



Annual report and accounts

April 2015 – March 2016

Contents

Foreword	2
Welcome to our annual report for 2015/16.....	2
Trust vision and strategy	4
Section 1: What we do	5
North Devon District Hospital (NDDH), Barnstaple.....	5
Our community services	6
Specialist community services.....	7
Section 2: News	8
Award-winning staff and services	13
A community that goes Over and Above.....	17
Modernising our hospital buildings	18
News from our community hospitals	19
Section 3: Corporate declarations	23
Sustainability statement	23
Our performance over the last 12 months.....	25
Our workforce.....	26
Consultancy	27
Patient experience of our services.....	27
Complaints and patient feedback	29
Disclosure of personal data related incidents.....	35
Health and safety	35
Emergency preparedness, resilience and response.....	36
Fraud policies and procedures	37
Executive team changes.....	37
Section 4: Annual governance statement	39
1. Scope of responsibility	39
2. The governance framework of the organisation.....	39
3. Risk assessment.....	44
4. The risk and control framework.....	46
5. Review of the effectiveness of risk management and internal control	48
6. Significant issues	48
Section 5: Remuneration report	51
Section 6: Head of internal audit report	55
Section 7: Accounts	60

Foreword

Welcome to our annual report for 2015/16.

Each year, this report gives us the opportunity to look at how well we have performed over the last 12 months, as well as the challenges we have faced and how we can continue to improve services for our patients.

This year has been one of great success for our services and staff, and we are extremely proud of our achievements. It has also been a year of huge change, not just for our Trust but for much of Devon.

In June 2015, we became part of the Success Regime in North, East and West Devon, along with other local trusts and health and care organisations. The Success Regime aims to protect and promote health and care services for patients in areas that are struggling with financial or quality problems. This year is the first time in the past nine years that the Trust has recorded a financial deficit at year end and this demonstrates the scale of the financial challenge we are facing across Devon.

In February 2016, the Success Regime published its Case for Change, setting out the key issues facing the local NHS and a number of opportunities to transform services. Our board unanimously agreed to endorse this Case for Change and we continue to work with health and social care organisations throughout Devon on detailed plans to bring about positive progress.

Even before we joined the Success Regime, we were transforming the way we run our services. 2015/16 saw an increased focus on shifting our resources from hospital beds to the care surrounding patients in their own homes. For several years we have been investing in enhancing our community health and social care teams to help people maintain their health and independence, primarily in their own homes.

Last summer we carried out a six-week public consultation on how we could achieve safe and effective care within our budget. In October 2015 the Trust board made a unanimous decision to retain community hospital beds at Holsworthy Community Hospital and South Molton Hospital and to replace community hospital beds in Bideford Community Hospital and Ilfracombe Tyrrell Hospital with an increased investment in community services.

The enormous pressures facing accident and emergency departments across the country are often in the headlines. This winter, we implemented a number of changes which have significantly improved our emergency department performance and patient flow through our services, enabling us to discharge people home in a timelier manner. As a result, this winter, we spent far fewer days on red escalation status and we have been recognised for this work on a national level.

Recruitment and retention of staff continues to be a focus for the Trust and 2015/16 saw us taking action to reduce our spending on agency workers to reduce our running costs.

Recruitment in several specialties is an ongoing challenge and in February, we had to make changes to the provision of ear, nose and throat (ENT) services due to a number of consultant vacancies. Unfortunately, there is a regional shortage of senior doctors in ENT and our vacancies left us with a service that was not viable in its current form. We have to ensure that services are safe and so we made arrangements with other hospitals in the area to provide treatment to the residents of North Devon. We understand that travelling to another hospital is less than ideal for many patients and this is being considered as part of the Success Regime.

A Care Quality Commission report published in November 2015 showed we have made significant improvements to our end of life, emergency, maternity and gynaecology services since they inspected the Trust in 2014 and gave us an overall rating of 'requires improvement'.

In particular, our community end of life services were moved up to a 'good' rating. We would like to thank all of our staff for making these improvements possible and we know their commitment will help us to continue making progress towards improving our overall rating.

In the autumn, we will see our community services in East Devon transfer to the Royal Devon and Exeter NHS Foundation Trust (RD&E), following NHS Northern, Eastern and Western Devon Clinical Commissioning Group's decision to award the contract for these services to the RD&E. We are currently working with the RD&E to ensure a safe handover. It has been a privilege to work with the health and social care professionals in Exeter, East and Mid Devon since 2011, and we wish all of our Eastern colleagues the very best for the future.

This year, we were successful in being awarded a contract to provide a new home care service. We will be launching Devon Cares in Northern and Mid Devon, a service which will manage local care providers to deliver high-quality home care. We believe we will be the first NHS trust to enter to home care market when we launch the service in 2016/17. The move will allow us to influence the quality of the increasing amount of care given outside of our hospitals. This is an exciting opportunity for the Trust and for our patients, which brings a completely new approach to domiciliary care.

The incredible commitment of our staff seems to get stronger every year, and they are increasingly winning regional and national awards for the care and innovations they deliver, many of which are highlighted within this report. In addition, the 2015 NHS Staff Survey results showed our staff are more satisfied than those at any other comparable trust and our overall results were even better than last year. We were also featured in a list of the best places to work in the NHS, produced by the Health Service Journal.

We are now heading into what will be a challenging 2016/17 as we continue to play our part in addressing a £130million projected overspend in Devon's budget, but we are sure there will still be much to celebrate at the Trust. We will continue to work hard to make improvements to our services in line with the CQC report, and we will continue to support our staff with their ideas, which help us to deliver high quality and compassionate care to our patients. We are confident that by working with our staff, with our communities and with other organisations, we can face the challenges head on and design sustainable services for the future.



Roger French
Chairman



Alison Diamond
Chief Executive

Trust vision and strategy

Our vision:

Delivering high quality and sustainable services that support your health and wellbeing.

Our strategic objectives:

We will deliver **high quality** care measured by effectiveness, safety and the person's experience of care.

We will ensure access to a **sustainable** range of services that are delivered locally through partnerships and networks.

People will tell their story only once. We will deliver **integrated health and social care**, seamlessly to meet the needs of individuals.

We will recruit and develop a flexible, fulfilled and multi-skilled **workforce** fully engaged in turning our vision into a reality.

We will **efficiently and effectively** run our services to benefit our local communities.

We will work in partnership with stakeholders to **promote independence and well-being**.

We will support **individuals and communities to have more influence** over how services are delivered and encourage others to do likewise.

Priorities for 2016/17:

The Success Regime Case for Change presents twenty transformation opportunities for NEW Devon which will be incorporated into the Sustainability and Transformation Plan (STP) and see the transformation of care in Devon by 2020.

There is system-wide agreement that whilst these longer term transformational workstreams are being developed, there are five areas of priority which each organisation in Devon will focus on in 2016/17:

- ▶ Priority 1: Bed based care – reduction in length of stay in acute and community hospitals and a subsequent reduction in bed based capacity
- ▶ Priority 2: Elective care – reduce the differences in the levels of elective (planned care) through a review of referral and conversion rates

- ▶ Priority 3: Continuing care – optimise the amount of money being spent on continuing care through close management of eligibility criteria
- ▶ Priority 4: Procurement – Joint procurement of clinical and non-clinical supplies through collaborative working across providers
- ▶ Priority 5: Agency spend – reduction in spending on agency staff through developing better processes for recruitment and deployment of staff

The 2016/17 operational plan for NDHT supports these priorities.

All of our activity supports our over-arching strategies of:

- ▶ Improved integration and co-ordination both within our services, and with other agencies
- ▶ Taking a place-based approach to the commissioning and delivery of services
- ▶ Shifting resource from acute care to out-of-hospital care
- ▶ Operational efficiency and effective resource utilisation

Section 1: What we do

We provide health and social care services that make a real difference to people's lives.

Our teams of health and care professionals work with patients and their families across Devon, to support their independence, health and wellbeing.

We offer both acute services, centred on North Devon District Hospital (NDDH), and integrated health and social care services in the community.

Our community-based and specialist staff are working increasingly in people's own homes, in line with the national priority of making sure treatment and care are as accessible as possible, with hospital stays reserved for those with more serious conditions.

We provide support to prevent people from being admitted to hospital and where admission is necessary, we work to make sure the stay is as short and effective as possible, before working with you on a safe discharge home.

Our values guide everything we do: you will receive excellent and safe care from staff who have integrity and compassion, and who understand that your needs are unique and that your care plan needs to be personal to you.

The Care Quality Commission inspected our services in 2014 and found our community services to be 'close to outstanding'. Our medical inpatient services at North Devon District Hospital (NDDH) were the first to be judged as 'outstanding' by the CQC.

Whilst we pride ourselves on the quality of our hospital inpatient care, we know you would much rather receive our care in your own home when it is safe to do so.

We offer a wide range of hospital, outpatient, home-facing and specialist services across most of Devon. We have a huge range of clinical expertise that we share across professional networks to ensure you get world-class care when you need it.

From its headquarters in Barnstaple and Exeter, the Trust is responsible for the management of, and services provided from, a number of bases.

North Devon District Hospital (NDDH), Barnstaple

In 2015/16, staff at Northern Devon Healthcare NHS Trust treated 28,398 inpatients, 414,146 outpatients and delivered 1,502 babies. They also saw 44,147 people in our accident and emergency department, and 40,888 in our minor injuries units.

The populations of Torridge and North Devon account for 94% of patients to NDDH, with the remaining 6% coming from residents from the Cornish and Somerset borders or tourists to the area. The influx of holiday-makers to the area means we see a huge increase in numbers visiting our accident and emergency department during the summer.

NDDH provides a 24/7 accident and emergency service. In 2012 it was designated as a trauma unit within a trauma network serving the whole of Devon and Cornwall. This ensures residents of Northern Devon have access to trauma services.

The Trust offers a range of general medical services, including cardio-respiratory, stroke care and gastroenterology. General surgical services include orthopaedics, vascular and colorectal specialities.

The Trust also runs very successful ophthalmology services, which use the latest procedures and techniques to treat glaucoma and macular degeneration.

The Trust offers patients a choice of local, specialist services and consultants from other neighbouring trusts hold clinics in the area. We work with Musgrove Park in Taunton on a vascular network, Derriford on a neonatal network and the Royal Devon and Exeter for cancer and haematology, and neurology, to name a few examples.



Highlights 2015/16:

- ▶ We celebrated the first birthday of our new £2.5million chemotherapy and day treatment centre – the Seamoor Unit - which has seen more than 10,000 patients since it opened in March 2015. The building has just been recognised with a South West property award.
- ▶ We completed an £850,000 refurbishment to our King George V (KGV) ward, so patients recovering from surgery can enjoy enhanced facilities and a better environment.
- ▶ We made significant improvements to our patient flow in 2015/16, thanks to staff's commitment to embedding the 'Breaking the Cycle' initiative into our core service.

As well as acute and community services, we have a range of intermediary services which aim to control and facilitate the flow of patients to and from the acute hospital.

Our pathfinder team at NDDH and our onward care team at RD&E liaise with the wards in both acute hospitals to organise timely and safe discharges for patients who require ongoing care or support after leaving hospital. As members of the local health and social care teams, the pathfinder and onward care teams develop and arrange any care packages that are required to ensure the patient can leave hospital, with the right support to live independently at home.

Our community services

Our teams of integrated health and social care community professionals across Devon work to rehabilitate patients, avoid admissions, and promote health, wellbeing and independence. The multidisciplinary teams include community nurses, social workers, physiotherapists, occupational therapists, community matrons and the voluntary sector. The teams deliver care to around 7000 people, often with very complex needs, providing support and treatment to enable them to live independently in their own homes. The teams currently cover the populations of Exeter, East, Mid and Northern Devon.



The integrated teams also provide a rapid response service. If a GP is worried about a patient whose health is deteriorating, they can call the community rapid response team who will arrive at the person's home within two hours. We then look at the health and social care needs of the patient, and the patient is provided with immediate support in their own home. Quite often this avoids an admission to hospital.

The Trust's 17 community hospitals across Exeter, East, North and Mid Devon provide local hubs of healthcare for their communities and a range of services that are easily accessible to the local population, including around 200 inpatient beds, and rehabilitation and outpatient clinics.

Some hospitals also offer specialist services such as minor injuries units, stroke rehabilitation and renal care. The resource centres in Barnstaple and Lynton provide a range of local outpatient and self-referral clinics, such as family planning clinics.

We have a community nursing centre in Exeter for people who are mobile enough to access treatment locally at a time of their convenience. This helps to encourage mobility and reduce social isolation.

The Trust has been pursuing an 'out of hospital' strategy for some years as the evidence shows that care delivered in or close to people's homes provides better, more person-centred care to patients which maintains their wellbeing and independence and delivers more system resilience in times of high demand for services.

The roles of community hospitals and the services offered by them are evolving as the needs of the local population change.

The development of health and wellbeing hubs has been a source of much interest for communities. We have experienced some challenges in this area, but we continue to engage with local people to explore the roles of community hospitals and we continue to work with our commissioners to produce a strategy.

Please note, in autumn 2016, there will be a change of provider for community services for adults with complex needs in Exeter, East and Mid Devon to the Royal Devon and Exeter NHS Foundation Trust (RD&EFT). We are currently working with the RD&EFT to ensure a safe handover of services.

Specialist community services

The Trust is the main provider of specialist community healthcare services across North, East, Mid and South Devon, including audiology, podiatry and sexual health.

It also provides stop smoking and bladder and bowel care services in these areas.

The Trust runs two walk-in centres in Exeter, based in Sidwell Street and at the RD&E. These services are led by specialist nurses, who can provide treatment for minor injuries or illnesses such as sprains, cuts and minor infections.

Healthy Teeth Devon

www.healthyteethdevon.nhs.uk

the centre

www.thecentresexualhealth.org

health promotion
De♥on

www.healthpromotiondevon.nhs.uk

**More information on the Trust's services is available online at:
www.northdevonhealth.nhs.uk**

Section 2: News

This section contains a round-up of Trust news from the past year (April 2015-March 2016). More news is available online at www.northdevonhealth.nhs.uk.

Trust supports Devon's 'Case for Change'

In June 2015, NHS England chief executive Simon Stevens announced that Northern, Eastern and Western Devon would be one of three areas in England where local health and care organisations would work together to make improvements for patients as part of the new Success Regime.

The purpose of the Success Regime is to protect and promote health and care services for patients in the local health and care systems that are struggling with financial or quality problems, or sometimes both.

The Success Regime programme began gathering evidence in the autumn, and in February 2016, a Case for Change document was published, setting out the key issues and challenges facing the NHS in Northern, Eastern and Western (NEW) Devon and a number of opportunities to transform services.

The Trust board unanimously agreed to endorse the Case for Change at its meeting in April 2016.

Roger French, Trust chairman, said: "The Case for Change sets out a compelling case for what needs to change and why to ensure the NHS delivers clinically and financially sustainable health and care services for people in Northern, Eastern and Western Devon.

"It is vital that everyone understands the challenges facing the NHS in Devon and that we all work together to plan how to maintain and improve services for patients across the county.

"The Trust is committed to playing its part in this process.

"We look forward to working with the Success Regime and partner organisations to identify the solutions, while involving staff, stakeholders, patients and the public every step of the way."

When the Case for Change was published, Ruth Carnall, chair of the Success Regime in the NEW Devon area, said: "There are some excellent NHS services across the county and we know how highly people value them.

"However, we also know that people's health varies greatly from one part of the county to

another, as does their ability to access some services.

"Many people spend too long in hospital and could fare better with more support in the community.

"Financially, the NHS is also living well beyond its means. By 2020, the NHS in the NEW Devon area will face a deficit of around £440 million if it continues as it is.

"The publication of the Case for Change is the start of our engagement with people about what needs to change and why.

"All of the local NHS organisations, and local authorities, are committed to working with each other to deliver system-wide improvements.

"It is important for people to understand the pressures on the NHS and to help us to plan how to maintain and improve services whilst meeting our financial obligations."

Details of how people can get involved in the next stage of the Success Regime programme will be made available in due course.

You can find the Case for Change document and summary paper published on 11 February 2016 on the Trust website, www.northdevonhealth.nhs.uk

Trust pleased with CQC recognition of achievements

- ▶ Chief inspector of hospitals for England, Sir Mike Richards, finds that the Trust 'requires improvement' in September 2014
- ▶ Inspectors visit again in August 2015
- ▶ Report published in November 2015 moves community end of life services up to a 'good' rating. It also confirms there has been good progress in improving services rated as 'requires improvement', but there is more to do to improve our overall Trust rating

In September 2014 the Trust was reported as 'good' or 'outstanding' by the Care Quality Commission for the majority of the services provided, but was required to make improvements in three specific aspects of care at North Devon District Hospital (NDDH): end of life care, emergency and urgent care, and maternity

and gynaecology services. Overall, the Trust was judged as 'requiring improvement'.

Inspectors visited again in August 2015. A report was then published in November 2015, which demonstrated that inspectors saw the improvements and progress the Trust had made in these three areas.

Dr Alison Diamond, chief executive, said: "We are really pleased that the CQC has recognised the improvements we have made across these aspects of care.

"We are particularly pleased our end of life services provided within our community hospitals and our health and social care teams have improved to a 'good' rating.

"This is a fantastic achievement for our patients and our staff who have worked so hard to improve the consistency and responsiveness of care we offer to patients near the end of their lives."

The CQC also highlighted areas of outstanding practice, including improvements in infection prevention and control measures in A&E, regular audits and good compliance with Trust policies, as well as a maternity unit open day which showcased a number of health and wellbeing opportunities and information for people using the services.

The report made clear that the Trust still had improvements to make in terms of patient flow through North Devon District Hospital and staffing ratios in A&E.

Speaking when the report was published, Dr Alison Diamond, chief executive, said: "We are committed to completing the remaining actions and thank the CQC for their constructive comments."

The re-inspection report published in November 2015 is available via the CQC website.

Delivering safe and effective care within the budget

In October 2015, the Trust board took a unanimous decision to retain community beds at Holsworthy and South Molton hospitals.

The decision, which followed a six-week public consultation called 'Delivering safe and effective care within the budget', was taken at a board meeting at North Devon District Hospital.

The board agreed with the preferred options of the public and stakeholders – firstly that beds should be retained at two community hospitals and secondly that the locations should be Holsworthy and South Molton. This decision means there will no longer be medical beds at Bideford and Ilfracombe.

Roger French, Trust chairman, said: "It is important that our staff know much we and the public value our community hospitals. The potential closure of community beds has been a highly emotive subject and people have expressed a great deal of passion and support for their local hospitals. I thank everyone that contributed their feedback and experiences to the consultation which allowed the Board to take into account the full range of views before making this difficult decision.

"After careful consideration of the consultation feedback and our own quality and clinical risk factors, we viewed that the best decision was to leave the beds in Holsworthy and South Molton as they served large, rural and dispersed populations. They also have the most modern buildings and do not struggle to fill staff vacancies."

The decision does not affect stroke inpatient services at Bideford.

Dr Alison Diamond, Trust chief executive, said: "Providing more care to people in their own homes is a model which is tried and tested and has proved to be safe and successful across Devon.

"Our community health and social care teams currently support around 7,000 patients across Devon in their own homes at any one time. At the same time, we are making it really clear that anyone who needs an admission to a community hospital bed will get one."

Around 1,000 people attended 21 public meetings in August and September 2015, in Ilfracombe, Holsworthy, South Molton, Bideford, Hatherleigh, Lynton and Barnstaple. The Trust received close to 600 consultation responses in total.

CCG decision on contract for community services in Eastern Devon

In December 2015, the Governing Body of NEW Devon Clinical Commissioning Group (CCG) announced that they intended to proceed to award the contract for Eastern community

services to the Royal Devon and Exeter NHS Foundation Trust (RD&E).

The CCG named the RD&E as the preferred provider in November 2014, a decision which was challenged by the Trust and resulted in a Monitor investigation. In December, subject to further detailed due diligence and contract finalisation, the CCG announced that the RD&E would be awarded the contract.

Services which are transferring include community hospitals, community therapies and nursing. We expect services to transfer in autumn 2016.

Alison Diamond, chief executive, said: "It has been an immense privilege to work with the health and social care professionals in Exeter, East and Mid Devon since 2011. We have achieved tremendous things on behalf of the communities we serve and we are rightly proud of the way we have transformed these services.

"We have enjoyed learning from each other and wish all our Eastern colleagues the very best in future. All our management and professional efforts are now going into effecting a legally sound and clinically safe transfer of staff to the RD&E."

Trust to become first to enter home care market

In April, the Trust announced it is set to become the first NHS trust to enter the home care market.

This follows a successful bid to Devon County Council, NHS Northern, Eastern and Western Devon Clinical Commissioning Group and South Devon and Torbay Clinical Commissioning Group for a new contract aimed at giving a vital boost to personal care services across the county.

The service, called Devon Cares, will share the Trust's vision to deliver high-quality care that supports people's health, wellbeing and independence.

The Council announced the decision to appoint the trust as 'prime contractor' for domiciliary care in Northern and Mid Devon in March and the plans have now been approved by the Trust's board.

As 'prime contractor', the Trust will not directly deliver domiciliary care; it will manage care providers to ensure a continually improving quality and consistency of service.



Through this contract, care workers and other staff will benefit from improved pay and support arrangements as well as more opportunities for training and a clearer career path.

The move will allow the Trust to influence the quality of the increasing amount of care given outside of its hospitals and to ensure care providers are working to support people's health and ability to live independently in their own homes.

Dr Alison Diamond, chief executive, said: "Devon Cares will act as a bridge between health and social care, which will help us to provide better, more joined-up care for our patients between home and hospital.

"Providing high quality, consistent care at home will also help us to prevent avoidable hospital admissions. We also believe this will also allow us to address many of the care capacity problems and blockages facing the wider health system in Devon."

The Trust will shortly begin a process to select care providers for Devon Cares, based on quality. In partnership with these providers, the Trust will aim to provide:

- ▶ Higher quality care and support for vulnerable people, underpinned by the NHS
- ▶ Greater independence for people to live their lives as fully as possible
- ▶ Better pay and conditions for care workers to boost recruitment and retention
- ▶ More training and career opportunities for care workers who can enter a career pathway which could lead to a job as a registered nurse
- ▶ Greater certainty for providers so that they can plan for the future and improve their responsiveness
- ▶ Greater integration with existing health and social care services so that people can get home more quickly

Dr Alison Diamond added: "This is a really exciting opportunity for both the Trust and for our patients.

“This is a completely new approach to domiciliary care that we hope will bring real benefits to people in Northern and Mid Devon.”

We have been appointed to manage domiciliary care in the following areas:

Zone 1: Bideford, Northam, Great Torrington and Holsworthy

Zone 2: Ilfracombe, Lynton, Lynmouth, Barnstaple and South Molton

Zone 3: Tiverton, Crediton and Cullompton

Trust joins campaign to enable carers to stay with dementia patients in hospital

In March 2016, we joined a national campaign which supports the rights of carers to stay with patients with dementia in hospital.

John’s Campaign was launched officially on the Trust’s wards, in both the acute and community hospitals, in March 2016.

John’s Campaign was founded by Nicci Gerrard after the death of her father, Dr John Gerrard, in November 2014. She believes her father, who had Alzheimer’s, would have benefitted greatly if she had been able to stay with him during his time in hospital.

Nicci now campaigns for the rights of carers of patients with dementia and similar conditions to stay with their loved ones, and to be involved with their care if they would like to be. Nicci’s co-campaigner, Julia Jones, supports her 91 year old mother June, who lives with Alzheimer’s and vascular dementia.

