guidance
- makes recommendations to the Council of Governors in relation to the appointment, re-appointment and removal of the external auditor and approves the remuneration and terms of engagement of the external auditor

Further, the Audit Committee reviews the work and findings of the external auditor and considers the implications of and management's responses to their work. This is achieved by:

- discussion and agreement with the external auditor, before the audit commences, of the nature and scope of the audit as set out in their annual plan
- discussion with the external auditors of their evaluation of audit risks and associated impact on the audit fee, and

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

Other Functions

The Audit Committee considers the work of other committees within the Trust, the work of which can provide relevant assurance to the Audit Committee's own scope of work. This particularly includes the Governance Committee because of its management of the Trust's Corporate Risk Register and the Clinical Audit function.

The Audit Committee also:

- reviews material changes to standing orders and standing financial instructions and schemes of delegation and
- receives a report from management on the review of data quality included in the Quality Report

Financial Reporting

The Audit Committee reviews and, if thought appropriate, recommends to the Board adoption of the annual report and financial statements, focusing particularly on:

- specific enquiry into the question of whether the Trust keeps proper books of account
- the integrity of the financial statements
- the wording in the Annual Governance Statement and other disclosures relevant to the terms of reference of the Committee
- changes in, and compliance with, accounting policies and practices
- unadjusted mis-statements in the financial statements
- major judgemental areas, and
- significant adjustments resulting from the audit
- The annual ISA260 report and Letter of Representation produced by External Audit in relation to the Annual Report, Quality Report and Accounts

The Audit Committee reviews and provides assurance on behalf of the Board to the Department of Health around the costing process and methodology as required by the Reference cost guidance.

Board of Directors Reporting Arrangements

The Chair of Audit Committee provides a report highlighting the key issues arising from the Audit Committee to the meeting of the Board that directly follows the Audit Committee. The minutes of the Audit Committee will also be available to the Board.

The Annual Governance Statement, which is included in the Annual Report, reviews in considerable detail the effectiveness of the system of internal control. By concurring with this statement and recommending its adoption to the Board, the Audit Committee also gives the Board its assurance on the effectiveness of the overarching systems of integrated governance, risk management and internal control.

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

Counter Fraud

The Counter Fraud Service for the RD&E is provided by Audit South West (ASW) via the services of a Local Counter Fraud Specialist (LCFS).

The LCFS's time during 2017/18 was predominantly spent on:

- Promoting an Anti-Fraud Culture
- Intelligence gathering
- Raising awareness of current fraud scams
- Giving advice in respect of fraud risks, attempted scams, procedures and policies
- Handling and investigating case referrals

NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK

A revised performance framework has been established by NHS Improvement to help ensure that Trusts meet NHS Constitutional Standards, with a particular focus on the 4-hour Emergency Department Waiting Time Standard. The purpose of the Framework is to identify where providers may benefit from, or require, improvement support across a range of areas. The Single Oversight Framework is closely aligned to the Care Quality Commission's (CQC) standards, and replaces Monitor's Risk Assessment Framework and the Trust Development Authority (TDA) Accountability Framework. It applies to both NHS Trusts and NHS Foundation trusts irrespective of their legal form, and is based on the principle of earned autonomy.

There is a new emphasis on the importance of leadership and improvement capability within NHS organisations, and an expectation that providers will engage constructively with local partners to build shared understanding of local challenges and patient needs, and to design solutions that will drive improvements in the care of the local population. Financial measures also play a key part in the Single Oversight Framework, and focus on sustainability, efficiency and control.

Many of the previous core performance metrics relating to access to services remain within the framework, including Referral to Treatment access targets, 4-hour maximum waiting times within the Emergency Department, and waiting times for diagnostic tests. The previous Cancer Standards have been consolidated and now focus on the delivery of the 62-day wait for first treatment target. Performance improvement trajectories have been agreed between providers, commissioners and regulators for 2018/19.

The Integrated Performance Report was refreshed for 2017/18 to reflect the new reporting regime and ensure robust scrutiny of the key indicators within the Single Oversight Framework.

CARE QUALITY COMMISSION (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status is registered in full without conditions.

The Trust underwent a planned, routine, announced Care Quality Commission Inspection in January and February 2019. The report was published on 30 April 2019. The Trust was rated overall "Good".

The inspection identified 13 "Must Take" actions and 76 "Should Take" actions. The Trust will present the detailed action plans to the Governance Committee (GC) on 7 June 2019. The GC will monitor progress of the action plans through to completion.

Below is a breakdown of the ratings for the Trust.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for Acute Services/Acute Trust

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Devon and Exeter Hospital (Wonford)	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019
Honiton Hospital	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Mardon Neuro-rehabilitation Centre	Good ↑ Feb 2019	Good →← Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Overall trust	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Community Health

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community health inpatient services	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community end of life care	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Overall*	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for primary medical services

Ratings for primary medical services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Castle Place Practice	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Ratings for Royal Devon and Exeter (Wonford)

Ratings for Royal Devon and Exeter Hospital (Wonford)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016
Medical care (including older people's care)	Good ↑ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019
Surgery	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Critical care	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019
Maternity	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Services for children and young people	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Outpatients	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019
Renal Services	Good Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019
Overall*	Requires improvement ↔ Apr 2019	Good ↔ Apr 2019	Outstanding ↔ Apr 2019	Good ↔ Apr 2019	Outstanding ↔ Apr 2019	Good ↔ Apr 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

STATEMENT OF ACCOUNTING OFFICER'S RESPONSIBILITIES

Statement of the Chief Executive's responsibilities as the accounting officer of the Royal Devon & Exeter NHS Foundation Trust

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

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

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

- observe the Accounts Direction issued by Monitor, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis
- make judgements and estimates on a reasonable basis
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual have been followed, and
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance and
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy
- prepare the financial statements on a going concern basis

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

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

Signed:



Suzanne Tracey

Chief Executive

Date: 22 May 2019

ANNUAL GOVERNANCE STATEMENT

Scope of responsibility

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

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of the Royal Devon and Exeter NHS Foundation Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in the Royal Devon and Exeter NHS Foundation Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The Trust has a comprehensive governance system in place which has been developed and enhanced over a number of years and continues to be subject to regular review to ensure its continued fitness for purpose. The current governance architecture was established in October 2011. A number of independent reviews have been undertaken over the years which have concluded that the governance system is robust.

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

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

The Board has appointed a Senior Independent Director to be available to Governors and Members if they have concerns where contact through the normal channels of Chairman, Chief Executive or Deputy Chief Executive/Chief Nurse, have failed to resolve them or for which such contact is inappropriate. In addition, the Trust has a Whistleblowing Policy to guide and protect staff who raise issues of concern. The Trust also has six Freedom to Speak Up Guardians who report to the Chief Executive and provide regular reports to the Governance Committee.

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

An electronic governance system, which has the ability to record, manage and triangulate incidents, complaints, risks and legal claims has been operational since June 2011.

An established cohort of senior clinical staff and Governance Managers trained to conduct Serious Incident (SI) Investigation is in place and additional staff are trained each year to add to the pool available. The Risk Management Team co-ordinates SI's and adverse incidents, which are reported and managed through the Incident Review Group (a sub group of the Safety and Risk Committee). In addition to direct feedback to relevant clinical teams, Lessons Learned briefings, highlighting learning points, are made available to all staff via the local intranet. All SI investigation reports and action plans are shared with the Trust's lead commissioner NEW Devon CCG.

The risk and control framework

The Board of Directors is responsible for the strategic direction of the Trust. It reviews the Board Assurance Framework ("BAF") quarterly in line with the Trust's Risk Management Policy. The BAF identifies the key risks and mitigations related to the Trust's strategic objectives and key priorities. The Board has identified a number of financial risks to the achievement of the corporate strategy including the Trust's ability to deliver the required cost savings, and the impact of financial pressure on performance targets.

The Board regularly updates its Register of Directors' Interests which is available on the Trusts website www.rdehospital.nhs.uk/trust/ft/documents alongside the register of interests for other Trust staff.

The Corporate Risk Register is reviewed by the Governance Committee each time it meets. The Governance Committee reports to the Board of Directors quarterly. The Audit Committee considers the Board Assurance Framework and the Corporate Risk Register when setting Internal Audit's annual work plan.

The Head of Governance attends both the Governance Committee and the Audit Committee. This supports continuity and oversight of agenda preparation and completion of actions. The Chair of the Governance Committee is also a member of the Audit Committee, ensuring the two Committees are aligned and there are not gaps in assurance.

The Board of Directors, as part of the Annual Plan reporting cycle, is responsible for the completion of the Corporate Governance Statement. The Board has adopted a process through which evidence is identified for each element of the statement

to provide assurance and support a decision of compliance or gap in compliance (i.e. risk). Where risk is identified this would be risk assessed, mitigating actions put in place and added to the appropriate risk register.

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

- Clinical Effectiveness Committee – chaired by the Medical Director
- Integrated Safeguarding Committee – chaired by the Deputy Chief Executive/ Chief Nurse
- Patient Experience Committee – chaired by a Non-Executive Director
- Safety and Risk Committee – chaired by the Chief Executive
- Workforce Governance Committee – chaired by the Director of People

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

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

- The Patient Safety and Mortality Group is accountable for delivery of the Trust's patient safety programme, review of adverse incidents, structured judgement reviews and learning from death reviews
- The Incident Review Group is chaired by the Deputy Chief Nurse and reviews all Serious Incidents Requiring Investigation (SI) and action plans
- Medical Gases Group
- Radiation Safety Group
- Infection Control and Decontamination Group is chaired by the Medical Director
- Health and Safety Group chaired by the Director of People
- Emergency Preparedness, Resilience and Response Group chaired by the Chief Operating Officer

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

- Clinical Audit and Guidelines Group
- Medicines Management Group

The Trust has a robust, responsive and reflective reporting and monitoring framework in place in relation to Mortality and Learning from Deaths. The Summary Hospital Mortality Indicator (SHMI) is the main mortality measure used within the organisation and detailed Trust and Divisional level mortality dashboards are scrutinised by the Patient Safety, Mortality and Review Group on a monthly basis. Mortality is reported to the Board of Directors monthly through the Integrated Performance Report with a detailed quarterly Learning from Deaths Report. The Board also receives Mortality reports through the Governance Committee structure. The Trust sets a low threshold in relation to responding to deviations in mortality rates, with deep dive case note reviews undertaken to ensure that the causes of any deviation(s) can be identified and acted upon, where required. Additionally, the Trust operates a standardised clinical review process whereby both expected and unexpected deaths are reviewed by the medical team. This ensures that learning can be identified and disseminated and actions taken where appropriate. The Trust is actively working to ensure the recommendations made as part of the CQC Learning from Deaths Review are being implemented and embedded in practice. This is overseen by the Trust's Governance Committee.

The Deputy Chief Executive / Chief Nurse and Medical Director have joint Director leadership and accountability for Clinical Governance. To ensure Executive Directors are aware of all safety issues in a timely manner and to utilise their expertise, Safety Huddles were introduced. The Safety Huddle comprises the Deputy Chief Executive / Chief Nurse, Medical Director, the Deputy Chief Nurse and the Head of Safety Risk and Patient Experience. The huddle takes place once a week and complements the formal Governance Performance System by looking at soft intelligence but also provides an opportunity to discuss incidents/concerns real time at a very senior level.

Risk identification and evaluation

The Trust has a Risk Management Policy which has been approved by the Governance Committee and clearly sets out the process for identifying

and managing risk and the Trust's risk appetite. It incorporates a standard methodology in which risk is evaluated using a likelihood/consequence matrix. The roles and responsibilities of staff in managing risk are defined and key posts highlighted. The Policy also includes the governance reporting structure and the terms of reference of the Governance Committee and all the committees reporting to the Governance Committee.

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

There are 23 current risks on the Corporate Risk Register. There are 9 risks with scores of 15 and above. Two relating to mental health pathways (external factors), two relate to cardiology (waiting times and care of patients with heart failure), one relates to capacity management, one relates to the Trust's ability to achieve cancer waiting times, one relates to capacity within the Emergency Department, one relates to nursing establishment, and one relates to IT legacy systems.

Robust action plans are in place and these risks are assigned to an appropriate Executive lead and manager who are responsible for ensuring that the risk is either eliminated or managed appropriately. A robust system is in place to monitor progress of action plans, which is undertaken by both the Head of Governance and the Manager of the risk to ensure that risks are proactively managed down the their end target score. A detailed report is produced by the Head of Governance to the Safety and Risk and Governance Committees each time they meet.

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

The Trust has a robust process for assessing risk to cost improvement plans (CIP). A Quality Impact Assessment is undertaken which includes

identification of risk, risk score and mitigating actions. The assessment is reviewed and if appropriate authorised by the Divisional triumvirate (Divisional Director, Associate Medical Director and Assistant Director of Nursing). Quality Impact Assessments with a risk score of 8 or above are reviewed by the Deputy Chief Executive/ Chief Nurse and Medical Director, with the Trust's Operations Board overseeing the total process.

Other sources used to identify risks include:

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

The Trust has systems and processes in place to assess whether there is sufficient suitably qualified competent staff to meet the treatment needs of our patients safely and effectively. The Trust benchmarks staffing and effectiveness against the national Model Hospital data with both staffing establishments and safe staffing data being reviewed and monitored by the Board in the Integrated Performance Report on a monthly basis.

The demand and capacity planning undertaken to inform the Trust operational plan identifies the broad workforce priorities and involves full clinical engagement with robust exploration of assumptions and appropriate challenge. The Trust is aiming however to improve its longer term workforce planning approach and is currently identifying its preferred model to support this work. The Trust's People Strategy encompasses a comprehensive implementation plan to address the workforce challenges for the future.

The Trust currently has 90% of nursing staff on an electronic rota and has been assessed independently as having effective rotas; utilising a full suite of rostering tools to support the deployment of staff at the right place and time. It continues to improve its ability to optimise staff utilisation with the addition of electronic job planning for Consultants; this is linked to both establishment and financial systems. The Allocate SafeCare tool is being rolled out across the wards and will enable a census three times a day to assess the acuity and care hours per patient day; Staffing tactical meetings happen daily and are supported further by an additional assessment in the afternoon to plan next day staffing levels.

The daily staffing plans are further supported by regular clinical establishment review which is presented to the Public Board of Directors. The reviews use the relevant tools as set out by the National Quality Board in 2016 and also detail clinical judgement, triangulated with safety metrics and patient outcomes to support safe and effective skill mix.

Where service changes are identified, such as a reduction of beds due to staffing shortfalls specifically in community hospital settings, they are always supported by a Quality Impact Assessment.

The Performance Assurance Framework also uses metrics including staffing and safety measures to assess the effectiveness and safety of care.

Recruitment and retention remains a priority for the Trust with a working group established to develop and monitor the implementation of a Retention Plan. Turnover has seen a significant improvement in year and there continues to be a focus across the organisation on recruiting to gaps and minimising agency usage. The Trust has a comprehensive agency reduction plan that is monitored through the Nursing and Medical workforce groups. This is also reported to the Board of Directors on a monthly basis.

The Trust believes the above is in line with the 'Developing Workforce Safeguards' recommendations on using evidence based tools, professional judgement and outcomes to ensure safe staffing processes exist and are in line with the National Quality Board guidance.

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

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the *'Managing Conflicts of Interest in the NHS'* guidance.

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

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK

Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

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

The Trust's Operational Plan, including financial, performance, quality and governance targets for 2017/18 and 2018/19, was approved by the Board of Directors in December 2016 with the financial and performance information being revised and approved by the Board in March 2017. There was a further submission of the 2018/19 plan on 30 April 2018. The Trust's draft Operational plan for 2019/20 was submitted following Board approval on 12 February 2019, the final submission was made on 4 April 2019. Overall performance is monitored via an integrated performance report at the monthly meetings of the Board of Directors. Operational management and the coordination of Trust services are delivered by the Executive Directors. Performance of individual clinical Divisions is monitored formally on a monthly basis through the Performance Assurance Framework which is led by the Chief Operating Officer and twice annually with all Executive Directors.

The Trust's External Audit Management Letter includes commentary on the economical, effective and efficient use of resources. The Internal Audit

Plan includes reviews which consider the economy, efficiency and effectiveness of the use of resources. The findings of internal and external audit are reported to the Board via the Audit Committee.

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

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

Information governance

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

An Information Security Forum, chaired by the Caldicott Guardian, deals with all aspects of information security and data confidentiality. Risks to information security are reported directly to the Information Security Forum (a sub group of the Information Governance Steering Group) and recorded on the Corporate Risk Register.

The Trust implemented the new General Data Protection Legislation (GDPR) on the 25 May 2018, following the implementation plan released by the Information Commissioners Officer. The plan focused on awareness, information the Trust holds, lawful basis for process data and the assignment of a Data Protection Officer. The Trust has successfully implemented almost all of the requirements with work still ongoing to complete the information assurance section; this has been reflected in the Data Security and Protection Toolkit.

The Trust has completed the annual Data Security and Protection Toolkit assessment and the Safety and Risk Committee and the Board of Directors has received a report regarding its system for control of Information Governance.

Trust published the annual Data Security and Protection Toolkit assessment on 28 March 2019, the first return under the new reporting standard which was released in April 2018. The return included 94 out of 100 mandatory evidence items and 34 of the 40 assertions confirmed. The Trust is currently rated as "standards not fully met (plan agreed)" by NHS Digital. A plan has been submitted to address the outstanding items and will be monitored through to completion by the Trusts Information Governance Steering Group.

During 2018/19 the Trust reported one Information Governance incident to the Information Commissioners Office in line with the reporting requirements. The incident involved a CCG approved third party contractor having access to patient notes to support transfer of care without consent. The incident was fully investigated by the Trust with mitigating actions put in place. The Information Commissioner has responded stating that no further action is required.

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

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

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

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

a consistent and effective approach to Waiting List Management.

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

Annual Quality Account

The Directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

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

The content of the Trust's Quality Report for 2018/19 builds on the 2017/18 report. It has been agreed by the Board of Directors and incorporates the views and priorities of Governors and the views of Trust members in setting priorities for improvement in 2019/20. The development of the report is led by the Deputy Chief Executive/ Chief Nurse. The views of NEW Devon CCG, as lead commissioner, Healthwatch Devon and Devon County Council Health Scrutiny committee have been sought.

The Trust uses the same systems and processes to collate, validate, analyse and report on data for the annual Quality Report as it does for other clinical quality and performance information. The data is subject to regular review and challenge at speciality, Divisional and Trust levels. In line with the Trust's commitment to openness and transparency, the data included is not just limited to good performance and is publicly reported at least on a quarterly basis. The Audit Committee undertake a review of the data assurance underpinning the Quality Report and through this process and other review of data, the Board of Directors are assured that the Quality Report represents a balanced view.

Internal Audit have a three year audit cycle to assess quality systems and data (similar to that in place for our financial systems), was agreed with our internal

auditors and built into the Internal Audit plans for future years. This will be an on-going process and the Board of Directors will use the recommendations from this work to further improve the robustness of the process underpinning the Quality Report. The most recent review of Data Quality was undertaken in February 2019 and was rated as "satisfactory". The next annual review will be undertaken during 2019/20.

Audit of mandated indicators

The indicators audited were:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

KPMG has provided a limited assurance opinion in respect of A&E four hour wait and maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and Governance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- The maintenance of a view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on corporate risk
- Review of the Board Assurance Framework and receipt of Internal and External Audit reports to the Audit Committee

- Personal input into the controls and risk management processes from all Executive Directors, Senior Managers and clinicians
- The review of the Trust's risk and internal control framework is supported by the Annual Head of Internal Audit opinion which states that significant assurance can be given, that there is a sound system of internal control and that controls are generally being applied
- Evidence gathering for core Care Quality Commission regulations and registration.
- Self-assessment against the Care Quality Commission's Essential Standards for Quality and Safety (reviewed by internal audit)
- Self-assessment against NHSI's Code of Compliance and NHSI's Governance Framework
- Performance monitoring by the Board of Directors of the Trust's strategy and operational milestones to achieve internal and external targets
- Results of the national patient and staff survey results and development of targeted action plans
- Delivery of the health and safety action plan
- The Trust's compliance with the Hygiene code
- The Trust's unconditional registration with the CQC, rated overall as 'Good' March 2019
- Safe Staffing reviews
- Safety thermometer

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

Conclusion

There are no significant internal control issues I wish to report in respect of 2018/19.

Signed:



Suzanne Tracey

Chief Executive

Date: 22 May 2019

OUR GOVERNORS AND MEMBERS

Council of Governors

The Trust's Council of Governors (CoG) is an integral part of the RD&E's governance structure providing a vital connection between the Trust, its members and the public.

During the year, the CoG has ensured that it has carried out, as effectively as possible, its joint roles of:

- holding the Board of Directors accountable and;
- representing the views of members and the wider public to the Trust

In carrying out these duties, the Trust seeks to support the CoG and individual governors to ensure that there is both the means and capacity to carry out its responsibilities effectively. At the same time, the Trust is mindful that the CoG is an elected representative voluntary body that has a distinct role separate to that of the Board of Directors.

The CoG met five times during the year to conduct its core business. During these meetings, the CoG collectively considers the performance of the Trust over a quarter highlighting any issues or concerns it may have in relation to the way in which the Board of Directors is managing performance. The performance report contains information about the Trust's operational performance and its adherence to various national targets, its financial performance and how it is performing in relation to the quality priorities set by the Governors themselves in the annual Quality Report. The report also provides details of what the Board has considered during the quarter in question. The quarterly CoG meetings also focus on updating the Governors themselves on a number of regular topics including updates from the three key working groups (see below), the Patient Experience Committee, and on elections. As well as transacting its core business of holding the Board accountable. During the year, different formats for the governor focused performance report were considered and further development is ongoing on the nature and type of information provided directly to the CoG to enable it collectively to meet its core duties. In addition to the standard agenda items (performance report, working group updates, Patient experience Committee updates, and election updates), the CoG meetings focused on:

- An update and discussions on the Corporate Strategy
- An update on the collaborative agreement between RD&E and NDHT
- An overview of the MY CARE programme
- A financial and operational performance update included updates on car parking/travel
- A Governance Committee update by the Chair of Governance, an Audit Committee update by Chair of Audit (a NED)
- Receiving the External Auditors report on the Trust Quality Report, a report on the performance of the External Auditors and an update on the tender process for the appointment of the Trust's External Auditors
- An overview of the appointment of Deputy Lead Governor process
- A Nominations Committee update to approve the extension to Peter Dillon's term of office
- An update on planning for EU exit (especially in the case of a "No Deal" exit)
- Presentation and discussions on the Board's new IPR
- Regular updates from the Chair and Chief executive on local, regional national issues
- A car parking update and discussion
- Discussing and agreeing the local quality indicator for Quality Report 2018/19
- Discussions on CoG performance report
- Update on the Devon STP

In addition to these issues, the CoG held an extraordinary meeting in April 2018 to discuss the proposed collaborative agreement between RD&E and NDHT. As part of this discussion, the CoG also agreed to meet the request for NHSI to extend the Chair's term of office up to the end of the Management Contract.

During the year the Governors held development sessions on:

- CoG contribution to the appraisal of the NEDs
- A decision on the appointment of a new Vice Chair
- Governor behaviours and code of conduct
- Governor input into the appraisal of the Chair
- A discussion on promoting wellbeing in the work place which was one of the Governor's quality priorities for 2018/19 and ongoing discussions on selecting quality priorities for 2019/20
- A meeting with CQC as part of Well-Led inspection
- Feedback from communities and members

This year continued emphasis was placed on collaborative working with the Board. Joint Development Day sessions focused on:

- The refreshed corporate strategy
- Discussion on the implications of the new arrangements with Northern Devon Healthcare trust
- Further updates and discussions on developments within the NHS regionally and nationally
- A joint review of the Constitution.
- An update and discussion on NHS 10 Year plan
- An overview and discussions on key population health in Devon
- A discussion and update on the Devon Sustainability and Transformation Partnership (STP)
- An overview of the Greater Exeter Strategy

The CoG has strengthened its relationship with the Board during the course of the year with much greater interaction and engagement between the two bodies. The relationship is one in which both the Board and CoG share the same broad objectives of acting in the interests of the organisation and patient care whilst retaining sufficient distance to enable the CoG to act as a critical friend and ensure that the Board is acting in the best interests of members and the public and has the right mix of experience and skills within the Non-Executive Directors to manage the key challenges facing the Trust. Non-Executive Directors regularly attend CoG meetings for informal face-to-face meetings as well as more formally representing some of the work they are responsible for at CoG meetings. A regular rota of Governors attending the public Board

meetings has also helped to enable the Governors to see the Board 'in practice' as well as help provide intelligence that individual Governors have used in contributing to the performance assessment of individual Non-Executive Directors. During the year, the Governors have developed a "score-card" to enable them to assess the contributions of individual NEDs at a number of meetings where their paths cross including Board of Director meetings.

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

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

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

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

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

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

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

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

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

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

Nominations Committee

The group discussed:

- Annual Chair and NED appraisals
- Re-appointment of Peter Dillon (extension of 1 year)
- Started work on appointment of a Chair
- Appointment of two new Non-Exec Directors, subsequently approved by CoG
- CoG Effectiveness Working Group
- Contributed to the review of the Constitution
- Reviewed various key documents
- Reviewed the information requirements for the effective running of CoG
- Review of Effectiveness – due to report later in 2019

Patient Safety & Quality Working Group

The Group discussed:

- The Group's lead drafted the Governor comment on the Quality Report 2017/18
- Agreed stronger ties between the group and the Patient Experience Committee
- Focused on the 2018/19 Quality Priorities – health and wellbeing of staff, communications with patients
- Chose the priorities for 2019/20 – Hospital at night, volunteers
- Received an update on the Trust's Patient Safety Programme

CoG Effectiveness and Patient Safety and Quality Working Groups added a standing item to their agendas during the year – items for escalation to the Head of Governance

Membership & Public Engagement

The group discussed:

- Electing a new Chair
- Recruitment of new members and the profile of existing members.
- Held a stall at Exmouth College Careers Fair to recruit new members
- Agreed how Governors could get involved with Community Conversations and the development of place based care
- Ensured that our membership data base was GDPR compliant
- Undertook a survey of members
- Discussed working with Healthwatch to reach out to underrepresented communities
- Sought to improve interest in becoming a governor and to encourage participation in elections
- Undertook a pilot to include membership forms in discharge notes in maternity, Sidmouth and Exmouth
- Devised and helped implement the Trust's Open Day in September 2018.
- Discussed the work being undertaken to improve access to deaf and hearing impaired users
- Discussed and help establish a new Staff Governors forum
- Attended a Governor Conference on engagement
- Put on a conference on functional medicine for members as well as other Medicine for Members events
- Refreshed the "meet your governor" leaflet and approved the prospective governor booklet.
- Discussed and agreed on plans for the Annual Members' Meeting
- Discussed and agreed how the Governors should play an active role on ensuring the public voice was taken into consideration in Board meetings
- Kicked off a discussion about the validity of current constituency boundaries.
- Planed an active role in developing the Trust's new website due to be launched at the end of 2019.

In addition to this work it is also worth noting that Governors have been involved during the year in:

- Prospective governors meetings
- New governor induction
- Patient-led Assessments of the Care Environment (PLACE)
- CoG representation by three governors on the Patient Experience Committee
- Governor attendance at regional and national Governor conferences

Governor Expenses

There were 17 claims for expenses from Governors during the year 2018-2019. The aggregate sum of expenses paid to Governors during this period was £2,197.20. In 2017/18 the figure was £1,601.05.

Our Members

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

About our members

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

The ongoing conversation with our members – expressed primarily through our Members' Say/Day events, through surveys of members and in the feedback from Governors – is a very important aspect of the Trust's work that provides genuine

added value in informing its work, whether that is in a relatively minor operational detail, potential service change, ways to improve services in the best interests of patients/public or on bigger and more strategic issues. The feedback from the interactive activities and focus groups at Members Say helps provide an agenda for the Governors as well as providing insight into the views of members – and thus the public – for the Board of Directors.

Trust Open Day

Last September we held our first Open Day in nearly a decade and, despite torrential rain all day, it was a great success. The event was attended by staff, members and the public who were able to take part in a wide range of activities on the day including behind the scenes tours, a health fair and other activities including Greek and Bollywood dance classes and the ability to make your own smoothies on the Smoothie Bike. Budding surgeons were able to get a close look at how robotic surgery works, see how clean their hands really were and were finally allowed to play with their food at the Fun with Food stall.

Despite the rain, our hospital choir, The Rhythm of Life, kept people entertained as did the Upcrowd Band, JJ Wilde and our hospital radio all braving the rain to put on a great show.

Perhaps the biggest success for those who attended were our behind-the-scenes tours where a total of thirteen departments, including the Centre for Women's Health, Laundry and AMU (complete with elephant mascot!), volunteered to give up their time to show members of the public around their departments. This provided an insight into the way the hospital worked that members of the public rarely see.

We received a lot of positive feedback from those who attended. A parent, who attended with her teenage son who was undecided about future career prospects in the NHS, said: "After three tours, a demo on the robot and some very useful conversations with Recruitment and Learning and Development he has gone away with a much clearer idea of what he would like to achieve and how to get there. I can't thank you enough".

