NHS
Royal Devon and Exeter
NHS Foundation Trust

Annual Report and Accounts 2020/21

Royal Devon and Exeter NHS Foundation Trust

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Royal Devon & Exeter NHS Foundation Trust
Annual Report and Accounts 2020/21

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CHAIRMAN'S INTRODUCTION

It is my pleasure to introduce our annual report and accounts for 2020/21

It goes without saying that this year has been a year like no other. 2020/21 has seen incredibly difficult times in the NHS and throughout our communities, but we have also seen a refocus on what really matters and what it means to be human.

I've been in awe of how our NHS staff have worked together to respond to the pandemic and of how amazing local people have been in supporting us to be our very best for them. The fundraising, the clapping outside front doors, the comments on social media…all have made our staff feel so supported and have demonstrated the strength of our communities. The NHS brand has been hugely reinforced, so much so that there has been a significant increase in people applying for nursing degrees.

Local scientists have been incredible too – the strong and long-standing relationship between the University and the RD&E means that our clinicians and scientists work incredibly well together, and over the last year, we have supported a number of research projects, including the Randomised Evaluation of COVID-19 thERapY (RECOVERY) trial which investigated whether existing medicines are effective against the disease.

The learning that we take from this experience will be really important. This challenging time has shown us more than ever how crucial it is to recognise the incredible work our health and care staff do and to demonstrate that we value them. We've seen what we can do together as communities when we've needed to – this has not been about individual organisations, but about how we work together so that we have a health service that provides for the day-to-day as well as more specialist needs.

We can also take huge learning as a Devon health and care system from how we established the Nightingale Hospital Exeter, which provided care to patients across the county, including North Devon and Torridge. The can-do attitude staff showed in getting things done efficiently and safely redefined the art of the possible.

As we enter 2021/22, now is the time to reset and recover our services – and our staff - on a sustainable basis. Our response to the pandemic has meant that inevitably, our waiting lists are not where we want them to be. Many people are waiting longer for their care than we would like and addressing this is of utmost importance to us. We have also seen a concerning fall in referrals and hope to see this return to normal expected levels. As always, we continue to work with our partners to ensure we are encouraging people to use their health services in the right way and to get any concerning symptoms checked out.

Although there is much concerning us when we consider where we are today, there is much to be excited about too. We have long highlighted the need to invest in Devon and it is fantastic that this is being recognised nationally – this includes funding to roll out a shared electronic health record from Eastern Devon to Northern Devon, an essential enabler of collaborative working and the proposed integration of NDHT and the RD&E.

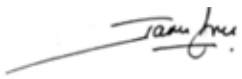
The development of the Integrated Care System (ICS) and Local Care Partnerships across Devon are hugely exciting too and provide us with the opportunity to work together to transform so we are delivering services sustainably in the context of the demographic challenges we face in Devon. It is great to see that the value individual providers place on their community and the need for collaboration is recognised within the recent Government proposals for legislation.

Overall, looking ahead to 2021/22, I am hugely optimistic. A year of such challenge has really shown us what we are made of in Devon. The NHS has a mountain to climb to get back to where it was, but we have hugely dedicated staff and a great leadership team across our organisations, with everybody absolutely committed to doing the best they can.

We have significant opportunities in the coming years, including funding for our estates and technology and working together to transform as part of the Devon ICS. The proposed integration of

the RD&E and NDHT is a huge part of this – with shared challenges, we have recognised that we will be stronger together, and over this coming year, we look forward to the work we need to do towards becoming a single organisation, so that together we can provide the very best care for our patients. After all, that is what we are here for.

The work detailed in this annual report demonstrates how much our amazing staff and communities are able to achieve even in the most challenging of times. Thank you.



James Brent
Chairman

PERFORMANCE REPORT: Overview

The purpose of this 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.

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.

Introduction by the Chief Executive

Welcome to our Annual Report & Accounts 2020/21.

Our report looks back at the last 12 months, summarising both our achievements and the unprecedented challenges we faced, and looks forward to some of the things we want to achieve over the course of the next financial year.

While the last year has been understandably dominated by the unprecedented COVID-19 pandemic, for me, our response has highlighted three key areas that I want to share: the sheer determination that our staff have shown in the face of great adversity; the strengthened partnership working across Devon; and the overwhelming support we have received from our local communities.

As the first wave of the COVID-19 pandemic continued into April 2020, our staff worked at a tremendous pace to ensure that we could provide safe care for those who needed us. We embarked on a rapid and extensive period of transformation that saw a wave of innovation flourish across all corners of our trust, and as the second and third COVID-19 waves arrived at our doors, we took those key learnings and continued to adapt to keep our patients and each other safe.

Despite the severe challenges we faced, the professionalism and dedication shown by all of our staff – including those working across the acute and community, those working remotely, and members of staff that were shielding - remained an unwavering constant. And so, before I go any further, I would like to take a moment to say this to my colleagues: from the very bottom of my heart, to every single person who is a part of the RD&E team, thank you. Your commitment, compassion and flexibility over the last year have been nothing short of extraordinary. On behalf of the RD&E Board of Directors and the communities we serve, I thank you.

The second area – partnership working - has been central to our region's response to the pandemic. There is no doubt that the RD&E has been on the COVID-19 frontline over the last year, but we certainly haven't been there alone. We have worked with neighbouring health and social care organisations to ensure patients with COVID-19 were treated in the most appropriate place - this includes the NHS Nightingale Hospital Exeter, which provided compassionate care to hundreds of people from as far away as Dorset and supported us to better cohort patients and continue providing non-COVID urgent care.

The last 12 months have highlighted how varied and valuable our partnership working is, and how important collaboration is in the NHS. Earlier this year, the Devon system submitted an application to become an Integrated Care System (ICS), and what we have achieved with our partners over the last year provides me with the confidence that we have developed strong foundations to continue building these partnerships into the future.

And finally, I want to single out the overwhelming support we have received from our local communities. The NHS is considered by many to be the beating heart of our nation – its primary purpose is to look after us when we need it most. What I find utterly heart-warming is that over the last year, when we have needed people to look after us, they have done so without question. We have been humbled by people's kindness and generosity, from the hours volunteered to support our services, the items gifted by local businesses and community groups, and the £116,000 raised for our #HelpUsHelpYou appeal. And so, on behalf of everyone at the RD&E, I would like to extend a huge thank you to our local communities for all they have done to show our staff just how valued they are.

In line with the national directive from NHS England and Improvement (NHSE/I), in March 2020 we took the difficult decision to temporarily pause a number of non-critical elective procedures. Since then, we have been carefully balancing the needs of those who require urgent care and those waiting for non-critical elective procedures. We know the impact that postponing surgery can have for patients, and we are working with partners across Devon to develop an approach to fully restore services as soon as possible.

It would be easy to reflect solely on our response to COVID-19, but that wouldn't provide an accurate summary of our year. Despite – and in many cases because of - the pandemic, we have achieved a tremendous amount.

In November 2020, the Boards of both RD&E and NDHT approved a 'Strategic Case' which signalled our intent to join together, building on a long-standing partnership between our organisations. In December 2020, this was approved by NHSE England and NHS Improvement (NHSEI) and to support the next stage of our integrated working, we brought together our Board and leadership teams. This included appointing a joint chief nursing officer, chief finance officer and deputy chief executive, who alongside our other Board members will operate at a strategic level across both sites and lead our organisations as we progress our proposed integration.

We are continuing to develop our integration business case and will submit this to NHSEI later this year. It is anticipated that the RD&E and NDHT will come together as a single organisation from April 2022, subject to the necessary approvals from the Boards and the Council of Governors (CoG) at RD&E who have a statutory role. Ensuring that our patients, staff and local communities feed into the integration process is really important to us and we have developed an extensive programme of engagement to understand what is important to these groups. We will continue to keep our stakeholders informed as we progress our proposed integration over the coming months.

In March, we announced our strategic alliance with NDHT and Torbay and South Devon NHS Foundation Trust (TSDFT). This alliance will see us collaborating more closely to secure sustainable, high-quality patient care for local people over the coming years into the future. Instead of working independently, this approach will enable us to find new ways to connect, communicate and collaborate so that we can better meet the healthcare needs of the communities we, NDHT and TSDFT serve.

Following an earlier decision to pause the launch of MY CARE as a result of the pandemic, we continued to get the programme back on track last summer and on 10 October 2020, we launched our new, state-of-the-art electronic patient record (EPR) system across the RD&E. The launch of MY CARE was the culmination of two and a half years work to improve how services are delivered at the trust, and I would like to thank every single person who has contributed to the successful rollout of the programme.

We are now looking at how we optimise MY CARE across the RD&E so that we make best use of it for our patients, as well as how we can best support NDHT as they prepare to rollout MY CARE across Northern Devon in 2022. This fantastic investment, which is part of the proposed integration between the RD&E and NDHT, will enable clinician sharing and virtual clinical input across Eastern and Northern Devon, helping to give patients the care they need closer to, or from, home. Having witnessed first-hand the impact digital records can have on patient care, we are really excited about the future of MY CARE and what this means for the communities we serve.

Inclusion is one of our core values - it is central to what we stand for and what we do, and the COVID-19 pandemic has reinforced why this is the case. The second Public Health England review on health inequalities (June 2020) recognised that the unequal impact of COVID-19 on BAME communities may be explained by several factors, including racism and discrimination, demonstrating in very tangible, health-related terms why inclusion is so fundamental.

We know that just holding inclusion as one of our values is not enough and that we must embody those values in all that we do, and so I am pleased to share that over the last year, we have made progress with our inclusion strategy. This involves launching our BAME and LGBTQ+ Networks, and working with a small group of staff to develop a Disability Network, supporting staff from these groups to advocate for their peers and influence organisational decision making. We have also secured funding to commence a reverse mentoring scheme, which will see members of the RD&E Executive team work with and learn from staff from underrepresented groups. I am acutely aware that there is much more to be done to make the RD&E more inclusive, but the progress we have made this year further cements our commitment to create a workplace that enables both diversity and inclusion to flourish.

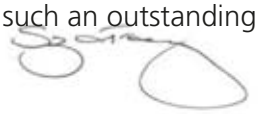
I am always delighted when our services and teams receive the recognition they deserve for the excellent care they continue to provide. The annual Care Quality Commission (CQC) Inpatient Survey looked at the care of 659 in-patients who were discharged from the RD&E in July 2019. Patients assessed the trust on a variety of areas during their stay, with

99 per cent of inpatients reporting that they were treated with dignity and respect and 99 per cent saying they had confidence and trust in our nurses and doctors. In addition, the National Cancer Patient Experience Survey found that we received more 'above expected' results than any other trust in the country, and that local mums rated our maternity services highly in the 2020 New Mothers' Experiences of Care Survey.

In September 2020, we launched our brand new RD&E website. The aim of our new website, which is designed to be simple to use and accessible to all, is to better meet the needs of our patients and communities. As well as promoting self-care and the different types of urgent care options available, the website includes the MY CARE patient portal and information about our sites and services.

Before coming to a close, I would like to express my thanks to our Council of Governors and members, who play an invaluable role in how we operate as an organisation. I would also like to thank James Brent, who agreed to stay on as RD&E and NDHT Chair to help ensure stability and continuity throughout the COVID-19 pandemic. James's term will end in March 2022 and we are now looking to begin recruiting for our new RD&E and NDHT Chair.

I would like to pay one final, heartfelt tribute to our staff, partners and local communities. I am extremely proud of the care and services we have delivered over the last year, and I consider it a great privilege to lead such an outstanding organisation.



Suzanne Tracey
Chief Executive Officer
Date: 14 June 2021

About the Royal Devon & Exeter NHS Foundation Trust

The Royal Devon and Exeter NHS Foundation Trust (RD&E) provides a full range of health and care services to around 450,000 people across Eastern and Mid-Devon.

We employ over 11,000 staff who work together to deliver integrated care across a number of sites, including a large acute hospital, twelve community hospitals, various community settings, and in people's homes. Over the last year, as part of our response to the COVID-19 pandemic, we've also provided services at the NHS Nightingale Hospital Exeter, the Exeter COVID-19 Vaccination Centre and Exeter Nuffield Health.

Our ability to offer more integrated care has been strengthened following the launch of MY CARE across the RD&E. This new, state-of-the-art electronic patient record (EPR) system stores patient information electronically, making it easier to join up information, regardless of where care is provided.

The Trust has an international reputation for providing high quality healthcare services, and as a teaching hospital that delivers undergraduate clinical education, we aim to inspire the next generation of healthcare professionals and transform the way care is delivered to our local communities.

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, means we are better able to respond to local needs and connect with the people and communities we serve.

Our Trust values were developed by our staff and form the cornerstone of all that we do, as individuals and as an organisation. Our values are:

- fairness
- honesty, openness & integrity
- respect & dignity
- inclusion & collaboration

Royal Devon and Exeter (Wonford) Hospital, Exeter

The Royal Devon and Exeter (Wonford) Hospital is our largest hospital in the Trust, where many of our acute clinical services are based, including our Emergency Department, Walk-in Centre and Minor Injuries Unit (MIU).

The hospital is home to a number of our highly acclaimed specialist units and centres, including:

- **The Princess Elizabeth Orthopaedic Centre:** our internationally renowned centre - which is widely recognised for its excellence and innovation - diagnoses, treats, and repairs bones, joints, muscles, ligaments and the spine.

- **The Centre for Women's Health:** our award-winning Maternity, Neonatal and Gynaecology services, which include specialist wards, operating theatres and the RD&E's birth centre and screening unit.
- **Mardon Neurorehabilitation Centre:** our purpose-built, 12-bed specialist neuro-rehabilitation inpatient unit, which is located near to the Wonford site.

Integrated health and social care community services

On any one day our community teams support up to 1680 people to remain safe and well within the community setting. This support can be provided in a variety of ways including:

- any of our three community inpatient settings (Exmouth, Tiverton and Sidmouth) for short term reablement and rehabilitation
- in an outpatient clinical setting with our specialist services (MSK Physio, Podiatry, Ambulatory care, Chronic Fatigue, Specialist rehab/ nursing teams)
- who work flexibly across community sites and GP Practices
- within a patient's own home/place of residency (community nursing/matrons, Rehabilitation, Urgent Community Response)

Our teams work closely with a wide number of health and care professionals, including colleagues working in the acute hospital, social care, primary care, mental health and the voluntary sector to support people to self-manage their long-term conditions, improve their mobility and maintain their independence.

We also support people who have an urgent need to either avoid an unnecessary hospital admission or support people home from hospital who may need short term support until they regain their independence or for specialist end-of-life care. We manage a range of inpatient and outpatient services across East and Mid-Devon from 12 community hospital locations, which provide local hubs for our community's healthcare that are easily accessible to our local population. These span a wide geographical area, and include minor injuries units and a variety of outpatient services.

Our Year

2020/21 was significantly impacted by the COVID-19 pandemic. In the face of great adversity, innovation thrived, partnerships flourished, and our staff went above and beyond to ensure the continued safety of their colleagues, patients and local communities.

Examples include:

Rapidly creating, developing and adapting our services

Last Spring, the trust underwent an extensive period of rapid transformation, quickly setting up and modifying services and ways of working to increase critical care capacity and ensure routine care could continue to be safely provided.

Just a few examples of this include:

- opening a Trauma assessment unit (TAU) to help ease pressures on the emergency department
- developing and operating an ITU surge plan to increase capacity for those seriously ill with COVID-19
- quickly opening, deep cleaning and closing COVID-19 wards to ensure that those with and without COVID-19 can be cared for safely and in line with infection prevention control guidance
- increasing the number of digital outpatient appointments, clinics and services to reduce the number of patients and staff onsite
- fast and successful rollout of MS Teams across the Trust to facilitate more efficient team working
- moving outpatient services such as urology out of the acute hospital and into our community hospitals to make more space for patients with COVID-19 and reduce footfall
- setting up the COVID-19 staffing hub to issue guidance and policies relating to staffing, coordinating staff redeployments and establishing a robust system for risk assessing employee's vulnerability to COVID-19
- ensuring that clinically extremely vulnerable patients still received the care they need – this included working with Nuffield Health Exeter Hospital to ensure the continuation of urgent cancer surgeries and other important treatments, and our services such as the renal team developing new COVID-secure ways of working

- changing our community maternity service model, including the home birth team, to keep pregnant women, their babies and their families safe
- developing the Family Liaison Service and a number of other initiatives to keep patients connected to their friends and families during the pandemic

Staff redeployments

Hundreds of staff from across the trust were redeployed to support our response to the COVID-19 pandemic. Some staff took on new roles entirely, which meant quickly learning new skills and taking on new responsibilities, while others worked in different services or from different locations – including remotely and from the NHS Nightingale Hospital Exeter.

Supporting the health and wellbeing of our staff

We've launched a number of initiatives and campaigns, including:

- a 'thank you' campaign, to share messages of thanks from our local community and patients with our staff
- a 'Winter Wellness' campaign which shared tips, resources and events to support staff to stay well over the winter months
- giving all staff an extra day of annual leave
- distributing COVID-secure snack packs across the Trust

Building and operating a Nightingale Hospital

To increase capacity across the country, the government commissioned seven Nightingale Hospitals. The NHS Nightingale Hospital Exeter, which was operated by the RD&E on behalf of the other NHS organisations across Devon, cared for hundreds of patients with COVID-19 during the height of the pandemic. It was staffed by healthcare workers from across Devon, including the RD&E, along with dozens of volunteers who gave up their time to help care for patients. Whilst caring for COVID-19 patients, the RD&E successfully delivered a number of services to the Nightingale, including therapy, medical imaging, pharmacy, end-of-life care, tissue viability, pathology and infection prevention and control.

Before the NHS Nightingale Hospital Exeter opened to COVID-19 patients, we worked with a number of partners to provide nearly 3,000 diagnostic tests to local people, ran overseas nurse training at the facility and hosted a Novavax COVID-19 vaccination trial from the site.

Rapid staff testing rollout

As part of our early response to the COVID-19 pandemic, we opened a drive-through COVID-19 testing centre at the Exeter Chiefs' home at Sandy Park in April 2020, helping health and care staff across Devon return to work as quickly and safely as possible. We also quickly rolled out lateral flow and LAMP staff testing at the RD&E to help us keep our staff and patients safe.

Operating a large vaccination site

We worked alongside NHS Devon Clinical Commissioning Group (Devon CCG), local businesses and voluntary organisations to quickly set up the Exeter COVID-19 Vaccination Centre, which the RD&E now operates.

In 2020/21:

- we cared for 151,568 inpatients, 39,357 day cases, and 411,777 outpatients
- our emergency department had 75,036 attendances, our minor injuries unit had 7,645 attendances, and our walk-in centre had 10,540 attendances
- we looked after 1,146 people in our community hospitals and 318,880 people in their homes
- 3,662 babies were delivered

Our year in pictures

New RD&E Patient Recruitment Centre to improve patient access to commercial clinical research

The RD&E was one of five NHS trusts in England selected to host a new Patient Recruitment Centre (PRC). The PRC, which is managed by the National Institute for Health Research (NIHR), makes it easier for patients across the South West to access clinical research opportunities and access potentially cutting edge new drugs and treatments before they become widely available within the NHS.

New helipad opens at Royal Devon and Exeter hospital

A brand new helipad at the RD&E opened in July, thanks to a £1million donation from the HELP Appeal. The hospital's previous helipad was unable to receive night landings, but the new helipad now has lighting and has been enlarged to enable the latest generation of air ambulances to land, which means patients with serious or life-threatening injuries will be able to get to our Emergency Department day or night.

CQC survey results praise RD&E inpatient services

The annual CQC NHS Inpatient Survey (659 respondents), which looks at the care provided to patients during their stay found that:

- 99% of inpatients reported that they were treated with dignity and respect
- 99% of patients surveyed had confidence and trust in nurses and doctors
- 99% of patients felt well looked after by non-clinical staff
- 98% of patients felt that staff worked well together
- 90% felt they had enough emotional support from staff

Exeter mum raises thousands for RD&E

An Exeter mum has smashed her fundraising target and raised over £6,000 for the RD&E. Melanie Peck's 22-month-old son, Will, was born with Pallister Hall syndrome, a rare genetic disease which means that he suffers from seizures, breathing difficulties and other complications. In order to give something back to the ward who cared for him, Melanie decided to fundraise for the RD&E Charity's Starfish Appeal, which is raising vital funds to enhance children's services and outpatient waiting areas at the RD&E.

UNICEF award RD&E neonatal unit as a gold standard

The Neonatal Unit at the RD&E was the first level 2 neonatal unit in the UK to achieve the UNICEF UK Baby Friendly Initiative Gold award, which was presented at the Trust last August and found that:

- 100% of mothers interviewed felt that they had been supported with developing a close and loving relationship with their baby
- 95% of mothers interviewed felt fully involved in their baby's care

RD&E launches new website

In September, we launched our new, patient-friendly website. The site, which was developed following engagement with the public, community groups, our members and our governors, provides a range of information on a number of areas, including:

- sites, services and ward information
- clinical resources (patient leaflets, videos etc.)
- the support available (including PALS, translation services and our learning disability liaison team)
- the latest corporate and RD&E Charity news

RD&E Goes Live with 'Game Changing' Transformation Programme this Weekend

At 4am on Saturday 10th October the RD&E went live with MY CARE: the biggest clinical transformation programme the RD&E has ever undertaken. This heralded the culmination of two and a half years work to improve how services are delivered at the Trust, supporting us to provide safer and better quality care for patients.

RD&E nurse receives regional award in recognition of research contributions

An RD&E research nurse has won a top award at the South West Research Awards, which is held by the NIHR Clinical Research Network South West Peninsula to recognise and celebrate those that go above and beyond in their commitment to research across the region. Sarah Benyon, Senior Research Nurse at the RD&E, received the Research Nurse or Midwife Award for her work in supporting the research and development portfolio for the RD&E's renal department.

Staff at the RD&E benefit from new rest areas thanks to generous public donations

During the first lockdown, the RD&E Charity launched the #HelpUsHelpYou Appeal, which was designed to raise money to directly support the wellbeing of staff at the RD&E. Donations to this appeal, along with funding from NHS Charities Together and matched with money from the Trust, was used to create two new lounges away from clinical areas where staff can take their breaks.

The Exeter Chiefs send messages of support to RD&E staff and the NHS

Exeter Chiefs, England and European Champions 2020, created a string of video messages to thank our staff for all they do. The videos were projected onto the side of one of our buildings each evening over the Festive period for all to see.

Marking the National Day of Reflection

The 'National Day of Reflection', which was led by Marie Curie, took place on Tuesday 23 March - the one year anniversary of the UK going into the first national lockdown. To commemorate all those who have died, support those who have been bereaved, and encourage colleagues to take a moment to reflect on the last year, we marked the national one minute silence, lit up parts of the RD&E Wonford site that evening and lit candles in the Chapel.

Research and development

This year has underlined the fundamental role research and clinical trials have in keeping our local communities healthy, safe and well. The Trust has made a significant contribution to research - in total, 6,649 participants have been recruited into RD&E trials, and thanks to the hard work of the research and development team, all COVID-19 studies and trials were recruited to and opened within just two weeks of site selection.

Here are just a few of the many achievements for research and development in 2020/21:

- The RD&E led the delivery of a phase 3 COVID-19 vaccine study, which tested the safety and effectiveness of the vaccine produced by US biotechnology company Novavax. Phase 3 studies involve thousands of people, giving researchers insights into the effects of a vaccine on a much larger population than phase 1 and 2 studies. Working with the National Institute of Health Research, we recruited 547 patients across a broad spectrum of age groups and backgrounds.
- The Trust participated in the world's biggest randomised clinical trial of COVID-19 treatments, called the RECOVERY Trial, recruiting 234 patients from across the Trust. This study showed that dexamethasone reduces deaths amongst the sickest patients by one third. The evidence for treatment was reviewed and implemented in three months and was immediately adopted for treating all COVID-19 patients. RECOVERY also demonstrated the benefits of tocilizumab reducing the risk of death when given to our hospitalised patients with severe COVID-19, shortening hospital stays and reducing the need for a mechanical ventilator.
- 425 staff were recruited to SIREN, which aims to find out whether healthcare workers who have evidence of prior COVID-19, compared to those who do not have evidence of infection, are protected from future episodes of infection. The results have given us information on how long people who have been infected are protected against reinfection, and also how the virus is transmitted when infected.
- We recruited 958 patients into the observational COVID-19 study - ISARIC. The study collates data and develops online risk assessment tools which can predict which hospital patients are more likely to deteriorate with a COVID -19 infection, supporting us to better plan the needs of individual patients.

Key developments

RD&E and NDHT integration

In December we got the green light from our regulators NHSE/I to take the next steps on further integration between RD&E and NDHT.

Following approval to proceed from NHSE/I, we are developing an Integration Business Case which describes in more detail how the two organisations become a single integrated organisation working across Northern and Eastern Devon for the benefit of both communities.

Both Trusts have worked together for a number of years and our partnership has strengthened since 2018 as a result of the Collaborative Agreement. Formally integrating is the next logical step in the evolution of our partnership and we are continuing to work closely together to develop detailed plans to join together in April 2022.

Although we aim to become one organisation by next April, the work will take place over a five-year period to bring our two diverse organisations together.

In order to support the next stage of joint working to become one organisation, we have been working to bring together our Board and leadership teams. The composition of the new Board is being progressed to ensure continuity and to retain organisational memory with a combination of existing NEDs from both Trusts and some new appointments.

In January 2021 we announced appointments to three key joint roles across the two Trusts. Chris Tidman, previously chief finance officer at RD&E, became deputy chief executive; Carolyn Mills was appointed as chief nursing officer; and Angela Hibbard – previously director of finance, performance and facilities at NDHT – became chief finance officer across both sites.

Our local population and staff are at the heart of all we do and their input, ideas and views are incredibly important to make this process a success — achieving a positive experience for staff and improving the care we offer our patients. Our teams are starting to capture feedback and thoughts from staff and our community to shape plans as we move forward.

Launching MY CARE at the RD&E and future plans

Following an earlier decision to pause the launch of MY CARE in response to the pandemic, the programmed resumed in the summer and on 7 October 2020, we launched our new, electronic patient record (EPR) system across the RD&E, which is supplied by renowned health software developers Epic. To support the 'go live' period, we trained over 1000 clinical and administrative 'Super Users' and worked with a number of partner organisations to minimise admissions and expedite discharges. Thanks to the hard work of the MY CARE programme team, staff across the RD&E and external partners, the launch was hugely successful.

The MY CARE programme, which is the biggest clinical transformation programme the RD&E has ever undertaken and a huge digital milestone for the NHS, has changed the way we deliver care. We no longer rely on inefficient paper-based processes and systems, and patient information is now stored electronically, making it easier for staff to provide even safer and more compassionate, personalised care. For patients, this means being able to see upcoming appointments, change appointment times and see a range of results through a personal electronic device, such as a laptop, mobile phone or tablet.

Following the successful rollout of MY CARE at the RD&E, in March we received approval of national funding to rollout the Epic electronic health record from Eastern Devon to Northern Devon as part of the continued partnership and proposed integration of NDHT and RD&E.

This is a fantastic investment for our patients and community. Having a shared patient record across NDHT and RD&E will help us to develop the way we deliver care to our patients in a way that helps to mitigate the rurality of northern Devon and makes the best use of our shared workforce.

A common patient record will enable clinician sharing and virtual clinical input. Where services are networked across sites, a shared patient record will mean that somebody who lives in Hartland can have a medication review with a consultant in Exeter remotely, meaning the patient gets the care they need and saves a very long journey.

Strategic alliance formalised

NDHT, RD&E and Torbay and South Devon NHS Foundation Trust (TSDFT) have agreed to form a Strategic Alliance which will see us collaborating more closely to secure sustainable, high-quality patient care for our populations into the future. The Trusts have set out our agreement by signing a Memorandum of Understanding.

Instead of working independently this approach will enable us to find new ways to connect, communicate and collaborate so that the health and care needs of local people are met.

TSDFT, RD&E and NDHT have been working together informally for some time as part of the SEND (Southern, Eastern, Northern Devon) acute network. We have strengthened our collaboration over the past 12 months as we have responded to the COVID-19 pandemic and worked to recover elective care.

We want to take the opportunity to build on this experience and make sure we are joined up in our thinking as we respond to some of the significant programmes of work underway, including joined up digital strategies, the development of the Integrated

Care System across Devon which will bring health and care providers together, and how the investment in infrastructure at both TSDFT and NDHT as part of the Government's Health Infrastructure Plan would best be used.

The Trusts are already successfully collaborating. For example, we have worked together across our acute medicine, obstetrics and gynaecology and urology services to ensure access to high quality care for our patients through sharing our resources.

This collaboration has supported our response to the COVID-19 pandemic. We have worked collectively to staff the Nightingale Hospital and have supported each other through offering our beds to one another to ensure the best possible care for our patients.

Devon Sustainability and Transformation Partnership – One Devon

The Devon Sustainability and Transformation Partnership (STP) worked successfully during the year to achieve designation as an Integrated Care System from 1 April 2021.

The new Integrated Care System (ICS) in Devon sees the three local authorities, NHS Devon CCG, NHS trusts, general practice, community services, mental health services, and the voluntary and community sector working together to improve the health of all residents, better support people living with multiple and long-term conditions, prevent illness, tackle variation in care and deliver joined up services while getting maximum impact for every pound spent.

Jane Milligan was appointed to take up the role as Chief Executive of the ICS from 1 April 2021. Its vision is: "Equal chances for everyone in Devon to lead long, happy and healthy lives" and its route to achieving this is being set out in the Devon Long Term Plan.

Partnership working under the STP has been at the heart of the Devon-wide response to COVID-19 and to the successful delivery of the vaccination programme. This has been underpinned by a common digital strategy that has allowed patients to be cared for safely through remote consultations and ensured the direct recording of vaccinations – even at non-NHS premises – on to the patient record.