The Trust already has flexible visiting in place, but being part of John’s Campaign means carers are now invited to stay with their loved ones whenever they want to. It also means carers have the opportunity to be involved with the care of their loved ones in a practical way.

Nurses will ask families and carers, at the point of admission to hospital, whether they have been caring for the person being admitted and if they would like to continue to be involved in their care. They will also make sure any advice the family and carer can give is written down in the patient’s care plan, and that everybody within

the multidisciplinary team caring for the patient knows that the family and carer are partners in care.

Tina Naldrett, deputy director of nursing and dementia clinical lead, said: “We know that having the support of a carer can lead to improved experience and outcomes for patients with dementia.

“We have always aimed to make sure carers are actively involved in the care of a loved one, but this campaign takes that one step further by letting carers decide how involved they would like to be.”

John’s Campaign is about giving carers the right to stay with their loved ones in hospital. It does not aim to place a duty upon carers.

Tina Naldrett added: “It’s about making carers feel welcome and letting them get involved if they want to, but of course we understand that many carers need respite themselves.

“This campaign is about giving carers the choice.”

Carers who would like to find out more about John’s Campaign are advised to talk to the nurse in charge when their loved one is admitted to hospital.

Nicci Gerrard and Julia Jones, from John’s Campaign, said: “We are thrilled and grateful that Northern Devon Healthcare NHS Trust has joined John’s campaign, opening its doors to the carers of those who are most vulnerable and frail and making a commitment to compassionate and person-centred care.

“We whole-heartedly welcome NDHT to our list and send out thanks.”



NDHT nurses – left to right: Laura Williams – Occupational Therapist, Lucy Sumner – Discharge Coordinator, Claire Vooght – Ward Sister, Vicki Fillingham – Clinical Matron and Alice Keith – Staff Nurse

More information is available on the John's Campaign page on the Trust website: www.northdevonhealth.nhs.uk/about/campaigns/johns-campaign.

A great place to work

This year, we received two honours which show the Trust is a great place to work. The Trust was rated the best NHS Trust of its kind in the country for staff satisfaction, in the NHS Staff Survey and it was named amongst the best places to work in the NHS by the Health Service Journal.

Trust ranked best in country for staff satisfaction

We came out on top of 84 NHS trusts in England in the NHS Staff Survey 2015. The survey scores, which have just been published, also placed us:

- ▶ First out of 39 trusts that run acute and community services
- ▶ First out of 24 trusts in the South West
- ▶ Sixth out of 138 trusts that run acute services but aren't classified as a specialist Trust

When compared to other trusts that run acute and community services, Northern Devon was rated better than average in 23 of the 32 key findings.

The Trust was ranked average in nine areas and was not below average in any.

Our high score for overall staff engagement covered whether employees would recommend the Trust as a place to work or receive treatment, staff motivation and the ability to contribute towards improvements.

The five key findings where staff felt the Trust stood out compared to similar Trusts were:

- ▶ Ability to contribute towards improvements
- ▶ Belief that the Trust provides equal opportunities for career progression or promotion
- ▶ Satisfaction with resourcing and support
- ▶ Agreeing that their role makes a difference to patients or service users
- ▶ Feeling recognised and valued by managers and the organisation

Dr Alison Diamond, chief executive, said: "This is another excellent set of results, after our staff rated us the best Trust in the South West and fourth in the country in 2014.

"The survey showed that our overall staff engagement had further improved since 2014, which is very encouraging, especially given the challenges we faced in the year leading up to the survey, such as the uncertainty over the proposed transfer of community services in our Eastern patch.

"We are delighted that staff continue to feel so positive about working for the Trust.

"We know that when staff enjoy their job, patients receive better and more compassionate care."

The Trust had a response rate of 48%, which was above average when compared to similar Trusts and represented an increase from 45% in 2014.

The full survey results for 2015 can be viewed at www.nhsstaffsurveys.com.

Trust named in Health Service Journal's 'Best Places to Work in the NHS'

We were named in a list of the best places to work in the NHS.



The Trust is one of 40 acute Trusts to make the list of the Best Places to Work in the NHS for 2015, compiled by flagship publications the Health Service Journal and the Nursing Times, and the independent research firm Best Companies Group.

The list celebrates NHS organisations that have worked hard to promote great staff engagement and create an environment where people enjoy their job.

The judging panel analysed performance in seven key areas – leadership and planning; corporate culture and communication; role satisfaction; work environment; relationship with supervisor; training, development and resources; and employee engagement and satisfaction.

Dr Alison Diamond, chief executive, said: "To be named one of the best places to work in

the NHS, anywhere in the country, is a fantastic achievement for the Trust.

“It recognises what I see every day – staff working as teams and doing their utmost to provide excellent care for our patients.

“We do our best to support our employees and create a positive working environment as we know that when staff enjoy their job, patients receive better and more compassionate care.”

Award-winning staff and services

Trust wins national award for enhancing care and support for breast cancer patients.

In December, our breast care team won a national award for its work to enhance care and support for breast cancer patients.

The Trust's breast care team won the collaborative working category for its joint work with colleagues from the lymphoedema service.

The team, based at North Devon District Hospital, comprises clinical nurse specialist Karen Hillman and breast care nurses Claire Herlihy and Amy Barrow.

They are a small, but dedicated team who work hard to improve the breast cancer journey of patients in North Devon.

The team started to work more closely with the lymphoedema service after its annual 'Moving Forward' event in 2012/13.



NORTH Devon breast care nurses Amy Barrow (left) and Claire Herlihy are pictured at the awards ceremony in London

The event is for patients diagnosed with breast cancer in the previous 12 months, who are invited to discuss survivorship topics such as diet and fitness, moving forward, anxiety, self-management and late effects of treatment.

An informal survey conducted on the day showed that of the 42 attendees, 31 (74%) would have liked more information about lymphoedema and 24 (57%) would have liked to have had measurements taken pre-operatively or before treatment.

The breast care and lymphoedema teams met to discuss how they could inform and assess patients in a practical way.

They started by raising funds to buy specialist equipment and setting up a pre-op assessment lymphoedema clinic.

At the clinic, patients diagnosed with breast cancer are told about the possible complications post-surgery and are booked into reserved appointments with lymphoedema nurses Hayley Moore or Georgina Martin.

“This has resulted in the patients being better informed and supported at a potentially very stressful time,” said Karen. “Feedback has been very positive.”

Trust wins two awards for work to train and educate care home staff in Northern Devon

The Trust's care home team added to the growing list of awards it has won for its innovative work to train, educate and support staff at local care homes.

We picked up two trophies at the first ever Star Awards, organised by Health Education England in the South West, at a ceremony in Taunton in March 2016.

The Trust beat 51 other entrants to win the Education and Training Team of the Year award.

The award recognises those who make a difference to patient safety, care and staff through education and training.

The news got better for the Trust when it was named the winner of the overall Chair's Award for NHS Values, beating more than 230 entrants including 23 other finalists.

This was awarded by Jane Barrie OBE DL, the independent chair of the South West Local Education Training Board, to highlight an

individual or team that has exemplified the values and behaviours in the NHS Constitution and brought them to life in a way that also inspires other staff.

The Trust received a trophy and certificate for each award as well as two £500 bursaries, which will be used for continuing professional development to help improve services for patients in Northern Devon.

Dr Alison Diamond, the Trust's chief executive, said: "This is a fantastic achievement for the team and is testament to the enthusiasm, dedication and innovation the staff continue to display in supporting care homes in Northern Devon.

"We put a lot of focus on education and training across the Trust, as it is key to improving the safety and quality of care for patients, and strive to follow the values and behaviours in the NHS Constitution at all times.

"We will now be highlighted as an area of excellent practice in education and training in the South West and across Health Education England, which is great news and well-deserved recognition for the team."

The team was also shortlisted for the Patient Safety Awards, led by the Health Service Journal and Nursing Times, and promoted its work at the Queen's Nursing Institute's annual Healthcare at Home Conference at the Royal College of General Practitioners in London.

One of the team members, Sarah Winfield-Davies, was honoured with the title of 'Queen's Nurse' this year.



The successful Northern Devon care homes team, pictured at the Star Awards in Taunton

Four nurses honoured with Queen's Nurse title

Sarah Winfield-Davies, a safeguarding adult nurse and nurse educator in the Northern Devon care homes team, Lisa Baker, a learning disability liaison nurse, and community matrons Rachel Armstrong and Louise Crackle were all honoured with the Queen's Nurse title this year. The title, given by the Queen's Nursing Institute, reflects a commitment to the values of community nursing, excellent patient care and a continuous process of learning and leadership.

Louise Crackle also received a long service award, in recognition of over 21 years' service as a community nurse.

Sarah Winfield Davies

Sarah Winfield-Davies is a safeguarding adult nurse and nurse educator in the Northern Devon care homes team.

Sarah has played a key role in the success of an innovative programme to train and support staff at care homes in Northern Devon.



Sarah said: "It is a great honour to become a Queen's Nurse and it's very satisfying to know that our work in Northern Devon is being recognised on a national level.

Lisa Baker

Lisa is the first learning disability liaison nurse in acute care to be given the prestigious award.

Lisa, who works at North Devon District Hospital, was recognised for her work to set up and develop the Trust's learning disability service.



She said: "I'm thrilled and honoured to become the first nurse in my position to become a Queen's Nurse.

“It’s great that the work we do here in North Devon has been recognised nationally and hopefully this will help to raise the profile of learning disability nursing.”

Rachel Armstrong



Rachel Armstrong (left) is presented with her award by Professor Viv Bennett, director of nursing for Public Health England.

Rachel, who has been in nursing for 35 years, is one of the Trust’s community matrons.

She is based at The Westbank Practice, which incorporates Starcross Surgery and The Limes Surgery in Exminster.

Her job involves case managing patients with long-term conditions as part of the local community nursing team.

Rachel, who lives in Exeter, said: “My role allows for the practice of advanced clinical skills and yet meeting patients in their own home keeps you grounded and reminds you of what really matters – dignity, compassion, respect and care.

“As well as my clinical practice with patients, I really enjoy supporting students, both medical and nursing.

“We all learn such a great deal from reflecting on each other’s experiences and sharing our knowledge.”

Louise Crackle

Louise moved into community nursing in 1992, initially as a staff nurse on the relief team covering most of Northern Devon before completing a bachelor’s degree and qualifying as a district nursing sister.



She was the district nurse in Torrington before becoming the community matron in Bideford in 2008.

Louise leads a team of three nurses in the Bideford health and social care team who help patients to remain healthy and independent in their own homes, reducing admissions to hospital and speeding up discharges.

Congratulations to all of our Queen’s Nurses for their fantastic achievements.

Trust celebrated for work with apprentices and young people

We were named ‘Large Employer of the Year’ for the success of our apprenticeship scheme at the regional Apprentice of the Year Awards 2016.

The awards are run by Education + Training Skills (ETS), a specialist provider of work-based learning across the South West.

The win recognises the success of the Trust’s apprenticeship scheme, which continues to bring benefits to both local learners and the organisation.

We work closely with local colleges and training providers and since 2008 have employed around 250 apprentices in healthcare assistant and business administration roles in North, Mid and East Devon.

This is the latest awards success for the Trust in relation to the opportunities it provides to young people.

In June 2015, Petroc named the Trust its ‘Most Supportive Large Employer’, recognising the support it showed students in aiding their progression towards a career in business administration.

The Trust was also recognised for its work to engage and support young people with learning disabilities in the workplace. Project SEARCH – a partnership between Northern Devon Healthcare NHS Trust, Petroc and Pluss – won an international award at the Project SEARCH annual conference in Phoenix, Arizona, in October 2015. The Barnstaple scheme was chosen because 86% of the students on its 2014/15 course went on to secure employment.

In November 2015, Gail Richards, the Trust’s Engaging the Young Workforce lead was named NHS Inclusivity Leader of the Year by the South West Leadership Academy, in recognition of

her work in engaging and developing learning disability interns across the Trust.

Darryn Allcorn, director for workforce and development, said: "This is yet another fantastic accolade which proves what we are doing with apprentices and young people is great.

"The award really reaffirms the benefits and opportunities these schemes can bring, both to the individuals and to the organisation, and we continue to promote apprenticeships as part of our overall recruitment strategy."

Dementia ward shortlisted for building excellence awards

Our flagship dementia ward at North Devon District Hospital was shortlisted three times for the South West LABC Building Excellence Awards in November 2015.



Fortescue was one of the first purpose-built dementia wards at an acute hospital in the UK when it opened in November 2014.

The 29-bed ward was shortlisted in the 'Best public service building', 'Best inclusive building' and 'Best change of use of an existing building or conversion' categories at the awards ceremony in Plymouth.

Representatives from Northern Devon Healthcare NHS Trust collected certificates alongside project partners from Morgan Sindall, David Wilson Partnership, Gates Partnership and Pivotal Design and Consultancy.



Pictured at the awards ceremony in Plymouth are (from left) Phil Humphrey, Rae Reynolds and Paul Humphreys, of the Trust's capital development team.

They were nominated by the building control team at North Devon Council.

The ward was designed especially for people with dementia or similar illnesses and contains a host of features to help patients feel at home, remain independent and reduce confusion.

The refurbishment involved extensive demolition and rebuilding work and cost around £800,000.

Five Trust projects showcased at national awards event in London

In September 2015, the Trust showcased five of its successful projects at one of the industry's biggest awards events.

The Trust was a multiple finalist in the HSJ Value in Healthcare Awards, which recognise and reward outstanding efficiency and improvement by the NHS.

The Exeter Community Nursing Centre, Exeter cluster pharmacy team and the orthopaedic department at North Devon District Hospital were shortlisted for the event in London.



Trust staff are pictured at the HSJ Value in Healthcare Awards event in London.

Also in the spotlight were ComPAS, the Trust's community patient administration system, and STAR, an online learning portal for staff.

The five projects are among a number of schemes the Trust has introduced to help it deliver safe, high-quality care while also saving money for the NHS.

They beat off competition from a record 532 entries received by organisers the Health Service Journal.

ComPAS was also a finalist in the EHI Awards, which celebrate the best IT projects in healthcare.

MORE INFORMATION

- ▶ The Exeter Community Nursing Centre, launched in April 2014, supports people who were previously visited in their own home by a community nurse but are mobile enough to access treatment locally at a time of their convenience. This has helped to free up time for nurses to care for patients who are less mobile and with more complex needs in their own home, leading to efficiency savings of around £50,000 in the first year.
- ▶ The Exeter cluster pharmacy team works to empower frail elderly patients to manage their own medicines safely at home, reducing risks and hospital admissions and achieving cost savings of over £250,000 a year.
- ▶ The North Devon District Hospital orthopaedic team launched an enhanced recovery programme in 2011, which has led to a dramatic reduction in the average length of stay for patients undergoing hip or knee replacements, as well as significant cost savings for the Trust.
- ▶ ComPAS, the Trust's community patient administration system, provides detailed data which helps to inform contract negotiations, workforce planning, operational delivery and communications, bringing significant improvements in productivity and estimated savings of £3.4million through reduced hospital admissions.
- ▶ STAR, an online learning management system where Trust staff can access, complete and track all their mandatory and optional training from any internet-enabled device, has brought significant benefits since its launch in 2013, including £1million savings in training costs for patient-facing staff.

A community that goes Over and Above

Seamoor Unit celebrates first birthday

The new chemotherapy and day treatment centre at North Devon District Hospital has celebrated a busy first year.

Since it opened at the end of March 2015, the Seamoor Unit has seen more than 10,000 patients, divided equally between the Unit's oncology and haematology services.

The £2.5million unit was made possible thanks to the Chemotherapy Appeal, a four-year fundraising campaign by the Trust's charity Over and Above.



The North Devon Cancer Care Centre Trust (NDCCCT) contributed £700,000 while the rest came thanks to the efforts and generosity of individuals, organisations and businesses.

Dr Alison Diamond, chief executive of the Trust, said: "We would like to reiterate our gratitude to everyone who contributed to this amazing project – staff, fundraisers, volunteers, the project team, the North Devon Gazette and many more.

"Thanks to you, we have a wonderful, state-of-the-art building which offers a fitting and comfortable environment for staff, patients and families, at a time in their lives when they need it the most."

Unit manager Emma Thoms said she didn't know what to expect in the first year, but patients had been delighted with the difference to the former cramped, shared facility at the hospital.

"We've had a lot of positive feedback from patients about the space and it being light and airy," she said.

Before the unit was built, many patients had to travel to Exeter for treatment.

Now they enjoy a better environment and an enhanced service that includes specialist nurses to offer telephone or face-to-face advice on dealing with side-effects of treatment.

Fundraising manager Ian Roome said: "A huge thank you to the people of North Devon and Cornwall for their dedicated fundraising, but our hospital charity Over and Above still needs to raise funds for additional medical services and equipment at the Unit which are not available on the NHS."



The Unit was officially opened in September 2015, by HRH the Earl of Wessex, Prince Edward.

The Trust continues to raise vital funds to support its services, including the Seamoor Unit, through its charity Over and Above.

Charity appeals through the year

The hospital charity, Over and Above, supports the work of the Trust and constantly strives to improve the services and facilities it offers to local people.

The charity's current appeal aims to raise £250,000 to purchase new equipment for the Special Care Baby Unit at North Devon District Hospital. This amount will enable us to purchase specialist incubators, ventilators and other neonatal medical equipment to help save the lives of babies that are born early or with difficulties. Thanks to the overwhelming support from local people, the appeal has raised £110,000 so far.

The appeal's priority is the purchase of three neonatal ventilators which cost £23,000 each. The Special Care Baby Unit recently trialed the ventilator and the fundraising team couldn't resist encouraging the staff to join them in the making of a fundraising spoof film of 'You're the one that I want' from the Grease musical, which can be seen on the charity website.

Throughout the year the charity organises lots of fun and adrenalin fuelled fundraising activities for the Special Care Baby Unit, the Seamoor Unit, and many of our other departments.

Our supporters have jumped out of aeroplanes, organised sponsored walks and quizzes, and even walked the Great Wall of China. Our popular annual fundraiser 'The Scrumptious

Croyde Trail' sold out again for its second year and Ivan Huxtable donated over £4,000 from his Exmoor Ramble to purchase specialist reclining armchairs to support our cardiology patients. The Croyde Ocean Triathlon and the Beach Breakers challenging course for mountain bikes, taking place in Woolacombe, are both raising money for Seamoor unit. These are just some of the amazing events organised to enable the hospital charity to fund much needed equipment to care for the people of North Devon.

We are extremely grateful to everybody who takes part in any of the events we organise, and also to those who organise events themselves or choose to raise money for Over and Above when taking part in an event.

To find out more about our fundraising events and our charity, visit www.overandabove.org.uk, contact the Fundraising Team on 01271 311772, or email ndht.charity@nhs.net



Modernising our hospital buildings

Patients benefit from refurbished ward at NDDH

Patients recovering from surgery at North Devon District Hospital can now enjoy enhanced facilities and a better all-round environment following a £850,000 refurbishment of King George V (KGV) Ward.

The refurbished ward, which opened in December, contains five side rooms with en-suite facilities, offering patients privacy and quiet space, and a single treatment room.

There are a further 18 beds in more spacious and modern bays, making a total of 24.

Marie Richards, KGV ward manager, said: “The ward looks fantastic and we would like to thank everyone involved in the refurbishment.

“The improved environment will make a huge difference to our patients and the staff working on the ward.”



NDDH chapel garden given a makeover thanks to friends' donation

THE courtyard garden next to the chapel at North Devon District Hospital was given a makeover thanks to a generous donation in memory of a former patient.

The garden offers a quiet outside space for users of the chapel, which is part of the hospital's faith centre.

The area was in desperate need of a facelift and this was made possible following the receipt of a donation by friends of Richard 'Dick' Cawthorne MBE, who had been visited and supported by the chaplaincy service before he died at NDDH in July 2012.



Friends of former patient Richard 'Dick' Cawthorne are pictured with staff at the opening of the chapel garden at NDDH.

Theatre storage areas at NDDH refurbished

We oversaw a major project at North Devon District Hospital to refurbish the anaesthetic rooms, prep rooms and surrounding storage areas of seven operating theatres with new cabinets.



The new Medstor cabinets ensure easy location of goods and eliminate stock-outs, and are perfect for high-volume storage needs and organising supplies quickly.

News from our community hospitals

Staff and patients celebrate 90th anniversary of Bideford Hospital

Staff and patients celebrated the 90th anniversary of Bideford Hospital in September.

The hospital, in Abbotsham Road, was opened on 23 September 1925 by Sir William Reardon Smith, a famous ship owner who was born in Appledore and founded his own company in Cardiff.

A wooden plaque to mark the opening is displayed in the current outpatient area.

The hospital catering team made and decorated a special cake to celebrate the anniversary, which was given to patients with their afternoon tea and to staff throughout the building.



Dorothy Perkins cuts the cake with Lyn Jewell.

New iPads offer communication support for Seaton patients

Patients in Seaton with communication and swallowing difficulties are benefitting from the use of two iPads with a variety of specialised apps.

The iPads were bought by Seaton and District Hospital League of Friends.

One is intended for inpatients at Seaton Community Hospital requiring communication support, with extra apps to enhance staff training.

The second will be used in the community for assessment, ongoing communication therapy and education.

The hospital has a number of admissions due to medical events that can affect communication, such as motor neurone disease, stroke, Parkinson's, multiple sclerosis and dementia.

As a result of these conditions, it can be very difficult and frustrating to communicate even basic needs.

This presents a poignant situation at a time when there is a strong desire to impart information, hopes and wishes to loved ones and professionals.

Dr Rob Daniels, a Seaton GP, initiated and supported the purchase of the iPads and Sue Renyard, community speech and language therapist, will use the technology to assist with assessment and ongoing support.

Sue said: "The importance of communication cannot be underestimated. Communication is at the heart of all our relationships.



Patient Nicola Hulland is pictured with Sue Renyard, community speech and language therapist, and one of the iPads.

"Every day we communicate with many people – family, friends, colleagues and strangers. Communication is an essential human need as well as a basic human right.

"It's exciting to have this modern technology to help people find their voice. Everyone deserves to be treated with respect and equality."

"The two iPads have been received with much gratitude and on behalf of the current and future beneficiaries of this technology, many thanks must go to all those involved with the Seaton and District Hospital League of Friends."



Torrington Hospital open days showcase services

Three open days took place at Torrington Hospital Health and Wellbeing Hub, to give visitors the opportunity to see how the space in the hospital is now being used clinically for day treatments such as blood transfusions and for physiotherapy.

They were also able to hear about the new services being provided from the hospital such as ultrasound, day treatments, and the depression and anxiety service.

Visitors and patients offered their feedback and suggestions regarding the services they wanted to see at Torrington Hospital and in November, we announced a monthly Audiology Service clinic would be starting at the hospital.

Following the success of the first two open days, Ageing Well recruited enough volunteers to begin a refreshment service on Wednesdays at Torrington Hospital, which began in November.

Trust physiotherapist joins charity mission to transform lives of patients in Kenya

In summer 2015, a physiotherapist from Okehampton took part in a charity mission to transform the lives of patients and improve services in rural Kenya.

Amy Souster spent 10 days on the Kenya Orthopaedic Project (KOP), joining a team of healthcare professionals from the UK tasked with educating and operating on as many local people in need as possible.

The team visited Nanyuki Teaching and Referral Hospital, which serves a population of over 100,000 in Northern Kenya.