GOVERNOR PROFILES

East Devon, Dorset, Somerset and the Rest of England

Peta Foxall - Lead Governor	<p>Peta was elected in September 2016 for a term of three years and became Lead Governor in September 2017, elected by her peers. She contributes to NHS governor support and development at a national level through her involvement with NHS Providers. Peta has a PhD in biological chemistry and professional expertise in healthcare as a practitioner, educator and researcher. She has extensive experience of leading and working in multi-professional teams within the NHS and higher education. Peta is also national chair of The Wildlife Trusts, elected in November 2017. She is the first woman in this senior leadership role and has a remit that covers the UK wide movement of 47 Wildlife Trusts and the central charity, the Royal Society of Wildlife Trusts.</p> <p>Peta is a member of the Nominations Committee, the NED Remuneration Committee and the Member and Public Engagement Group of the RD&E's Council of Governors.</p>
Barbara Sweeney	<p>Barbara was elected as a public governor in September 2017. She has spent her working life in operational and strategic management in health and education and has just retired from the further education sector where her role was to promote strong governance. She has four children, three of whom work in the health service and her late husband was an academic GP and strong believer in the power of the patients' voice. Barbara hopes that through her role as governor she can continue his legacy. She also serves as a trustee on the board of Hospiscare.</p>
Kay Foster	<p>Kay lives in Exmouth and was elected in September 2014 for a term of three years and re-elected in 2017 for a further three years. She is a retired State Registered Nurse and Midwife with over thirty years of nursing experience. She held a Sisters' post at the RD&E in ITU and CCU. Kay also served as a Nursing Officer with Queen Alexandra Royal Army Nursing Corps for 18 years retiring in the rank of Major. She has a BSc (Hons) in Health Services Management.</p> <p>Kay is a member of the following committees: Patient Experience, Patient Safety and Quality, Nomination, & and she is Chair of Public Membership & Engagement Group. Kay has also been part of a subcommittee looking at improving the Royal Devon and Exeter Hospital patient web site. As a Governor elected to represent East Devon, Somerset and the Rest of England, Kay is a founder member of Living Well Devon Living (LWD) "a voluntary social enterprise group with a passion to improve community health. We aim to educate and support diet, behaviour and lifestyle changes for optimal health." livingwelldevon.co.uk</p>
Douglas Hull	<p>Douglas lives in Axminster and was elected in September 2016 for a term of three years. He has served on Town, District and County Councils in East Devon over the course of the last fifty years.</p>

Exeter and South Devon

Faye Doris	Faye was elected in September 2016 for a term of three years. Faye lives in Exeter and is a retired nurse, midwife, Supervisor of Midwives and Associate Professor of Midwifery for the University of Plymouth. She was responsible to the university for the education and practice of midwives across the southwest peninsula. Faye has been a senior manager at the RD&E for two years and at Plymouth University for over 20 years. She was initially the Head of School for the Health Professions which included Dietetics, Midwifery, Podiatry, Physiotherapy and Occupational Therapy. She also chaired the Race Equality Committee and was very involved in the promotion of diversity and inclusion. She was a member of the University's Academic Board for three years. Nationally, Faye was a member of the Nursing and Midwifery Council's Lead Midwife for Education Group. Faye's key skills include; leadership and management, selection and recruitment, listening, evaluating and responding to staff and stakeholder feedback. Faye is Chair of the Patient safety and Quality working group and is a member of the Trust's Equality, Diversity and Inclusion Steering Group. She is also a member of the Patient Experience Committee. Faye was elected Deputy Lead Governor in November 2018.
Rosemary Shepherd	Rosemary was elected September 2017 for a term of three years. She worked at an Exeter school where she was responsible for Welfare and Home Visits for new admissions, before moving on to become PA to the Administrator at the Northcott Theatre. She then went on to work in an Administrative role at the University before concentrating more on Voluntary roles. She has co-ordinated the Volunteers at Exeter Health Centre, been the regional Treasurer of the Foundation of small businesses and Treasurer of DUK Exeter and East Devon Group.
Tony Ducker	Tony was elected in September 2017 for his second three year term. Tony spent his career in the NHS, including five years as a Lecturer in the Department of Child Life and Health at St George's Medical School and twenty-two years as a Consultant Neonatal Paediatrician in Kent. He served on various hospital and regional committees including a National Institute for Health and Care Excellence (NICE) guideline group. Tony spent 28 years as a doctor in the Territorial Army serving in four medical units including five years as Commanding Officer in 220 (1st Home Counties) Field Ambulance. Since retirement Tony has worked with Clinical Commissioning Groups (CCGs) as Lead Clinician for the appraisal of neonatal units in East of England and South West England and currently runs a small medico-legal practice. Tony retired to South Devon 13 years ago. He is Chairman of the CoG Effectiveness working group.
John Murphy	John Murphy was elected in September 2018 for a three-year term. For over twenty years he worked in the NHS and for the Department of Health. At NHS Devon, he worked on supporting community hospitals, including the new Newton Abbot hospital. He helped set up the league of friends at Whipton Hospital in Exeter. At Cornwall and Isles of Scilly primary care trust, John answered questions from the public on controversial issues about the way health care is delivered. Working for Devon and Cornwall at NHS England, he looked into patient experience of local health services. His particular interests are in improving team working, delivering better communications among staff and patients and with local communities served by the RD&E.
Abdul Latif	<p>Born in Bantwa in 1934, I moved to Pakistan in 1947 where I studied for a Bachelor's Degree in Accounting, Auditing, Banking, Economics, Law and Business Administration. In 1961 I moved to the UK for further studies and qualified with an ACMA after 5yrs and gained Fellowship of the ICMA. I have a total of 43yrs of Financial Management experience including 11yrs in the USA.</p> <p>I hope that my Financial Management background will help me make a positive contribution to the benefit of RD&E Foundation Trust.</p>

Mid, North, West Devon and Cornwall

James Bradley	James was initially elected in September 2014 for a term of three years, re-elected in September 2017 for a further one year and in 2018 for a further three years. James was a Chartered Environmental Health Officer and Chartered Safety and Health Practitioner. Having completed a military career, has worked in Local Government, the National Health Service and finally as an international consultant. He is a member of both the NHS England Public and Patient Voice Assurance Group and Clinical Frailty Programme Board for Specialised Services, a member of Devon County Council Commissioning Involvement Group, member of the South West Academic Health Science Network Quality Improvement Panel, a member of the Public Patient Reference Group of the College of Optometrists, Devon Health and Social Care Forum, Vice Chair of Okehampton Medical Centre Patient and Public Group and Trustee of West Devon Community and Voluntary Services. James lives with his wife and cat near Okehampton.
Chris Wilde	Christopher was elected in September 2014 and re-elected in 2016 for a further three years. Christopher has been an owner of a general dental practice, as well as a Managing Director of a limited company specialising in dental material research. Christopher was Chairman of a government-sponsored group (SW-Smart) of research companies. Christopher lives in Tiverton.
Cynthia Thornton	<p>Cynthia retired to Willand in 2003. She has had wide nursing experience, initially in the acute sector, followed by ten years as a district nursing sister and a further twelve years when she held University teaching and research posts in East London and Reading.</p> <p>Cynthia was first elected in September 2008 for three years and re-elected in 2011 until 2014. During this period she was Chair of the Member and Patient Engagement Group and a member of the nominations Committee. Following a two year break she was re-elected for a further three years in 2016. During the latter period she has represented the Governors on the Audit Committee and is a member of the Nominations Committee and the Remuneration Committee.</p>

Appointed

Cllr Phil Twiss	I am elected as the County Councillor for the electoral division of Feniton and Honiton and serve the interests of all residents, regardless of political persuasion. I became a Councillor to make a positive contribution to my local Community.
Professor Angela Shore	<p>Angela was appointed on behalf of the University of Exeter</p> <p>in 2016. She is Vice Dean Research at the University of Exeter Medical School and principal investigator of a large team of scientists and clinicians in vascular medicine based at the hospital. As Scientific Director of the Exeter NIHR Clinical Research Facility she facilitates Experimental Medicine Research for the RD&E/Medical School collaboration. Angela is President of the British Microcirculation Society and a member of the International Liaison Committee for World Microcirculation Research.</p>

Staff

Catherine Geddes	Catherine was first appointed in September 2016 for a term of 2 years and re-elected in September 2018 for a further term of three years. Catherine's career with the Royal Devon and Exeter NHS Foundation Trust began as a student nurse in 1995. As a staff nurse, she worked in both the community and within the acute setting at the RD&E. In 2000 she qualified as a midwife and spent the next 11 years working in both community and hospital settings. After gaining her PGCE Catherine took a career break in 2009 and spent a year teaching student nurses and midwives in Western Australia. Catherine successfully completed her PGCert in obstetrics and gynaecology ultrasound in 2011 and has been the Clinical Lead Midwife sonographer in the centre of Women's Health since 2014.
Hazel Hedicker	Following a career in the hospitality industry, Hazel commenced employment with the NHS in 1994 and joined the RD&E in March 2000 having previously worked for another large southwest acute Trust. Having spent 16 years as a senior operational manager within two Facilities divisions, her career changed direction and she joined the Transformation Programme Team in May 2012. Hazel has since managed numerous trust-wide transformation projects supporting colleagues with both clinical and non-clinical redesign and change. In October 2018 she joined the MY CARE programme team providing project management support for the Clinical Pathway Improvement workstream. Hazel has a Masters degree in Business Administration and is a fully qualified Prince 2 Practitioner. She has a keen interest in Communications & Engagement, in particular the engagement of patients, carers and staff with service redesign and change. She has held the appointment of staff governor since 2013 and was re-appointed for a second 3-year term in September 2016.
Susie Costello	Susie has worked at the RD&E since 2005 as a dietitian. For the past 5 years she has been the paediatric team lead dietitian. Her clinical areas of interest are eating disorders, inherited metabolic disorders, gastroenterology and neonatal nutrition. She was elected as a staff governor in September 2017 for a 3 year term. Through her work with child and adolescent mental health services, and her experience as a line manager, Susie has a keen interest in workplace mental health. Susie has also completed an innovation certificate and is interested in NHS innovation to improve patient care.
Dominic Hazell	Dominic started his career at the RD&E as a Student Physiotherapist in 2008. Since qualifying as a Chartered Physiotherapist he has worked throughout multiple departments within both the Acute and Community settings at the RD&E. He has previous experience acting as a workplace steward for the Chartered Society of Physiotherapy since 2014 and his current role as a Senior Musculoskeletal Physiotherapist is located at Exmouth Hospital. Dominic was elected as a Staff Governor in September 2018 for a term of 2 years.

Newly elected Governors to CoG

Election Results

The results of the election were declared on 7 September 2018.

East Devon, Dorset & Somerset and the Rest of England

Richard Bowes was re-elected for a term of three years. The turnout was 24.9%.

Mid, North, West Devon & Cornwall

James Bradley was re-elected uncontested for a term of three years. Two vacancies remain and the CoG decided at its August 2018 meeting that the vacancies would be carried to the next routine round of elections in 2019.

Exeter & South Devon

Abdul Latif and John Edward Murphy were elected uncontested, each for a term of three years. Two vacancies remain and the CoG decided at its August 2018 meeting that the vacancies would be carried to the next routine round of elections in 2019.

Staff

The results of the election in the staff constituency was declared and circulated to CoG, on 7 September 2018. Catherine Geddes was re-elected for a term of three years and Dominic Hazell elected for a term of two years. The turnout was 13.7%.

The Board confirmed that all elections to the Council of Governors are held in accordance with the election rules as stated in the Constitution. Governors can be contacted via email at: rde-tr.foundationtrust@nhs.net The Governor's Register of Interests is available for inspection on the Trust website or from the Trust Secretary (01392 404551).

Summary of attendance of Governors at CoG meetings for 2018/19

Name of Governor	Extraordinary CoG April 2018	Jun-18		Aug-18		Annual Members Meeting - Sept 2018	Nov-18		Mar-19	
		Public	Confidential	Public	Confidential		Public	Confidential	Public	Confidential
Barr, Geoff	A	P	A	A	A	P				
Baxendale-Nichols, Michelle	P	P	P	P	P	A	DNA	DNA		
Bloxham, Ray	A									
Bowes, Richard	P	P	P	P	P	A	P	P		
Bradley, James	A	P	P	P	P	A	P	P	P	P
Costelloe, Susie	P	P	P	P	P	A	P	P	P	P
Doris, Faye	P	P	P	A	A	P	P	P	P	P
Ducker, Tony	A	P	P	P	A	A	P	P	P	P
Foster, Kay	A	P	P	P	P	A	P	P	P	P
Foxall, Peta	P	P	P	P	P	P	P	P	P	P
Geddes, Catherine	P	P	P	A	A	A	P	P	A	A
Hall, Linda	A	P	P	P	P	A				
Hazell, Dominic						P	P	P	A	A
Hedicker, Hazel	P	P	P	P	P	P	P	P	A	A
Hull, Douglas	A	P	A	P	P	P	A	A	A	A
James, Michael	P	P	P	P	P	A				
Latif, Abdul						P	P	P	P	P
Llewellyn, Trish	P	A	A	P	P	A	P	P		
Murdoch, Alan	P	P	P	P	P	P	P	P		
Murphy, John						P	P	P		
Shepherd, Rosemary	P	P	P	A	A	P	P	P	P	P
Shore, Angela	A	P	P	A	A	A	P	P	P	P
Sweeney, Barbara	P	P	P	P	P	P	P	P	P	P
Thornton, Cynthia	P	P	P	P	P	P	P	P	P	A
Twiss, Phil		A	A	P	P	A	P	P	P	A
Wilde, Christopher	P	A	A	P	P	P	P	P	P	P
James Brent, Chairman	P	A	A	A	A	P	P	P	P	P
Present		P								
Apologies		A								
Did Not Attend		DNA								
Not in post										

VOLUNTARY DISCLOSURES

Equality and Diversity

The Board of Directors has continued in its plans to execute the 'Towards Inclusion' campaign in order to realise its ambition "to be recognised by our community (and nationally) as an employer of choice and an exemplar organisation which values diversity and is truly inclusive". The programme is being led by the Trust's Chief Executive, and structures are in place to direct the plan of work and to assess the effectiveness.

An Inclusion Lead has been appointed, and commenced in post in January 2019. Since appointment, the Trust has been conducting visits to other exemplar organisations in order to inform and direct the programme of work. The trust has also made an application to NHS Employers to join the 2019 Partners programme, and we eagerly await the results of our application.

Throughout the year work has continued to progress against the stated Board Equality & Diversity objectives and this has included continuation of staff focus groups on race and disability, and with the establishment of a staff and patient hearing impaired focus group.

Gender Pay Gap

From 2017, any organisation that has 250 or more employees must publish and report specific figures about their gender pay gap. The gender pay gap is the difference between the average earnings of men and women, expressed relative to men's earnings. The Trust must publish their gender pay gap data and a written statement on their public-facing website, this can be found at:

<http://www.rdehospital.nhs.uk/documents/trust/diversity/gender-paygapreport.pdf>

and report their data to government online using the gender pay gap reporting service.

Our report, presented below, can be viewed at

<https://gender-pay-gap.service.gov.uk/Viewing/search-results>

Women's hourly rate is:	
25.9% LOWER (mean)	10.9% LOWER (median)
Pay quartiles:	
How many men and women are in each quarter of the employer's payroll.	
Top quartile	
30.8% MEN	69.2% WOMEN
Upper middle quartile	
17.7% MEN	82.3% WOMEN
Lower middle quartile	
18.0% MEN	82.0% WOMEN
Lower quartile	
20.8% MEN	79.2% WOMEN
Women's bonus pay is:	
48.2% LOWER (mean)	43.3% LOWER (median)
Who received bonus pay:	
6.2% OF MEN	0.6% OF WOMEN

The Office for National Statistics (ONS), in reporting the gender pay gap, focuses on the median average rather than the mean, as this is less open to distortion by those at the extreme ends of the pay range. There are a number of factors contributing to the reported pay gap and these are explored more fully in the report published on our website. These include the NHS being predominantly female, women dominating the largest staff group of registered and unregistered caring roles that tend to be concentrated around the median pay and hospitals having a relatively large, predominantly male, group of high earners in its medical consultant body.

Our headline gender pay gap is smaller than both the median national average, for all employers and the hospital sector mean average. Our gender pay gap based on the median indicator, which is the most reliable and widely used overall gender pay gap measure, is also better than our own unofficial benchmark, derived from the large employers who have reported, using the nationally mandated process.

Due to structural issues within the pay system across the hospital sector, regarding the bonus system for consultants, which is called ACCEA (Advisory Committee on Clinical Excellence Awards), gender inequality is greater than would be expected against any national benchmark measure to do with the mean average, or payment of bonuses. Only Consultants are eligible for ACCEA award payments. Although female representation at consultant level has gradually increased, the consultant body remains predominantly male. In addition, historically, ACCEA payments have also been cumulative and these differential payments increase at higher levels and so, tend to increase with length of service/age.

Comparison with the previous year's data shows that our pay gap using the mean average indicator has remained stable, but there has been an increase in the pay gap using the median average although, as noted above, our performance against this indicator is still respectable. A national review of ACCEA payments has been undertaken to review and address this point and it is expected that, over time, this gap will start to reduce.

Other than for medical and dental staff (doctors) all jobs are evaluated using the national Agenda for Change (AfC) job evaluation scheme. This process evaluates the job and not the post holder and makes no reference to gender or any other personal characteristics of existing or potential job holders. Outside of the Executive Directors and a small number of other senior roles, all remuneration is made in accordance with the AfC pay bands.



Royal Devon and Exeter
NHS Foundation Trust

Quality Report 2018/19

Royal Devon & Exeter NHS Foundation Trust

WE WORK TOGETHER



HOME . COMMUNITY . HOSPITAL

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CHIEF EXECUTIVE'S INTRODUCTION

Welcome to our annual Quality Report 2018/19.

I am delighted to introduce our latest annual Quality Report.

Our Quality Report provides an overview of the ongoing and continuous improvements made by staff over the course of the year to improve the quality and safety of the care we provide. Quality is fundamental to the RD&E and this report provides a summary of the progress made against the priorities set out last year, some of our key achievements as well as the challenges we have faced in delivering high quality care.

The report also looks forward by setting new priorities for the coming year including those set by our Governors. In addition, the report provides a commentary on our quality performance during the year from our Governors, our principal commissioners (New Devon Clinical Commissioning Group), Devon Health and Wellbeing Scrutiny Committee and Devon Healthwatch.

In testing times, it never ceases to amaze me that, working together as teams, our people find new ways of working or seek to make small but significant changes in what we do to improve clinical outcomes, patient safety, and experience. For me, this demonstrates that the “golden thread” that we identified when we refreshed our corporate strategy last year, remains a distinguishing and important factor that drives improvement. The three key factors that make the RD&E such a special and dynamic place are:

- A clear focus on compassion, kindness and caring
- Working as a team
- A never-ending imperative to improve our services for patients

Over the course of 2018/19, the Trust delivered real tangible improvements in the quality of care all of which are down to the hard work of our staff, governors and volunteers. Behind every example cited in this report of what we have done differently or where we have made adjustments to improve care, you can see that this “golden thread” acts as a driver of change. These qualities give us much to celebrate as you will see over the following pages; but I am also conscious that these qualities are not to be taken for granted. It is vitally important that we nurture and cherish these important attributes and ensure that all staff, including our new recruits, take on board the RD&E way of doing things.

For the last 5 years or more we have been highlighting that the way that healthcare is organised and managed will need to shift with a much greater emphasis given to preventing ill health, keeping people well for longer, supporting people to manage their own care needs in the community and at home and providing more individualised support. This agenda remains central to our future plans as we set out when we published our refreshed corporate strategy last year. Our new service model is about expanding our focus on ill-health and hospital-based care (whilst recognising that this remains hugely important) to basing services on a collaboration with individuals, families and communities. Ensuring that we look beyond the acute hospital to focus on ensuring the quality and safety of patients in their own homes or in the community is absolutely critical. That is why I am really pleased that in our Quality Report this year, we highlight some of the changes and improvements we have made to quality and safety in each of these care settings. I want to highlight just a few of our notable achievements that illustrate that we are applying the clear-sighted focus on service improvement and quality across all the areas in which we operate:

- **Home:** Our comprehensive assessment approach is central to shifting the conversation to patient identified goals: “what matters to me?” I am delighted that we are now involving our key stakeholders – primary care and our partners in the STP – to roll out this approach that helps strengthen people’s independence. This is so important to shifting our own focus, aligning our partners and, fundamentally, it leads to better outcomes for our patients.
- **Community:** We have undertaken a range of initiatives at the community level to support people better when their life goes out of balance. Putting in place new Health and Wellbeing coaches in East Devon to work with and alongside primary care colleagues has helped provide a simple but effective way of enabling patients to self-manage their own health and wellbeing. As the Report sets out, 100% of those who have received this service would recommend it to their friends and family. Helping support people stay well is better for patients and enables them to stay at home.
- **Hospital:** The “ENSURE” initiative in our Intensive Care Unit (ICU) is a great example of improving the quality of care for our patients who may face life changing conditions. The multi-disciplinary approach is a well-established approach in patient care, but what marks this out is the conscious effort to “walk in the shoes” of patients, families and carers to understand their perspectives and to use this to improve the care for people in ICU.

All of the improvements in quality of care set out in this Report are the result of the hard work, dedication and commitment of our people to make a difference. Our staff are the beating heart of our organisation and that is why we have taken a number of steps over recent years to better engage them, to listen to them, to promote greater participation and involvement in decision making and seek ways to improve their health and wellbeing in the workplace. It is pleasing that the efforts we have made have resulted in improvements in both staff engagement scores in the annual staff survey and in the quarterly outcomes from the staff friends and family test indicating that the vast majority of staff would recommend the RD&E as a place to receive treatment or to work.

We are committed to continuing this important work during the coming year and beyond because we know that our staff are key to the delivery of excellent, high quality patient care. It is essential that we value everyone who works at the RD&E and that the efforts they go to every day to make a difference to our patients are recognised. I am confident that by fostering our culture of learning and continual improvement we will provide our patients with the safe, high quality care and positive experience they deserve.

The Quality Report is prepared in line with the requirements set out in the Quality Accounts legislation (part of the Health Act 2009) and NHS Improvement’s annual reporting guidance. To the best of my knowledge and belief, the information contained in this document is accurate and, on behalf of the Board, I am confident to stand by its contents.



Suzanne Tracey
Chief Executive
Date: 22 May 2019

PROGRESS ON OUR 2018/19 PRIORITIES

Governor Priorities

- **Verbal Communication of Staff to Patients**
- **Promoting Wellbeing at Work**

Verbal Communication of Staff to Patients

The Trust has worked on several elements of communication with patients over the last year. We acknowledge there is always more to do. We are also aware that communication is often at the heart of any complaint that we receive. As such learning from miscommunication is as important as ever (please refer to Complaints Handling – Communication Issues on page 56 of the Annual Report).

One of the key changes this year have been our ability to communicate effectively with all of our patients and their carers/families. Both verbal and non-verbal communication lines have altered, with the inclusion of the Trust's Facebook page, appointment reminder services and revisiting the hearing loops in some of our Out-Patient areas. Further work around our patients, relatives and visitors with learning disabilities has been undertaken so that we can effectively communicate and engage with this group of people. We have actively engaged the Learning Disability Partnership Board and a local 3rd sector organisation to help us develop our approach. Some of the people living with learning disability who are helping us are keen to explore how they might become special advisors or "inspectors".

We are further working to implement the NHS Improvement published Learning Disability Improvement standards. There are four standards which include:

- Respecting and protecting rights
- Inclusion and Engagement
- Workforce
- Learning Disability services standard (aimed solely at specialist Mental Health Trusts providing care to people with learning disabilities, autism or both)

As a Trust we are enhancing our ability to be inclusive. Through our volunteer plan for 2018-2021 we are very much looking to ensure wider inclusivity in our volunteer workforce, to match that of our employed workforce. Furthermore in the last year we have appointed a new Inclusion Lead for the Trust, who is assisting us with getting wider communication right.

This year has seen our Non-Executive Directors becoming part of our Quality Assessment Process that looks at each individual ward and department area, ensuring that we are delivering the right care in the right environment. As part of this assessment the Non-Executive Directors have been undertaking patient questionnaires with the patients to ensure we get live feedback. This also enables a two way conversation about how the Board of Directors is able to act on feedback and communicate that change directly with our patients.

Each year the Clinical Divisions update their patient engagement plans and this year has been no different. Through performance assurance meetings these are reviewed and scrutinised to ensure learning and improvement around communication with our patients, relatives and visitors. Over the last year a number of small changes, including updating clinic letter templates to provide better information and updating the reminder services for outpatient appointments have been made on the back of these plans.

Within the Trust's Community Division we talk to 120 patients per month to get the views of how their care is progressing or has been. From this we make improvements to the way we deliver care or the way in which we communicate. This will continue to give us rich information and feedback.

Promoting Wellbeing at work

The Trust has continued to implement a programme of work designed to deliver the Health and Wellbeing (H&WB) Strategy. Throughout the year we have continued to integrate both the Occupational Health and Health & Wellbeing (OH & WB) offerings into a combined Occupational Health & Wellbeing service. This integrated service has created a direct link between Divisions to the services of a specialist OH Nurse, enabling Divisions to focus on hot spots and to enable the OH & WB service to respond directly to service requests.

The Trust operates a comprehensive OH & WB service, which is Consultant-led, with access to specialist nurses, an in-house physiotherapy service, Staff Support & Counselling and a dedicated H&WB improvement practitioner. In addition to this, the Trust provides a free of charge access to an Employee Assistance Programme (EAP), which is available to staff and their families on a 24/7 365 days a year basis to ensure that support is there when employees need it.

Throughout 2018/19 the Trust has undertaken a comprehensive programme of activities to support the health & wellbeing of staff. These activities have encompassed training, workshops, activity sessions including in certain instances funding for activities. Key highlights of delivery include:

- Staff Health & Wellbeing Fair held, with over 200 staff attending
- We undertook a H&WB staff survey in order to enable staff to inform the delivery of the strategy. In total, 2,037 staff completed the survey and came from across the Trusts, from all staff groups, and this informed our programme of work.
- We have implemented 'Making Every Contact Count' initiative into all aspects of Occupational Health & Wellbeing.
- Over 50 teams have benefitted from funding for health and wellbeing initiatives from the Staff Lottery including team socials, massages, improved staff garden areas, fruit boxes, pedometers.
- We have embedded health and wellbeing into our 'Management Essentials' training – approx. 126 managers trained to date.
- Campaigns promoting 'Break Culture', and 'Hydration Station' competitions ran across the Trust with the aim of promoting taking your break and staying hydrated.
- Mental Health First Aid (MHFA) Implemented with in-house training capability to ensure cost-effective sustainability.
- Sixty-four Staff Health and Wellbeing Champions and 60 Mental Health Champions trained.
- Over four hundred staff have completed a newly-developed Stress Self-Management Workshop.
- New workshops have been developed and piloted including:
 - Understanding Stress Management in the Workplace –Workshop for Managers developed and piloted
 - Building Resilience Course launched
- The Trust has signed the "Time to Change" Employers Pledge, a national campaign designed to break down the stigma of discussing mental health.
- Menopause at Work – Masters level research supported and completed. A menopause staff survey completed – over 800 staff completed the survey and a menopause focus group has been formed with Staff Side to review the research, survey results and to make recommendations to the Board of Directors.
- We have held Menopause at Work workshops and over 180 staff have attended. These will continue in 2019.
- Five new staff fitness classes launched at community sites, and a range of activities including yoga, Pilates, circuits and running sessions are held at Wonford
- We have provided free bike check days – over 130 staff have had free bike checks.
- We have launched a 'Park and Walk' scheme to promote active travel.
- We have formed a 'Smoke Free Committee' and are developing a new smoking policy.
- We have recruited a Dietician for 1 day per week in Occupational Health to support staff, deliver talks and to provide 1:1 support to staff who may have conditions such as Irritable Bowel Syndrome, etc.

Work commenced on the review of the staff appraisal process and documentation, which provides an ideal opportunity to discuss individual health & wellbeing and this work has continued into 2019.

The Trust was shortlisted as a finalist in the Annual Reward and Employee Benefit Association (REBA) Health & Wellbeing Awards. These industry-wide awards are designed to recognise excellence in promoting H&WB and it was a great accolade to be shortlisted as a finalist.

Effectiveness of the delivery of the H&WB programme is monitored by the Workforce Governance Committee (WGC) and key metrics to gauge the effectiveness of the actions include key metrics from the Annual Staff Survey, sickness absence figures and with linkage to the Commissioning for Quality and Innovation (CQUIN) scheme for H&WB. Measures of performance have been mixed; and further work continues to review against these measures in order to understand where we can improve.

In 2019, our key focus will be to:

- Continue to progress the menopause work that has been commenced.
- Continue to focus on mental health.
- Commence work into supporting the financial wellbeing of our staff.
- Continue to engage with managers at all levels to reinforce responsibility for managing staff health & wellbeing.
- Continue to deliver the comprehensive programme of work to improve the health & wellbeing of our staff.

Levels of sickness absence remain high within the Trust, and a comprehensive review of sickness, along with a major review of the Attendance Policy has already commenced; both of these will ensure that our staff will continue to feel valued and cared for.

PROGRESS ON OUR 2018/19 PRIORITIES

Trust Priorities

- **Promoting independence of patients**
- **Use of patient feedback**
- **Health and wellbeing of staff**
- **Safety Programme**

Promoting independence of patients

Following on from the Your Road to Wellbeing campaign, the Trust appointed 6 practice coaches to work with the wards over the next 2-3 years in a systematic way, supporting patients in keeping their independence in hospital and early discharge back to their home or the community. The coaches are senior members of our existing nursing and AHP cohorts with the skills and knowledge to supportively challenge staff and patients and their families, as well as supporting the multidisciplinary team in empowering patients and their carers to maximise their recovery and reduce length of stay in a bed that is not their own.

Reporting through the Happy Healthy at Home Programme are the following key pieces of work which all aim to re-able people to maximise their independence within their home environment, and is also aimed at empowering staff to work to their maximum skillset.

Intermediate Care approach on all three community hospital wards Embedding the model which includes different skill mix of staff (more Therapists and Support Workers, increased involvement of the voluntary sector), access to greater range of equipment/kit/TEC (technology enabled care) which can all be made available to patients at home. A different daily rhythm on the community ward ensures all board rounds/conversations/contacts are adding value to the person achieving their goals. The objective to always aim for home after the short stay – hopefully with decreased or no care needs.

Technology Enabled Care (TEC) Is more accessible for community staff with education around what is available and how to access it including pendant alarms (6 week duration initially) which will contact/alert our new 'roving responders' who working closely with the out of hours nursing team.

Development of the Comprehensive Assessment. Is being piloted in Exeter and involves having one assessment which will be accessed and updated by GPs, community teams, Devon Partnership Trust (DPT), South West Ambulance Service Trust (SWAST), Devon Doctors On Call Service (DDOC) and 111. This is a holistic assessment which will make clear what matters to the person including their goals. This will ensure a joined up approach and communication.

Increased staff resource to support people to return to their home environment or to remain within their home environment, ensuring our teams work to their maximum skill set and utilise other resource (i.e. voluntary sector) when appropriate. Extra resource comes through additional Trusted Assessors, building on our current resource. These posts are key for linking with care homes when people come into hospital ensuring that we assess their needs. Increased social care resource within the acute hospital and staff in Care Direct Plus (CDP) is helping to plan for patients with longer term care requirements.

Increased external resource: 'Community Connector' roles provide social prescribing within 3 clusters, specifically: Honiton/Ottery, Seaton/Sidmouth/Axminster and Woodbury/Exmouth/Budleigh - linking with the Fire Service to access people in their 'Advocate roles' as they often do home checks including fire and crime prevention.

Simplifying the process to support people

home will release time for Therapists and Nurses in hospitals to care/support patients and re-able them whilst they are there. It will draw on the experience of the community teams to lead the discharge out of Hospital.

Health and wellbeing of staff

Please see page 5 of this report for the update on progress made this year.

The use of patient feedback

The Trust continues to engage with and learn from patients and carers through feedback from a number sources. Complaints, concerns, comments, national and local surveys, Patient Opinion and other patient experience tools such as the Care Quality Assessment Tool (CQAT), 'What Went Well, Even Better If', Patient Reported Outcome Measures (PROMs) and the Friends and Family Test are all utilised to gain feedback.

From 1 July 2018 the national KO41 complaint codes have been adopted by the Trust for the analysis of complaints and concerns. There are 20 main subject headings with each of these having further descriptors for deeper analysis. This change is providing a broader analysis of themes. This enables a greater depth of coding so that we can drill down into specifics rather than general complaint issues.

An extensive review of the Trust's visiting times has taken place during 2018/19, with a trial (08:00-20:00hrs) being implemented in Feb 2018. Subsequent reviews took place in July 2018 and January 2019; patient feedback was obtained via CQAT and a Twitter poll. The view was generally positive in that patients wanted extended visiting hours, however they felt 8am was too early. As a result, from the 1 April 2019 the Trust has adopted 10:30-20:00hrs visiting hours. The pilot and subsequent changes have been made as a direct result of patient feedback.

The National in-patient survey is a key source of feedback and will guide the Trust on improvements to patient experience during admission to hospital. As is undertaken every year decisive actions will be delivered in response to the survey.

Work is underway to develop 'Patient Stories' to explore how we can listen more actively to themes from patient experience across the RD&E. Exeter University attended the Patient Experience Committee (PEC) in September 2018 to explore this work with us, and we have set up a patient led, patient experience session. This is innovative in that the stories and themes will be self-selected by the patient led group and not influenced by the Trust.

Safety Programme updates (2018/2019)

Local Safety Standards for Invasive Procedures (LocSSIPs)

This year the LocSSIPs agenda (which is a safety process designed per procedure) has moved forwards with over 60% of all procedure types now having LocSSIPs in place. The remaining procedures are covered through local standard operating procedures or guidelines and as each are reviewed they are moved into the LocSSIPs format. The work will be completed through the summer months.

Maternity Safety Programme

Maternity services have various inter-connecting work streams in progress to improve the safety, care and experience of families using maternity services. These work streams have been amalgamated into a safety improvement plan.

The actions are aligned to 5 main themes:

- Learning and best practice - multi-disciplinary training plan/saving babies lives roll out / ATAIN – avoidable term admissions
- Leadership – Board level champion / safety huddle roll out / birth rate plus acuity tools on labour ward and inpatient ward
- Prevention – flu/pertussis service launched / sepsis launch / Healthy Mums and Tums launched
- Data – national maternity dashboard roll out
- Innovation – standardised homebirth kits / maternity and neonatal safety improvement programme – wave 2

This is a dynamic improvement plan monitored on a quarterly basis through the Maternity Governance Group. Maternity services (in conjunction with neonatal and paediatric services) have robust processes in place to review and report mortality and morbidity.

The National Healthcare Safety Investigation Branch (HSIB) undertakes maternity investigations on all term babies born following labour who have one of the following outcomes:

- Maternal Deaths: Direct or indirect maternal deaths in the perinatal period (during or within 42 days of the end of pregnancy).
- Intrapartum stillbirth: where the baby was thought to be alive at the start of labour but was born with no signs of life.
- Early neonatal death: when the baby died within the first week of life (0-6) days of any cause.
- Severe brain injury diagnosed in the first 7 days of life, when the baby:
 - Was diagnosed with grade III hypoxic ischaemic encephalopathy (HIE); or
 - Was therapeutically cooled (active cooling only); or
 - Had decreased central tone and was comatose and had seizures of any kind.

The HSIB investigation process was launched at the RD&E in July 2018. We currently have four cases under review by the HSIB which is in line with other providers. It has been decided Devon-wide that all HSIB cases, regardless of harm caused, will be StEIS reportable. (Reporting a serious incident must be done by recording the incident on the Strategic Executive Information System (StEIS). This system facilitates the reporting of serious incidents and the monitoring of investigations between NHS providers and commissioners).

Work on the maternity safety programme is progressing well and continues to be monitored by the Patient Safety & Mortality Review Group.

Sepsis CQUIN

The Commissioning for Quality and Innovation (CQUIN) scheme has two key elements:

- Emergency Department and Acute Inpatient Settings; Timely identification and screening – We are achieving this target (94.22% against the target of 90% - please refer to the Commissioning for Quality and Innovation schemes detailed on page 30 for further information).
- Emergency Department and Acute Inpatient Settings; Timely Treatment – We are partially achieving this target with work ongoing to improve.

The Trust is performing well with the timely identification of patients, but continues to work on improvements for the timely treatment of sepsis. Improvements are being aided by the implementation of the National Early Warning System (NEWS2) on the 23 January 2019. In order to embed the implementation of a new track and triggers system (NEWS2) a Senior Nurse was employed to lead the work. An extensive programme of work has been undertaken to provide additional education to all clinical staff with regards to the early identification and timely management of patients with sepsis. Alongside the implementation of NEWS2 and the Trust sepsis bundle has been updated. Further information on the Sepsis CQUIN can be found on page 30.

Learning from Excellence (LfE)

Safety in healthcare has traditionally focused on avoiding harm by learning from error. This approach may miss opportunities to learn from excellent practice. Excellence in healthcare is highly prevalent, but there is no formal system to capture it. We tend to regard excellence as something to gratefully accept, rather than something to study and understand.

The LfE Trust wide launch took place on the 4th June 2018. This launch was not as successful as the team would have hoped and a limited number of nominations have been received. The LfE champions attended the Care Matters Forum (Matron/Senior Nurse/Senior AHP) in January 2019. The plan is to rebrand to 'Greatix' as it felt that this will have a more positive response. The use of DATIX system is used to report any incidents or near misses. 'Greatix' will be an avenue to report excellence in care and treatment.

Mortality work

There has been extensive development against the measures associated with mortality over the year. The Trust has seen an improved Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR) position. Both of these metrics have returned to within the 'as expected' ranges. There have been a number of key work streams undertaken:

- Review of clinical coding has been completed and an improvement in data quality is already being noted.
- Purchase and implementation of the DATIX mortality electronic module, to allow better recording, review and analysis of mortality.
- Structured Judgement Reviewer numbers have increased to provide a greater review of deaths in the organisation.
- Structured Judgement Review (SJR) process has been refined and number of reviews of deaths has increased. Additionally peer review is also now in place to provide a quality standard for the reviews.