It has also fostered close co-operation among Devon's acute hospitals in Exeter, Barnstaple and Torbay to increase resilience at times of high demand and ensure that services can be made available to patients even in highly specialist areas where recruitment of consultants can be challenging.

As well as helping integration by creating many joint posts between the CCG and local authorities, the STP has forged strong links with voluntary, community and social enterprise organisations. This means collaborative working at a Devon-wide level to better meet the needs of patients and service users, but also strong partnerships in local communities where particular challenges can be met.

This has given rise to award-winning innovation, such as the Devon STP carers hospital service, which carried off a 2020 Health Service Journal award for its work to identify unpaid carers while they were still in hospital, reduce admissions and readmissions, and prevent crisis and a breakdown of caring arrangements.

A joint CCG initiative with Devon County Council and the voluntary sector in the form of Westbank Community Care and Health, the scheme at the Royal Devon and Exeter NHS Foundation Trust reduced ongoing health needs by 22%, reduced admissions by 16%, prevented carer breakdown in 15% of cases, and helped more timely discharge.

To support the thousands of staff who work across the STP, a Devon Health and Wellbeing Hub was set up. One of 40 across the country, to provide guidance and support to colleagues who have been under tremendous pressure since the beginning of the pandemic.

The Devon STP did work during the year to understand and improve the experience of care of our Black, Asian and Minority Ethnic (BAME) communities, taking account of the stark inequalities nationally among different ethnic groups. This has been highlighted by the COVID-19 pandemic.

It also worked to reach particular groups which may be disadvantaged. For example, partners worked with Devon and Cornwall Police to help ensure that those without access to the internet got vital information about COVID-19 and how to get help. A special *Devon Together* newsletter providing this information was delivered to 300,000 homes, mostly in rural and isolated communities.

Community projects focussed on wellbeing have flourished under the STP. One Northern Devon, for example, has gone from strength to strength, with collaborative working across both the region and its individual towns helping improve lives within these communities. These Devon STP schemes are now up and running in different forms across the county. The new ICS will give added focus to this work.

Our strategy

The Trust's core corporate strategy remained the same as set three years ago – see below. However, as a result of the global pandemic and the direction set by NHSEI in response to COVID-19, the delivery of the Trust's strategy was paused during the majority of the financial year.

Nevertheless, the challenges faced by NHS providers remain:

- demand for services has and continues to grow every year. This is, in part, because of advances in healthcare which means that people are living longer often with multiple conditions.
- there remain entrenched health inequalities in England with people who are more affluent enjoying 19 more years in good health than those who are poorer. These inequalities in health outcomes are mirrored in Devon which is often perceived as a prosperous county. Despite recent increases in funding for the NHS, there remains a gap between rising demand and the resources available.

In many ways some of these challenges have or will be amplified by the pandemic. Waiting times will be a significant issue that the Trust will face. In addition, the direction set out in the Government health and social care White paper in January 2021, highlighted the significant extent to which inequalities were driving poorer health outcomes for some compared to others.

Our strategy seeks to provide a clear roadmap for the Trust so that it could continue to provide and deliver high quality, safe care to people who require hospital services amidst an ongoing challenging environment. However, the strategy did not account for the most serious and challenging threat that the NHS as a whole faced since its inception in 1948. Nevertheless, our strategic approach – with the emphasis on high quality services, supporting our staff and their health and wellbeing, and moving towards a digital first approach has helped the Trust steer its way through the last year.

Despite the pause in delivering our strategy, the Trust made good progress on key elements including the roll out of the MY CARE programme in the summer of 2020. This is covered elsewhere in this report.

Similarly, good progress has been made in working with other NHS providers and primary care to enable greater collaboration between clinical teams to support operational delivery across all sites in Devon through service delivery networks. This has been accelerated through the joined up response across the system to the pandemic both in managing COVID cases but also through the collaborative approach to setting up the Nightingale hospital in Exeter. In March a memorandum of understanding was agreed with South Devon Healthcare Trust to form a Strategic Alliance which will see us collaborating more closely to secure sustainable, high-quality patient care for our populations into the future.

This aligns to the recent Government white paper which heralds a new, collaborative approach to delivering healthcare amongst providers.

Instead of working independently this approach will enable us to find new ways to connect, communicate and collaborate so that the health and care needs of local people are met.

TSDFT, RD&E and NDHT have been working together informally for some time as part of the SEND (Southern, Eastern, Northern Devon) acute network. We have strengthened our collaboration over the past 12 months as we have responded to the COVID-19 pandemic and worked to recover elective care.

We want to take the opportunity to build on this experience and make sure we are joined up in our thinking as we respond to some of the significant programmes of work underway, including joined up digital strategies, the development of the Integrated Care System across Devon which will bring health and care providers together, and how the investment in infrastructure at both TSDFT and NDHT as part of the Government's Health Infrastructure Plan would best be used.

The Strategic Alliance will see us collaborating on all strategic and transformation opportunities and all opportunities for incoming investment. We will be considering our resources, workforces, and challenges together and making decisions in the best interests of the whole population. The initial focus will be on the delivery of high quality, sustainable acute care for our populations.

The Collaborative Agreement and now the proposed merger with NDHT is part of the same process of strengthening and sustaining clinical services for the future.

Our existing strategy

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."

Our values of fairness, honesty, openness & integrity, respect & dignity, and inclusion and collaboration have remained constant. The Trust is 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 co-ordination and make services easier to navigate
- help connect and support people, services, community initiatives and voluntary group 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 requires 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 needs to take into account that the causes of good and poor 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. In addition, tackling the issues we face as an institution can only really be tackled by working together as a system and the STP and emerging Integrated Care Systems (ICS) are key to helping the NHS in Devon collectively define a new of delivering integrated health and care to the population of the county.

Key issues and risks

Operational

2020/21 was a year unlike any other for NHS Trusts, including the RD&E, as it sought to respond to the challenges of the COVID-19 pandemic. The financial year commenced with the NHS at Level 4 – the highest Incident level - whereby the response to the then newly emergent COVID-19 pandemic was coordinated nationally. At this time, Trusts were required to plan for the postponement of all non-urgent elective operations for a period of at least three months from 15 April 2020 as the NHS was directed to free up the maximum amount of possible inpatient and critical care capacity. This pattern of needing to flex and balance COVID and non-COVID service delivery through successive waves of increased COVID prevalence and patient hospitalisations was to become a recurrent feature of the financial year. Co-ordination of the Trust's response to the pandemic has taken place through its Incident Management Framework, including Strategic Command, which has itself been in place throughout the entirety of 2020/21.

As summarised by the outline of performance against the key performance indicators in the table below, 2020/21 has been a year of considerable performance challenge. In keeping with other NHS providers nationwide it has been necessary that available NHS capacity has been prioritised for delivery of emergency care, including to those with COVID-19. Due to the need for social distancing and strict infection prevention and control requirements to remain in place, there has been a continued reduction in capacity regardless of the number of COVID-19 patients, with waiting times for both diagnostics and for treatment including elective surgery increasing considerably during the course of the pandemic.

Indicator	Measure	Standard / target	2019/20	2020/21
18-weeks RTT	% admission – incomplete pathways	92%	73.1% (March 2020)	52.2% (March 2021)
	Total number of open pathways	30,251 (2018/19) 34,293 (2019/20)	33,279	54,047 (March 2021)
Cancer Access	Urgent referrals seen within 2 weeks – all cases	93%	77.2% (span of year)	73.9% (span of year to March 2021)
	Breast cancer symptomatic referrals seen within 2 weeks	93%	61.7% (span of year)	25.2% (span of year to March 2021)
	Cancer treatment started within one month of diagnosis	96%	94.2% (span of year)	96.1% (span of year to March 2021)
	Cancer treatments started within 2 months of urgent GP referral	85%	71.3% (span of year)	73.0% (span of year to March 2021)
Waiting Times	A&E maximum waiting times of 4 hours (Eastern Devon)	95%	86.5% (March 2020)	81.1% (March 2021)

In relation to delivery of the 4-hour A&E target, the impact of Coronavirus in 2020/21 was initially positive with focussed system working and reductions in demand facilitating significant improvements in patient flow through the hospital. As emergency demand has increased during the second half of the financial year, performance has more latterly been impeded by workforce shortfalls across the Trust's medical and nursing establishments, and a number of impacts arising from COVID requirements. A task force incorporating senior representation from across the Trust and from system partners is being established, to identify and progress actions to overcome barriers to increased performance as the Trust heads into the new financial year.

In 2020/21 elective referral volumes have fluctuated considerably, particularly when compared to 2019/20 – the emergent trend has been significantly reduced levels of referrals occurring at times of national lockdown, particularly during Spring 2020, prior to returning towards more typical volumes of referrals when national lockdown restrictions have been able to be eased. This volatility in demand, combined with the reductions in available physical capacity as a result of requirements for social distancing and

enhanced infection prevention and control provision, have required a nimble organisational and workforce response, particularly in relation to urgently referred patients.

The availability of capacity within the independent sector procured nationally as part of the COVID-19 response has played a significant role in mitigating against the risk of reduced physical capacity by enabling key, urgently required, services for non COVID patients including those requiring surgery for cancer to continue to be delivered in a safe non-COVID environment. Where it has not been possible to undertake surgery, due to the non-availability of specialist equipment in alternative theatre environments, or where it has not been clinically appropriate to undertake the surgery during the COVID-19 pandemic, alternative non- or more minimally invasive treatments have been identified.

The additional capacity made available within the independent sector however has not been sufficient to compensate for the lost capacity due to social distancing and infection prevention and control requirements. As a result, performance more broadly in respect of routine elective waiting times targets has been challenging throughout 2020/21.

Following the national direction to develop plans to resume non-urgent elective care, the Trust has established a clinically led group led by the Trust's Deputy Medical Director, and which reports to the Strategic Command, to assess the requirements of and available capacity for non-COVID related elective service provision. This group has successfully coordinated a programme where the priority order for the resumption of elective activity has been established. Since elective services first started to resume in Summer 2020 it has overseen the recommencement of elective activity across all specialities within the Trust, albeit at lower levels than prior to the pandemic, whilst ensuring there is sufficient capacity to treat patients with COVID-19 on an ongoing basis. In addition, it has overseen a programme where all patients on the elective waiting list are clinically reviewed to ensure that any change in their symptoms are understood to determine each individual patient's prioritisation status for surgery.

Additional inpatient capacity has been created, when needed, through the standing up of the NHS Nightingale Hospital Exeter, which whilst a system asset has been hosted by the RD&E. When not required for COVID-19 inpatient care, the facility entered standby mode and supported the system by providing increased diagnostic provision (echocardiography, CT and ultrasound). Following its permanent acquisition as a system asset in March 2021, it is anticipated that this valuable additional capacity might continue to bring system benefit for elective recovery, with scoping work being undertaken for the provision of endoscopy and MRI from this location.

The impact of the COVID-19 pandemic has brought significant opportunity for change in the way that the Trust's estate is used for clinical service delivery, with a number of key initiatives undertaken to enable the continued provision of outpatient services at maximum levels during the pandemic. These initiatives have included:

- the relocation of a number of outpatient services to Ottery St Mary and Whipton community hospitals
- the co-location of medical and surgical outpatients on the Trust's Wonford site (which has in turn also supported the Trust's redevelopment of its Emergency Department)
- a step change in the format of delivery of outpatient consultation, with significantly increased provision of virtual outpatient consultations

As summarised by the outline of performance against the key performance indicators in the table above, as the Trust enters the new 2021/22 financial year a significant and likely multi-year programme of recovery of elective service delivery awaits. The challenge of the Coronavirus pandemic experienced in 2020/21 is reflected in the depth of the challenge in elective recovery which now needs to be addressed, alongside responding to any future periods of increased hospitalisations associated with the ongoing Coronavirus pandemic.

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. A key tenet of the Trust's Performance Framework is Monthly PAF meetings, chaired by the Deputy Chief Operating Officer, with support from the Director of Nursing, Director of Operational Finance, and Deputy Director of People, which take place with each of the four Clinical Divisions. At the meetings, divisional and speciality 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. The actions identified by the Divisions are tested and challenged in the meetings. During 2020/21, as a result of the COVID-19 pandemic, it has been necessary that the routine schedule of PAF meetings has needed to be interrupted, with management of the Trust's emergency response to the COVID pandemic coordinated through Strategic Command, which at the height of first wave of the pandemic in Spring 2020, met twice daily. Accordingly, the PAF meetings in 2020/21, when held, have taken a particular focus upon the actions being taken, and further support required, to enable the restoration of elective care service delivery.

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 to Board includes a wide range of national and local performance indicators grouped under the following themes:

- quality and 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 indications 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. During 2020/21, a suite of additional indicators relating to the delivery of services in response to the COVID pandemic have been incorporated into the Integrated Performance Report, grouped under the six themes outlined above.

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 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 trust wide performance could mask individual areas of concern.

Quality

Continued financial constraints and the delivery of Cost Improvement programme (CIP) have the potential risk of impacting on the quality of the service. The risk mitigation centres on the robust quality assurance framework which is in place. Assurance is provided through mechanisms including the Integrated Performance Report, the Performance Assurance Framework and Internal Audit Reports. Together, these approaches incorporate 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 recorded a deficit of £16.1m for 2020/21 within its Financial Accounts. However, the Trust's financial accounts demonstrate a break-even position after excluding impairment charges and donated income as these transactions are excepted by NHSEI when assessing the Trust's underlying operational financial performance.

The continued presence of COVID-19 undoubtedly creates the key issue and risk facing the Trust in 2021/22, not just from a clinical and operational viewpoint but also from a financial perspective.

The financial position in 2020/21 was supported by additional funding for COVID-19 enabling the Trust to break-even. Guidance released for 1 April 2021-30 September 2021 suggests continued additional financial support which should allow organisations to again break-even, and the Trust Board have signed off a financial plan for H1 on that basis. There is however significant uncertainty relating to 1 October 2021-31 March 2022 for which the guidance and funding envelopes are not expected to be released until the summer.

The expectation is that from the second 6 months of the financial year, additional "top-up" income received from Commissioners relating to COVID-19 will cease, which will highlight the Trust's underlying deficit which forms part of the wider Devon STP system deficit. However, it is not yet clear if this return to a pre-COVID funding regime will be

enacted and therefore this underlying deficit may be mitigated in part. It is possible that the majority of income will continue to be received on a block basis for 2021/22 rather than being based on actual patient activity under a Payment by Results (PbR) basis This is particularly relevant given the expected social-distancing measures that are likely to remain in place for some time. There has also been national consultation on moving to a more cost-based payment mechanism on a longer-term basis.

During 2020/21, nationally, the cost improvement programmes were put on hold due to COVID-19 which is part of the reason for the increase in underlying deficit from previous years. For 2021/22, the Trust's CIP programme will be determined by both the impact of national (NHSEI) and local Devon STP assumptions. The focus will be on recovery of services and therefore the productivity agenda will play heavily into the Trust's CIP programme.

The plan agreed with the Trust and NHSE/I for 2021/22 relating to both halves of the financial year will form part of a 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 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 over recent years has been a key concern for the Trust, albeit in 2020/21 the Trust was grateful to receive additional funding to increase the capacity of the Accident & Emergency Department. For 2021/22 as in 2020/21 the Devon STP will be allocated a capital envelope which all organisations must operate within. Given the significant level of capital requirement such as backlog maintenance that exists within some organisations within the STP, and the committed level of funding required in 2021/22 which has been agreed previously, there is limited funding available to increase capacity within the Trust for recovery from COVID other than through the Nightingale Accelerator funding or potentially through national funding projects such as Community Hubs.

Equality of service delivery

The RD&E aims to provide safe, high-quality services, delivered with courtesy and respect to all.

The RD&E is committed to working to become a national exemplar for diversity and inclusion. We aim to create a positive sense of belonging for everyone, regardless of their background or identity, to value visible and invisible differences and to create a sense of belonging.

For us, inclusion is about positively striving to meet the needs of different people and creating environments where everyone feels respected and able to achieve their full potential. However, we know that there is a lot to learn and do, and we are committed to doing so because it's the right thing to do for both staff and the people we care for. No person (staff, patient or public) will receive less favourable treatment on the grounds of the nine protected characteristics as governed by the Equality Act 2010 regardless of race, age, disability, ethnicity, nationality, gender, gender reassignment, sexual orientation, religion or belief, marriage and civil partnerships.

Inclusion is central to our mission

The RD&E corporate strategy sets out a vision to 'deliver safe, high quality, seamless services delivered with courtesy and respect'. The strategy emphasises that the Trust is a values-driven organisation and inclusion is central to achieving its mission.

Our Board of Directors has increasingly understood that inclusion is fundamental to the approach the organisation takes to organisational development, culture change, service improvement, and public and patient engagement. Moreover, while the focus on protected characteristics in this field must remain central to our work, there is a keen sense that there are other barriers that reduce equality of access or which lead to discrimination and our work must reflect this broader understanding.

We aim to:

- Improve everyone's – patients, carers, staff – experience of the RD&E in line with our values and inclusion ambition
- Ensure our services are delivered in a way that is demonstrably inclusive and that enables equality of access for all
- Create an environment where our staff have an ongoing sense of belonging and everyone is able to flourish and progress equally.

The Trust has appointed an Inclusion Lead – to provide strategic oversight of the inclusion agenda.

We have refreshed our approach to inclusion to ensure that it:

- Fully reflects the central importance of inclusion to our corporate strategy;
- Builds on the steer provided by the Board – who are vital to setting the tone and leadership on inclusion – drawing upon the experience and insight of our staff and the communities we serve – i.e. developed in a way that is inclusive;
- Takes into account the need to build a social movement for change within the organisation - focussing on attitudinal shifts and changing ways of working, to fully embrace diversity and inclusion.
- The Trust aims to ensure that all of its healthcare services are accessible and inclusive to everyone in line with our legal duties under the Equality Act 2010.
- Over the last two years we have initiated two projects to promote improved access for specific patients' groups that have expressed the view that they face barriers in accessing heath care services. We have held workshops with people who are deaf or who are hard of hearing to better understand and respond to the issues they have raised with us. As a result of this work, we have put in place improved access to BSL interpreters, to mobile hearing loops and we have started to develop improved staff awareness of deaf and hearing loss issues.
- We have and continue to work with a group of people with learning disabilities to ensure that we enable improved access to healthcare services. This has resulted in improved understanding about the issues faced by the learning disabled community and the introduction of improved communication materials.
- We take a zero tolerance approach to instances of racism. We expect all staff to challenge any breach of these rights and to report them through procedures such as grievance, disciplinary, whistle blowing or incident reporting. We are also working hard to meet the requirements made on all NHS organisations of the accessibility information standard. In addition, we aim to make our website as easy to use and understand as possible. We want visitors with disabilities to have the same benefit from using our website as those who are able-bodied

Learning disability liaison

The Trust has a dedicated team of Learning Disability Liaison nurses. The team support people living with a learning disability, and those who care for them, to access our hospital services in a way that works for each individual. This includes supporting patients with a learning disability during their time in hospital and providing education, advice and support to our staff.

Access Support Card

The 'Access Support Card' is an initiative launched by the RD&E to assist patients and staff with improved communications. Any patient or carer with a communication difficulty or disability can have one. Patients simply show their bright yellow card to staff on arrival at the RD&E to indicate a need for extra support or assistance. Staff will then respond by putting in place the extra support necessary, as far as possible.

Support may include:

- enabling a patient to arrange future appointments before leaving the site
- providing information in a way that the patient can understand; for example using interpretation or translation services, Braille, audio, large print, or an easy to read format
- arranging appropriate support for the patient to access their appointment, for example a hospital volunteer to assist
- ensuring, with patient consent, that any 'special requirements' are flagged on a person's clinical notes, so that staff can best support them

The Access Support Card includes a patient's NHS number and an emergency contact number.

The cards help reassure patients that we are prepared and can offer the support they need. The card may also help to promote independence for patients who otherwise may need someone to accompany them.

ACCOUNTABILITY REPORT

Enhanced Quality Governance Reporting

Patient Care

The Trust as a public benefit corporation remains 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 the 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 population served by the Trust.

All Governors are involved with identifying yearly priorities with a quality perspective. The Governors and members contribute to the quality agenda in a variety of ways, although these have been somewhat reduced due to our pandemic response.

Performance Against key Healthcare Targets

The Trust has continued to work towards delivering the key national health care targets relating to quality throughout 2020/21.

The Trust monitors quality through a wide suite of metrics through its internally developed Ward to Board framework. The Home, Community, Hospital framework is fully embedded across all clinical Divisions within the Trust. This incorporates process and outcome metrics across a range of domains relating to quality of care including tissue viability, nutrition, infection control, and falls.

At mid-point in 2020/21 the Trust:

- Achieved a hand hygiene compliance rate of 95%
- Undertook risk assessments for the likelihood of
    - Developing pressure ulcers for 96.2% of patients
    - Falls for 90.1% of patients
    - Venous thromboembolism (VTE) for 90% of patients
    - Nutritional needs for 93.1% of patients

Monitoring Improvement in Quality

The Trust adopts a balanced scorecard approach to monitoring quality, presented through the Board's Integrated Performance Report (IPR). The Governance Committee has a comprehensive oversight of the quality and safety of care, including all inpatient, outpatient areas and community services.

The Trust's 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 is also presented to the Board of Directors where Divisions report by exception any ward / department/ service that flags on the framework.

The completion of CQAT visits were curtailed by the requirement to minimise footfall throughout the hospital to reduce the risk of COVID-19 spread. These have recommenced in March 2020.

In addition, the Trust uses the Performance Assurance Framework (PAF) to provide assurance that performance, including quality and safety indicators are effectively monitored and reported to support managers to achieve the required indicators.

Service Improvements

Maternity Services

As a Trust we have participated in the annual Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme since 2017/18. The scheme, developed in partnership with the national maternity safety champions, Dr Matthew Jolly and Professor Jacqueline Dunkley-Bent OBE, incentivises Trusts that meet ten safety actions designed to improve the delivery of best practice in maternity and neonatal services:

The team includes Jo Bassett, Deputy Head of Midwifery who has led the initiative for the past two years along with co-ordination from Alexis Webb, Cluster Manager for Obstetrics and Gynaecology. Project management support is provided by the Transformation Programme Team (TPT) who have played a key role in the past two years providing a consistent, robust approach to reviewing standards and timescales. The scheme would not be the success it is without named leads for each of the ten safety action standards. They, together with all the maternity and neonatal staff, are all key stakeholders in embedding the safety and quality initiatives in practice to ensure that safe effective care is delivered.

Since our full compliance in year two we have secured recurrent funding which has directly and positively impacted the delivery of best practice in maternity and neonatal services. This funding was directly related to safety action standard six 'Saving Babies' Lives Care Bundle' and included capital and workforce resource to enable the service to perform the additional ultrasound scans required to detect growth restriction in babies.

Ear Nose and Throat

During the initial response to the COVID-19 pandemic, the ENT team readjusted daily job plans to enable the redeployment of junior staff to other areas. With the suspension of routine operating this gave us more consultant time during normal working hours and allowed us to think about new ways of delivering safe emergency care during the pandemic. We developed a new daily rota and on call system providing a rapid access 'hot clinic' every day for acute referrals from primary care and our Emergency Department as well as follow up patients who required urgent assessment due to symptom deterioration. These clinics were consultant-delivered and enabled safe, timely urgent care within the constraints of the COVID-19 response. We also adapted our on-call regime to have a consultant on call overnight to allow consultant-delivered acute care during the initial critical first wave of the pandemic.

The restructuring of the daily service provision allowed us to reconsider other aspects of our service and with fresh eyes and increased flexibility of ideas. Several new ways of working were developed, both temporary and permanent. A temporary change to our referral triage management allowed us to telephone triage of all referrals to the department including 2WW to provide direct advice and guidance to our patients and to successfully direct patients to limited outpatient resources. We reduced the need for outpatient attendance for non-cancer referrals and were able to initiate treatment and investigation without initial face to face assessment to reduce hospital footfall. The roll out of MY CARE has allowed us to continue some of these positives indefinitely.

Patient Surveys

National inpatient survey 2019 (published in July 2020)

659 inpatients who had received their care at the Trust responded to the latest Care Quality Commission (CQC) national inpatient survey, a response rate of 56%.

Overall 89% of patients rated their experience as 7/10 or more whilst 99% said they had been treated with respect and dignity and had confidence and trust in the doctors.

Key Improvements in 2019

- Discharge: 85% of patients reported that staff discussed need for additional equipment or home adaption
- Discharge: 88% of patients reported that staff discussed need for further health or social care services
- Discharge: 70% of patients were told of danger signals to be aware of
- Discharge: 88% knew what would happen next with care after leaving hospital

Areas for Improvement

- Planned admission: 69% of patients felt they were admitted as soon as necessary
- Procedure: 95% of patients felt they had their questions beforehand answered
- Overall: 13% were asked to give their views on quality of care
- Hospital: 62% of patients were not bothered by noise at night from other patients
- Care: 93% of patients reported that staff helped control pain

National cancer patient experience survey 2019 (published in June 2020)

This annual survey looks at how cancer patients feel about the care provided by the NHS, with results published by NHS England.

Cancer patients receiving treatment at the Trust rated their treatment positively, with an average score of 8.9 out of 10.

In total, 1015 patients responded out of a total of 1411 patients, a response rate of 72%.

The Trust was rated above average in several areas, including:

The Trust rated above the national average on 27 questions, including:

- patients got understandable answers to questions all or most of the time 90%
- GP given enough information about patient's condition and treatment 97%

- patients felt they were treated with respect and dignity while in hospital – 92%
- patients were told who to contact if they were worried about their condition or treatment after leaving hospital – 98%
- patients felt that they had all the information needed about the operation before it took place – 98%

Other areas where the RDE scored highly included:

- patient felt that treatment options were completely explained – 85%
- patient given clear written information about what should or should not do after leaving hospital – 86%
- patient given the name of a CNS who would support them through their treatment – 94%
- received all the information needed about the test – 96%.

The patient comments overall were positive providing a narrative to care provided, however themes were noted for improvement / consideration, car-parking, food, administration processes, & waiting times.

Learning from patient feedback

The Trust uses patient feedback to make improvements to the service provided. The free text narrative is important as this allows us to make the small changes in a responsive manner to improve the experience of care for patients in real time.

You said Feedback was received from patients with regard to the long waiting times in the West of England Eye Unit outpatients – sometimes for 3 or more hours during the course of their appointment – due to having to wait for various visual tests to be carried out before seeing the consultant.	We did! The Matron reviewed the process for patients checking in and having visual tests. Patients are now greeted by a nurse after check in at reception; the nurse will then carry out all visual checks, scans and administer drops before the patient sits back down in the waiting room to await their consultation.
You said A patient with end stage cancer expressed a wish to get married but thought it was too late.	We did! The ward team worked together to arrange a Registrar to conduct the service. A clinical room within the ward was transformed into a suitable venue and a member of the ward team made a cake which was iced and decorated with flowers. Celebratory drinks were also arranged.
You said There was no designated waiting area / quiet room for women and families on the Labour Ward. If a family were bereaved or if they needed to wait prior to elective caesarean or whilst waiting when a woman was in theatre, there was no where they could sit.	We did! With a change in the triaging model of care, one of the designated admission rooms on the labour ward was underutilised. The labour ward administrator presented a proposal to The League of Friends requesting some funding. This was approved and the room was redecorated, soft furnishings and sofas were purchased. Infection control advised on the requirements so that the room can be returned to a more clinical space if required. A local artist also allowed her seascape prints to be used so all of the labour rooms are named after a Devon seaside location.
You said When a community nurse is required for a patient's at end of life care it can be problematic if the patient was previously unknown to community nursing services. This is because building a relationship and understanding their specific circumstances is important and takes time.	We did! Hospice and Community Nursing now work together to hold regular weekly meetings to ensure that pertinent information is shared between the teams to allow further collaborations and to adopt consistent approach for future patient care. This also allows our community nurses to form a relationship with the patient earlier in their journey.

Complaints Handling

The complaints and concerns performance for the period 1 April 2019 to 31 March 2020 shows an overall increase of 13% in the numbers received (1,363 complaints) when compared to the same period for 2018-2019 (1,204). The overall rate of complaints remains low at 0.14% of all attendees and admissions.

All complaints are required to be acknowledged within three working days in line with Trust policy and statutory legislation. During the year, 95% of complaints were acknowledged within this timeframe.

During the year 64% of complaints were responded to within the Trust target of 45 days. This is monitored by the organisation on a quarterly basis at the Patient Experience Committee (PEC) and the monthly divisional Performance Framework meetings. Delays in investigations are often due to complex issues, issues which span more than one division or third-party organisations involvement. It should be noted that, as a result of the pandemic, PEC was stood down throughout 2020.

All feedback from patients and their families is used to help us further improve our services. A detailed analysis on patient experience including complaints is presented on a quarterly basis to the PEC. The Committee ensures that learning from complaints and Demonstrating Difference examples are shared.

The top themes for complaints (not including concerns) received by the RD&E are in line with the national themes and are as detailed below:

Theme	No of Complaints	% of Total
Communication with Patient	235	40%
Appoint Delay (Waiting Time)	111	19%
Communication with relatives /carers	86	15%
Attitude of Nursing Staff	81	14%
Attitude of medical staff	78	13%

Stakeholder relations

Communicating with, involving, and including stakeholders are at the heart of our approach. Stakeholder engagement is about understanding and involving the different groups interested or impacted by our work and building relationships with them.