“They have 150 beds and six doctors who try to provide a service that covers every medical condition seen in this area,” said Amy, a physiotherapist in the Okehampton community rehabilitation team.



“There is minimal government funding and patients are required to pay for their surgery, hospital stay, dressing changes and all aspects of their care.”

Amy, who is based at Okehampton Hospital and

works for the Northern Devon Healthcare NHS Trust, was joined by another physiotherapist, a consultant orthopaedic surgeon, two anaesthetists, two scrub nurses, a physiotherapist and a theatre healthcare assistant from Plymouth.

The team in Kenya was completed by a surgical assistant practitioner and a radiographer from Torbay, two doctors from Exeter and an orthopaedic registrar from Birmingham.



The project started with a clinic run by the doctors and physiotherapists where local people came with their injuries and x-rays hoping the team would treat them and improve their lives.

“The majority of people came with a leg or arm fracture which could have been many years on from the initial injury,” said Amy, 32, who lives in Exeter.

“Some of the fractures still had open wounds and the bones were infected, and in some instances the bones weren’t united.

“It was very intense and motivating to see the morale of people sharing single beds if they couldn’t afford a bed to themselves, sharing crutches and frames, helping each other out with language and translation and being motivated to get up and move as soon as they could.



“It was an eye-opening and incredible experience that will stay with me forever.”

The trip was led by charities EGHO (Exploring Global Health Opportunities) and MEAK (Medical and Educational Aid to Kenya).

For more information about EGHO or MEAK, visit <http://egho.co.uk> or www.meak.org.



Amy Souster (right) is pictured with other members of the Kenya Orthopaedic Project team. On the left is Nichola Giblin, who used to work with Amy in Okehampton.

Honiton Hospital staff help town's bid to become dementia friendly

STAFF at Honiton Hospital are playing their part in the town's bid to become dementia friendly.

In October 2015, healthcare assistants Donna Guyett, Beki Beal and Tina Butler held a display at the Dementia Friendly Fayre at The Beehive in Honiton.

The event marked the launch of the Honiton Dementia Action Alliance (HDAA) and attracted more than 150 visitors.

The alliance brings together local groups and organisations who are committed to transforming the lives of people with dementia and their carers.

The event included an update on Honiton's bid to become a dementia-friendly town and speeches by mayor Caroline Kolek and local MP Neil Parish.

Donna, Beki and Tina have initiated daily activities for patients on the ward at Honiton Hospital and undergone extra training in dementia.

Matron Michaela Dicks said she was "very proud" of the trio and said they had "gone the extra mile" with their dementia work.

She said: "They were part of a big event talking to the public about dementia and how we can support people with dementia in our town, and promoting the excellent work our hospital and the Trust does in this area of medicine."



Pictured at the Dementia Friendly Fayre in Honiton are (from left) Donna Guyett, Beki Beal and Tina Butler.

Section 3: Corporate declarations

Sustainability Statement

The Trust has a corporate duty to maintain safe and efficient services, but as a large user of resources we must also be environmentally sustainable in the services we provide with a minimal impact on the local community and infrastructures.

By ensuring the efficient use of its resources the Trust has tasked itself to reduce this impact. The benefit of such control is that it also supports the Trust's aim to reduce operational costs. To allow the Trust to demonstrate this, it has adopted the NHS software the Good Corporate Citizen guide (GCC). The GCC identifies nine areas that trusts should focus on which, once scored for compliance, can be benchmarked with other similar organisations. These areas are:

1. Travel:

The Trust continues to promote healthy travel within its workforce by advertising public transport access, and encouraging more people to use public transport and where possible lift-sharing. In addition the Trust offers access to the cycle to work scheme supporting its use with the provision of onsite changing facilities at all sites for those wishing to participate.

To further support this, due to the size of the estate, innovative ways are being explored to reduce the need for travel, or reduce its impact on the environment. Teleconferencing is used where possible, especially for large pan-Trust meetings. In addition, the partnership arrangement with Enterprise car rentals has allowed access to a newer, more efficient car fleet for business mileage, thereby reducing the grey fleet of inefficient private cars used in the past by staff.

2. Procurement:

The NHS has been tasked by government to standardise and reduce the extensive range of goods/services it provides to deliver healthcare services. To meet this requirement the Trust's procurement department has reviewed its purchasing in partnership with a network of other NHS Trusts. This has allowed it to reduce and standardise the number of product/service ranges it purchases. In addition this review has also supported, where practical, a more sustainable approach with its suppliers in the selection of goods and services, and this has

become a key factor of the purchase selection process. Actions adopted that assist in this are:

- ▶ The reduction in packaging of goods
- ▶ The environmental impact of energy consumed by equipment is obtained
- ▶ Sustainable disposal of equipment at end of life is identified
- ▶ The promotion of local services/goods to reduce carbon miles from transport
- ▶ Methods of delivery from the NHS Supply Chain fleet i.e. vehicle use, times of delivery etc.

3. Facilities:

Energy:

A key target is to reduce energy usage within the Trust's estate. Success will automatically bring a reduction in energy costs and carbon produced (CO₂). To support this target, the Trust is in the final stages of completing an Energy Performance Contract (EPC). The EPC has provided a major investment in the Trust's infrastructures which, from savings made will allow a payback of the investment within five years. This will release funds to support healthcare delivery and the development of healthcare facilities. Once the EPC is completed, the Trust's energy usage will immediately start to decrease by at least 20% of its present annual usage. This energy reduction will assist the Trust in achieving its Government-levied target on CO₂ production and place the Trust in line with the best performers within the NHS.

Waste:

The Trust continues to be proactive in all areas of waste management and monitors the contract with SRCL, Viridor and other waste contractors very closely. To maintain quality and to continually improve standards, the Trust has adopted a partnership approach. This has allowed the Trust to obtain and use the expertise of effective specialist contractors, particularly in tapping into new innovations. Within these contracts the Trust works with the contractors to look at improving effective segregation and increased recycling to reduce the waste volumes the Trust produces, while at the same time ensuring that any innovative techniques do not affect compliance to relevant legislation.

4. Work force:

The Trust is actively involved in the continual improvement of the working environment and facilities for all its work force. From a sustainability perspective the Trust ensures there is a continual monitoring of the work environment and facilities through the use of staff surveys and feedback. A key aim for 2016 will be raising the sustainability agenda throughout the Trust. We need to engage with staff and encourage them to suggest ways the Trust could improve its sustainable reputation, by changing the way we work and deliver services.

5. Community engagement:

The first new area for the Trust within the GCC relates to community engagement and the importance of how the Trust and its services assist the local population to build healthy, sustainable lives and communities. It looks at what facilities and support we make available to our staff i.e. childcare and carer support. It makes reference to how the Trust communicates sustainability to all staff, whether through training or communication packages. To achieve such compliance also requires the Trust to partner with local organisations, potentially sharing assets and resources with local communities, and to engage with service users about their experience of our services.

6. Buildings:

The use of sustainable products in all developments remains a key requirement of the Trust. In addition, the target to design such developments to deliver and exceed the energy savings expected of a new build remains a fundamental challenge especially on old building stock. The Department of Health benchmarks all of the Trust's estate. This is to ensure it is fit for purpose, supports the delivery of modern healthcare services and is energy efficient based on energy consumed per metre of area.

The new chemotherapy unit was the latest major development within the Trust's estate and was awarded the national standard of "excellent" through the Building Research Establishment Environmental Assessment Methodology (BREEAM). The Trust is now looking to improve the quality of all its existing buildings to at least "good" as a national standard.

7. Adaptation:

This is the second new area for the Trust within the GCC. This relates to the Trust's understanding of how the risks posed by climate change could affect services and service users. This section links in with the Trust's emergency planning, and challenges the Trust to consider how floods, and extreme temperatures, hot or cold, could affect its ability to deliver healthcare services. The Trust meets a great deal of this section through its processes for service and area development through business case approval, and ultimately by the design and delivery of projects.

8. Models of care:

This is the third new area for the Trust within the GCC. This relates to involving staff to contribute ideas on how to deliver services in a more environmentally sustainable way. It requires us to educate clinical staff about how they can contribute to the delivery of sustainable healthcare and how they can try to reduce the carbon impact in some areas of services they provide. This area builds on the area "Community Engagement". This is by assessing the practical approach the Trust takes in its sustainable approach to service delivery.

It also looks at the provision of health education and its promotion to staff, the public, and visitors around the benefits of healthy lifestyles and that the Trust looks at more environmentally sustainable models of care, particularly in relation to long term conditions, chronic disease or those who are vulnerable. There is a requirement for the reduction in waste from certain resources i.e. pharmaceutical waste, the re-use of medicines, control and efficient stock management. Such benefits can only be achieved through clinician engagement in this area during patient care and treatment. A key factor for the Trust in its CO₂ reduction has been "care closer to home", which has resulted in people being treated in their own home or local outpatient facilities. By providing local facilities this has also resulted in a reduction in distance travelled by the public, thereby reducing vehicle-produced CO₂ and also the impact of vehicle congestion on the NDDH acute site.

Our performance over the last 12 months

All NHS organisations are required to deliver certain levels of performance to ensure we can monitor the care we provide to patients.

It is really important that our patients have confidence in the quality of care provided by their local NHS.

The full 12 months of 2015/16 performance can be found on our website, www.northdevonhealth.nhs.uk/about/performance

A summary of our key performance indicators is included in the table below.

	Target	2014-15	Quarterly Totals			
			Q1 2015	Q2 2015	Q3 2015	Q4 2015
		Value	Value	Value	Value	Value
RTT Incomplete % <18wks TOTAL	92.0%	95.3%	95.3%	95.0%	94.7%	94.4%
A&E, MIU & WIC Attendances and 4 Hour Breaches	95%	96.6%	96.6%	96.6%	96%	94.6%
Cancer 62 Day Waits (aggregate measure) - Total Treated < 62 Days from Urgent GP Referral	85%	80.6%	88.2%	84.6%	92.8%	90.4%
Cancer 62 Day Waits (Open Exeter) Overall Total Treated < 62 days from urgent GP referral	85%	76.6%	83.1%	78.2%	88%	83.6%
Cancer 62 Day Waits (aggregate measure) - Total Treated < 62 Days Screening Service	90%	75%	100%	100%	71.4%	100%
Cancer 31 Day Waits - Total Treated < 31 Days from Diagnosis - (Decision to treat)	96%	97.3%	96.6%	95.9%	97%	100%
Cancer 31 Day Waits - Total Treated < 31 Days Subsequent Surgical Treatment	94%	89%	94.1%	91.5%	86.8%	93.1%
Cancer 31 Day Waits - Total Treated < 31 Days Subsequent Drug Treatment	98%	99.1%	99%	98.7%	100%	100%
Cancer 2 Week Waits (aggregate measure) - Total Seen within 14 Days of Urgent GP Referral	93%	83.6%	92%	91.8%	95.2%	96.5%
Cancer 2 Week Waits (aggregate measure) breast symp	93%	61.6%	77.8%	87.7%	93.9%	91.5%
C.Difficile over 3 days - avoidable: NDDH	7	1	1	0	0	0
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes	Yes	Yes	Yes	Yes	Yes
Data Completeness: community services - referral to treatment	50%	99.83%	99.8%	99.73%	98.63%	97.5%
Data Completeness: community services - referral information	50%	100%	100%	100%	100%	100%
Data Completeness: community services - treatment information	50%	99.72%	99.6%	99.67%	99.23%	98.15%

Our workforce

At the close of 2015/16, Northern Devon Healthcare NHS Trust employed 4,505 staff.

The tables of data below show the following information:

► Table 1: workforce data by gender and age

Age band	Female	Male	Total
16 - 19	13	6	19
20 - 24	172	26	198
25 - 29	352	81	433
30 - 34	365	66	431
35 - 39	369	76	445
40 - 44	455	107	562
45 - 49	568	99	667
50 - 54	627	97	724
55 - 59	530	96	626
60 - 64	260	62	322
65 - 69	54	12	66
70 +	10	2	12
Grand total	3775	730	4505

► Table 2: workforce data by pay band

Pay Band	Total
Band 1	163
Band 2	753
Band 3	717
Band 4	326
Band 5	957
Band 6	772
Band 7	376
Band 8+	160
Medical & Dental	281
Grand Total	4505

Effective communication and consultation with our staff remains key to our success in providing the highest quality services. During 2015/16 we continued to deliver executive team roadshows across the Trust to ensure staff are engaged with the challenges and opportunities facing the Trust and can contribute their ideas as to how we can work effectively to deliver safe, high-quality care. This year we have also involved non-executive directors in a number of community staff engagement sessions which has given them an excellent opportunity to meet staff from across the Trust and to better understand the issues that are important to them.

We have embedded the principles of Listening into Action into business as normal, having had an extremely successful year as a Pioneer Trust in 2014/15. Current projects include the Electronic Health Record and development of an internal coaching network for employees within the Trust.

Our 2015 national staff survey results ranked the Trust as having the best overall score in the "combined acute and community" comparison group as well as being best in the South West for all NHS Trusts. We scored highly in overall staff engagement, which covers whether staff would recommend the Trust as a place to work or receive treatment, motivation and their ability to contribute towards improvements. The survey showed that our overall staff engagement had further improved since 2014.

We continue to work in partnership with our staff side and trade unions colleagues to ensure that staff are appropriately consulted and supported in the workplace. During the latter part of the year we have been undertaking significant due diligence work to support the safe and effective transfer of our Eastern Community Services to the Royal Devon and Exeter Hospital.

Employee consultations

- Pathology review of management structure and stand-by provision
- Paediatric care – developing skill mix
- Operations divisional restructure – test of change
- Closure of Willow Ward at Bideford Hospital and review of hotel services
- Mardon unit – transfer to new premises
- WEB – 7 day working
- RIC – relocation of base

During 2015/16 the junior doctor contract national negotiations have been on-going and the Trust has experienced a number of days of strike action by junior doctors. As a Trust we have put in place contingency plans to mitigate the disruption to services. Our staff have been fantastic in pulling together to ensure services are safe and consistent during any action and we have worked closely with trade unions and staff to ensure any impact is kept to a minimum.

Staff engagement survey score

The National Staff Survey 2015, which sampled 849 randomly-selected staff, was run between September and December 2015. Our response rate was 48%, which was above average when compared to similar trusts and a 3% increase on last year's 45%.

The Trust's score on the overall indicator of staff engagement was 3.93, an increase on 2014's score of 3.88 and above average when compared with trusts of a similar type (the average score was 3.79). Possible scores ranged from 1, indicating that staff are poorly engaged and 5 indicating that staff are highly engaged.

Involving and empowering staff

The Trust became a Listening into Action (LiA) organisation in 2014, quickly benefitting from the structured approach to involving and empowering staff that complemented our existing values.

It is clear from the success we have seen through using the approach that staff are increasingly aware of their opportunity to be at the heart of change and improvements to our services.

This has ensured the Trust remains committed to using the Listening into Action approach for a further year.

Our second year of LiA has seen a significant expansion of the number of projects using the approach, with a growing recognition that 'how' we go about change and improvement, and 'who' we involve, are critical to success and sustainability.

This has been reflected in our results in the national NHS Staff Survey, which continue to demonstrate high levels of staff engagement during challenging times across the organisation.

Workforce diversity

The Trust continues to be committed to providing high quality services which are accessible and appropriate to meet the needs of the diverse communities it serves, working collaboratively with internal and external key stakeholders and partners to ensure our services and policies do not discriminate or disadvantage anyone.

Equality and Diversity (E&D) are at the heart of our Trust strategy and values and we recognise that supporting, developing and enabling a

diverse workforce enables us to continue to build on high standards of patient care.

The Workforce & Organisational Development directorate continues to work collaboratively to support a large number of departments offering operational advice and training on deaf/deaf-blind communication awareness, disability equality, equality impact assessment, human rights and learning disabilities awareness.

Our annual equality and diversity and Workforce Race Scheme reports are available on the Trust website www.northdevonhealth.nhs.net

Sickness absence

The sickness absence remains at 3.5% in year with the Trust setting a stretch target to improve this figure. Absence remains at a low level compared to the national averages.

Consultancy

In 2015-16, the Trust spent £86,000 on consultancy services. This enlisted support of 4 external consultant companies who provided specialist expert input into specific service reviews and valuation issues, where such experience did not exist in the workforce.

Patient experience of our services

In 2015/16 our patient experience programme continued to cover the majority of services provided by the Trust. This means that whether patients are in an inpatient care setting, clinic or in their own home, they have the opportunity to tell us about their experience of that service.

At Board-level, the Trust's director of nursing has responsibility for patient experience which includes delivery of our patient experience strategy and annual programme, compliance with the national Friends and Family Test reporting and demonstrating that we have used patient experience feedback to improve the experience of care. Patient experience also features as the third element of the Trust's quality strategy, placing it firmly at the heart of the Trust's continuous drive to improve the quality of services we provide.

We have developed a patient experience programme that covers the majority of services provided by the Trust: in hospital, clinic or in the patient's home. Patients can provide their

feedback in real-time through the inpatient surveys at North Devon District Hospital, social media, Mystery Shopping, Patient Opinion, postal surveys, focus groups, face-to-face engagement, PALS/complaints and, of course, routinely throughout the Trust via the Friends and Family Test.

At the start of each Board meeting, a patient story is presented which articulates the experience of a patient in our care. Patient stories are obtained from patients we meet either through complaints, service transformation projects, letters to the Chief Executive or patients who have approached the Trust. It allows the Board to see the impact of decisions they are making. For example, recently a patient attended the Board meeting to talk about their experience of having undiagnosed lymphoedema for 19 years. She explained the impact this had had on her life and how eventual referral to the lymphoedema service had been life-changing. She highlighted that numerous clinicians in primary and secondary care had dismissed her

own research into the matter delaying diagnosis by years. The board appreciated that the patient had taken the time to speak to them about her experience and is looking at ways of raising the profile of the lymphoedema service inside and outside the hospital setting.

The Trust publishes the Friends and Family Test performance reports and detailed feedback reports on its website under the Board Reports. We are currently collecting on average 2,000 pieces of patient experience feedback every month. Our patient experience data is shared and welcomed by clinical and operational teams. The patient experience team provides a report to the NDDH acute / maternity ward within two-three hours of the feedback being given and a report to other services on a monthly or bi-monthly basis. In addition, it is shared with the patient safety and quality team in recognition of the importance of patient experience in assessing the quality of NHS services alongside effectiveness and safety.

You said

Meals for parents / carers should be provided on our paediatric ward so that parents / carers do not need to leave their children.

You said

More entertainment should be provided for older children in the children's outpatients department at NDDH.

We did

Parents / carers can purchase meals on the ward in the form of either a microwaved meal or a patient meal from the trolley.

We did

Computer games are now available for teenagers.

You said

Higher chairs are needed for patients who have mobility and / or back problems in the waiting area in x-ray area A at NDDH.

You said

Better parking facilities should be provided at Exeter Community Hospital.

We did

A different style of chair has been introduced to resolve this issue.

We did

The parking area has now been designated a 'patient only' parking area with five spaces and four disabled parking spaces.

Via the Learning from Patient Experience Group, the patient experience feedback is routinely compared alongside staff experience and operational data in recognition of the close links between staff experience, operational pressures and patient experience.

The Friends and Family Test programme includes the following services:

NDDH

Acute inpatient wards
A&E department
Maternity
Outpatients
Daycases

Community

Community hospital inpatient wards
Community hospital outpatients
Community hospital day cases
Community children's nursing
Minor injury units
Walk-in centres

Home-facing services

Community therapy
Community nursing

Specialist community services

Sexual health
Podiatry
Bladder and bowel
Dental
Chronic fatigue syndrome / ME

The patient experience strategy can be accessed here: www.northdevonhealth.nhs.uk/2013/04/patient-experience-strategy/

The patient experience strategy uses the following structure to articulate achievements:

Capture the experience using all available and appropriate tools to capture the experience of patients, carers and staff.

Understand the experience by identifying the 'touch-points' of a service and gaining knowledge on **what** people feel when experiencing our services and **when** they feel it.

Improve the experience by ensuring the feedback is heard and understood by the relevant clinical and managerial teams.

Receiving, analysing and presenting feedback and then involving users and staff in developing the solution completes the 'you said, we did' governance cycle.

Disseminate and measure the improvement by 'You said, we did'. Below are just some examples of how we have used patient feedback to make real changes.

More information on our patient experience can be found in the Patient Experience 2015/16 annual report or on the patient experience section on our website – www.northdevonhealth.nhs.uk/patient-experience

Complaints and patient feedback

Complaints continue to be a vital source of feedback from our service users, carers and relatives and in line with Trust policy; a complaint becomes formal in accordance with the complainant's wishes. A complaint may originate from a concern (written or verbal) which was impossible to resolve through the Patient Advice and Liaison Service (PALS).

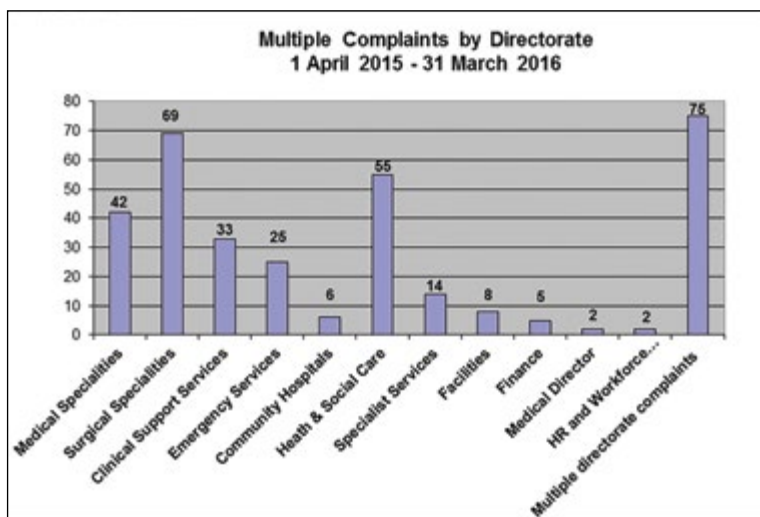
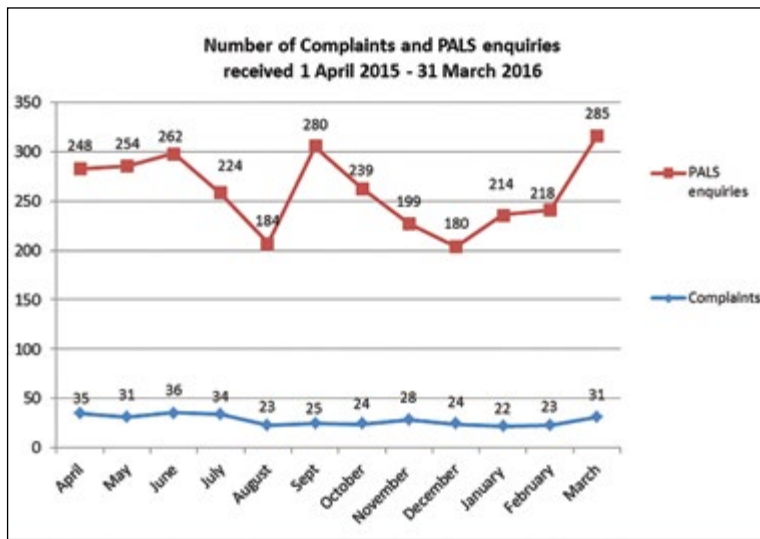
During the year period, 336 complaints were received, which is a slight increased level of activity on 2014/2015 (323) and 2787 PALS enquiries were received, which is an increase of 283 on 2014/2015. The combined complaints and PALS activity demonstrates a positive reflection on how patients and service users feel able to provide feedback on their experience, which the Trust welcomes and encourages. During the period, no complaints were received by the Care Quality Commission (CQC).