IMPROVEMENTS TO QUALITY AND SAFETY 2018/19

Home - Community - Hospital

HOME

Place based care in Tiverton

Early Supported Discharge Stroke (ESD) The ESD work stream went live on 28 January 2019 in the Tiverton & Cullompton cluster. This service will support the existing service pathways which enable people to either remain at home following a crisis or facilitate their timely discharge out of hospital. The aim of the service is to provide a clinically led, integrated early supportive discharge service for stroke patients. Ensuring patients receive appropriate assessment, rehabilitation and care which facilitates early hospital discharge and effective recovery. This represents an extension of the longstanding model covering parts of the Eastern locality.

Multispecialty Clinic (Castle Place GP Practice Patients) A multispecialty clinic has been set up with staff from Tiverton Hospital, Castle Place Practice, Age UK and League of Friends including staff from nursing, therapy and GPs and is running at Tiverton Hospital on a fortnightly basis.

Comprehensive Assessment Framework/ Development

The development of a comprehensive assessment is a fundamental part of the Trust's focus on prevention through the improvement of health and wellbeing for the population. The comprehensive assessment will ensure that people who are frail have a full preventative assessment led by the integrated community team, through the GP Core Groups. This assessment will focus on supporting the individual to be really clear about "what matters to me" and to work with teams to agree a plan, maximising their own strengths and maintaining their independence with our support should they become unwell. The plan will describe to all members of the health and care team what the person wants in the event that their condition deteriorates or they become unwell. This will become an important document to support the care for those who are most frail in our communities.

Since 2018, a Sustainability and Transformation Partnership (STP) framework for the comprehensive assessment has been developed in partnership with primary care, social care and mental health. Working with the STP and a software provider this form is being digitised to enable all agencies to access real-time plans. Pilots in Eastern Devon are planned early this year. Our community teams are being trained to undertake the comprehensive assessment and this will be underpinned by strength-based training; ensuring that we support people to maintain their independence. Our local GPs already identify people who are most frail in our communities and the comprehensive assessment will support working across community teams to agree a plan to support these individuals. The comprehensive assessment documentation will support this planning and provide an improved preventative approach. This work is in partnership with the STP Devon end of life form also going live early 2019.

COMMUNITY

Admiral nursing services in community (patients with complex dementia needs) – WEB & SAS

Across East Devon there are four Admiral Nurses in post. The primary role for Admiral Nurses is to support carers who are caring for people with dementia. Carers report that having Admiral Nurses help in navigating pathways and coordinating support from agencies is incredibly useful and enables them to remain focused on looking after their loved one. A feedback form is being developed and outcome measures are being recorded in line with the national guidance.

Patient Y on first visit explained that she had lost her husband, moved from Tiverton to Exmouth, is now living with her daughter and grandchildren and had no friends in the area. She also expressed although she did a lot domestically and for her grandchildren, she was really missing cooking as her daughter did all of this. Patient Y, with the assistance of 'Ways 2 Wellbeing', has: tried several different exercise classes and now intends to attend seated Zumba on a weekly basis, is volunteering one morning a week in a kitchen supervising and working 1:1 with young adults with learning difficulties, which has solved her feelings of loss around cooking, she has had an induction and joined as a member the Budleigh

HUB Gym, she is socially more active meeting people regularly for coffee and with the additional help of a Stop Smoking Nurse has also given up smoking and has not smoked for five weeks now.

Health Coaches in our communities – Honiton and Seaton

Honiton and Seaton communities have been supported by two Health and Wellbeing Coaches since June 2018. In February 2019 a further two coaches joined our communities in Woodbury, Exmouth and Budleigh cluster and one coach in Sidmouth. The Health Coaches offer advice about healthy living, diet, exercise and how to maintain chronic conditions in a healthy way.

The team of Health and Wellbeing Coaches work closely with primary care and community health and social care teams. Making a referral is simple and effective and the coaches have received 183 referrals to date.

The overall impact of this service is measured by two key outcomes:

- The Patient Activation Measure (PAM) level which indicates a person's confidence and ability to self-manage their health and wellbeing
- The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS) which indicates feelings and mental wellbeing of a person from their perspective.

From the people who have been supported by the Health and Wellbeing Coaches 100% of them would recommend this scheme to friends or family, and all reported improvements in their mental health and wellbeing.

Intermediate care in community hospitals – Tiverton, Exmouth, Sidmouth

Across the three community hospital inpatient units the Trust has further embedded the enabling approach to rehabilitation, supporting people to maximise their opportunity for independence before returning to their home environment.

Additional funding has increased the number of Therapists and Support Workers on shift and has also bought more equipment which can often improve how people function with an aid. The revised daily routine at the community inpatient units has really helped to embed the enabling focus which includes breakfast clubs, activity sessions and a daily board round with all members of the multi-disciplinary team which ensures that everyone is working towards the same goal.

With the new ways of working we have been able to provide more intensive rehabilitation meaning that people on average are able to return home with a reduced hospital stay. We have a weekly review of feedback, clinical outcomes and activity which helps the team to identify areas of good practice which can be celebrated and shared as well as areas which they could improve on.

HOSPITAL

Comfort Exeter

The Emergency Department (ED) aims to provide emergency clothing and essential personal items for vulnerable patients or those in need of extra support though well enough to leave ED. It was recognised by the ED team that sometimes patients although medically fit, required a little extra help. We give away 'comfort bags' that contain essential items, such as toiletries, sanitary products and socks, to support vulnerable patients with their ongoing health needs and provide comfort and dignity after discharge. The pack also includes a 'survival guide' that details food banks, soup kitchens, emergency accommodation and how to appropriately access healthcare. Comfort Exeter was produced by ED staff keen to introduce initiatives to improve not only the care received by patients while in the department but also their holistic needs after leaving it. The Comfort Exeter project has now been running for 1 year and continues to grow and adapt to patient requirements. Local trusts, charities and the South West Ambulance Service Trust has also taken a keen interest. Taunton hospitals are working towards the launch of Comfort Taunton. It would be our hope that this spreads nationally and are currently looking to submit details of the work for a national award.

Ambulance handovers

A change in process developed by the Emergency Department has resulted in a significant reduction in the ambulance handover time. This is recorded in minutes lost over 15 minutes and the department consistently performs well against the other Trusts in the South West. This not only benefits the patients who have been brought into the department but helps to ensure that crews are released as quickly as possible to attend those still waiting for ambulances to attend to them.

Acute Medical Unit

In September 2018, the Trust was awarded funding by the Department of Health to help improve patient flow through the Acute Medical Unit (AMU). This work had to be completed by the 24 December 2018, leaving just a few weeks to design, build and open the new area. The build focused on redesigning the Medical Triage Unit within AMU to help the hospital manage increasing numbers of admissions in a safe and timely fashion.

AMU needed to continue operating as normal during the build and staff and patients coped admirably with the temporary loss of space and facilities. The project required support from the whole team; everyone had a role to play and the completion of the build in time for Christmas was a great morale booster at one of our busiest times of year.

The new unit provides a much more comfortable patient experience, with a dedicated waiting area and four rooms to allow healthcare staff to assess patients safely, whilst maintaining their privacy. There is also a near-patient testing room which allows the rapid diagnosis of certain infectious illnesses, allowing patients to receive early treatment and limit infection risks to others.

Traditionally patients arrived in AMU and were taken to a bed to be assessed; the rebuild has changed the way we work with a greater emphasis on trying to manage patients on an “ambulatory basis” without admission to hospital. Around 20% of patients are now managed on an outpatient basis.

The new unit has also provided improved facilities for staff, with additional toilets, a new staff room, consultants office and garden area. The whole team is enjoying the benefits of working in a modern, well-designed environment.

NeoNatal Unit (NNU) Parent Led Ward Rounds

The normal development of an infant’s brain is interrupted by being born too early and is further impacted upon by the care provided after birth and into their toddler years. Evidence shows the impact premature birth has on an infant’s behavioural, emotional, social and sensory development, which can have a lasting and devastating effect on the child and their family.

This is why it is vital that parents are with, and caring for, their baby on the NNU.

By enabling parents to lead the ward round, the NNU commits to parents being true partners in their baby’s care.

Parent led ward rounds started in September 2018 following a series of parent and staff focus groups. Parents on the NNU are now invited to present their baby on the ward round. Parents are a constant in their baby’s lives, unlike the rest of the neonatal team. They are best placed to communicate what is important about their baby.

Feedback has been encouraging. Parent’s value having this opportunity and report that being actively involved reduces their anxiety and prepares them for going home.

ENSURE – ENabling and SUPporting REcovery after Intensive Care

For patients and their families, an illness which requires a stay in the Intensive Care Unit (ICU) can be life changing. Even after discharge home, physical and psychological problems (such as flashbacks and anxiety) can remain, hindering recovery and placing strain on relationships and day to day living.

The RD&E ENSURE clinic is a multidisciplinary clinic, run one morning a week for 5 weeks, for groups of up to 11 patients and their relatives. Over the 5 weeks, patients and their families receive general and focused care from physiotherapy, pharmacy, psychology, dieticians, ICU medical and nursing staff, citizens advice and Neighbourhood Friends, as well as vital peer support from each other.

The strength of the clinic is that many of the professionals involved work on intensive care, and are experienced in the challenges that our patients and families meet during their stay there. The clinic supports these people effectively because the multi-disciplinary team have designed it to allow time to listen and support the patients and relatives in their recovery.

The Clinic team has also found that the opportunity to talk to our patients and their families and to see their experiences through their eyes has provided the team with a unique and hugely valuable insight to be able to improve the care delivered to the patients on the unit.

Patients who have benefitted from the service have said the following:

- With so much gratitude and congratulations on your excellent therapy clinic
- Whilst I do lack energy and my mobility is not what it was I do have a much more positive outlook and I want to thank you for what you have done and again express my sincere thanks to the ENSURE clinic
- I cannot thank you enough for all the help you gave to me and my son – your support and care was fantastic and really helped to change his situation in very real and practical ways.

Mardon Neuro-rehabilitation Centre - Creative Space Therapy

There is good evidence that an enriched environment enhances inpatient rehabilitation and improves outcomes.

Mardon Neurorehabilitation Unit League of Friends has purchased a recurring six week course with Creative Space, an organisation including artists, providing arts & crafts activities on a weekly basis for in patients within the Mardon Neurorehabilitation Unit. This occurs on a Thursday in the communal dining area; a large space with good lighting and views of the garden. All patients are enabled to participate in the creative activities which vary each week. These include painting using different media, clay work, stencilling, using wool and felt to create a picture or 3D object.

The art sessions occur outside of formal therapy sessions and have been found to be very beneficial for the wellbeing of the patients. The group sessions provide an opportunity for communal socialising, listening and an opportunity to explore artistic skills that some patients never knew they had.

Following these sessions patients have requested that their art work is displayed and we have created a 'gallery wall' in the dining area, with the display changed at regular intervals. The art work is also included in the quarterly Mardon Newsletter, a publication developed between the rehabilitation team and patients.

Volunteer Plan 2018 - 2021

This year has seen the beginning of the 3 year plan to improve and expand on the fantastic work already undertaken by our volunteers.

Through this plan we aim to do just as we outlined in our corporate objectives. We have a steady stream of people from a wide variety of ages and backgrounds approaching us to volunteer in our organisation. We aim to be able to offer them the very opportunity that they want, in being part of this organisation's delivery of its world-class specialisms.

Connecting people, communities and services couldn't be any closer than to our volunteers who are our communities. These are individuals who understand this part of Devon and what it means to live in and around our various premises. The value that they will bring to enhancing the wider understanding cannot be underestimated and that is why we want to grow this team.

The Trust is currently recruiting a Volunteer Coordinator to take the work of this valued group forward and expand what we can do. Assisting our patients who live with dementia through activities, befriending and movement. Assisting people to get to appointments, music and art activities for those who are in hospital for extended periods and helping our youth groups and organisations to take part in public engagement activities all form part of our plan.

The vision of this plan is to identify and deliver realistic, sustainable and innovative plans for the resource, recruitment, management and mobilisation of volunteers and volunteering over the next two years.

OUR PRIORITIES FOR 2019/20

Governor Priorities

Patient's Experience at Night

Getting a restful night when receiving care in the acute hospital or a community provision is essential to a patient's wellbeing.

It is acknowledged that achieving this can be a challenge for the staff providing care.

Governors would like to support all care that helps a patient to achieve this by asking:

- Whether there is a strategy or plan in place that promotes a restful night for all patients in the acute and community hospital environment.
- What actions are taken to promote a restful night in wards where there is a need for frequent assessments and treatment such as the Acute Medical Unit (AMU)?
- How is active care at home by community nurses under the discharge to home pathway help a patient to get a restful night?
- How is a restful night monitored?
- Is there a Care Quality Assessment Tool (CQAT) question that considers the patient experience at night?
- What actions are taken to manage patients' expectations in relation to noise at night?

What would a good patient experience at night look like?

- There would be a strategy/plan in place that is embedded across the Integrated Trust that recognises the importance of a restful night to patients and promotes it.
- Care Quality Assessment Tool (CQAT) outcomes for the Acute, Community and Community Connect Service will indicate the quality of the patient experience at night.
- The patient experience at night would be reported on at the Patient Experience Committee (PEC) as part of the dialogue in the Performance Report, when considering the CQAT outcomes.

Qualitative feedback from patient stories, shared with the Patient Experience Committee, the Board of Directors and the Royal Devon and Exeter Foundation Trust via members, governors and patient surveys will provide feedback about this aspect of care.

This priority will be monitored and reported through the Patient Experience Committee which is a sub Committee of the Governance Committee.

Volunteer Provision

The value of volunteers is clearly shown in reports from the Kings Fund (2018), National Health Service England (NHSE) 2017 and the draft Royal Devon and Exeter NHS Foundation Trust (RDEFT) proposed Volunteer Plan 2019 – 2020. Governors wish to acknowledge the value of volunteers to patients, carers, staff and the volunteers themselves.

In supporting the RDEFT proposed Volunteers Plan 2019 – 2020 we ask:

- How will this plan be embedded across the acute and community services?
- How will the Trust attract a diverse range of volunteers in line with the core values of Diversity and Inclusion?
- How does the Trust plan to meet its stated intention in the proposed Plan of doubling the number of volunteers across the Trust by the end of March 2020?
- How will the Trust monitor the conversion of an interest to become a volunteer to the numbers who become volunteers?

What would improvement look like?

- The Volunteer Coordinator as set out in the proposed Plan (Draft Volunteer Plan 2019/20) is in post.
- The Volunteer Plan 2019/20 is embedded across the acute and community services as measured by the number of volunteers.
- RD&EFT should use all opportunities to promote volunteering e.g. Open Days and Career Fairs and the benefits that volunteers bring to patients, staff and the volunteers themselves.
- Volunteering is highlighted at Open Days and Career Fairs as an opportunity to gain experience in the National Health Service for those wishing to pursue a career in healthcare.
- The RDEFT recognises the Investing in Volunteers Standards within its Volunteers Plan 2019/20.
- There is a minimum increase of 100 volunteers across the acute and community services within the timeframe set out in the draft Plan. This will be reported on in the annual volunteers report to the Patients Experience Committee (PEC).

This priority will be monitored and reported through the Patient Experience Committee which is a sub Committee of the Governance Committee.

OUR PRIORITIES FOR 2019/20

Trust Priorities

- **Ensuring patients/people only spend as long within any stage of the care pathway that adds value to them**
- **Reducing the Trust's need for and dependence on temporary staffing**
- **Safety Programme**

Time spent within the care pathway

Although these are challenging times for the NHS, we believe there are real opportunities to forge a new approach to meeting the health and wellbeing needs of the people we serve. By seizing these opportunities, the prospect of improving the health and wellbeing of our citizens, reducing health inequalities, and enabling people to stay well, stay supported and stay connected is achievable.

Over the last five years we have been developing a new "service model" or "care model" that shifts from a narrow focus on ill-health and hospital-based care to basing services on a better understanding of the needs, strengths and capacities of individuals, families and communities, working with them as partners in their own care. This means shifting from asking people "what is the matter with you?" to asking "what matters to you?"

How are things changing?

Our new approach places greater emphasis on:

- Preventing ill health, keeping people well for longer and focusing on independence and wellbeing, including through the best evidence based practice and research
- Supporting people to manage their own care needs in the community and at home and providing more individualised support
- Working with and alongside communities and volunteers to support people in the places and communities where they live
- Harnessing technology, including a new care record system, that empowers people through access to their own information
- Understanding the needs and objectives of individuals and working with them to support them appropriately, treating people as equal partners in their own health and well-being

- Helping to prevent people from becoming acutely unwell by focusing on their health and wellbeing including their mental health
- Working with partner organisations - either voluntary or statutory – to address the wider determinants of ill-health.
- Focusing on a strengths (rather than deficit) based approach – be it the strengths of the individual or through place based care, the strengths of the local community.

Over the past couple of years we have seen great progress in a number of areas where we have integrated care so that people can receive more care in their own homes or within their local community together with promoting independence and self-management wherever possible. Where people have needed care from the acute services we have also made changes such as Advice & Guidance, which may prevent the need for individuals to travel to the acute site of Wonford.

Within 2019/20 we are going to have a focus on urgent care; building on the integration principles outlined above, to augment the quality of urgent care offer across Eastern Devon.

Urgent Care: If a person's health deteriorates so that their condition/s requires urgent (though not emergency) treatment, then they will either be triaged through the 111 service or through primary care. If they then require further assistance, then a person with an urgent condition may most appropriately be seen in an urgent care centre or at home where they are able to access short term support from our urgent community response team. Alternatively, their GP (or other primary care professional) together with hospital consultants may decide to rapidly admit them to an urgent care centre or be seen in an ambulatory unit in the main hospital to assess their health status and be treated. Depending on their condition, some people may be seen by newly established "hot clinics" in a number

of specialities set up to treat urgent cases. If their condition can be managed effectively then they may be able to return home at this stage. If they require further tests or treatments, they may need to be admitted onto a ward.

This work will seek to engage local people and communities to create together the urgent care offer which improves their experience, provides care as locally as possible and only requires people to spend time out of their usual place of residence for as long as adds value to them.

This work aligns with the 'One Plan' – the Trust's operational plan and will be monitored by the Strategic Delivery Group [SDG] which regularly reports to the Board of Directors.

Temporary Staffing

The Trust is focusing on minimising its reliance on high cost Nursing and Medical agencies in the coming year, by developing strategies to address the reasons for usage such as vacancies and staff absences. By working towards an improved staff bank offer, staff bank hours will increase and agency hours will reduce. Ultimately, we will be able to improve our core staffing levels, thereby improving the patient's experience and quality of care. This will also support the joint work providers across Devon are undertaking to ensure a consistent approach towards agency rates and usage.

This will be achieved through improved rostering of staff, a clear understanding of the levels of care patients require through collecting data and acuity and dependency scores 3 times a day, an improved staff bank offer, and improved recruitment and retention of all staff groups. During the last year the Trust has had to use 25.7% agency workers to fill its temporary workforce requirements. The Trust will aim to significantly reduce its requirement for temporary workforce aiming to increase recruitment, continue its focus on retention strategies. The Trust will seek to reduce agency spend and to working within the Agency cap, aiming to reduce costs for the coming year.

This work aligns with the 'One Plan' – the Trust's operational plan and forms part of the Productivity work stream. Progress will be monitored by the Strategic Delivery Group [SDG] which regularly reports to the Board of Directors.

Safety programme for 2019/20

Every year the Trust develops a Safety Programme which has at its heart a desire to safeguard our patients and provide the very best quality care we can. We often describe safety and quality as the 'golden threads' which run throughout the fabric of the RD&E.

For 2019/20 the Safety Programme will include a focus on:

- Medication, safety, storage & security
- Pressure Ulcer reduction
- Maternity Safety Programme
- Sepsis
- Acute Kidney Injury
- Reducing harm from falls
- Mortality – learning from deaths

In addition, we will be spending some time looking at the safety culture within the Trust – what are the human factors and environmental factors which we must pay attention to? We will also look at the opportunities that technology enhanced learning, such as simulation affords us in further enhancing our safety, quality and continuous improvement.

A Quality Improvement (QI) approach closely aligns to the priority we will give to our safety programme and this year will see the Trust publish a QI Strategy.

The Safety Programme reports to the Trust's Safety and Risk Committee, which reports to the Governance Committee which is a sub-committee of the Board of Directors.

DISCLOSURES

Disclosures contained in this section:

- Duty of Candour
- Learning From Deaths
- Seven Day Services
- NHS Doctors and Dentists – rota gaps and improvement plan
- Freedom to Speak Up and Whistleblowing
- Review of Services
- Participation in Clinical Audit
- Participation in Clinical Research
- Goals Agreed with Commissioners

Duty of Candour

The Trust remains committed to being open and honest with patients and their families when things go wrong. The Trust implemented a process for Duty of Candour from August 2013 which was communicated and led through the Trust's Governance system. Monitoring of compliance of Duty of Candour happens at different levels. The Trust uses its electronic incident reporting system Datix for overseeing the Duty of Candour requirements. Duty of Candour compliance is monitored through the Trust's Incident Review Group. This compliance is also reported through to the Safety and Risk Committee and is included in the monthly Integrated Performance Report to the Board.

Learning from deaths

During 2018/19 1,532 patients of the Royal Devon and Exeter NHS Foundation Trust died. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 369 in the first quarter
- 337 in the second quarter
- 376 in the third quarter
- 450 in the fourth quarter

These figures include all deaths that occurred during an inpatient stay at any of the Trust's Acute or Community sites. Of these, there were 8 deaths of patients with a documented learning disability.

During 2018/19, 25 stillbirth, neonatal deaths and child death subject to Child Death Overview Panel review were recorded at the Royal Devon and Exeter NHS Foundation Trust. This comprised of the following number of deaths which occurred in each quarter of that reporting period:

- 8 in the first quarter
 - 0 Neonatal deaths after 22 weeks
 - 3 Stillbirths ≥ 24 weeks (5 if including TOP)
 - 5 children's deaths subject to Child Death Overview Panel review
- 3 in the second quarter
 - 1 Neonatal death after 22 weeks
 - 2 Stillbirths after 24 weeks
 - 0 children's deaths subject to Child Death Overview Panel review
- 5 in the third quarter
 - 1 Neonatal death after 22 weeks
 - 1 Stillbirth after 24 weeks
 - 3 children's deaths subject to Child Death Overview Panel review
- 9 in the fourth quarter
 - 1 Neonatal death after 22 weeks

By 31 March 2019, 139 case record reviews and 56 investigations had been carried out in relation to 193 of the deaths included above.

In one case, a death was subjected to both a case record review and investigation. The number of deaths in each quarter for which a case record review or an investigation was carried out was:

- 94 in the first quarter (92 SJRs, 2 investigations)
- 57 in the second quarter (45 SJRs – 12 investigations)
- 40 in the third quarter (2 SJRs – 38 investigations)
- 4 in the fourth quarter (0 SJRs – 4 investigations)

These numbers have been drawn from the incident reporting system which hosts both incident investigations and mortality review records. Cases for mortality review are selected in line with the Trust's policy when one of a number of criteria are met e.g. clinical concerns or a complaint following a death, alerts received from external agencies, unexpected death etc. Mortality review is performed by senior clinicians using the Royal College of Physicians' Structured Judgement Review (SJR) methodology. Incident investigations are carried out where a reported incident occurs within a final hospital episode before death. The level of investigation depends on the nature of the reported incident. Of the 56 investigations cited above, 2 met the nationally defined criteria of a Serious Incident Requiring Investigation (SIRI).

By 31 March 2019, all stillbirth cases are recorded on Datix and reviewed using a screening tool to determine any level of harm. Each stillbirth and neonatal case was also subjected to a multidisciplinary panel review using the national Perinatal Mortality Review tool (PMRT) and also discussed in the Trust's Perinatal Mortality and Morbidity Meeting. This includes video conferencing with other hospitals involved in care.

Child deaths occurring in the hospital and in the local community are subject to individual case review meetings or hospital mortality and morbidity meetings. This includes participation from other hospitals and community health workers. There is a natural delay in completion of these cases due the length of time for post mortem reports to become available.

The Royal Devon and Exeter NHS Foundation Trust is unable to provide a reliable figure for the number of deaths in the reporting period which were judged more likely than not to have been due to problems in the care provided to the patient, due to the following reasons:

- The Trust has adopted the Royal College of Physicians' (RCP) National Mortality Case Record Review (NMCRR) Programme methodology known as the 'Structured Judgement Review' (SJR).

The Royal College of Physicians has stated that "SJR methodology does not allow the calculation of whether a death has a greater than 50% probability of being avoidable" and, further, that "The NMCRR programme, supported by the RCP, does not endorse the comparison of data from the SJR between trusts."

As such, the Trust can only present the data available which is summarised below:

Judgments of overall care for cases subjected to SJR

	Very Poor	Poor	Adequate	Good	Excellent	Total
18/19 Q1	1	12	26	38	15	92
18/19 Q2		5	19	10	11	45
18/19 Q3	1			1		2
18/19 Q4						
Total	2	17	45	49	26	139

Of the cases above, three SJRs have identified issues warranting further inquiry and have been escalated for further investigation.

In relation to incident investigations arising from episodes in which a patient died, there was no investigative outcome in which it was considered that the incident contributed to death. A total of three investigations in the reporting period have resulted in the Trust exercising its obligations in relation to Duty of Candour.

For stillbirth and neonatal death the PMRT review tool facilitates methodology to attain a judgement in regard to the likelihood that death was due to a problem in care.

Stillbirths and late fetal losses					
PMRT Grading	No care issues	Care issues: no difference to outcome	Care issues: may have made a difference to outcome	Care issues: likely to have made a difference to outcome	Total
Care of the mother and baby up to the point that the baby was confirmed as having died	4	1			5
Care of the mother following confirmation of the death of her baby	5				5
Total	9	1			10

Neonatal Deaths					
Grading of					
PMRT Grading	No care issues	Care issues: no difference to outcome	Care issues: may have made a difference to outcome	Care issues: likely to have made a difference to outcome	Total
Care of the mother and baby up to the point of birth of the baby	2				2
Care of the baby up to the point of death of the baby	2				2
Care of the mother following death of her baby	2				2
Total	6				6

Regarding 2018/19 child deaths, two cases have been reviewed through paediatric mortality and morbidity meeting. One case was classed as definitely not avoidable and the other as probably avoidable but not very likely (using the University of Sheffield classification that was published at the launch of the national learning for deaths initiatives).

Where there is confirmed or suspicion of care issues, the case is investigated through Datix and currently two cases of child death are subject to Datix investigation.

Of the neonatal deaths, two cases have been subject to external review by the newly convened HSIB. Neither of the final reports are yet available.

SJR activity in 2018/19 drew heavily from three distinct groups of patients selected for review. These were patients with an admitting diagnosis of sepsis, pleural collapse and chronic renal failure. Emergent themes and learning, actions undertaken and an initial impact assessment of those actions undertaken from all reviews were as follows.

Planning and delivery of end-of-life care and Advanced Care Planning in the Community:

A theme around management of end of life decision making has emerged. Reviews found examples where care has been judged poor in relation to seeking the views of patients and family members regarding end of life care plans, communicating these plans effectively and acting on their content consistently. A number of reviews have identified delayed recognition of dying and transfer of dying patients from their place of residence to hospital in their final hours resulting in 'medicalisation' of death.

This issue has been recognised with the work currently being developed by the Trust in partnership with the community setting. There is a need pre-empt this issue in the community when people are 'well' so that care is considered well in advance of need. To this end, plans are underway to resource staff in community settings and primary care to identify patient's wishes in respect of end of life care.

There has been an effort in the community, and specifically by GPs, to focus on people who trigger on the electronic Frailty Index (eFI). The frailty index is a set of evidence based criteria used to measure the health status of older individuals - as a proxy measure of aging and vulnerability to poor outcomes. GPs and community teams have co-created a comprehensive assessment tool (Comp Ax) which can be completed by any member of the healthcare team with the patient and their family. This enables patients' needs and choices to be established at a time when the person's condition and physical wellbeing is stable and made available to inform personalised care towards the end of life.

Advanced care planning forms an integral component of the collaborative comprehensive assessment project which seeks to promote the following principles:

- Admission avoidance – the system focuses on keeping patients well in their own home as the first choice.
- Everyone has opportunity to receive rehabilitation & optimise independence to enable them to return to their home as soon as is possible.
- Patients and their carers will only need to tell their story once

Comp Ax is an electronic system is currently being implemented across the Eastern Locality to enable core groups of care providers to access information when the person or their circumstances become unstable. As it develops Comp Ax will be accessible across organisations (e.g. primary care, ambulance staff, acute hospital etc.) ensuring that the records travel with the patient wherever their care needs are best delivered. The sharing of these records will be permitted by the use of an electronic notification system.

Following a successful pilot utilising a paper based comprehensive assessment tool, with the Assessment documentation held by the patient in their homes; the comprehensive assessment process is being transferred to a software solution, which will be initially piloted within three GP Surgeries in Exeter before wider implementation during 2019.

[Delay in the recognition, escalation or treatment of sepsis and sepsis recognition - NEWS2 \(National Early Warning Score\):](#)

There were instances where there was judged to have been a delay in the recognition, escalation or treatment of sepsis. In none of these cases did the reviewer articulate concern that these likely contributed to death.

NEWS2 was adopted across the whole Trust as its system for detection of deteriorating patients on 23 January 2019. This screening tool permits the identification of more unwell patients using a score derived from frequently recorded patient observations. Higher scores mandate increased frequency of observation, medical review and actions in relation to the consideration and treatment of sepsis.

Monthly sepsis audits are carried out in all ward areas (including ED) reviewing sepsis triggers, escalation, diagnosis and compliance with the Sepsis 6 treatment, particularly time to antibiotic. The data is submitted centrally, collated and monitored by the Safety and Risk team. All acute inpatient areas have deteriorating patient champions who collect and submit the data supported by their Matrons. Good practice (detected from the audit) can be shared via the champions to help improve care. The champions also have direct access to the Senior Nurse for Safety for any concerns or question about deterioration/sepsis.

The Trust is 98% compliant with all relevant recommendations outlined within NICE guideline for sepsis (Sepsis: recognition, diagnosis and early management (NG51), last updated September 2017), with the exception of three recommendations which relate to the provision of information leaflets for adults, this work is currently in progress.

[Frequency of senior medical review:](#)

Analysis of themes emerging from SJR records found an association between problems in care and lack of senior medical review. The SJR methodology cannot support the conclusion that one is caused by the other in the cases examined. But a strong evidence base exists for the assertion that care outcomes are dependent on the experience of those providing it. Indeed, where timely senior input was evidenced elsewhere, this was often associated with meaningful and decisive care interventions (including timely and appropriate refocusing on treatment with palliative intent). The reviews acknowledge that senior input may be secured by a variety of means and that these exchanges may not always reach the documentation.

[Conduct of pleural aspiration and intercostal drain placement and implementation of national guidance for intercostal drainage and monitoring of compliance:](#)

As a result of the focus of SJR activity on patients diagnosed with pleural collapse, these procedures received greater scrutiny than would be expected had the case selection been random. The conduct of this procedure was judged poor on two occasions due to the lack of evidence of a consent conversation and scant details of the procedure itself. On one occasion, samples sent from the procedure did not reach the laboratory.

The Trust has reviewed its processes and introduced locally agreed protocols for all interventional procedures (referred to as LocSSIPs). A LocSSIP which combines a consent and procedure checklist has been developed and implemented following approval by the relevant governance groups.

In addition, the Respiratory service has appointed a pleural fellow from August who will be increasing training offerings across the trust to further improve standards.

An audit of compliance with this LocSSIP will be undertaken in six months and will be reported to the Respiratory Governance Group. LocSSIP

developments report to the Patient Safety Group and an overview is maintained within the PAF (Performance Assurance Framework). The impact will be confirmed on completion of audit and the start of new pleural fellow.

Consistency and legibility of SJR review statements:

From the analysis of the reviews it was evident that problems have been recognised. However perceptions of what constitutes poor care vary. The tendency of some reviewers to use language that describes care in a way that is not objectively verifiable can contribute to this issue. The early use of hand-written records to document review findings did not always make it easy to transcribe or draw meaning from the SJR.

Discussion and review of cases by the reviewers in the SJR forum and further development of the mortality module has led to a greater consistency in both narrative and judgments provided. This is evident in the content of the reviews entered onto the system.

A regular forum in which reviewers can discuss cases now supports an internal calibration on commentary and statements of the quality of care. The problems in care where harm is deemed to have or possibly have occurred are reviewed as part of the discussion. The forum provides an opportunity to highlight high quality SJRs to reviewers and shape their practice in terms of objectivity and clarity.

The team has abandoned hand-written records and reviewers now directly input their work into a purpose built electronic database (hosted by incident reporting software Datix).

Multiple admissions/ coding:

There were a number of instances in which cases had been coded with a diagnosis of sepsis but where evidence of true sepsis was not clear from the notes. A contributing factor is the heightened awareness amongst junior medical staff of the importance of sepsis and the tendency to include the term in the notes. Terms that are largely interchangeable for clinicians were being interpreted differently by clinical coders (e.g. chest infection vs chest sepsis).

The education and training provided during the course of implementation of NEWS2, will enhance understanding of sepsis and its use as a primary diagnosis.

This remains an ongoing process of review and benchmarking against the National sepsis dashboard, which includes data regarding activity levels and coding practice in order to identify any areas for further investigation and detection of further educational requirements.

A thematic stillbirth review is undertaken each calendar year. The main themes identified included:

- babies measuring <10th centile at delivery. However the majority of those babies were identified antenatally and care was planned appropriately.
- Reduced fetal movements. All cases were found on the first report of reduced fetal movements to maternity services.