Effective engagement relies on our commitment to listen and communicate openly and honestly with stakeholders. NHS Services are of particular importance and interest to most people – whether provided in the community or in hospital. By working with our stakeholders, our goal is to achieve improved mutual understanding and trust. We want to listen to the ideas of local people and understand them better to help us make improvements to the way we provide services. We aim to create a culture of partnership with patients, staff and the community; for patients to be involved in their care, for ongoing listening and learning and for everyone to work together in the design and delivery of services for the continuous improvement of the healthcare services. Nevertheless, there is a need for a balance between providing clinically effective and safe service that are acceptable to stakeholders, and making the best use of scarce resources. The ladder of participation (below) sets out our approach to involve and engage stakeholders:

Devolving	Placing decision-making in the hands of the community and individuals. For Example, Personal Health Budgets or a community development approach.
Collaborating	Working in partnership with communities and patients in each aspect of the decision, including the development of alternatives, and the identification of the preferred solution.
Involving	Working directly with communities and patients to ensure that concerns and aspirations are consistently understood and considered. For example, partnership boards, reference groups, and service users participating in policy groups.
Consulting	Obtaining community and individual feedback on analysis, alternatives and / or decisions. For example, surveys, door knocking, citizens' panels and focus groups.
Informing	Providing communities and individuals with balanced and objective information to assist them in understanding problems, alternatives, opportunities, solutions. For example, websites, newsletters and press releases.

We have identified 10 key factors that will drive the approach we will take to effective stakeholder engagement over the coming three years.

1. Framed by stakeholder analysis, management and audience insights

Effective stakeholder engagement is about building sustainable relationships with people who are affected by what we do. It relies on our commitment to listen and communicate openly and honestly with stakeholders. NHS Services are of particular importance and interest to most people – whether provided in the community or in hospital. By working with our stakeholders, our goal is to achieve improved mutual understanding and trust. By sharing more about the work we do and how we do it, we hope that local people will feel that they know us better as an organisation. We want to listen to the ideas of local people, users, patients and communities (both spatial and communities of interest) and understand them better to help us make improvements to the way we provide services.

We will ensure that our work is guided by a high-quality stakeholder analysis using a range of techniques. The identification of our key stakeholders and their interests will drive an intentional programme of work designed to inform them or to shift their opinion or behaviours as appropriate. We will seek to manage these relationships in an intentional and coherent way.

We will use data (hard and soft) to improve our understanding of our stakeholders/audiences and use this intelligence to improve what we do. This insight into stakeholder views will be incorporated into our implementation planning.

2. Cohesive messaging that people can understand and relate to using multiple channels

We will ensure that we focus on developing compelling and understandable messaging that helps achieve the desired communication or engagement outcomes. These messages will be conveyed using the most appropriate communication and engagement channels (reaching out to many of our stakeholders requires multi-channel approaches and this will continue as an integral part of this strategy). We will harness our creativity to maximise the impact of our messaging. We will continue to explore and exploit the power of social media to convey our messages to our key audiences. We'll use established and innovative methods to ensure that we involve people in a way that suits them. Within this we will need to continue using existing tools to have a dialogue with people, whilst developing and testing new methods to involve and talk to people, especially across a developing range of digital platforms.

3. New and existing partnerships or coalitions working coherently to achieve common goals

Our corporate strategy is clear that the Trust wants to lead the change towards a new model of care. It is equally clear that this cannot be done in isolation but can only be achieved through the development of trust-based relationships with key partners in Devon and beyond. We will ensure that the organisation is equipped to develop strong partnership working and ensures that these relationships are coherently and effectively managed.

4. Changing mind-sets and behaviours

The ladder of participation – set out below – sets out the purpose of much of what the communications, inclusion and engagement (CIE) strategy involves. From informing stakeholders at one level right through to co-production of services, the purpose of CIE is to create a response from identified stakeholders. Communicating and engaging for a purpose suggests the need to consider how best to frame messages and information in a way that maximises the impact and encourages/ incentivises stakeholders to take a particular course of action. This "nudge" theory or the application of behavioural science will be intentionally incorporated as part of the CIE approach.

5. Develop a motivating and energising common cause illustrated by compelling human stories

There is considerable evidence that powerful and well told stories can have a significant impact on the intended audience. In creating strong narratives that create a compelling rationale for change, we will use a wide range of stories told creatively to achieve our CIE goals. We will use social marketing/ content marketing and (appropriate) disruptive messaging to tell the stories we need to tell to create the conditions for change. In a period of profound and unsettling change, it is important to win hearts and minds and the trust of our stakeholders as we navigate through change. The Trust has a positive reputation among its different stakeholders (see section 2) and it is therefore important that this level of trust and confidence in our brand is built on and enhanced over the coming years.

6. Engage diverse communities in co-production, mobilisation and the creation of a social movement for change

The changes in the way that care is delivered and the focus on wellbeing can only be delivered with strong and resilient communities that build on their own strengths and assets. This shift away from reliance on tackling ill health rather than keeping people well and supported will require significant efforts to build a social movement for change. We will seek to work with and alongside communities supporting them to use their "sustainable energies" to create strong, resilient places that promote good health and living well, acknowledging the impact of wider issues concerning environment, housing, economic opportunities and mental health. We will help ignite and foster community-driven development to:

- empower and enable strong, resilient communities that support people to live well in their local place
- help break down barriers to help create the right conditions for communities to take the leading role in their own wellbeing
- encourage and support communities to build on community strengths, citizen action and empowerment

In order to develop genuine and on-going engagement and dialogue with people and communities, we need to rethink our methodology and put in place a new approach that takes on board and involves people in a way that goes beyond what the Trust has done before. We have already begun this journey with community conversations and we now need to build on this approach. This strategy sets out a renewed approach to public engagement in the context of being a Foundation Trust which, given its standing as public benefit organisation, implies that we use some of our existing links – through Governors and members - into the community to deliver this aspiration

7. Inclusion, equality and diversity

We will undertake a programme of work internally and externally designed in a way that means the Trust ensures that our services are delivered in a way that means that all individuals are treated fairly and with respect and where everyone has equal access to our services. We will ensure that our people are treated fairly and with respect at all times, we create an ongoing sense of belonging, and everyone is able to flourish and progress. Health and care affects everyone, so our communication and engagement needs to embrace a diverse range of people. We will include all groups in the community and ensure our communication and engagement activity is accessible to everyone. This includes being mindful of the nine protected characteristics as well as other groups whom we often overlook (for example working age people).

8. Bring our strongly held values to life

In everything we do, we will be driven by our values and the golden thread (teamwork; constantly striving for better; compassion and kindness) that makes the RD&E a special place. We will ensure that we uphold and positively promote our values and position the organisation as vales driven in all we do. We will ensure that our approach is based on the principles of inclusion, human rights and on upholding the NHS Constitution. We will ensure that our people, our patients and our communities are treated fairly and with respect and that everyone has equal access to the services we provide. We will seek to advise colleagues on the basis of our values as well as our professional expertise on communications, inclusion and engagement.

9. Legal framework

The NHS Act 2006 (as amended by the Health and Social Care Act 2012) places legal duties on the NHS to make arrangements to involve patients and the public in the development and consideration of proposals for service change. The NHS is accountable to the public, communities and patients that it serves; and has a duty to involve people in decisions about their care and in any plans to change how that care is delivered. The Health and Social Care Act 2012 says the NHS has a duty to involve people in decisions about their health care and to consult and involve people when planning or changing commissioned health services – failing to engage with stakeholder's means falling short of that standard.

Communications and engagement must follow robust processes, which are in line with NHSE guidelines, national legislation, the Four Tests of Service Change and the Gunning principles. It is essential that we meet the requirements of the law governing public engagement. Failing to do so will undermine the credibility of the project, will lead to delays and may involve additional costs if the process we have followed can be legally challenged. In addition, the team helps manage the work of our Governors and oversee the Trust's membership – all important aspects of the legal framework for Foundation Trusts. Finally, the Trust has a responsibility to deliver mandatory projects as set for FTs such as the writing and production of the Annual Report, Staff Friends and Family test and the Annual Staff Survey.

10. Capacity building

Effective engagement, inclusion and communications is a responsibility of all staff at the RD&E. Managers and leaders have a particular need to ensure that they are upholding high standards whether they are communicating with patients or each other.

As outlined earlier, staff rely on messages being cascaded down to them and this is something that all managers need to ensure happens effectively. To ensure this happens, we need to do more to engage and build the capacities of our workforce to ensure they recognise the value of effective engagement, they understand the need to engage and empower staff, and they always uphold the principles of our Towards Inclusion agenda.

Institutional stakeholders

We have tracked the views of institutional stakeholders over the last few years. The latest survey was undertaken in October – December 2018 (and finalised in the Spring of 2019) shows that the stakeholder community has a high level of regard for the RD&E. In particular, stakeholders felt that the RD&E has a good reputation as an acute hospital, with nearly two thirds (64%) agreeing with this statement. However, despite a broad level of agreement, the proportion of stakeholders indicating that they have confidence in the RD&E has decreased by 9 percentage points to 52% in 2018. More than half of respondents (54%) in 2018 agreed that the RD&E is trustworthy (compared to 57% in 2015).

Notably, a higher proportion of stakeholders in 2018 (68%) would be likely to speak positively about the RD&E, compared to 64% in 2015. More than half of survey respondents (54%) in 2018 also indicated that they had a very favourable or favourable overall opinion of the RD&E, compared to a slightly higher 58% in 2015.

Although stakeholders generally held a high level of regard for the RD&E, the findings suggests that respondents would value a higher level of joined-up working from the RD&E, as well as greater knowledge on how the RD&E can work with external organisations in the future. The gap between the perceived importance of knowing how the RD&E can work with their organisation to achieve common goals (60%) and the levels of existing knowledge about this (just 8%) was large.

It is encouraging that the RD&E is held in high regard amongst the stakeholder community. However, findings also suggested that with changes and pressures on the RD&E, such as taking over management of community hospitals across Exeter, and East and Mid Devon, as well as the Northern Devon Healthcare Trust, stakeholders feel they need to be more integrated with the RD&E and work more closely to achieve common goals. A new survey was due in 2020 but was pushed back as a result of the pandemic.

Disclosures

Statement as to disclosure to auditors

The Annual 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 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.

Remuneration 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 with Mr Stephen Kirby remaining 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 the Director of People and their senior team as required.

There has been one change to the membership of the RC during 2020-21, with Jane Ashman having left the Board of Directors on the 30 September 2020 at the end of her term of office. The 10 September 2020 RC was Jane Ashman's last meeting prior to her departure.

The Committee's main purpose is to set rates of remuneration and terms and conditions of service for the Chief Executive, Executive Directors and Very Senior Managers (VSMs), who are remunerated on 'spot' salaries outside of nationally agreed pay scales. This encompasses those persons in senior positions having authority or responsibility for directing or controlling the major activities of the Trust. Non-Executive Director and Chairman remuneration is dealt with by the Non-Executive Director Remuneration Committee (NEDRC, see page 123).

In-year remuneration decisions

One of the key achievements for 2020/2021 is the successful delivery of the MY CARE Programme (see page 18). The RC has provided appropriate challenge to proposals made by the Senior Leadership Team in relation to the MY CARE programme including reviewing of 'flight risk' of key individuals. As a result, the RC reviewed the contract terms of a number of staff, pivotal to the successful delivery of this programme. In addition, the RC has also reviewed and agreed to the remuneration of three of the VSMs within the MY CARE Senior Programme Leadership Team based on the achievement of key objectives.

In 2014 new tax rules were introduced to limit the amount of tax relief that employees can obtain on their pension contributions, impacting senior NHS staff who have faced significant tax bills as a result of either a pay rise, or because they earn over a certain threshold. The RC agreed an alternative interim pension scheme for employees who opted out of NHS pension scheme before 1 August 2019 due to tax issues, provided they were in a position to opt back in and met the previously agreed eligibility criteria.

The Chancellor announced at his 11th March 2020 budget a further change to the Pension tax regime to take effect from tax year beginning 6th April 2020. This was designed to reduce the number of people affected by the tapering of the annual allowance. The annual allowance being the amount of pension growth allowable in any one year before being subject to tax. This new rule extended the income threshold from £110,000 to £200,000, meaning that an employee would only be assessed under the taper rules if annual earnings were less than £200,000. In the event that an employee had earnings over £200,000, the annual allowance would taper if the 'adjusted income' was over £240,000. Adjusted income being the annual earnings plus the annual £40,000 allowable for pension growth. In effect, this threshold increase has taken the vast majority of trust employees outside the scope of the annual allowance pension tax charge. Further to this announcement the interim pension scheme ceased on the 30th September 2020.

The RC received the objectives and performance summary of the Chief Executive from the Chairman of the Trust in addition to that of the Executive Directors, reported by the Chief Executive. The RC also reviewed the remuneration for the Trust's Chief Executive & Executive Directors taking into account the expanded remit across two Trusts using a robust benchmarking process.

The RC has also reviewed and agreed to a number of structure changes in the senior leadership team, including the forming of a Joint Executive team across the RD&E and NDHT to support our ongoing work towards becoming a proposed integrated organisation. This included the agreement to appoint 3 non Board level, Joint Director posts to lead in Governance, Strategy and Programmes. In addition, the RC approved a robust Site Leadership Directors team at each Trust. These plans and associated costs were scrutinised and agreed under the principle that the new structure could cost no more than the existing structure.

The forming of the Joint Executive team has resulted in the cessation of additional payments in relation to NDHT responsibilities as this now forms part of the basic pay package for the Executive Directors.

In light of the duly awaited national VSM pay framework, a full benchmarking exercise for VSM

employees on spot salaries was not carried out by the RC; however, the Deputy Chief Operating Officer post at the RD&E was flagged as having been under remunerated, both in terms of the level of experience and also when compared to counterparts elsewhere; therefore, a decision was made to uplift this salary accordingly. In addition, the salary for the Director of Nursing position was agreed by the RC in order to recruit to this post.

All 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 using NHS Provider data, national median data provided by NHSE/I and individual performance data for Chief Executive and the Executive Directors. The RC gave due consideration to the Gender Pay differentials at Executive Director level and made a commitment to ensure that female employees who are currently below benchmark would be fairly remunerated in line with benchmarks in the future, subject to requisite experience and satisfactory performance.

This benchmarking review resulted in changes to salaries of two executives: The Chief Executive and Director of People. Additionally, two executives moved into roles with adjusted remits and salaries were set accordingly as a result of the changes to form a Joint Executive team. These were the Deputy Chief Executive Officer, a new post in the Trust and the Chief Finance Officer, who formerly worked in this capacity in NDHT.

In total five Executive Directors exceeded the £150k threshold, including one Executive who has exceeded the threshold for the first time. This was the Chief Finance Officer and the uplift was in recognition of the expanded remit across both Trusts. A positive opinion without comment was received from the Minister of State for Care on all of these uplifts and all Executive Director salaries remained below the national benchmarks provided by NHSE/I.

In addition, the national recommendations for cost of living uplifts were reviewed by the RC for the Chief Executive, Executive Directors and VSMs. The RC made a decision to apply the 1.03% uplift in line with national recommendations.

In accordance with HM Treasury guidance the Chief Executive contract includes a clause permitting 10% of salary to be reclaimed if performance is not considered to be satisfactory. In addition, new contracts were issued to the other Executive Directors in light of the new joint roles, to include this earn back clause as recommended by NHSE/I.

NAME	17 July 2020*	10 Sept 2020	13 Jan 2021*	13 Jan 2021
J Brent	P	P	P	P
J Ashman	P	P		
P Dillon	P	P	P	P
J Kay	P	P	P	P
S Kirby	P	P	P	P
H Khalil	P	P	P	A
A Matthews	P	P	P	P
C Bones	A	P	P	P

* (joint with NDHT)

RD&E NED Attendance at RC meetings in 2020/21

The planned RCs in April 2020 and July 2020 were stood down due to the COVID-19 pandemic; however an alternative extraordinary joint meeting with NDHT RC was held during July 2020 to discuss and agree the future Senior Nursing structure across both organisations.

The 13 January 2021 meeting was split into two parts with one part of the RC dedicated to RD&E business, the other part being joint with the NDHT RC to review shared items, including the review of the new joint Executive Director structure.

Senior Managers Remuneration Procedure

Remuneration Principles

The Remuneration principles remain unchanged and are listed as follows:

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 Executive Directors on an annual basis and Very Senior Managers bi-annually in comparator Foundation Trusts. This work will be undertaken on behalf of the RC by the Associate Director of People and other members of the senior HR team. 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 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, 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

The RC completed the review of the Benchmarking Methodology at the January 2021 Committee in order to reflect changes in benchmarking information at a national level and to improve the accuracy of recommendations. Further information about the new benchmarking approach can been seen below:

Data Sources

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. Information from the most recent NHS Providers Remuneration Survey was provided, utilising data returned by 143 Trusts, equating to 64% of all Trusts. This data is sorted by Trust size based on FTE and Trusts are divided into small, medium or large Trusts. The RD&E and combined RD&E / NDHT Trusts both fall within the 'large' group. The median is used to provide a source of benchmark data for comparison purposes.

The NHS Provider data allows filtering by geographic region; so, when looking at national data, this information was filtered to exclude London to provide the most accurate recommendations and avoid over-inflation.

Categorisation	FTE
Small Acute NHS Trusts and FTs	<3000
Medium Acute NHS Trusts and FTs	3000-5999
Large Acute NHS Trusts and FTs	>6000

The second set of data that used is provided by NHSE/I. The NHSE/I benchmarking data for 19/20 included a new size category for 'supra large' Trusts, so data is now split by small, medium, large, extra-large and supra large Trusts, which are further split by lower quartile, median and upper quartile. The thresholds of these categories can be seen below.

The RD&E alone falls into the 'extra-large' category, with the combined RD&E and NDHT Trusts falling within the 'supra large' category.

Categorisation	Turnover
Small Acute NHS and Foundation Trusts	£0-£200m
Medium Acute NHS and FTs	£200-400m
Large Acute NHS and FTs	£400-500m
Extra Large Acute NHS and FTs	£500-£750m
Supra Large Acute NHS and FTs	£750m+

Benchmarking Approach

The following process was agreed by the RC to identify the most appropriate benchmarks for each scenario to provide the most fair and accurate recommendations:

Role Scope	NHSI Comparator	NHS Provider Comparator	Other factors
Joint Executive Board (Including Director of Governance)	Supra Large Acute NHS and FTs median	Large Acute Foundation Trusts National Peer Average	
Joint Directors (e.g. Joint Director of Strategy)	Supra Large Acute NHS and FTs median	Large Acute Foundation Trusts National Peer Average	-15% to reflect the post is not board level
Site Director RD&E (e.g. RD&E Director of Nursing)	Extra Large Acute NHS and FTs lower quartile	Large Acute Foundation Trusts National Peer Average	-20% to reflect the post is not board level

Once the most appropriate benchmarks are identified, the mean average of the two sources of data are taken to provide the final benchmark. This is then assessed against the post holders' remuneration, taking into account the levels of experience and performance.

The RC are also provided with 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 and VSM positions.

Where for some positions, there is not a clear comparator role, NHSE/I and NHS Providers will be contacted directly to understand if there are any national benchmarks outside of the published information. Where this is not the case, comparator Trusts will be contacted to understand remuneration of similar roles. Any national changes to Agenda for Change will also be considered for these roles.

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

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)
2019/20		**£000**	**£**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
J Brent	Chairman	45-50	-	-	-	-	45-50	20-25	20-25
J Ashman	Non-Executive Director *(resigned 30 September 2020)*	5-10	-	-	-	-	5-10	-	5-10
C Bones	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
P Dillon	Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
J Kay	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
H Khalil	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
S.Kirby	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
A Matthews	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
P Adey	Chief Operating Officer *(resigned 31 March 2021)*	155-160	-	37.5-40	-	-	195-200	85-90	110-115
H Foster	Director of People	140-145	-	-	-	-	140-145	65-70	70-75
A Harris	Executive Medical Director	210-215	-	112.5-115	-	-	325-330	140-145	185-190
A Hibbard	Chief Financial Officer *(appointed 1 January 2021)*	35-40	-	67.5-70	-	-	105-110	50-55	55-60
C Mills	Chief Nursing Officer *(appointed 18 January 2021)*	30-35	-	7.5-10	-	-	35-40	15-20	15-20
D Thomas	Interim Chief Nurse *(resigned 18 January 2021)*	100-105	-	120-122.5	-	-	220-225	-	220-225
C Tidman	Deputy Chief Executive *(appointed 1 January 2021)*	165-170	-	90-92.5	-	-	255-260	35-40	220-225
S Tracey	Chief Executive	230-235	-	62.5-65	-	-	295-300	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.

There are no benefits in kind reported this year relating to the mileage allowance paid over and above the HM Revenue & Customs allowance for Executive Directors as this is now taxed at source.

The Payment Settlement Agreement with HMRC under which Non-Executive Directors official mileage was paid and the Trust made payments for Tax and NI based on grossed up figures ceased with effect from 31st March 2019, as per HMRC regulations. All Non-Executive mileage over HMRC threshold is now taxed at source.

The remuneration shown in the 'Recharges to Northern Devon Healthcare NHS Trust' column for J Brent, P Adey, H Foster, A Harris, Angela Hibbard, Carolyn Mills, C Tidman 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.

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)
2019/20		**£000**	**£**	**£000**	**£000**	**£000**	**£000**	**£000**	**£000**
J Brent	Chairman	45-50	-	-	-	-	45-50	20-25	20-25
J Ashman	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
C Bones	Non-Executive Director *(appointed 18 November 2019)*	0-5	-	-	-	-	0-5	-	0-5
P Dillon	Non-Executive Director	15-20	-	-	-	-	15-20	-	15-20
J Kay	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
H Khalil	Non-Executive Director *(appointed 18 November 2019)*	0-5	-	-	-	-	0-5	-	0-5
S.Kirby	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
S Knowles	Non-Executive Director *(resigned 27 November 2019)*	5-10	-	-	-	-	5-10	-	5-10
A Matthews	Non-Executive Director	10-15	-	-	-	-	10-15	-	10-15
P Adey	Chief Operating Officer	150-155	-	105.0-107.5	-	-	260-265	130-135	130-135
J Cooper	Executive Director People *(resigned 2 August 2019)*	75-80	-	-	-	-	75-80	35-40	35-40
H Foster	Director of People *(appointed 5 August 2019)*	90-95	-	-	-	-	90-95	45-50	45-50
A Harris	Executive Medical Director / Deputy Chief Executive	205-210	-	0.0-2.5	-	-	205-210	100-105	100-105
D Thomas	Interim Chief Nurse *(appointed 30 September 2019)*	60-65	-	152.5-155.0	-	-	215-220	-	215-220
C Tidman	Chief Financial Officer / Deputy Chief Executive	155-160	-	-	-	-	155-160	-	155-160
S Tracey	Chief Executive	215-220	-	40.0-42.5	-	-	260-265	130-135	130-135
E Wilkinson-Brice	Deputy Chief Executive / Chief Nurse *(resigned 27 September 2019)*	70-75	-	-	-	-	70-75	-	70-75

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

There are no benefits in kind reported this year relating to the mileage allowance paid over and above the HM Revenue & Customs allowance for Executive Directors as this is now taxed at source.

The Payment Settlement Agreement with HMRC under which Non-Executive Directors official mileage was paid and the Trust made payments for Tax and NI based on grossed up figures ceased with effect from 31st March 2019, as per HMRC regulations. All Non-Executive mileage over HMRC threshold is now taxed at source.

The remuneration shown in the 'Recharges to Northern Devon Healthcare NHS Trust' column for J Brent, P Adey, H Foster, A Harris and S Tracey (and J Cooper up to date of resignation) 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.

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 2020-21 was £140-£145k (2019-20, £155k - £160k). This was 4.6 times (2019-20, 5.3 times) the median remuneration of the workforce, which was £30.8k (2019-20, £29.7k).

In 2020-21, 75 (2019-20, 36) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £145k to £244k (2019-20, £160k to £217k).

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, Deputy Chief Executive, Medical Director, Director of People and Chief Operating Officer are recovered from Northern Devon Healthcare Trust under the terms of the Management Contract and as a result Chris Tidman is the highest paid Director for the purposes of the calculation as a proportion of his salary was only shared for the period of his duration as Deputy Chief Executive (1st Jan 21). The three-year national pay deal is responsible for the change in median pay for employees.

	2020/21	2019/20
	£000	£000
Band of highest paid Director - as above	140-145	155 – 160
Median remuneration received by employees within the Trust	30.8	29.7
Ratio	4.6	5.3

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 x PE) + LSE) – (20 x 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.

Name and Title		Real increase in pension at age 60 (bands £2,500)	Real increase in pension related lump sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2020 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value at 31 March 2020
		£000	£000	£000	£000	£000	£000	£000
P Adey	Chief Operating Officer *(resigned 31 March 2021)*	2.5-5	0-2.5	65-70	155-160	1396	1298	51
H Foster	Director of People	-	-	-	-	-	-	-
A Harris	Executive Medical Director	5-7.5	17.5-20	75-80	225-230	1814	1597	159
A Hibbard	Chief Financial Officer *(appointed 1 January 2021)*	0-2.5	0-2.5	30-35	50-55	445	374	11
C Mills	Chief Nursing Officer *(appointed 18 January 2021)*	0-2.5	0-2.5	60-65	180-185	1360	1279	6
D Thomas	Interim Chief Nurse *(resigned 18 January 2021)*	2.5-5	7.5-10	40-45	100-105	764	638	77
C Tidman	Deputy Chief Executive *(appointed 1 January 2021, previously Chief Financial Officer)*	2.5-5	7.5-10	60-65	150-155	1140	1018	91
S Tracey	Chief Executive	2.5-5	2.5-5	50-55	100-105	1000	902	62

Supporting notes re table above;

Hannah Foster joined the pension scheme for part of the year, but then opted out and took a refund from NHS Pensions so no amounts are included in relation to pension for her.

Chris Tidman opted in to the pension scheme 01/04/20-30/06/20, opted out, and then back in 01/12/2020 - 31/03/2021.

Suzanne Tracey opted out of the pension scheme on 30/11/20.

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.

Cast 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.

Name and Title		Real increase in pension at age 60 (bands £2,500)	Real increase in pension related lump sum at age 60 (bands £2,500)	Total accrued pension at age 60 at 31 March 2020 (bands of £5,000)	Total accrued related lump sum at age 60 at 31 March 2020 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2020	Cash Equivalent Transfer Value at 31 March 2019	Real Increase in Cash Equivalent Transfer Value at 31 March 2020
		£000	£000	£000	£000	£000	£000	£000
P Adey	Chief Operating Officer	5-7.5	7.5-10	60-65	155-160	1298	1136	135
J Cooper	Executive Director People *(resigned 2 August 2019)*	-	-	-	-	-	-	-
H Foster	Director of People *(appointed 5 August 2019)*	-	-	-	-	-	-	-
A Harris	Executive Medical Director / Deputy Chief Executive	0-2.5	0-2.5	60-65	190-195	1494	1513	-
D Thomas	Interim Chief Nurse *(appointed 30 September 2019)*	0.00	0.00	0.00	0	638	488	138
C Tidman	Chief Financial Officer / Deputy Chief Executive	-	-	-	-	-	-	-
S Tracey	Chief Executive	2.5-5	0-2.5	45-50	95-100	902	821	61
E Wilkinson-Brice	Deputy Chief Executive / Chief Nurse *(resigned 27 September 2019)*	-	-	-	-	-	-	-

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.

NHS Pensions are using pension and lump sum data from their systems without any adjustment for a potential future legal remedy required as a result of the McCloud judgement. (This is a legal case concerning age discrimination over the manner in which UK public service pension schemes introduced a CARE benefit design in 2015 for all but the oldest members who retained a Final Salary design.). We believe this approach is appropriate given that there is still considerable uncertainty on how the affected benefits within the new NHS 2015 Scheme would be adjusted in future once legal proceedings are completed.

Future Remuneration 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
• Basic salary	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. 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	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. 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.	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.
• Benefits	N/A	N/A	N/A
• Pension	Provides a solid basis for recruitment and retention of top leaders in sector.	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	Contribution rates are set by the NHS Pension Scheme.
• Bonus	N/A	N/A	N/A
• Fees	N/A	N/A	N/A

Signed:

Suzanne Tracey
Chief Executive Officer

Date: 14 June 2021

Staff Report

The most important asset for health and social care is the people who deliver it. Yet the NHS faces significant challenges in having a workforce that has the right skills in the right places, that is not overloaded or stressed, and that is motivated and empowered. These challenges were further compounded in 2020/21 by the unprecedented effects of COVID-19.

Over the following pages the Trust will share some of the key initiatives it has introduced to support and enable our people to give of their best, delivering the high quality services our communities expect and deserve.

We would like to thank our staff, volunteers and Governors who contribute so much every day to making the RD&E a great organisation, always striving to do the right thing for our patients, people and communities.

Staff Numbers

Note 5.3 Average number of employees (WTE basis)	Expected sign	A09CY01 Total Accounts 2020/21 No.	A09CY01P Permanent Accounts 2020/21 No.	A09CY01O Other Accounts 2020/21 No.	A09PY01 Total Accounts 2020/21 No.	A09PY01P Permanent Accounts 2020/21 No.	A09PY01O Other Accounts No.	Maincode Subcode
Medical and dental	+	**921**	902	19	**860**	836	24	**STA0370**
Ambulance staff	+	**2**	2		**2**	2		**STA0380**
Administration and estates	+	**1,600**	1,481	119	**1,543**	1,433	110	**STA0390**
Healthcare assistants and other support staff	+	**2,755**	2,504	251	**2,597**	2,453	144	**STA0400**
Nursing, midwifery and health visiting staff	+	**2,107**	2,031	76	**2,023**	1,936	87	**STA0410**
Nursing, midwifery and health visiting learners	+	**16**	16		**17**	17		**STA0420**
Scientific, therapeutic and technical staff	+	**770**	752	18	**740**	719	21	**STA0430**
Healthcare science staff	+	**209**	209		**207**	207		**STA0440**
Social care staff	+	**0**			**0**			**STA0450**
Other	+	**15**	15		**0**			**STA0480**
Total average numbers	+	**8,395**	**7,912**	**483**	**7,989**	**7,603**	**386**	**STA0490**
Of which:								
Number of employees (WTE) engaged on capital projects	+	**146**	144	2	**140**	136	4	**STA0500**

Staff numbers continue to increase, by over 5% over the last year. Much of that growth is due to the Trust recruiting additional un-registered nursing & support staff. In a challenging environment for recruiting healthcare professionals, the Trust's workforce has seen a net increase of 84 nurses & 61 doctors compared with the same point a year ago.