The top five complaint themes were clinical care and treatment (37%), communication (21%), access to clinical services (15%), attitude of staff (12%), and discharge arrangements (5%).

The division with the highest number of complaints for the financial year was multi-directorate complaints (75), the Acute Service Delivery Unit (ASDU) consisting of surgical specialties (69), and Community Service Delivery Unit (CSDU) consisting of Health and Social Care services (55).

The graph below shows the breakdown of complaints received by Service Delivery Unit.

Out of the 6 complaints received for the community hospitals, South Molton hospital received two complaints, with Crediton, Exmouth, Honiton and Torrington, receiving one each respectively. Of the 55 complaints for Health and Social Care services, over half



v(32) related to concerns raised surrounding Continuing Healthcare (CHC) assessments.

All complaints are required to be acknowledged within three working days, in line with Trust policy. During the period, 98% of complaints were acknowledged within this timeframe.

The Customer Relations Manager(s) continue to routinely telephone complainants on receipt of their complaint (where contact details are available) to discuss and agree a way forward, and a meeting with relevant senior staff/clinicians involved in the patient's/complainant's care is offered at the outset. During this conversation the issues for investigation and resolution are agreed with the complainant to ensure we adequately address the issues of concern.

Complaint response performance

During the period, 92% of complaints were responded to within the agreed timeframe or an agreed extension to the timeframe, which is an increase of 1% on the last reporting period (2014/2015). In order to monitor and prevent late responses to complainants, the Trust reviews the key performance indicator (KPI's) relating to timeliness of investigations as part of the monthly performance review meetings with our service directorates and our commissioners, Northern Eastern, Western (NEW) Devon Clinical Commissioning Group.

Outcomes and remedial actions from closed complaints

During the period, 336 complaints were closed following investigation. Of these closed complaints, 57 required action to be taken as a result of the concern raised. Of these 57:

- ▶ 23 related to clinical care and treatment
- ▶ 10 related to communication
- ▶ 6 related to attitude of staff
- ▶ 5 related to accessing clinical services
- ▶ 3 related to discharge planning
- ▶ 3 related to patient property
- ▶ 2 related to confidentiality and consent matters
- ▶ 2 related to information provision
- ▶ 1 related to bereavement matters
- ▶ 1 related to medical issues
- ▶ 1 related to quality of facilities

Learning and improved communication identified as a result of complaints this financial year:

Examples of remedial actions undertaken can be seen below.

- ▶ A review of the equipment located within the maternity rooms will be undertaken in response to a patient's experience and difficulties they experienced
- ▶ Training was undertaken with ophthalmology doctors surrounding the importance of seeking immediate advice from a senior colleague/consultant if they had concerns regarding a patient's condition, and to ensure a patient's medical records are available for review during a consultation to enable the opportunity to look back at past medical history and any relevant management plans that may assist in the on-going treatment. Junior doctors were also encouraged to bring cases and share learning with their colleagues at teaching sessions each week
- ▶ A training programme for surgical junior doctors in performing and documenting Doppler tests was implemented alongside raising awareness of the need to have consultant review of all patients seen in the emergency department/medical admissions unit (MAU) within 24 hours.
- ▶ Awareness was raised surrounding the appropriate prescribing of antibiotics and insulin.
- ▶ The ophthalmology team appointed an additional locum consultant to assist with capacity issues and appointment delays.
- ▶ In their role as clinical tutor, a consultant will provide feedback and training to junior doctors following the management of an obs and gynae patient.
- ▶ It was identified that agency staff needed additional support in completing a Continuing healthcare (CHC) assessment due to their frequency of completion.
- ▶ A revised post fall checklist has been put in place within the community hospitals to aid nursing staff with monitoring a patient's condition following a fall. Green stickers on the front of medical notes are also being used to provide a visual prompt to the multi-disciplinary teams (MDT) who may be involved in the management of a patient at risk of repeated falls.
- ▶ The rapid response team will be implementing a number of remedial actions to improve their communication with carers working for the service, particularly during the night. A hard copy of the rota will be available to help quickly identify relevant staff working during the night when staff do not have easy access to an electronic copy, alongside the intention to develop a more robust IT management system to reduce the risk of staff/patient allocation error.
- ▶ A leaflet for patients and carers on the use and functions of a syringe driver has been developed by Marie Curie, Hospice and Northern Devon Healthcare NHS Trust. The Trust is also in the process of reviewing its syringe driver policy and based on a relatives' experience it will consider the impact of users and carers as part of the policy and create a patient leaflet to support the policy.
- ▶ Protocols between the domestic provider, Sodexo, and the day surgery unit (DSU) have been revised to ensure adequate domestic services support is provided to DSU when the unit is utilised out of hours in response to hospital bed escalation.

- ▶ A working group has been formed between staff working in the acute hospital and community setting to identify how communication can be improved between the two groups to support effective discharge planning and referrals between the two groups.
- ▶ Considerable work has been undertaken by the central Continuing Healthcare (CHC) admin hub and wider nursing teams undertaking the assessments to improve the timely completion of assessments. This includes a review of the current systems and processes used to record referral information/assessment requests, providing up to date contact details for families going through the process, alongside reminding CHC nurses to ensure there is robust documentation of all interactions with patients and or relatives.
- ▶ A patient marker was placed on our electronic patient administration system (PAS) to assist the medical and site management team in preventing a patient from being moved to an outlying ward, where possible, due to their pre-existing medical condition.
- ▶ A relative was reimbursed for the provision of inconvenience pads that they had to provide due to an error and a delay in the prescription.
- ▶ A patient was reimbursed for a diagnostic procedure they underwent privately due to the need for the imaging being unfortunately missed by the medical team.

Reflection undertaken by medical and nursing staff

5 doctors, 8 nursing practitioners, and 4 allied health professional have reflected on their management of a patient.

Breakdown of complaints by the top five subject matters

The following two charts identify the top five subject matters for the complaints received during the financial year.

The directorates mainly involved in the top five areas of care were:

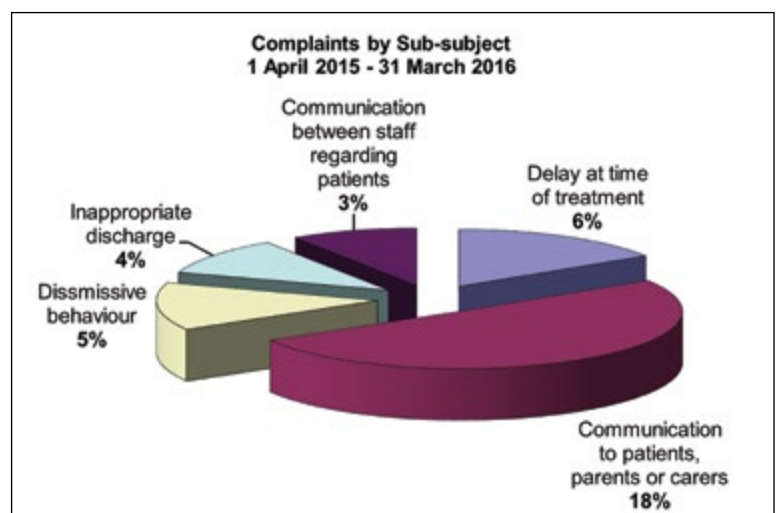
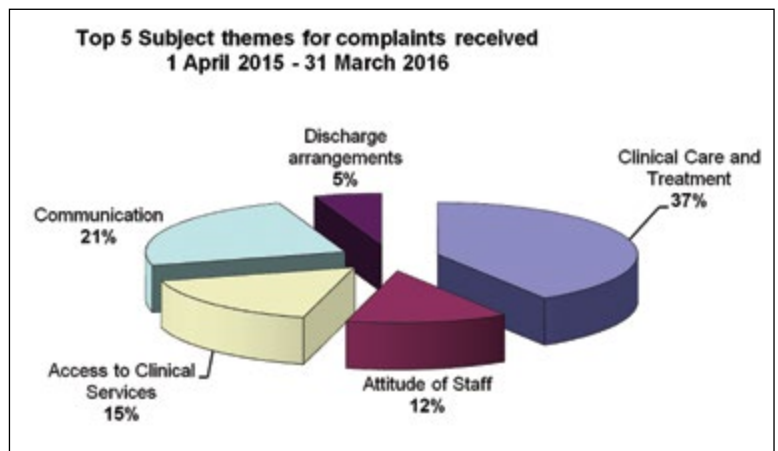
Clinical care and treatment – Multiple directorate complaint (52)

Attitude of staff – Multiple directorate complaint (23)

Access to clinical services – CSDU Health and Social Care services (28)

Communication – CSDU Health and Social Care services (38)

Discharge arrangements – Multiple directorate complaint (19)



The directorates mainly involved in the top five subjects above were:

Communication to patients, parents or carers

- Multiple directorate complaint (28)

Delay at time of treatment – Health and social care services (23)

Dismissive behaviour – Multiple directorate complaint (12)

Inappropriate discharge – Multiple directorate complaint (16)

Communication between staff regarding patients – Multiple directorate complaint (8)

Parliamentary and Health Service Ombudsman complaints

Table 1.

Complaints referred by Outcome	Apr	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Request received from Ombudsman	0	2	1	0	0	0	0	0	0	0	0	1	4
Issue not upheld with no further action	1	0	0	2	0	0	0	0	1	0	1	0	5
Issue upheld and recommendations made	0	0	0	0	0	0	1	0	0	0	0	0	1
Issue partially upheld	0	0	1	0	0	0	1	0	0	0	0	0	2

Summary of main themes of PALS issues/matters

The division with the highest amount of PALS feedback was the Acute Service Delivery Unit (ASDU) for Surgical Specialties (784), followed by Clinical Support and Logistics Service Delivery Unit (CLSDDU), Clinical Support Services (731), and Acute Service Delivery Unit (ASDU) for Medical Specialties (643). The overall number of PALS contacts was 2787. The high number of enquiries received for clinical support services has been as a result of difficulties in contacting the Central Management Centre, who manage referral bookings within the Trust.

The top five PALS themes were: access to clinical services (34%), information provision (23%), communication (20%), clinical care and treatment (7%), and attitude (5%). Historically the information provision category has represented the highest number of PALS enquires and the change within this financial year has been attributed to the number of enquiries the PALS team received about problems in contacting the Choose and Book team, which are recorded as

problems accessing clinical services. The level of activity been experienced by the PALS team in relation to this issue is being monitored by the respective team and service manager.

The tables below show the number of PALS issues by subject matter/directorate for the year.

Table 2. PALS issue by subject matter

	2015/16	2014/15
Access to Services - Clinical	954	1001
Access to Services - Physical	31	18
Admission arrangements	6	7
Attitude of Staff	143	106
Benefits	3	5
Bereavement	2	7
Clinical Care and Treatment	204	246
Communication	569	260
Compliments	28	160
Confidentiality issues	3	14
Discharge arrangements	35	81
Equality and Diversity	2	7
Quality of Facilities	21	23
Hotel Services	13	20
Information Provision	641	395
Medical Records	61	45
Patient's Property	16	31
Privacy and Dignity	3	8
Security	2	8
Transport	50	62
Totals	2787	2504

Table 3. PALS issue by Service Delivery Unit

Directorate	2015/16	2014/15
ASDU - Medical Specialties	643	527
ASDU - Surgical Specialties	784	652
CLSDDU - Clinical Support Services	731	586
CLSDDU - Emergency Services	148	168
CSDU - Community Hospital	12	47
CSDU - Health & Social Care	89	112
CSDU - Specialist Service	61	88
Director of Nursing	191	78
Director of Facilities	97	77
Director of Finance	16	13
Medical Director	7	0
Trust wide	8	156
Totals:	2787	2504

Service improvements

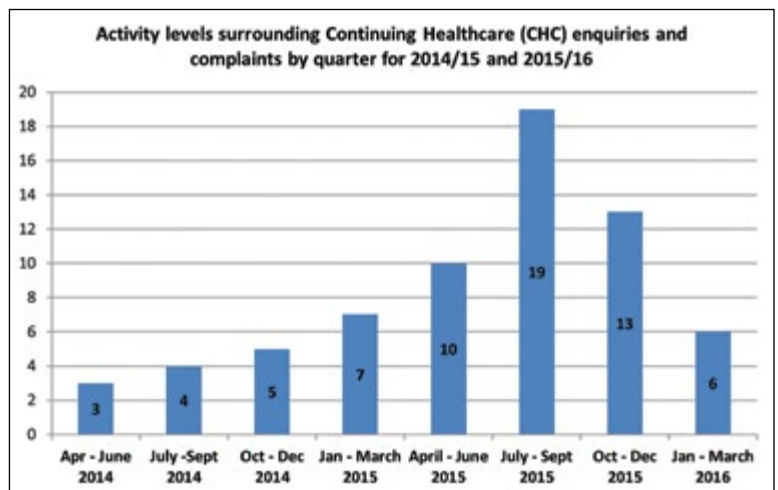
Within the year, two trends were identified and action undertaken involving formal complaints received for Continuing Healthcare (CHC) assessments and PALS contacts where patients found it difficult to get hold of the Choose and Book office in relation to outpatient appointment enquiries. Work was undertaken by the respective service teams to improve the situation for patients and the following sections provide more detail in respect to these two areas, both of which were monitored throughout the year by our Learning from Patient Experience Group and Trust Board via the Customer Relations Performance Report:

Formal complaints received for Continuing Healthcare (CHC) assessments

A continuing healthcare (CHC) assessment is undertaken where it is considered a patient may have a primary health need that meets the threshold for that care to be funded through NHS funding. Such care could include community nursing care at home, provision of care within a nursing home, or provision of end of life care from healthcare services. An assessment for such eligibility has two stages; firstly a CHC checklist (screening tool) is undertaken to determine if the patient required a full CHC assessment, and if this is indicated, a more detailed assessment is undertaken including the application of a DST (decision support tool), which is designed to enable a multi-disciplinary team (MDT) make a robust recommendation on CHC eligibility via an appropriate full health needs assessment. Where the DST concludes eligibility, there is a local quality assurance process

within the Trust to review the clinical evidence collated to determine the eligible need, before submitting the application to our Commissioners for external review and ratification. Where the assessment determines a non-eligible need, the patient and/or family member is advised and they have the right of appeal against this decision under the national framework. The appeals process is managed by the local Commissioners of healthcare via the respective Clinical Commissioning Group.

Issues of concern can relate to the outcome of an assessed need, considerations from relatives about a lack of involvement in the process, or the timeliness in which the assessment is completed. In relation to the latter, the Trust has undertaken significant work to address identified capacity and quality issues through a quality improvement initiative. This has included a weekly review of patients on the assessment allocation list by the CHC lead nurses to clinically prioritise assessments; the delivery of a training programme for health and social care staff who undertake the assessments; a re-alignment of the central CHC team into our Operations Directorate; alongside an improved internal quality assurance review process to verify assessments prior to a final review and ratification by the Clinical Commissioning Group. Complaint activity is being monitored to review the effectiveness of the quality improvement initiative and the graph below shows a breakdown of activity by quarter for the last two financial years. A reduction in complaints is starting to be seen following the quality improvement initiative.



PALS contacts where patients found it difficult to get hold of the Choose and Book office

A trend was noticed during the reporting period January – March 2014 (Q4 2103/14) for the number of contacts made with the PALS team surrounding difficulties patients have experienced in contacting the Central Management Centre (CMC) with queries surrounding hospital appointments. The for Clinical Support Services directorate (now Planned Care directorate) advised this issue had arisen due to capacity within the CMC team and additional resources were implemented to assist with this operational situation.

This trend is continuing to be monitored through the graph below, and a reduction in the number of issues raised via PALS has been seen with a couple of variances in Q1 and Q3 within 2015/16. This trend will continue to be monitored via our Learning from Patient Experience committee until a sustainable reduction in activity is seen.

Disclosure of personal data related incidents

In accordance with the Health and Social Care Information Centre (HSCIC), supported by the Department of Health (DH), the Information Commissioner’s Office (ICO), NHS England and the Information Governance Alliance, the Trust is required to publicly report all information governance and cyber security serious incidents requiring investigation (SIRIs) which are assessed as meeting level two.

For the 2015/16 financial year, the Trust reported:

Zero information governance SIRIs

Zero cyber security SIRIs

Health and Safety

Twice a year, the Trust Board receives a report from the internal Health and Safety Committee in order to highlight the key issues, decisions taken and risks discussed over the previous six months.

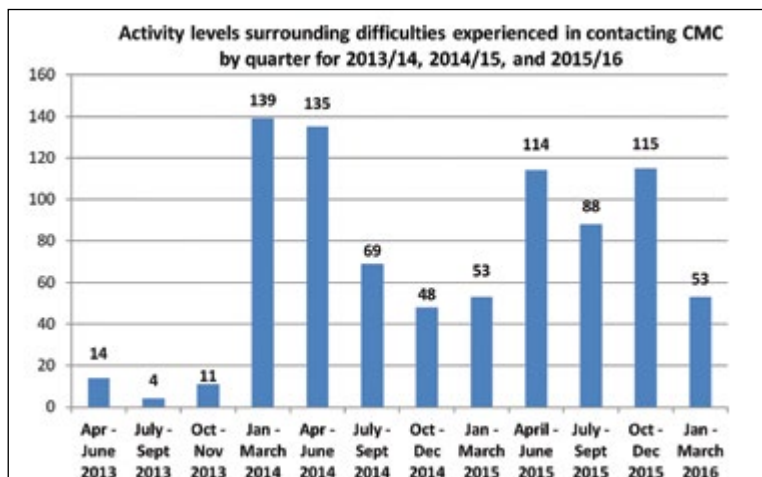
Members of the Committee include union appointed safety representatives, management representatives, specialist advisors and a Non-Executive Director.

The Board oversees this work to ensure that health and safety matters are being appropriately identified and managed in accordance with Health and Safety Executive (HSE) Legislation.

The Trust has duties under law including:

- ▶ Health and Safety at Work etc Act 1974.
- ▶ Management of Health and Safety at Work Regulations 1999.
- ▶ Regulatory Reform Fire Safety Order 2005.

Over the last financial year, we had the following focus



1. Receiving and responding to staff incident reporting:

We encourage all our staff to report any incidents or near misses that occur at work. We consider this an essential part of providing safe, effective and high quality services.

All health and safety related incidents are reviewed by the health and safety manager and other specialists e.g. back care advisor to ensure managers have taken appropriate actions.

Incidents categorised under health and safety are reviewed by the health and safety manager to ensure any incidents are identified for the purposes of statutory external reporting e.g. RIDDOR (see next section).

In this financial year (1 April 2015 to 31 March 2016), we received the following incidents relating to health and safety (see table 1 for the number and percentage per quarter of incidents).

Table 1.

Incident category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Patient Accidents (including falls)	517 (71%)	482 (65%)	438 (66%)	427 (65%)
Staff accidents	100 (14%)	100 (13.5%)	106 (16%)	115 (18%)
Violence and Aggression	88 (12%)	114 (16%)	93 (14%)	83 (12.5%)
Fire	13 (2%)	32 (4%)	26 (5%)	24 (3.5%)
Visitor / Contractor Accidents	8 (1%)	10 (1.5%)	3 (0.5%)	6 (1%)
Total	726	738	666	655

It should be noted that patient accidents, including falls are also reviewed by the head of physiotherapy and occupational therapy and are presented at the Patient Safety Operational Group to provide a Trust wide approach for the management of patient accidents.

2. RIDDOR Regulations:

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), certain categories of incident are reported externally to the Health and Safety Executive (HSE). As an example, a member of staff having a sickness absence for more than seven days following a work related accident is a RIDDOR reportable event.

Quarter 1, 2015-16, eight incidents were reported under RIDDOR

Quarter 2, 2015-16, eight incidents were reported under RIDDOR

Quarter 3, 2015-16, six incidents were reported under RIDDOR

Quarter 4, 2015-16, eleven incidents were reported under RIDDOR

The incidents reported to the HSE fell under the following RIDDOR categories:

- ▶ Specified Injuries (Bone Fracture) – 5
- ▶ Specified Injuries (Loss of Consciousness) – 1
- ▶ More than 7 days absence from Work – 21
- ▶ Light Duties for more than 7 days – 3
- ▶ Occupational Disease (work related upper limb disorder) – 2
- ▶ Dangerous Occurrence (Uncontrolled release of asbestos fibres) – 1

More information on the Trust’s approach to health and safety can be found in the bi-annual reports to the Northern Devon Healthcare Trust Board on www.northdevonhealth.nhs.uk.

Emergency preparedness, resilience and response

The Civil Contingencies Act

The Civil Contingencies Act (2004) ensures that the United Kingdom is prepared to deal with major disruptive challenges and emergencies, however they might occur. Under the Act, the Trust is classed as a category one responder and has the following key responsibilities:

- ▶ To assess the risks of an emergency occurring and using this information to inform contingency planning;
- ▶ To put emergency plans in place;
- ▶ To have business continuity arrangements in place;
- ▶ To put in place arrangements to make information available to the public and maintain arrangements to warn, inform and advise the public in the event of an emergency;

- ▶ To share information with other local responders to enhance coordination;
- ▶ To cooperate with other local responders to enhance coordination and efficiency.

The Trust's director of operations has the overall strategic responsibility for emergency preparedness, resilience and response across the Trust, and for providing assurance to the Trust Board that the organisation is meeting its statutory and legal requirements.

NHS Core Standards

NHS England's Core Standards for emergency preparedness, resilience and response are the minimum standards which NHS organisations and providers of NHS-funded care must meet to comply with the requirements of NHS England's planning framework, the NHS Contract and the Civil Contingencies Act 2004.

The Trust undertook a self-assessment against the named Core Standards in August 2015 and of the 47 applicable standards, the Trust identified as being:

- ▶ Fully compliant with 43 of the standards (green)
- ▶ Partially compliant with four of the standards (amber)

Where the Trust was not fully compliant with a standard, work was undertaken to assess the gaps and identify what work would be required for the Trust to become fully compliant. In each of these cases, this work has been included as part of the Trust's on-going work programme to support its emergency preparedness, resilience and response.

Incident Response Plan

The Trust's Incident Response Plan sets out how it will respond to a major incident or an emergency which requires the involvement from one or more healthcare organisations. The Trust's plan fully complies with national guidance for emergency preparedness, resilience and response and is reviewed and updated on a regular basis.

Fraud policies and procedures

The Trust has a clear strategy for tackling fraud, corruption and bribery. This is documented in the Counter-Fraud Policy, which details responsibilities and how to report suspicions of fraud or bribery.

The Trust has support from an independent Local Counter Fraud Specialist (LCFS) to ensure risks are mitigated and systems are resilient to fraud and corruption. An annual Anti-Fraud Work Plan is approved by the Audit Committee.

The director of finance and the Audit Committee oversee the work of the LCFS. Reports on progress with delivery, together with details of referrals received and investigations are provided to the Audit Committee. The LCFS also highlights to Committee any issues that have arisen so that appropriate action can be taken.

The risk-based programme of anti-fraud work was delivered in 2015/16, addressing all strategic areas of the national counter-fraud strategy. The LCFS has developed key relationships across the Trust and this, coupled with the work undertaken by the LCFS, has resulted in the development of an anti-fraud culture within the Trust.

Executive team changes

In this financial year, we said goodbye to Debbie Bennion, interim director of nursing. Debbie left the Trust in September 2015 to take up a role as director of nursing for the Princess of Wales Hospital in Bridgend, Wales.