The learning points for the Child reviews reflect good team work, individualised care and forward care planning. Both were babies under 1 year of age with chronic lung disease. Both cases were not avoidable deaths however the timing of one death led the classification to be 'probably avoidable but not very likely'.

Four of the child deaths involved babies in unsafe sleeping positions at home.

Two case were road accidents and two cases of child suicides. A further involved suicide.

68 case record reviews and 0 investigations completed after 31 March 2018 which related to deaths which took place before the start of the reporting period.

The SJR methodology in use by the Trust does not support the attainment of a judgement in regard to the likelihood that death was due to problems in care.

As such, the Trust can only present the data available which is summarised below:

Judgments of overall care for cases subjected to SJR

	Very Poor	Poor	Adequate	Good	Excellent	Total
17/18 Q1			1	10	7	18
17/18 Q2		3	1	8	4	16
17/18 Q3			2	16	4	22
17/18 Q4		4	4	3	4	12
Total		4	8	37	19	68

- 35 in the first quarter – 35 SJRs – 0 Incidents
- 37 in the second quarter – 37 SJRs – 0 Incidents
- 43 in the third quarter – 43 SJRs – 0 Incidents
- 66 in the fourth quarter – 61 SJRs – 5 Incidents

	Very Poor	Poor	Adequate	Good	Excellent	Total
17/18 Q1	1	1	9	17	7	35
17/18 Q2	3	7	10	9	8	37
17/18 Q3	1	5	8	22	7	43
17/18 Q4		9	18	24	10	61
Total	5	22	45	72	32	176

Seven Day Services

The results of the most recent Seven Day Services bi-annual audit, undertaken in Spring 2018, demonstrates the Trust is compliant with the four priority Clinical Standards – Time to first consultant review; Access to diagnostics; Access to key interventions and ongoing review. Moving into 2019/20, the Trust will seek to maintain and further improve levels of compliance, principally with the four priority standards (Standard 2 -Time to first consultant review within 14 hours of admission; Standard 5 - Access to diagnostics and reporting; Standard 6 - Access to key interventions; Standard 8 - Ongoing (once or twice daily) consultant review) but will continue to make progress with delivering the remaining six Clinical Standards. Progress and rates of compliance will be demonstrated through the newly implemented Board Assurance Framework for Seven Day Services, reporting to the Trust's Governance Committee.

NHS Doctors and Dentists – rota gaps and improvement plan

The Medical Workforce Strategy Group receives, on a monthly basis, a detailed operational update from each of the Clinical Divisions, which outlines the current and forecast position regarding the medical workforce (all training and non-training grades) and includes the numbers of rota gaps / vacancies and actions being taken to resolve or mitigate the impacts of these gaps. In addition, an Annual consolidated report is also produced and presented to the Medical Workforce Strategy Group. This reporting process is inclusive of the exception reporting processes governed by the Trust's Guardian of Safe Working Hours.

Although an improving position, the Trust is continues to experience intermittent rota gaps across a range of Medical staff rotas, from a total of 330 rota slots there were 29.3 vacancies / gaps (8.88%) in 2018/19. Many of these gaps have been covered using internal locums/bank doctors (doctors already working on the rota undertaking additional shifts) or by the use of external agency doctors.

In 2019/20 the Trust will continue to develop alternative workforce models, such as recruitment of Physicians Associates, expanding Nurse Practitioners, expanding clinical secretaries to support trainees with ward administration, increasing non-medical prescribers and surgical care practitioners. Additionally the Trust will continue to develop and recruit to split/joint portfolio roles, such as research fellows, simulation fellows and quality improvement fellows.

The Trust will also continue to work with the Junior Doctors Forum to identify opportunities to improve working practices for junior doctors as part of hospital at night and hospital out of hours and within the Trust's Quality Improvement Academy.

In quarter three of 2019/20 the Clinical Establishment Review process will commence, which makes an assessment of the overall clinical workforce position against the projected workforce needs for the following year and will make recommendations regarding increasing or decreasing the clinical workforce based on a wide range of supporting indicators.

Freedom to Speak Up and Whistleblowing

Following the recommendations made by Sir Robert Francis in the Mid Staffordshire NHS Foundation Trust Public Enquiry; the Trust appointed three Freedom to Speak Up Guardians in January 2017, expanding the service in September 2018 with the appointment of three additional Guardians. The six Guardians all have different roles and backgrounds (Catering Manager, two Senior Nurses, Clinical Lead Occupational Therapist, Consultant Emergency Physician and Community Support Worker) and are available for all staff employed by the Trust across all sites.

The Guardians act in a genuinely independent and impartial capacity, to support staff who raise any concerns (patient safety, quality of care, harassment and bullying etc.) and they have direct access to the Chief Executive, Chairman of the Trust, and Chair of the Governance Committee as required. The Guardians report to the Governance Committee twice a year, and onwards to the Board of Directors.

The Guardians have been working alongside the Senior Leadership Team and the Human Resource Department to support the organisation in becoming a more open and transparent place to work, where all staff are actively encouraged and enabled to speak up.

Work has essentially focused on raising awareness of the FTSUG role by the production of leaflets and posters and information on the Trust's intranet, HUB. The Guardians have undertaken visits to wards and departments across many sites (which will be repeated on a continual basis), and have attended Health and Wellbeing roadshows and staff team briefings and meetings as requested.

The Lead Guardian completes and submits regular data reports to the National Freedom to Speak Up Guardians Office. The data supporting these returns is discussed at monthly meetings between the FTSUGs and the Head of Governance to ensure that appropriate advice and action has been provided to staff who access the service, in a way that is appropriate to the individual (confidentiality and anonymity are crucial) and also to identify any themes which may require trust wide action.

The Trust also has a well-established, robust formal route for raising concerns through the Trust's Whistleblowing Policy and process. The Head of Governance works with the Chief Executive, the Chair of the Trust and Chair of Governance Committee to ensure that all concerns raised through the Whistleblowing Policy are acknowledged, investigated and reported through the Governance Committee (GC). The GC's role is to ensure that the process has been followed, that actions have been undertaken, learning is shared Trust wide and more importantly that any staff who do speak up do not suffer detriment.

The Trust is totally committed to further enhancing its processes to support staff to raise concerns, work will continue during 2019/20 to seek opportunities for further improvements.

REVIEW OF SERVICES

During 2018/19, the Royal Devon and Exeter NHS Foundation Trust provided and/or sub-contracted 69 relevant health services.

The Royal Devon and Exeter NHS Foundation Trust has reviewed all the data available to them on the quality of care in 69 of these relevant cases.

The income generated by the relevant health services reviewed in 2018/19 represents 100% per cent of the total income generated from the provision of relevant health services by the Royal Devon and Exeter NHS Foundation Trust for 2017/18.

In the event of any further query with regards to the lower level of potential CQUIN income in 2018/19 than was achieved in 2017/18, these figures reflect the reduced weightings – in line with national guidance mandated by NHS England – for the delivery of CQUIN schemes by acute providers in 2018/19, as a result of the increased weighting for STP engagement and participation in STP transformation.

Participation in Clinical Audit

During 2018/19, 57 national clinical audits and 3 national confidential enquiries covered relevant health services that the Royal Devon and Exeter NHS Foundation Trust provides.

During that period the Royal Devon and Exeter NHS Foundation Trust participated in 91% (53) national clinical audits and 100% (3) national confidential enquiries which it was eligible to participate in.

The national clinical audits and national confidential enquiries that the Royal Devon and Exeter NHS Foundation Trust was eligible to participate in during 2018/19 are listed in Annex F.

The national clinical audits and national confidential enquiries that the Royal Devon and Exeter NHS Foundation Trust participated in during 2018/19 are listed in Annex F.

The national clinical audits and national confidential enquiries that the Royal Devon and Exeter NHS Foundation Trust participated in, and for which data collection was completed during 2018/19 are listed alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered by the terms of that audit or enquiry in Annex F.

The reports of 21 national clinical audits were

reviewed by the provider in 2018/19 and the Royal Devon and Exeter NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided as detailed in Annex F.

The reports of 36 local clinical audits were reviewed by the provider in 2018/19 and the Royal Devon and Exeter NHS Foundation Trust intends to take the following action to improve the quality of healthcare provided as detailed in Annex F.

Participation in Clinical Research

In 2018-19 the Trust had 544 REC approved studies open, including 43 studies led by RDE Chief Investigators including Clinical Trials of Investigational Medicinal Products and medical devices; studies were open in 27 of 30 specialty areas and by 22 March 2019 6,306 patients had been recruited (4401 to NIHR adopted studies and 1905 to other studies). In 2018 there were 305 publications from Trust staff.

Study: 'Pivotal' (Proactive IV iron therapy in haemodialysis patients)

The Trust took part in the PIVOTAL study a pioneering clinical trial funded by Kidney Research UK investigating the optimum amount of intravenous iron that can be given to patients on dialysis to treat anaemia effectively and safely. A complication of being treated for kidney failure using haemodialysis is that patients develop anaemia and iron deficiency. This is a condition that leaves people feeling exhausted and seriously reduces their quality of life. Intravenous iron is a routine part of anaemia management in haemodialysis patients worldwide. However, there has been little evidence to guide optimum dosing, and no consistency in approach across the UK or globally.

The PIVOTAL trial gathered evidence from two different clinical approaches. Some patients were given high doses of iron to increase the levels of iron in their body (proactive high-dose) whilst another group received lower doses of iron only as per normal routine treatment when their iron levels got too low (reactive low-dose).

The trial demonstrated that a higher-dose of intravenous iron reduced the risk of death, hospitalisation for heart failure, and other major cardiovascular events. There was also no increased infection risk in those receiving a higher dose of iron which is important, given previous research has

suggested that iron might increase bacterial growth and infection. There were also other benefits in the higher dose group including a reduction in the dose of erythropoietin (EPO) required - this could be beneficial because high doses of EPO have been associated with an increased risk of cardiovascular events, such as strokes and fewer blood transfusions - this reduces the risk of developing antibodies which can affect the chance of a successful transplant in the future.

Study: Vertex 105

Orkambi is a precision medicine drug beneficial for around 50% of patients with cystic fibrosis with a particular gene mutation, the drug can slow decline in lung function - the main cause of death among people with cystic fibrosis - by 42%, this drug, costing £100,000 per patient is not currently available for general use in the NHS. Taking part in the Vertex 105 study enabled ten patients at RD&E with Cystic Fibrosis to receive the drug; the participation of patients in this study allows further evidence to be gathered to provide evidence to NICE the body that appraises these drugs of its benefit to support wider use.

Study: 'Alignment'

Alignment is a Trust sponsored study opened to recruitment in January 2019 and is being led by Prof Andy Toms using the MAKO robot for primary knee replacement surgery. The overall aim is to assess whether using an alternative alignment technique for the surgery improves the functional outcome when compared to the more traditional alignment technique – both techniques will utilise the MAKO robot to guide the surgeon in precise implantation of the prosthesis. RD&E is one of the first UK trusts to have installed and to undertake research using this surgical robot offering a unique opportunity for our patients to benefit from this cutting edge technology.

Study: 'Mammographic surveillance in women aged 35-39 at enhanced familial risk of breast cancer' short name = FH02

The FH02 study which the Trust participated in has supported a change in NICE guidelines. The trial looked at women with a high family risk of breast cancer and whether the screening age for these patients should be lowered. The study picked up 55 cancers earlier than they would probably have been identified previously and means in the future breast screening age for these high risk patients is changing to 35 years of age from 40.

Study: 'Is the management of Cystic Fibrosis improved by the use of online video calling to engage patients? A feasibility study using exercise as a model'.

The research team looked at the use of Skype to deliver an exercise intervention to patients with Cystic Fibrosis, they found it was feasible, and also acceptable among participants. The research findings have implications for clinical practice and could allow care teams to engage patients remotely in exercise. Having found it was feasible to deliver an exercise intervention in this way, the team suggest further research is undertaken to assess the efficacy of this way of working on supporting patients with treatment adherence and disease management supporting better health outcomes.

Dr Tim McDonald won the award for Excellence in Improving Outcomes for Patients at the NHS Healthcare Science Awards. This for his contributions to diabetes diagnosis and health care sciences in the UK. The award celebrates an exceptional individual who uses their scientific ability to benefit the NHS and its users, and who demonstrates the crucial contribution that science has in sustaining the NHS.

Professor Maggie Shepherd, become the first nurse ever to be awarded the Arnold Bloom lecture, at the Diabetes UK Professional Conference. Prof Shepherd themed her lecture on improving patient care in monogenic diabetes through research and education and addressed the beneficial impact of a correct, early diagnosis, and future challenges. The Arnold Bloom lecture is awarded to a healthcare professional working in diabetes care who has contributed significantly to improving the quality of clinical care for people with diabetes.

Professor Shepherd was also one of 70 nurses and midwives to be awarded funding under the NIHR NHS '70@70'. The 70 successful applicants will form a new community of senior clinical nurses and midwives who will champion the promotion of an embedded research active culture, encourage and support innovation, and inform research priorities in their organisations. Through protected time they will be able to dedicate two days a week (over a period of three years) to fostering a culture of innovation, with the ultimate goal delivering of high quality, evidenced based nursing, midwifery and healthcare practice.

Goals Agreed with Commissioners

A proportion of the Trust income in 2018/19 was conditional on achieving quality improvement and innovation goals between the Trust and any person or body they entered into a contract, agreement or arrangement with for the provision of relevant health services, through the Commissioning for Quality and Innovation payment framework.

Further details of the agreed goals for 2018/19 and for the following 12 month period are available electronically at **www.rdehospital.nhs.uk**

The 2018/19 NHS Planning guidance continued the potential for Trust to earn additional income, conditional upon achieving quality improvement and innovation goals. The Trust agreed a suite of schemes for which the Trust could earn an additional £4.282m of income in 2018/19. In 2017/18 the Trust received payment to the value of £4.410m.

QUALITY SCHEMES

Commissioning for Quality and Innovation (CQUIN) Schemes for Delivery in 2018/19

Due to the timing of the production of the Quality Report and the process to agree Q4 2018/19 achievement with commissioners, the key achievements listed below are focused on the first three quarters of the year where there is a measurable target.

Clinical Commissioning Group CQUIN schemes

Name of Scheme – Improving NHS Staff Health & Wellbeing

Objective

This CQUIN encourages the introduction of additional health & wellbeing initiatives for NHS staff, including initiatives for physical health, mental health and improved access to physiotherapy for staff with musculoskeletal issues. It also includes health promotion activities including stop smoking support, healthy eating and weight management, and advice on the menopause, as measured by implementation of an agreed Staff health & wellbeing Action Plan.

Key Achievements

Throughout 2018/19 the Trust has undertaken a comprehensive programme of activities to support the Health & Wellbeing of staff. These activities have encompassed training, workshops, activity sessions and funding for activities. The following are included as examples of the activities undertaken:

- Staff Health & Wellbeing Fair held, with over 200 staff attending
- Sixty four Staff Health & Wellbeing Champions and 60 Mental Health Champions trained, and Occupational Health Link Nurses appointed for each Division
- Over 40 teams have benefitted from funding for Health & Wellbeing initiatives from the Staff Lottery including team socials, massages, improved staff garden areas, fruit boxes, pedometers.
- Mental Health First Aid implemented through in-house training
- Over 400 staff have completed Stress Self-Management Workshop, and over 170 staff have attended Menopause at Work talks

- New workshops have been developed and piloted including:
 - Understanding Stress Management in the Workplace –Workshop for Managers
 - Building Resilience Course
- The Trust has signed the “Time to Change” Employers Pledge
- Five new staff fitness classes launched at community sites, and a range of activities including Yoga, Pilates, Circuits & Running sessions are held at Wonford

Name of Scheme – Improving NHS Staff Health & Wellbeing: Healthy Food for NHS Staff, Visitors and Patients

Objective

This CQUIN encourages the continued ban of price promotions and advertisement on NHS premises of sugary drinks and foods high in fat, sugar or salt; the continued ban of sugary drinks and goods high in fat, sugar and salt from checkouts and ensuring the continued provision of healthy options for staff working night shifts.

It also encourages the increased provision of drinks that are low in sugar or contain no added sugar; the increased provision of confectionery containing less than 250 kcal and the increased proportion of pre-packed sandwiches and other pre-packed meals that contain less than 400kcal and less than 5grams of saturated fat per 100g, including through food and retail outlets. It is intended that this CQUIN will support a continuing change in food provision on hospital premises to include healthy options in particular for staff working night shifts; to restrict the availability and choice of sugary drinks and foods high in fat, sugar and salt, including from checkouts and banning the advertisement on NHS premises of such drinks and food products.

Key Achievements

- The targets which were met for the 2017/18 CQUIN scheme continue to be maintained throughout the Trust's in-house catering outlets, and through on-site charitable outlets, vending offers and WH Smith. Boots continue to work on achieving these targets and are compliant with the exception of advertising.
- All food outlets (including vending offers) within the Trust have agreed to adhere to the Trust's agreement to sign up to the NHS England pledge to reduce sugar sweetened beverage sales to only 10% of volume sold from March 2018. To date all areas are achieving this target.
- All catering providers on site, along with our vending suppliers, have reduced the amount of confectionery and sweet lines so no more than 20% of lines stocked contain 250kcal or more. This will continue to be monitored and reduced.
- At least 25% of pre-packed sandwiches & other savoury pre-packed meals (wraps, salads, pasta salads) that are available for sale will contain 400kcal (1680 KJ) or less per serving. This is being achieved in all outlets on site.

Name of Scheme – Improving NHS Staff Health & Wellbeing: Improving the Uptake of Flu Vaccinations Amongst Front Line Staff

Objective

This CQUIN scheme intends to encourage NHS providers to achieve an uptake of the flu vaccination by frontline clinical staff of 75%, by 28 February 2019.

Key Achievements

- By the end of February 2018, 76.68% of front line staff within the Trust's acute services had been vaccinated and 76.39% of front line staff within the Trust's community services. This represents achievement for the third consecutive year of greater than 75% within the Trust's acute services and, for the first time, the community services have achieved a similar uptake rate.

Name of Scheme – Reducing the Impact of Serious Infections (Sepsis)

Objective

This CQUIN scheme is to ensure that patients who meet specific criteria are screened for sepsis, and that those patients who present with sepsis via the Emergency Department (ED), or by direct admission to the Acute Medical Unit or Surgical Assessment Unit, as well as those who may develop sepsis whilst already an inpatient, are administered intravenous antibiotics within one hour of the diagnosis of sepsis.

Key Achievements

- 94.22% of patients meeting the criteria for severe sepsis screening, were screened for sepsis (Q3) against a target of 90%
- 73% of patients on inpatient wards who presented or deteriorated with severe sepsis, red flag sepsis or septic shock were administered intravenous (IV) antibiotics within 60 minutes (Q3) against a target of 90%
- The National Early Warning Scoring (NEWS2) was implemented Trust wide on the 23 January 2019, following an extensive education and training package for staff
- Changes made from January 2019 to the way in which we audit screening and treating of sepsis, will allow increased visibility of practice across the Trust.

Name of Scheme – Reducing the Impact of Serious Infections (Antimicrobial Resistance & Sepsis)

Objective

This CQUIN scheme seeks to reduce the consumption of all antibiotics, particularly Carbapenems, and to encourage a focus on antibiotic stewardship by ensuring antibiotic prescriptions are reviewed within 72 hours of initiation. Antibiotic use is a key driver in the spread of antibiotic resistance and measures to address unnecessary or inappropriate prescribing are crucial to minimise this unintended consequence. Reviewing antibiotics after 24-72 hours of treatment allows clinicians to change therapy in light of new information (e.g. new blood, microbiology and imaging results) and depending on the patient's clinical improvement. This helps to ensure treatment is tailored to the individual/infection and that no unnecessary antibiotics are prescribed.

Key Achievements

- At the end of Quarter 3, the Trust has a proportional antibiotic use of 66.7% from the World Health Organisation's AWARe categories, achieving the CQUIN target of 55%.
- 88.7% of sampled sepsis patients had a documented 24-72 hour review - achieving the CQUIN target of 75% for Quarter 3. The requirements for the review were more detailed this year, and included that the review had to be carried out by an appropriate clinical person (ST3 or higher doctor, clinical microbiologist or antimicrobial stewardship pharmacist), that they should state the outcome of the review, and a rationale for continuing intravenous therapy.
- At the end of Quarter 3 the Trust is in a good position to meet the 3% reduction in Carbapenem consumption (measured in DDD/1000 admissions).

Name of Scheme – Improving Services for People with Mental Health Needs who Present to A&E

Objective

This CQUIN scheme is to achieve a 20% reduction in the volume of attendances to ED for a selected cohort of people who frequently attend ED and for whom the benefit from mental health and psychosocial interventions has been clearly identified. Furthermore, this CQUIN scheme seeks to establish improved services to ensure this reduction is sustainable.

Key Achievements

- Weekly mental health training sessions for staff in ED continue to be delivered by Devon Partnership NHS Trust
- Service users who frequently attend ED are identified and care plans developed jointly between the Trust and Devon Partnership NHS Trust, with engagement from partners such as South Western Ambulance Service NHS Foundation Trust and RISE (Recovery and Integration Service), a Devon-wide adult substance misuse service, working with people with alcohol and drug problems.
- Improvements to the coding of Mental Health patients attending ED to better identify patient need across providers and inform pathway improvements
- Pathway improvements will continue to be driven through the Flow Coaching Academy ED 'Big Room' – Improving the pathway for people attending the Emergency Department with mental health needs

Name of Scheme – Offering Advice & Guidance

Objective

This CQUIN scheme seeks to encourage trusts to set up and operate Advice & Guidance services for non-urgent GP referrals, thereby allowing GPs to access consultant advice prior to referring patients to secondary care. It is intended that this then supports patients receiving care in the most appropriate location, close to home wherever possible, and that referrals are only made where necessary, thereby reducing pressure on secondary care.

Key Achievements

- GPs now have a structured way of asking for advice from our consultants in a range of specialties including Dermatology, Paediatrics, Urology, Neurology, Cardiology, Genetics, Haematology, Microbiology, Pain Management, Diabetic Foot Podiatry, Nephrology, Biochemistry, Respiratory Medicine, Gastroenterology, Lymphoedema, and Gynaecology. Further specialties are planned in 2019/20.
- Eighty percent of the requests for Advice & Guidance are responded to within 48 hours
- The provision of an Advice & Guidance service within each of these specialties has avoided unnecessary referral letters being received by the Trust and outpatient appointments, thereby enabling consultant time to be directed towards the care of other patients.

Name of Scheme – Preventing Ill Health by Risky Behaviours – Alcohol & Tobacco

Objective

This CQUIN scheme is intended to support improvements in health promotion activities, through discussions with all adults who are admitted to one of the Trust's acute or community hospitals, whether they smoke, and what their alcohol intake is. For those that do smoke, this CQUIN supports the provision of very brief advice regarding quitting smoking, onward referral to stop-smoking services and the provision of stop smoking medication, where appropriate. For those patients that do drink above identified lower risk levels, this CQUIN encourages the Trust to offer very brief advice regarding reducing their alcohol intake, and onward referral to a specialist alcohol advisory service, if the patient is potentially alcohol-dependent.

This initiative was first rolled out in the Trust's community hospitals in 2017/18 and has been further embedded there in 2018/19 as well as implemented in the Trust's main acute hospital.

Key Achievements

Within the Trust's Acute Services

- The work to achieve the Risky Behaviours CQUIN has seen an increasing number of patients referred to the Stop Smoking Service at the Royal Devon and Exeter NHS Foundation Trust and to the Together Drug and Alcohol service to support a reduction in alcohol consumption. The ward whiteboard system is used by staff to facilitate the referral of patients who have been admitted to hospital.
- In Quarter 3, 94% of acute patients received a tobacco screen and 93% of acute patients received screening for alcohol.
- Staff across all wards are engaging in the 20 minute ward training delivered by the Stop Smoking Service and are enthusiastic about engaging in the delivery of Very Brief Advice with patients across both topics. Staff have reported that they are delighted that their patients can receive support and treatment quickly to help change their behaviours and lifestyle.

Within the Trust's Community Services

- Following the roll-out of this CQUIN to the Trust's acute services in 2018/19, the work to achieve the Risky Behaviours CQUIN within the community hospitals now involves a small number of patients who have not been previously admitted to – and screened within – the Trust's acute services. The majority of patients in community hospital beds have been transferred from the acute hospital where the screening should already have happened. Patients who are admitted to community hospitals straight from home tend to be patients who are at the end of their life where screening is not appropriate.
- Staff across the community hospitals are participating in the training associated with this CQUIN, and are fully engaged with discussing with patients their alcohol and smoking consumption, providing brief advice and onward referral where appropriate.
- Staff continue to take an active role in the health promotion agenda.

Name of Scheme – Improving the Assessment of Wounds

Objective

National research indicates that over 30% of chronic wounds (defined as wounds that have failed to heal within four weeks or longer) do not receive a full assessment based on research evidence and best practice guidelines. The objective of this CQUIN scheme is to increase the proportion of patients on the community nursing team's caseload with wounds, who in the event that the wound has failed to heal within 4 weeks, receive a full wound assessment.

Key Achievements

- Following baseline audits undertaken in 2017/18, individual results were fed back to all teams and targeted interventions were implemented for the teams with less than 50% compliance.
- The teams were re-audited in Q2 2018/19 with a further improvement of the full assessment of patients with chronic wounds from 61% (Q4 2017/18) to 66%. Twenty nine teams were audited, and showed an improvement in assessment ranging from 3% to 26%.
- A third audit has been undertaken in Q4 2018-19 with results still being calculated and an overall full assessment target of 80%.

Name of Scheme – Personalised Care & Support Planning

Objective

The objective of this CQUIN scheme is to identify a group of patients with chronic, long term conditions who would benefit from support planning, including interventions to support them to develop their own knowledge, skills and confidence to manage their own health and wellbeing, and enablers that help them to understand the local support mechanisms that are available to them. In the latter half of 2018/19 an evaluation has been undertaken of the quality and impact of the personalised care and support planning conversations, and learning identified in terms of potential for future development and use of the approach.

Key Achievements

- Completion of baseline activation scores for all patient cohorts

- Undertaking motivational interviewing and support planning for all patients with low activation levels.
- Re scoring of patients to see if activation levels have increased
- The Patient Activation Measure (PAM) has worked well and the Trust is currently working with Devon Clinical Commissioning group to extend the PAM licences for a further two years.

NHS England CQUIN Schemes

Name of Scheme – Enhanced Supportive Care – Access for Advanced Cancer Patients

Objective

There is growing evidence that good supportive care provided early to patients with advanced cancer can improve quality of life, possibly lengthen survival and reduce the need for aggressive treatments near the end of life. This CQUIN scheme seeks to ensure that patients with advanced cancer are, where appropriate, referred to a Supportive Care Team.

Key Achievements

- Improved patient experience - over 500 patients, (1535 contacts month 1 -9) have benefited from the service associated with this CQUIN scheme in 2018/19
- Electronic capture of holistic needs through the Integrated Palliative care Outcome Scale (IPOS) has demonstrated that intervention by this Supportive Care Team reduces symptom burden thereby improving quality of life across all tumour sites for patients with advanced disease. The positive feedback from patients has been overwhelming regarding this one-stop approach to care
- There has also been an unquantifiable benefit from the Supportive Care Team supporting staff involved in service provision, staff reporting improvement in wellbeing, in a time when recruitment is such a challenge, these benefits should not be underestimated.
- Involving patients and their families in informed decision making regarding treatment and advanced care planning. The team has helped to avoid crises, therefore reducing unplanned use of hospital and community health care services, including emergency admissions. A conservative estimate of the cost associated with these avoided crisis activities for this time period exceeds £600,000.

Name of Scheme – Nationally Standardised Dose Banding for Adult Intravenous Anticancer Therapy (SACT)

Objective

This CQUIN scheme incentivises the standardisation of chemotherapy doses for cancer patients in order to increase safety, improve efficiency and support parity of care across all providers of chemotherapy in England.

Key Achievements

- This is the third year of this CQUIN.
- Sixty medicines have been targeted as being suitable for dose banding
- More than 98% of patients received their chemotherapy using the dose banding approach. This is an improvement from 95% last year.

Name of Scheme – Optimising Palliative Chemotherapy Decision Making

Objective

This CQUIN scheme seeks to ensure that documented peer discussion takes place between nursing and medical colleagues when making decisions regarding the commencement or continuation of chemotherapy for patients with advanced cancer. The objective of this is to ensure that both the beneficial as well as the harmful effects of chemotherapy are balanced and regularly reviewed for each individual patient.

Key Achievements

- 75% of patients with advanced disease are peer reviewed by the multi-disciplinary team to ensure the chemotherapy pathway is appropriate
- Promotion of multi-disciplinary team working to ensure patients with advanced disease are receiving appropriate treatments. This is in turn supported by a process whereby all deaths within 31 days of chemotherapy are reviewed by the multi-disciplinary team.
- This new approach to care links in seamless with Enhanced Supportive Care, providing oncologists an option to refer patients for ongoing management and support of symptoms.

Name of Scheme – Spinal Surgery (Networks, Data, MDT Oversight)

Objective

This CQUIN scheme supports the creation and operation of a spinal surgery network, the identification of appropriate data flows and the establishment of a multi-disciplinary team (MDT) meeting for spinal surgery patients with data reported to the British Spinal Registry. This CQUIN aims to ensure that patient selection for specialised surgery is carefully discussed and the optimum treatment option is chosen in all cases.

Key Achievements

- Peninsula Spinal Network recognised as one of the most advanced networks in country at national regional leads meeting by NHS England Clinical Reference Group Chairman
- Peninsula Spinal Network meeting three times per year in accordance with CQUIN requirements
- Exeter Spine Unit compliant with all CQUIN requirements of complex spine centres (including British Spinal Registry compliance)
- NHS England have asked the Trust to continue to host the Peninsula Spinal Network in 2019/20 and provide a Consultant Spinal Surgeon to continue as Regional Spinal Network Clinical Lead

Name of Scheme – Hospital Medicines Optimisation

Objective

This CQUIN scheme incentivises the faster adoption of best value medicines with a particular focus on the uptake of best value generics and biosimilars. A generic drug is a copy of a brand-name drug that has exactly the same pharmacological effects as those of their brand-name counterparts. A biosimilar is a biologic medical product which is an almost identical copy of the original product. The CQUIN also supports the use of lowest cost dispensing channels, reducing waste and ensuring improved reporting of usage of all NHS England excluded drugs that are dispensed.

Key Achievements

- The Trust endeavours to use the best value brands of medicine. Biosimilar Adalimumab has been adopted and patients are actively being transitioned to this formulation. This is expected to save £1.5 million in the first year.
- All treatments that can be supplied by a VAT efficient route i.e. via Boots or Homecare, are being supplied by this method
- The Trust now records all pharmacy purchases with Pharmex. This allows NHS England to understand the national picture on procurement and tender in line with this data.
- An audit was conducted to review our systemic antifungal stewardship. This will lead to the development of an antifungal policy.

Name of Scheme – **Armed Forces CQUIN**

Objective

This CQUIN scheme encourages the adoption of processes to support the embedding of the Armed Forces Covenant and NHS Constitution, ensuring that members of the Armed Forces Community, who for operational reasons may need to move home frequently during their military service, suffer no disadvantage in accessing health services.

Key Achievements

- Following the successful hosting of a part time Defence Medical Welfare Service (DMWS) Officer, successful appointment of a full time DMWS Officer, to commence in post in May 2019
- The Trust has been awarded a Silver Award for the Employer Recognition Scheme (ERS) for the Armed Forces
- One of first 25 acute hospitals nationwide to be awarded Veterans Aware Kite Mark, as part of the Veterans Covenant Hospital Alliance (VCHA), which acknowledges Trusts as an exemplar of the best care for veterans.

Name of Scheme – **Newborn Bloodspot Screening**

Objective

This CQUIN scheme seeks to decrease the numbers of avoidable repeat blood spot samples taken from newborn babies by maternity providers to a consistent position of less than 2%. The Trust's performance in 2016/17 was 4.45%. Analysis of the reasons for avoidable repeat samples being needed at that time included insufficiency of the sample taken, and incorrect demographic detail.

Key Achievements

- A reduction in the number of avoidable bloodspots since the CQUIN scheme was commenced: 2018 – 2019 1.78%, 2016-2017 4.45%, 2017-2018 1.88%, Improved quality control by peer review of all samples taken.
- Continued education of staff within the mandatory training sessions, ensuring that they are fun, to encourage participation.
- Close observation of all repeats looking for any 'themes' for repeats that require action.

Name of Scheme – Secondary Dental Network**Objective**

This CQUIN scheme focusses on facilitating patient centred care through requiring Trusts to ensure that consultant and / or specialist staff in Oral Surgery, Orthodontic, Restorative Dentistry and special care Dentistry are actively participating in the Managed Clinical Networks (MCN) for Dental Services, where invited to do so.

Key Achievements

- Trust representation at all Oral Surgery and Orthodontic Dental Network Meetings.
- The Orthodontic MCN has been piloting a new Orthodontic referral form for roll-out from April 2019. This universal referral proforma will standardise referrals across the region and ensure equitable care.
- The Oral Surgery MCN is proposing that NHS England and the MCN run a Southwest Symposium day in early summer 2019. This would bring together NHS England, the MCN and Health Education England to meet providers, triaging clinicians and Devon Referral Support Services (DRSS) staff. The aim of the symposium is primarily to improve communication and report on NHS England and MCN activity. There will be workshops for referral and triage patterns and outliers, as well as a review of commissioning issues.
- The Oral Surgery MCN has also undertaken a review of the current triage process and has now completed Oral Surgery and Oral Medicine Referral Guidance documents for general dental practitioners, providers, RMCs and the LDN website.
- The RD&E has been working closely with NHS England with regard to the Restorative Dentistry service and has requested an invite to participate in the Restorative Dentistry MCN.