Staff Costs

Staff costs for 2020/21 and 2019/20 are summarised in the table below.

Note 5.2 Employee Expenses (Group **after** consolidation of charity)	A09CY01 **Total 2020/21 £000**	A09CY01P **Permanent 2020/21 £000**	A09CY01O **Other 2020/21 £000**	A09PY01 **Total 2020/21 £000**	A09PY01P **Permanent 2020/21 £000**	A09PY01O **Other 2020/21 £000**
Salaries and wages	316,945	315,307	1,638	283,420	281,995	1,425
Social security costs	27,955	27,955	0	25,746	25,746	0
Apprenticeship levy	1,503	1,503	0	1,382	1,382	0
Pension cost - employer contributions to NHS pension scheme	37,308	37,308	0	34,396	34,396	0
Pension cost - employer contributions paid by NHSE on provider's behalf	16,337	16,337	0	15,046	15,046	0
Pension cost - other	225	225	0	173	173	0
Other post employment benefits	0	0	0	0	0	0
Other employment benefits	0	0	0	0	0	0
Termination benefits	148	148	0	105	105	0
Temporary staff - external bank	0	0	0	0	0	0
Temporary staff - agency/contract staff	8,152	0	8,152	10,592	0	10,592
NHS charitable funds staff	0	0	0	0	0	0
TOTAL GROSS STAFF COSTS	408,573	398,783	9,790	370,860	358,843	12,017
"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	**408,573**	**398,783**	**9,790**	**370,860**	**358,843**	**12,017**
Cost capitalised as part of assets	7,252	7,252	0	7,605	7,605	0
Total employee benefits excl. capitalised costs	401,321	391,531	9,790	363,255	351,238	12,017

Note 6.1 Reporting of other compensation schemes - exit packages 2020/21 Note that columns G, I and M are entered in £000. NHS Trusts - note that the GAM advises local accounts should be in £		A09CY17 Number of compulsory redundancies 2020 /21 No.	A09CY18 Cost of compulsory redundancies 2020 /21 £000	A09CY19 Number of other departures agreed 2020 /21 No.	A09CY20 Cost of other departures agreed 2020 /21 £000	A09CY21 Total number of exit packages 2020 /21 No.	A09CY22 Total cost of exit packages 2020 /21 £000	A09CY23 Number of departures where special payments have been made 2020 /21 No.	A09CY24 Cost of special payment element included in exit packages 2020 /21 £000	Maincode Subcode
Exit package cost band (including any special payment element)										
<£10,000	+			8	34	8	34			STA0560
£10,000 - £25,000	+			2	24	2	25			STA0570
£25,001 - £50,000	+	1	47	1	30	2	77			STA0580
£50,001 - £100,000	+					0	0			STA0590
£100,001 - £150,000	+	1	101			1	101			STA0600
£150,001 - £200,000	+					0	0			STA0610
>£200,000	+					0	0			STA0620
Total	**+**	**2**	**148**	**1**	**88**	**13**	**235**	**0**	**0**	STA0630
FTs refer to annex 1 to chapter 2 of the FT Annual Reporting Manual 2020/21. NHS Trusts refer to paragraph 3.57(h) and annex 3 to chapter 3 of the Group Accounting Manual 2020/21. Note that an 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 2019/20 Note that columns G, I and M are entered in £000. NHS Trusts - note that the GAM advises local accounts should be in £		A09CY17 **Number of compulsory redundancies 2019 /20** No.	A09CY18 **Cost of compulsory redundancies 2019 /20** £000	A09CY19 **Number of other departures agreed 2019/20** No.	A09CY20 **Cost of other departures agreed 2019 /20** £000	A09CY21 **Total number of exit packages 2019 /20** No.	A09CY22 **Total cost of exit packages 2019/20** £000	A09CY23 **Number of departures where special payments have been made 2019 /20** No.	A09CY24 **Cost of special payment element included in exit packages 2019 /20** £000	Maincode Subcode
Exit package cost band (including any special payment element)										
<£10,000	+			27	70	27	70			STA0560
£10,000 - £25,000	+			5	65	5	65			STA0570
£25,001 - £50,000	+			1	25	1	25			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	**+**	**0**	**0**	**33**	**160**	**33**	**160**	**0**	**0**	STA0630

Note 6.3 Exit packages: other (non-compulsory) departure payment			A09CY25 Payments agreed 2020/21	A09CY26 Total value of agreements 2020/21	A09PY25 Payments agreed 2020/21	A09PY26 Total value of agreements 2020/21	Maincode
		Expected sign	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		+	10	58	26	105	STA0750
Exit payments following employment tribunals or court orders		+	1	30	7	55	STA0760
Non-contractual payments requiring HMT approval (special severance payments)*	*i*	+					STA0770
Total**		+	**11**	**88**	**33**	**160**	STA0708
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.

Redundancy is based on one month's pay for each completed year of reckonable service (between 2 and 24 years).

PILON is based on the notice period held within the employees contract of employment and can range from 1 month to 3 months basic pay

A settlement agreement will be made following an Employment Tribunal in conjunction with Trust Solicitors advice on amount to be paid.

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 2021 is reported in the table below.

	Female	Male	Total
Directors	5	8	13
Employees*	7,161	2,057	9,218

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

In line with statutory reporting the Trust publicly reported its gender pay gap report in line with requirements. This is available via gender-pay-gap.service.gov.uk.

The data required to be reported by 31st March 2021 was a snapshot of our data from 31st March 2020. The data shows women occupy **68.07%** of the highest paid jobs and **80.11%** of the lowest paid jobs and women's median hourly wage is **11.26% lower** than men.

Much of the Trust's pay is aligned to national pay agreements and the gender pay gap is similar to other NHS hospital organisations where there is a higher proportion of men in senior medical roles and greater numbers of women roles at lower bands.

Actions are in place seek to reduce the gap in areas within the control of the trust.

Post-Brexit Update

The Trust has continued to monitor the impact of Brexit by regularly reviewing exit interviews and numbers. We have encouraged relevant staff to apply for the pre-settled status since the scheme was announced and has provided regular reassurance to our staff that they are both valued and an integral part of the RDE workforce. Help has been on hand to assist any EU worker to make a pre-settled application. Managers have been encouraged to discuss openly that these staff have secured roles within the Trust and are very much needed. In addition, the Trust has maintained a strong presence recruiting in Europe for both nurses and radiographers and has successfully employed some very professional and good quality individuals.

Sickness Absence

Data for The Trust's sickness absence is available from the NHS Digital website. It provides quarterly sickness absence rates by NHS England region and monthly sickness absence rates by NHS England Region, staff group, organisation type and organisation.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates

Trust Turnover

Data for The Trust's turnover is available from the NHS Digital website. It provides quarterly attrition rates by NHS England region and monthly attrition rates by NHS England Region, staff group, organisation type and organisation.

https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics/

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 this training will be expanded in the future.

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.

The Trust is an NHS Employers Diversity and Inclusion Partner and continues to enact the D&I agenda, including disability, at a National level.

Recruitment

The Trust's 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 asked to attend a selection process are invited to provide details on any reasonable adjustments that they require so that these can be implemented.

Once a conditional offer of employment has been made, all applicants for employment with the Trust complete an online Health Questionnaire as part of the conditional offer process that is reviewed by the Occupational Health Service (OHS). If issues are identified, the individual will be invited to attend the OHS where an assessment is completed and recommendations are made to the recruiting Line Manager so that whenever possible the person may be employed safely and with the necessary adjustments in place to enable them to carry out the role.

Experts from both the Occupational Health Service and Human Resources are available to provide advice on reasonable adjustments and guidance to managers during and after the recruitment process.

During the probationary period of a new employee to the Trust, the line manager will ensure that reasonable adjustments are provided as appropriate at the commencement of employment. During each of the subsequent review meetings line managers will consider the adjustments required to support the employee's disability throughout the process. If line managers require further guidance on the Equality Act and Disabilities, they can contact the Specialist HR Services Team.

The Specialist HR Services Team provides a wealth of guidance and signposting to managers and employees including reference to the 'Managing My Health At Work' booklet which is a practical guide for staff experiencing stress, anxiety or depression.

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 discussions with Line Managers and 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 a 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.

Members of the Specialist HR Services Team have undertaken a Level 2 Certificate in Understanding Specific Learning Difficulties and the Trust has access to an Online Assessment Tool which identifies whether dyslexia is indicated and provides a range of recommendations and further references to be discussed with the Line Manager supported by HR.

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.

The Trust also has a number of 'Freedom to Speak up Guardians' in post across grades and divisions. The FTSUG 's work with senior management in the organisation to help develop a culture in which staff feel able to "speak up" if they feel that the Trust values are being compromised.

Support for employees' psychological wellbeing

The Trust has dedicated provision in place to support staff's health at work and wellbeing. This includes a comprehensive Occupational Health and Wellbeing team incorporating specialist nurse advisers, occupational physicians and an in-house Staff Support & Counselling Service for employees. This is further supported with a contracted Employee Assistance Programme, which is available for all staff and their dependants to access. The staff counselling team provides one to one counselling and relevant interventions such as trauma therapy within NICE Guidelines and the BACP Ethical Framework.

The Occupational Health and Wellbeing Team also deliver a wide range of courses, education and engagement events focused on prevention and early intervention of psychological ill health. All staff can access Stress Awareness Workshops, Mindfulness Courses and Sleep Coaching Courses.

The Trust continues to provide a dedicated one-day course in mental health training for managers which forms part of the managers' training offer, with over 100 managers completing this training to date. This is in addition to the standard 2-day course on offer to Trust employees.

In the past two years over 100 mental health champions have been recruited and trained in Mental Health First Aid, and are available to support staff in their departments.

The Trust has also invested in Trauma Response Incident Management (TRiM) training, in order to increase the support and response after an adverse incident and this has been applied in several areas of the Trust following our COVID-19 response.

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 Equality 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

Valuing & developing our people

The Trust has continued the roll-out of the Valuing YOU Appraisal Scheme which was first launched in 2019.

The scheme focuses on the importance of the value that our people bring every day in their roles and ensuring that the appraisal conversations had are relevant and meaningful to both the person and the organisation. There is considerable emphasis on the importance of having regular informal and formal "conversations".

The scheme takes a more agile approach and supports an ongoing conversation rather than just once a year. One to ones are done at least once a quarter to touch base and to ensure conversations are meaningful. The scheme focuses on health and well-being, agreeing objectives and discussing progress, talking about any learning and development and supporting individuals with their career aspirations. The scheme is no longer directly linked to our NHS pay scheme.

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 2020-21 financial year was £1,402,000 compared to £1,006,000 in 2019/20.

Trade Union Facility Time

The Trust is proud of its work with its Trades Unions, and works in collaboration with their representatives throughout the Trust. Our Partnership Forum is the formal group where our Staffside and management representatives formally engage and consult.

As part of the Trade Union (Facilities Time Publication Requirements) Regulations 2017, the Trust is required to report facility time, which is paid time-off during working hours for trade union representatives to carry out trade union duties.

The 2020 report provided to the Cabinet Office is reflective of the period 1 April 2019 to 31 March 2020.

(https://www.gov.uk/government/statistical-data-sets/public-sector-trade-union-facility-time-data)

Number of Trade Union Representatives

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
31	27.03

Percentage of time spent on facility time

Percentage of time	Number of Employees
0%	11
1-50%	17
51-99%	3
100%	0

Percentage of pay bill spent on facility time

	Figures
Total cost of facility time	£83,192.64
Trust's total pay bill	£283,420,000
Percentage of the total pay bill spent on facility time	0.03%

Staff Survey

The RD&E employs over 11,000 people all of whom perform a range of different functions, working together to achieve the best and safest outcomes for people who require acute and community care and working with communities and other stakeholders to keep people well and supported at home. While staff at the RD&E share a common purpose, there is a great deal of diversity in the roles and functions staff perform – it is the effective blending of all that enables the RD&E to have great teams working in the best interests of the people we are here to serve, our patients and the public.

For the RD&E staff engagement:

- helps to deliver continued improvements and programmes of change - 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.
- helps connect clinicians with the organisation as well as the professional agenda and take on leadership roles.
- can improve sickness absence.

The Trust has developed a multi-year programme focused on improving 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 consciously sought to build a culture in which staff engagement is viewed as mission-critical. Our approach to staff engagement focuses on:

- creating the conditions for optimum staff engagement
- assisting people to prepare for and actively participate in changes to care
- contributing to improved patient care now and in the future
- ensuring engagement efforts are as inclusive as possible

Staff engagement is more than informing staff through internal communications. Having staff that are informed and have access to the information they require to do their jobs is important. However, there are a range of factors including reward, values and behaviours, recognition and leadership as well as giving staff "voice" and influence over their work through greater empowerment.

Our methodology is one that encompasses the whole organisation and is based on the understanding that all staff have a level of responsibility to consider and act on 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 scale of change required to deliver health and care differently into the future, and we need to support them to do that. 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 are at the heart of these changes as we lead the way in helping to innovate and transform services, to ensure that our way of delivering care and services is fit for the future.

In the context of the changes required, there is a need to address 'old ways of working and traditional cultural norms in order to facilitate a new model of care. We have begun this process through cross learning between the acute and the community elements of our organisation.

Approach and key activities

As noted above, the Trust takes an integrated and holistic approach to improving staff engagement. Picker Institute (2019) established that:

> *"Across roles and organisations, the best predictors of job satisfaction were whether the employee felt that the organisation acts fairly in career progression, values their work, provides opportunities to use their skills, recognises good work and gave an appropriate amount of responsibility"*

After reviewing evidence from the evolving research base, we have refreshed our approach to staff engagement to create optimum conditions for job satisfaction, with focus on outcomes in the following areas, for staff to feel:

1. Valued: Nurture a culture of gratitude and appreciation and implement mechanisms for recognition and award, raising awareness/flagging issues that undermine this
2. Listened to: Promote two-way dialogue between staff and management and implement tools, activities and training to facilitate active listening and outcomes and amplify staff "voice"

3. Connected: Generate a welcoming and inclusive work environment in which staff feel a genuine sense of belonging, involving people in a meaningful set of values and behaviours and inspiring them with a clear and compelling strategic narrative
4. Employees are informed: Staff receive open, honest and timely information through a range of appropriate channels to enable them to go about their work fully engaged and motivated.
5. Empower employees to drive positive change: Cultivate an environment in which staff are trusted and supported to play an active role in continuous improvement and changes to care.
6. Employee wellbeing: Assist efforts to ensure colleagues feel supported and well in their work and personal life

As the above environment and culture is generated, the RD&E's reputation as a good employer is enhanced, consequently improving staff retention and better, safer care.

The following section highlights some of our core activities designed to boost staff engagement levels.

Values and behaviours

We will continue to embed our values with a focus on quality improvement and inclusion as well as emphasising our values continuously in our activities, including:

- induction and orientation day for new staff
- attraction and recruitment approach
- learning and development programmes
- a new PDR approach – our new Valuing You appraisal scheme launched in 2019 and is more closely aligned with our V&Bs
- our staff recognition and awards scheme; Extraordinary People

Our approach to staff engagement is increasingly aligned with the Trust's focus on building an inclusive culture where everyone is valued for the person they are. This integration between our inclusion and engagement agenda will continue into the future.

Staff engagement activities

The year was dominated by the global pandemic and this impacted in the work undertaken during the year. Nevertheless, we were able to continue with a number of initiatives as well as responding to support staff through this difficult period. These are some of the activities undertaken to enhance staff engagement over the last year:

- We conducted a local staff survey in May 2020, with focus on feedback on local communication, engagement, wellbeing and charity initiatives which included consultation around how to improve the working environment, using charity funds. This resulted in improvement across the Trust to staff gardens, two new staff lounges and improvements to staff rooms across our divisions.
- The Trust has continued to engage each division and larger department in developing and implementing bespoke, local engagement plans, based on responding to the evidence collated from the staff survey and other local/ anecdotal evidence. Local plans developed by Divisional Directors and Managers are made available for all colleagues to view and share best practice via our intranet. Our in-house tool, the Everyday Engagement Toolkit, guides managers through their engagement planning. This approach has helped drive improvements in staff engagement and other relevant indicators.
- The sharing of the Engagement plans and support from the communications and engagement team has enabled best practice and cross fertilisation to take place. It has also enabled bespoke support to be targeted at those parts of the workforce that have specific issues to tackle or where there is underperformance. Connecting Care Communication Cells continue to play a role in cascading messages and engaging staff to identify and solve problems at different levels.
- A pilot project has been running where junior doctors' engagement planning was in focus, with colleagues working across the organisation to support and deliver an engagement plan for this staff group.
- We are continuously refreshing our approach to Executive Webinars (now called 'Feedback'), whereby staff vote on topics they are interested in hearing about from the Exec team, with issues of strategic and operational importance. The Feedback sessions are held monthly as 30 min webinars (real time broadcast, with recordings available to view/ listen to after the event).

- The webinar sits alongside three other communication products.
- A staff bulletin, which is a summary of key updates that all staff need to be aware of. These updates (via email and intranet) have been running daily during the COVID-19 pandemic, and have been adjusted and improved throughout the year, following staff and union feedback.
- During the COVID-19 pandemic we ran a 'thank you' campaign sharing messages of support and gratitude from the general public, this was well received.
- During the increasingly challenging months leading up to Christmas (due to the pandemic) we created a supportive programme to boost morale across the Trust, including issuing pin badges, snack packs, charitable donations to each colleague and a personal letter of thanks to each colleague from our Executive Team. Numerous opportunities for free wellness activities were promoted as well as creating a template for festive online team gatherings. As part of a festive calendar we issued a 'Team Spotlight' feature whereby we celebrated teams across the Trust on our intranet and also on social media.
- Our Manager/Leaders' Briefing and Heads of Department meetings have been created to support the cascading of information at the Communications Cells, i.e. team or ward meetings.
- Our intranet (HUB) is the main way in which staff prefer to find out key information about the Trust, keep up-to-date with news, access vital policies and comment on key issues.
- Our award scheme – Extraordinary People – was refreshed following staff feedback from the May local staff survey and has continued to be a success. The scheme regularly attracts on average over 90 entries each time it is run.
- For the third year in a row we ran a supportive winter pressure campaign; #RDEWinterWellness – promoting wellbeing activities and compassion in action, calling for nominations of compassionate leaders across the Trust. This generated engagement across the organisation and encouraged self-care and a compassionate approach to working together throughout the organisation.
- A manager training module has been developed and launched, as part of the Trust's existing 'Manager & Leadership Essentials' training programme, called 'Enabling Staff Engagement' whereby delegates learn why good staff engagement is key to great management and patient care, understand the pillars of good engagement and how to put this into practice. We are drafting content for a Compassionate Leadership module to be rolled out in the same programme.
- Staff seminars on a variety of Health and Wellbeing topics and Schwartz Rounds are promoted to staff
- We undertake "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 senior management

NHS staff survey

The NHS staff survey is conducted annually and since 2018 the results from the questions are grouped to give scores across key indicators – in 2020 there were 10 indicators. The indicator scores are based on a score out of 10 for certain questions with the indicator score being the average of those. Scores for each indicator together with that of the survey benchmarking group (Acute Trusts and Combined Acute and Community Trusts) are presented below.

The RD&E response rate to the 2020 Staff Survey was 44% (2019: 49%), compared to 45% of the average similar trust. The survey was conducted during the COVID-19 pandemic when we had high staff absence, due to shielding or staff unwell with the virus. In October 2020 we rolled out the new electronic patient record system, EPIC, via the MY CARE programme – these factors are likely to have impacted on the response rate.

Key findings on staff sentiment

In terms of staff sentiment against four key indicators the trust has continued to perform well and is rated above average by our people.

Staff sentiment indicator	Acute and Community Trusts 2020 average	RD&E outcome 2020	RD&E outcome 2019
Staff recommending the organisation as a place to work (Q18c)	67%	**71%**	72%
Staff recommending that if a friend or relative needed treatment would be happy with the standard of care provided (Q18d)	74%	**84%**	85%
Staff feeling care of patients/ service users is organisations top priority Q18a)	79%	**83%**	84%
Staff think the organisation acts on concerns raised by patients/ users (Q18b)	74%	**75%**	77%

The overall 'NHS staff engagement' indicator, is assessed by combining the answers to nine key questions from the NHS Staff Survey. The RD&E score was 7.1 (out of 10) comparing to 7.0 nationally for Acute and Acute & Community Trusts.

From the 10 key indicator areas, staff scored the Trust above the national average in the following areas:

- equality, diversity & inclusion
- health and wellbeing
- morale
- safe environment – bullying and harassment
- staff engagement

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 (subject to Board review):

- quality of care
- immediate managers
- pockets of the Trust with low engagement scores

As part of the 2019 and the 2020 NHS Staff Survey, staff had the opportunity to respond to a couple of locally added questions. Colleagues were asked what key aspect they think is good about working at the RD&E – from a choice of 18 variables, the following three topics had the most votes:

Job Security	**25%** (20% in 2019)
Working Relationships/ Local Co-operation	**23%** (16% in 2019)
Patient/Service User Satisfaction	**8%** (9% in2019)

Colleagues were also asked to pin point one key area to improve within the Trust (again of 18 variables), the overall responded:

Staffing Levels	20% (32% in 2019)
Pay & Benefits	18% (12% in 2019)
Travel to Work/Parking	14% (15% in 2019)

The increase in the score around Staffing Levels is significant and it is encouraging to see that the recent recruitment has been noticed and made a difference to staff.

Summary of Results: Overall staff survey response

	2019/20	2020/21		Trust improvement /deterioration
Response rate	RD&E	RD&E	Combined Acute & Community Trusts	
	49%	44%	45%	4% decrease

During 2019 and 2020, the scale of the MY CARE programme was significantly pulling on a high number of staff from across the Trust, and in October 2020 the MY CARE EPR was rolled out – this, in combination with the second wave of COVID-19 while preparing to open the NHS Nightingale Hospital Exeter and start a mass vaccination programme may have impacted on response rates.

Summary of Results: Selected indicators

	2020/21		2019/20		2018/19	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Equality, diversity and inclusion	9.2	9.2	9.4	9.2	9.2	9.2
Health and wellbeing	6.2	6.1	6	6	6.3	6.4
Immediate managers	6.7	6.8	7.1	6.9	7.0	6.8
Morale	6.3	6.2	6.4	6.2	6.4	6.5

	2020/21		2019/20		2018/19	
	Trust	Benchmarking Group	Trust	Benchmarking Group	Trust	Benchmarking Group
Quality of care	7.2	7.5	7.3	7.5	7.4	7.5
Safe environment – bullying and harassment	8.3	8.1	8.3	8.2	8.4	8.1
Safe environment – violence	9.5	9.5	9.5	9.5	9.5	9.5
Safety culture	6.7	6.8	6.9	6.8	6.9	6.7
Staff engagement	7.1	7	7.3	7.1	7.3	7.4
Team working	6.4	6.5	6.7	6.7	6.8	6.6

2020 Action Plan, Priorities and Targets

The Trust was planning a 'You Said, We will' approach for 2020 but when COVID-19 struck, plans had to be put on hold and the communications and engagement team's capacity was diverted to supporting colleagues during the pandemic.

Future Staff Engagement Priorities and Targets

As we exit the COVID-19 pandemic, the Trust is currently reviewing the NHS Staff Survey 2020 findings, results from other surveys and managers' input. The plan includes developing a response by a newly formed Staff Survey Task and Finish Team. The team has representatives from across the Trust, including managers, staff side, staff governors, staff group representatives and the Engagement Team. Our plans are under review at the time of writing but the key areas we are considering include:

- propose quarterly updates to staff, e.g. from HR on staffing levels, plans and pipeline
- continue the successful delivery of the Health and Wellbeing programme
- continue to communicate the Trust's plans and actions around travel/parking provision
- promote Compassionate Leadership, devise a training course for managers
- use intel gathered from staff on barriers to providing excellent Quality of Care across the Trust, with the aim to remove or reduce these barriers
- promote the implementation of the Valuing You appraisal/PDR system
- continuing the successful work from 2019 to make even better use of patient/service user feedback
- continuing to promote our Values and Behaviours – within for example, the refreshed Towards Inclusion strategy, the new Induction Programme and the new PDR
- continue to support remedial work for staff groups, divisions and departments with low staff engagement scores - and implementation of localised engagement plans
- continue to deliver decisively on basic needs, raised by staff, e.g. physical environment; staff rooms, queues in canteen, outdoor space for staff to take breaks
- individual Executives to adopt and champion prioritised staff engagement areas

We will continue the conscious effort to improve on the Trust staff experience, with the aim to maintain our position to score above the national average as measured by the engagement score in the NHS staff survey and other feedback mechanisms.

Off Payroll Payments

There were no off-payroll engagements as of 31 March 2021, 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 2021, for more than £245 per day and that last for longer than six months

Number of existing engagements as of 31 March 2020	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 between four or more years at time of reporting.	0

There were no new off-payroll engagements between 1 April 2020 and 31 March 2021.

Table 2: For all new off-payroll engagements, or those that reached six months in duration, between 1 April 2019 and 31 March 2020, 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 2019 and 31 March 2020	0
Of which….	0
Number assessed as within the scope of IR35	0
Number assessed not as 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 a board member 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 2020 and 31 March 2021

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.	17

In any cases where individuals are included within the first row of this table the trust should set out:

- Details of the exceptional circumstances that led to each of these engagements.
- Details of the length of time each of these exceptional engagements lasted.

Board Assurance Framework (BAF)

The BAF is a Board-owned document whose primary role is to inform the Board about the totality of risks or obstacles that may impede it 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. Over the past two years the BAF has been on an evolutionary journey, in parallel with the redevelopment of the wider governance arrangements within the Trust. A review of the BAF by Internal Audit, undertaken in March 2021, reported a Satisfactory rating.

Audit Committee

The Audit Committee is a formal, statutory committee of the Board of Directors, chaired by Mr Alastair Matthews (a Non-Executive Director with a financial background) who took over from Mr Peter Dillon as Chair in August 2020.

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

Five 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, the Trust's Chief Operating Officer, Chief Financial Officer (from January 2021), Director of Operational Finance, Head of Governance and a Trust Governor.

As part of the external audit plan for 2020/21, KPMG highlighted a number of significant audit opinion risks or areas of focus which have been considered by the Audit Committee.

Valuation of land and buildings (Not a significant audit risk for 2020/21)

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.

A full valuation of land and buildings was last carried out by a commercial valuer for the Trust in 2019/20.

For 2020/21 an assessment of the change in building indices and the local index factor has been undertaken. This assessment has indicated that there is little change in the indices between the date of the full valuation carried out in 2019/20 and the valuation date as at 31st March 2021. No revaluation adjustment has therefore been made in the accounts for 2020/21, other than that relating to the purchase of the Nightingale Hospital of £9.6m following the purchase in March 2021.

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

Fraud risk from Revenue Recognition

KPMG professional standards require them to make a rebuttable presumption that the fraud risk from revenue recognition is a significant risk.

KPMG recognise that the incentives in the NHS differ significantly to those in the private sector which have driven the requirement to make a rebuttable presumption that this is a significant risk. These incentives in the NHS include the requirement to meet regulatory and financial covenants, rather than broader share-based management concerns.

This risk relates to NHS income at the period end and non-NHS income throughout the year.

Around 94% of the Trust's income is received from other NHS organisations, with the majority (58%) 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 and reported their findings to the Audit Committee.

KPMG have identified one control deficiency relating to credit note authorisation for which management action will be taken.

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 from this audit.

Fraud risk from Expenditure Recognition

During 2020/21, NHSEI have removed Trust control totals and provided funding at a system level. The setting of fixed funding envelope for the system can create an incentive for management to understate the level of non-pay expenditure around the period end, due to the pressures on the Trust to contribute to the system position, compared to that which has been incurred.

At planning, KPMG noted that they considered this would be most likely to occur through understatement of expenditure at the end of the year. However, as additional funding has been released into the NHS and the funding for future periods remain uncertain, KPMG have reassessed the risk.

They consider this would now be most likely to occur through overstatement of expenditure through manipulating accruals at the end of the year to bring forward expenditure which should be deferred to the following year.

KPMG have performed a number of procedures to respond to the significant risk, including:-

- Assessing the design and implementation of controls for reviewing manual expenditure accruals at the end of the year
- Inspecting invoices for material expenditure in the period immediately prior to 31st March 2021 to determine whether expenditure has been recognised in the correct accounting period
- inspecting journals posted as part of the year end close procedures that increase the level of expenditure recorded in order to critically assess whether there was an appropriate basis for posting the journal and the value could be agreed to supporting evidence.

The results of KPMG's testing relating to expenditure recognition was satisfactory.

Valuation of MyCare

The Trust went live with the EPR project, MyCare, during 2020/21.

Accounting standards require the MyCare asset to be valued based upon the cost of replacing it with a similar asset. If the Trust was to implement a similar system in the future, then retained knowledge would be such that the Trust would be in a position to maximise efficiencies, therefore reducing the cost to replace it. In addition, the Trust would be replacing one system in future, rather than the many systems which have been replaced, which would be inherently more efficient and cost effective to replace. The Trust would therefore anticipate significant efficiencies/savings in the development and implementation phases of functionally similar software. The impact of COVID-19 also increased the costs of the implementation and these costs would not be expected to occur in any future replacement.