Dr Nicola Ryley appointed as interim director of nursing

Dr Nicola Ryley joined the Trust as interim director of nursing in October 2015. Nicola joined the Trust from Aneurin Bevan University Health Board in South Wales where she had been assistant director of nursing for five years, and was responsible for the leadership and professional regulation of over 6,000 nursing and allied staff.



Nicola has held senior clinical, operational and leadership roles across a range of NHS organisations that both provide and commission healthcare for adults and children, with extensive experience of the acute, community, mental health, learning disability, primary care and prison service sectors. Nicola led the design and implementation of the largest pilot project in the UK in respect of nursing revalidation.

Board changes

One non-executive director left the Board during the year. Lesley Crawford resigned from the Board in October 2015, having served as a board member since July 2014.

The Trust welcomed a new non-executive director and an associate non-executive director to the Board. Tony Neal joined the Board in January 2016 as a non-executive director. Tony has a background in IT and in business consultancy, with a particular focus on organisational visioning, development and change, and has extensive board-level experience with BT and Fujitsu. He is chairman of governors at a local primary school and is involved in volunteering activities in his local community.



Jonathan Broad joined the Board in February 2016 as an associate non-executive director. Jonathan has previously held positions with Devon and Cornwall Housing Trust and Devon and Cornwall Housing



Association, and was chairman of the North Devon Primary Care Trust Patient and Public Involvement Forum. He is lay adviser to the South West Academic Health Science Network on patient and public involvement, and chairman of the medicines optimisation project group. In addition, he is a lay member of the NHS Northern, Eastern and Western Devon Clinical Commissioning Group clinical policy committee. Jonathan is also chairman of governors at a local primary school.

Section 4: Annual governance statement

1. Scope of responsibility

- 1.1. As Accountable Officer I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives, whilst safeguarding quality standards, 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 organisation is administered prudently and economically and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the Accountable Officer Memorandum for Chief Executives of NHS Trusts.
- 1.2. In the delivery of my responsibilities and objectives I am accountable to the Board and my performance is reviewed regularly and formally by the Chairman on behalf of the Board.

2. The governance framework of the organisation

System of internal control

- 2.1. The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives. It can therefore only provide reasonable and not absolute assurance of effectiveness.

It is based on having a number of individual controls in place: policies and procedures covering important business activities, how staff are appointed and managed, the Standing Financial Instructions and Scheme of Delegation, the checks and balances inherent in internal and external audit reviews, Executive Director and Trust Board oversight.

The system of internal control has been in place in Northern Devon Healthcare NHS Trust for the year ended 31 March 2016 and up to the date of approval of the annual report and accounts.

Trust Board

- 2.2. The Trust Board has overall responsibility for the strategy, activity and integrity of the Trust. The Director of Strategy and Transformation has the Trust Secretary role as part of his portfolio and provides senior leadership in corporate governance.
- 2.3. The Trust Board met on five occasions during the financial year of 2015/16 on the following dates:
 - ▶ 25 May 2015
 - ▶ 28 July 2015
 - ▶ 6 October 2015
 - ▶ 1 December 2015
 - ▶ 2 February 2016
- 2.4. At its meeting on 28 July 2015 the Board agreed to move the bi-monthly Board meeting back a week, from the last week of the month, to the first. This enabled more up-to-date performance information to be presented to the Board, thus strengthening assurance. It did mean, however, that there were only five Board meetings during the financial year.
- 2.5. The Board conducts its business in accordance with the Standing Orders and Standing Financial Instructions. The papers of the Trust Board are published on the Trust website.
- 2.6. The Trust Board consists of a Non-Executive Chairman, five Non-Executive Directors and five Executive Directors (including the Chief Executive). There is also an associate Non-Executive Director who attends Board meetings. The Director of Workforce and Organisational Development, Director of Facilities, Director of Strategy and Transformation and the Associate Director of Health and Social Care also attend the Trust Board meetings.

Chart 2 – Attendance at Trust Board

Name	Role	Attendance
Non-Executive Directors		
Roger French	Chairman	5/5
Tim Douglas-Riley	Non-Executive Director	4/5
Robert Down	Non-Executive Director	4/5
Pauline Geen	Non-Executive Director	5/5
Nick Lewis	Non-Executive Director	5/5
Lesley Crawford (May, July 15)	Non-Executive Director	2/5
Tony Neal (Feb 16)	Non-Executive Director	1/5
Executive Directors		
Alison Diamond	Chief Executive	5/5
Debbie Bennion (May, July)	Interim Director of Nursing	2/5
Nicola Ryley (Oct, Dec, Feb)		3/5
Andy Robinson	Director of Finance and Performance, Deputy Chief Executive	5/5
Robert Sainsbury	Director of Operations	4/5
George Thomson	Medical Director	5/5
In attendance		
Jonathan Broad	Associate Non-Executive Director	1/5
Andy Ibbs	Director of Strategy and Transformation	5/5
Darryn Allcorn	Director for Workforce and Development	4/5
Iain Roy	Director of Facilities	4/5
Keri Storey	Assistant Director of Health and Social Care	4/5

NB: Tony Neal and Jonathan Broad were both appointed in January 2016, so had only one Board meeting to attend.

Board Briefings

2.7. The Trust Board meets in between Board meetings for Board Briefings where issues are discussed in detail prior to being presented at Trust Board.

Thirteen Board Briefings have been held through the financial year of 2015/16 where items have been discussed, updated and challenged. These are the large operational and financial issues that affect the daily function of the Trust, including:

- ▶ Operational Plan
- ▶ Integrated Business Plan
- ▶ Effectiveness of the Trust Board and sub-committees
- ▶ Electronic Health Record
- ▶ CIP Programme
- ▶ Health and Wellbeing Hubs
- ▶ Quality Account
- ▶ Board Assurance Framework
- ▶ Perfect Week
- ▶ CQC Inspections
- ▶ Community Transfer of Services Programme
- ▶ Monitor Well-Led Framework
- ▶ End of Life Services
- ▶ Mortality Review Committee
- ▶ Contract for 2016/17
- ▶ Patient Flow
- ▶ Agency Spend
- ▶ Domiciliary Care Tender
- ▶ Vision and Values, SWOT and PESTLE
- ▶ Strategic Objectives
- ▶ 2016/17 Programme of Work

Going Concern Opinion on the 2015/16 Statutory Accounts

2.8. The Board approved the Going Concern Opinion that stated there are material uncertainties related to events or conditions that may cast significant doubt about the Trust’s ability to continue as a going concern but the going concern basis remains appropriate.

Board Strategy and Development Days

2.9. Three Board Strategy and Development Days have been held during the year and one Board Away Day. These days are used to assess the performance of the Board as well as its own effectiveness. In addition, PRISM Workshops have been undertaken by the Board members. PRISM is a recognised diagnostic tool which was used to assess the Board’s effectiveness and performance in six key result areas, including achievement of the Board’s goals, internal and external relationships, the Board’s approach to team working, organisational culture and team morale.

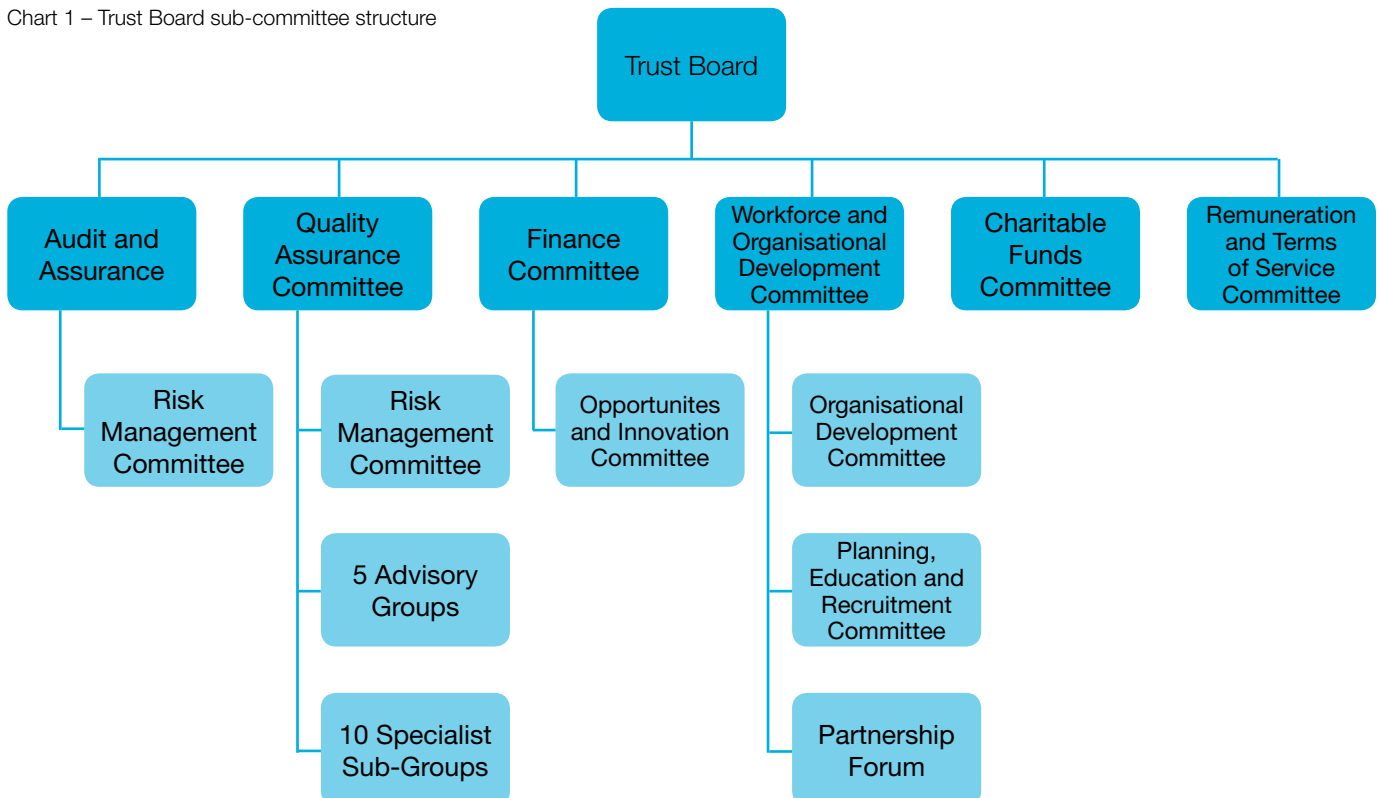
Sub-committees of the Trust Board

2.10. The Trust Board is supported by sub-committees whose membership includes Non-Executive Directors. For some, the membership only includes Non-Executive Directors and Executive Directors are in attendance (these are marked ‘*’ below). Others have members of staff who act as specialist advisors (marked ‘#’ below). The Sub-Committees are:

- ▶ Audit and Assurance Committee *
- ▶ Charitable Funds Committee #
- ▶ Finance Committee
- ▶ Quality Assurance Committee #
- ▶ Remuneration and Terms of Service Committee *
- ▶ Workforce and Organisational Development Committee #

2.11. Non-Executive Directors also sit on the Risk Management Committee which reports to both the Audit and Assurance and Quality Assurance Committees.

Chart 1 – Trust Board sub-committee structure



- 2.12. The Board has overall responsibility for the effectiveness of the governance framework and requires that each of its sub-committees has agreed terms of reference which describe their duties, responsibilities and accountabilities together with the process for assessing and monitoring effectiveness. All the sub-committees have at least one Non-Executive member. The sub-committee Chairs are all Non-Executive Directors. The Chairs of the sub-committees routinely present written and verbal reports to the Board highlighting key issues and decisions at their meetings.
- 2.13. A formal compliance report for each sub-committee is reported to Board annually, outlining the activity undertaken during the year against the individual committee's terms of reference.

Audit & Assurance Committee

- 2.14. The Audit Committee has provided the Board with assurance on the key aspects of their work, to include:
- ▶ An effective system of internal control and risk management
 - ▶ An effective internal audit function that meets NHS Internal Audit Standards
 - ▶ Reviewing the findings of the External Auditor and other significant assurance functions
 - ▶ Reviewing and reporting on the Annual Report and Financial Statements

Charitable Funds Committee

- 2.15. The Charitable Funds Committee manages and monitors all aspects concerned with the charitable funds within Northern Devon Healthcare NHS Trust.
- The Committee's main functions include:
- ▶ Approving charitable funds policies and procedures
 - ▶ Considering and monitoring the risk profile of charitable fund investments
 - ▶ Receiving spending plans for each charitable fund and approving them on behalf of the Trust Board
 - ▶ Supporting and monitoring fundraising on behalf of the Trust's charities

Finance Committee

- 2.16. The Finance Committee maintains robust financial management by monitoring financial performance and making recommendations to the Executive Team or to the Trust Board as appropriate.

The Committee's main functions include:

- ▶ Receiving and approving financial strategy and policy documents
- ▶ Monitoring the financial management of income and expenditure
- ▶ Approving and monitoring the financial management of the balance sheet
- ▶ Approving and assessing the commercial management issues

Quality Assurance Committee

- 2.17. The Quality Assurance Committee provides leadership and assurance that clinical governance systems and processes are in place and effective in providing safe, high quality care.

The Committee's main functions include:

- ▶ Clinical governance management
- ▶ Clinical governance compliance
- ▶ Risk management
- ▶ Quality governance assurance

Remuneration and Terms of Service Committee

- 2.18. The Remuneration and Terms of Service Committee determines the remuneration and conditions of service of the Chief Executive, Executive Directors, other Directors who report to the Chief Executive and staff not on National Terms and Conditions of Service, ensuring that it complies with current statutory and NHS requirements.

The Committee's main functions include:

- ▶ Determination of appropriate remuneration and terms of service for the Chief Executive, Executive and other Directors who report to the Chief Executive and staff not on National terms and conditions
- ▶ Determination of Performance Awards
- ▶ Determination of Contractual Arrangements

Workforce and Organisational Development Committee

- 2.19. The Workforce and Organisational Committee provides advice and assurance to the Trust Board on all matters relating to the workforce, including workforce strategy and planning and pay and rewards. It also has responsibility for organisational development, including health and well-being and equality and diversity. The Committee's main functions include:
- ▶ Approving the Workforce and Organisational Development Strategies and action plans
 - ▶ Approving pay and reward strategies
 - ▶ Approving a strategic workforce plan
 - ▶ Providing assurance on the delivery of the workforce strategic and corporate objectives and performance against key performance indicators
 - ▶ Receiving assurance on the management and mitigation of workforce risks

Corporate Governance

- 2.20. The UK Corporate Governance Code sets out standards of good practice in relation to Board leadership and effectiveness, remuneration, accountability and relations with stakeholders. Although compliance with the Code is not required by NHS Trusts, best practice principles are applied to the function and effectiveness of the Trust Board.
- 2.21. The Trust Board has carried out assessments of its own corporate governance arrangements and effectiveness through three Board Strategy and Development days held during the year.
- 2.22. In addition, it was agreed at the March 2015 Trust Board meeting that a self-assessment would be undertaken using the Well-Led Governance Framework as preparation for the foundation trust application process. This replaced the Board Governance Assurance Framework, which was independently assessed in June 2012, and the Quality Governance Framework which was independently assessed in August 2012. The Well-Led Framework is aligned with the Care Quality Commission well-led inspection questions together with the Keogh and Francis recommendations.

- 2.23. Each of the four domains listed below is assessed using the 'red, amber, green' scoring criteria:
- ▶ Domain 1 – Strategy and planning
 - ▶ Domain 2 – Capability and culture
 - ▶ Domain 3 – Process and structure
 - ▶ Domain 4 – Measurement
- 2.24. At the Trust Board meeting on 6 October 2015 the Board received the draft self-assessment and supporting evidence. Of the ten questions, nine were assessed as 'green'. One question in Domain 2 relating to supporting continuous learning and development across the organisation was assessed as 'amber' as there was insufficient evidence in place to demonstrate the success of performance improvement and the learning that is shared across the Trust.

Quality Governance

- 2.25. The Interim Director of Nursing and the Medical Director are responsible for quality and safety in the organisation. In addition there are designated roles of Head of Corporate Governance and Head of Quality and Safety providing leadership and support in their respective areas.
- 2.26. The Quality Assurance Committee is a sub-committee of the Trust Board and the over-arching committee with responsibility for quality governance. It receives and monitors routine reports on the annual clinical audit programme; reviews and approves serious incident investigation reports (including Never Events); and reviews the content of the draft Quality Account prior to approval by the Trust Board.
- 2.27. Quality governance issues are monitored closely by the Trust Board through routinely presented detailed performance reports, and written and verbal reports highlighting key issues and risks from the Quality Assurance Committee.
- 2.28. During the year a number of improvements to the incident escalation and investigation process were made to improve the thoroughness of investigations; the quality of the reports and action plans; and the timeliness of investigations.

- 2.29. A significant change was the formation of a Serious Incident Review Group, consisting of the Director of Strategy and Transformation, Medical Director and Interim Director of Nursing, as well as a Deputy Medical Director, the Heads of Midwifery, Quality and Safety and Corporate Governance. Its role is to quality assure investigations, providing support and challenge to the investigators.
- 2.30. The improvements to the process were encapsulated in a revised Incident Escalation and Investigation Policy that was approved by the Quality Assurance Committee in January 2016.
- 2.31. The Trust continues to be a high reporter of patient safety incidents reported to the National Reporting and Learning System compared with similar small acute trusts. The organisation has robust incident reporting processes embedded throughout the organisation as indicated by the high incident reporting culture. A robust process has been developed for escalating reported incidents for a decision on whether they should be designated as a serious incident requiring investigation and formally investigated. There were 25 Serious Incidents Requiring Investigation identified during 2015-16.
- 2.32. On completion of the comprehensive formal investigation of serious incidents, the reports are reviewed by the Executive Lead for the investigation and presented to the Quality Assurance Committee for approval. Summary reports of the individual serious incident investigations are then presented to the Trust Board for ratification.
- 2.33. Actions highlighted in both the Significant Event Audit reports and the Serious Incident Investigation reports are recorded on the Corporate Risk Register and performance monitored and reported via the Trust's risk management systems.

Never Events

- 2.34. Potential Never Events are escalated to the SIRI Review Group for information and are reported to our commissioners who confirm whether the incident meets the Never Event Criteria. Once identified, the incident is investigated, reported, the report approved and action plan monitored in the same way as a serious incident requiring investigation. One Never Event was reported in 2015/16.

Quality Account

- 2.35. The Quality Account is produced on an annual basis and undergoes rigorous scrutiny and external audit. Each year the key themes for the subsequent year's quality initiatives are agreed by the Quality Assurance Committee. The Quality Account reports on progress against these initiatives.

3. Risk assessment

- 3.1. The processes for risk assessment and management are set out in the Trust's Risk Management Policy which was updated to reflect changes in process and include guidance on SMART actions. The revised policy was approved by the Risk Management Committee in September 2015.
- 3.2. It is recognised that risk may be identified through a number of different routes including alert notices from external agencies; Internal Audit reviews; external inspections; incidents and near misses; workplace risk assessments and regulation-specific risks.
- 3.3. Once a risk has been identified a risk assessment is completed to create an auditable record, identify scoring and control measures in place, and set out the proposed treatment and actions to reduce the risk. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to risks. All risks are given a numerical risk rating based on a 5 x 5 risk matrix multiplying the potential consequence (impact) of the risk by its likelihood. The maximum score based on the risk matrix is 25.
- 3.4. All risks are recorded on the Corporate Risk Register which is held on the DATIX risk module and performance monitored to completion of actions through established risk management processes.
- 3.5. Risk actions are updated on a monthly basis and all exceptions are reported to the Risk Management Committee, including action plan due date extensions, changes to risk score, and no responses to update requests. Exceptions for risks with a score of 15+ are routinely discussed in detail by the Committee.

Risk profile

- 3.6. As at 31 March 2016 there were 105 open risks recorded on the Corporate Risk Register (Figure 1). During the year from 1 April 2015 – 31 March 2016, 365 new risks were recorded and 469 risks were accepted as the mitigating actions had been completed and the risk re-scored.
- 3.7. Over the last three years, both the absolute number of open risks, and the proportion of which are high (15+), has reduced. This has been as a result of three factors:
- ▶ Increased emphasis on ensuring actions are completed by their due date. This was the major factor over the first two of the last three years;
 - ▶ More recently, the grouping together of action plans that were previously linked to separately identified risks, but which were actually the same risk (for example, there were a number of action plans produced as a result of Significant Event Audits into individual pressure damage incidents. These have been grouped together, as having separate action plans ran the risk of learning being too localised and not adopted across the organisation);
 - ▶ Removing from the Risk Register those action plans resulting from Internal Audit Investigations. The action plans are still monitored and reported on in the same way, it is just that they are no longer identified as risks on the Corporate Risk Register.

Figure 1: Risk profile of open risks as at 31 March 2016

Risk score	No. of risks
High (15+)	15
Moderate (8-12)	84
Low (1-6)	6
Totals	105

High level risks

- 3.8. Major risks are monitored through the Principal Risk Map; a listing of the high-scoring risks (15+) linked to each Principal Risk. Principal Risks are risks which might prevent the Trust strategic objectives being achieved. The Principal Risk Map is routinely presented to the Risk Management Committee and the Audit and Assurance Committee.

Figure 2: High level risks recorded on the Corporate Risk Register as at 31 March 2016

Risk ID	Risk Description	Current score
2060	Risk of lack of robust governance arrangements – Community Hospitals	15
2787	Risk of non-achievement of Strategic Objective 2 Sustainable Services	16
2791	Risk of non-achievement of Strategic Objective 5 - Efficient & effective	15
2991	Risk of inappropriate use of Caroline Thorpe Ward for patients with mental health or social issues.	15
3133	Risk of financial loss from drug wastage for chemotherapy drugs	16
3218	Risk of planned HDU (paramedic) transport not being available in a timely manner	15
3586	Risk that the Trust will exceed the Clostridium Difficile limit / target set by the Department of Health	15
3593	Risk of breaching the 18 week Referral to Treatment target - Persistent Pain Service.	15
3613	Risk of inaccurate reporting against the Department of Health Referral to Treatment standards	16
3642	Risk of failure to maintain safe standards in maternity due to failing to recognise a deteriorating patient, CTG interpretation, failure to escalate or poor communication.	20
3684	Risk of incidents and maintaining patient safety due to the reduction in clinical mass of trained experienced nurses - Glossop	15
3713	Risk of failing to provide a safe and secure environment leading to potential harm to staff, patients and visitors - A & E	15

Risk ID	Risk Description	Current score
3715	Risk of failing to provide a safe and secure environment leading to potential harm to staff, patients and visitors - MAU	15
3724	Risk of failing to meet the CQC expectations - August 2015	16
3767	Risk of not being able to effectively monitor the patient's condition within the emergency department	15

Data security breaches and lapses

- 3.9. No data security breaches or lapses occurred during 2015-16 (1 April 15 to 31 March 16) and no issues were reported to the Information Commissioners Office.