CARE QUALITY COMMISSION (CQC)

The Trust is required to register with the Care Quality Commission and its current registration status is registered in full without conditions.

The Trust underwent a planned, routine, announced Care Quality Commission Inspection in January and February 2019. The report was published on 30 April 2019. The Trust was rated overall "Good".

The inspection identified 13 "Must Take" actions and 76 "Should Take" actions. The Trust will present the detailed action plans to the Governance Committee (GC) on 7 June 2019. The GC will monitor progress of the action plans through to completion.

Below is a breakdown of the ratings for the Trust.

Key to tables					
Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓
Month Year = Date last rating published					

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019	Good →← Apr 2019

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for Acute Services/Acute Trust

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Royal Devon and Exeter Hospital (Wonford)	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019
Honiton Hospital	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Mardon Neuro-rehabilitation Centre	Good ↑ Feb 2019	Good →← Feb 2019	Outstanding ↑ Feb 2019	Good →← Feb 2019	Good ↑ Feb 2019	Good ↑ Feb 2019
Overall trust	Requires improvement →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019	Outstanding →← Apr 2019	Good →← Apr 2019

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Community Health

Ratings for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community health inpatient services	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019
Community end of life care	Requires improvement Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019	Requires improvement Apr 2019
Overall*	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

*Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Ratings for primary medical services

Ratings for primary medical services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Castle Place Practice	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019

Ratings for Royal Devon and Exeter (Wonford)

Ratings for Royal Devon and Exeter Hospital (Wonford)

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016	Good Feb 2016	Outstanding Feb 2016	Outstanding Feb 2016
Medical care (including older people's care)	Good ↑ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019	Good ↔ Apr 2019
Surgery	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Critical care	Good Feb 2019	Good Feb 2019	Outstanding Feb 2019	Good Feb 2019	Outstanding Feb 2019	Outstanding Feb 2019
Maternity	Requires improvement Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Services for children and young people	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016	Good Apr 2016
End of life care	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016	Good Feb 2016
Outpatients	Good Apr 2019	Good Apr 2019	Good Apr 2019	Requires improvement Apr 2019	Good Apr 2019	Good Apr 2019
Renal Services	Good Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019	Outstanding Apr 2019
Overall*	Requires improvement ↔ Apr 2019	Good ↔ Apr 2019	Outstanding ↔ Apr 2019	Good ↔ Apr 2019	Outstanding ↔ Apr 2019	Good ↔ Apr 2019

*Overall ratings for this hospital are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

NHS Number and General Medical Practice Code Validity

The Royal Devon and Exeter NHS Foundation Trust submitted records during 2018/19 to the Secondary Uses Service for inclusion in the Hospital Episodes Statistics which are included in the latest published data.

The percentage of records in the published data:

- Which included the patient's valid NHS number was:
 - 99.7% for admitted patient care
 - 99.9% for outpatient care
 - 97.7% for accident and emergency care
- Which included patient's valid General Medical Practice Code was:
 - 100% for admitted patient care
 - 100% for outpatient care
 - 99.9% for accident and emergency care

Information Governance

On 28 March 2019 the Trust published the annual Data Security and Protection Toolkit assessment, the first return under the new reporting standard which was released in April 2019. The return included 94 out of 100 mandatory evidence items and 34 of the 40 assertions. The Trust is currently rated as "standards not met" by NHS Digital. A plan has been submitted to address the outstanding items and will be monitored through to completion by the Trust's Information Governance Steering Group.

Clinical Coding

The Trust was not subject to the Payment by Results - Payment and Tariff Assurance Audit (PaTAF) during 2018/19.

Core Indicators

The Trust has chosen the safety, effectiveness and patient experience indicators which reflect the Board of Directors approach to monitoring performance, adopting a balanced score card approach. A mixture of process and outcome measures provide assurance of cause and effect.

Indicator Group	Indicator	Indicator Description	Data: Most recent reporting period	Data: Previous reporting period	The Royal Devon and Exeter NHS Foundation Trust considers that this data is as described for the following reasons:	The Royal Devon and Exeter NHS Foundation Trust intends to take/has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by:	Audited?	Source of measure	Definition
Domain 1 - Preventing people from dying prematurely	Summary Hospital-level Mortality Indicator (SHMI)	SHMI The Summary Hospital-level Mortality Indicator (SHMI) reports on mortality at trust level across the NHS in England. The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there. It covers all deaths reported of patients who were admitted to non-specialist acute trusts in England and either die while in hospital or within 30 days of discharge. SHMI values for each trust are published along with bandings indicating whether a trust's SHMI is '1 - higher than expected', '2 - as expected' or '3 - lower than expected'. For any given number of expected deaths, a range of observed deaths is considered to be 'as expected'. If the observed number of deaths falls outside of this range, the trust in question is considered to have a higher or lower SHMI than expected. Trusts are advised to use the banding descriptions i.e. 'higher than expected', 'as expected', or 'lower than expected' rather than the numerical codes which correspond to these bandings. This is because, on their own, the numerical codes are not meaningful and cannot be readily understood by readers.	October 2017 – September 2018 SHMI: 1.0576 (as expected) (12 trusts higher than expected, 101 as expected and 17 lower than expected)	October 2016 - September 2017 SHMI: 1.1115 (as expected) (15 trusts higher than expected, 105 as expected and 15 lower than expected)	1. There is a nine month cross over between each reporting period. 2. The SHMI values are comparable to those calculated independently by the University Hospitals Birmingham Foundation Trust Healthcare Evaluation Data (HED) system.	The national publication scheme represents a lag in real time values and the Trust actively seeks ways to identify areas of concern. The Trust actively monitor changes through the use of Alerts for key clinical diagnoses groups as presented by the use of the HED tool. The Trust monitors this data regularly via the Patient Safety Group, Safety & Risk Committee and the monthly Board Report. All in hospital deaths are reviewed as part of the Mortality Review Group.	Internal Clinical Coding Audit (part of DSPT)	NHS Digital	National Definition
		Palliative Coding The SHMI methodology does not make any adjustment for patients who are recorded as receiving palliative care. This is because there is considerable variation between trusts in the coding of palliative care. However, in order to support the interpretation of the SHMI, various contextual indicators are published alongside it, including indicators on the topic of palliative care coding. Reported here, is the percentage of patient deaths with palliative care coded at either diagnosis or specialty level for the trust for the reporting period.	October 2017 - September 2018 Palliative Coding Spells: 25.7% (Highest 59.5%, Lowest 14.3%, National average 33.6%) The Trust is not a specialist centre for palliative care unlike those with the highest values.	October 2016 - September 2017 Palliative Coding: 21.5% (Highest 59.8%, Lowest 11.5%, National average 31.5%)	1. There is a nine month cross over between each reporting period. 2. The coding rates are comparable to those calculated independently by the University Hospitals Birmingham Foundation Trust Healthcare Evaluation Data (HED) system. 3. Increases in the palliative coding rate figures were seen following completion of specific interventions intended to improve recording.	The Trust monitors this data regularly via the Patient Safety & Mortality Review Group. Changes to the process for identifying patients in receipt of palliative care have been made to the Trust's systems to better identify patients in receipt of palliative care in line with national guidance. Any trends or changes in palliative coding rates are reviewed by the Patient Safety and mortality Group and further actions such as provision of targeted education is provided to specific areas.	No	NHS Digital	National Definition

Indicator Group	Indicator	Indicator Description	Data: Most recent reporting period	Data: Previous reporting period	The Royal Devon and Exeter NHS Foundation Trust considers that this data is as described for the following reasons:	The Royal Devon and Exeter NHS Foundation Trust intends to take/has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by:	Audited?	Source of measure	Definition
Domain 3 - Helping people to recover from episodes of ill health or following injury	PROMS; patient reported outcome measures	Patient Reported Outcome Measures (PROMs) are a means of collecting information on the effectiveness of care delivered to NHS patients as perceived by the patients themselves; reported at NHS Trust / independent sector provider and CCG level as scores for:	April 2017 - September 2017	April 2016 - March 2017	Following a national consultation in 2016, NHS England took the decision to discontinue the mandatory varicose vein surgery and groin-hernia surgery national PROM collections. NHS England will continue with the hip and knee surgery PROM collections.	The data is reviewed regularly by the Surgical Services Division through their Governance structure.	No	NHS Digital Indicator Portal	National Definition
		Groin Hernia	Groin Hernia						
			EQ-5D: 0.09 (England 0.09, Lowest 0.03, Highest 0.14)	EQ-5D: 0.11 (England 0.09, Lowest 0.06, Highest 0.14)	The low values for Groin and Hernia reflect the discontinuation for mandatory collection. PROMS scores for Hip and Knee are comparable or better than the national average and consistent with other patient satisfaction measure results. The finalised report is based on 6 months of data and is therefore not comparable to previous years.	PROMs are useful tools in obtaining data on patients' perceptions of their health and experiences whilst receiving care and can be subjective in response.			
		EQ-VAS: 2.96 (England -1.15, Lowest -9.20, Highest 3.61)	EQ-VAS: 3.03 (England -0.24, Lowest -6.50, Highest 3.27)						
		Varicose Vein	Varicose Vein						
		(i) Groin hernia surgery	EQ-5D: N/A* (England 0.09, Lowest 0.04, Highest 0.13)	EQ-5D: N/A* (England 0.09, Lowest 0.01, Highest 0.15)		To reduce any bias the questionnaires are completed in the patient's home environment in their own time.			
		(ii) Varicose vein surgery							
		(iii) Hip replacement surgery	EQ-VAS: N/A* (England 0.1, Lowest -5.42, Highest 5.35)	EQ-VAS: N/A* (England 0.08, Lowest -4.90, Highest 6.27)					
		(iv) Knee replacement surgery							
		The casemix-adjusted average health gain scores are:	Aberdeen Varicose Vein Questionnaire: N/A* (England -8.45, Lowest -14.07, Highest -0.93)	Aberdeen Varicose Vein Questionnaire: N/A* (England -8.25, Lowest -18.08, Highest 2.12)					
			April 2017 - March 2018	EQ-5D: 0.46 (England 0.44, Lowest 0.31, Highest 0.54)					
			Hip replacement primary						
		The EQ-5D™ Index collates responses given in 5 broad areas (mobility, self-care, usual activities, pain/ discomfort, and anxiety/ depression) and combines them into a single value, comparing pre- and post-operative scores.	EQ-5D: 0.49 (England 0.47, Lowest 0.38, Highest 0.57)	EQ-VAS: 14.89 (England 14.23, Lowest 8.52, Highest 20.15)					
			EQ-VAS: 14.89	Oxford Hip Score: 23.31 (England 21.79, Lowest 16.42, Highest 25.07)					
			(England 14.23, Lowest 8.29, Highest 19.05)	Hip replacement revision					
			Oxford Hip Score: 23.65 (England 22.68, Lowest 18.87, Highest 26.29)	EQ-5D: 0.31 (England 0.29, Lowest 0.24, Highest 0.36)					
		EQ VAS is a simple and easily understood 'thermometer'-style measure based on a patient's self-scored general health on the day that they completed their questionnaire, but which provides an indication of their health that is not necessarily associated with the condition for which they underwent surgery and which may have been influenced by factors other than healthcare comparing pre- and post-operative scores.	Hip replacement revision	EQ-VAS: N/A* (England 7.15, Lowest 1.60, Highest 13.8)					
			EQ-5D: N/A* (England 0.29, Lowest 0.14, Highest 0.32)	Oxford Hip Score: N/A* (England 13.90, Lowest 10.73, Highest 17.66)					
			EQ-VAS: N/A* (England 7.65, Lowest 1.88, Highest 9.54)	Knee replacement primary					
			Oxford Hip Score: 15.28 (England 13.503, Lowest 10.256, Highest 16.5)	EQ-5D: 0.36 (England 0.324, Lowest 0.242, Highest 0.40)					
			Knee replacement primary	EQ-VAS: 9.27 (England 6.97, Lowest 1.00, Highest 14.50)					
			EQ-5D: 0.36 (England 0.34, Lowest 0.23, Highest 0.42)	Oxford Knee Score: 18.43 (England 16.54, Lowest 12.50, Highest 19.88)					
	EQ-VAS: 9.75 (England 8.28, Lowest 2.51, Highest 14.32)	Knee replacement revision							
	Oxford Knee Score: 19.07 (England 17.26, Lowest 13.16, Highest 120.63)	EQ-5D: N/A* (England 0.27, Lowest 0.15, Highest 0.29)							
		EQ-VAS: N/A* (England 3.49, Lowest 2.30, Highest 7.52)							
	The AVVQ allows patients to self-assess the severity of their varicose veins via a 13-item measure covering all aspects of their varicose veins including physical symptoms such as pain, ankle oedema, ulcers, the effect on daily activities, and cosmetic issues.	Knee replacement revision	Oxford Knee Score: N/A* (England 12.36, Lowest 8.61, Highest 13.87)						
		EQ-5D: N/A* (England 0.29, Lowest 0.17, Highest 0.39)							
		EQ-VAS: N/A* (England 4.89, Lowest 1.25, Highest 10.20)	* N/A refers to values that have been suppressed due to low patient numbers or non-submission						
		Oxford Knee Score: N/A* (England 13.12, Lowest 9.37, Highest 15.44)							
		* N/A refers to values that have been suppressed due to low patient numbers or non-submission							

Indicator Group	Indicator	Indicator Description	Data: Most recent reporting period	Data: Previous reporting period	The Royal Devon and Exeter NHS Foundation Trust considers that this data is as described for the following reasons:	The Royal Devon and Exeter NHS Foundation Trust intends to take/has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by:	Audit-ed?	Source of measure	Definition
		<p>The percentage of patients readmitted to any hospital in England within 28 days of being discharged from hospital after an emergency admission during the reporting period; aged:</p> <p>0 to 15</p> <p>16 or over</p>	Data is no longer nationally published	<p>April 2011 - March 2012</p> <p>(i) 0 to 15: 7.88% (National N/A*, Lowest 6.40%, Highest 14.94%)</p> <p>(ii) 16 or over: 10.01% (National 11.45%, Lowest 9.34%, Highest 13.8%)</p> <p>*National values for this age range are no longer published. 'Lowest' and 'Highest' values are from the 'Large acute' trust category of which the RD&E is assigned</p>	<p>1. Numbers (better than) national performance.</p> <p>2. Increase broadly in line with national trend.</p> <p>Please note that this indicator was last updated on NHS Digital in December 2013 and future releases have been suspended following a methodology review.</p>	<p>Whilst no longer nationally reported Readmission data is monitored by Divisions through their Governance structures and Trust wide in the monthly Board Report.</p> <p>The Trust is aware that changes in NHS working practices such as streaming patients into ambulatory care settings and the transfer of community inpatient services and the subsequent recording on Patient Systems can have a detrimental effect to a reported figure. National work is ongoing to identify a metric definition and recording for ambulatory care, that means they will not negatively affect what is an inpatient based figure.</p>	Yes	NHS Digital	National Definition

Indicator Group	Indicator	Indicator Description	Data: Most recent reporting period	Data: Previous reporting period	The Royal Devon and Exeter NHS Foundation Trust considers that this data is as described for the following reasons:	The Royal Devon and Exeter NHS Foundation Trust intends to take/has taken the following actions to improve this percentage/proportion/score/rate/number, and so the quality of its services, by:	Audited?	Source of measure	Definition
Domain 4 - Ensuring people have a positive experience of care	Responsiveness to the personal needs of patients	The trust's score with regard to its responsiveness to the personal needs of its patients during the reporting period (score out of 100). The indicator value is based on the average score of five questions from the National Inpatient Survey, which measures the experiences of people admitted to NHS hospitals.	April 2017 - March 2018 72.1 (England 68.6, Lowest 60.5, Highest 85.0)	April 2016 - March 2017 71.7 (England 68.1, Lowest 60.0, Highest 85.2)	The Trust continues to ask these questions as part of the care quality assessment tool (a real time audit).	The Patient Experience committee reviews the full report and oversees any actions required. The 2018/19 Survey has been completed and is being compiled nationally. Results will be available in August 2019.	No	NHS Digital Indicator Portal	National Definition
	Staff who would recommend the trust to their family or friends	The percentage of staff employed by, or under contract to, the trust during the reporting period who would recommend the trust as a provider of care to their family or friends.	2018 Staff Survey 85.8% (All Trusts 71.3%, Combined Acute & Community Trusts 69.9%)	2017 Staff Survey 84% (All Trusts 70%, Combined Acute & Community Trusts 68%)	Pickering Institute that oversaw the 2018 staff survey are an approved Survey Contractor having met the necessary data quality standards. They have expertise in this field as the organisation that runs the survey co-ordination centre which oversees survey programmes for acute, mental health and primary care for the Care Quality Commissions.	The Trust Communications & Engagement Team has several work streams at Corporate, Divisional and local levels including leadership training and staff engagement meetings.	Internal audit 2013/14	NHS England	National Definition
Domain 5 - Treating and caring for people in a safe environment	Patients admitted to hospital who were risk assessed for venous thromboembolism	The percentage of patients who were admitted to hospital and who were risk assessed for venous thromboembolism (VTE) during the reporting period.	October - December 2018 (Q3 17/18) 94.38% (England 95.65%, Lowest 54.86%, Highest 99.82%)** Acute/Community only	October-December 2017 (Q3 17/18) 94.19% (England 95.36%, Lowest 76.08%, Highest 100%)	The focus has been on sustaining performance against this target. This has been achieved through a relentless focus by ward clinical teams to ensure that all eligible patients are risk assessed in a timely manner.	The focus has been on sustaining performance against this target. This has been achieved through a relentless focus by ward clinical teams to ensure that all eligible patients are risk assessed in a timely manner.	No	NHS England	National Definition

	Rate of C.difficile infection	The rate per 100,000 bed days of trust apportioned cases of C. difficile infection that have occurred within the trust amongst patients aged 2 or over during the reporting period.	April 2017 - March 2018 8.1 (England 14.0, Lowest 0, Highest 91.0)	April 2016 - March 2017 6.0 (England 13.2, Lowest 0, Highest 82.7)	The Trust has continued to implement effectively measures proven to reduce the risk of C.difficile infection, namely: <ul style="list-style-type: none"> • Antimicrobial Stewardship • Environmental hygiene including an annual deep clean programme • Hand hygiene • Isolation of symptomatic patients on a designated ward • Hand hygiene • Rapid laboratory diagnostics • Provision of written guidance and policy supported by education 	The Trust will continue striving to eliminate avoidable C.difficile infection, however, the rate of infection is now below the regional and national rate and given the aging population served by this hospital a further reduction may not be possible.	No	Public Health England	National Definition
	Patient safety incidents and the percentage that resulted in severe harm or death	The number and where available, rate of patient safety incidents that occurred within the trust during the reporting period, and the percentage of such patient safety incidents that resulted in severe harm or death. A patient safety incident is defined as 'any unintended or unexpected incident(s) that could have, or did, lead to harm for one or more person(s) receiving NHS funded healthcare'.	October 2017 - March 2018 Total Incidents: 5180 % resulting in severe harm or death: 0.058% (October - December 2017 - England 0.49%)	October 2016 - March 2017 Total Incidents: 7455 % resulting in severe harm or death: 0.027% (England 0.51%)	The data is directly uploaded from Datix and subject to vigorous data quality checks by the Trust and NRLS.	The Trust has targeted areas of lower reporting to ensure a consistent open reporting culture across all areas. This work is on-going.	Internal audit 2013/14		National Definition

NHS IMPROVEMENT SINGLE OVERSIGHT FRAMEWORK

Indicator for disclosure (limited to those that were included in Single Oversight Framework (SOF) for 2018/19)		2018/19	2017/18	Source of Measure	Definition	Audited?
Maximum time of 18 weeks from point of referral to treatment (RTT) in aggregate - patients on an incomplete pathway		82.91%	88.2%	NHS England	National	External KPMG 2017/18
A&E: maximum waiting time of four hours from arrival to admission/transfer/discharge	• Trust position	91.54%	90.9%	NHS England submission	National	External KPMG 2018/19
	• Eastern Devon System includes Tiverton/Okehampton/Exmouth MIUs	93.14%	92.8%			
All cancers: 62-day wait for first treatment from:	• urgent GP referral from suspected cancer	73.63%	81.52%	NHS Digital	National	External KPMG 2018/19 Internal Audit 2013/14
	• NHS Cancer Screening Service referral	93.90%	93.56%	NHS Digital	National	External PWC 2012/13
Maximum 6-week wait for diagnostic procedures		86.68%	93.23%	NHS England	National	
C.difficile: variance from plan		-14	-9	Public Health England	National	

STATEMENT FROM THE COUNCIL OF GOVERNORS

Annex A

I am the Chair for the Patient Safety and Quality Working Group (PSQWG) and write this report on behalf of the Group and the Council of Governors. It has been an interesting year during which we were involved or kept informed of a number of quality initiatives across the Royal Devon and Exeter NHS Foundation Trust. I am pleased to share some of these in this report.

Governor's Quality Priorities 2018/2019

We focussed on looking at a priority around the patient experience and identified 'Communication' as a strong theme that came through in conversations with patients, complaints, Council of Governor's meetings and the Patient Experience Committee. As I write we will get the Trust response to this at the Council of Governors Development Day on the 30 May 2019. It is however reassuring to note the various actions taken by the Trust on communications in this report.

Our second quality priority focussed on staff and 'Promoting Wellbeing at Work'. We were aware that stress was cited regularly as a cause of staff sickness and wanted assurance around the measures of support available. We received a response to this at our Development Day on the 25 January 2019. Governors were impressed by the appointment of a Wellbeing Lead and the breadth of support that is now available and embedded across the hospital and community services. The wellbeing thread is seen throughout the Trust and visible in activities such as exercise groups, the Health and Wellbeing Fayre in March 2019, encouraging a 'Break Culture' with the accompanying 'Break Stations'. We commend the Health and Wellbeing initiatives.

Fulfilment of Governor's Role

The role of the Governor is to hold the Non-Executive Directors (NEDs) to account and work with the Executive and Non-Executive Directors in meeting the needs of patients. We are members of our local communities, Staff Governors and appointed Governors from the University of Exeter and Devon County Council.

We fulfil the role in the following ways:

- Seeking assurance through three Governors attending the monthly Board of Directors meeting,
- Participating in Committees such as the Patient Experience Committee and Audit Committee
- The Lead Governor being a member of the MyCare Board
- A Governor sitting on the Equality Diversity and Inclusion Steering Group
- A Governor being part of the Royal Devon and Exeter NHS Foundation Trust and University of Exeter Group looking at patient stories.

Wider Engagement

We have been able to be involved in other ways with the local communities and have been pleased by the response of the Trust, to the feedback provided by two Governors, on the needs of the Deaf and Hard of Hearing. Two successful workshops have been held with the Deaf and Hard of Hearing Community, which included British Sign Language users, the younger age group, the older age group and local establishments for the hard of hearing. This engagement has been welcomed and has resulted in learning across all hospital Divisions which will be of benefit to patients.

We have been pleased to be involved in the judging panels for the Extraordinary People's Awards for staff and welcomed the additional Patient Choice Award introduced in March 2019.

Things that the Trust have done well

We celebrate the completion of the Nursing Associate Programme and the Operating Department Practice Programme (ODP). They have resulted in a welcome increase of staff to the Trust. We appreciate the work that has been done around ambulance hand over times in the Accident and Emergency Departments and the results that are being seen since the new approach to handovers.

The introduction of the extended visiting times of 10.30 – 20.00 hours has been evaluated positively by patients.

We were pleased to meet with the Care Quality Commission in January 2019 when they visited the Trust. Whilst acknowledging there is still work to be done, we congratulate the Trust on an overall rating of 'Good' with 'Outstanding' for 'all services are caring'.

Quality Priorities 2019/2020

- The Patient Experience at Night
- Volunteers Provision

These have emerged from discussions with Governors. Car Parking has remained an ongoing concern and the Chief Executive is now providing an update on this at every Council of Governors meeting. Cardiology and the waiting list and its management and effect on patients was another area of concern. A Question on Notice was raised with the Chairman of the Trust. A response was provided at the Board of Directors meeting in March 2019 and has been sent to every Governor. The Trust is responsive to questions raised and shares challenges experienced.

Challenges for the Trust and Council of Governors

Recruitment of future Governors is challenging. We are looking at using all opportunities including wider use of social media along with face to face opportunities to recruit. Encouraging Governors across age groups is also an area of focus.

The Council of Governors thank the Board of Directors and the staff for their hard work and dedication and are proud to represent their communities in this Trust.

Faye Doris

Public Governor, Exeter and South Devon

Deputy Lead Governor

Chair, Patient Safety and Quality Working Group

9 May 2019

STATEMENT FROM THE NHS DEVON CCG

Annex B

NHS Northern Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) & South Devon and Torbay Clinical Commissioning Group, (SDT CCG) (as of 1st April 2018 known as 'NHS Devon CCG') would like to thank the Royal Devon and Exeter NHS Foundation Trust (RDEFT) for the opportunity to comment on its quality account for 2017/18. RDEFT is commissioned by NHS Devon CCG to provide a range of secondary and integrated community services across Mid and East Devon. We seek assurance that care provided is safe and of high quality, that care is effective and that the experience of that care is a positive one.

As Commissioners we have taken reasonable steps to review the accuracy of data provided within this Quality Account and consider it contains accurate information in relation to the services provided and reflects the information shared with the Commissioner over the 2018/19 period.

During 2018/19 we recognise that there have been a number of challenging issues for RDEFT. These include: long waits for patients in respect to elective treatment, (for both Referral to Treatment (RTT) waiting and 52 week waiting), delays to diagnostic testing, Emergency Department handover delays and delays to some cancer pathways.

We recognise the work undertaken by the Trust to address issues of long waiting times for treatment. The Trust continues to undertake clinical reviews of patients with extended waits and the backlog of long waits (over 52 weeks) has continued to fall, demonstrating the Trust's commitment to improving patient care.

With regards to ambulance handover delays, we can confirm that the Trust has undertaken to review and develop processes within the emergency department that has resulted in a significant reduction in the ambulance handover time, benefiting patients who have been brought into the department, as well as supporting the ambulance Trust in helping to release crews as quickly as possible.

In respect to Cancer Services we recognise and welcome the Trust's continued commitment to the ongoing re-design and review of both the cancer pathways and current workforce in order to support the needs of the local population.

The Quality Account highlights a number of positive results against key objectives for 2018/19. These include:

- **Health and wellbeing of staff:** The Trust has continued to implement a programme of work designed to deliver the Health and Wellbeing (H&WB) Strategy. The Trust has undertaken a comprehensive programme of activities to support the Health & Wellbeing of staff. As a result of these initiatives we note and congratulate the Trust on being shortlisted as a finalist in the Annual Reward and Employee Benefit Association (REBA) Health & Wellbeing Awards.
- **Improving Delayed Transfers of Care, (DTC)** performance: We are happy to confirm significant reductions in these occurrences as a result of the work undertaken across the Trust.
- **The use of patient feedback:** it is encouraging to see that the Trust continues to engage with and learn from patients and carers through feedback from several sources. Complaints, concerns, comments, national and local surveys, 'Patient Opinion' and other patient experience tools such as the Care Quality Assessment Tool (CQAT), 'What Went Well, Even Better If', Patient Reported Outcome Measures (PROMs) and the Friends and Family Test are all utilised to gain feedback. We again recognise the provider's ongoing commitment to supporting further development of patient feedback as a priority for the coming year.
- **Mortality:** we recognise extensive development within the Trust in line with measures associated with mortality over the year. The Trust has seen an improved Summary Hospital Mortality Index (SHMI) and Hospital Standardised Mortality Ratio (HSMR) position. Key work streams are in place which include: the review of clinical coding, implementation of the DATIX mortality electronic module, to allow better recording, review and analysis of mortality and continued improvement in respect to the Systematic Judgement Review (SJR) process, leading to an increased review of deaths undertaken and the embedding of learning as a result.

- Safety Programme: Other improvements to Quality stated in the report are noted, with reference to the ongoing development of a number of safety initiatives including the Maternity Safety Programme, Local Safety Standards for Invasive Procedures (LocSSIPs) and Sepsis & Learning from Excellence, (Lfe). We look forward to working with the Trust during 19/20 on this year's Safety Programme.

Care Quality Commission (CQC) involvement:

We welcome and support the provider's open and transparent communication of their involvement with the CQC during 2018/19 as part of this Quality Account and note the openness regarding improvement actions taken by the provider to address identified issues.

We can confirm that as a commissioner, we have worked closely with the RDEFT during 2018/19 and will continue to do so in respect to all current and future CQC reviews undertaken, in order to receive the necessary assurances that actions have been taken to support continued, high quality care.

We would like to congratulate the provider on their continued achievement of the overall CQC rating of 'Good' (inspection undertaken January-February 2019, report published 30 April 2019).

The Trust aspire to continuous improvement with quality being a 'golden thread' that runs through the organisation and as evidenced within this quality account. We can confirm it reflects our experience as commissioner.

The CCG looks forward to working with RDEFT in the coming year, in continuing to make improvements to the quality of the services provided to the people of Devon.

Lorna Collingwood-Burke

Chief Nursing Officer/Caldicott Guardian
NHS Devon Clinical Commissioning Group. Chair of the Nurse Forum and nurse representative on the national board, NHS Clinical Commissioners.

8 May 2019

STATEMENT FROM HEALTHWATCH DEVON



Annex C

Healthwatch Devon welcomes the opportunity to provide a statement in response to the quality account produced by the Royal Devon & Exeter NHS Foundation Trust for the year 2018/19. Our statement is based on our knowledge of the Trust and its services and on the feedback we have received about the quality of the services it provides.

[Review of quality performance in 2018/19](#)

Governors' Priority 1 Verbal communication of staff to patients

Good communication with patients is important in achieving good quality, effective and safe patient care and Healthwatch Devon recognises the achievements made within this priority.

Governors' Priority 2 Promoting wellbeing at work

Wellbeing within the workplace is important to all organisations and Healthwatch Devon notes the significant efforts within this priority made by the Governors.

Trust Priority 1: Promoting independence of patients

Healthwatch Devon agree that such initiatives as this are extremely important for providing effective patient care and is looking forward to the positive results this initiative has the potential to deliver. The development of the Comprehensive Assessment is of particular interest to Healthwatch Devon as this involves multi service coordination and we are looking forward to learning the results of the pilot scheme.

Trust Priority 2: The use of patient feedback to improve the services provided by the Trust.

The use of patient feedback is a valuable source of information for an organisation to use to be able to improve the patient experience, also assisting the patients prompt recovery thereby releasing resource for subsequent patients. This can only aid the reputation of the hospital and its staff which will ultimately reflect in the user sentiment which Healthwatch Devon collates.

Trust Priority 3: Health and wellbeing of staff

Healthwatch Devon supports all programs that focus on the wellbeing of an organisations staff and would like to complement the Royal Devon & Exeter NHS Foundation Trust on the progress made with this priority.

Trust Priority 4: Safety Programme

Healthwatch Devon recognises the progress made for this priority and that the Learning from Excellence initiative wasn't as successful as first hoped but continued perseverance by a relaunch from the Trust shows the determination of the Trust to make this element of the Safety Programme a success.

Priorities for 2019/20

Healthwatch Devon are looking forward to the service improvements that next year's priorities can provide:

- Governors' priority 1: Improving the Patient's Experience at Night.
- Governors 'Priority 2: Increase Volunteer Provision
- Trust Priority 1: Ensuring patients/people only spend for as long within any stage of the care pathway that adds value to them
- Trust Priority 2: Minimising Temporary Staffing
- Trust Priority 3: Safety Programme

STATEMENT FROM THE HEALTH AND WELLBEING SCRUTINY COMMITTEE



Annex D

Devon County Council's Health and Adult Care Scrutiny Committee has been invited to comment on the Royal Devon and Exeter NHS Foundation Trust's Quality Account for the year 2018/19. All references in this commentary relate to the reporting period of the 1st of April 2018 to the 31st of March 2019 and refer specifically to the Trust's relationship with the Scrutiny Committee.

The Scrutiny Committee commends the Trust on a comprehensive Quality Account for 2018-19 and believes that it provides a fair reflection of the services offered by the Trust, based on the Scrutiny Committee's knowledge.

In terms of the priorities for 2018-19 Members appreciate the work undertaken by the Trust in the embedding the Intermediate Care approach on all three community hospital wards. This has been an issue of importance to Members. The Committee notes that the progress of the Trust in improving the safety, care and experience of families using maternity services during 2018/19 has been positive but recognises that time is needed to make all the changes required.

The Committee appreciates the Trust's first 2018/19 priority, promoting the independence of patients. Members also fully agree with the Trust's increased attention on improved sepsis identification and treatment.

Members also continue to applaud the Trust's improvements to Quality and Safety in the Home, Community and Hospital. Furthermore, members support the ongoing work to improve end of life care.

The Committee fully supports the Trust's Quality Priorities for Improvement 2019/20 and expects that the Trust will continue to safeguard patients and provide the very best quality care the Trust can. Members also appreciate the Trust's priority to ensure patients only spend as long within any stage of the care pathway as adds value to them.

The Committee also supports the Trust's goal of reducing the Trust's need for and dependence on temporary staffing. The expansion of the Freedom to Speak Guardians scheme is also strongly supported by members.

Members anticipate that regular information on the progress of improving patients experience of urgent and emergency care will be shared by the Trust.

The Committee welcomes a continued positive working relationship with the Trust in 2019/20 and beyond to ensure the best possible outcomes for Devon residents.