In order to ensure the asset is recorded at fair value in line with the Trust's accounting policies, and due to the complexities of the calculation, an external consultancy firm (PWC) with experience of work on similar valuations was engaged by the Trust. This external assessment enabled additional assurance to be given to both the AC and external auditors KPMG.

The final report from PWC identified that the valuation of the asset was £43.4m, which therefore gave rise to an impairment of £18.6m.

KPMG have carried out their work to test the assumptions supporting the valuation, and have not identified any material issues from the work carried out.

Going Concern

As a result of the revised auditing standard for Going Concern (ISA 570) there are a number of key changes for 2020/21 including:-

- enhanced coverage of going concern in the audit report including a positive statement that the use of the going concern basis is appropriate and the auditor has not identified a material uncertainty on going concern
- more detailed audit requirements on risk assessment procedures including on the Trust and the environment; the financial reporting framework and the system of control
- under the new standard detailed substantive procedures will be required in all cases whereas the current standard allows reduced requirements if no events or conditions that may cast significant doubt of the organisations ability to continue as a going concern
- requirement to consider reporting material uncertainties to external regulatory and enforcement authorities

After making enquiries and recognising the uncertainty that exists in Q1 & Q2 of 2021/22, the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver the full range of mandatory services for the 12 months from the date of approval

of the financial statements and fulfil any liabilities as they fall due. The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the 12 months from the date of approval of the financial statements.

On this basis, the Trust has adopted the going concern basis for preparing the accounts.

KPMG have concluded that it is appropriate to prepare the financial statements on a going concern basis.

For further details, please see Note 1 to the Accounts on page 16.

Other Issues considered by the Audit Committee

Value for Money (VfM) arrangements

For 2020/21 the VfM reporting requirements have been amended following publication of the revised Audit Code of Practice. The change in guidance requires a separate commentary from external audit which includes:-

- a summary of the external audit risk assessment against each of the three VfM criteria (Financial sustainability, Governance and Improving economy, efficiency and effectiveness) setting out their view of the arrangements in place compared to industry standards
- a summary of any further work undertaken against identified significant risks and the findings from this work and
- recommendations raised from the work undertaken and follow up of previous recommendations

As a result of the significant change in VfM requirements, the AC requested an Internal Audit review of VfM at the Trust. This concluded that there was a significant assurance on VfM arrangements in place.

KPMG have included a commentary in their auditors' annual report.

Joint Audit Committee with North Devon Healthcare NHS Trust (NDH Trust)

As part of the closer working arrangements with NDHT, the Audit Committees of both organisations have agreed to meet as a joint Committee from July 2021. Whilst there will still be a requirement for organisation specific issues to be dealt with for 2021/22, work has already started to align processes and reporting. This has been made easier due to the RDE and NDHT having the same Internal and External Auditors as well as a shared Counter Fraud function.

Effectiveness of the external auditors

KPMG LLP were appointed as external auditors to the Trust from 2019/20 for a five-year period to 31st October 2024 under a competitive tender process.

In addition to the procurement tender exercise, the Audit Committee annually assesses 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 assurance that the external auditors provided a quality, timely and cost-effective external audit service.

The external auditors have not provided any non-audit services to the Trust in 2020/21.

Review of Whistleblowing and Freedom to Speak up

As part of the Internal Audit assurance plan for 2020/21 Internal Audit carried out a review of whistleblowing and freedom to speak up. The overall objectives of this review were to provide assurance that existing Whistleblowing processes in place within the Trust are sound, as documented within the Trust's Whistleblowing policy, and similarly, the role of the Trust's Freedom To Speak Up Guardians is in line with national guidance.

The Audit Committee concluded that there are appropriate arrangements in place to allow staff and other individuals, where relevant to raise, in confidence concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety and other matters.

Meeting schedule

The Audit Committee met six times during 2020/21. The names of members and their attendance at 2020/21 meetings are as follows:

NAME	Apr 2020	June 2020	Aug 2020	Oct 2020	Nov 2020	Feb 2020
A Matthews	P	P	P	P	P	P
P Dillon	P	P	P	P	P	P
S Kirby	P	P	P	P	P	P
J Kay	P	P	A	A	A	P
C Bones	P	P	P	P	P	A

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, 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
- receives a report from management on the review of data quality included in the Quality Report and
- is given the opportunity, where possible, to review the accountancy element of any significant financial transaction within the Trust prior to its presentation to the Board of Directors for approval.

Financial Reporting

The Audit Committee reviews and, if thought appropriate, recommends to the Board approval 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

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 are also 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 2020/21 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

NHS England and NHS Improvement's NHS Oversight Framework provides the framework for overseeing providers and identifying potential support needs. The framework looks at five themes:

- quality of care
- finance and use of resources
- operational performance
- strategic change
- leadership and improvement capability (well-led).

Based on information from these themes, providers are segmented from 1 to 4, where '4' reflects providers receiving the most support, and '1' reflects providers with maximum autonomy. A foundation trust will only be in segments 3 or 4 where it has been found to be in breach or suspected breach of its licence.

Segmentation

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

This segmentation information is the trust's position as at 10th May 2021. Current segmentation information for NHS trusts and foundation trusts is published on the NHS Improvement website.

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 Governance Committee 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
Urgent Care	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good Apr 2019	Good 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 & 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	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.

The Trust underwent a routine Inspection as part of the CQC's Winter Inspection Programme on the 19th January 2021 on the Trust's Infection, Prevention and Control arrangements.

The inspection report noted the following:

- Leaders operated effective governance processes. Staff at all levels were clear about their roles and accountabilities. Governance structures and the communication within them were effective to ensure that changes and learning supported patient safety across the trust.
- Leaders understood and managed the priorities and issues the service faced. They were visible and approachable in the service for both patients and staff.
- Staff felt respected, supported and valued. The service had an open culture where staff could raise concerns without fear.
- It was evident from speaking with staff that the challenges caused by the pandemic were both physically and mentally challenging, but they remained passionate about providing quality care to their patients.
- The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats. The information systems were integrated and secure.
- Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact.

- All staff were committed to continually learning and improving services. There were systems and processes for learning, continuous improvement, and innovation. Leaders and staff also collaborated with partner organisations to help improve services for patients.

The report outlined two actions that the Trust should take to improve further:

- The Trust should continue to monitor compliance with appropriate levels of personal protective equipment, including enhanced personal protective equipment to ensure its use is in line with national guidance. The trust should improve those areas of infection prevention and control practice which are not currently being followed in line with national guidance.
- The Trust should consider ways in which it can further promote staff and patient engagement with compliance with cleaning of shared use equipment.

These actions form part of the ongoing IPC action plan which will be monitored through to completion by ICDAG and the Clinical Reference Group, who report into the Governance Committee.

Due to the targeted focus of the inspection, the overall rating of the Trust and Royal Devon & Exeter Hospital does not change and remains 'Good' in both cases.

Signed:

Suzanne Tracey
Chief Executive Officer

Date: 14 June 2021

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 Officer

Date: 14 June 2021

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 2021 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.

During the last twelve months, and as a direct result of the COVID-19 pandemic, the Trust temporarily adjusted its governance system with the Board of Directors approving a "Governance Lite" approach. The main changes were the pausing of some Committees and Sub Groups of the Governance Committee, with the direct reporting of essential groups such as Health and Safety and the Incident Review Group and Divisional governance risks and gaps in assurance to the Governance Committee. A review of the Trust's Governance Lite arrangements was undertaken by Internal Audit in October 2020 which reported that "overall the Trust has designed and operated sound governance arrangements as approved by the Board of Directors during the COVID-19 pandemic".

The Audit Committee monitors and oversees both internal control issues and the process for risk management. Audit Southwest (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 Officer or Deputy Chief Executive, 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 five Freedom to Speak Up Guardians who report to the Chief Executive Officer 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 Incidents Requiring Investigation (SIRI) is in place and additional staff are trained each year to add to the pool available. The Risk Management Team co-ordinates SIRIs 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 SIRI investigation reports and action plans are shared with the Trust's lead commissioner; NHS 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 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 Director 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 by 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 four key sub committees:

- Clinical Effectiveness Committee (during Governance Lite, renamed Clinical Reference Group) – chaired by the Deputy Medical Director
- Integrated Safeguarding Committee – chaired by the Chief Nursing Officer
- Safety and Risk Committee – chaired by the Chief Executive Officer
- People, Workforce, Planning and Wellbeing Committee – chaired by the Chief People Officer

These four Committees are responsible for monitoring and managing specific types of risk.

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

- The Patient Safety Group is accountable for delivery of the Trust's patient safety programme, review of adverse incidents and Mortality and Morbidity Reviews
- The Incident Review Group is chaired by the Director of Nursing and reviews all Serious Incidents Requiring Investigation (SIRI) and action plans
- Medical Gases Group
- Radiation Safety Group
- Infection Control and Decontamination Group is chaired by the Joint Directors of Infection Prevention and Control
- Health and Safety Group is chaired by the Chief People Officer
- Emergency Preparedness, Resilience and Response Group is 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.

All deaths that occur in the Acute Trust and Community Hospitals are reviewed within 24 working hours by a Medical Examiner, in line with the National Medical Examiner System. This system is responsible for ensuring accuracy of death certification, referral of cases as appropriate to Her Majesty's Coroner, and identification and escalation of governance issues to the Trust and Mortality service. Cases are identified for specialist review in line with National Guidance, and those that fulfil the CQC Duty of Candour regulations (Section 20) identified. Themes identified from this comprehensive review are presented monthly to the Mortality Review Group which reports into the Safety and Risk Committee.

The Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR) are used within the organisation to monitor trends in data quality and mortality. A detailed Trust level mortality dashboard is scrutinised by the Mortality and Review Group on a monthly basis. Mortality is reported to the Board of Directors monthly through the Integrated Performance Report and quarterly through a detailed Learning from Deaths Report. The Board also receives relevant mortality reports by escalation from the Governance Committee. 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. In the last financial year, this additional scrutiny has focussed on deaths following COVID-19 diagnosis.

The Trust is actively working to ensure the recommendations made as part of the NHSI Learning from Deaths Review are being implemented and embedded in practice. This is overseen by the Trust's Governance Committee.

The Chief Nursing Officer and Chief Medical Officer 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 are in place. The Safety Huddle comprises of the Chief Nursing Officer, Chief Medical Officer, the Director of Nursing, Deputy Medical Director and the Assistant Director for Safety and Quality. 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 in real time at a 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 32 current risks on the Corporate Risk Register. There are 13 risks with scores of 15 and above:

- One related to capacity management
- One related to achieving cancer waiting time targets
- Five related to demand and capacity on individual services i.e. emergency department, ophthalmology, medical imaging, cardiology and heart failure.
- Two related to workforce i.e. junior doctors and nursing establishments
- Two related to mental health pathways (external factors)
- Two related to COVID-19, i.e. infection control measures and the disruption to diagnostic/ treatment pathways as a result of the COVID-19 pandemic. A further four risks related to COVID-19 also sit on the CRR with scores of between 12 and 8.

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 Director of Governance and the Manager of the risk

to ensure that risks are proactively managed down to their end target score. A detailed report is produced by the Director of Governance to the Safety and Risk and Governance Committees on a predefined frequency.

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 Director 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 Chief Nursing Officer and Chief Medical Officer, 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

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 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 uses an e-rostering system for nurses, midwives and care staff. The Allocate Safe Care tool is used to undertake a census three times a day to assess the acuity and care hours per patient day; Staffing tactical meetings happen daily. As a minimum, an establishment and skill mix review is undertaken annually for each clinical area.

The reviews use relevant national guidance as set out and also detail clinical judgement, triangulated with safety metrics and patient outcomes to 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 use 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. The plan is multi-facetted and includes improvements in our wellbeing offerings, career and succession planning and improved employee communication. Work is ongoing to review and embed additional employee recognition schemes, thus further improving morale, engagement and retention. Turnover has seen a significant improvement, reducing by 1.9% in year, and there continues to be a focus across the organisation 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 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 and all regulatory requirements have been met.

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

Although the Trust has managed a stable level of financial performance over a number of years the Trust is not immune to the financial challenges facing the NHS. The 2020/21 financial year was expected to be particularly challenging given the financial constraints of the Devon STP. However, the finance regime was paused due to the COVID-19 response and additional income paid to Trusts and systems to ensure all costs could be covered, enabling all Trusts to achieve breakeven. Whilst this provided the stability needed during an exceptional year the additional income was non-recurrent only meaning the underlying deficit of the Trust remained.

The Trust's draft Operational plan for 2020/21 was submitted on 22 October 2020prior to Board approval on 28 October 2020. Subsequent updates were brought to the board as the finance regime changed during the COVID-19 period.

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.

An element of assurance provided to the Board is the rigidity of the financial control processes. An internal audit review was undertaken of the financial controls put in place during the COVID-19 pandemic which concluded the Trust's financial processes and governance arrangements during the COVID-19 pandemic were sound and followed national guidance.

As we move into the 2021/22 financial year the non-recurrent income remains for the first half of the year ensuring Trusts continue to achieve breakeven but guidance for the second half of the year is yet to be issued. A potential return to a previous business as usual finance regime will result in a deficit position for the Trust and plans are being developed for the mitigation of this eventuality as part of the wider Devon STP. The focus will be on productivity to ensure that recovery of elective waiting lists can be prioritised whilst ensuring sound cost control to avoid worsening the underlying deficit.

The Trust's External Audit ISA260 Report 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. In addition, they have annual reviews of the Trust's risk management and governance arrangements.

Information governance

Information governance and data security is managed by the Information Governance Steering Group, led by the Deputy Medical Director. The Chief Medical Officer is 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 has completed the Data Protection and Security 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.

On 30 September 2020 the Trust published the annual Data Security and Protection Toolkit assessment, which had been delayed by NHS Digital due to COVID-19. The return included 115 out of 116 mandatory evidence items and 39 of the 40 assertions, with one outstanding item delayed by COVID-19. The Trust completed this item in December 2020 and is currently rated as "Standards Met" by NHS Digital.

The 2020/2021 annual Data Security and Protection Toolkit assessment has also been delayed due to COVID-19 with an extension to 30 June 2021. The initial baseline was published on 26 February 2021 with work progressing for full submission in June 2021.

During 2020/21 the Trust reported two Information Governance incidents to the Information Commissioners Office in line with the reporting requirements. One of the incidents involved a staff member inappropriately accessing the data of another member of staff who had been seen in the Emergency Department. The other was regarding a disclosure of radiology images which included the reports for two different patients in the disclosed information. The Information Commissioner has responded to both incidents stating "No Further Action", with the recommendation to investigate the causes of the incidents to ensure we understand how and why they occurred and what steps we need to take to prevent them from happening again. The incidents were fully investigated by the Trust with mitigating actions put in place, including the recommendations from the Information Commissioner.

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 of Directors, 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 Trust has produced a Quality Account which will be submitted with the Annual Report in June 2021. Following guidance provided by NHSE/I there is no requirement for the Quality Account to be externally assured.

The Trust has established systems and processes to collate, validate, analyse and report on data for the annual Quality Account as it does for other clinical quality and performance information. The data is subject to regular review and challenge at speciality, 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 Account 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 March 2021 and the result was 'satisfactory'.

The next annual review will be undertaken during 2021/212.

Audit of mandated indicators

Following guidance provided by NHSE/I the Trust is not required to undertake an audit of mandated indicators.

COVID-19

The Trust initiated its pandemic plans in line with national guidance on 4 March 2020. The Local Resilience Forum (LRF) declared an LRF Major Incident on 16 March 2020 and an Incident (Gold) Management Team was established which has met every day since. The Incident Management Framework of Gold (which has a number of hubs and groups within its structure) sits alongside the Trust's existing Governance Performance System as outlined above.

During the first wave of the pandemic the Trust and indeed the wider South West were not impacted by COVID-19 in the same way as other Trusts have been throughout the country as the disease prevalence and profile has been much lower than predicted. We believe that the lock down arrangements put in place by the Government had a significantly positive impact for the region. This has allowed the Trust time to plan and prepare and put in arrangements, such as the hosting of the Devon and Cornwall Nightingale Hospital, in readiness for a second surge. The Nightingale Hospital was opened in November 2020 and discharged its last patients in February 2021 and remains in a state of readiness.

As already detailed, as part of the Trust's planning and preparedness and as a direct result of COVID-19, the Trust reviewed its Governance arrangements, taking a "Governance Lite" approach. The four Sub Committees of the Governance Committee were revised and where appropriate replaced to provide a flatter structure. Some sub groups and Divisional Governance groups paused, but were replaced with direct access into the Governance Committee via Executive Leads. The new arrangements were approved by the Board of Directors (and shared with the Trust's Internal Auditors) in May 2020 for an initial period of three months. The effectiveness and outcome of Internal Audit's review concluded in October 2020. The Board of Directors concluded that Governance Lite had served the Trust well and approved a return to the previous governance performance system. The focus on Governance did not change during COVID-19 with patient and staff safety remaining the highest priority for the Board of Directors.

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 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

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 2020/21.

Signed:

Suzanne Tracey
Chief Executive Officer

Date: 14 June 2021

Directors' Report

The RD&E is an 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 CoG
- 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 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 CoG
- 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 CoG, 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 Board's meeting schedule for 2020/21 was affected by the COVID-19 pandemic, with additional confidential meetings held and the Board meetings in public for April, May and June 2020 stood down. This was as part of the Trust's revised Governance Performance System during COVID-19, allowing the Board to focus on the Trust's response to the pandemic. Using MS Teams virtual meeting technology, the Trust commenced Board meetings in public again from July 2020.

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 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 NHSI'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 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:

- the Trust's response to the COVID-19 pandemic, including the Nightingale Hospital Exeter, a revised Governance Performance System, staff health and wellbeing and the Devon Mass Vaccination Programme
- operational Performance both COVID-19 and non-COVID-19
- reset and recovery after COVID-19
- corporate strategy
- Devon Sustainability and Transformation Programme (STP)
- Devon Integrated Care System (ICS)
- Local Care Partnerships
- NHS and Devon System Long Term Plan
- Peninsula Clinical Services Strategy
- proposed integration with Northern Devon Healthcare Trust (NDHT)
- collaborative working in South, East, North Devon (SEND)
- the MY CARE Programme
- Board Assurance Framework
- workforce including deep dives into sickness absence
- responding to and Learning from Deaths quarterly reports
- Guardian of Safe Working Hours quarterly reports
- regular reports from the Audit and Governance Committees
- domiciliary care
- inclusion
- research and development
- infection prevention and control
- staff and patient survey results
- Pathology Network
- Ockenden Maternity Report
- emergency preparedness, resilience and response
- patient stories
- The Board met as the Corporate Trustee

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:

https://www.rdehospital.nhs.uk/about-us/foundation-trust/foundation-trust-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.

As result of COVID-19 and the decision to focus on the Trust's response to the pandemic, some of the scheduled Development Days were stood down; however, a small number did go ahead. These included:

- Joint Development Days with the Board of NDHT, focussing on strategy, the proposed integration and Board composition.
- A joint Development Day with the CoG, focussing on the RD&E and NHDT strategic outline case and an update on COVID-19 and reset and recovery

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 of the Executive Directors 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 the Annual Governance Statement (pages 106-114 of this report).

Well Led

The Trust's approach to Well Led is outlined within the Accountability Report (page 34) and also within the Annual Governance Statement (page 99)

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.

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 is based on the principles of the UK Corporate Governance Code.

Summary Board Attendance 2020/21

P = Public C = Confidential EC = Extraordinary Confidential	April 20					May 20			June 20		July 20		Aug 20	Sept 20	
	6th			29th		11th	20th		24th		29th			30th	
	EC			P*	C	EC	P*	C	P*	C	P	C	C	P	C
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
Prof C Bones	P				P	P		P		P	P	P		A	A
Mr P Dillon	P				P	P		P		P	P	P		P	P
Mrs H Foster	P				P	A		P		P	P	P		A	A
Prof A Harris	P				P	P		P		P	P	P		A	A
Mrs A Hibbard															
Prof J Kay	P				P	P		P		P	A	A		P	P
Prof H Khalil	P				P	P		P		P	P	P		P	P
Mr S Kirby	P				P	P		P		P	P	P		P	P
Mr A Matthews	P				P	P		P		P	P	P		P	P
Mr C Mills															
Mr D Thomas	P				P	P		P		P	P	P		P	P
Mr C Tidman	P				P	P		P		P	P	P		P	P
Mrs S Tracey	P				P	P		P		P	P	P		P	P

P = Public C = Confidential EC = Extraordinary Confidential	Oct 20		Nov 20				Dec 20	Jan 21		Feb 21		Mar 21	
	28th		13th	20th	25th		23rd	27th		24th		31st	
	P	C	EC	EC	P	C	C - Joint with NDHT	P	C	P	C	P	C
Mr J Brent	P	P	P	P		P	P	P	P	P	P	P	P
Mr P Adey	P	P	P	P		P	A	P	P	P	P	A	A
Mrs J Ashman													
Prof C Bones	P	P	A	A		P	P	A	P	P	P	P	P
Mr P Dillon	P	P	P	P		P	A	P	P	P	P	P	P
Mrs H Foster	A	A	A	A		P	P	P	P	P	P	P	P
Prof A Harris	P	P	P	P		P	A	P	P	P	P	P	P
Mrs A Hibbard								P	P	P	P	P	P
Prof J Kay	P	P	P	P		P	A	P	P	A	A	P	P
Prof H Khalil	A	A	P	P		P	P	P	P	P	A	P	P
Mr S Kirby	P	P	P	P		P	P	P	P	P	P	P	P
Mr A Matthews	P	P	P	P		P	P	P	P	P	P	P	P
Mr C Mills								P	P	P	P	P	P
Mr K Orford												P	P
Mr D Thomas	P	P	P	P		P	P						
Mr C Tidman	P	P	P	P		P	P	P	A	P	P	P	P
Mrs S Tracey	P	P	P	P		P	P	P	A	P	P	P	P

Board of Directors

Non-Executive Directors

James Brent, Chair

James joined the Trust in May 2012 and is both Chairman of the Board of Directors and CoG. He was an investment banker for twenty-five years and established Akkeron Group which has key business activities in hotels, urban regeneration and leisure. He is also Chairman of Hawksmoor Investment Management Limited, a private client investment and fund management group. 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 of Plymouth University.

James was appointed as Chairman of Northern Devon Healthcare NHS Trust on 1 July 2018.

Jane Ashman, Non-Executive Director (until September 2020)

Jane joined the Trust in April 2014. A Social Worker by profession for 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. As well as her Non-Executive Director role at the RD&E, until recently Jane was the independent Chair of two Safeguarding Adult Boards and undertook Serious Case Reviews and Domestic Homicide Reviews for other agencies when the need arises.

Chris Bones, Non-Executive Director

Chris joined the Trust in November 2019. He started his career in Human Resources and held senior roles reporting to the Board in both Diageo and Cadbury Schweppes.

He was appointed as Principal (later Executive Dean) of Henley Business School, publishing a book on the causes of the 2008 financial crash, which won the UK's Management Book of the Year Prize in 2012. He has held a number of non-executive roles in the public and private sector.

In 2011 he established an e-commerce consulting business in Exeter that has grown rapidly and now supports a number of leading brands from offices in Exeter, London and New York. He is a past Chair of the Trustee Board for the Terrence Higgins Trust and is the current Chair of the Chartered Institute of Legal Executives. Chris is a member of the Audit and Governance Committees. Chris is the Chair of the Patient Experience Committee.

Peter Dillon, Vice Chair

Peter joined the Trust in July 2013. After more than two decades at Deloitte and running his own financial advisory business, Peter is now Finance Director at The Rivers Trust, a national charity for education about and improvement of the UK's rivers. Until November 2015 Peter was also a Non-Executive Director in the Devon & Cornwall Housing Group, a social and affordable housing provider. Peter was previously chair of the Patient Experience Committee, Audit Committee and the Trust's Charity Sub-Committee, and until recently a member of the MY CARE Programme Board. Peter was appointed Vice Chair on 1 September 2018.

Janice Kay CBE, 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 Senior Independent Director in April 2017.

Hisham Khalil, Non-Executive Director (Voting Board member from September 2020 – date)

Hisham joined the Trust in November 2019. Hisham is the Head of the Peninsula Medical School, Faculty of Health, University of Plymouth. He is also a Consultant ENT Surgeon, University Hospitals Plymouth NHS Trust with an interest in Rhinology and Endoscopic Skull Base surgery. Hisham completed his surgical training in North Wales and the South West of England. He is a Non-Executive Director, University Hospitals Plymouth, NHS trust. and was the ENT South West Peninsula Clinical Research Network lead.

Hisham is a National Teaching Fellow and a Principal Fellow of the Advance Higher Education. He has a Doctorate Degree in Otolaryngology and is a Fellow of the Royal College of Physicians and Surgeons in Glasgow. He is also an External Assessor for the Irish Medical Council and a General Medical Council Associate. Hisham has been committed to the learning and teaching of undergraduate and postgraduate students and trainees in Medicine, Dentistry and Nursing. Outside medicine, Hisham has an interest in poetry and landscape photography. Hisham is a member of the Governance Committee and Chair of the Organ Donation Group.

Steve Kirby, Non-Executive Director

Steve joined the Trust in September 2017. Following a period in the NHS, he worked internationally in health, running hospitals before moving to consulting. As a Partner at KPMG and then Ernst & Young, he has consulted to 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, 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 Committee.

Alastair Matthews, Non-Executive Director

Alastair joined the Trust in October 2018. He has broad strategic financial and commercial experience gained in both the private and public sectors. He was Chief Financial Officer at the University of Plymouth for 5 years until November 2020. 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 the Chair of the Trust's Audit Committee and Integration Programme Board.

Kevin Orford, Non-Executive Director

Kevin joined the RD&E Board on 29 March 2021. Kevin has a background in finance with previous roles as both an Executive Director and a Non-Executive Director in the NHS and as a Trustee on charity boards. He has previously served as a Non-Executive Member for Governance (Audit and Risk Committee Chair) for Southern Derbyshire Clinical Commissioning Group and was formerly Director of Finance and then Chief Executive of East Midlands Strategy Health Authority. He has a special interest in finance, governance and audit and their role in delivering high quality patient care.

Kevin is a Non-Executive Director of Northern Devon Healthcare Trust. He also serves on the Board of the Intellectual Property Office.

Executive Directors

Suzanne Tracey, Chief Executive

Suzanne 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 RD&E to take up the role of Director of Finance in 2008 and subsequently Deputy Chief Executive/Chief Financial Officer. Suzanne was appointed Chief Executive in 2016. She is also the Chair of the Healthcare Financial Management Association (HFMA) Provider Faculty and past President of the HFMA.

Suzanne was appointed as Chief Executive of Northern Devon Healthcare NHS Trust (NDHT) on 18th June 2018.

Professor Adrian Harris, Executive Medical Director

Adrian joined the NHS in 1981 and qualified from the Royal Free Hospital, University of London in 1986. He has been the Executive Medical Director since April 2015 and was appointed as Consultant Emergency Physician at the RD&E in February 1996. 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 training in Emergency Medicine in 1990. He is an Honorary Associate Professor in Healthcare Leadership and Management at the University of Exeter Medical School.

In his spare time, Adrian is a practicing sports physician and is the Director of Sports Medicine for the Exeter Chiefs Rugby Football Club.

Adrian was appointed as Interim Medical Director at Northern Devon Healthcare MHS Trust in June 2018 and as Executive Medical Director in December 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 RD&E 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 formally appointed as Executive

Director of Operations in March 2016. From March 2017 has assumed the role of Chief Operating Officer.

Pete was also appointed as interim Chief Operating Officer at Northern Devon Healthcare NHS Trust from August 2018.

Chris Tidman, Deputy Chief Executive

Chris joined the Trust in September 2017, 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. Chris was appointed to the role of Deputy Chief Executive in January 2021.

Hannah Foster, Director of People

Hannah joined the Trust in August 2019, coming to the NHS from Flybe, the Exeter-based airline, where she was Director of People. Prior to her Flybe role, Hannah also held top strategic posts for the Church of England and global educational provider Pearson, helping both organisations develop key culture and organisational growth programmes. As well as strategic and business acumen, Hannah brings a strong voluntary and charitable ethos to both the Royal Devon & Exeter NHS Foundation Trust and the Northern Devon Healthcare NHS Trust.

Hannah actively supports a number of charities, including being a Trustee of Exeter homeless support charity St Petrock's, and she is a member of the Greater Exeter Skills Board.

Carolyn Mills, Chief Nurse (from 18 January 2021)

Carolyn joined the RD&E and Northern Devon Healthcare Trust (NDHT) as joint Chief Nursing Officer in January 2021. Carolyn is an experienced nurse whose career in the NHS spans over 30 years, including working in the acute, community and academic sectors. Previous to joining the RD&E and NDHT, Carolyn worked for Hillingdon Hospitals NHS Trust, University College London Hospitals NHS Foundation Trust in Assistant Chief Nurse positions and was Director of Nursing at NDHT between 2005-2014.

From 2014 to 2021, Carolyn was Chief Nurse at University Hospitals Bristol & Weston NHS Foundation Trust, where she had experience of merging together University Hospitals Bristol NHS Foundation Trust and Weston Area HealthTrust.

Dave Thomas, Interim Chief Nurse (until 18 January 2021)

Dave is an experienced nurse of over 30 years, having originally trained in Buckinghamshire. He specialised in Trauma Nursing in his early career and has utilised these skills in both NHS and military roles throughout his career. Dave moved to the South West in 2000, where he has held a number of roles, including one of the first male Modern Matron roles, and later a regional role in service redesign and change. Dave has been at the RD&E for the last six years and took up the post as Interim Chief Nurse following a spell as the Interim deputy to this role.