4. The risk and control framework

- 4.1. As Chief Accounting Officer I have overall responsibility for risk management within the Trust and this is incorporated into the Risk Management Strategy 2016-19. I have delegated responsibility to the Director of Strategy and Transformation who is the lead director for risk management.
- 4.2. The Trust recognises the need for a robust focus on the identification and management of risks, and therefore this is an integral part of our overall approach to quality and safety. The Risk Management Strategy sets out the key responsibilities for managing risk within the organisation, including the ways in which risks are identified, evaluated and controlled. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to organisational risks. This determines the Trust's approach to risk with clear processes for the management and monitoring of risk assessments as defined within the Risk Management Strategy and Risk Management Policy.
- 4.3. Line management and professional structures ensure that responsibility for the implementation of risk management procedures and prevention and control of risks are in line with the scheme of delegation. All staff have a responsibility for the management of clinical and

non-clinical risks according to their roles and duties within the Trust.

- 4.4. All risks recorded on the Corporate Risk Register have been categorised against one of the six Trust Strategic Objectives. All high scoring risks, i.e. with a risk score of 15+, are reviewed at the Risk Management Committee to assess whether the individual high-scoring risk represents an example of a principal risk to the organisation. This process has been developed to allocate high scoring risks to 'themes'. To date, twelve Principal Risks have been identified. Individual high-scoring risks may be allocated to one or more of the Principal Risks.
- 4.5. The Trust has a strong track record in the identification, prevention and mitigation of risks. The processes are embedded in the culture of the organisation and through other robust systems such as the 'ward to board' assurance process and discussion of incidents and risk assessments at relevant groups such as the Drugs and Therapeutics Committee and Maternity Services Patient Safety Forum.
- 4.6. During the annual internal audit of its risk management processes the Trust asked the Auditor to check for evidence that actions reported as closed had indeed been undertaken. This audit, only completed just before the writing of this Annual Governance Statement has identified that in a small number of areas, such evidence does not exist. I have therefore agreed that a larger audit of this area will be undertaken in 2016/17.
- 4.7. The table below shows the risks that have been accepted and closed during the year 2015-16 and demonstrates the effectiveness of processes to manage and mitigate risks.

Figure 3: Accepted and closed risks by initial risk score and current risk score

Initial Risk Score	Initial number of risks	Outcome / Final Risk Score			
		No Risk	Low	Medium	High
Low (1 – 6)	107	5	102	0	0
Medium (8 – 12)	300	9	158	133	0
High (15+)	62	6	30	24	2
Totals	469	20	290	157	2

Board Assurance Framework

- 4.8. A Board Assurance Framework (BAF) has been in place throughout the year which is designed and operating to meet the requirements of the Annual Governance Statement as outlined by the Trust Development Authority. The formation and maintenance of the BAF is the responsibility of the Director of Strategy & Transformation.
- 4.9. The BAF is informed by and aligned with the Trust's corporate risk register, and provides a structure for the Trust Board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key principal risks which might prevent the Trust strategic objectives being achieved.
- 4.10. The Board recognises that an effective risk management process must be in place to ensure efficient and timely delivery of the Trust's five year strategy. This process requires:
- ▶ An agreed set of strategic objectives aligned to advancing the strategic vision;
 - ▶ An assessment of the Principal Risks to the achievement of the strategic objectives, derived from the annual analysis of both SWOT (strengths, weaknesses, opportunities and threats) and PESTLE (political, economic, social technological, legal and environmental); and
 - ▶ A review of existing controls and assurance mechanisms in place to manage the strategic risks and ensure delivery of the strategic objectives.
- 4.11. A process for identifying gaps in the controls and the established assurance systems make up the annual corporate objectives for the Trust which in turn are translated into personal performance objectives for Directors and the annual work programmes for the Board's sub-committees. Progress reports are presented to the Trust Board four times a year, to the first meeting after the quarter-end. This ensures the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions with explicit timescales for delivery.

Counter fraud and security management arrangements

- 4.12. The Trust aims to reduce fraud to a minimum and employs the services of a Local Counter Fraud Specialist (LCFS) in line with the NHS directions on counter fraud arrangements. The LCFS routinely reports counter fraud activity and progress against the agreed work plan to the Audit and Assurance Committee. These reports form part of the evidence supplied to NHS Protect and the external audit review of arrangements.
- 4.13. In addition the Trust employs a Local Security Management Specialist (LSMS) in line with the NHS Protect national framework to reduce issues relating to security. Their role is to work within the national legal framework for tackling violence and security management, providing advice and guidance to ensure an environment that is safe and secure and supports delivery of high standards of clinical care. The LSMS routinely reports security management activity to the Security Incident Review Group.

Committee structure

- 4.14. The Audit & Assurance Committee and Quality Assurance Committee, which are both sub-committees of Trust Board, and the Risk Management Committee are the three main committees for risk related matters. Other committees/groups are responsible for the oversight of specific risk management areas such as Health and Safety and medicines management.
- 4.15. The Audit and Assurance Committee is responsible for scrutinising the overall systems of internal control (clinical and non-clinical) and for ensuring the provision of effective independent assurance via internal audit and external audit. It has a role in monitoring the management of high-scoring risks. High-level clinical risks are monitored by the Quality Assurance Committee. The Terms of Reference of the two Board sub-committees reflect these functions.

Training

- 4.16. Risk management training requirements are documented in the Risk Management Policy and included on the Trust induction days and annual refresher training. Practical risk assessment courses are also available and can be booked through the Staff Training Access Resource (STAR).

5. Review of the effectiveness of risk management and internal control

- 5.1. As Accounting Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive directors within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the Quality Report attached to this Annual Report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Assurance Committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Head of Internal Audit Opinion

- 5.2. In accordance with NHS internal audit standards, the Head of Internal Audit is required to provide an annual opinion statement to the Trust, based on the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This is achieved through a risk-based plan of work agreed with Trust management and approved by the Audit and Assurance Committee.
- 5.3. The Head of Internal Audit provided an overall opinion of "Significant Assurance" on the effectiveness of the organisation's internal control systems and financial governance.
- 5.4. The Director of Internal Audit has provided a Head of Internal Audit Opinion commenting on the current status of the Board Assurance Framework and the effectiveness of the systems of internal control reviewed by Internal Audit. This has been used in the preparation of this statement.

6. Significant issues

Care Quality Commission Chief Inspector of Hospitals Inspection

- 6.1. The Trust underwent a re-inspection in August 2015 following the Chief Inspector of Hospitals (CIH) Inspection in July 2014. The re-inspection looked at the areas identified for improvement in the CIH Inspection. The Trust had implemented an action plan to return to compliance but the Care Quality Commission identified further improvements the Trust could make to improve services.
- 6.2. A more detailed action plan was developed from the report to address each service and has been implemented through to completion. This action plan was monitored by exception at the Executive Directors' Group and monitored through the Clinical Services Executive Group and Quality Assurance Committee.

Success Regime

- 6.3. The significant clinical and financial issues facing the Northern, Eastern and Western Devon (NEW Devon) health system will lead to, if they are not tackled, a deterioration in the quality of care and a £442 million deficit over the next five years. Accordingly, in June 2015 NHS England, the Trust Development Authority and Monitor announced that the NEW Devon health system would be one of the first three Success Regimes. The aim of the Success Regime is for the various organisations involved in the health system to work together, with some external support, to deliver clinically and financially sustainable services in Devon.
- 6.4. Next year (the 2016/17 financial year) there will be a pan-Devon shared saving requirement of £130 million to meet a balanced budget. This means that individual organisations will all be transforming services together to ensure our collective efforts work towards clinically and financially sustainable health and social care services for Devon.

Transforming Community Services (Eastern)

- 6.5. In December, the Northern, Eastern and Western Devon Clinical Commissioning Group (NEW Devon CCG) confirmed its intention to transfer a large part of the Eastern community services to the Royal Devon & Exeter Foundation Trust (RD&E).

- 6.6. The rationale for transferring services is to further integrate the excellent community health and social care services across East Devon with the acute services in RD&E. Therefore both staff groups will be learning from each other as we further improve and develop the way we care for our patients.
- 6.7. Subject to further and detailed due diligence and contract finalisation the NEW Devon CCG has announced that the RD&E will be providing the Eastern community services from 1 June 2016.

Transforming Community Services (Northern)

- 6.8. In November 2014, NEW Devon CCG confirmed that the Trust was its Preferred Provider of community services in the Northern Locality.
- 6.9. The Trust is currently undertaking the Strategic Diligence process with the CCG, and it is anticipated that a new, three-year contract for the continued provision of these services will be awarded imminently.

Closure of community hospital beds

- 6.10. In line with the CCG strategy of Care Closer to Home, and their consultation of the number of community hospital beds required the Trust moved to close community hospital beds in Bideford Hospital whilst at the same time investing in community services to enable more people to be looked after at home. The beds closed in November 2015, with the increased investment in community services in place before winter.

Junior Doctors' Industrial Action

- 6.11. Due to the current dispute between the British Medical Association (BMA) and NHS Employers on the Junior Doctors' contract, the BMA announced a number of days of industrial action. The Trust anticipated some disruption to NDDH services and worked closely with trade unions and staff to ensure the impact on services was minimal.

Agency spend

- 6.12. Monitor and the Trust Development Authority (TDA) published guidance which introduced caps on the amount each Trust could spend on agency staff. The Trust was set a 6% cap based on our nursing pay budget and the previous year's spend. The Trust is projecting to meet this target by the end of the 2015/16 financial year.

Devon Cares: Trust is awarded a major new contract for domiciliary care services

- 6.13. Devon County Council (DCC) issued an invitation to tender for the provision of domiciliary care across Devon using a Primary Contractor model to increase efficiency and improve consistency of governance within the domiciliary care sector.
- 6.14. Following a competitive tendering exercise, Devon County Council has awarded the primary contract to the Trust for North Devon, Torrington and Mid Devon. We have been working with a number of established domiciliary care providers to develop a new approach to delivering care across Devon.
- 6.15. This five-year contract supports our vision of health and social care working better together to improve the lives of patients. We also believe that a more integrated service would benefit the Trust by helping us get people out of hospital more quickly when they are ready to go home, and reduce the number of people who are admitted in the first place.

Notification of Contravention and Improvement Notices (Asbestos)

- 6.16. The Trust was issued with two Improvement Notices by the Health & Safety Executive (HSE) for contravening the statutory provisions in the Control of Asbestos Regulations 2012, Regulation 4(8), 4(9) and 4(10); the Health & Safety at Work etc. Act 1974, Sections 2(1) and 3(1); and the Management of Health & Safety Regulations 1999, Regulation 5(1).
- 6.17. This related to an incident where contractors were able to cut holes in ceiling tiles containing asbestos without the proper safeguards being in place. Detailed action plans were drawn up in response to deliver compliance and outline the measures taken to provide assurances in respect of the management of asbestos and control of contractors. The Health and Safety Executive has confirmed that the Trust has delivered the agreed action plan and the Improvement Notice has been lifted.

Smartcare – electronic health record

- 6.18. Smartcare, the major development being undertaken by the Trust to revolutionise its patient computer systems, has been a major project during the year – involving clinical staff throughout the Trust in its development, design and training. The programme is expected to deliver a new inpatient electronic health record from July 2016, with a new community system in place during early 2017.

Performance

- 6.19. The sustained focus from the organisation on the action plan to achieve cancer targets throughout 2015-16 has resulted in measurable improvements across all standards – 2 weeks, 31 days and 62 days. Detailed work has taken place to review patient pathways and improve processes to support this achievement, and each patient is individually managed through their pathway by the cancer teams. Partnership working with NEW Devon CCG has also supported the Trust to engage with GPs regarding referral patterns, referral quality and patient information. The Trust will continue to focus on this standard with the intention to improve performance further in 2016-17.
- 6.20. The Referral to Treatment (RTT) Admitted and Non-Admitted access targets were abolished in early 2015, leaving the RTT Incomplete standard of 92% (i.e. those patients still waiting for treatment) as the sole measure of compliance with patients' constitutional rights to start treatment within 18 weeks. The Trust has consistently exceeded this at provider level, achieving an average of 95% throughout 2015-16. The detailed work involved in maintaining this level of performance is driven through weekly operational meetings with all key departments, regular review and close monitoring of patients still waiting for treatment.
- 6.21. Performance against the A&E 4-hour wait standards for all types (i.e. Emergency Department, Minor Injuries Units and Walk-In Centres) can be challenging to achieve in times of winter pressures or summer holidays. However, performance across the year was 96% against the 95% target. During 2015-16 the Trust participated in the Emergency Care Intensive Support Team (ECIST) 'Breaking the Cycle/Perfect Week' programme on three separate occasions, learning

valuable lessons from each iteration of this programme. Additional focus has also been placed on reporting a number of key patient flow indicators (e.g. morning discharge, delayed transfers of care) which has supported performance against the 4-hour wait standard by moving patients more quickly through their hospital journey.

Staff Survey

- 6.22. In the results of the 2015 National NHS Staff Survey the Trust had the best overall score of all NHS Trusts in the country (not including Foundation Trusts).
- 6.23. The Trust was also ranked top in the 'combined acute and community' sector which is the new benchmarking group we are part of, containing 39 Trusts, and we were also the highest-scoring NHS provider in the South West.
- 6.24. In the category of 'acute non-specialist' (i.e. any provider with an acute hospital, which was not a specialist Trust) NDHT had the 6th best results in the country (out of 138).
- 6.25. The Trust scored highly in overall staff engagement, which covers whether employees would recommend the Trust as a place to work or receive treatment, motivation, and the ability to contribute towards improvements.

Top 100 employers

- 6.26. In July 2015 the Trust was named in the top 100 of best employers in the UK and was featured in the Health Service Journal and Nursing Times. This award recognises organisations that have worked hard to promote great staff engagement and create an environment where people can enjoy their work.
- 6.27. The list was compiled by analysing data from the recent NHS staff survey, and independent research firm Best Companies Group identified 120 top performing NHS organisations. Data was categorised into seven core areas: leadership and planning, corporate culture and communication, role satisfaction, work environment, relationship with supervisor, training, development and resources, employee engagement and satisfaction.



Dr Alison Diamond, Chief Executive
Northern Devon Healthcare NHS Trust

Date: 22 April 2016

Section 5: Remuneration report

Introduction

Section 243B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a remuneration report containing information about directors' remuneration. In the NHS, the report will be in respect of the senior managers of the NHS body. The definition of a senior manager is:

"Those persons in senior positions having authority or responsibility for direction or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole rather than the decisions of individual directorates or departments."

For the purposes of this report, this covers the Trust's non-executive directors, associate non-executive directors, executive directors and associate directors.

A) Remuneration

2015-16

Name and title	(a)	(b)	(c)	(d)	(e)	(f)
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (a to e)
A Diamond - Chief Executive	165-170				75-77.5	245-250
A Robinson - Director of Finance and Performance	130-135				27.5-30	160-165
R Sainsbury - Director of Operations	110-115				55-57.5	165-170
G Thomson - Medical Director	190-195				195-197.5	390-395
N Ryley - Interim Director of Nursing (1)	45-50				112.5-115	160-165
I Roy - Director of Facilities	85-90				17.5-20	105-110
D Allcorn - Director for Workforce and Development	100-105				142.5-145	240-245
A Ibbs - Director of Strategy and Transformation	100-105				25-27.5	130-135
R French - Chairperson	15-20					15-20
P Geen - Non-executive Director	5-10					5-10
N Lewis - Non-executive Director	5-10					5-10
T Douglas-Riley - Non Executive Director	5-10					5-10
R Down (Non-Executive Director	5-10					5-10
Lesley Crawford (2)	0-5					0-5
Tony Neal (3)	0-5					0-5
Jonathan Broad (4)	0-5					0-5

(1) The Director of Nursing commenced 19 October 2015

(2) The non-executive left in October 2015

(3) The non-executive commenced in January 2016

(4) The non-executive commenced in February 2016

Policy for remuneration of Directors

The Trust's remuneration policy for Executive Directors observes the Department of Health's Pay Framework for Very Senior Managers (VSMs) and all Trust VSM Executive Directors salaries reflected the Framework except for the Director of Strategy and Transformation who is paid in line with Agenda for Change recommendations.

There were no performance pay awards.

2014-15

Name and title	(a)	(b)	(c)	(d)	(e)	(f)
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension- related benefits (bands of £2,500)	TOTAL (a to e)
J Kelly - Chief Executive (1)	15-20					15-20
A Diamond - Chief Executive (2)	160-165				117.5-120	280-285
K Marsh - Director of Nursing (3)	95-100				155-157.5	250-255
A Robinson - Director of Finance and Performance	130-135				15-17.5	145-150
K Lyons - Director of Operations (4)	30-35				(10-12.5)	15-20
R Sainsbury - Director of Operations (5)	45-50				90-92.5	135-40
G Thomson - Medical Director (6)	80-85				60-62.5	140-145
I Roy - Director of Facilities	85-90				7.5-10	95-100
D Allcorn - Director for Workforce and Development	85-90				95-97.5	180-185
A Ibbs - Director of Strategy and Transformation	100-105				10-12.5	105-110
R French - Chairperson	15-20					15-20
J Reynolds - Non-executive Director (7)	0-5					0-5
P Geen - Non-executive Director	5-10					5-10
C Snow - Non-executive Director	0-5					0-5
N Lewis - Non-executive Director	5-10					5-10
T Douglas-Riley - Non Executive Director	5-10					5-10
L Crawford - Non-Executive Director (8)	0-5					0-5
R Down (Non-Executive Director (9))	0-5					0-5

(1) The Chief Executive left on 30 April 2014

(2) The Chief Executive transferred from the post of Medical Director on 1st May 2014

(3) The Director of Nursing transferred from an interim position on 8 April 2014

(4) The Director of Operations left on 30 June 2014

(5) The Director of Operations commenced on 3 November 2014

(6) The Medical Director commenced on 3 November 2014

(7) The non-executive director left on 31 May 2014

(8) The non-executive director commenced on 1 July 2014

(9) The non-executive director commenced on February 2015

B) Pension Benefits

Name and title	2015-16										2014-15										
	Real increase in pension at age 60	(bands of £2500 to £3000)	Real increase in pension lump sum at age 60	(bands of £5000 to £5000)	Total accrued pension at age 60 at 31 March 2016	(bands of £000 to £000)	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash	Employers Contribution to Stakeholder Pension	Real increase in pension at age 60	(bands of £2500 to £3000)	Real increase in pension lump sum at age 60	(bands of £5000 to £5000)	Total accrued pension at age 60 at 31 March 2015	(bands of £000 to £000)	Lump sum at age 60 related to accrued pension at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2015	Cash Equivalent Transfer Value at 31 March 2014	Real Increase in Cash
A Diamond - Chief Executive	2.5-5	7.5-10	25-30	85-90	556	481	45	0	5-7.5	15-17.5	25-30	75-80	481	362	86	0					
A Robinson - Director of Finance and Performance	0-2.5	2.5-5	40-45	120-125	841	799	13	0	0-2.5	0-2.5	35-40	115-120	799	743	17	0					
R Sainsbury - Director of Operations	2.5-5	0-2.5	20-25	60-65	300	271	12	0	0-2.5	2.5-5	15-20	55-60	271	205	54	0					
Dr G Thomson - Medical Director	7.5-10	15-17.5	65-70	195-200	1,191	1,038	112	0	0-2.5	2.5-5	55-60	175-180	1,038	938	64	0					
N Ryley - Director of Nursing	2.5-5	12.5-15	40-45	125-130	879	744	51	0													
I Roy - Director of Facilities	0-2.5	2.5-5	35-40	115-120	792	760	12	0	0-2.5	0-2.5	35-40	110-115	760	713	15	0					
D Allcorn - Director for Workforce and Development	5-7.5	12.5-15	25-30	70-75	359	273	69	0	2.5-5	12.5-15	15-20	55-60	273	203	53	0					
A Ibbs - Director of Strategy and Transformation	0-2.5	(0-2.5)	30-35	90-95	548	525	3	0	(0-2.5)	0-2.5	25-30	85-90	525	489	0	0					

Notes:

- (1) As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
- (2) A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
- (3) 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.
- (4) The Trust pension values are recorded using Consumer Price Index (CPI) rather than Retail Price Index (RPI) in previous years.
- (5) For directors employed during the year prior year figures not available.
- (6) NHS Pensions have used existing factors effective on 15 March 2016 to calculate CETVs.

C) Fair Pay Multiples

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 Northern Devon Healthcare Trust in the financial year 2015/16 was £170,000-£175,000 (2014/15 £165,000-£170,000) This was 7.06 (2014/15 6.9) times the median remuneration of the workforce which was £24,063 (2014/15, £23,825)

Total remuneration includes salary, non-consolidated performance related pay, benefits in kind as well as severance payments. It does not include employer pension contributions and the cash equivalent transfer values of pensions.

The multiple has changed this year due to an increase in pay of the highest paid director.

In 2015/16 zero (2014/15 zero) employees received remuneration in excess of the highest paid director. Remuneration ranged from £13,000-£170,000 (2014/15 £13,000-£165,000).

D) Non-Executive Directors

The dates of contracts and unexpired terms of office for the non-executive directors (NEDs) are as follows:

Name	Appointment start date	Appointment end date
Roger French (Chair)	01.02.11	31.07.17
Nick Lewis^ (NED)	01.08.11	31.07.17
Pauline Geen* (NED)	03.03.11	02.03.17
Tim Douglas-Riley (NED)	28.05.13	27.05.17
Lesley Crawford (NED)	01.07.14	05.10.15
Robert Down (NED)	09.02.15	08.02.17
Tony Neal (NED)	05.01.16	04.01.18
Jonathan Broad* (Associate NED)	01.02.16	31.01.18

^ Audit Committee chair

* Audit Committee member

Non-executive directors are paid an allowance for their work on the Board and do not hold a contract of employment with the Trust. There is no period of notice required for non-executive directors and their appointment is organised by the NHS Trust Development Authority.

E) Executive Directors

Name	Position	Contract Type	Start date	Employment status
Alison Diamond	Chief Executive	Permanent	01.05.14	
Andy Robinson	Director of Finance and Performance	Permanent	15.11.06	
Rob Sainsbury	Director of Operations	Permanent	03.11.14	
George Thomson	Medical Director	Permanent	03.11.14	
Nicola Ryley	Director of Nursing	Interim	19.10.15	Fixed term to 18.04.17
Iain Roy	Director of Facilities	Permanent	19.04.99	
Darryn Allcorn	Director for Workforce and Development	Permanent	11.02.15	
Andy Ibbs	Director of Strategy and Transformation	Permanent	01.10.12	

Section 6: Head of internal audit report

Head of internal audit opinion on the effectiveness of the system of internal control at Northern Devon Healthcare NHS Trust for the year ended 31 March 2016

Roles and responsibilities

The whole Board is collectively accountable for maintaining a sound system of internal control and is responsible for putting in place arrangements for gaining assurance about the effectiveness of that overall system.

The Annual Governance Statement is an annual statement by the Accounting Officer, on behalf of the Board, setting out:

- ▶ how the individual responsibilities of the Accounting Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- ▶ the governance framework of the organisation including the board's committee structure, the structure and use of the Board Assurance Framework, as assessment of the board's effectiveness and its compliance with the Corporate Governance Code;
- ▶ how risk is assessed and managed including a description of the risk management and review processes;
- ▶ the conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control deficiencies together with assurances that actions are or will be taken where appropriate to address issues arising.

The organisation's Assurance Framework should bring together all of the evidence required to support the Annual Governance Statement requirements.

In accordance with Public Sector Internal Audit Standards, the Head of Internal Audit (HoIA) is required to provide an annual opinion, based upon and limited to the work performed, on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes (i.e. the organisation's system of internal control). This is achieved through a risk-based plan of work, agreed with management and approved by the Audit and Assurance Committee, which should provide

a reasonable level of assurance, subject to the inherent limitations described below.

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board takes into account in making its Annual Governance Statement.