14 May 2019

STATEMENT OF DIRECTORS' RESPONSIBILITIES FOR THE QUALITY REPORT

Annex E

The directors are required under the Health act 2009 and the National Health Service (Quality Accounts) Regulations to prepare Quality Accounts for each financial year.

NHS Improvement has issued guidance to NHS foundation Trust Boards on the form and content of Annual Quality reports (which incorporate the above legal requirements) and on the arrangements that NHS Foundation Trust Boards should put in place to support the data quality for the preparation of the quality report.

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

- The content of the Quality Report meets the requirements set out in the NHS Foundation Trust annual reporting manual 2018/19 and supporting guidance
- The content of the Quality Report is not inconsistent with internal and external sources of information including:
 - board minutes and papers for the period April 2018 to March 2019
 - papers relating to quality reported to the board over the period April 2018 to March 2019
 - feedback from commissioners 8 May 2019
 - feedback from governors dated 9 May 2019
 - feedback from local Heathwatch organisations dated 17 May 2019
 - feedback from Overview and Scrutiny Committee dated 14 May 2019
 - the Trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009, dated 31 January 2018
 - the latest national patient survey
 - the national staff survey 26 February 2019
 - the Head of Internal Audit's annual opinion of the Trust's control environment dated 17 May 2019
 - CQC inspection report dated 30 April 2019
- The Quality Report presents a balance picture of the NHS Foundation Trust's performance over the period covered
- The performance information reported in the Quality Report is reliable and accurate
- There are proper internal controls over the collection and reporting of the measures of performance included in the Quality Report, and these controls are subject to review to confirm that they are working effectively in practice.
- The data underpinning the measures of performance reported in the Quality Report is robust and reliable, conforms to specified data quality standards and prescribed definitions, is subject to appropriate scrutiny and review and
- The Quality Report has been prepared in accordance with NHS Improvement's annual reporting manual and supporting guidance (which incorporates the Quality Accounts regulations) as well as the standards to support data quality for the preparation of the Quality Report.

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

By order of the board

22 May 2019
Chairman



22 May 2019
Chief Executive



CLINICAL AUDIT

Annex F

The national clinical audits and national confidential enquiries that Royal Devon and Exeter NHS Foundation Trust participated in, and for which data collection was completed during 2018-19 are listed below alongside the number of cases submitted to each audit or enquiry as a percentage of the number of registered cases required by the terms of that audit or enquiry (where known).

Name of audit / Clinical Outcome Review Programme	Trust eligible	Trust participated	Participation rate
MEDICAL SERVICES DIVISION			
Myocardial Ischaemia National Audit Project (MINAP)	Yes	Yes	580**
Cardiac Rhythm Management (CRM)	Yes	Yes	100% (926)
National Audit of Percutaneous Coronary Interventions (PCI)	Yes	Yes	1069**
National Heart Failure Audit	Yes	Yes	346**
National Audit of Cardiac Rehabilitation	Yes	Yes	921*
National Cardiac Arrest Audit (NCAA)	Yes	Yes	110*
Sentinel Stroke National Audit Programme (SSNAP)	Yes	Yes	754**
National Congenital Heart Disease (CHD)	No	N/A	N/A
National Audit of Pulmonary Hypertension	No	N/A	N/A
Adult Cardiac Surgery	No	N/A	N/A
Inflammatory Bowel Disease (IBD)	Yes	Yes	293**
National Asthma and COPD Audit Programme	Yes	Yes	106***
Adult Community Acquired Pneumonia	Yes	Yes	65**
Non-Invasive Ventilation- BTS	Yes	Yes	20**
National Diabetes Inpatient Audit	Yes	No	0%
National Diabetes Inpatient Audit Harms	Yes	Yes	100%
National Pregnancy in Diabetes Audit	Yes	Yes	23**
National Audit of Dementia	Yes	Yes	56*
Major Trauma: The Trauma Audit & Research Network (TARN)	Yes	Yes	108% (500/463)
National Clinical Audit of Specialist Rehabilitation for Patients with Complex Needs following Major Injury (NCASRI)	No	N/A	N/A
Seven Day Hospital Services	Yes	Yes	100%
Royal College Emergency Medicine-Feverish Children	Yes	Yes	100% (62)
Royal College Emergency Medicine- Vital Signs in Adults	Yes	Yes	100% (213)
Royal College Emergency Medicine- VTE Risk in Lower Limb Immobilisation	Yes	Yes	100% (78)
Falls & Fragility Fracture Audit Programme (FFFAP) National Audit of Inpatient Falls	Yes	Yes	100% (2)
National Clinical Audit of Psychosis	No	N/A	N/A
MEDICAL SERVICES DIVISION			
National Audit of Anxiety and Depression	No	N/A	N/A
Prescribing Observatory for Mental Health (POMHUK)	No	N/A	N/A

Name of audit / Clinical Outcome Review Programme	Trust eligible	Trust participated	Participation rate
SURGICAL SERVICES DIVISION			
National Joint Registry (NJR)	Yes	Yes	1717*
Case Mix Programme (CMP)	Yes	Yes	100% (1017)
National Ophthalmology Audit	Yes	No	0%
BAUS: Cystectomy	Yes	Yes	56*
BAUS: Radical Prostatectomy	Yes	Yes	257*
BAUS: Nephrectomy	Yes	Yes	83*
BAUS: Percutaneous Nephrolithotomy	Yes	Yes	9*
BAUS: Female Stress Urinary Incontinence	Yes	No	0%
Elective Surgery (National PROMs Programme)	Yes	Yes	872*
National Vascular Registry (NVR)	Yes	Yes	169**
National Emergency Laparotomy Audit (NELA)	Yes	Yes	173**
Falls & Fragility Fracture Audit Programme (FFFAP) Fracture Liaison Service Database	Yes	No	0%
Falls & Fragility Fracture Audit Programme (FFFAP) National Hip Fracture Database	Yes	Yes	646*
National Clinical Audit form Rheumatoid & Early Inflammatory Arthritis (NCAREIA)	Yes	Yes	100%
National Mortality Case Record Review Programme	Yes	Yes	N/A
National Bariatric Surgery Registry	No	N/A	N/A
Neurosurgical National Audit Programme	No	N/A	N/A
SPECIALIST SERVICES DIVISION			
National Bowel Cancer Audit (NBOCA)	Yes	Yes	300**
Oesophago-gastric Cancer (NAOGC)	Yes	Yes	110**
National Lung Cancer Audit (NLCA)	Yes	Yes	232**
National Prostate Cancer	Yes	Yes	240**
National Audit Of Breast Cancer in Older People (NABCOP)	Yes	Yes	510**
National Audit of Care at End of Life (NACEL)	Yes	Yes	100%
UK Cystic Fibrosis Registry	Yes	Yes	186*
National Maternity and Perinatal Audit (NMPA)	Yes	Yes	100% (3893)
National Paediatric Diabetes Audit (NPDA)	Yes	Yes	100%
National Neonatal Audit Programme (NNAP)	Yes	Yes	100% (650)
Paediatric Intensive Care (PICANet)	No	N/A	N/A
National Audit of Seizures & Epilepsies in Children & Young People- Epilepsy12	Yes	Yes	72*
Maternal, Newborn and Infant Clinical Outcome Review Programme (MBRRACE-UK)	Yes	Yes	100%

Name of audit / Clinical Outcome Review Programme	Trust eligible	Trust participated	Participation rate
SPECIALIST SERVICES DIVISION			
Learning Disability Mortality Review Programme (LeDeR)	Yes	Yes	100%
National Comparative Audit of Blood Transfusion Programme: Use of FFP & Cryo & Other Blood Components in Neonates & Children	Yes	Yes	100%
National Comparative Audit of Blood Transfusion Programme: Management of Massive Haemorrhage	Yes	No	0%
Serious Hazards of Transfusion (SHOT):UK National Haemovigilance scheme	Yes	Yes	100%
Mandatory Surveillance of Bloodstream Infections and Clostridium Difficile Infection	Yes	Yes	100%
Reducing the Impact of Serious Infections (Antimicrobial Resistance and Sepsis)	Yes	Yes	110%
Surgical Site Infection Surveillance	Yes	Yes	100%
COMMUNITY SERVICES DIVISION			
National Audit of Intermediate Care (NAIC)	Yes	Yes	100%
National Diabetes Foot Care Audit	Yes	Yes	391*
NATIONAL CONFIDENTIAL ENQUIRY INTO PATIENT OUTCOME & DEATH (NCEPOD)/ REVIEW PROGRAMME			
Medical and Surgical Clinical Outcome Review Programme (NCEPOD):	Yes	Yes	100%
Pulmonary Embolism			100%
Acute Bowel Obstruction			
Child Health Clinical Outcome Review Programme (NCEPOD):	Yes	Yes	100%
Long Term Ventilation in 0-25 year olds			
Mental Health Clinical Outcome Review Programme	No	N/A	N/A

* No case requirement outlined by national audit provider/unable to establish baseline.

** Provisional, data not yet finalised/cleansed/data submission on-going

*** Incomplete awaiting HES data

The reports of 20 national clinical audits were reviewed by the provider in 2018-19, and the Royal Devon and Exeter NHS Foundation Trust intends to take the following actions to improve the quality of healthcare provided:

National Clinical Audit/ Confidential Enquiry Title	Actions
Serious Hazards of Transfusion (SHOT) 2016	<p>Local audit of transfusions in patients who are at risk of Transfusion Associated Circulatory Overload (TACO) to establish whether risk of TACO is being taken into account in RD&E.</p> <p>Blood Track Advisor module currently in development will include a risk assessment for TACO.</p> <p>A local package of education that would comply with this recommendation has been written.</p> <p>Add PCC to Blood Transfusion Safety e-learning module.</p> <p>Laboratory Standard Operating Procedure to be updated to obtain antibody history from patient or originating hospital.</p>
Serious Hazards of Transfusion (SHOT) 2017	Implementation of EPR (electronic patient record) clinical advisory system for risk assessment of pre-transfusion associated circulatory overload (TACO) undertaken whenever possible
National Comparative Patient Blood Management in Scheduled Surgery	<p>Preparation for Surgery to see patients at least 14 days prior to surgery</p> <p>Clear pathway for patients with iron deficiency anaemia identified at Preparation for Surgery developed</p>
National Comparative Audit of Blood Transfusion: 2016 Audit of Red Cell & Platelet Transfusion in Adult Haematology Patients	<p>Establish a Chronic Transfusion Plan for patients referred to the nurse led Bone Marrow Support service on Yarty Day Case Unit.</p> <p>Update the Blood Transfusion Safety e Learning module.</p>
SSNAP Audit (Aug 2016-Nov 2017)	<p>Develop Stroke Early Supported Discharge covering the whole RD&E catchment.</p> <p>Extend stroke nurse practitioner cover to 24/7 to improve out of hours care</p> <p>Agreement that all stroke presentations have access to an urgent scan 8am-9pm in line with national average.</p> <p>Work with the South West Cardio Vascular Clinical Network on a South West wide solution to service availability.</p> <p>Increase patient and carer representation within the governance structure; provide additional means for patients and carers to feed back.</p>

National Clinical Audit/ Confidential Enquiry Title	Actions
National Vascular Registry	Reviewed and no actions required
National Heart Failure Audit 2015-16	<p>Development of business case to appoint a second heart failure consultant.</p> <p>Review current heart failure nurse provision (community and hospital) and develop business case to increase.</p> <p>Review of echo service structure/capacity with business case to expand provision to allow:</p> <p>Compliance with NICE acute heart failure quality standard 103.</p> <p>Provide transthoracic echo within 48 hours of admission.</p> <p>Introduction of inpatient serum NTproBNP testing for earlier diagnosis and risk assessment of heart failure</p>
3rd National Emergency Laparotomy Audit (NELA) Dec 2015-16	<p>A perioperative medicine service is now in place with the substantive recruitment of a perioperative medicine consultant. Plans for further expansion of this service are being progressed.</p> <p>The P-POSSUM (risk scoring systems for predicting the mortality & morbidity of patients undergoing procedures) is now documented more extensively in the anaesthetic charts.</p> <p>The perioperative consultant CT report happens within 12 hours from admission in most cases. On-call radiologist is available to report on scans as required.</p>
National Neonatal Audit Project (NNAP) 2017	Reviewed and no actions required
National Hip Fracture Database 2016 data	Reviewed and no actions required
Royal College of Emergency Medicine Pain in Children	<p>Education for triage nurses to highlight efficient triage and the importance of pain scoring and analgesia provision.</p> <p>Decluttering of the triage rooms to try and reduce triage times.</p> <p>Ongoing work to improve the environment and staffing of triage to a more efficient level.</p> <p>Ongoing work with regard to the Children's Analgesia and Vital Signs (CATS) project.</p> <p>Regular staff updates and triage teaching.</p> <p>Make sure vital signs at triage are an integral part of the Rapid Assessment Triage process for children.</p>

National Clinical Audit/ Confidential Enquiry Title	Actions
Royal College of Emergency Medicine Fractured Neck of Femur	<p>A further audit of this patient type after the Royal College audit collection period closed was conducted.</p> <p>There has been a focused drive to improve the care of these patients.</p> <p>A 'NOF-ember' campaign was carried out focusing on this cohort of patients and consisted of activity analysis. The campaign resulted in a significant improvement in time to x-ray and time to admission, and a small improvement in time to referral.</p> <p>The learning from this will inform the ongoing education and review of the pathway for patients with a fractured neck of femur.</p>
Royal College of Emergency Medicine Procedural Sedation	Reviewed and no actions required
National Maternity and Perinatal Audit 2017	Reviewed and no actions required
RCOG Clinical Indicators Programme Benign Gynaecology Care	Reviewed and no actions required
Seven Day Services	<p>The Trust was compliant with all standards. It will continue to deliver quality improvements, where appropriate, in order to further strengthen and improve compliance with the 7 Day Service clinical standards. This includes a more contemporary review of the remaining six clinical standards (non-priority) and to map the wealth of existing and on-going work against the relevant standards.</p>
National Audit of Breast Cancer in Older People 2018	Reviewed and no actions required
National Lung Cancer Audit	Reviewed and no actions required
Cystic Fibrosis	Reviewed and no actions required
National Mortality Case Record Review Programme	See section 'Learning from Deaths' of the Quality Report

The reports of 36 local audits were reviewed by the provider in 2018/19 and the Royal Devon and Exeter NHS Foundation Trust intends to take/took the following action to improve the quality of healthcare provided:

Specialty	Local Clinical Audit Title & Aim	Actions
Anaesthetics	Management of Intravenous Lines After Anaesthesia Aim: To address safety issue at local level, identify methods to reduce patient risk, and bring current practice in line with Association of Anaesthetists of Great Britain & Ireland recommendations for verbal and written handover of intravenous line management to recovery staff.	<p>Agreed to include a section in new Anaesthetic Chart to prompt verbal handover to recovery as well as for documentation and signature of written handover.</p> <p>A re-audit will be conducted to review the implementation of this new Anaesthetics Chart.</p>
Anaesthetics	RE-AUDIT-Adult Orthopaedic Antibiotic Prophylaxis Surgical Audit Aim: To assess local adherence to guidelines following initial audit reforms	<p>Audit results highlight improvement in practice in comparison to original audit results of May 2016. Still room for improvement for adherence to Trust protocol.</p> <p>Agreed to revise and change the Antibiotic Guidelines for Elective Orthopaedic Procedures.</p>
Dermatology	Phototherapy Service Audit Aim: To assess the quality of service provided to Phototherapy patients in comparison with the British Association of Dermatologists' (BAD) audit standards	<ul style="list-style-type: none"> The audit findings were as follows: The Trust is generally very compliant with high standards of care in provision of our phototherapy service. Since the audit of 2016 a patient feedback questionnaire has been introduced for use at the end of a course of phototherapy. Not all patients were able to start phototherapy within 6 weeks of referral. Not all phototherapists in the unit have undergone some form of educational activity in phototherapy within the last year As a result of the latter, it was agreed to introduce an education element at Dermatology Governance meetings.
Dermatology	Wound Infection Rates Following Skin Surgery Aim: <ol style="list-style-type: none"> To ensure that surgical infection rates are within expected parameters. To identify infection rates by procedure type and anatomical location. 	<ul style="list-style-type: none"> Audit concluded that overall infection rates are broadly in keeping with, or better than, previously published data from other centres. Following discussion and presentation, agreed that a post-operative infection audit will be conducted biannually, where individual surgeons will input their data into a collective spreadsheet for collation and analysis. Re-audit due for 2019.
Gastroenterology	An audit of Gastric Ulcers in Accordance with JAG Standards Aim: To ensure compliance with gastric ulcer follow up: all gastric ulcers should have repeat endoscopy within 12 weeks after initial diagnosis.	<p>Agreed that a local policy regarding Helicobacter Pylori be developed and to incorporate biopsy and repeat gastroscopy.</p>

Specialty	Local Clinical Audit Title & Aim	Actions
Healthcare for Older People	Atrial Fibrillation and Anti-Coagulation Aim: To assess if patients on the Acute Medical Unit (AMU) and the Acute Stroke Unit (ASU) are being correctly managed in line with NICE CG80, particularly focusing on anticoagulation prescribing and counselling.	<p>Audit results found that the Trust is mostly compliant with NICE guidelines with regards to prescribing appropriate anticoagulation. Follow up Echocardiograms were requested appropriately.</p> <p>Improvement needed with accurately documenting patient counselling and also communication with GPs.</p> <p>Agreed that a pro forma be instigated on AMU to improve anticoagulation prescribing prior to discharge and communication with GPs. Patient leaflets to be circulated, teaching to junior doctors and reminders to Consultants regarding education around offering counselling.</p> <p>A re-audit due for 2019.</p>
Healthcare for Older People	Senior (consultant or registrar) review before, during and after a Medical Emergency Team (MET) call during November 2017 Aim: To analyse the MET calls that occurred at the RD&E in the month of November 2017 and see if recommendations from the previous audit in 2013 have been implemented and are there any new learning points.	<p>Resuscitation Group to contact the MyCare team to ensure that there is a resuscitation/MET call section in the new electronic notes and help with its development.</p> <p>Resuscitation Group to be involved with the medical team to implement winter planning, extra medical registrar/cover during night shifts.</p> <p>Resuscitation Group to encourage handover to day team and encourage Treatment Escalation Plan (TEP) discussions when attending future calls.</p> <p>New Early Warning Score (EWS) form will be implemented Trust wide.</p>
Intensive Care Unit	Central Line Audit 2017-18 Aim: To monitor current practice of compliance with Central Vascular Catheter (CVC) Care Bundle (High Impact Intervention no1).	<p>Compliance result 68% due to three wards not documenting that they had observed the site daily.</p> <p>Eleven wards gained 100% compliance as they fulfilled each element in the Central Vascular Catheter (CVC) Care Bundle compliance tool.</p> <p>Agreed Practice Educators raise awareness that the insertion site for any Vascular Access Device (VAD) must be inspected at least daily for signs of phlebitis and infection.</p> <p>A re-audit to be conducted in 2019</p>
Intensive Care Unit	Peripheral Cannula Phlebitis Rate Aim: Following a change of standard peripheral cannula dressing at the end of 2017, to identify whether it is fit for purpose, stays in place and prevents movement of the cannula thus reducing risk of mechanical phlebitis.	<p>Audit identified following areas where standards not being fully met:</p> <p>Documentation completed for all cannula daily.</p> <p>Dressings being covered by additional tape.</p> <p>Agreed Matrons would discuss the need to complete VIP stickers and only use one dressing at the daily Board Round and further, to inform Practice Educators and Anaesthetists.</p> <p>Re-audit due for 2019.</p>

Specialty	Local Clinical Audit Title & Aim	Actions
Maternity	<p>RE-AUDIT-Documentation of Offer & Consent-Antenatal & Newborn Screening Programme</p> <p>Aim: To establish whether the National Screening Committee (NSC) standards are being met in regard to adequate documentation of offer and consent for the six antenatal and newborn screening programmes.</p>	<p>The audit found standards were met for all six positive cases. Agreed to implement a Maternity Newsletter which is emailed to every midwife in order to keep them up-to-date with information.</p> <p>A further re-audit is due for Autumn 2019.</p>
Maternity	<p>Coverage and Uptake of Influenza and Pertussis Vaccinations in Pregnant Women</p> <p>Aim: To establish if the introduction of the maternity based Pregnancy Immunization Programme had increased uptake of the flu and pertussis vaccinations.</p>	<p>The audit concluded both the Influenza and the Pertussis vaccine uptakes exceeded the interim and longer term 'uptake ambitions' of 55% for the 2017/2018 flu vaccination season and the threshold of 50% and a standard of 60% for the year 2017/2018 for pertussis.</p> <p>Although positive results were achieved, it was identified that a large proportion of mothers who declined the vaccines were from Eastern Europe. Agreed to translate the consent record and information regarding vaccines available into an appropriate language.</p>
Maternity	<p>Annual caesarean audit-decision to delivery interval (NICE CG132)</p> <p>Aim: To ensure compliance with NICE CG132 guidance and identify areas for improvement and instigate teaching to relevant parties if required.</p>	<p>The audit found that 3/40 women were not delivered within the time frame set out by NICE CG132.</p> <p>Area of improvement is documentation of reasons for any delay in the decision to delivery interval. If caesarean is downgraded clinically this needs to be accurately recorded in the notes and on the operation record.</p>
Paediatrics	<p>Measurement of Blood Pressure in Paediatric Inpatients</p> <p>Aim: To explore local practice in blood pressure measurement in paediatric patients admitted acutely and electively to Bramble Ward to assess compliance with National guidelines</p>	<p>The audit highlighted several areas for improvement:</p> <ul style="list-style-type: none"> Monitoring of blood pressure is not meeting National recommendations for screening for hypertension. Medical admissions were less likely to have their blood pressure taken than surgical patients. If blood pressure is high it is not consistently recognised by nursing or medical staff. Blood pressure is not being used effectively when assessing acutely unwell patients. <p>The following recommendations were agreed:</p> <ul style="list-style-type: none"> Education of nursing staff around paediatric BP (theory followed by practical sessions on manual BP) Equipment – to facilitate manual BP Develop local resources - Flow chart to support staff in recognising and acting on high or low blood pressure

Specialty	Local Clinical Audit Title & Aim	Actions
Paediatrics	Attention Deficit Hyperactivity Disorder (ADHD) (NICE CG72) Aim: For the Community Paediatric and Child Health Team to evaluate the ADHD Guideline to improve assessment, diagnosis and treatment of children and young people referred to the service	<p>As a result of the audit, it was agreed to:</p> <ul style="list-style-type: none"> Use the DSM-V Criteria form for diagnosis and this would be circulated. To use the Ready Steady Go forms To develop ADHD information packs and leaflets about the Service
Pain Management	Monitoring Patients Receiving Epidurals Aim: To establish percentage compliance with monitoring for epidural analgesia and to determine complication rates relating to epidural analgesia.	<p>As a result of the audit, it was agreed to:</p> <ul style="list-style-type: none"> Continue education Discuss with Anaesthetic team to review protocols, the use of Patient Controlled Epidural Analgesia (PCEA) and increase in initial infusion rate if PCEA not used Discuss with Anaesthetic team regarding tunnelling of epidural catheters and fixation of filters/catheter connection
Pain Service	Assessing the impact of PainAD in identification of pain Aim: To assess the impact of using the PainAD scale on the identification and management of pain in cognitively impaired adults unable to verbalise the presence of pain.	<p>The audit found that there is some evidence that using PainAD assists in more accurate identification of pain and aids in analgesic decision making, however, further evaluation of the tool in practice is needed.</p> <p>It was therefore agreed to:</p> <ul style="list-style-type: none"> Promote use of PainAD within the Trust, with ongoing educational input regarding appropriate use of tool To identify use of PainAD scale on Dementia Care Pathway Explore further audit/research possibilities
Ophthalmology	Rate of Endophthalmitis Following Procedures Aim: To ensure Trust rates of endophthalmitis do not greatly differ from National rates following cataract surgery (<0.1%). To ensure Trust rates of endophthalmitis do not greatly differ from National rates following intra-vitreous injection (0.13%)	<p>No intervention was required as it was found that complication rates at the Trust are lower than the National complication rate.</p> <p>Re-audit in 12 months.</p>
Oral and Maxillofacial Surgery	RE-AUDIT-Reporting of radiographs Aim: To compare current practice with set standards (100% reporting target and 80% location target) and previous local audits.	<p>This re-audit found that:</p> <ul style="list-style-type: none"> The presence of a radiograph report to be at 84%. The location of the radiograph was noted in 75% of cases. It was agreed remind and educate the Oral and Maxillofacial Surgery Clinical team of the legal requirement to write an appropriate radiograph report. Further re-audit to be conducted 2019

Specialty	Local Clinical Audit Title & Aim	Actions
Orthodontics	<p>Are clinical photographs in the Orthodontic Department meeting standards?</p> <p>Aim: To ensure that clinical photographs are meeting photographic standards and to ensure that clinicians have access to the medical photographs</p>	<p>The audit found 21% of clinical photographs taken within the Orthodontic Department met the desired standards.</p> <p>For clinician access to medical photographs, the audit found that 32% of clinical photographs were accessible within the notes after a 3 month period, even though the Medical Photography Department were good at returning the printed photographs.</p> <p>The following actions were agreed:</p> <ul style="list-style-type: none"> Print out a hard copy of the standards to keep in Orthodontic Department. Hold a photography training workshop in the Orthodontic Department. Ensure all new staff members receive appropriate training. Develop new photographic protocol. Create shared drive between Orthodontic Department and medical photography. Re-audit due for 2019
Radiology	<p>Report Turnaround Times 2017</p> <p>Aim: To assess the turnaround times for Imaging from different referral sources against Local Standard Operating Procedures</p>	<p>After presentation of the audit it was agreed to conduct a re-audit in 2019 and focus on Inpatient Plain Film and GP imaging areas.</p>
Radiology	<p>Are anti-coagulated patients admitted with a head injury receiving head Computed Tomography (CT) scans according to NICE CG176</p> <p>Aim: To evaluate whether patients on oral anticoagulation admitted to RD&E following a head injury are investigated in accordance with NICE head injury guidance and local policy.</p>	<p>Audit found that of the 779 patients who attended ED in the specified time frame and were coded as having a head injury, 56 were anticoagulated and 44 of these anticoagulated patients met the inclusion criteria stated above.</p> <p>Agreed posters regarding the NICE guidelines to be visible in ED and also to ensure Radiology registrars are involved with the Peninsula Radiology On Call reporting group.</p>
Renal	<p>Fluid Intake and Allowance of Haemodialysis Patients</p> <p>Aim:</p> <p>Ascertain understanding of fluid allowance for patients on haemodialysis.</p> <p>Establish compliance of Interdialytic Weight Gain (IDWGs) of 4% Ideal body weight as per European Best Practice Guidelines (EBPG).</p> <p>Establish which healthcare professionals should be providing the initial advice regarding fluid allowances.</p> <p>Identify gaps in education and training for staff.</p> <p>Identify links between diabetes control and high IDWGs.</p>	<p>Audit highlighted several issues which need to be addressed through close working between the dialysis nurses, dietitians and renal consultants.</p> <p>All patients have recommended daily fluid intake documented in Renal nursing notes or on Proton in a suitable location (diet screen/dialysis prescription)</p> <p>Health promotion project of a poster to highlight exactly what counts as fluid as only 78% of patients were able to identify 5 potential sources of fluid.</p>

Specialty	Local Clinical Audit Title & Aim	Actions
Renal	<p>Adequacy Measures in Peritoneal Dialysis</p> <p>Aim:</p> <ol style="list-style-type: none"> 1. To assess the current performance the Renal unit in meeting the targets set by the Renal Association for peritoneal dialysis adequacy assessment. 2. To assess the contribution of residual renal function to meeting these targets. 3. To assess the use of medication to preserve residual renal function. 	<p>Conclusions from this audit were:</p> <ul style="list-style-type: none"> ▪ Adequacy outcomes met in 78% of cases. ▪ Frequency of testing met in 34% of cases. ▪ 61.24% of cases had a residual renal Kt/V >40%. ▪ Of those cases who met target Kt/V, 79.6% had a residual renal function of >40%. ▪ Drugs make no difference to preservation of residual function. ▪ Possibility of additional staffing to be investigated. ▪ Re-audit due for 2019.
Stroke	<p>RE-AUDIT-Stroke Thrombolysis and Blood Pressure Control</p> <p>Aim: To review whether the Specialty are using the updated Blood Pressure Protocol correctly and safely and whether the changes have led to reducing the door-to-needle-time in thrombolysed patients, who require blood pressure treatment.</p>	<p>Audit found the protocol is being followed correctly and safely, the flexibility of the protocol is allowing treatment to be tailored to patients. It also found that a glyceryl trinitrate (GTN) patch is being used successfully as first line agent.</p>
Therapies	<p>Audit of Texture Modified Food on Otter Ward</p> <p>Aim: To assess and evaluate whether Texture C Puree Food is appropriate and safe for patients with head and neck cancer following oral surgery</p>	<p>The audit found that Texture C Puree Food was not as suitable as Texture B meals for head and neck cancer patients following oral surgery and</p> <p>As a result, agreed that adequate Texture B foods and fluids would be provided and to discontinue giving Texture C foods. The Catering Department would be informed and a new Texture B menu made available.</p>
Therapies	<p>Feeding with Accepted Risk Guideline Audit</p> <p>Aim: To assess the use and compliance of the Trust's Clinical Guideline for Feeding with Accepted Risk</p>	<p>It was found that the term 'feeding at risk' was confusing and was often directed to patients feeding with thickened food and fluid at safe consistencies. Following presentation at the Nutritional Steering Group, it was agreed that further education would be implemented and the Clinical Guideline be updated to become the 'Eating and Drinking with Accepted Risk.'</p>
Trauma & Orthopaedics	<p>Treatment Escalation Plan Completion in Hip Fractures</p> <p>Aim: To determine how many hip fracture patients that are ASA 4 (most at risk of death) have a completed Treatment Escalation Plan</p>	<p>This Regional audit undertaken in collaboration with the South West Orthopaedic Research Division found that the Royal Devon and Exeter had excellent compliance. It was agreed to conduct a re-audit in January 2020.</p>
Urology	<p>Use of Bone Scan as a Screening Tool in Prostate Cancer</p> <p>Aim: To evaluate Trust compliance of Bone Scan in Primary 4 Prostate Cancer to assess our metastatic pick up rate and whether we are able to streamline its use.</p>	<p>As a result of the audit it was agreed to Bone Scan patients with:</p> <ul style="list-style-type: none"> ▪ Gleason $\geq 4+4$ ▪ Gleason 4+3 PSA >20 ▪ Gleason 4+3 PSA <20 and high % core positive for cancer and single involved core +/- if high risk and not intermediate
Ears, Nose, Throat	<p>RE-AUDIT-Trache-Oesophageal Speech Valve complications</p> <p>Aim: To reduce complication rates from speech valves in patients who have had a laryngectomy.</p>	<p>Reviewed and no actions required</p>

Specialty	Local Clinical Audit Title & Aim	Actions
Dermatology	<p>What proportion of patients referred via the 2ww to Dermatology are surgically treated on the day of their clinic visit?</p> <p>Aim: To determine if Melanoma and Squamous Cell Carcinoma are seen within two weeks of referral from primary care and to analyse other data collected to provide feedback, with the aim of facilitating discussion around improvement</p>	Reviewed and no actions required
Healthcare for Older People	<p>Use of Botulinum Toxin in hemifacial spasm</p> <p>Aim: To determine whether patients treated with botulinum toxin for hemifacial spasm in the Royal Devon and Exeter (RD&E) Hospital are 'moderately' impaired in at least one of the four criteria specified by the Clinical Commissioning Group.</p>	Reviewed and no actions required
Gynaecology	<p>Laparoscopic Treatment of Utero-vaginal Prolapse (NICE IPG584)</p> <p>Aim: To audit the practice of laparoscopic sacrohysteropexy and laparoscopic sacrocolpopexy for utero-vaginal prolapse, performed by one gynaecologist at two sites and to audit the complication rates.</p>	Reviewed and no actions required
Neurology	<p>Management of Myotonic Dystrophy</p> <p>Aim: To determine how closely the management of people with myotonic dystrophy adheres to best practice guidelines in the catchment area of the Royal Devon and Exeter Hospital.</p>	Reviewed and no actions required
Oncology	<p>Neo-Adjuvant Pertuzumab in Locally Advanced HER2 Positive Breast Cancer</p> <p>Aim: To review adherence to NICE guidelines (TA424) and response rate.</p>	Reviewed and no actions required
Stroke	<p>The use and appropriateness of routine Post-Thrombolysis Stroke CT Scans</p> <p>Aim: To ascertain what proportion of thrombolysed patients receive a second Computerised Tomography (CT) scan and whether the results are acted upon.</p>	Reviewed and no actions required
Therapies	<p>Are Renal Dialysis Patients Meeting their Protein and Energy Requirements?</p> <p>Aims:</p> <p>To estimate the protein and energy intakes via a 3-day food diary.</p> <p>To compare estimated protein and energy intakes against British Dietetic Association standards.</p> <p>To establish if additional support is needed for specific inter-patient groups undergoing maintenance dialysis.</p>	Reviewed and no actions required

Independent Auditor's Report to the Council of Governors of Royal Devon and Exeter NHS Foundation Trust on the Quality Report

We have been engaged by the Council of Governors of Royal Devon and Exeter NHS Foundation Trust to perform an independent assurance engagement in respect of Royal Devon and Exeter NHS Foundation Trust's Quality Report for the year ended 31 March 2019 (the 'Quality Report') and certain performance indicators contained therein.