Dave is also the champion for the veterans and employer relationships with the Military and recently assisted the Trust to achieve the Gold Employer rating for the Ministry of Defence employer recognition scheme.

Angela Hibbard, Chief Finance Officer (from 1st January 2021)

Angela joined the NHS in 2003 as a management accountant in South Devon and Torbay NHS Trust. She joined Royal Cornwall NHS Trust in 2008 to lead their medium term financial and cost improvement planning, before moving to the South West Specialised Commissioning Team. During the transition into the new commissioning structures in 2012, Angela took on the role of Head of Finance for NHS England leading on the finance function for commissioning of primary care. She joined the Northern, Eastern and Western Devon Clinical commissioning Group as Deputy Chief Finance Officer in 2014, before moving to Northern Devon Healthcare NHS Trust as Director of Finance in 2018.

Angela was appointed as Chief Finance Officer for the Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust in January 2021.

Non-Executive Director appointments

The Chairman and Non-Executive Directors are appointed by the 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.

During 2020/21, one NED, Jane Ashman, reached the end of her term of office in September 2020. In January 2021, the Committee started work to recruit two new substantive NEDs to the Board of Directors and approved the appointment of Kevin Orford, a NED at NDHT, to the Board of Directors from March 2021 for the period up to the date of the proposed integration with NDHT. This appointment was made to ensure the correct balance of NEDs and Executive Directors on the Board following the implementation of the new Executive Director structure from 1 January 2021.

Membership of Nominations Committee
(as at 31 March 2021)

- Chairman of the Trust – James Brent (Chair)
- Lead Governor - Peta Foxall
- Tony Ducker (Exeter & South Devon)
- Faye Doris (Exeter & South Devon)
- Barbara Sweeney (East Devon, Dorset & Somerset & Rest of England)
- Tony Wilkinson (East Devon, Dorset & Somerset & Rest of England)
- Michael James (Mid, North, West Devon & Cornwall)
- Marcus Pipe (Mid, North, West Devon & Cornwall)
- Hazel Hedicker (Staff)
- Angela Shore (Appointed)

Non-Executive Director Remuneration Committee

The Non-Executive Director Remuneration Committee (NEDRC) comprises six Governors and is chaired by the Lead Governor. The Committee is supported by the 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 CoG at a general meeting. During the year 2020/21, the Committee met once on 10 February 2021. Following this meeting, it made a recommendation to the CoG at its 1 March 2021 meeting that the current rate of remuneration for NEDs (£13,303) was satisfactory and that Mr Orford receive this rate of remuneration for the period he was on the RD&E Board. This was approved by the CoG.

Membership of NEDRC
(as at 31 March 2021)

- Peta Foxall (Lead Governor and Chair of the NEDRC)
- Hazel Hedicker (Staff Governor)
- Barbara Sweeney (East Devon, Dorset, Somerset and the Rest of England)
- Tony Ducker (Exeter and South Devon)
- Marcus Pipe (Mid, North, West Devon and Cornwall)
- Phil Twiss (Appointed Governor)

Our Governors and Members

Council of Governors (CoG)

The Trust's 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 undertake 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 global pandemic had a significant impact on the work of the CoG but, as in other parts of the Trust, the CoG rapidly adopted new ways of working primarily through the use of video technology, and this enabled the CoG to carry out its core duties. Throughout the last year Governors have continued to do their best at ensuring the public voice was present in key discussions but many Governors have experienced some issues in ensuring that they stayed in touch with constituents during lockdown.

The CoG has strengthened its relationship with the Board over the last few years with a greater degree of interaction and engagement between the two bodies. The pandemic has however meant that the interaction between Governors and NEDs has been somewhat less than in previous years and this is now being addressed through the engagement on the proposed integration between the RD&E and NDHT.

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 NEDs to manage the key challenges facing the Trust. The NEDs 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 NEDs. During the year, the Governors have developed a feedback form to enable them to assess the contributions of individual NEDs at a number of meetings where their paths cross including Board of Director meetings. Governors have been able to use video technology to have access to the public part of the Board meeting and raise questions as appropriate.

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 met four times during the year to conduct its core business and once in an extraordinary meeting. During these meetings, the CoG collectively considered 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, which essentially summarises the performance information that goes to the Board, 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.

Key highlights for Governors year 2020/21

Reappointment of three Non-Executive Directors

The Trust reappointed three Non-Executive Directors this year considering the circumstances of the global pandemic:

- Peter Dillon (vice chair) for one year to 27 July 2021. As this extension was beyond 7 years, approval was sought and gained from the regulators.
- Jane Ashman was extended from 1 April 2020 to 30 September 2020.
- Steve Kirby was reappointed for a second full term from 1 September 2020 to 31 August 2023.

These extensions were agreed at the CoG meeting on 9 April 2020 on the recommendation of the Nominations Committee.

At its August 2020 meeting, the Council resolved to:

- extend Professor Kay's term of office from 31 March 2021 to 31 March 2023.
- to further extend Peter Dillon's term of office from 28 July 2021 to 31 March 2022 having received permission from the regulators

The CoG also sought to commence recruitment for two new Non-Executive Directors (one with clinical experience and one with social care/local government experience) to replace Professor Bones (who had relocated to Scotland) and Professor Khalil who remained on the Board of University Hospitals Plymouth and therefore this was viewed as a position that may make potential conflicts of interest harder to manage.

In March 2021, the Council agreed to the recommendation to appoint Kevin Orford as a NED to the Board of the RD&E for the period up to the date of the transaction with NDHT. Mr Orford is a NED at NDHT.

Chair recruitment

In light of the pandemic and the proposed integration with NDHT, the CoG approved the recommendation to halt the recruitment process for a Joint Chair and to re-appoint Mr Brent as RD&E Chair from 1 July 2020 to 30 June 2021. Later in the year, again as a result of the same issues, the Council agreed to seek permission from the regulators for an extension to the Chairman's term of office until the end of March 2022.

Chairman/NED Appraisals

The CoG provided feedback that was used as part of the appraisals of the NEDs. All appraisals were satisfactory. The Senior Independent Director conducted the annual appraisal of the Chairman which included feedback for the Council as part of the process. The appraisal was satisfactory.

Elections to the CoG

As a result of the pandemic and the direction set out by NHSE/I, the CoG approved an amendment to paragraph 20 of the Trust Constitution and to not hold routine elections in 2020. It approved the recommendation to offer those Governors whose terms of office came to an end in September 2020 a one-year extension to September 2021. It approved the recommendation to explore the use of Chair discretion to apply terms of office shorter than 3 years to some of the posts in the routine 2021 election.

Lead Governor election

Peta Foxall was re-elected as the Lead Governor.

Council of Governor meetings

In addition to the standard agenda items: performance report, working group updates, Patient Experience Committee (PEC) updates, election updates, MY CARE updates, progress reports on the proposed integration with NDHT strategic and operational and strategic updates from Chair and CEO, the following issues were discussed at the formal CoG meetings:

April 2020

- An extraordinary meeting was called to consider recommendations from the Nominations Committee in relation to Chair and NED terms of office and to consider a proposal regarding the elections to the CoG.

June 2020

- The Council also considered breaches by a Governor of the Governors' Code of Conduct.
- The Council received an update on the COVID-19 position at the Trust and the recovery plan; the Devon system position; a Trust staffing update and a Trust finance update.

August 2020

- The Council received updates on the COVID-19 pandemic response, the MY CARE Programme, the Care Quality Commission (CQC) Inpatient Survey 2019, the collaborative agreement with NDHT, the development of the integrated care system, and a car parking / travel update.
- Professor Chris Bones provided an update on the Patient Experience Committee.

November 2020

- The CoG received an update on Patient-Led Assessment of the Care Environment (PLACE).
- NED Steve Kirby provided an update in order to provide assurance on what the NEDs were doing to ensure the performance of the Board of Directors and to ensure governance remained a focus.
- The Council reviewed the success of the Annual Members meeting and related events and also received a membership update.

March 2021

- Governors received an update on their role in the proposed transaction with NDHT and also were able to talk in small groups with NEDs to receive their assurance about the integration process.
- The Council received updates on the COVID-19 pandemic response and recovery, the recent Government white paper, the strategic alliance with South Devon Healthcare Trust, the proposed integration with NDHT, and a financial overview.
- NED remuneration and Nominations Committee issues.

CoG Development Days

The global pandemic and its impact on our governance meant that we suspended development days for the first six months of the financial year. We then held the following development days:

November 2020

- Joint with the Board of Directors: focus on the proposed integration with NDHT and reset and recovery from the COVID-19 pandemic

January 2021

- The CoG received and discussed COVID-19, an update on the Integrated Care System development, future quality priorities, and patient discharge and flow.

March 2021

- The CoG participated in a workshop run by NHS Providers on the Governor role in significant transactions, a workshop on the proposed transaction and how they hold NEDs accountable, and the CoG effectiveness review.

The work of the CoG

The CoG has continued to organise itself through three key working groups:

- CoG Effectiveness
- Public and Member 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 the Trust Chairman, the Lead Governor and Deputy Lead Governor, 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 members' website.

The following sets out some of the key highlights for the CoG working groups over the year.

CoG Coordinating Committee (Chair: Peta Foxall, Lead Governor)

During the year, the Committee:

- took part in an investigation into breaches of the Governors' Code of Conduct
- planned agendas for CoG meetings and CoG Development Days
- discussed the Trust's Governance Performance System 'Governance Lite', including the use of video conferencing to continue the work of the Council during an extraordinary year as organisations were still being encouraged by NHSE/I not to meet face-to-face
- received regular updates from the Working Groups
- monitored Governor attendance at CoG meetings
- Elections to CoG in 2021 were discussed in relation to the deferred elections in 2020 and the impact on voting rights, as well as current vacancies
- updates on the proposed integration with NDHT, including the role of the CoG in the transaction
- considered feedback from the joint CoG and Board development days
- discussed a review of the Patient Experience Committee which was being reviewed in light of a new Patient and Public Experience Strategy
- shared feedback on the 2020 Annual Members Meeting and engagement event

Patient Safety and Quality Working Group (Chair: Faye Doris)

The purpose of the working group is to contribute a lay/governor perspective to the Trust's Patient Experience Committee (PEC) and to the development of the Trust's Quality Account submissions and future priorities on quality. During the year the Group:

- discussed the Trust's on-going review of how it engages and involves patients, including a review of the Patient Experience Committee (PEC) of which there are Governor members and which was currently stood down
- reviewed its work plan and discussed when it would be provided with updates on the 2020/21 Quality Priorities
- received its annual Patient Safety Programme Update. This included an update on elements of the Programme including the maternity safety programme, the medicine safety programme and the Trust's Sepsis programme, and work to reduce noise at night (linked to the Governor Priority from 2019/20 patient experience at night).
- held its annual election for Chair and Vice Chair, with Michael James elected as the new Chair

CoG Effectiveness working group (Chair: Tony Ducker)

The purpose of this working group is to enhance the effectiveness of the CoG by ensuring that its knowledge base, processes and operations are fit for the purpose defined in the Health and Social Care Act 2012. During the year the Group:

- reviewed the Document Review List and its work plan.
- the CoG Effectiveness Review.
- noted the Trust Constitution was due for routine review in 2021 and that any review of membership constituencies and composition of the CoG would need to consider the formal coming together of the Trust with Northern Devon Healthcare Trust.
- reviewed the suite of Governor Code of Conduct documents, including the Standard Operating Procedure for the Process for Alleged Breach of the Governors Code of Conduct. This work was being led by the Document Review Group, a task and finish group, which has met several times since August 2020 to focus on the review of the documents.
- Elected a new Chair, with Bob Maskell replacing Tony Ducker

Public and Member Engagement working group (PMEG) (Chair: Kay Foster)

The purpose of the working group is to ensure that the CoG is meeting its duty to represent the interests of members of the Trust and the interests of the public and contribute a Governor perspective to the development of the Trust's engagement work. During the year, the group discussed:

- how best to engage with the community in North Devon if the proposed integration was to go ahead.
- the election of a new Chair and Vice Chair

Other activities

- Prospective governors' meetings
- New governor induction
- Patient-led Assessments of the Care Environment (PLACE)
- Governor attendance at regional and national Governor conferences
- Three governor members continued to serve on the Patient Experience Committee
- Development of the Trust's new website

Governor Expenses

The aggregate claims for expenses from Governors during the year 2020/21 was £91.05. In 2019/20 the figure was £1,778.41. The significant reduction in expenses occurred because meetings were held online.

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. During the year the Trust continued to provide regular updates to members during the pandemic but other than the online engagement exercise with members at the Annual Members meeting – see below.

Annual Members' Meeting (AMM) 2020 and Engagement event

All Trust Members (public and staff), Governors and other stakeholders were invited to join our virtual AMM and preceding engagement event on 30 September 2020. The decision to run the event virtually was based on the need for social distancing due to the COVID-19 pandemic.

The Member engagement part of the event included two pre-recorded 'MedExe' sessions focusing on lessons learned from the first wave of the COVID-19 pandemic; and on MY CARE. Following these talks, two focus groups took place with one focusing on feedback on our new website and the second on the Governors' quality priorities.

Following the engagement event, we then moved to the statutory Annual Members' Meeting which provided an overview of the previous financial year, the accounts and plans for future by the RD&E's Chief Executive Suzanne Tracey and Chair, James Brent. This was followed by an assurance report from our external auditors and a roundup of the Governors' year by Lead Governor Peta Foxall.

Based on advice from NHS Digital, NHS Providers and the experiences of other Trusts, we delivered the sessions via MS Teams Live and MS Teams.

83 delegates signed up to the live event. Recordings of the Engagement session and the AMM events were made available on our members' website post event.

Broadly speaking the event was a success. While the number of Members who attended the event were lower than hoped, the outcome should be viewed as encouraging – given the context of the pandemic. Positive feedback was also received verbally by James Brent and Suzanne Tracey. Our approach this year was to tread carefully in promoting the event as the

technology was untested and we knew from other parts of the country there were at least occasions where the AMM had to be run twice due to technical hiccups.

We are delighted to report a similar positive sentiment from feedback from our members' evaluation by those who were signed up to the event. The overall organisation leading up to this year's event as excellent/good and the initial information, e-news update and joining instructions for the event as excellent.

The majority of members who responded to the survey also deemed the delivery of the AMM as either good or excellent.

Governor profiles

Governors in post throughout 2020/21 to 31 March 2021

East Devon, Dorset, Somerset and the rest of England	
Peta Foxall - Lead Governor	Peta was re-elected as Public Governor in September 2019 for a term of three years. She has been a member of the RD&E's CoG since 2013 and carries out the responsibilities of the Lead Governor following election to that role by her peers in 2017. Peta has extensive experience of leading and working in multi-professional teams, primarily within the NHS, higher education and third sector organisations. She is a committed advocate for social action and demonstrates that in several ways, through volunteering in the local community and as the national Chair of The Wildlife Trusts and Trustee for Step Up To Serve.
Barbara Sweeney	Barbara was elected as a public governor in September 2017, with her term extended in 2020 for one year to 2021. She has lived in East Devon for 40 years and has recently retired from further education where she worked in governance. During her working career she has also held senior positions in management in healthcare and in higher education. Three of her four children work in the NHS and her late husband was an academic GP in Exeter. Her particular interest is in the quality of patient experience, and on the CoG she has been elected to sit on the Patient Experience Committee and the Nominations Committee. She also sits on the Patient and Members Engagement Group. Barbara is a Trustee at Hospiscare. Other Board experience includes eight years as a Governor of Exeter College.
Kay Foster	Kay Foster has been a Governor since 2014. Her term was extended in 2020 for one year to 2021. She is a retired State Register Nurse and Midwife with over thirty years nursing experiences. 18 years of this was spent serving as a Nursing Officer with the Queen Alexandra Royal Army Nursing Corps, retiring in the rank of Major. She gained a wide variety of experiences with many global postings including Saudi Arabia during the First Gulf War. She has a BSc (Hons) in Health Services Management. During six years as Governor, Kay has been a member of a number of subcommittees and Chairs the Public Members Engagement Group (PMEG). Separate from the RD&E she in the co-founder of Living Well Devon (LWD) a voluntary social enterprise group serving the community of East Devon encouraging Education and Empowerment of Optimal Health-Life Style Medicine. Kay is very proud to be a Governor of the RD&E Foundation Trust which provides quality healthcare to the community and Governors play an important role: "as a governor you will hold non-executive directors to account for the performance of the board and represent the interests of NHS foundation trust members and the public."
Bob Maskell	Bob was elected in September 2019 for one year, with his term been extended in 2020 until 2021. He has lived in East Devon all his life and his current home is in Exmouth. After completing a short career commission in the Royal Navy, attaining the rank of Lieutenant, Bob worked in export trading before moving to a customer support role in managed computer services. He has over 30 years' experience in customer facing roles. Bob has been actively involved with a local charity, the Exeter MS Thaerapy Centre, for more than 15 years and has served on their board of trustees, completing a period as chair in 2017. Having resigned as a trustee in April 2019 he continues to volunteer at the Centre as an Oxygen therapy operator.

Rachel Noar	Rachel was elected in September 2019 for a term of three years. She is Deaf and lives in Ottery St Mary. Her family's first language is British Sign Language (BSL). Rachel worked with young Deaf people at Derby College, as an Independent Support Worker, encouraging them to develop independent living skills. She went on to study Contemporary Arts/ Computer Animation, gaining an MA. She became a consultant for a disability board for East Midlands Art Council and was a member of the board of EQUATA, an arts agency for Deaf/disabled. She worked as an Advisory Deaf Inclusion worker for DCC. Rachel has also supported hearing families with deaf babies/toddlers and worked with nurseries and schools to develop the inclusion of Deaf children in mainstream situations. Since developing MS, she has become the full time mother of two boys.
Tony Wilkinson	Tony was elected in 2019 for a three year term. After studying philosophy at university, Tony first worked for the government on tax policy and then moved to the private sector to work on financial advice for developing countries. He later moved to investment management and finished his financial career with a spell directing IT. In retirement, he has published two books on ethics and is working on a book on political philosophy. He has been an advisor, trustee and local chair at Citizens Advice. Tony is delighted to contribute as a Governor and believes the NHS is one of the best things about our country. He hopes the skills acquired in his varied career will help in holding the Board to account, the central task of the CoG. Beyond that, he hopes to improve communication to help the community to feel connection and involvement with their hospitals.

Exeter and South Devon

Faye Doris	Faye was elected in September 2016 for a term of three years and was re-elected in September 2019 for a further three years. She lives in Exeter and is a retired nurse, midwife and Associate Professor of Midwifery for the University of Plymouth. She has been an active member of the CoG at RD&E NHS FT and was elected Deputy Lead Governor in 2018. Faye is the Chair of the Patient Safety and Quality Working Group of the CoG, and a member of the RD&E NHS FT Patient Experience Committee and the Equality, Diversity and Inclusion Steering Committee. She brings to the Council experience of leadership and management, listening and responding to stakeholder and staff feedback. As a governor Faye supports all aspects of inclusivity and is a member of the Deaf and Hard of Hearing Working Group at RD&E NHSFT. She believes in the NHS providing safe and effective care that is kind, compassionate and fair to all.
Tony Ducker	Tony was elected for his second three year term in September 2017. His term was extended in 2020 for one year to September 2021. 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 and national committees including a National Institute for Health and Care Excellence (NICE) guideline group. Tony spent 27 years as a member of the Territorial Army including 5 as commanding officer of 220 Field Ambulance in Maidstone. Since retiring, he has worked with Clinical Commissioning Groups as Lead Clinician for the appraisal of neonatal units in East of England and South West England. Tony continues to work in his medico legal practice and is involved in the local community including two local U3As.

Olwen Goodalla	Olwen was elected as governor in September 2019 for a term of three years. Now retired from lecturing at Exeter University, her work has been in education and psychology. As a teacher, psychologist and lecturer for over 40 years, she has worked with all ages in a wide variety of contexts. She has been a school governor for 17 years. Olwen has volunteered regularly - helping to set up & work with the Exeter Rape Crisis Line and now at the Foodbank. In her role as RD&E Governor, she hopes to represent and advocate for service users and their families. She has recent experience of providing an outsider's perspective, both teaching at the medical school and also public involvement in medical research. Olwen looks forward to supporting the work of a hospital she greatly respects.
Desmond Kumar	Desmond was elected for a three year term in 2019. He was born in Guyana, South Africa on a sugar plantation next to the river Demerara. His family arrived in London in 1962, where he went to school and then moved to Exeter to study Mathematics and Economics at the University. After qualification, he joined the Devon & Cornwall Police force and was posted all around Devon. After running his own business, he taught at Blundell's School, later moving to schools in Ottery and Honiton. During this time, he coached hundreds of young people basketball, many who have gone on to represent their country and played in Europe and the USA. He is passionate about supporting our young people and believes that we all need to do our bit to help our community.

Mid, North, West Devon and Cornwall

James Bradley	James was re-elected in September 2018 for a term of three years. James was a Chartered Environmental Health Officer and Chartered Safety and Health Practitioner who having completed a military career has worked in Local Government, the National Health Service and finally as an international consultant. He is an independent lay member of the NHS England Specialised Services Public and Patient Voice Assurance Group, lay member for NHS England Specialised Services Clinical Frailty Programme of Care Board, Member of Devon County Council Commissioning Involvement Group, Chair of Okehampton Medical Centre Patient Participation Group, Member of South West Academic Health Science Network Quality Assurance panel, Expert Advisor for the University of Surrey on their Therapeutic Radiographer and Dietitian Prescribing Project Advisory Group, Trustee of West Devon Community and Voluntary Services and Treasurer of Devon Health and Social Care Forum. He is a passionate and committed individual in regard to ensuring that the lay voice and perspective is always articulated and the patient perspective is heard whenever and wherever the need arises. His hobbies include gardening, stamp collecting and helping others, especially his wife.
Peter Flatters	Peter was elected Governor in September 2019 for a three year term. His previous career concerned the collection, interpretation and presentation of scientific data. After University he worked for ICI as a Field Team Leader, conducting Agrochemical Trials on farms across Southern England. Later, he moved into R&D Planning with ICI before transferring to the University of Bristol's Long Ashton Research. When the research station closed, he became a rural Sub-Postmaster in a Devon village. He ran the PO for eight years, steering people through varied business, from fishing licences to Banking and guiding pensioners through the transition to chip and PIN cards. His background in science, regulation and customer service provides a sound preparation for Hospital Governance.

Monika Herpoldt-Bright	Monika was elected for a three year term in September 2019. She is a retired Cabin Service Director with a degree in education who lives just outside Crediton. Having been raised and educated in Exeter she is very aware of the needs of the community. She has volunteered for the past 16 years as a Samaritan and was privileged to be their Director. She now has a national role as a Quality Mentor. Having been a cancer patient and more recently having had one of her sisters undergoing major surgery she is very aware not only of the negative aspects of the hospital, but more especially what an amazing asset to the community the RD&E is.
Michael James	Michael was elected for a second term of three years as Governor in September 2019. He has always been very active as a governor and worked hard to insure the specific and special rural aspects of decision making is as high up all agendas as possible. He is a member of the Patient Safety & Quality Working Group keeping the particular interests of safety and the wellbeing of those he represents properly considered. His working background was in Science, Engineering and Business, big and small. For many years he was the Devon Chairman of a Nation Federation of small specific businesses. Before retiring in 2011, he, his wife and children ran a village shop in the Heart of Devon. He is fond of investigating and enjoying the many cultures and differences of people in Devon and around the world. He travels as often as possible and has been an active member of the community. His hobbies include Family and Local History, specialist gardening and experimental cooking.
Marcus Pipe	Marcus was elected in September 2019 for a term of one year. His term was extended in 2020 for one year to September 2021. Formerly Deputy Police and Crime Commissioner for Dorset, he has a good grasp of governance and understands the difference between being involved in the executive functions of the organisation and holding others to account for how those executive functions are performed. Marcus was formerly a Civil Servant, primarily serving in the Ministry of Justice and during that time he spent 15 years as a Magistrate. More recently he has been a Legal Ombudsman. Since his appointment as a Governor, Marcus has also worked part time providing care to the elderly.

Staff	
Catherine Geddes	Catherine was first appointed in September 2016 for a term of two years and re-elected in September 2018 for a further term of three years. She is a member of the Patient Safety and Quality Working Group. 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	Hazel was appointed staff governor in 2013 and was re-appointed for a second 3-year term in September 2016. (This has been extended for an additional year due to COIV-19 disruptions). 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.

Dominic Hazell	Dominic was elected as a Staff Governor in September 2018 for a term of two years. His term was extended by one year to September 2021. 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.
Rob Biggar	Rob was elected as staff governor in September 2019 for a three year term. He is the lead physicist in radiotherapy treatment planning, with a background of eight+ years providing service development and direct patient care, within oncology. Rob has experience at different NHS trusts across Merseyside and Wirral before moving to the RD&E. Rob's role requires solving complex technical, clinical and logistical problems and help implement solutions to improve patient safety and clinical outcomes. Rob is also an honorary lecturer at the University of Liverpool. He is a member of the Institute of Physics and a chartered scientist.
Anum Shuja	Anum was elected for a term of one year in September 2019, which was extended in 2020 for an additional year until September 2021. Anum has over a decade of experience in client services and relationship management. Anum has worked for both, the private and not for profit sector in a diverse set of service providing roles. Anum joined the RD&E in 2018, as a Patient Experience Lead for the Community Services Division. This allowed her to continue her ambition of working in the service industry in a role that focused on care for others. Anum is passionate about the NHS - both, as a service user, and as an employee. She believes that the organization should continue striving for the highest level of care, by ensuring the staff and patients are at the centre of every decision made. Anum is particularly interested in improving communication between the senior team and the diverse staff population. In her spare time, Anum enjoys spending time with her family and volunteers at her local school.

Appointed

Cllr Phil Twiss	Councillor Phil Twiss is one of two appointed Governors and represents Devon County Council starting his term of office in May 2018, running until May 2021. He is the County Council member for the Feniton & Honiton Division. Phil sits on the DCC Adult Health Scrutiny Committee reporting to the Leader of the Council Health as the Scrutiny liaison and has developed an interest in the whole Health and wellbeing agenda. The RD&E NHS Trust is an important part of his learning that is shared with others as part of contributing to improving services on behalf of all residents in Devon.
Professor Angela Shore	Angela was appointed on behalf of the University of Exeter in 2016. She is Professor of Cardiovascular Sciences and was Vice Dean Research at the University of Exeter Medical School until 2019. Angela is 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, was Treasurer for the European Society for microcirculation for over 10 years and is a member of the International Liaison Committee for World Microcirculation Research.

Other Governors in post during the year

- Andrew Beresford (East Devon, Dorset, Somerset and Rest of England) – until June 2020
- John Murphy (Exeter and South Devon) – until September 2020
- Chris Green (Exeter and South Devon) – until January 2021

Elections to CoG 2020

As a consequence of the COVID-19 pandemic, NHSE/I contacted all Foundation Trusts to propose changes in order to reduce the burden of reporting and to free up senior capacity to prioritise the management of the COVID-19 pandemic.

In light of this direction and taking into account the need to focus on managing COVID-19, the Council of Governors proposed some temporary changes to the Constitution at an extraordinary meeting on 9 April 2020. The RD&E Board subsequently approved the proposed changes to the Constitution to ensure business continuity, maintain good governance, and to pay heed to ongoing government guidance on social distancing and avoiding non-essential travel. The changes approved by the RD&E Board were:

- to remove the need for routine Council of Governor elections in 2020
- to offer those Governors whose term of office came to an end in September 2020 an extension to September 2021. The proposal was made in order to maintain the status quo of the Council and to not disadvantage those Governors whose term of office was due to end in September 2020.

The Governors who had their terms extended in line with these changes were:

- Kay Foster (East Devon, Dorset and Somerset and Rest of England)
- Bob Maskell (East Devon, Dorset and Somerset and Rest of England)
- Barbara Sweeney (East Devon, Dorset and Somerset and Rest of England)
- Tony Ducker (Exeter & South Devon)
- Marcus Pipe (Mid, North, West Devon & Cornwall)
- Dominic Hazell (Staff)
- Hazel Hedicker (Staff)
- Anum Shuja (Staff)

At its extraordinary meeting in April 2020, the Council of Governors agreed that a plan would be developed to ensure that annual elections are maintained from 2021 onwards bearing in mind the need to retain the balance of the different categories of Governors on the Council (as set out as requirements 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 2020/21

P = Public C = Confidential	Extraordinary CoG meeting	Jun 20		Aug 20		Sept 20 AMM	Nov 20		Mar 21	
Name of Governor	C	P*	C	P	C		P	C	P	P
Beresford, Andrew	N/A		N/A							
Biggar, Rob	P		P	P	P	P	P	P	P	P
Bradley, James	P		P	P	P	P	P	P	P	P
Doris, Faye	P		P	P	P	P	P	P	P	P
Ducker, Tony	P		P	P	P		P	P	P	P
Flatters, Peter	P		P	P	P	P	P	P	P	P
Foster, Kay	A		P	P	P	P	P	P	P	P
Foxall, Peta	P		P	P	P	P	P	P	P	P
Geddes, Catherine	A		P	A	A		A	A	A	A
Goodall, Olwyn	A		P	P	P	A	P	P	A	A
Green, Christopher	P		P	A	A	P	P	P		
Hazell, Dominic	P		P	A	A		A	A	P	P
Hedicker, Hazel	P		P	A	A	P	P	P	P	P
Herpoldt-Bright, Monika	P		P	P	P		P	P	P	P
James, Michael	P		P	P	P		P	P	P	P
Kumar, Desmond	P		P	P	P		A	A	P	P
Maskell, Bob	P		P	P	P		P	P	P	P
Murphy, John	P		P	A	A					
Noar, Rachel	P		P	A	A	P	P	P	P	P
Pipe, Marcus	A		P	A	A		A	A	P	P
Shore, Angela	P		P	P	P		P	P	P	P
Shuja, Anum	P		P	A	A	P	P	P	P	P
Sweeney, Barbara	P		P	P	P		P	P	P	P
Twiss, Phil	P		A	P	P		P	P	P	A
Wilkinson, Tony	P		P	P	P	P	P	P	P	P
James Brent, Chairman	P		P	P	P	P	P	P	P	P

Present	P
Apologies	A
Did Not Attend	DNA
Not in post	
*	Public meeting not held due to COVID in June

Voluntary Disclosures

Modern Slavery

The Trust fully supports the Government's objectives to eradicate modern slavery and human trafficking.