The head of internal audit opinion

The purpose of my annual HoIA Opinion is to contribute to the assurances available to the Accountable Officer and the Board which underpin the Board's own assessment of the effectiveness of the organisation's system of internal control. This Opinion will, in turn, assist the Board in the completion of its Annual Governance Statement, and may also be taken into account by the Care Quality Commission in relation to compliance with Outcomes.

My opinion is set out as follows:

1. Basis for the opinion;
2. Commentary;
3. Overall opinion.

The **basis** for forming my opinion is as follows:

1. An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
2. An assessment of the range of individual opinions arising from risk-based audit assignments contained within internal audit risk-based plans that have been reported throughout the year. This assessment has taken account of the relative materiality of these areas and management's progress in respect of addressing control weaknesses;
3. Any reliance that is being placed upon third party assurances.

In relation to this opinion, we have carefully considered:

- ▶ The significance of the ‘Assessment Ratings’ given in Internal Audit Reports.
- ▶ The Trust’s response to its in-year CQC inspection.

The **commentary** below provides the context for my opinion and together with the opinion should be read in its entirety.

Care Quality Commission Actions

The CQC visited the Trust in August 2015 for an unannounced follow-up focussed inspection. The CQC assessed the Trust as “Requires Improvement” overall, with the same rating applied to the specific areas of Urgent and Emergency Services, Maternity and Gynaecology and End of Life Care. Breaches of the Health & Social Care 2009 Regulations were identified in these areas during the previous CQC inspection in July 2014. The Trust has an action plan to track the 38 actions required from this visit. As at 18th March 2016, all actions have been completed and the Trust is awaiting CQC acceptance of the completed actions.

Progress against all CQC actions is monitored by the Trust’s Quality and Assurance Committee (QAC) and Trust Board. The last update provided to the Trust Board was in February 2016.

My **overall opinion** is that:

Significant assurance can be given that there is a generally sound system of internal control, designed to meet the organisation’s objectives, and that controls are generally being applied consistently. However, some weakness in the design and/or inconsistent application of controls put the achievement of particular objectives at risk. In drawing this conclusion, we have carefully considered the potential impact of the unconfirmed closure of risk actions and the number of internal audits that received medium and/or high rated impact assessments. The Trust is taking the appropriate action to improve controls in these areas.

Internal Audit’s work has been taken forward in three broad categories (Assurance Framework, Financial Assurance and Corporate Assurance). The following descriptions summarise the opinions and assurances from the reviews undertaken in these areas.

Audit	Assurance Rating		Impact Assessment	
Performance Management (A&E 4-Hour Wait)	Amber		Medium	
Risk Management	Green	Amber	Low	Medium
Care Quality Commission (Position Statement)	Green		Low	
Board Assurance Report	Green		Low	

In relation to the reviews noted above, the following comments are made:

Performance Management (A&E 4-Hour Wait) – Medium-October 2015

Whilst the arrangements for internal (Trust Board) and external (NHS England) reporting were sound, improvements could be made in the Trust-wide management of breaches to the 4-hour target, which could potentially reduce the number of breaches.

Risk Management – Low / Medium – April 2016

Overall, appropriate arrangements are in place with respect to most of the areas we reviewed regarding risk management. Improvement is required however in Risk / Action Leads identifying appropriate “SMART” actions and in ensuring that action closure is based on appropriate evidence, as highlighted from our review of closed actions including actions for risks rated at 15+.

Board Assurance Framework – Low – April 2016

The Board Assurance Report (BAR) clearly links to the Trust’s Strategic Objectives and risk management systems. The Board has recognised that an effective risk management process must be in place to ensure effective and well-timed delivery of the Trust’s five-year strategy.

Financial assurance

Internal Audit completed reviews on the following financial areas of the Trust:

Audit	Assurance Rating	Impact Assessment
CIP (Cost Improvement Programme) (2014/15)	Amber	Medium
High Level Financial Controls	Green	Low
Payroll	Green	Low
Capital Accounting	Green	Low
Budgetary Control	Green	Low

Cost Improvement Programme (CIP) – Medium – June 2015

Based on our examination of the documentation for the three projects we reviewed, we can confirm that, overall, systems were in place to evidence and support the CIP process within the Trust and achieve the necessary savings for the year reviewed in line with the targets. We found that there was appropriate documentation in place for each of the projects reviewed, however we found some inconsistencies in the underlying treatment of financial adjustments.

It was difficult to confirm some of the financial information. This was in part due to the Finance Lead for the relevant project not being the Finance Manager for the applicable service. We also found that there were inconsistencies in how the savings were accounted for. In some instances, the budget was adjusted by an authorised virement, and in others, by adjusting the budget during the budget-setting exercise. In addition, the CIP was accounted for through the budget and by round-sum amounts. No evidence of reconciliation of actual savings by project was provided.

ISAE3402 Third Party Assurance report in respect of IT General Controls in respect of the Electronic Staff Record (ESR)

In common with all NHS bodies, the Trust utilises the Electronic Staff Record (ESR) for its HR functions. An established routine is in place whereby third party assurance is provided annually within an Independent Service Auditor's ISAE 3402 third party assurance report, which helps to inform the Trust's Annual Governance Statement on Internal Control. This covers the IT general controls operated by McKesson UK and IBM UK in relation to the ESR.

We are satisfied that the 2015-16 Independent Service Auditor's report provided by PricewaterhouseCoopers, dated 13th May 2016, provides reasonable assurance in respect of the IT general controls operated by McKesson UK and IBM UK in relation to the national Electronic Staff Record. This supports the organisation's Annual Governance Statement.

The audit work conducted by PricewaterhouseCoopers covered the following six areas:

- ▶ Change Management;
- ▶ Logical Security;
- ▶ Problem Management and Performance and Capacity Planning;
- ▶ Physical Security and Environmental Controls;
- ▶ Computer Operations; and
- ▶ Payslip Distribution.

The key messages in the overall audit opinion of the Report of Independent Service Auditor are as follows:

- ▶ the accompanying process description fairly presents the IT general controls for the Electronic Staff Record (ESR) service that were designed and implemented throughout the period 1 April 2015 to 31 March 2016;
- ▶ The controls related to the control objectives stated in the description were suitably designed to provide reasonable assurance that the specified control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2015 to 31 March 2016 and customers applied the complementary customer controls contemplated in the design of NHS ESR Programme;
- ▶ the controls tested, which together with the complementary customer controls referred to in the scope paragraph of the report, if operating effectively, were those necessary to provide reasonable assurance that the control objectives stated in the description were achieved, operated effectively throughout the period from 1 April 2015 to 31 March 2016.

The overall conclusion from their audit opinion was that for the period 1 April 2015 to 31 March 2016, the control environment and IT general controls for the ESR service were suitably designed and effective in helping to achieve objectives in relation to the areas above, providing that complementary customer controls contemplated in the design of NHS ESR Programme's controls are suitably designed and operating effectively, along with related controls at the NHS ESR Programme.

Detailed testing identified four areas where controls were either not designed or operating efficiently, however this did not adversely impact upon the overall control environment.

Corporate assurance

Internal Audit has completed reviews on the following corporate areas of the Trust:

Audit	Assurance Rating		Impact Assessment
Ward Level Medicines Management	Red		High
Use of Volunteers*	Red		Medium
Clinical Records Management (2014/15)	Amber		Medium
Governance of Medicines (Pharmacy)	Amber		Medium
JAG Accreditation for Endoscopy*	Amber		Medium
IM&T Agency Consultants*	Amber		Medium
IT Asset Management (2014/15)	Amber		Low
Exmouth Community Hospital (2014/15)	Amber		Low
Public Health (2014/15)	Amber		Low
Agency Workers (Non-Nursing)	Amber		Low
Patient Leaflets	Amber		Low
Holsworthy Community Hospital	Draft Amber		Draft Low
Medical Devices	Draft Amber		Draft Medium
Governance Structure (Committees)	Amber	Green	Low
Patient Nutrition (2014/15)	Green		Low
Safe Surgery Checklist (2014/15)	Green		Low
Community Services: Paediatric Nursing (2014/15)	Green		Low
Publication Scheme	Green		Low
Incident Reporting	Green		Low
Emergency Preparedness	Green		Low
Recruitment	Green		Low
IGT Requirement 604	Green		Low
Dental Service	Draft Green		Draft Low

Ward Level Medicines Management – High – October 2015

A number of patient safety issues were identified within this review. We reported continued poor practice in attending to internal audit findings.

The Trust has an approved and comprehensive Medicines Policy, which was due for review in November 2014. The policy had been harmonised and applies to the Trust as a whole.

Standard Operating Procedures (SOPs) are in place to ensure that the administration, supply, and storage of drugs are undertaken in line with legislative requirements, which are available on the Trust's intranet site, however these are not always complied with.

The Trust has reported that dates for all but one action to implement all the recommendations in this report have been completed. A separate action plan has been developed by the Interim Director of Nursing to address the report findings and this was shared with the Audit Committee in April 2016, which was assured by the progress made.

Use of Volunteers – Medium – October 2015

Although the Trust had recently updated the Volunteer Policy, which provides staff with guidance as to the recruitment, management, training and record-keeping requirements for volunteers within the Trust, it does not include several key areas identified in the Lampard Report including safeguarding training for volunteers, Disclosure and Barring Service (DBS) checks and a VIP policy and does not include improvements, which we previously recommended in our 2012 Audit Report.

We highlighted that there was no overarching Manager of Volunteers within the Trust. There is a Volunteer Lead, however the role is currently limited to providing guidance to managers wishing to recruit volunteers.

Additionally, we highlighted improvements that were needed in the operation of controls around recruitment, supervision, the volunteer register and the use of volunteers by the League of Friends.

The Trust has extended dates for addressing the recommendations in the report to allow for HR involvement in revising the Volunteer Policy/ confirming training requirements. Work has progressed in the interim, where possible, corporately (named Manager in post, volunteer register updated and completed).

Clinical Records Management – Medium – September 2015

Our review of the management of healthcare records was completed through site visits to five eastern community hospitals, liaising with senior staff to confirm whether records were managed consistently across the Trust. Overall, we found that although clinical records were managed similarly across the eastern services, current practice does not follow Trust policy, despite the policy being harmonised following the integration of the eastern services with the Trust in 2011.

Specifically, many eastern services locations do not have sufficient capacity for the storage of records and have not been audited regularly as required in the Trust policy and as occurs in the acute Trust. The eastern community hospitals request records from the RD&E and follow their procedures in doing so. This practice was not included in the Trust's Health Records Policy. Additionally, the Trust's policy did not include any guidance relating to the use of electronic mobile devices for recording clinical patient information.

The Trust has reported that the majority of the recommendations made following our review will remain open until the transfer of eastern services takes place.

Governance of Medicines (Pharmacy) – Medium – February 2016

There are areas where we consider processes could be strengthened to enable the department to meet Key Performance Indicators (KPIs) and to improve clinical activity at ward level.

- ▶ The Pharmacy Improvement Plan, Strategy and Medicines Reconciliation Policy need updating.
- ▶ The number of medicines reconciliations completed within 24 hours should be improved.
- ▶ Non-pharmaceutical items currently distributed through Pharmacy should be distributed through Procurement to reduce storage requirements.
- ▶ A process to determine the cost of drugs waste should be established in order to identify potential savings.

Endoscopy Booking Practices – Medium – September 2015

Based on our review, there appeared to be an opportunity to improve efficiencies within the Endoscopy Booking Team by adopting the common booking practices in place throughout the Trust, where practical. This would not impact the Trust's ability to meet JAG (Joint Advisory Group on Gastrointestinal Endoscopy) accreditation standards.

The current appointment booking processes for Endoscopy patients relies on a paper-based system. There is a lack of understanding by staff of patient choice options and a lack of booking list validation, and inconsistent / unclear referrals are received from GP practices.

A possible option to consider may be to merge the Endoscopy Booking function with the Booked Admissions Department, which manages the majority of inpatient and day case

bookings for the Trust. This could help mitigate the impact of staff shortages and allow for more efficient booking practices to be introduced.

IM&T Agency Consultants – Medium – January 2016

We reviewed the procurement arrangements for the EHR project and identified that the Trust needed to ensure that in undertaking such projects, it ensures tendering decisions demonstrate compliance with public procurement regulations, Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions (SO/SFI) requirements. It also needs to document its resourcing decisions and have sufficiently detailed policies for staff engaging agency workers. Any lessons learned should be applied to future IM&T capital projects and other Trust projects to ensure sound governance and operational arrangements are applied.

Medical Devices – Draft Medium – May 2016

Overall, appropriate system arrangements are in place regarding medical devices. The lack of awareness from Trust staff and a lack of a tracking mechanism have identified a number of areas where improvements should be made regarding the number of devices which have not received timely maintenance.

Other work

Information Governance Review (v13)

Our annual review of the Trust's evidence to support the Information Governance Toolkit (V13) self-assessment is a compliance review, and as such, no assurance rating was provided. Instead we provided an opinion on the evidence presented at a point in time, i.e. February 2016, for 13 toolkit requirements. We confirmed that the Trust's Information Governance (IG) Team has a structured approach to reviewing and updating the evidence in the IG Toolkit.

Eastern Hotel Services

We undertook a benchmarking review of the eastern hotel services at the request of the Director of Facilities.

Jenny McCall

Director of Audit

Section 7: Accounts

1. Statement of the chief executive’s responsibilities as the accountable officer of the Trust

The Chief Executive of the NHS Trust Development Authority has designated that the Chief Executive should be the Accountable Officer to the trust. The relevant responsibilities of Accountable Officers are set out in the Accountable Officers Memorandum issued by the Chief Executive of the NHS Trust Development Authority. These include ensuring that:


- ▶ there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- ▶ value for money is achieved from the resources available to the trust;
- ▶ the expenditure and income of the trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- ▶ effective and sound financial management systems are in place; and
- ▶ annual statutory accounts are prepared in a format directed by the Secretary of State with the approval of the Treasury to give a true and fair view of the state of affairs as at the end of the financial year and the income and expenditure, recognised gains and losses and cash flows for the year.

To the best of my knowledge and belief, I have properly discharged the responsibilities set out in my letter of appointment as an Accountable Officer.

I confirm that, as far as I am aware, there is no relevant audit information of which the 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 trust’s auditors are aware of that information.

I confirm that the annual report and accounts as a whole is fair, balanced and understandable and that I take personal responsibility for the annual report and accounts and the judgments required for determining that it is fair, balanced and understandable.

NB: sign and date in any colour ink except black

Signed 
 Chief Executive
 Date 27/5/16

2. Statement of director’s responsibilities in respect of the accounts

The directors are required under the National Health Service Act 2006 to prepare accounts for each financial year. The Secretary of State, with the approval of the Treasury, directs that these accounts give a true and fair view of the state of affairs of the trust and of the income and expenditure, recognised gains and losses and cash flows for the year. In preparing those accounts, directors are required to:

- ▶ apply on a consistent basis accounting policies laid down by the Secretary of State with the approval of the Treasury;
- ▶ make judgements and estimates which are reasonable and prudent;
- ▶ state whether applicable accounting standards have been followed, subject to any material departures disclosed and explained in the accounts.

The directors are 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 direction of the Secretary of State. They are 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.



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

Each of the Trust’s Directors has submitted that as far as they are aware, there is no relevant information relating to the Trust’s operations or finances of which the organisation’s auditors are unaware.

Each of the Trust’s Directors has also confirmed that they have taken all necessary actions to make themselves aware of all relevant organisational information, and to establish that the auditors are equally aware of that information.

By order of the Board

NB: sign and date in any colour ink except black


 Chief Executive
 Date 27/5/16

 Finance Direct
 Date 27/5/16

Annual accounts for the period: 1 April 2015 to 31 March 2016

Trust name	Northern Devon Healthcare NHS Trust
This year	2014-15
Last year	2013-14
This year ended	31 March 2015
Last year ended	31 March 2014
This year commencing:	1 April 2014
Last year commencing:	1 April 2013

Independent auditor's report to the board of directors of Northern Devon Healthcare NHS Trust

We have audited the financial statements of Northern Devon Healthcare NHS Trust for the year ended 31 March 2016 on pages 4 to 37 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

This report is made solely to the Board of Directors of Northern Devon Healthcare NHS Trust, as a body, in accordance with Part 5 of the Local Audit and Accountability Act 2014. Our audit work has been undertaken so that we might state to the Board of the Trust, as a body, those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Board of the Trust, as a body, for our audit work, for this report or for the opinions we have formed.

3. *Respective responsibilities of Directors, the Accountable Officer and auditor*

As explained more fully in the Statement of Directors' Responsibilities set out on page 60, the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

As explained in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for the arrangements to secure economy, efficiency and effectiveness in the use of the Trust's resources. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. Section 21(5)(b) of the Local Audit and Accountability Act 2014 requires that our report must not contain our opinion if we are satisfied that proper arrangements are in place.

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 its use of resources are operating effectively.

4. *Scope of the audit of the financial statements*

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Directors; and the overall presentation of the financial statements.

In addition we read all the financial and non-financial information in the annual report and accounts to identify material inconsistencies with the audited financial statements and to identify any information that is apparently materially incorrect based on, or materially inconsistent with, the knowledge acquired by us in the course of performing the audit. If we become aware of any apparent material misstatements or inconsistencies we consider the implications for our report.

5. *Scope of the review of arrangements for securing economy, efficiency and effectiveness in the use of resources*

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2015, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to form a view on whether, in all significant respects, the Trust had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

6. *Opinion on financial statements*

In our opinion the financial statements:

- ▶ give a true and fair view of the financial position of the Trust as at 31 March 2016 and of the Trust's expenditure and income for the year then ended; and
- ▶ have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England.

7. *Opinion on other matters*

In our opinion:

- ▶ the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England; and
- ▶ the other information published together with the audited financial statements in the Annual Report and Accounts is consistent with the financial statements.

8. *Matters on which we are required to report by exception*

We are required to report to you if:

- ▶ in our opinion the governance statement does not comply with the NHS Trust Development Authority's guidance; or
- ▶ we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- ▶ we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- ▶ we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or

- ▶ we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2016.

We have nothing to report in respect of the above responsibilities.

9. *Certificate*

We certify that we have completed the audit of the accounts of Northern Devon Healthcare NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.



Jonathan Brown
for and on behalf of KPMG LLP, Statutory Auditor

Chartered Accountants
100 Temple Street
Bristol
BS1 6AG

27-May-16

Please note the page numbers 4 to 37 referred to in this statement are reflective of the accounts document submitted to the Department of Health. The page numbers have changed during the formatting of this report.

Statement of Comprehensive Income for year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Gross employee benefits	10.1	(159,549)	(155,372)
Other operating costs	8	(76,503)	(73,748)
Revenue from patient care activities	5	219,045	218,647
Other operating revenue	6	14,190	16,038
Operating surplus/(deficit)		(2,817)	5,565
Investment revenue	12	18	23
Other gains and (losses)	13	133	(1)
Finance costs	14	(1,244)	(1,055)
Surplus/(deficit) for the financial year		(3,910)	4,532
Public dividend capital dividends payable		(3,761)	(3,818)
Transfers by absorption - gains		0	0
Transfers by absorption - (losses)		0	0
Net Gain/(loss) on transfers by absorption		0	0
Retained surplus/(deficit) for the year		(7,671)	714
Other Comprehensive Income		£000s	£000s
Impairments and reversals taken to the revaluation reserve		375	(3,837)
Net gain/(loss) on revaluation of property, plant & equipment		4,315	6,057
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Other gain/(loss) (explain in footnote below)		0	0
Net gain/(loss) on revaluation of available for sale financial assets		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Other pension remeasurements		0	0
Reclassification adjustments			
On disposal of available for sale financial assets		0	0
Total Other Comprehensive Income		4,690	2,220
Total comprehensive income for the year*		(2,981)	2,934
Financial performance for the year			
Retained surplus/(deficit) for the year		(7,671)	714
Prior period adjustment to correct errors and other performance adjustments		0	0
IFRIC 12 adjustment (including IFRIC 12 impairments)		463	298
Impairments (excluding IFRIC 12 impairments)		2,132	3,297
Adjustments in respect of donated asset reserve elimination		429	(1,972)
Adjustment re absorption accounting		0	0
Adjusted retained surplus/(deficit)		(4,647)	2,337

The notes on pages 67 to 104 form part of this account.

Statement of financial position as at 31 March 2016

	NOTE	31 March 2016 £000s	31 March 2015 £000s
Non-current assets:			
Property, plant and equipment	15	136,027	133,754
Intangible assets	16	6,194	3,686
Investment property	18	0	0
Other financial assets		0	0
Trade and other receivables	22.1	971	983
Total non-current assets		143,192	138,423
Current assets:			
Inventories	21	3,496	3,132
Trade and other receivables	22.1	8,956	12,240
Other financial assets	24	0	0
Other current assets	25	0	0
Cash and cash equivalents	26	1,291	2,450
Sub-total current assets		13,743	17,822
Non-current assets held for sale	27	201	845
Total current assets		13,944	18,667
Total assets		157,136	157,090
Current liabilities			
Trade and other payables	28	(19,342)	(20,803)
Other liabilities	29	0	0
Provisions	35	(30)	(50)
Borrowings	30	(697)	(292)
Other financial liabilities	31	0	0
DH revenue support loan	30	0	0
DH capital loan	30	0	0
Total current liabilities		(20,069)	(21,145)
Net current assets/(liabilities)		(6,125)	(2,478)
Total assets less current liabilities		137,067	135,945
Non-current liabilities			
Trade and other payables	28	0	0
Other liabilities	31	0	0
Provisions	35	(30)	(39)
Borrowings	30	(10,065)	(8,320)
Other financial liabilities	31	0	0
DH revenue support loan	30	(4,667)	0
DH capital loan	30	0	0
Total non-current liabilities		(14,762)	(8,359)
Total assets employed:		122,305	127,586
FINANCED BY:			
Public Dividend Capital		52,740	55,040
Retained earnings		34,418	40,356
Revaluation reserve		35,147	32,190
Other reserves		0	0
Total Taxpayers' Equity:		122,305	127,586

The notes on pages 67 to 104 form part of this account.