Scope and subject matter

The indicators for the year ended 31 March 2019 subject to limited assurance consist of the following two national priority indicators:

- A&E: maximum waiting time of four hours from arrival to admission, transfer or discharge;
- maximum waiting time of 62 days from urgent GP referral to first treatment for all cancers;

We refer to these national priority indicators collectively as the 'indicators'.

Respective responsibilities of the directors and auditors

The directors are responsible for the content and the preparation of the Quality Report in accordance with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* issued by NHS Improvement.

Our responsibility is to form a conclusion, based on limited assurance procedures, on whether anything has come to our attention that causes us to believe that:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the *Detailed requirements for quality reports for foundation trusts 2018/19* ('the Guidance'); and
- the indicators in the Quality Report identified as having been the subject of limited assurance in the Quality Report are not reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

We read the Quality Report and consider whether it addresses the content requirements of the NHS

Foundation Trust Annual Reporting Manual and consider the implications for our report if we become aware of any material omissions.

We read the other information contained in the Quality Report and consider whether it is materially inconsistent with:

- Board minutes and papers for the period April 2018 to May 2019;
- papers relating to quality reported to the board over the period April 2018 to May 2019;
- feedback from commissioners, dated 8 May 2019;
- feedback from governors, dated 9 May 2019;
- feedback from local Healthwatch organisations, dated 17 May 2019;
- feedback from Overview and Scrutiny Committee, dated 14 May 2019;
- the trust's complaints report published under regulation 18 of the Local Authority Social Services and NHS Complaints Regulations 2009;
- the latest national patient survey;
- the latest national staff survey, dated 26 February 2019;
- Care Quality Commission Inspection, report published 30 April 2019
- the 2018/19 Head of Internal Audit's annual opinion over the trust's control environment, dated 17 May 2019; and
- any other information included in our review.

We consider the implications for our report if we become aware of any apparent misstatements or material inconsistencies with those documents (collectively, the 'documents'). Our responsibilities do not extend to any other information.

We are in compliance with the applicable independence and competency requirements of the Institute of Chartered Accountants in England and Wales (ICAEW) Code of Ethics. Our team comprised assurance practitioners and relevant subject matter experts.

This report, including the conclusion, has been prepared solely for the Council of Governors of Royal Devon and Exeter NHS Foundation Trust as a body, to assist the Council of Governors in reporting the NHS Foundation Trust's quality agenda, performance and activities. We permit the disclosure of this report within the Annual Report for the year ended 31 March 2019, to enable the

Council of Governors to demonstrate they have discharged their governance responsibilities by commissioning an independent assurance report in connection with the indicator. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Council of Governors as a body and Royal Devon and Exeter NHS Foundation Trust for our work or this report, except where terms are expressly agreed and with our prior consent in writing.

Assurance work performed

We conducted this limited assurance engagement in accordance with International Standard on Assurance Engagements 3000 (Revised) – ‘Assurance Engagements other than Audits or Reviews of Historical Financial Information’, issued by the International Auditing and Assurance Standards Board (‘ISAE 3000’). Our limited assurance procedures included:

- evaluating the design and implementation of the key processes and controls for managing and reporting the indicator;
- making enquiries of management;
- testing key management controls;
- limited testing, on a selective basis, of the data used to calculate the indicator back to supporting documentation;
- comparing the content requirements of the NHS Foundation Trust Annual Reporting Manual to the categories reported in the Quality Report; and
- reading the documents.

A limited assurance engagement is smaller in scope than a reasonable assurance engagement. The nature, timing and extent of procedures for gathering sufficient appropriate evidence are deliberately limited relative to a reasonable assurance engagement.

Limitations

Non-financial performance information is subject to more inherent limitations than financial information, given the characteristics of the subject matter and the methods used for determining such information.

The absence of a significant body of established practice on which to draw allows for the selection of different, but acceptable measurement techniques which can result in materially different measurements and can affect comparability. The precision of different measurement techniques may also vary. Furthermore, the nature and methods used to determine such information, as well as the measurement criteria and the precision of these criteria, may change over time. It is important to read the quality report in the context of the criteria set out in the *NHS Foundation Trust Annual Reporting Manual* and supporting guidance.

The scope of our assurance work has not included governance over quality or the non-mandated indicator, which was determined locally by Royal Devon and Exeter NHS Foundation Trust.

Conclusion

Based on the results of our procedures, nothing has come to our attention that causes us to believe that, for the year ended 31 March 2019:

- the Quality Report is not prepared in all material respects in line with the criteria set out in the NHS Foundation Trust Annual Reporting Manual and supporting guidance;
- the Quality Report is not consistent in all material respects with the sources specified in the Guidance; and
- the indicators in the Quality Report subject to limited assurance have not been reasonably stated in all material respects in accordance with the NHS Foundation Trust Annual Reporting Manual and the six dimensions of data quality set out in the Guidance.

KPMG LLP

Chartered Accountants

66 Queen Square

Bristol

BS1 4BE

24 May 2019

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

ANNUAL ACCOUNTS

YEAR ENDED 31 MARCH 2019

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

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

NHS Improvement, in exercise of the powers conferred on Monitor by the NHS Act 2006, has given Accounts Direction which require the Royal Devon and Exeter NHS Foundation Trust to prepare for each financial year a statement of accounts in the form and on the basis required by those Directions. The accounts are prepared on an accruals basis and must give a true and fair view of the state of affairs of the Royal Devon and Exeter NHS Foundation Trust and of its income and expenditure, items of comprehensive income and cash flows for the financial year.

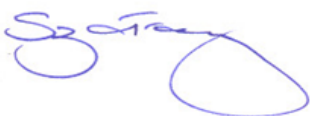
In preparing the accounts, the Accounting Officer is required to comply with the requirements of the Department of Health and Social Care Group Accounting Manual and in particular to:

- observe the Accounts Direction issued by NHS Improvement, including the relevant accounting and disclosure requirements, and apply suitable accounting policies on a consistent basis;
- make judgements and estimates on a reasonable basis;
- state whether applicable accounting standards as set out in the NHS Foundation Trust Annual Reporting Manual and the Department of Health and Social Care Group Accounting Manual have been followed, and disclose and explain any material departures in the financial statements;
- ensure that the use of public funds complies with the relevant legislation, delegated authorities and guidance;
- confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS Foundation Trust's performance, business model and strategy; and
- prepare financial statements on a going concern basis.

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

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

Signed:



Suzanne Tracey - Chief Executive

Date: 22 May 2019



Independent auditor's report

to the Council of Governors of Royal Devon and Exeter NHS Foundation Trust

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

1. Our opinion is unmodified

We have audited the financial statements of Royal Devon and Exeter NHS Foundation Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion:

- the financial statements give a true and fair view of the state of the Trust's affairs as at 31 March 2019 and of its income and expenditure for the year then ended; and
- the Trust's financial statements have been properly prepared in accordance with the Accounts Direction issued under paragraphs 24 and 25 of Schedule 7 of the National Health Service Act 2006, the NHS Foundation Trust Annual Reporting Manual 2018/19 and the Department of Health and Social Care Trust Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Overview

Materiality: £10.5m (2018:£10m)
financial statements as a whole 2% of Operating Income (2018: 2%)

Risks of material misstatement vs 2018

Recurring risks	Valuation of Land and Buildings	◀▶
	Recognition of NHS and non-NHS Income	◀▶
Event driven	New: Recognition of Non Pay Expenditure	▲

Key

- ◀▶ Risk level unchanged from prior year
- ▼ Decreased risk in the year
- ▲ Increased risk in the year

2. Key audit matters: our assessment of risks of material misstatement

Key audit matters are those matters that, in our professional judgment, were of most significance in the audit of the financial statements and include the most significant assessed risks of material misstatement (whether or not due to fraud) identified by us, including those which had the greatest effect on: the overall audit strategy; the allocation of resources in the audit; and directing the efforts of the engagement team. We summarise below, the key audit matters, in decreasing order of audit significance, in arriving at our audit opinion above together with our key audit procedures to address those matters and our findings from those procedures in order that the Trust's governors as a body may better understand the process by which we arrived at our audit opinion. These matters were addressed, and our findings are based on procedures undertaken, in the context of, and solely for the purpose of, our audit of the financial statements as a whole, and in forming our opinion thereon, and consequently are incidental to that opinion, and we do not provide a separate opinion on these matters.

	The risk	Our response
Valuation of Land and Buildings (£195.3 million; 2018: £181.4 million) <i>Refer to page 117 (Annual Report - Audit Committee Report), page 17 (accounting policy) and page 32 (financial disclosures).</i>	<p>Subjective estimate:</p> <p>Land and buildings are required to be held at current value in existing use. As hospital buildings are specialised assets and there is not an active market for them they are usually valued on the basis of the cost to replace them with an equivalent asset.</p> <p>When considering the cost to build a replacement asset the Trust may consider whether the asset would be built to the same specification or in the same location. Assumptions about changes to the asset must be realistic.</p> <p>Valuations are completed by an external expert, engaged by the trust using construction indices and so accurate records of the current estate are required. Full valuations are completed every five years, with interim desktop valuations completed in interim periods.</p> <p>Valuations are inherently judgemental, therefore our work focused on whether the valuer's methodology, assumptions and underlying data, are appropriate and correctly applied. The effect of these matters is that, as part of our risk assessment, we determined that the valuation of land and buildings has a high degree of estimation uncertainty, with a potential range of reasonable outcomes greater than our materiality for the financial statements as a whole.</p> <p>Royal Devon and Exeter Hospital NHS Foundation Trust completed an indexation exercise of Trust estate, supported by an external valuer at 31 March 2019, resulting in a £18.1 million increase in the value of the land and buildings.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Assessing valuer's credentials: We considered the scope, qualifications and experience of the Trust's valuer, to identify whether the valuer was appropriately experienced and qualified to undertake the valuation; — Test of details: We undertook the following tests of details: <ul style="list-style-type: none"> — We tested the completeness of the estate covered by the last full valuation to the Trust's underlying records of the estate held, including additions to land and buildings during the year; — We critically assessed the assumptions used within the valuation by assessing the assumptions used to derive the carrying value of assets against BCIS all-in- tender price index and industry norms; — We compared the accuracy of the base data used in the indexation exercise to the data used in the most recent full valuation and the underlying accounting records; — We re-performed the calculation of gains or losses on revaluation for all applicable assets and checked whether the accounting entries were consistent with the NHS Trust Group Accounting Manual; and — For a sample of assets added during the year we agreed that an appropriate valuation basis had been adopted when they became operational and that the Trust would receive future benefits. <p>Our findings</p> <p>We found the resulting valuation of land and buildings to be balanced.</p>

2. Key audit matters: our assessment of risks of material misstatement

	The risk	Our response
<p>Recognition of NHS and non-NHS income</p> <p>(£534.5 million; 2018: £505.8 million)</p> <p><i>Refer to page 117 (Annual Report - Audit Committee Report), page 14 (accounting policy) and page 25 (financial disclosures).</i></p>	<p>Effects of Irregularities:</p> <p>Of the Trust's reported income from activities, £426.4 million (2018, £404.8 million) came from commissioners (Clinical Commissioning Trusts (CCG) and NHS England). Income from CCGs and NHS England represent 80% of the Trust's total income. The majority of this income is contracted on an annual basis, however actual achievement is based on completing the planned level of activity and achieving key performance indicators (KPIs). If the Trust does not meet its contracted KPIs then Commissioners are able to impose fines, reducing the level of income from contracts.</p> <p>An agreement of balances exercise is undertaken between all NHS bodies to agree the value of transactions during the year and the amounts owed at the year end. 'Mismatch' reports are produced setting out discrepancies between the submitted balances and transactions between each party, with variances over £300,000 being required to be reported to the National Audit Office to inform the audit of the Department of Health and Social Care consolidated accounts.</p> <p>The Trust reported total income of £104.8 million (2018: £98.0 million) from other activities principally, Research and Development income, Private Patient income, Provider Sustainability Funding and Education and Training. Much of this income is generated by contracts with other NHS and non-NHS bodies which are based on varied payment terms, including payment on delivery, milestone payments and periodic payments.</p> <p>Within other income the Trust received Provider Sustainability Funding (PSF) from NHS Improvement. This is received on a quarterly basis subject to achieving defined financial and operational targets. The Trust received £22.6 million of PSF (2018: £16.8 million).</p> <p>As such there is a risk of fraudulent revenue recognition over both NHS and Non-NHS income.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Control observation: We tested the design and operation of process level controls over revenue recognition; — Tests of details: We undertook the following tests of details: <ul style="list-style-type: none"> ▪ We agreed Commissioner income to the signed contracts and selected a sample of the largest balances (comprising 89% of income from patient care activities) to agree that they had been invoiced in line with the contract agreements and payment had been received; ▪ We inspected invoices for material income in the month prior to and following 31 March 2019 to determine whether income was recognised in the correct accounting period, in accordance with the amounts billed to corresponding parties; ▪ We assessed the outcome of the agreement of balances exercise with CCGs and other NHS providers and compared the values they are disclosing within their financial statements to the value of income captured in the financial statements. We sought explanations for any variances over £300,000, and all balances in dispute, and challenged the Trust's assessment of the level of income they were entitled to and the receipts that could be collected; ▪ We assessed the judgements made by management in order to receive the transformation funding recorded in the financial statements, including the Trust's performance against the required targets to confirm eligibility for the income and agreed bonus amounts to correspondence from NHSI; and ▪ We tested material other income balances by agreeing a sample of income transactions through to supporting documentation and/or cash receipts. <p>Our findings</p> <p>We found the resulting recognition of NHS and non-NHS income to be balanced.</p>

2. Key audit matters: our assessment of risks of material misstatement

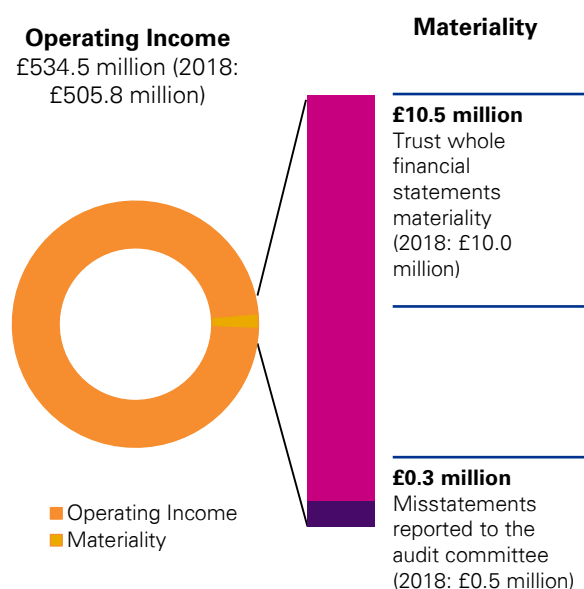
	The risk	Our response
<p>Non-Pay Expenditure recognition</p> <p>Non-Pay, Non-Depreciation expenditure (£176.4 million; 2018: £164.7 million)</p> <p><i>Refer to page 118 (Annual Report - Audit Committee Report), page 15 (accounting policy) and page 26 (financial disclosures).</i></p>	<p>Effects of irregularities</p> <p>As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. There is a risk that the Trust may manipulate expenditure to meet externally set targets and we had regard to this when planning and performing our audit procedures.</p> <p>This risk does not apply to all expenditure in the period. The incentives for fraudulent expenditure recognition relate to achieving financial targets and the key risks relate to the manipulation of creditors and accrued non-pay and non-depreciation expenditure at year-end, as well as the completeness of the recognition of provisions or the inappropriate release of existing provisions.</p>	<p>Our procedures included:</p> <ul style="list-style-type: none"> — Control observation: We tested the design and operation of process level controls over expenditure approval; — Test of Details: We undertook the following tests of details: <ul style="list-style-type: none"> ▪ We agreed a specific item sample of non-pay expenditure transactions to supporting evidence and cash; ▪ We inspected invoices for material expenditure in the month prior to and following 31 March 2019 to determine whether expenditure was recognised in the correct accounting period relevant to when services were delivered; ▪ We assessed the completeness and judgements made within the expenditure balance, specifically accrued expenditure; ▪ We inspected confirmations of balances provided by the Department of Health as part of the AoB exercise and compared the relevant payables recorded in the Trust's financial statements to the receivables balances recorded within the accounts of other providers and other bodies within the AoB boundary. Where applicable we investigated variances and reviewed relevant correspondence to assess the reasonableness of the Trust's approach to recognising expenditure to other providers and other bodies within the AoB boundary; <p>Our findings</p> <p>We found the resulting recognition of Non Pay, Non Depreciation Expenditure to be balanced.</p>

3. Our application of materiality

Materiality for the Trust financial statements as a whole was set at £10.5 million (2018: £10 million), determined with reference to a benchmark of operating income (of which it represents approximately 2%). We consider operating income to be more stable than a surplus- or deficit-related benchmark.

We agreed to report to the Audit Committee any corrected and uncorrected identified misstatements exceeding £0.3 million (2018: £0.5 million), in addition to other identified misstatements that warranted reporting on qualitative grounds.

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



4. We have nothing to report on going concern

The Accounting Officer has prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over their ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

Our responsibility is to conclude on the appropriateness of the Accounting Officer's conclusions and, had there been a material uncertainty related to going concern, to make reference to that in this audit report. However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

In our evaluation of the Accounting Officer's conclusions, we considered the inherent risks to the Trust's business model, including the impact of Brexit, and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period. We evaluated those risks and concluded that they were not significant enough to require us to perform additional audit procedures.

Based on this work, we are required to report to you if we have anything material to add or draw attention to in relation to the Accounting Officers statement on page 1 on the use of the going concern basis of accounting with no material uncertainties that may cast significant doubt over the Trust's use of that basis for a period of at least twelve months from the date of approval of the financial statements.

We have nothing to report in these respects, and we did not identify going concern as a key audit matter.

5. We have nothing to report on the other information in the Annual Report

The directors are responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information.

In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Remuneration report

In our opinion the part of the remuneration report to be audited has been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2018/19.

Corporate governance disclosures

We are required to report to you if:

- we have identified material inconsistencies between the knowledge we acquired during our financial statements audit and the directors' statement that they consider that the annual report and financial statements taken as a whole is fair, balanced and understandable and provides the information necessary for stakeholders to assess the Trust's position and performance, business model and strategy; or
- the section of the annual report describing the work of the Audit Committee does not appropriately address matters communicated by us to the Audit Committee; or
- the Annual Governance Statement does not reflect the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2018/19, is misleading or is not consistent with our knowledge of the Trust and other information of which we are aware from our audit of the financial statements.

We have nothing to report in these respects.

6. Respective responsibilities

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 1, the Accounting Officer is responsible for the preparation of financial statements that give a true and fair view. They are also responsible for: such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

We have nothing to report on the statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- any reports to the regulator have been made under Schedule 10(6) of the National Health Service Act 2006.
- any matters have been reported in the public interest under Schedule 10(3) of the National Health Service Act 2006 in the course of, or at the end of the audit.

We have nothing to report in these respects.

We have nothing to report in respect of our work on the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in the use of resources.

We have nothing to report in this respect.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

The Trust is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources

Under Section 62(1) and Schedule 10 paragraph 1(d), of the National Health Service Act 2006 we have a duty to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in the use of resources .

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Report on our review of the adequacy of arrangements for securing economy, efficiency and effectiveness in the use of resources

We are required by guidance issued by the C&AG under Paragraph 9 of Schedule 6 to the Local Audit and Accountability Act 2014 to report on how our work addressed any identified significant risks to our conclusion on the adequacy of the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources. The 'risk' in this case is the risk that we could come to an incorrect conclusion in respect of the Trust's arrangements, rather than the risk of the arrangements themselves being inadequate.

We carry out a risk assessment to determine the nature and extent of further work that may be required. Our risk assessment includes consideration of the significance of business and operational risks facing the Trust, insofar as they relate to 'proper arrangements'. This includes sector and organisation level risks and draws on relevant cost and performance information as appropriate, as well as the results of reviews by inspectorates, review agencies and other relevant bodies.

The significant risks identified during our risk assessment are set out overleaf together with the findings from the work we carried out on each area.

Significant Risk	Description	Work carried out and judgements
Financial Sustainability	<p>Whilst the context of the financial challenges within the NHS is noted, the underlying deficit and stretching CIP target presents a significant risk to our assessment of the adequacy of arrangements in place at the Trust specifically in relation to planning finances effectively.</p> <p>The Trust continues to operate with an underlying deficit.</p>	<p>Our work included:</p> <ul style="list-style-type: none"> — Considering the nature of any cash support the Trust is receiving from NHSI and its performance against any conditions attached to the support. — Assessing the Trust's arrangements for managing working capital, including the processes for forecasting and monitoring cash flows and delivering cash savings. — Considering the arrangements in place to deliver recurrent cost improvements by assessing the Trust CIP delivery against the planned CIP target and the use of recurrent and non-recurrent savings. — Comparing the Trust use of agency staff against the agency cap set by NHS Improvement. — Evaluating the Trust position as at 31 March 2019 against the forecast position and considering the future financial plans to assess the ongoing financial sustainability. <p>Our findings on this risk area:</p> <ul style="list-style-type: none"> — As at 31 March 2019 the Trust has reported a £19.6 million surplus against planned surplus of £6.3 million. — The Trust cash balance at year end was £82.4 million, against a planned cash balance of £64.1 million, with the Trust not requiring revenue support borrowings in year. — The 2019/20 operational plan forecasts a surplus position of £8.3 million, without the need for non-recurrent central funding. — The Trust delivered £20.5 million of the £23.3 million Cost Improvement Plans for 2018/19, of which 40% were recurrent savings. — The Trust has incurred £11.6 million of agency expenditure against an agreed agency cap of £8.7 million. <p>As a result of these matters, we are able to satisfy ourselves that the Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2019.</p>

THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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

CERTIFICATE OF COMPLETION OF THE AUDIT

We certify that we have completed the audit of the accounts of Royal Devon and Exeter NHS Foundation Trust in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice issued by the National Audit Office.



Jonathan Brown
for and on behalf of KPMG LLP (Statutory Auditor)

Chartered Accountants
66 Queen Square
Bristol
BS1 4BE
24 May 2019

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2019 have been prepared by the Royal Devon and Exeter NHS Foundation Trust in accordance with paragraphs 24 and 25 of Schedule 7 to the National Health Service Act 2006 and are presented to Parliament pursuant to Schedule 7, paragraph 25 (4) (a) of the National Health Service Act 2006.

Signed:



Suzanne Tracey - Chief Executive

Date: 22 May 2019

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED
31 MARCH 2019

	Note	2018/19 £000	2017/18 £000
Income from activities	3	429,631	407,777
Other operating income	4	104,824	98,020
Operating income		534,455	505,797
Operating expenses	5	(517,198)	(486,822)
Operating surplus		17,257	18,975
Finance costs			
Finance income	10	444	96
Finance expense	11	(587)	(645)
PDC dividends payable		(4,768)	(5,420)
Net finance costs		(4,911)	(5,969)
Other gains / (losses)	12	7,213	(1)
Surplus for the year		19,559	13,005
Other comprehensive income			
Revaluation gains on property, plant and equipment	16.3	18,125	-
Total comprehensive surplus for the year		37,684	13,005

The above reported revaluation gains on property, plant and equipment does not benefit the Trust's cash position. The majority of the Trust's buildings are classed as specialised assets and are valued on the basis of the cost to replace them with a modern equivalent asset. The increase in value represents a rise in construction prices since the last revaluation.

STATEMENT OF FINANCIAL POSITION AS AT
31 MARCH 2019

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	212	206
Property, plant and equipment	16	230,437	199,749
Investment in joint venture	17	5	5
Trade and other receivables	19	1,153	866
Total non-current assets		231,807	200,826
Current assets			
Inventories	18	7,775	8,649
Trade and other receivables	19	41,568	38,316
Cash and cash equivalents	23	82,440	23,529
Total current assets		131,783	70,494
Current liabilities			
Trade and other payables	20	(46,543)	(39,785)
Borrowings	21	(1,417)	(1,270)
Provisions	22	(257)	(233)
Other liabilities	20	(3,381)	(3,102)
Total current liabilities		(51,598)	(44,390)
Total assets less current liabilities		311,992	226,930
Non-current liabilities			
Borrowings	21	(52,948)	(11,320)
Provisions	22	(343)	(380)
Other liabilities	20	(2,139)	-
Total non-current liabilities		(55,430)	(11,700)
Total assets employed		256,562	215,230
Financed by taxpayers' equity			
Public dividend capital		157,531	153,883
Revaluation reserve		49,035	33,424
Income and expenditure reserve		49,996	27,923
Total taxpayers' equity		256,562	215,230

The notes on pages 14 to 38 form part of these accounts.

The Annual Accounts on pages 10 to 38 were approved by the Board of Directors on 22 May 2019 and signed on its behalf by :



Suzanne Tracey - Chief Executive

Date: 22 May 2019

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2019

	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total £000
Taxpayers' equity at 1 April 2017	153,065	34,857	13,485	201,407
Surplus for the year	-	-	13,005	13,005
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(1,433)	1,433	-
Public dividend capital received	818	-	-	818
Taxpayers' equity at 31 March and 1 April 2018	153,883	33,424	27,923	215,230
Surplus for the year	-	-	19,559	19,559
Revaluations - land and buildings	-	18,125	-	18,125
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(1,426)	1,426	-
Transfer to retained earnings on disposal of assets	-	(1,088)	1,088	-
Public dividend capital received	3,648	-	-	3,648
Taxpayers' equity at 31 March 2019	157,531	49,035	49,996	256,562

Public dividend capital ("PDC")

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

Revaluation reserve

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

Income and expenditure reserve

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

**CASH FLOW STATEMENT FOR THE YEAR ENDED
31 MARCH 2019**

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus		17,257	18,975
Non-cash income and expense			
Depreciation and amortisation		10,658	12,188
(Increase) in trade and other receivables		(3,487)	(13,112)
Decrease in inventories		874	412
Increase in trade and other payables		5,448	1,199
Increase in other liabilities		2,418	630
(Decrease) / increase in provisions		(13)	14
Income recognised in respect of capital donations		(71)	(715)
Net cash generated from operations		33,084	19,591
Cash flows from investing activities			
Interest received		444	96
Purchase of intangible assets		(75)	-
Purchase of property, plant and equipment		(24,753)	(8,032)
Sale of property, plant and equipment		11,348	2
Receipt of cash donations to purchase capital assets		71	715
Net cash used in investing activities		(12,965)	(7,219)
Cash flows from financing activities			
PDC received		3,648	818
Loans received		43,033	-
Loans repaid		(1,305)	(1,270)
Interest paid		(1,764)	(642)
PDC dividend paid		(4,820)	(5,282)
Net cash used in financing activities		38,792	(6,376)
Increase in cash and cash equivalents		58,911	5,996
Cash and cash equivalents at 1 April		23,529	17,533
Cash and cash equivalents at 31 March	23	82,440	23,529

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES

NHS Improvement, in exercising the statutory functions conferred on Monitor, has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Accounting convention

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

Going concern

The Trust recognised a surplus of £19.6m for the year ending 31 March 2019. The Trust has prepared its annual plan for the year ending 31 March 2020, which includes a detailed cash flow forecast, for the next 12 months, which provides assurance that the Trust will remain within their current facilities. The Directors have therefore a reasonable expectation that the Trust has adequate resources to continue in operational existence for the foreseeable future. For this reason, they consider it appropriate to continue to adopt the going concern basis in preparing the accounts.

1.1 Income recognition

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

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

A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. At contract inception, the Trust assesses the outputs promised in the research contract to identify as a performance obligation each promise to transfer either a good or service that is distinct or a series of distinct goods or services that are substantially the same and that have the same pattern of transfer. The Trust recognises revenue as these performance obligations are met, which may be at a point in time or over time depending upon the terms of the contract.

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.2 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.

Pension costs

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

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

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

1.3 Expenditure on other goods and services

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

1.4 Intangible assets

Recognition

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

Intangible assets are capitalised when they are capable of being used in the Trust's activities for more than one year and have a cost of at least £5,000.

Internally generated intangible assets

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

Measurement

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

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

Amortisation and impairment

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

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

Software

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

Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful lives.

Asset category

Software licences

Useful life
(years)
3 - 10

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Intangible assets (continued)

Research and development

Expenditure on research is not capitalised.

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

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

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

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

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

1.5 Property, plant and equipment

Recognition

Property, plant and equipment are capitalised where:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably and;
- has an individual cost of at least £5,000; or
- the items form a group of assets which individually have a cost of more than £250, collectively have a cost of at least £5,000, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- form part of the initial equipping and setting-up costs of a new building or on refurbishment, may also be "grouped" for capitalisation purposes.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Property, plant and equipment (continued)

Measurement and revaluation

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

Property assets

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

Buildings with a number of components that have significantly different asset lives, e.g. fixed plant are depreciated over the useful economic life of the component.

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

Non-property assets

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

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

Subsequent expenditure

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

Depreciation

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

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

<u>Asset category</u>	<u>Useful life (years)</u>
Freehold property - buildings	16 - 53
Freehold property - dwellings	32 - 37
Plant and machinery	4 - 21
Equipment - transport	5 - 8
Equipment - information technology	3 - 11
Equipment - furniture and fittings	5 - 10

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.5 Property, plant and equipment (continued)**

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

Impairment

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

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

Increases in asset values arising from revaluation are recognised in the revaluation reserve, except where, and to the extent that, they reverse an impairment previously recognised in operating expenses, such reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have been if the original impairment had never been recognised.

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

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

1.6 Donated, government grant and other grant funded assets

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

1.7 Inventories and work in progress

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

Work in progress comprises goods in intermediate stages of production.

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

1.8 Provisions

The Trust provides for legal or constructive obligations that are of uncertain timing or amount at the Statement of Financial Position date on the basis of where it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount required to settle the obligation. The Trust uses HM Treasury's pension rate of 0.29% (2017/18 - 0.1%), in real terms, as the discount rate for early retirement and injury benefit provisions.

Clinical negligence costs

NHS Resolution operates a risk pooling scheme under which the Trust pays an annual contribution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the Trust is disclosed at note 22, but this value is not recognised in the Trust's accounts.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.8 Provisions (continued)****Non-clinical risk pooling**

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

1.9 Value Added Tax

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

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

1.10 Contingent liabilities

The Trust has contingent liabilities in respect of NHS Resolution legal claims arising in the normal course of activities. Where the transfer of economic liabilities in respect of legal claims is possible the Trust discloses the estimated value as a contingent liability in note 25.

1.11 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the Trust has no beneficial interest in them. However, they are disclosed in a separate note, note 28, to the accounts in accordance with the requirements of HM Treasury's Financial Reporting Manual.

1.12 Losses and special payments

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

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

1.13 Critical accounting estimates and judgements

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

Accounting judgement - Modern Equivalent Asset valuation

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

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.14 Leases

Operating leases

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

Leases of land and buildings

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

1.15 Public dividend capital

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

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

Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for donated assets and the average daily cash held with the Government Banking Service. Average relevant net assets are calculated as a simple means of opening and closing relevant net assets in the pre-audit version of the accounts after adjusting for the average daily cash held within the Government Banking Service. The dividend charge would not be revised should any adjustments to net assets occur as a result of any changes between the draft and audited accounts.

1.16 Financial instruments and financial liabilities

Recognition

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

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

De-recognition

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

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

Classification and measurement

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.16 Financial instruments and financial liabilities (continued)****Loans and receivables**

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

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

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

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

Other financial liabilities

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

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

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

Impairment of financial assets

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

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

1.17 Corporation tax

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

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)**1.18 Consolidation of NHS charitable funds**

The Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity. The Charity has not been consolidated within these annual accounts as the value of the Charity is low and consolidation into the Trust's accounts would have no material effect. Further information relating to transactions between the Trust and the Charity is disclosed in note 26.

1.19 Interests in other entities**Joint ventures**

Joint ventures are arrangements in which the Trust has joint control with one or more other parties, and where it has the rights to the net assets of the arrangement. Joint ventures are accounted for using the equity method.

1.20 Transfers of functions to / from other NHS bodies

For functions that have been transferred to the Trust from another NHS body, the assets and liabilities transferred are recognised in the accounts as at the date of transfer. The assets and liabilities are not adjusted to fair value prior to recognition. The net gain / loss corresponding to the net assets/ liabilities transferred is recognised as a transfer by absorption within the Statement of Comprehensive Income, but not within operating activities.

For property plant and equipment assets and intangible assets, the cost and accumulated depreciation / amortisation balances from the transferring entity's accounts are preserved on recognition in the Trust's accounts. Where the transferring body recognised revaluation reserve balances attributable to the assets, the Trust makes a transfer from its income and expenditure reserve to its revaluation reserve to maintain transparency within public sector accounts.

Adjustments to align the acquired assets / liabilities to the foundation trust's accounting policies are applied after initial recognition and are adjusted directly in taxpayers' equity.