Modern slavery is the recruitment, movement, harbouring or receiving of children, women or men through the use of force, coercion, abuse of vulnerability, deception or other means for the purpose of exploitation. Individuals may be trafficked into, out of or within the UK, and they may be trafficked for a number of reasons including sexual exploitation, forced labour, domestic servitude and organ harvesting.

The Royal Devon & Exeter NHS FT fully supports the Government's objectives to eradicate modern slavery and human trafficking and recognises the significant role the NHS has to play. We are strongly committed to ensuring our supply chains and operational activities are free from ethical and labour standards abuses.

Slavery and human trafficking statement for financial year 2020/21

During the last financial year the Trust took, and continues to take, the following:

- We confirm the identities of all new employees and their right to work in the United Kingdom
- All staff are appointed subject to references, health checks, immigration checks and identity checks. This ensures that we can be confident, before staff commence duties, that they have a legal right to work within our Trust
- We have a set of values and behaviours that staff are expected to comply with, and all candidates are expected to demonstrate these attributes as part of the selection process
- By adopting the national pay, terms and conditions of service, we have the assurance that all staff will be treated fairly and will comply with the latest legislation. This includes the assurance that staff received, at least, the national minimum wage from 1 April 2015
- We have various employment policies and procedures in place designed to provide guidance and advice to staff and managers but also to comply with employment legislation
- Our equality and diversity, grievance, prevention of harassment & bullying and equality & diversity policies additionally give a platform for our employees to raise concerns about poor working practices
- Our policies and practices promote and support diversity and inclusion both as an employer and service provider; we recognise and acknowledge that diversity and inclusion are key corporate social responsibilities and a Diversity Network for all staff has been in place since 2017
- Our mandatory safeguarding training includes modern slavery as a topic; all clinical staff receive training as part of our Trust bespoke level 2 safeguarding adult e-learning training and also level 3 safeguarding adult training
- Our Trust "Safeguarding Adult Policy", and the Devon multi-agency safeguarding policy, to which our Trust is a partner signatory, also includes modern slavery. Our policy sign posts to the Modern Slavery helpline and website for further information. We also share information via our Safeguarding newsletter to raise awareness
- Our Freedom to Speak: Raising Concerns (Whistleblowing) Policy gives a platform for employees to raise concerns for further investigation, and our Freedom To Speak Up Guardian and Safeguarding teams actively ensure they are accessible to staff
- Our standard terms and conditions require suppliers to comply with relevant legislation. A large proportion of the goods and services procured are sourced through Government supply frameworks and contracts which also require suppliers to comply with relevant legislation

Review of effectiveness

We intend to take further steps to identify, assess and monitor potential risk areas in terms of modern slavery and human trafficking, particularly within supply chains. We aim to:

- Raise awareness and support our staff to understand and respond to modern slavery and human trafficking, and the impact that each and every individual working at our Trust can have in keeping present and potential future victims of modern slavery and human trafficking safe
- Train Procurement staff to understand modern slavery and trafficking and how to identify it.

- Ensure that all staff continue to have access to training on modern slavery and human trafficking which will provide the latest information and the skills to deal with it
- Impact assess all new or reviewed policies for diversity and inclusion compliance

The Board of Directors has considered and approved this statement and will continue to support the requirements of the legislation.

This statement is made pursuant to section 54(1) of the Modern Slavery Act 2015 and constitutes our slavery and human trafficking statement for the financial year ended 31 March 2020.

Sustainability Report

Summary

During the last year there has been ongoing works to improve the sustainability performance of the RD&E. Primarily this has been focused on reducing energy and water consumption and gearing up plans for a green restart of our services, in line with the recent NHS pledge to reach Net Zero by 2040. This means improving services through green initiatives so that we can continue to offer our patients the best quality, sustainable care in an NHS fit for the challenges of the 21st Century.

Luke Mitchell (Energy and Sustainability Manager) has been joined by Olly Mawson in the role of Sustainability and Engagement Officer to work on bold new programmes, to help engage staff and put Sustainability at the heart of the Trust's COVID recovery.

The Sustainability Engagement Officer role that Olly has taken on is designed to support and embed sustainability across the Trust, through assisting with projects and helping staff to identify and implement sustainable improvements. Everyone has a role to play in our journey to Net Zero by empowering staff to identify sustainable and green changes in their department, we can ensure we make our Trust sustainable and more climate-resilient.

Below are a few of the exciting plans that are currently in progress:

Wildflowers and Biodiversity

Luke putting in stakes for the wildflowers

You might have noticed that our Wonford site has a new addition in the form of two wildflower beds. Working with the RSPB and engaging with our own teams here, we have added these initial beds on Barrack Road for the benefit of pollinators as well as staff and visitors. We have plans to add more wildflowers on site and will be engaging both Estates team colleagues as well as staff across the Trust to make these areas fit for purpose and allow all to benefit. These plans form part of our Biodiversity and Outdoor Wellbeing Action plan (BOWAP) that will provide key actions that aim to transform our greenspaces, both for biodiversity as well as the wellbeing of all those that use our hospital sites.

Green Team

We have already had some amazing successes in previous years in helping staff to make sustainable changes in their area and this year we are being more ambitious – we are launching the Green Team initiative which is a rolling improvement programme designed to help teams in clinical and non-clinical environments make sustainable improvements. Open to both RD&E and NDHT staff, it aims to embed a culture of sustainability at all levels and raise awareness that the climate emergency is also a health emergency.

Previous entrants for the Green Team

Green Pledges

Recovering from the COVID-19 pandemic, many people's lives will have been irreversibly changed. Many of our habits, from what we buy to how we commute to work have changed. We have been calling on people to reflect about the past year and any new green habits they have taken up (litter picking, cycling to work, walking in their local woodland) and pledge to keep these things going. We understand that it is these actions and pledges that help build momentum in sustainability and will encourage all staff to be involved in promoting their green pledge.

North Devon

The merger of NDHT and RD&E brings exciting opportunities to bolster our sustainability efforts. Both Trusts have recently carried out multi million pound capital projects to reduce energy and water consumption and are now looking to make broader improvements.

'Solar Selfie' - L to R: Olly Mawson, Luke Mitchell, Steve Gladwin and Clare Jones

Sustainability team photo: Olly Mawson, Luke Mitchell Steve Gladwin (ND Assurance, Compliance & Sustainability Manager) and Clare Jones (ND Energy, Sustainability and Compliance Officer).

Energy, Water and Carbon Reduction

In 2019 the RD&E contracted with Centrica Business Solutions to deliver an Energy Performance Contract and the construction phase successfully completed in November 2020. This project saw the installation of ~£7m of high efficiency generation and demand reduction technologies aimed at reducing carbon dioxide (CO_2) emissions and achieving substantial, guaranteed, cost savings.

Following a detailed audit of RD&E sites, proposals were developed and agreed in partnership with the Estates team. The improvements were installed across the estate and included:

- Sensors for air conditioning units to minimise run times
- Improvements to the ventilation systems
- Insulation
- LED light fittings
- Photovoltaic (PV) panels
- Water-saving systems such as automatic hand taps and efficient toilet flushes
- Replacement boilers
- Heating system control upgrades
- 1.5MWe Combined Heat and Power (CHP) generator

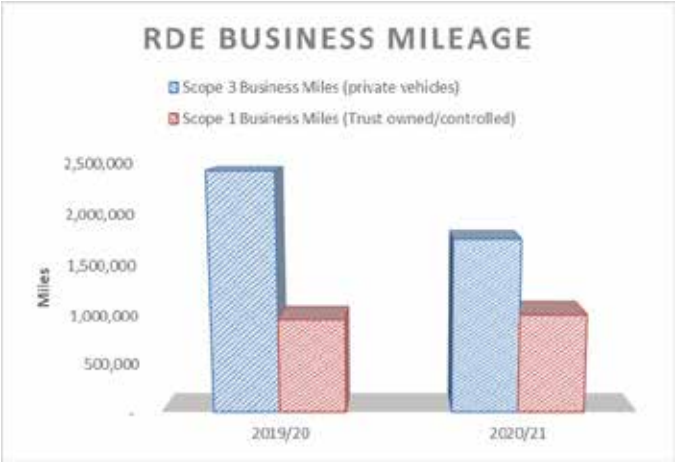
These improvements will reduce the Trust's annual utility costs by over £800,000 and cut CO_2 emissions by 2,200 tonnes per year. This is around a 20% reduction in building CO_2 emissions and at least a 17% reduction in utilities costs.

At the end of 2020 the Estates and Facilities Team developed another project and secured £200k in grant funding from the Public Sector Decarbonisation Scheme (PSDS) to deliver further CO_2 reduction work. This project will capture waste heat and use it in the Linen Decontamination Unit, saving £20k and 237t/CO_2 each year. This project is currently underway and is scheduled for completion in June 2021.

Trust data:

Travel:

	2019/20	2020/21
Scope 3 Business Miles (private vehicles)	2,418,758	1,753,710
Scope 1 Business Miles (Trust owned/controlled)	948,961	1,000,848



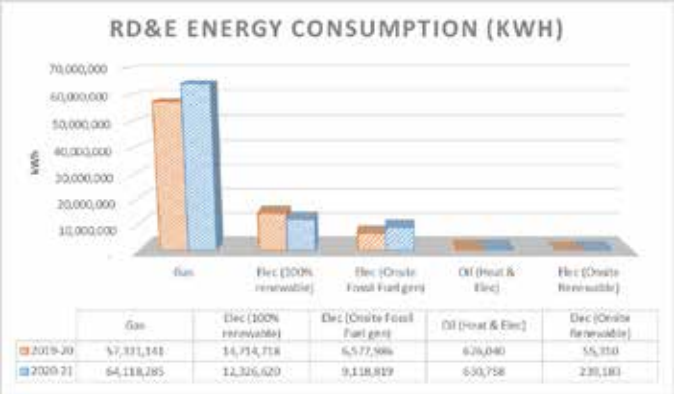
Waste:

	2019-20		2020-21	
	tonnes	£	tonnes	£
Clinical waste	812	307,222	722	278,465
Domestic/black bag waste (0% to landfill)	867	157,332	794	160,022
Recycling (including: Dry Mixed, Paper, WEE)	111	31,894	102	33,988
Food Waste	30	3,906	123	8,808

The reduction in clinical and domestic waste in 2020-21 was caused by many of the normal hospital functions being shut down due to COVID.

Utilities

	kWh	
	2020-21	2019-20
Gas	64,118,285	57,331,141
Elec (100% renewable)	12,326,620	14,714,718
Elec (Onsite Fossil Fuel gen)	9,118,819	6,577,986
Oil (Heat & Elec)	630,758	626,040
Elec (Onsite Renewable)	239,183	55,310



Gas usage increased due to the installation of the new CHP generator, which has increased the amount of onsite electrical generation. The increased ventilation of buildings due to COVID also resulted in a 9.93% increase in heating gas use.

ROYAL DEVON AND EXETER NHS FOUNDATION TRUST

ANNUAL ACCOUNTS

YEAR ENDED 31 MARCH 2021

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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, and overseeing the use of public funds, 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 and disclose any material uncertainties over going concern.

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.

As far as I am aware, there is no relevant audit information of which the Foundation Trust's auditors are unaware, and I have taken all the steps that I ought to have taken to make myself aware of any relevant audit information and to establish that the entity's auditors are aware of that information.

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:

Date: 14 June 2021

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

Opinion

We have audited the financial statements of Royal Devon and Exeter NHS Foundation Trust ("the Trust") for the year ended 31 March 2021 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Trust 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 2021 and of its income and expenditure for the year then ended; and
- 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 and the Department of Health and Social Care Group Accounting Manual 2020/21.

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.

Going concern

The Directors have 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 its 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").

In our evaluation of the Directors' conclusions, we considered the inherent risks to the Trust's business model and analysed how those risks might affect the Trust's financial resources or ability to continue operations over the going concern period.

Our conclusions based on this work:

- we consider that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate;
- we have not identified, and concur with the Directors' assessment that there is not a material uncertainty related to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for the going concern period.

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.

Fraud and breaches of laws and regulations – ability to detect

Identifying and responding to risks of material misstatement due to fraud

To identify risks of material misstatement due to fraud ("fraud risks") we assessed events or conditions that could indicate an incentive or pressure to commit fraud or provide an

opportunity to commit fraud. Our risk assessment procedures included:

- Enquiring of management, the Audit Committee and internal audit and inspection of policy documentation as to the Trust's high-level policies and procedures to prevent and detect fraud, including the internal audit function, and the Trust's channel for "whistleblowing", as well as whether they have knowledge of any actual, suspected or alleged fraud.
- Reading Board and Audit Committee minutes.
- Using analytical procedures to identify any usual or unexpected relationships.
- Reviewing the Trust's accounting policies.

We communicated identified fraud risks throughout the audit team and remained alert to any indications of fraud throughout the audit.

As required by auditing standards, and taking into account the current financial regime, we performed procedures to address the risk of management override of controls and the risk of fraudulent revenue recognition, in particular the risk of incentive for revenue to be manipulated into the wrong period around the year end.

In line with the guidance set out in Practice Note 10 Audit of Financial Statements of Public Sector Bodies in the United Kingdom we also recognised a fraud risk related to expenditure recognition, particularly in relation to year-end accruals. We consider this risk to be applicable to non-payroll and non-depreciation expenditure.

We also performed procedures including:

- Identifying journal entries and other adjustments to test based on risk criteria and comparing the identified entries to supporting documentation. These included unexpected account pairings and unexpected users.
- Evaluating the business purpose of significant unusual transactions.
- Assessing significant estimates for bias.
- Inspecting transactions in the period prior to and following 31 March 2021 to verify revenue had been recognised in the correct accounting period.
- Inspecting transactions in the period prior to 31 March 2021 to verify expenditure had been recognised in the correct accounting period.
- Evaluating accruals posted as at 31 March 2021 and verifying accruals are appropriate and accurately recorded.
- Assessing the completeness of disclosed related party transactions and verifying they had been accurately recorded within the financial statements

Identifying and responding to risks of material misstatement due to non-compliance with laws and regulations

We identified areas of laws and regulations that could reasonably be expected to have a material effect on the financial statements from our general sector experience and through discussion with the directors and other management (as required by auditing standards), and from inspection of the Trust's regulatory and legal correspondence and discussed with the directors and other management the policies and procedures regarding compliance with laws and regulations.

As the Trust is regulated, our assessment of risks involved gaining an understanding of the control environment including the entity's procedures for complying with regulatory requirements.

We communicated identified laws and regulations throughout our team and remained alert to any indications of non-compliance throughout the audit.

The potential effect of these laws and regulations on the financial statements varies considerably.

The Trust is subject to laws and regulations that directly affect the financial statements including financial reporting legislation. We assessed the extent of compliance with these laws and regulations as part of our procedures on the related financial statement items.

Whilst the Trust is subject to many other laws and regulations, we did not identify any others where the consequences of non-compliance alone could have a material effect on amounts or disclosures in the financial statements.

Context of the ability of the audit to detect fraud or breaches of law or regulation

Owing to the inherent limitations of an audit, there is an unavoidable risk that we may not have detected some material misstatements in the financial statements, even though we have properly planned and performed our audit in accordance with auditing standards. For example, the further removed non-compliance with laws and regulations is from the events and transactions reflected in the financial statements, the less likely the inherently limited procedures required by auditing standards would identify it.

In addition, as with any audit, there remained a higher risk of non-detection of fraud, as these may involve collusion, forgery, intentional omissions, misrepresentations, or the override of internal controls. Our audit procedures are designed to detect material misstatement. We are not responsible for preventing non-compliance or fraud and cannot be expected to detect non-compliance with all laws and regulations.

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; and
- in our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2020/21. We have nothing to report in this respect.

Remuneration and Staff Reports

In our opinion the parts of the Remuneration and Staff Reports subject to audit have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2020/21.

Accounting Officer's responsibilities

As explained more fully in the statement set out on page 2, 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

Report on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report if we identify any significant weaknesses in the arrangements that have been made by the Trust to secure economy, efficiency and effectiveness in its 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 paragraph 1(d) of Schedule 10 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 and related statutory guidance having regard to whether the Trust had proper arrangements in place to ensure financial sustainability, proper governance and the use of information about costs and performance to improve the way it manages and delivers its services. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice to report to you if:

- any reports to the Regulator have been made under paragraph 6 of Schedule 10 of the National Health Service Act 2006.
- any matters have been reported in the public interest under paragraph 3 of Schedule 10 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.

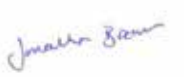
THE PURPOSE OF OUR AUDIT WORK AND TO WHOM WE OWE OUR RESPONSIBILITIES

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 for the year ended 31 March 2021 in accordance with the requirements of Schedule 10 of the National Health Service Act 2006 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP
Chartered Accountants
66 Queen Square
Bristol
BS1 4BE

15 June 2021

FOREWORD TO THE ACCOUNTS

These accounts for the year ended 31 March 2021 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.

Signed:

Date: 14 June 2021

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2021

	Note	2020/21 £000	2019/20 £000
Income from activities	3	**511,421**	468,713
Other operating income	4	**145,331**	96,965
Operating income		**656,752**	565,678
Operating expenses	5	**(667,820)**	(593,799)
Operating (deficit)		**(11,068)**	(28,121)
Finance costs			
Finance income	10	**20**	684
Finance expense	11	**(756)**	(542)
PDC dividends payable		**(4,289)**	(4,410)
Net finance costs		**(5,025)**	(4,268)
Other gains / (losses)	12	**9**	(5)
(Deficit) for the year		**(16,084)**	(32,394)
Other comprehensive income			
Revaluation gains on property, plant and equipment	16.3	**9,468**	5,357
Total comprehensive (deficit) for the year		**(6,616)**	(27,037)

The Trust's deficit for the year in both 2020/21 and 2019/20 includes transactions relating to impairment charges of £18.6m in 2020/21 (£26.5m in 2019/20). The Annual Report (page 85) provides further details of the 2020/21 impairment.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2021

	Note	31 March 2021 £000	31 March 2020 £000
Non-current assets			
Intangible assets	15	**42,135**	265
Property, plant and equipment	16	**270,474**	249,125
Investment in joint venture	17	**5**	5
Trade and other receivables	19	**2,595**	2,455
Total non-current assets		**315,209**	251,850
Current assets			
Inventories	18	**10,801**	8,709
Trade and other receivables	19	**24,405**	35,132
Cash and cash equivalents	23	**63,543**	58,081
Total current assets		**98,749**	101,922
Current liabilities			
Trade and other payables	20	**(69,657)**	(49,479)
Borrowings	21	**(6,029)**	(3,171)
Provisions	22	**(372)**	(352)
Other liabilities	20	**(9,009)**	(5,163)
Total current liabilities		**(85,067)**	(58,165)
Total assets less current liabilities		**328,891**	295,607
Non-current liabilities			
Borrowings	21	**(66,132)**	(59,074)
Provisions	22	**(1,617)**	(1,436)
Other liabilities	20	**(1,959)**	(2,048)
Total non-current liabilities		**(69,708)**	(62,558)
Total assets employed		**259,183**	233,049
Financed by taxpayers' equity			
Public dividend capital		**193,805**	161,055
Revaluation reserve		**40,342**	30,874
Income and expenditure reserve		**25,036**	41,120
Total taxpayers' equity		**259,183**	233,049

The notes on pages 13 to 35 form part of these accounts.

The Annual Accounts on pages 9 to 35 were approved by the Board of Directors on 26 May 2021 and signed on its behalf by :

Date: 14 June 2021

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2021

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	**Total**
	£000	£000	£000	**£000**
Taxpayers' equity at 1 April 2019	157,531	49,035	49,996	**256,562**
Deficit for the year	-	-	(32,394)	**(32,394)**
Land and buildings impairment charge - previous revaluation element transfer to I&E reserve	-	(22,260)	22,260	**-**
Revaluations - land and buildings	-	5,357	-	**5,357**
Transfer of the excess of current cost depreciation over historical cost depreciation to the income and expenditure reserve	-	(1,258)	1,258	**-**
Public dividend capital received	3,524	-	-	**3,524**
Taxpayers' equity at 31 March and 1 April 2020	161,055	30,874	41,120	**233,049**
Deficit for the year	-	-	(16,084)	**(16,084)**
Revaluations - land and buildings	-	9,468	-	**9,468**
Public dividend capital received	32,750	-	-	**32,750**
Taxpayers' equity at 31 March 2021	**193,805**	**40,342**	**25,036**	**259,183**

Public dividend capital ("PDC")
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 organisation. It also includes additional PDC issued by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health and Social Care as a public dividend capital dividend. 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 2021

	Note	2020/21 £000	2019/20 £000
Cash flows from operating activities			
Operating (deficit)		**(11,068)**	(28,121)
Non-cash income and expense			
Depreciation and amortisation		**12,959**	9,705
Impairments		**18,594**	26,508
Decrease in trade and other receivables		**9,966**	5,834
Increase in inventories		**(2,092)**	(934)
Increase in trade and other payables		**10,784**	4,097
Increase in other liabilities		**3,757**	1,691
Increase in provisions		**202**	1,187
Income recognised in respect of capital donations		**(2,249)**	(1,498)
Net cash generated from operations		**40,853**	18,469
Cash flows from investing activities			
Interest received		**20**	684
Purchase of intangible assets		**(25,535)**	(93)
Purchase of property, plant and equipment		**(44,536)**	(48,994)
Sale of property, plant and equipment		**23**	-
Receipt of cash donations to purchase capital assets		**110**	1,498
Net cash used in investing activities		**(69,918)**	(46,905)
Cash flows from financing activities			
PDC received		**32,750**	3,524
Loans received		**10,584**	9,154
Loans repaid		**(3,014)**	(1,270)
Interest paid		**(2,125)**	(2,221)
PDC dividend paid		**(3,668)**	(5,110)
Net cash used in financing activities		**34,527**	4,077
Increase / (decrease) in cash and cash equivalents		**5,462**	(24,359)
Cash and cash equivalents at 1 April		**58,081**	82,440
Cash and cash equivalents at 31 March	23	**63,543**	58,081

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 2020/21 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, intangible assets, inventories and certain financial assets and liabilities at their value to the business by reference to their fair value.

Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the entity's services in the public sector is normally sufficient evidence of going concern. The Directors have a reasonable expectation that this will continue to be the case.

International Accounting Standard 1 (IAS 1) requires the Board to assess, as part of the accounts preparation process, the Trust's ability to continue as a going concern. In the context of non-trading entities in the public sector, the anticipated continuation of the provision of a service in the future is normally sufficient evidence of going concern. The financial statements should be prepared on a going concern basis unless there are plans for, or no realistic alternative other than, the dissolution of the Trust without the transfer of its services to another entity within the public sector.

In preparing the financial statements, the Board of Directors have considered the Trust's overall financial position against the requirements of IAS1.

The Trust recorded a deficit of £16.1m for the year ended 31 March 2021, however, excluding impairment charges and donated income the Trust achieved a break even position. The Trust's cash balance as at the 31st March 2021 was £63.5m. The Trust has operated throughout the whole of 2020/21 under a fixed income financial regime. It has been confirmed that this arrangement will operate until at least 30 September 2021. The Trust is awaiting further guidance on planning for the remainder of the financial year, however, the current cash position, with future funding and potential borrowing is expected to be sufficient to cover cash requirements for the remainder of the going concern period.

It is also noted that the cash regime within the NHS for new financial revenue support will be in the form of non-repayable Public Dividend Capital, rather than interest bearing loans. Therefore, should the Trust be in need of cash support it will not be in the form of repayable debt.

Based on the factors outlined above, the Board of Directors has a reasonable expectation that the Trust will have access to adequate resources to continue to deliver the full range of mandatory services for the 12 months from the date of approval of the financial statements and fulfill any liabilities as they fall due. The Directors consider that this provides sufficient evidence that the Trust will continue as a going concern for the 12 months from the date of approval of the financial statements. On this basis, the Trust has adopted the going concern basis for 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).

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.1 Income recognition (continued)

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019/20 and 2020/21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below.

2020/21
The main source of income for the Trust is contracts with commissioners for health care services. In 2020/21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at a Sustainability and Transformation Partnership level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

Comparative period (2019/20)
In the comparative period, the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of health care was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

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.

1.2 Expenditure on employee benefits

Short-term employee benefits

Salaries, wages and employment-related payments such as social security costs and the apprenticeship levy are recognised in the period in which the service is received from employees. The cost of annual leave entitlement earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry-forward leave into the following period.

Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employers, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

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, mastheads, publishing titles, customer lists and similar items are not capitalised as intangible assets.

Expenditure on research is not capitalised. Expenditure on development is capitalised where it meets the requirements set out in IAS 38.

Measurement and revaluation

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.

The fair value of intangible assets is determined where necessary by a valuation undertaken by a professionally qualified independent valuer. Valuations are carried out primarily on the basis of depreciated replacement cost, where the asset is a non-cash generating asset. The frequency of the revaluation is dependent on the change in the fair value of the intangible asset. Revaluation gains and losses and impairments are treated in the same manner as for property, plant and equipment (see note 1.5).

Amortisation and impairment

Intangible assets are amortised over their expected useful lives in a manner consistent with the consumption of economic or service delivery benefits.

The carrying value of intangible assets is reviewed for impairment if events or changes in circumstances indicate the carrying value may not be recoverable.

Software

Software which is integral to the operation of hardware, e.g. an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software which is not integral to the operation of hardware, e.g. application software, is capitalised as an intangible asset.

Purchased computer software licences are capitalised as intangible assets where expenditure of at least £5,000 is incurred and amortised over the shorter of the term of the licence and their useful lives.

Asset category	Useful life (years)
Software licences	3 - 15

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.4 Intangible assets (continued)

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.

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. Note 16.3 provides details of the most recent valuation which was undertaken.

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.

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.5 Property, plant and equipment (continued)

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:

Asset category	Useful life (years)
Freehold property - buildings	14 - 45
Freehold property - dwellings	19
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.

Finance-leased assets (including land) are depreciated over the shorter of the useful life or the lease term, unless the Trust expects to acquire the asset at the end of the lease term in which case the assets are depreciated in the same manner as owned assets above.

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 credited to income at the same time, 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.

The donated and grant funded assets are subsequently accounted for in the same manner as other items of property, plant and equipment.

In 2020/21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.7 Inventories and work in progress (continued)

In 2020/21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

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 -0.95% (2019/20 -0.50%), 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.

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 NHS Resolution 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.13 Critical accounting estimates and judgements (continued)

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.

Accounting judgement - Intangible Asset valuation

The intangible asset relating to the Health Record System has been valued on a depreciated replacement cost basis and therefore management has used an external valuer to assess what the current replacement cost would be, taking into account the learning curve of the Trust over the past five years and current market prices, with the assumption that any replacement software would provide the same required functionality.

Revisions to accounting estimates are recognised in the period in which the estimate is revised.

1.14 Leases

Finance leases

Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease. The implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for an item of property plant and equipment. The annual rental charge is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to finance costs in the Statement of Comprehensive Income.

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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

1.16 Financial instruments and financial liabilities (continued)

Classification and measurement

Financial assets are categorised as 'loans and receivables'. Financial liabilities are classified as 'other financial liabilities'.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments that are not quoted in an active market. They are included in current assets.

The Trust's loans and receivables comprise: cash and cash equivalents, NHS receivables, accrued income and 'other receivables'.

Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Other financial liabilities

Other financial liabilities are recognised initially at fair value, net of transaction costs incurred, and measured subsequently at amortised cost using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash payments through the expected life of the financial liability or, when appropriate, a shorter period, to the net carrying amount of the financial liability.

They are included in current liabilities except for amounts payable more than 12 months after the statement of financial position date, which are classified as non-current liabilities.

Interest on financial liabilities carried at amortised cost is calculated using the effective interest method and charged to finance costs. Interest on financial liabilities taken out to finance property, plant and equipment or intangible assets is not capitalised as part of the cost of those assets.

Impairment of financial assets

At the statement of financial position date, the Trust assesses whether any financial assets are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced through the use of a bad debt provision that is determined specifically on individual assets.

1.17 Corporation tax

The Trust is a Health Service Body within the meaning of s519A of the Income and Corporation Tax Act 1988 and accordingly is exempt from taxation in respect of income and capital gains within categories covered by this. There is a power for HM Treasury to dis-apply the exemption in relation to specified activities of an NHS foundation trust (s519A (3) to (8) of the Income and Corporation Taxes Act 1988). Accordingly, the FT is potentially within the scope of corporation tax in respect of activities which are not related to, or ancillary to, the provision of healthcare, and where the profits there from exceed £50,000 per annum. Until the exemption is dis-applied then the FT has no corporation tax liability.

1.18 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.

NOTES TO THE ACCOUNTS

1. ACCOUNTING POLICIES (CONTINUED)

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 have received financial information relating to operating segments in the form of analysis of variances against budget. The analysis focusses on variances to budget and does not provide details of total income and expenditure by operating segment. As this analysis is not in a suitable format to be reconciled to the Trust's income and expenditure per the Statement of Comprehensive Income, the information has not been included within these Accounts.