2. Segmental analysis

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

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

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

NOTES TO THE ACCOUNTS

2.1 Segmental analysis (continued)

	Surgical Services	Medical Services	Specialist Services	Community Services	Corporate and other	Trust total	Reconciliation between segmental analysis and figures reported in SOCI		
							SOCI balance	(Increase) / decrease to SOCI surplus	Note
	£000	£000	£000	£000	£000	£000	£000	£000	
NHS clinical income	122,170	145,326	120,817	53,293	10,141	451,747			
Non-patient income - staff	997	1,134	702	12	-	2,845			
RTA income	249	245	180	82	-	756			
Services provided	3,834	5,684	7,909	855	2	18,284			
Education income	7,465	4,468	1,997	489	1	14,420			
R&D income	5,068	8,757	2,604	6	-	16,435			
Non-patient income - other	6,449	7,924	8,683	6,785	127	29,968			
Total income *	146,232	173,538	142,892	61,522	10,271	534,455	542,112	(7,657)	[a]
Pay costs									
Medical staff	35,334	29,188	19,347	1,413	-	85,282			
Nursing staff	29,817	44,171	20,901	20,380	4	115,273			
Admin. staff	4,060	6,245	5,184	5,195	2	20,686			
AHP staff	10,234	11,225	13,427	9,666	18	44,570			
Other staff	3,114	4,686	1,993	1,606	-	11,399			
Non-pay costs									
Drugs	8,738	22,320	26,126	404	-	57,588			
Clinical supplies	18,113	15,830	13,473	1,215	1	48,632			
Non clinical supplies	1,791	2,085	857	355	-	5,088			
Other non-pay	10,943	14,968	12,982	8,903	157	47,953			
Total pay & non-pay expense *	122,144	150,718	114,290	49,137	182	436,471	517,642	81,171	[a] [b] [c] & [d]
Contribution	24,088	22,820	28,602	12,385	10,089	97,984			
Contribution %	16.5%	13.1%	20.0%	20.1%	N/A	18.3%			
Overheads * [excludes interest, depreciation, and PDC]	20,446	22,383	14,885	12,342	13	70,069	-	(70,069)	[b] & [f]
EBITDA [e]	3,642	437	13,717	43	10,076	27,915			
EBITDA %	2.5%	0.3%	9.6%	0.1%	N/A	5.2%			
Depreciation and amortisation and profit on asset disposal*	1,492	772	1,177	4	-	3,445	-	(3,445)	[c]
Total operating surplus / (deficit)	2,150	(335)	12,540	39	10,076	24,470	24,470	-	
PDC dividend and net interest payable*	1,612	1,619	1,675	5	-	4,911	4,911	-	[d]
Net surplus / (deficit)	538	(1,954)	10,865	34	10,076	19,559	19,559	-	
Net margin %	0.4%	(1.1%)	7.6%	0.1%	N/A	3.7%			

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

Note

[a] Finance income totalling £444k and gains on disposal of assets of £7,213k are shown gross in the SOCI and net in the segmental analysis.

[b] Overhead costs totalling £70,069k have been separately disclosed as they are not directly attributable at the service line level.

[c] Depreciation and amortisation costs totalling £10,658k, less gains on disposal of assets of £7,213k have been separately disclosed as they are not directly attributable at the service line level.

[d] PDC and net interest payable costs totalling £4,911k have been separately disclosed as they are not directly attributable at the service line level.

[e] Earnings before interest, taxation, depreciation and amortisation.

[f] Community services overheads include property rental charges of £3.7m

NOTES TO THE ACCOUNTS

2.2 Segmental analysis (continued) 2017/18 comparatives

	Surgical Services	Medical Services	Specialist Services	Community Services	Corporate and other	Trust total	Reconciliation between segmental analysis and figures reported in SOCI		
							SOCI balance	(Increase) / decrease to SOCI deficit	Note
	£000	£000	£000	£000	£000	£000	£000	£000	
NHS clinical income	118,128	132,023	118,172	50,650	34	419,007			
Non-patient income - staff	671	1,304	568	104	-	2,647			
RTA income	235	226	177	76	-	714			
Services provided	3,825	5,392	6,863	623	-	16,703			
Education income	5,163	5,572	2,678	632	-	14,045			
R&D income	5,111	8,796	2,346	-	-	16,253			
Non-patient income - other	6,959	8,363	8,532	7,360	5,214	36,428			
Total income *	140,092	161,676	139,336	59,445	5,248	505,797	505,893	(96)	[a]
<u>Pay costs</u>									
Medical staff	33,444	26,823	18,420	1,894	-	80,581			
Nursing staff	29,222	40,538	19,660	19,078	-	108,498			
Admin. staff	3,906	6,165	5,327	4,821	6	20,225			
AHP staff	9,602	10,015	13,623	8,381	1	41,622			
Other staff	2,703	3,887	1,627	1,345	-	9,562			
<u>Non-pay costs</u>									
Drugs	7,454	23,016	24,746	259	-	55,475			
Clinical supplies	16,925	13,961	13,385	1,366	-	45,637			
Non clinical supplies	1,210	1,581	534	344	-	3,669			
Other non-pay	10,135	13,539	12,641	7,760	141	44,216			
Total pay & non-pay expense *	114,601	139,525	109,963	45,248	148	409,485	486,919	77,434	[a] [b] [c] & [d]
Contribution	25,491	22,151	29,373	14,197	5,100	96,312			
Contribution %	18.2%	13.7%	21.1%	23.9%	N/A	19.0%			
Overheads * [excludes interest, depreciation, PDC and impairments]	18,934	18,921	13,663	13,629	3	65,150	-	(65,150)	[b] [f]
EBITDA [e]	6,557	3,230	15,710	568	5,097	31,162			
EBITDA %	4.7%	2.0%	11.3%	1.0%	N/A	6.2%			
Depreciation, amortisation and impairments *	4,072	3,620	3,913	295	288	12,188	-	(12,188)	[c]
Total operating surplus / (deficit)	2,485	(390)	11,797	273	4,809	18,974	18,974	-	
PDC dividend and net interest payable *	2,000	1,804	2,154	11	-	5,969	5,969	-	[d]
Net surplus / (deficit)	485	(2,194)	9,643	262	4,809	13,005	13,005	-	
Net margin %	0.3%	-1.4%	6.9%	0.4%	N/A	2.6%			

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

Note

[a] Finance income totalling £96k is shown gross in the SOCI and net in the segmental analysis.

[b] Overhead costs totalling £65,150k have been separately disclosed as they are not directly attributable at the service line level.

[c] Depreciation and amortisation costs totalling £12,188k have been separately disclosed as they are not directly attributable at the service line level.

[d] PDC and net interest payable costs totalling £5,969k have been separately disclosed as they are not directly attributable at the service line level.

[e] Earnings before interest, taxation, depreciation and amortisation.

[f] Community services overheads include property rental charges of £3.6m

NOTES TO THE ACCOUNTS

3. Income from activities

	2018/19 £000	2017/18 £000
Elective income	76,676	78,389
Non-elective income	86,866	83,086
First outpatient income	21,858	20,628
Follow up outpatient income	20,962	20,752
High cost drugs and devices income from commissioners	50,780	48,236
Other NHS clinical income	95,906	91,201
A & E income	13,397	11,509
Private patient income	1,594	1,800
Other non-protected clinical income	-	90
Community services income from CCGs and NHS England and Devon County Council	56,271	52,086
Agenda for Change pay award central funding	5,321	-
	<u>429,631</u>	<u>407,777</u>
Income from commissioner requested services	428,037	405,887
Income from non-commissioner requested services	1,594	1,890
	<u>429,631</u>	<u>407,777</u>

3.1 Income from activities - by source

	2018/19 £000	2017/18 £000
NHS England	103,649	97,307
Clinical commissioning groups	317,378	307,460
Department of Health and Social Care	5,321	-
NHS trusts	135	47
NHS other	-	144
Local authorities	23	-
Non-NHS - private patients	1,137	1,316
Non-NHS - overseas patients (non-reciprocal)	457	484
NHS injury scheme	756	714
Non-NHS - other	775	305
	<u>429,631</u>	<u>407,777</u>

NHS Injury Scheme income is subject to a provision for doubtful debts of 21.89% (2017/18 - 22.84%) to reflect expected rates of collection based upon historical experience.

3.2 Income from overseas visitors

	2018/19 £000	2017/18 £000
Income recognised this year	457	484

3.3 Additional information on revenue from contracts with customers recognised in the period

	2018/19 £000
Revenue recognised in the reporting period that was included within contract liabilities at the previous year end.	<u>3,102</u>

4. Other operating income

	2018/19 £000	2017/18 £000
Research and development	18,483	18,137
Education and training	14,477	13,993
Charitable and other contributions to expenditure	71	715
Non-patient care services to other bodies	35,089	22,676
Staff recharges	3,977	4,025
Provider sustainability funding / Sustainability transformation funding	22,628	16,834
Rental revenue from operating leases	123	121
Other	9,976	21,519
	<u>104,824</u>	<u>98,020</u>

Included within "Non-patient care services to other bodies" are laundry services, transport services, payroll services, IT services, procurement services, estates services, diagnostic services, pharmacy services, GP trainee income and drug sales totalling £28.7 million (2017/18 - £22.6 million). Better Care Funding of £5.3 million is also included in this category. In 2017/18 Better Care Funding of £5.8 million was included in "Other".

Included within "Other income" above is catering income of £2.3 million, (2017/18 - £2.2 million), car parking income of £2.1 million (2017/18 - £2.1 million), nursery/crèche income of £1.4 million (2017/18 - £1.3 million), staff accommodation £0.6 million (2017/18 - £0.5 million) and Better Care Funding was reported in this category in 2017/18 £5.8 million. Also included in 2017/18 was non-recurring commercial income of £4.9 million.

NOTES TO THE ACCOUNTS

5. Operating expenses

	2018/19 £000	2017/18 £000
Services from NHS and DHSC bodies	2,360	4,892
Services from non-NHS and non-DHSC bodies	1,228	164
Employee expenses - executive directors (see note 5.1)	923	1,116
Employee expenses - executive directors recharged to NDHT (included in income)	339	-
Employee expenses - non-executive directors (see note 5.1)	126	141
Employee expenses - non-executive directors recharged to NDHT (included in income)	19	
Employee expenses - staff	307,473	284,923
Drug costs	57,666	55,829
Supplies and services - clinical (excluding drug costs)	49,187	45,576
Supplies and services - general	6,058	5,504
Establishment	7,574	5,086
Research and development - not included in employee expenses	12,690	12,370
Research and development - included in employee expenses (see note 6.1)	5,024	4,914
Education and training - not included in employee expenses	1,250	600
Education and training - included in employee expenses (see note 6.1)	13,227	13,153
Transport	2,269	2,462
Premises	13,319	11,852
Increase / (decrease) in bad debt provision	102	(32)
Depreciation	10,589	12,064
Amortisation of intangible assets	69	124
Audit fees - statutory audit	58	58
Non-audit fee - audit related assurance services	8	7
Non-audit fee - other non-audit services	2	37
Internal audit fees	246	239
Clinical negligence - amounts payable to NHSLA (premiums)	12,273	13,324
Losses, ex gratia and special payments	353	417
Consultancy	895	529
Other	11,871	11,473
	517,198	486,822

"Other expenditure" above includes operating lease expenditure and patient travel.

Services provided by NHS Property Services previously included within Services from NHS and DHSC bodies is now classified within premises in 2018/19.

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

5.1 Directors' remuneration and other benefits

	2018/19 £000	2017/18 £000
Aggregate directors' remuneration	1,332	1,157
Employer's contribution to pension scheme	75	100
Total	1,407	1,257

In the year ended 31 March 2019 four directors accrued benefits under defined benefit pension schemes (2018 - six).

5.2 Auditor's remuneration

The audit fee, which includes statutory audit and quality accounts, was £66,000 in 2018/19 (2017/18 - £65,000). Fees of £2,000 (2017/18 £37,000) were incurred for professional advice relating to non-audit services.

5.3 Auditor's liability

The Board of Governors has appointed KPMG LLP as external auditors. The engagement letter signed on 8th December 2014, states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed £1 million in the aggregate in respect of all services (2017/18 - £1 million).

NOTES TO THE ACCOUNTS

5.4 Operating leases

	2018/19 £000	2017/18 £000
Operating lease payments recognised in expenses	<u>5,483</u>	<u>5,674</u>

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

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

	2018/19			2017/18		
	Land and buildings £000	Other £000	Total £000	Land and buildings £000	Other £000	Total £000
No later than 1 year	3,920	1,303	5,223	3,388	1,070	4,458
Later than 1 year and no later than 5 years	7,987	3,202	11,189	2,980	2,756	5,736
Later than 5 years	<u>13,403</u>	<u>322</u>	<u>13,725</u>	<u>2,586</u>	<u>452</u>	<u>3,038</u>
	<u>25,310</u>	<u>4,827</u>	<u>30,137</u>	<u>8,954</u>	<u>4,278</u>	<u>13,232</u>

6. Staff costs and numbers

6.1 Staff costs

	2018/19 £000	2017/18 £000
Salaries and wages	261,112	243,265
Social security costs	23,600	21,880
Apprenticeship levy	1,288	1,191
Employer contributions to NHSPA	31,823	29,561
Termination benefits	172	856
Agency and contract staff	<u>11,627</u>	<u>7,641</u>
	<u>329,622</u>	<u>304,394</u>
Costs capitalised as part of assets	<u>2,390</u>	<u>49</u>
	<u>327,232</u>	<u>304,345</u>
Analysed into operating expenses (see note 5):		
Employee expenses staff	307,812	284,923
Employee expenses executive directors	923	1,116
Research and development	5,024	4,914
Education and training	13,227	13,153
Internal Audit staff costs	<u>246</u>	<u>239</u>
	<u>327,232</u>	<u>304,345</u>

6.2 Average number of persons employed including directors

	Permanent employees Number	Other employees Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	816	19	835	779
Administration and estates	1,309	119	1,428	1,531
Healthcare assistants and other support staff	2,380	124	2,504	2,041
Nursing, midwifery and health visiting staff	1,841	89	1,930	1,965
Scientific, therapeutic, technical and healthcare science staff	901	17	918	875
Total	<u>7,247</u>	<u>368</u>	<u>7,615</u>	<u>7,191</u>

6.3 Staff exit packages

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Exit package cost				
Less than £10,000	21	61	66	276
£10,000 to £25,000	5	83	19	299
£25,001 to £50,000	<u>1</u>	<u>27</u>	<u>7</u>	<u>281</u>
Total number	<u>27</u>	<u>171</u>	<u>92</u>	<u>856</u>

Exit packages relate to staff redundancies and payments in lieu of notice and include employer's NIC.

NOTES TO THE ACCOUNTS

7. Pensions

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that "the period between formal valuations shall be four years, with approximate assessments in intervening years". An outline of these follows:

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account recent demographic experience), and to recommend contribution rates payable by employees and employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase from 14.38% to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

8. Retirements due to ill-health

During 2018/19 there were seven (2017/18 - four) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £313,000 (2017/18 - £87,000). The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

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

In 2018/19 the Trust incurred less than £1k (2017/18 - less than £1k) arising from claims made under this legislation. The total liability accruing as a result of late payments is £nil (2017/18 £nil).

10. Finance income

	2018/19 £000	2017/18 £000
Interest on cash and cash equivalents	444	96

11. Finance expense

	2018/19 £000	2017/18 £000
Loans from the Independent Trust Financing Facility	586	644
Unwinding of discount on provisions	1	1
Total	587	645

NOTES TO THE ACCOUNTS

12. Other gains / (losses)

	2018/19 £000	2017/18 £000
Gains on disposal of assets	7,213	-
Losses on disposal of assets	-	(1)
Total	7,213	(1)

13. Better Payment Practice Code

	2018/19 Number	2018/19 Value £000	2017/18 Number	2017/18 Value £000
Total non-NHS trade invoices paid in the year	147,981	258,618	123,983	244,751
Total non-NHS trade invoices paid within target	132,471	237,948	108,460	222,785
Percentage of non-NHS trade invoices paid within target	89.5%	92.0%	87.5%	91.0%
Total NHS trade invoices paid in the year	3,102	21,301	2,599	25,097
Total NHS trade invoices paid within target	2,355	15,637	2,151	22,509
Percentage of NHS trade invoices paid within target	75.9%	73.4%	82.8%	89.7%

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.

14. Losses and special payments

	2018/19 Number	2018/19 Value £000	2017/18 Number	2017/18 Value £000
Losses:				
Cash losses	33	27	14	2
Bad debts and claims abandoned	74	229	91	314
Stores losses, including damage to buildings	1	34	1	54
Total losses	108	290	106	370
Special payments - Ex-gratia	58	63	73	47
Total losses and special payments	166	353	179	417

15. Intangible assets

15.1 Intangible assets at 31 March 2018

	Software licences £000
Fair value at 1 April 2017	1,970
Fair value at 31 March 2018	1,970
Accumulated amortisation at 1 April 2017	1,640
Provided during the year	124
Accumulated amortisation at 31 March 2018	1,764
Net book value	
Purchased at 31 March 2018	206
Total at 31 March 2018	206

15.2 Intangible assets at 31 March 2019

Fair value at 1 April 2018	1,970
Additions - purchased	75
Fair value at 31 March 2019	2,045
Accumulated amortisation at 1 April 2018	1,764
Provided during the year	69
Accumulated amortisation at 31 March 2019	1,833
Net book value	
Purchased at 31 March 2019	212
Total at 31 March 2019	212

NOTES TO THE ACCOUNTS

16. Property, plant and equipment

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

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2018	9,255	177,076	2,128	3,248	47,856	1,298	10,641	45	251,547
Additions - purchased	-	3,982	-	19,406	3,392	268	168	-	27,216
Additions - donated	-	13	-	6	52	-	-	-	71
Reclassifications	-	3,280	-	(3,614)	38	-	296	-	-
Revaluation	457	3,548	(8)	-	-	-	-	-	3,997
Disposals	(114)	(4,296)	-	-	(198)	-	-	-	(4,608)
Total at 31 March 2019	9,598	183,603	2,120	19,046	51,140	1,566	11,105	45	278,223
Accumulated depreciation at 1 April 2018	-	6,995	105	-	35,695	1,015	7,943	45	51,798
Provided during the year	-	7,198	105	-	2,377	61	848	-	10,589
Revaluation	-	(13,918)	(210)	-	-	-	-	-	(14,128)
Eliminated on disposals	-	(275)	-	-	(198)	-	-	-	(473)
Accumulated depreciation at 31 March 2019	-	-	-	-	37,874	1,076	8,791	45	47,786
Purchased at 31 March 2019	9,598	179,980	2,120	19,040	12,568	490	2,314	-	226,110
Donated at 31 March 2019	-	3,623	-	6	698	-	-	-	4,327
Total at 31 March 2019	9,598	183,603	2,120	19,046	13,266	490	2,314	-	230,437

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

NOTES TO THE ACCOUNTS

16. Property, plant and equipment (continued)

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

	Freehold land	Freehold buildings excluding dwellings	Freehold dwellings	Assets under construction and payments on account	Plant and machinery	Transport equipment	Information technology	Furniture and fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2017	9,255	172,696	2,128	1,428	46,012	1,221	10,011	45	242,796
Additions - purchased	-	2,227	-	4,087	1,600	94	153	-	8,161
Additions - donated	-	528	-	-	187	-	-	-	715
Reclassifications	-	1,625	-	(2,267)	165	-	477	-	-
Disposals	-	-	-	-	(108)	(17)	-	-	(125)
Total at 31 March 2018	9,255	177,076	2,128	3,248	47,856	1,298	10,641	45	251,547
Accumulated depreciation at 1 April 2017	-	-	-	-	32,351	935	6,525	45	39,856
Provided during the year	-	6,995	105	-	3,452	94	1,418	-	12,064
Eliminated on disposals	-	-	-	-	(108)	(14)	-	-	(122)
Accumulated depreciation at 31 March 2018	-	6,995	105	-	35,695	1,015	7,943	45	51,798
Purchased at 31 March 2018	9,255	166,690	2,023	3,248	11,401	283	2,698	-	195,598
Donated at 31 March 2018	-	3,391	-	-	760	-	-	-	4,151
Total at 31 March 2018	9,255	170,081	2,023	3,248	12,161	283	2,698	-	199,749

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

NOTES TO THE ACCOUNTS

16. Property, plant and equipment (continued)

16.3 Revaluation of land, buildings and dwellings

The Trust's land, buildings and dwellings were revalued as at 31 March 2019. An increase in value of £18.1m has been recognised within the revaluation reserve and is due to a rise in the construction price indices as provided by the District Valuation Office. The Trust's specialised buildings and associated land are valued using the depreciated replacement cost method, based upon providing a modern equivalent asset (MEA). A fundamental principle of MEA valuations is that a hypothetical buyer would purchase the least expensive site that would be suitable and appropriate for the existing operations. The valuation of the Trust's specialised land and buildings is therefore based upon the Trust hypothetically being located on a suitable alternative site away from the city centre, where the cost of the land would be significantly lower, but where the Trust would still be able to re-provide its services.

It is impracticable to disclose the extent of the possible future effects of key valuation assumptions or another source of estimation uncertainty at the end of the reporting period. In such cases, the entity discloses, on the basis of existing knowledge, that outcomes within the next financial year that are different from the assumptions around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the assets in future periods. However, based on all currently available knowledge, the Directors believe the current valuation to be appropriate.

17. Investments in associates and joint ventures

	31 March 2019 £000	31 March 2018 £000
Carrying value at 1 April	5	5
Carrying value at 31 March	5	5

In 2016/17 the Trust acquired a 20% shareholding in a new company Dextco Limited. Dextco Limited is a joint venture between the Trust and a number of local public sector bodies with the aim of developing energy projects in Exeter.

18. Inventories

18.1 Inventories held at year end

	31 March 2019 £000	31 March 2018 £000
Drugs	1,714	1,753
Work in progress	88	93
Consumables	5,386	6,363
Energy	258	167
Inventories carried at fair value less costs to sell	329	273
Total inventories	7,775	8,649

18.2 Inventories recognised in expenses

	2018/19 £000	2017/18 £000
Inventories recognised in expenses	65,046	62,995
Write-down of inventories recognised in expenses	34	54
Total inventories recognised in expenses	65,080	63,049

19. Trade and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	36,651	-
NHS receivables*	-	16,211
Non-NHS receivables*	-	4,529
Provision for impaired receivables	-	(78)
Prepayments	3,825	3,343
Accrued income*	-	13,102
Allowance for impaired contract receivables / assets*	(547)	-
Other receivables	378	245
PDC dividend receivable	232	180
VAT receivable	1,029	784
Total current trade and other receivables	41,568	38,316
Non-current		
Contract receivables*	1,153	-
Accrued income*	-	866
Total trade and other receivables	42,721	39,182

Provision for impairment of receivables

At 1 April	78	110
Impact of IFRS 9 (and IFRS 15) implementation on 1 April 2018 balance	420	-
Increase in provision	108	258
Amounts utilised	(59)	(290)
At 31 March	547	78

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

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

NOTES TO THE ACCOUNTS

19. Trade and other receivables (continued)

19.1 Ageing of impaired financial assets

	31 March 2019 Trade and other receivables £000	31 March 2018 Trade and other receivables £000
0 - 30 days	-	-
30 - 60 Days	-	-
60 - 90 days	-	-
90 - 180 days	344	708
Over 180 days	2,791	2,061
	3,135	2,769

19.2 Ageing of non-impaired financial assets past their due date

0 - 30 days	5,083	4,814
30 - 60 days	618	970
60 - 90 days	1,283	1,134
90 - 180 days	2,035	827
Over 180 days	-	-
	9,019	7,745

20.1 Current trade and other payables

	31 March 2019 £000	31 March 2018 £000
NHS payables	6,294	3,436
Trade payables - capital	3,619	2,306
Other trade payables	4,233	3,438
Other taxes payable	6,668	6,095
Other payables	4,643	4,338
Accruals	21,086	20,172
	46,543	39,785
Other liabilities		
Other deferred income	3,381	3,102

20.2 Non current other liabilities

Other deferred income	2,139	-
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21. Borrowings

Current	31 March 2019 £000	31 March 2018 £000
Loans from Foundation Trust Financing Facility	1,273	1,270
Other Loans	144	-
	1,417	1,270
Non-current		
Loans from Foundation Trust Financing Facility	10,050	11,320
Other Loans	42,898	-
	52,948	11,320
Total borrowings	54,365	12,590
Amounts falling due within:		
In one year or less by instalments	1,417	1,270
Between one and five years by instalments	18,948	5,082
Over five years by instalments	34,000	6,238
	54,365	12,590

Foundation Trust Financing Facility

Two loans are repayable to the Secretary of State for Health and Social Care. The first loan of £17 million, was entered into in the year ended 31 March 2006. It is repayable over a 20 year period, ending 30 March 2026, by equal quarterly instalments and the interest rate of the loan is fixed at 4.55% per annum. The second loan of £10 million, was entered into in the year ended 31 March 2007, and is repayable over a 25 year period, ending 30 March 2032, by equal quarterly instalments and the interest rate of the loan is fixed at 5.05% per annum.

Other loans

New loans have been received within the year ended 31 March 2019. Loans of £21m have been received from both Hitachi Capital and Siemens Bank. The loans are repayable over a 12 year period ending September 2030, in equal quarterly instalments commencing December 2020.

Another loan of £1m was received from Epic Limited. The loan is repayable over an 11 year period ending March 2029.

	Loans from DHSC £000	Other loans £000	Total £000
Carrying value at 1 April 2018	12,590	-	12,590
Cash movements:			
Financing cash flows - payments and receipts of principal	(1,270)	42,998	41,728
Financing cash flows - payments of interest	(586)	(1,177)	(1,763)
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	3	-	3
Application of effective interest rate	586	1,221	1,807
Carrying value at 31 March 2019	11,323	43,042	54,365

NOTES TO THE ACCOUNTS

22. Provisions

	Early retirements £000	Legal claims £000	Injury benefits £000	Total £000
At 1 April 2018	103	206	304	613
Arising during the year	(23)	70	9	56
Utilised during the year	(10)	(17)	(16)	(43)
Reversed unused	-	(26)	-	(26)
At 31 March 2019	70	233	297	600

Expected timing of cash flows:

	31 March 2019 £000	31 March 2018 £000
In one year or less	257	233
Between one and five years	96	105
Over five years	247	275
	600	613

Legal claims relate to employee and public liability claims.

In 2018/19 the analysis of provisions has been revised to separately identify provisions for injury benefit liabilities. In previous periods, these provisions were included within other provisions.

Contingent liabilities relating to legal claims are shown in note 25.

NHS Resolution is carrying provisions as at 31 March 2019 in relation to Existing Liabilities Scheme and in relation to Clinical Negligence Scheme on behalf of the Trust of £169.6m (2018 - £157.5m).

23. Cash and cash equivalents

	31 March 2019 £000	31 March 2018 £000
At 1 April	23,529	17,533
Net change in the year	58,911	5,996
At 31 March	82,440	23,529
Broken down into:		
Cash at commercial banks and in hand	23	24
Cash with Government Banking Service	82,417	23,505
Cash and cash equivalents as in SoFP and Cash Flow Statement	82,440	23,529

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

24. Capital commitments

Commitments under capital expenditure contracts, which relate to property, plant and equipment, at the statement of financial position date were £9,727,000 (2018 - £1,167,000).

25. Contingent liabilities

	31 March 2019 £000	31 March 2018 £000
Contingent NHS Resolution legal claims	-	-

NOTES TO THE ACCOUNTS

26. Related party transactions

The Trust is a public benefit corporation established under the NHS Act 2006. The Department of Health has the power to control the Trust and therefore can be considered to be the Trust's parent. The Trust's Accounts are included within the NHS Foundation Trust Consolidated Accounts, which are included within the Whole of Government Accounts. The Department of Health is accountable to the Secretary of State for Health. The Trust's ultimate parent is therefore HM Government.

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

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

The Royal Devon and Exeter NHS Foundation Trust is the Corporate Trustee of the Royal Devon and Exeter NHS Foundation Trust General Charity ("Charity"), registered charity number 1061384, registered office Bowmoor House, Barrack Road, Exeter, EX2 5DW. The Charity's objective is for any charitable purpose and purposes relating to the National Health Service wholly or mainly for the Royal Devon and Exeter NHS Foundation Trust. The Trust has received during the year £58,000 (2017/18 - £58,000) revenue income, £318,000 grant income (2017/18 £Nil) and £71,000 (2017/18 - £715,000) capital contributions from the Charity. At 31 March 2019 the Trust was due £51,000 (2017/18 - £92,000) from the Charity. The Charity's most recent audited accounts were for the year ended 31 March 2018 and the Charity held aggregated reserves of £2,997,000.

During the year the Royal Devon and Exeter NHS Foundation Trust has had a significant number of material transactions with the Department of Health and Social Care ("DoHSC"), and with other entities for which the DoHSC is regarded as the parent of those entities. Income from activity - by source (note 3.1) and the operating expense (note 5) provides details of revenue transactions with those entities. Below are considered to be the significant material transactions.

	Income £000	Expenditure £000	Receivables £000	Payables £000
2018/19				
Department of Health (excludes PDC dividend)	21,784	50	121	-
Health Education England	17,369	42	1,772	31
NHS England (Includes Bristol North Somerset and South Gloucester)	128,792	-	20,441	32
NHS North East West Devon CCG	289,858	78	3,948	957
NHS Somerset CCG	4,383	-	-	60
NHS South Devon and Torbay CCG	17,415	-	84	51
Northern Devon Healthcare NHS Trust	5,419	1,267	811	517
2017/18				
Department of Health (excludes PDC dividend)	16,350	-	309	25
Health Education England	16,655	4	1,770	28
NHS England (Includes Bristol North Somerset and South Gloucester)	116,301	-	18,808	-
NHS North East West Devon CCG	279,335	83	2,703	880
NHS Somerset CCG	4,656	-	76	3
NHS South Devon and Torbay CCG	17,213	-	232	51
Northern Devon Healthcare NHS Trust	5,410	3,097	1,143	715

NOTES TO THE ACCOUNTS

27. Financial instruments

A financial instrument is a contract that gives rise to both a financial asset in one entity and a financial liability or equity instrument in another entity. IFRS 7, Financial Instruments: Disclosures, requires disclosure of the role that financial instruments have had during the period in creating or changing the risks an entity faces in undertaking its activities. The financial assets and liabilities of the Trust are generated by day to day operational activities rather than being held to change the risks facing the Trust in undertaking its activities.

Credit risk

Credit risk arises when the Trust is exposed to the risk that a party is unable to meet its obligation to the Trust in respect of financial assets due.

Financial assets mainly comprise monies due from clinical commissioning groups (CCG) and NHS England for services rendered by the Trust in fulfilment of service agreements, and cash balances held on deposit. It is considered that financial assets due from these organisations pose a low credit risk as these entities are funded by HM Government.

A significant proportion of the Trust's cash balances are held on deposit with the Government Banking Service, and as such the credit risk on these balances is considered to be negligible.

Liquidity risk

Liquidity risk arises if the Trust is unable to meet its obligations arising from financial liabilities. The Trust's financial liabilities mainly arise from net operating costs, which are mainly incurred under legally binding annual service agreements with CCG and NHS England, and liabilities incurred through expenditure on capital projects. Other liquidity risks are loans repayable to the Foundation Trust Financing Facility.

Income from contracted activities with CCG and NHS England are based upon a nationally set tariff, which under Payment by Results is paid to the Trust in twelve monthly instalments throughout the year; any performance in excess of agreed targets is paid in accordance with the terms of the relevant contract. Payment by instalments allows the Trust to accurately forecast cash inflows and through the preparation and review of cash flow forecasts, as well as the controls in place governing the authorisation of expenditure, ensures that the Trust maintains sufficient funds to meet obligations as they fall due.

Market risk

Market risk arises when the Trust is exposed to the risk that the fair value or future cash flows of a financial instrument will fluctuate because of changes in market prices. Market risk comprises three types of risk: currency risk, interest rate risk and other price risk.

Currency risk

The Trust receives income denominated in sterling. The Trust, on occasion, does enter in agreements to make payments in non-sterling denominated currencies. Non-sterling payments are principally short term liabilities and for non-significant amounts. Given this, the Trust does not consider that it is exposed to any material currency risk and therefore has elected not to hedge its exposure.

Interest rate risk

The Trust does not enter into contracts where cash flows are determined by the use of a variable interest rate.

Other price risk

The Trust enters into legally binding contracts with both its customers and suppliers that stipulate the price to be paid. As such it does not consider itself exposed to material other price risk.

NOTES TO THE ACCOUNTS

27. Financial instruments (continued)

27.1 Financial assets by category

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Loans and receivables £000
NHS receivables	16,211
Accrued income	13,968
Other receivables	4,696
Cash at bank and in hand	23,529
Total at 31 March 2018 under IAS 39	58,404
	Held at amortised cost £000
Trade and other receivables excluding non financial assets	37,635
Cash and cash equivalents at bank and in hand	82,440
Total at 31 March 2019 under IFRS 9	120,075

An analysis of any impairment of financial assets is provided in note 19.1.

27.2 Financial liabilities by category

	Other financial liabilities £000
Borrowings	12,590
NHS payables	3,436
Other payables	7,776
Accruals	20,172
Capital payables	2,306
Provisions under contracts	613
Total at 31 March 2018 under IAS 39	46,893
	Held at amortised cost £000
Loans from the Department of Health and Social Care	11,323
Other borrowings	43,042
Trade and other payables excluding non financial liabilities	39,873
Total at 31 March 2019 under IFRS 9	94,238

27.3 Fair value

For all of the financial assets and liabilities at 31 March 2019 and 31 March 2018 the fair value is equal to book value.

28. Third party assets

The Trust held £145 cash at bank and in hand at 31 March 2019 (2018 - £nil) relating to monies held on behalf of patients.

NOTES TO THE ACCOUNTS

29. Initial application of new accounting standardsIFRS 9 Financial Instruments

IFRS 9 as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £0k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £420k.

IFRS 15 - Revenue from Contracts with Customers

IFRS 15 as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018). There was no accounting effect for the year ending 31 March 2019.

30. Accounting standards issued and not adopted

The accounts have been prepared in accordance with the 2018/19 Department of Health and Social Care Group Accounting Manual (GAM) issued by Department of Health. The accounting policies contained in that manual follow International Reporting Standards (IFRS) and HM Treasury's Financial Reporting Manual to the extent that they are meaningful and appropriate to NHS foundation trusts. Below is a list of recent standards issued but not yet adopted in the NHS. It is not known or it is reasonably estimated that when these accounting standards are adopted they will not materially affect the Trust's annual accounts.

IFRS 16 Leases