3. Income from activities

	2020/21 £000	2019/20 restated £000
Block contract / system envelope income*	**366,586**	335,705
High cost drugs and devices income from commissioners	**62,295**	54,295
Other NHS clinical income	**1,232**	2,756
Private patient income	**478**	1,662
Other clinical income	**6,065**	1,506
Community services income from CCGs and NHS England and Devon County Council	**58,428**	57,743
Additional pension contribution central funding**	**16,337**	15,046
	511,421	468,713

*As part of the coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020/21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

**The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019/20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

3.1 Income from activities - by source

	2020/21 £000	2019/20 £000
NHS England	**139,864**	129,091
Clinical commissioning groups	**370,122**	336,320
NHS trusts	**225**	337
Local authorities	**11**	18
Non-NHS - private patients	**389**	1,301
Non-NHS - overseas patients (non-reciprocal)	**89**	361
NHS injury scheme	**586**	953
Non-NHS - other	**135**	332
	511,421	468,713

NHS Injury Scheme income is subject to a provision for doubtful debts of 22.43% (2019/20 - 21.79%) to reflect expected rates of collection based upon historical experience.

NOTES TO THE ACCOUNTS

3.2 Income from overseas visitors

	2020/21 £000	2019/20 £000
Income recognised this year	**89**	361

4. Other operating income

	2020/21 £000	2019/20 £000
Research and development	**20,710**	18,991
Education and training	**16,347**	14,094
Charitable and other contributions to expenditure	**2,249**	1,498
Non-patient care services to other bodies	**29,468**	39,709
Staff recharges	**4,614**	4,368
Provider sustainability funding / Marginal rate emergency tariff funding	**-**	6,583
Reimbursement and top up funding *	**59,830**	-
Rental revenue from operating leases	**5**	19
Other	**12,108**	11,703
	145,331	96,965

Included within "Non-patient care services to other bodies" are laundry / decontaminations services, transport services, payroll services, IT services, audit services, diagnostic services, GP trainee income, Winter Funding and drug and pharmacy sales totalling £25.3 million (2019/20 - £34.5 million). Better Care Funding of £2.9 million (2019/20 - £3.8million) is also included in this category.

Included within "Other income" above is catering income of £1.4 million, (2019/20 - £2.9 million), car parking income of £0.3 million (2019/20 - £2.3 million), nursery/crèche income of £1.1m (2019/20 - £1.3 million), staff accommodation £0.5 million (2019/20 - £0.6 million), contributions to expenditure consumables (inventory/equipment) donated from DHSC group bodies £5.8m (2019/20 - £nil).

* Reimbursement and top up funding includes the reimbursement of COVID-19 costs, Nightingale site costs and top-up relating to months one to six within 2020/21.

5. Operating expenses

	2020/21 £000	2019/20 £000
Services from NHS and DHSC bodies	**4,240**	2,884
Services from non-NHS and non-DHSC bodies	**8,128**	8,308
Employee expenses - executive directors (see note 5.1)	**843**	795
Employee expenses - executive directors recharged to NDHT (included in income)	**504**	450
Employee expenses - non-executive directors (see note 5.1)	**120**	125
Employee expenses - non-executive directors recharged to NDHT (included in income)	**28**	25
Employee expenses - staff	**380,507**	343,658
Drug costs	**66,481**	59,407
Supplies and services - clinical (excluding drug costs)	**56,929**	52,874
Supplies and services - general	**7,639**	5,862
Establishment	**9,268**	7,109
Research and development - not included in employee expenses	**14,203**	12,947
Research and development - included in employee expenses (see note 6.1)	**5,319**	5,264
Education and training - not included in employee expenses	**2,472**	1,269
Education and training - included in employee expenses (see note 6.1)	**13,882**	12,826
Transport	**2,623**	2,042
Premises	**38,451**	16,063
Increase in bad debt provision	**63**	18
Depreciation	**11,595**	9,665
Amortisation of intangible assets	**1,364**	40
Impairments - buildings	**-**	26,508
Impairments - intangibles	**18,594**	-
Audit fees - statutory audit	**84**	74
Non-audit fee - audit related assurance services	**-**	2
Internal audit fees	**266**	262
Clinical negligence - amounts payable to NHSLA (premiums)	**13,125**	12,461
Losses, ex gratia and special payments	**102**	276
Consultancy	**1,402**	1,006
Other	**9,588**	11,579
	667,820	593,799

"Other expenditure" above includes operating lease expenditure and patient travel.
The total employer's pension contributions are disclosed in note 6.1.

NOTES TO THE ACCOUNTS

5.1 Directors' remuneration and other benefits

	2020/21 £000	2019/20 £000
Aggregate directors' remuneration	**1,376**	1,314
Employer's contribution to pension scheme	**119**	81
Total	**1,495**	1,395

In the year ended 31 March 2021 seven directors accrued benefits under defined benefit pension schemes (2019/20 - four).

5.2 Auditor's remuneration

The audit fee, which includes statutory audit and quality accounts, was £84,000 in 2020/21 (2019/20 - £76,000), this includes £5,000 for the audit of the Trust's general charity.

5.3 Auditor's liability

The Board of Governors has appointed KPMG LLP as external auditors. The engagement letter signed on the 3rd June 2020 states that the liability of KPMG, its members, partners and staff (whether in contract, negligence or otherwise) shall in no circumstances exceed 125% of the annual fee in the aggregate in respect of all services (2019/20 - 125% of the annual fee).

5.4 Nightingale Hospital

During 2020/21 the Trust was a host Trust for a Nightingale facility as part of the regional coronavirus pandemic response.

The costs incurred by the Trust in operating the facility have been included within the Operating expenses note 5 in these accounts. The total costs associated with the facility are disclosed below for information; this includes where existing resources were redeployed so the note below does not represent the additional cost to the Trust of operating the facility. Incremental costs associated with operating the facility have been reimbursed by NHS England.

	Gross costs 2020/21 £000
Set up costs:	
Staff costs	**803**
Other operating costs	**21,237**
Running costs:	
Staff costs	**1,724**
Other operating costs	**3,904**
Total gross costs	**27,668**

5.5 Operating leases

	2020/21 £000	2019/20 £000
Operating lease payments recognised in expenses	**6,041**	5,577

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.

5.6 Future aggregate minimum lease payments due under non-cancellable operating leases are as follows:

	2020/21			2019/20		
	Land and buildings £000	Other £000	Total £000	Land and buildings £000	Other £000	Total £000
No later than 1 year	**4,186**	**1,439**	**5,625**	4,114	1,574	5,688
Later than 1 year and no later than 5 year	**16,742**	**2,094**	**18,836**	15,871	3,371	19,242
Later than 5 years	**14,705**	**126**	**14,831**	17,675	83	17,758
	35,633	**3,659**	**39,292**	37,660	5,028	42,688

NOTES TO THE ACCOUNTS

6. Staff costs and numbers

6.1 Staff costs

	2020/21 £000	2019/20 £000
Salaries and wages	**316,945**	283,420
Social security costs	**27,955**	25,746
Apprenticeship levy	**1,503**	1,382
Employer contributions to NHSPA	**53,870**	49,615
Termination benefits	**148**	105
Agency and contract staff	**8,152**	10,592
	408,573	370,860
Costs capitalised as part of assets	**7,252**	7,605
	401,321	363,255
Analysed into operating expenses (see note 5):		
Employee expenses staff	**380,507**	343,658
Employee expenses executive directors	**843**	795
Employee expenses - executive directors recharged to NDHT (included in income)	**504**	450
Research and development	**5,319**	5,264
Education and training	**13,882**	12,826
Internal Audit staff costs	**266**	262
	401,321	363,255

6.2 Average number of persons employed including directors

	Permanent employees Number	Other employees Number	2020/21 Total Number	2019/20 Total Number
Medical and dental	902	19	**921**	860
Ambulance staff	2	-	**2**	2
Administration and estates	1,481	119	**1,600**	1,543
Healthcare assistants and other support staff	2,504	251	**2,755**	2,597
Nursing, midwifery and health visiting staff	2,047	76	**2,123**	2,040
Scientific, therapeutic, technical and healthcare science staff	961	18	**979**	947
Other	15	-	**15**	-
Total	**7,912**	**483**	**8,395**	7,989

6.3 Staff exit packages

Exit package cost	2020/21 Number	2020/21 £000	2019/20 Number	2019/20 £000
Less than £10,000	**8**	**34**	27	70
£10,000 to £25,000	**2**	**24**	5	65
£25,001 to £50,000	**2**	**77**	1	25
£100,001 to £150,000	**1**	**101**	-	-
Total number	**13**	**236**	33	160

Exit packages relate to staff redundancies and payments in lieu of notice and include employer's NIC.

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 2021, is based on valuation data as at 31 March 2020, updated to 31 March 2021 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.

NOTES TO THE ACCOUNTS

7. Pensions (continued)

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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

8. Retirements due to ill-health

During 2020/21 there were two (2019/20 - seven) early retirements from the Trust agreed on the grounds of ill-health. The estimated additional pension liabilities of these ill-health retirements will be £110,000 (2019/20 - £489,000). 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 2020/21 the Trust incurred less than £1k (2019/20 - less than £1k) arising from claims made under this legislation. The total liability accruing as a result of late payments is £nil (2019/20 £nil).

10. Finance income

	2020/21 £000	2019/20 £000
Interest on cash and cash equivalents	**20**	684

11. Finance expense

	2020/21 £000	2019/20 £000
Loans from the Independent Trust Financing Facility	**467**	541
Other loans	**290**	-
Unwinding of discount on provisions	**(1)**	1
Total	**756**	542

12. Other gains / (losses)

	2020/21 £000	**2019/20 £000**
Gains on disposal of assets	**9**	-
Losses on disposal of assets	**-**	(5)
Total	**9**	(5)

13. Better Payment Practice Code

	2020/21 Number	**2020/21 Value £000**	2019/20 Number	2019/20 Value £000
Total non-NHS trade invoices paid in the year	**129,104**	**365,506**	147,828	284,435
Total non-NHS trade invoices paid within target	**116,274**	**333,254**	132,053	264,010
Percentage of non-NHS trade invoices paid within target	**90.1%**	**91.2%**	89.3%	92.8%
Total NHS trade invoices paid in the year	**3,635**	**31,771**	3,473	33,193
Total NHS trade invoices paid within target	**2,824**	**26,133**	2,822	28,248
Percentage of NHS trade invoices paid within target	**77.7%**	**82.3%**	81.3%	85.1%

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.

NOTES TO THE ACCOUNTS

14. Losses and special payments

	2020/21 Number	2020/21 Value £000	2019/20 Number	2019/20 Value £000
Losses:				
Cash losses	**4**	**1**	16	12
Bad debts and claims abandoned	**43**	**37**	77	185
Stores losses, including damage to buildings	**1**	**32**	1	25
Total losses	**48**	**70**	94	222
Special payments - Ex-gratia	**35**	**32**	59	54
Total losses and special payments	**83**	**102**	153	276

15. Intangible assets

15.1 Intangible assets at 31 March 2020

	Software licences £000
Fair value at 1 April 2019	2,045
Additions - purchased	93
Fair value at 31 March 2020	**2,138**
Accumulated amortisation at 1 April 2019	1,833
Provided during the year	40
Accumulated amortisation at 31 March 2020	**1,873**
Net book value	
Purchased at 31 March 2020	265
Total at 31 March 2020	**265**

15.2 Intangible assets at 31 March 2021

	IT In-house and 3rd party software £'000	Software licences £'000	Total £'000
Fair value at 1 April 2020	-	2,138	2,138
Additions - purchased	26,663	540	27,203
Transferred into use - from property, plant and equipment (note 16.1)	34,625	-	34,625
Impairments	(18,594)	-	(18,594)
Disposals	-	(62)	(62)
Fair value at 31 March 2021	**42,694**	**2,616**	**45,310**
Accumulated amortisation at 1 April 2020	-	1,873	1,873
Provided during the year	1,238	126	1,364
Eliminated on disposals	-	(62)	(62)
Accumulated amortisation at 31 March 2021	**1,238**	**1,937**	**3,175**
Net book value			
Purchased at 31 March 2021	41,456	679	42,135
Total at 31 March 2021	**41,456**	**679**	**42,135**

The impairment charge of £18.6m has arisen due to the fair valuation of the Trust's new Health Record System, note 15.3 provides further details.

15.3 Impairment

The Trust has invested in a new Health Record System and this was brought into operational use on the 10th October 2020. Capital expenditure had previously been recorded within the Property, Plant and Equipment note. This previous expenditure has been transferred to Intangibles (see note 15.2). A fair valuation has been undertaken by PwC, in accordance with the Department of Health and Social Care - Group Accounting Manual 2020-2021 and HM Treasury guidance, particularly The Government Financial Reporting Manual 2020-2021. The valuation complies with IAS 36 Impairment of Assets. As the Health Record System is a non-cash generating asset the depreciated replacement cost methodology was used for the valuation. An impairment charge of £18.6m has been recorded, the main basis being that the replacement cost would be lower than the original cost incurred, as the replacement asset only has to perform the same functions as the original asset and is not a like-for-like replacement. (See Annual Report page 85 for more details).

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 2020	9,914	163,975	2,380	49,997	59,612	1,600	13,410	45	300,933
Additions - purchased	-	19,855	-	19,836	12,797	84	3,293	-	55,865
Additions - donated	-	20	-	-	2,200	-	29	-	2,249
Reclassifications - net total transferred to Intangible assets (note 15.2)	-	13,655	-	(53,420)	3,860	-	1,280	-	(34,625)
Revaluation	-	9,468	-	-	-	-	-	-	9,468
Disposals	-	-	-	-	(202)	-	-	-	(202)
Total at 31 March 2021	**9,914**	**206,973**	**2,380**	**16,413**	**78,267**	**1,684**	**18,012**	**45**	**333,688**
Accumulated depreciation at 1 April 2020	-	-	-	-	40,792	1,170	9,801	45	51,808
Provided during the year	-	6,314	125	-	3,689	100	1,367	-	11,595
Eliminated on disposals	-	-	-	-	(189)	-	-	-	(189)
Accumulated depreciation at 31 March 2021	**-**	**6,314**	**125**	**-**	**44,292**	**1,270**	**11,168**	**45**	**63,214**
Purchased at 31 March 2021	9,914	196,539	2,255	16,413	31,039	414	6,811	-	263,385
Donated at 31 March 2021	-	4,120	-	-	2,936	-	33	-	7,089
Total at 31 March 2021	**9,914**	**200,659**	**2,255**	**16,413**	**33,975**	**414**	**6,844**	**-**	**270,474**

At the statement of financial position date there was one asset held under a finance lease, at a value of £2.0 million (2019/20 £Nil). There were no assets held under hire purchase contracts or private finance initiative (PFI).

During the year the Trust purchased the site of the Exeter Nightingale Hospital. In accordance with the Trust's Accounting Policy the asset has subsequently been revalued by professional valuers when brought into use. The valuation was undertaken by Gerald Eve, who are professionally qualified valuers, and was in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual, International Financial Reporting Standards and it also complies with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings that would give the same service potential as is provided by the actual estate that the Trust owns, note 16.3 provides further details.

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 2019	9,598	183,603	2,120	19,046	51,140	1,566	11,105	45	278,223
Additions - purchased	-	3,852	-	34,854	8,024	34	1,247	-	48,011
Additions - donated	-	140	-	1,000	358	-	-	-	1,498
Reclassifications	-	3,727	-	(4,903)	118	-	1,058	-	-
Impairment	(80)	(26,556)	-	-	-	-	-	-	(26,636)
Reversals of impairments	128	-	-	-	-	-	-	-	128
Revaluation	268	(791)	260	-	-	-	-	-	(263)
Disposals	-	-	-	-	(28)	-	-	-	(28)
Total at 31 March 2020	**9,914**	**163,975**	**2,380**	**49,997**	**59,612**	**1,600**	**13,410**	**45**	**300,933**
Accumulated depreciation at 1 April 2019	-	-	-	-	37,874	1,076	8,791	45	47,786
Provided during the year	-	5,501	119	-	2,941	94	1,010	-	9,665
Revaluation	-	(5,501)	(119)	-	-	-	-	-	(5,620)
Eliminated on disposals	-	-	-	-	(23)	-	-	-	(23)
Accumulated depreciation at 31 March 2020	**-**	**-**	**-**	**-**	**40,792**	**1,170**	**9,801**	**45**	**51,808**
Purchased at 31 March 2020	9,914	160,734	2,380	48,991	17,890	430	3,609	-	243,948
Donated at 31 March 2020	-	3,241	-	1,006	930	-	-	-	5,177
Total at 31 March 2020	**9,914**	**163,975**	**2,380**	**49,997**	**18,820**	**430**	**3,609**	**-**	**249,125**

There were no assets held under finance leases, hire purchase contracts or private finance initiative (PFI) at the statement of financial position date.

The Trust's land, buildings and dwellings were revalued as at 31 March 2020. The valuation was undertaken by the Jones Lang LaSalle (JLL), in accordance with International Financial Reporting Standards and also complied with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings that would give the same service potential as is provided by the actual estate that the Trust owns, note 16.3 provides further details.

NOTES TO THE ACCOUNTS

16. Property, plant and equipment (continued)

16.3 Revaluation of land, buildings and dwellings

Other than for the new Nightingale Hospital, no valuation of the Trust's land, buildings and dwellings was required at 31 March 2021. They were last valued as at 31 March 2020, and this valuation is still considered to be appropriate, based upon the movement in the BCIS indices, and after reviewing for any impairment. The Trust's specialised buildings and associated land were 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 was 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. In 2019/20 there was a net overall reduction of £21.1m in the value of the Trust's Estate. A £26.5m impairment was incurred, mainly due to the valuer, Jones Lang LaSalle (JLL), identifying greater functional obsolescence of the buildings, this was recognised as an impairment charge to the Statement of Comprehensive Income. An increase in value of £5.4m was recognised within the revaluation reserve and was mainly due to a general rise in construction costs.

Functional obsolescence arises where the design or specification of the asset no longer fulfils the function for which it was originally designed. In some cases, functional obsolescence can be absolute, as the asset is no longer fit for purpose. In other cases, the asset will still be capable of use, but at a lower level of efficiency than the modern equivalent or may be capable of modification to bring it up to a current specification. Specialised buildings particularly hospitals tend to become functionally obsolete for specific services before they become physically obsolete which results in inefficient space utilisation. The valuation reflected that for many of the Trust's buildings there are improved building technologies, construction techniques and advanced new materials that are now available compared to that previously used, i.e. the construction of roofs, floors, windows, doors and walls.

The valuation exercise was carried out in March 2020 with a valuation date of 31 March 2020. In applying the Royal Institute of Chartered Surveyors (RICS) Valuation Global Standards 2020 ('Red Book'), the valuer has declared a 'material valuation uncertainty' in the valuation report. This is on the basis of uncertainties in markets caused by COVID-19. The values in the report have been used to inform the measurement of property assets at valuation in these financial statements. With the valuer having declared this material valuation uncertainty, the valuer has continued to exercise professional judgement in providing the valuation and this remains the best information available to the Trust.

To provide further clarification, JLL has advised, the inclusion of the 'material valuation uncertainty' declaration above does not mean that the valuation cannot be relied upon. Rather, the phrase is used in order to be clear and transparent with all parties, in a professional manner that – in the current extraordinary circumstances – less certainty can be attached to the valuation than would otherwise be the case.

During the pandemic the Trust was the regional host for the Nightingale Hospital. During the year the Trust's Board of Directors, with the support of NHSEI, agreed to purchase the site of the Exeter Nightingale Hospital. This decision was based upon undertaking appropriate due diligence and it was assessed that purchasing the site offered best value for money. In accordance with the Trust's Accounting Policy the asset has subsequently been revalued by professional valuers when brought into use and the revaluation recognises an uplift of £9.5m. The valuation was undertaken by Gerald Eve, who are professionally qualified valuers, and was in accordance with the Royal Institution of Chartered Surveyors (RICS) Appraisal and Valuation Manual, International Financial Reporting Standards and it also complies with HM Treasury's requirements to value land and buildings on the basis of utilising modern equivalent buildings, in line with the JLL valuation in March 2020, that would give the same service potential as is provided by the actual estate that the Trust owns.

17. Investments in associates and joint ventures

	31 March 2021 £000	31 March 2020 £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 2021 £000	31 March 2020 £000
Drugs	**1,990**	2,368
Work in progress	**-**	71
Consumables	**8,331**	5,819
Energy	**232**	201
Inventories carried at fair value less costs to sell	**248**	250
Total inventories	**10,801**	8,709

NOTES TO THE ACCOUNTS

18.2 Inventories recognised in expenses

	2020/21 £000	2019/20 £000
Inventories recognised in expenses	**73,487**	79,442
Write-down of inventories recognised in expenses	**190**	25
Total inventories recognised in expenses	**73,677**	79,467

In response to the COVID 19 pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020/21 the Trust received £5,528,000 of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

19. Trade and other receivables

	31 March 2021 £000	31 March 2020 £000
Current		
Contract receivables	**16,089**	28,805
Prepayments	**5,227**	4,502
Allowance for impaired contract receivables / assets	**(628)**	(565)
Other receivables	**463**	911
PDC dividend receivable	**311**	932
VAT receivable	**2,943**	547
Total current trade and other receivables	**24,405**	35,132
Non-current		
Contract receivables	**1,322**	1,371
Other receivables	**1,273**	1,084
Total non-current trade and other receivables	**2,595**	**2,455**
Total trade and other receivables	**27,000**	37,587

Provision for impairment of receivables	31 March 2021 £000	31 March 2020 £000
At 1 April	**565**	547
Increase in provision	**(78)**	(58)
Amounts utilised	**141**	76
At 31 March	**628**	565

The provision for impairment of receivables relates to specific receivables over 3 months old.

19.1 Ageing of impaired financial assets

	31 March 2021 Trade and other receivables £000	31 March 2020 Trade and other receivables £000
0 - 30 days	**-**	-
30 - 60 Days	**-**	-
60 - 90 days	**-**	-
90 - 180 days	**1,705**	502
Over 180 days	**4,431**	6,529
	6,136	7,031

19.2 Ageing of non-impaired financial assets past their due date

0 - 30 days	**703**	12,148
30 - 60 days	**414**	878
60 - 90 days	**305**	151
90 - 180 days	**941**	1,727
Over 180 days	**-**	-
	2,363	14,904

20.1 Current trade and other payables

	31 March 2021 £000	31 March 2020 £000
NHS payables	**6,600**	4,980
Trade payables - capital	**11,849**	2,455
Other trade payables	**3,654**	3,377
Other taxes payable	**7,680**	7,131
Other payables	**5,298**	4,937
Accruals	**34,576**	26,599
	69,657	49,479
Other liabilities		
Other deferred income	**9,009**	5,163

NOTES TO THE ACCOUNTS

20.2 Non current other liabilities

	31 March 2021 £000	31 March 2020 £000
Other deferred income	**1,959**	2,048

21. Borrowings

Current	31 March 2021 £000	31 March 2020 £000
Loans from Foundation Trust Financing Facility	**1,270**	1,270
Other Loans	**4,587**	1,901
Obligations under finance leases	**172**	-
	6,029	3,171
Non-current		
Loans from Foundation Trust Financing Facility	**7,509**	8,779
Other Loans	**56,750**	50,295
Obligations under finance leases	**1,873**	-
	66,132	59,074
Total borrowings	**72,161**	62,245
Amounts falling due within:		
In one year or less by instalments	**6,029**	3,127
Between one and five years by instalments	**40,711**	28,514
Over five years by instalments	**25,421**	30,604

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

Loans of £21m were received from both Hitachi Capital and Siemens Bank in the year ended 31 March 2019. The loans are repayable over a 12 year period ending September 2030, in equal quarterly instalments commencing December 2020.

A loan of £15.5m has been received from a supplier (received in 2020/21, 2019/20 and 2018/19). The loan is repayable over an 11 year period ending March 2029.

A loan of £5.5m has been received from Salix (received in 2019/20). The loan is repayable over a 7 year period ending October 2027.

	Loans from DHSC £000	Other loans £000	Finance leases £000	Total £000
Carrying value at 1 April 2020	10,049	52,196	-	62,245
Cash movements:				
Financing cash flows - payments and receipts of principal	(1,270)	8,840	-	7,570
Financing cash flows - payments of interest	(467)	(1,658)	-	(2,125)
Non-cash movements:				
Additions	-	-	2,045	2,045
Application of effective interest rate	467	1,959	-	2,426
Carrying value at 31 March 2021	**8,779**	**61,337**	**2,045**	**72,161**

22. Provisions

	Early retirements £000	Legal claims £000	Injury benefits £000	Other £000	**Total £000**
At 1 April 2020	66	222	311	1,189	**1,788**
Arising during the year	2	88	18	207	**315**
Utilised during the year	(11)	(25)	(17)	-	**(53)**
Reversed unused	-	(60)	-	-	**(60)**
Unwinding of discount	-	-	(1)	-	**(1)**
At 31 March 2021	**57**	**225**	**311**	**1,396**	**1,989**

Expected timing of cash flows:	31 March 2021 £000	31 March 2020 £000
In one year or less	**372**	352
Between one and five years	**240**	223
Over five years	**1,377**	1,213
	1,989	1,788

Legal claims relate to employee and public liability claims.

Contingent liabilities relating to legal claims are shown in note 25.

NHS Resolution is carrying provisions as at 31 March 2021 in relation to Existing Liabilities Scheme and in relation to Clinical Negligence Scheme on behalf of the Trust of £207.2m (2019/20 - £167.0m).

Other provisions relate to the estimated clinicians' pension tax. An equal amount due from NHSE is included in Receivables.

NOTES TO THE ACCOUNTS

23. Cash and cash equivalents

	31 March 2021 £000	31 March 2020 £000
At 1 April 2020	**58,081**	82,440
Net change in the year	**5,462**	(24,359)
At 31 March 2021	**63,543**	58,081
Broken down into:		
Cash at commercial banks and in hand	**25**	25
Cash with Government Banking Service	**63,518**	58,056
Cash and cash equivalents as in SoFP and Cash Flow Statement	**63,543**	58,081

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 £7,408,000 (2019/20 - £13,502,000).

25. Contingent liabilities

	31 March 2021 £000	31 March 2020 £000
Contingent NHS Resolution legal claims	-	-

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 Newcourt House, Newcourt Road, Exeter, EX2 7JU. 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 (2019/20 - £58,000) revenue income, £Nil grant income (2019/20 £850,000) and £110,000 (2019/20 - £1,498,000) capital contributions from the Charity. At 31 March 2021 the Trust was due £47,000 (2019/20 - £588,000) from the Charity. The Charity's most recent audited accounts were for the year ended 31 March 2020 and the Charity held aggregated reserves of £2,463,000.

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
2020/21				
Department of Health (excludes PDC dividend)	**19,168**	**-**	**1,221**	**-**
Health Education England	**19,517**	**-**	**741**	**-**
NHS England (Includes Regional offices / Commissioning hubs)	**186,814**	**63**	**4,384**	**2,225**
NHS Devon CCG	**359,085**	**389**	**952**	**259**
NHS Somerset CCG	**5,179**	**-**	**12**	**-**
Northern Devon Healthcare NHS Trust	**6,344**	**1,547**	**1,155**	**73**
2019/20				
Department of Health (excludes PDC dividend)	16,863	-	98	-
Health Education England	17,389	-	1,032	-
NHS England (Includes Bristol North Somerset and South Gloucester)	122,121	-	7,564	62
NHS Devon CCG	326,982	275	4,551	1,169
NHS Somerset CCG	4,257	-	-	228
Northern Devon Healthcare NHS Trust	5,982	1,616	2,128	409

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 FTFF and commercial loan providers.

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 into 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 Carrying value of financial assets

	Held at amortised cost £000
Trade and other receivables excluding non financial assets	31,606
Cash and cash equivalents at bank and in hand	58,081
Total at 31 March 2020	89,687

	Held at amortised cost £000
Trade and other receivables excluding non financial assets	**18,519**
Cash and cash equivalents at bank and in hand	**63,543**
Total at 31 March 2021	**82,062**

An analysis of any impairment of financial assets is provided in note 19.1.

27.2 Carrying value of financial liabilities

	Held at amortised cost £000
Loans from the Department of Health and Social Care	10,049
Other borrowings	52,196
Trade and other payables excluding non financial liabilities	42,348
Total at 31 March 2020	104,593

	Held at amortised cost £000
Loans from the Department of Health and Social Care	**8,779**
Other borrowings	**63,382**
Trade and other payables excluding non financial liabilities	**61,977**
Total at 31 March 2021	**134,138**

NOTES TO THE ACCOUNTS

27.3 Fair value

For all of the financial assets and liabilities at 31 March 2021 and 31 March 2020 the fair value is equal to book value.

28. Third party assets

The Trust held £4,880 cash at bank and in hand at 31 March 2021 (2019/20 - £110) relating to monies held on behalf of patients.

29. Accounting standards issued and not adopted

The accounts have been prepared in accordance with the 2020/21 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.

IFRS 16 - Leases

IFRS 16 Leases will replace IAS 17 Leases, IFRIC 4 Determining whether an arrangement contains a lease and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the statement of financial position for most leases: some leases are exempt through application of practical expedients explained below. For those recognised in the statement of financial position the standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the standard retrospectively with the cumulative effect of initially applying the standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments. For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022/23, The Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the standard in 2022/23 is currently impracticable. However, the Trust does expect this standard to have a material impact on non-current assets, liabilities and depreciation.

30. Forthcoming merger with Northern Devon Healthcare NHS Trust

The Board of Directors of the Royal Devon and Exeter NHS Foundation Trust and the Northern Devon Healthcare NHS Trust have announced their intention to merge their operations, assets and liabilities into one single new Trust. The merger will be subject to due diligence, and review and approval by the Trust Board, Regulators NHSEI and the Council of Governors. The planned merger date is 1st April 2022.