The financial statements on pages 63 to 104 were approved by the Board on 27th May 2016 and signed on its behalf by:

Chief Executive:  Date: 27/5/16

Statement of changes in taxpayers' equity for the year ending 31 March 2016

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2015	54,040	40,356	32,190	0	127,586
Changes in taxpayers' equity for 2015-16					
Retained surplus/(deficit) for the year		(7,671)			(7,671)
Net gain / (loss) on revaluation of property, plant, equipment			4,315		4,315
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of available for sale financial assets			0		0
Impairments and reversals			375		375
Other gains/(loss) (provide details below)				0	0
Transfers between reserves		1,733	(1,733)	0	0
Reclassification Adjustments					
Transfers between revaluation reserve & retained earnings in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution		0	0	0	0
Originating capital for Trust established in year	0				0
Permanent PDC received - cash	0				0
Permanent PDC repaid in year	(2,300)				(2,300)
PDC written off	0	0			0
Transfer due to change of status from Trust to Foundation Trust	0	0	0	0	0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pensions remeasurement				0	0
Net recognised revenue/(expense) for the year	(2,300)	(5,938)	2,957	0	(5,281)
Balance at 31 March 2016	52,740	34,418	35,147	0	122,305
Balance at 1 April 2014	54,591	39,672	29,940	0	124,203
Changes in taxpayers' equity for the year ended 31 March 2015					
Retained surplus/(deficit) for the year		714			714
Net gain / (loss) on revaluation of property, plant, equipment			6,057		6,057
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			(3,837)		(3,837)
Other gains / (loss)				0	0
Transfers between reserves		(30)	30	0	0
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
Transfers between revaluation reserve & retained earnings reserve in respect of assets transferred under absorption		0	0		0
On disposal of available for sale financial assets			0		0
Originating capital for Trust established in year	0				0
New temporary and permanent PDC received - cash	449				449
New temporary and permanent PDC repaid in year	0				0
Other movements	0	0	0	0	0
Net actuarial gain/(loss) on pension				0	0
Other pension remeasurement				0	0
Net recognised revenue/(expense) for the year	449	684	2,250	0	3,383
Balance at 31 March 2015	55,040	40,356	32,190	0	127,586

Statement of cash flows for the year ended 31 March 2016

	NOTE	2015-16 £000s	2014-15 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		(2,817)	5,565
Depreciation and amortisation	8	8,259	8,741
Impairments and reversals	17	2,132	3,297
Other gains/(losses) on foreign exchange	13	0	0
Donated Assets received credited to revenue but non-cash	6	0	0
Government Granted Assets received credited to revenue but non-cash		0	0
Interest paid		(1,245)	(1,055)
PDC Dividend (paid)/refunded		(3,620)	(4,042)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		(364)	(505)
(Increase)/Decrease in Trade and Other Receivables		3,036	(1,828)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		(547)	3,197
Plus assets classified as held for sale in the year		0	0
Provisions utilised		(34)	(27)
Increase/(Decrease) in movement in non cash provisions		5	(435)
Net Cash Inflow/(Outflow) from Operating Activities		4,805	12,908
Cash Flows from Investing Activities			
Interest Received		18	23
(Payments) for Property, Plant and Equipment		(8,388)	(12,169)
(Payments) for Intangible Assets		(3,120)	(2,087)
(Payments) for Investments with DH		0	0
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	0
Proceeds of disposal of assets held for sale (PPE)		1,010	10
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Investment with DH		0	0
Proceeds from Disposal of Other Financial Assets		0	0
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(10,480)	(14,223)
Net Cash Inform / (outflow) before Financing		(5,675)	(1,315)
Cash Flows from Financing Activities			
Gross Temporary (2014/15 only) and Permanent PDC Received		0	449
Gross Temporary (2014/15 only) and Permanent PDC Repaid		(2,300)	0
Loans received from DH - New Capital Investment Loans		0	0
Loans received from DH - New Revenue Support Loans		16,667	0
Other Loans Received		2,441	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		0	0
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		(12,000)	0
Other Loans Repaid		0	0
Cash transferred to NHS Foundation Trusts or on dissolution		0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(292)	(286)
Capital grants and other capital receipts (excluding donated / government granted cash receipts)		0	0
Net Cash Inflow/(Outflow) from Financing Activities		4,516	163
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		(1,159)	(1,152)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		2,450	3,602
Effect of exchange rate changes in the balance of cash held in foreign currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end	26	1,291	2,450

Notes to the accounts

1. Accounting policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2015-16 issued by the Department of Health. The accounting policies contained in that manual 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 Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1. Accounting convention

These 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 financial liabilities.

1.2. Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3. Movement of assets within the DH Group

Transfers as part of reorganisation fall to be accounted for by use of absorption accounting in line with the Treasury FReM. The FReM does not require retrospective adoption, so prior year transactions (which have been accounted for under merger accounting) have not been restated. Absorption accounting requires that entities account for their transactions in the period in which they took place, with no restatement of performance required when functions transfer within the public sector. Where assets and liabilities transfer, the gain or loss resulting is recognised in the SOCI, and is disclosed separately from operating costs.

Other transfers of assets and liabilities within the Group are accounted for in line with IAS 20 and similarly give rise to income and expenditure entries.

1.4. Charitable funds

Under the provisions of IAS 27 Consolidated and Separate Financial Statements, those Charitable Funds that fall under common control with NHS bodies are consolidated within the entity's financial statements. In accordance with IAS 1 Presentation of Financial Statements, restated prior period accounts are presented where the adoption of the new policy has a material impact.

In accordance with IAS1 Presentation of Financial Statements the Trust has reviewed the accounts of its NHS Charitable Fund and deemed it not material to be consolidated within the Trust's own accounts.

1.5. Pooled budgets

The Trust does not have any pooled budget arrangements.

1.6. Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS 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. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.6.1. Critical judgements in applying accounting policies

The Trust has not made any specific critical judgements, apart from those involving estimations based on historical factors and other relevant information.

1.6.2. Key sources of estimation uncertainty

The Trust does not have any areas of estimations uncertainty at the end of the reporting period that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.7. Revenue

Revenue 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 revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of *length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

Where income is received for a specific activity that is to be delivered in the following year, that income is deferred.

The NHS trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The NHS trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.8. Employee Benefits

Short-term employee benefits

Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees, *except for bonuses earned but not yet taken which, like leave earned but not yet taken is not accrued for at the year end, on the grounds of immateriality.

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the trust commits itself to the retirement, regardless of the method of payment.

1.9. Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

1.10. Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- ▶ 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 will be supplied 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
- ▶ the item has cost of at least £5,000; or
- ▶ Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, 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
- ▶ Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

Where a large asset, for example a building, includes a number of components with significantly different asset lives, the components are treated as separate assets and depreciated over their own useful economic lives.

Valuation

All property, plant and equipment are measured initially at cost, representing the cost 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.

Land and buildings used for the Trusts's services or for administrative purposes are stated in the statement of financial position at their revalued amounts, being the fair value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- ▶ Land and non-specialised buildings – market value for existing use; or
- ▶ Specialised buildings – depreciated replacement cost.

HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the

revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.11. Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- ▶ the technical feasibility of completing the intangible asset so that it will be available for use;
- ▶ the intention to complete the intangible asset and use it;
- ▶ the ability to sell or use the intangible asset;
- ▶ how the intangible asset will generate probable future economic benefits or service potential;
- ▶ the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it; and

- ▶ the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement

The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market or where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

1.12. Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the NHS trust expects to obtain economic benefits or service potential from the asset. This is specific to the NHS trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end, with the effect of any changes recognised on a prospective basis. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the NHS trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss.

The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.13. Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

1.14. Government grants

Government grant funded assets are capitalised at their fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15. Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.16. Leases

Leases are classified as finance leases when substantially all the risks and rewards of ownership are transferred to the lessee. All other leases are classified as operating leases.

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor.

Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

Contingent rentals are recognised as an expense in the period in which they are incurred.

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases.

The NHS trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the NHS trust's net investment in the leases. Finance lease income is allocated to accounting periods so as to reflect a constant periodic rate of return on the trust's net investment outstanding in respect of the leases.

Rental income from operating leases is recognised on a straight-line basis over the term of the lease. Initial direct costs incurred in negotiating and arranging an operating lease are added to the carrying amount of the leased asset and recognised on a straight-line basis over the lease term.

1.17. Private Finance Initiative (PFI) transactions

HM Treasury has determined that government bodies shall account for infrastructure PFI schemes where the government body controls the use of the infrastructure and the residual interest in the infrastructure at the end of the arrangement as service concession arrangements, following the principles of the requirements of IFRIC 12. The Trust therefore recognises the PFI asset as an item of property, plant and equipment together with a liability to pay for it. The services received under the contract are recorded as operating expenses.

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:

- a) Payment for the fair value of services received;
- b) Payment for the PFI asset, including finance costs; and
- c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

Services received

The fair value of services received in the year is recorded under the relevant expenditure headings within 'operating expenses'.

PFI Asset

The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value in accordance with the principles of IAS 17. Subsequently, the assets are measured at fair value, which is kept up to date in accordance with the Trust's approach for each relevant class of asset in accordance with the principles of IAS 16.

PFI liability

A PFI liability is recognised at the same time as the PFI assets are recognised. It is measured initially at the same amount as the fair value of the PFI assets and is subsequently measured as a finance lease liability in accordance with IAS 17.

An annual finance cost is calculated by applying the implicit interest rate in the lease to the opening lease liability for the period, and is charged to 'Finance Costs' within the Statement of Comprehensive Income.

The element of the annual unitary payment that is allocated as a finance lease rental is applied to meet the annual finance cost and to repay the lease liability over the contract term.

An element of the annual unitary payment increase due to cumulative indexation is allocated to the finance lease. In accordance with IAS 17, this amount is not included in the minimum lease payments, but is instead treated as contingent rent and is expensed as incurred. In substance, this amount is a finance cost in respect of the liability and the expense is presented as a contingent finance cost in the Statement of Comprehensive Income.

Lifecycle replacement

Components of the asset replaced by the operator during the contract ('lifecycle replacement') are capitalised where they meet the Trust's criteria for capital expenditure. They are capitalised at the time they are provided by the operator and are measured initially at their fair value.

The element of the annual unitary payment allocated to lifecycle replacement is pre-determined for each year of the contract from the operator's planned programme of lifecycle replacement. Where the lifecycle component is provided earlier or later than expected, a short-term finance lease liability or prepayment is recognised respectively.

Where the fair value of the lifecycle component is less than the amount determined in the contract, the difference is recognised as an expense when the replacement is provided. If the fair value is greater than the amount determined in the contract, the difference is treated as a 'free' asset and a deferred income balance is recognised. The deferred income is released to the operating income over the shorter of the remaining contract period or the useful economic life of the replacement component.

Assets contributed by the NHS trust to the operator for use in the scheme continue to be recognised as items of property, plant and equipment in the NHS trust's Statement of Financial Position.

Other assets contributed by the NHS trust to the operator

Assets contributed (e.g. cash payments, surplus property) by the NHS trust to the operator before the asset is brought into use, which are intended to defray the operator's capital costs, are recognised initially as prepayments during the construction phase of the contract. Subsequently, when the asset is made available to the NHS trust, the prepayment is treated as an initial payment towards the finance lease liability and is set against the carrying value of the liability.

1.18. Inventories

Inventories are valued at the lower of cost and net realisable value using the weighted average cost formula. This is considered to be a reasonable approximation to fair value due to the high turnover of stocks.

1.19. Cash and cash equivalents

Cash is cash in hand and deposits with any financial institution repayable without penalty on notice of not more than 24 hours. Cash equivalents are investments that mature in 3 months or less from the date of acquisition and that are readily convertible to known amounts of cash with insignificant risk of change in value.

In the Statement of Cash Flows, cash and cash equivalents are shown net of bank overdrafts that are repayable on demand and that form an integral part of the NHS trust's cash management.

1.20. Provisions

Provisions are recognised when the NHS trust has a present legal or constructive obligation as a result of a past event, it is probable that the NHS trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 0.4% in real terms (2.35% for employee early departure obligations).

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.21. Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the NHS trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at Note 35.

1.22. Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority 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 as and when they become due.

1.23. Carbon Reduction Commitment Scheme (CRC)

CRC and similar allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from deferred income. The provision is settled on surrender of the allowances. The asset, provision and deferred income amounts are valued at fair value at the end of the reporting period.

1.24. Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the NHS trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non- occurrence of one or more uncertain future events not wholly within the control of the NHS trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.25. Financial assets

Financial assets are recognised when the NHS trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are classified into the following categories: financial assets at fair value through profit and loss; held to maturity investments; available for sale financial assets, and loans and receivables. The classification depends on the nature and purpose of the financial assets and is determined at the time of initial recognition.

Financial assets at fair value through profit and loss

The Trust has no material contracts that contain embedded derivatives.

Held to maturity investments

The Trust has no held to maturity investments.

Available for sale financial assets

The Trust has no available for sale financial assets.

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. Fair value is determined by reference to quoted market prices where possible.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised 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 expenditure and the carrying amount of the asset is reduced directly.

1.26. Financial liabilities

Financial liabilities are recognised on the statement of financial position when the NHS trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

Financial guarantee contract liabilities

The trust has no financial guarantee liabilities.

Financial liabilities at fair value through profit and loss

The Trust has no material contract liabilities that contain embedded derivatives.

Other financial liabilities

After initial recognition, all other financial liabilities are measured at amortised cost using the effective interest method, except for loans from Department of Health, which are carried at historic cost. The effective interest rate is the rate that exactly discounts estimated future cash payments through the life of the asset, to the net carrying amount of the financial liability. Interest is recognised using the effective interest method.

1.27. 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 fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are stated net of VAT.

1.28. Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.29. 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. Details of third party assets are given in Note 44 to the accounts.

1.30. Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities (except for donated assets and cash balances with the Government Banking Service). The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

In accordance with the requirements laid down by the Department of Health (as the issuer of PDC), the dividend for the year is calculated on the actual average relevant net assets as set out in the "pre-audit" version of the annual accounts. The dividend thus calculated is not revised should any adjustment to net assets occur as a result the audit of the annual accounts.

1.31. 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 legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that 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 NHS Trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32. Subsidiaries

The Trust has no subsidiaries.

1.33. Associates

The Trust has no associates.

1.34. Joint arrangements

The Trust has no joint ventures.

1.35. Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the SOCI on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.36. Accounting Standards that have been issued but have not yet been adopted

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2015-16. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

- ▶ IFRS 9 Financial Instruments – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted;
- ▶ IFRS 15 Revenue for Contracts with Customers – Application required for accounting periods beginning on or after 1 January 2017, but not yet adopted by the FReM: early adoption is not therefore permitted; and
- ▶ IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted.

2. Pooled budget

The Trust has no pooled budgets.

3. Operating segments

The Trust has considered the requirements in IFRS8 for segmental analysis. Having reviewed the operating segments reported internally to the Board, the Trust is satisfied that it is appropriate to aggregate these as, in accordance with IFRS8: Operating Segements, they are similar in each of the following aspects:

- ▶ The nature of the products and services;
- ▶ The type of customer for their products and services;
- ▶ The methods used to distribute their products or provide their services; and
- ▶ The nature of the regulatory environment.

The trust therefore has just one segment, "healthcare".

	Healthcare		Total	
	2015-16 £000s	2014-15 £000s	2015-16 £000s	2014-15 £000s
Income	233,235	234,685	233,235	234,685
Surplus/(Deficit)				
Segment surplus/(deficit)	0	0	0	0
Common costs	(237,145)	(230,153)	(237,145)	(230,153)
Surplus/(deficit) before interest	(3,910)	4,532	(3,910)	4,532
Net Assets:				
Segment net assets	122,305	127,586	122,305	127,586

4. Income generation activities

The Trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care. The Trust does not undertake any activities where income generation is material.

5. Revenue from patient care activities

	2015-16 £000s	2014-15 £000s
NHS Trusts	78	55
NHS England	17,578	15,680
Clinical Commissioning Groups	187,566	192,406
Foundation Trusts	330	395
Department of Health	0	0
NHS Other (including Public Health England and Prop Co)	0	0
Additional income for delivery of healthcare services	2,300	0
Non-NHS:		
Local Authorities	10,054	9,348
Private patients	322	327
Overseas patients (non-reciprocal)	12	15
Injury costs recovery	732	359
Other	73	62
Total Revenue from patient care activities	219,045	218,647

6. Other operating revenue

	2015-16 £000s	2014-15 £000s
Recoveries in respect of employee benefits	1,153	953
Patient transport services	279	0
Education, training and research	5,221	4,303
Charitable and other contributions to revenue expenditure - NHS	0	0
Charitable and other contributions to revenue expenditure -non- NHS	241	242
Receipt of donations for capital acquisitions - Charity	132	2,532
Support from DH for mergers	0	0
Receipt of Government grants for capital acquisitions	0	0
Non-patient care services to other bodies	4,692	4,468
Income generation (Other fees and charges)	952	862
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Other revenue	1,520	2,678
Total Other Operating Revenue	14,190	16,038
Total operating revenue	233,235	234,685

7. Overseas Visitors Disclosure

	2015-16 £000s	2014-15 £000s
Income recognised during 2015-16 (invoiced amounts and accruals)	12	15
Cash payments received in-year (re receivables at 31 March 2015)	9	0
Cash payments received in-year (iro invoices issued 2014-15)	11	3
Amounts added to provision for impairment of receivables (re receivables at 31 March 2014)	0	0
Amounts added to provision for impairment of receivables (iro invoices issued 2014-15)	0	0
Amounts written off in-year (irrespective of year of recognition)	3	0

8. Operating expenses

	2015-16 £000s	2014-15 £000s
Services from other NHS Trusts	776	800
Services from CCGs/NHS England	67	73
Services from other NHS bodies	0	0
Services from NHS Foundation Trusts	3,580	3,576
Total Services from NHS bodies*	4,423	4,449
Purchase of healthcare from non-NHS bodies	48	0
Purchase of Social Care	0	
Trust Chair and Non-executive Directors	49	50
Supplies and services - clinical	32,206	29,778
Supplies and services - general	7,225	6,740
Consultancy services	86	361
Establishment	5,505	5,038
Transport	329	1,331
Service charges - ON-SOFP PFIs and other service concession arrangements	394	371
Service charges - On-SOFP LIFT contracts	0	0
Total charges - Off-SOFP PFIs and other service concession arrangements	0	0
Total charges - Off-SOFP LIFT contracts	0	0
Business rates paid to local authorities	1,252	1,280
Premises	8,606	7,602
Hospitality	63	61
Insurance	2	9
Legal Fees	345	329
Impairments and Reversals of Receivables	30	50
Inventories write down	0	0
Depreciation	7,546	7,911
Amortisation	713	830
Impairments and reversals of property, plant and equipment	2,102	3,295
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets	0	0
Impairments and reversals of non current assets held for sale	30	2
Internal Audit fees	110	
Audit fees	57	76
Other auditor's remuneration	12	12
Clinical negligence	3,967	2,589
Research and development (excluding staff costs)	0	0
Education and Training	990	879
Change in Discount Rate	0	0
Other	413	705
Total Operating expenses (excluding employee benefits)	76,503	73,748
Employee Benefits		
Employee benefits excluding Board members	158,293	154,390
Board members	1,256	982
Total Employee Benefits	159,549	155,372
Total Operating Expenses	236,052	229,120

* Services from NHS bodies does not include expenditure which falls into a category below.

9. Operating leases

9.1. Northern Devon Healthcare NHS Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2015-16 Total £000s	2014-15 £000s
Payments recognised as an expense					
Minimum lease payments				456	455
Contingent rents				0	0
Sub-lease payments				0	0
Total				456	455
Payable:					
No later than one year	0	0	329	329	340
Between one and five years	0	0	238	238	251
After five years	0	0	0	0	0
Total	0	0	567	567	591
Total future sublease payments expected to be received:				0	0

9.2. Northern Devon Healthcare NHS Trust as lessor

The trust has no lessor agreements.

10. Employee benefits and staff numbers

10.1. Employee benefits

Employee Benefits - Gross Expenditure 2015-16

	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	138,917	121,697	17,220
Social security costs	9,632	9,632	0
Employer Contributions to NHS BSA - Pensions Division	14,742	14,742	0
Other pension costs	0	0	0
Termination benefits	0	0	0
Total employee benefits	163,291	146,071	17,220
Employee costs capitalised	3,742	2,529	1,213
Gross Employee Benefits excluding capitalised costs	159,549	143,542	16,007

Employee Benefits - Gross Expenditure 2014-15

	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	134,172	118,182	15,990
Social security costs	9,766	9,766	0
Employer Contributions to NHS BSA - Pensions Division	14,300	14,300	0
Other pension costs	30	30	0
Termination benefits	0	0	0
TOTAL - including capitalised costs	158,268	142,278	15,990
Employee costs capitalised	2,896	2,516	380
Gross Employee Benefits excluding capitalised costs	155,372	139,762	15,610

10.2. Staff numbers

	2015-16			2014-15
	Total number	Permanently employed number	Other number	Total number
Average Staff Numbers				
Medical and dental	298	256	42	281
Ambulance staff	4	4	0	2
Administration and estates	679	664	15	660
Healthcare assistants and other support staff	1,212	1,126	86	1,177
Nursing, midwifery and health visiting staff	1,210	1,106	104	1,208
Nursing, midwifery and health visiting learners	0	0	0	0
Scientific, therapeutic and technical staff	569	554	15	554
Social Care Staff	0	0	0	0
Healthcare Science Staff	0	0	0	0
Other	0	0	0	0
TOTAL	3,972	3,710	262	3,882
Of the above - staff engaged on capital projects	85	58	27	52

10.3. Staff sickness absence and ill health retirements

	2015-16 Number	2014-15 Number
Total Days Lost	29,412	27,343
Total Staff Years	3,702	3,593
Average working Days Lost	7.94	7.61
	2015-16 Number	2014-15 Number
Number of persons retired early on ill health grounds	4	3
	£000s	£000s
Total additional pensions liabilities accrued in the year	196	251

10.4. Exit packages agreed in 2015-16

Exit package cost band (including any special payment element) 2015-16

	*Number of compulsory redundancies Number	*Cost of compulsory redundancies £s	Number of other departures agreed Number	Cost of other departures agreed £s	Total number of exit packages Number	Total cost of exit packages £s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £s
Less than £10,000	0	0	0	0	0	0	0	0
£10,000-£25,000	2	25,254	0	0	2	25,254	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	2	25,254	0	0	2	25,254	0	0

Exit package cost band (including any special payment element) 2014-15

	*Number of compulsory redundancies Number	*Cost of compulsory redundancies £s	Number of other departures agreed Number	Cost of other departures agreed £s	Total number of exit packages Number	Total cost of exit packages £s	Number of departures where special payments have been made Number	Cost of special payment element included in exit packages £s
Less than £10,000	3	19,864	5	24,805	8	44,669	0	0
£10,000-£25,000	0	0	0	0	0	0	0	0
£25,001-£50,000	0	0	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0	0	0
Total	3	19,864	5	24,805	8	44,669	0	0

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS Scheme. Exit costs in this note are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages agreed in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10.5. Exit packages - other departures analysis

	2015-16		2014-15	
	Agreements Number	Total value of agreements £000s	Agreements Number	Total value of agreements £000s
Voluntary redundancies including early retirement contractual costs	0	0	5	25
Mutually agreed resignations (MARS) contractual costs	0	0	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	0	0	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval*	0	0	0	0
Total	<u>0</u>	<u>0</u>	<u>5</u>	<u>25</u>
Non-contractual payments made to individuals where the payment value was more than 12 months of their annual salary	0	0	0	0

This disclosure reports the number and value of exit packages agreed in the year. Note: the expense associated with these departures may have been recognised in part or in full in a previous period.

As a single exit packages can be made up of several components each of which will be counted separately in this Note, the total number above will not necessarily match the total numbers in Note 10.4 which will be the number of individuals.

*includes any non-contractual severance payment made following judicial mediation, and £0 relating to non-contractual payments in lieu of notice.

The Remuneration Report includes disclosure of exit payments payable to individuals named in that Report.

10.6. Pension costs

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 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 are accepted as providing suitably robust

figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2016, is based on valuation data as 31 March 2015, updated to 31 March 2016 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension 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 their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012.

The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

11. Better Payment Practice Code

11.1. Measure of compliance

	2015-16 Number	2015-16 £000s	2014-15 Number	2014-15 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	62,322	73,561	63,172	70,480
Total Non-NHS Trade Invoices Paid Within Target	50,707	62,144	60,114	67,435
Percentage of NHS Trade Invoices Paid Within Target	81.36%	84.48%	95.16%	95.68%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,143	85,636	2,166	77,394
Total NHS Trade Invoices Paid Within Target	1,597	78,928	2,110	76,567
Percentage of NHS Trade Invoices Paid Within Target	74.52%	92.17%	97.41%	98.93%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid.

11.2. The Late Payment of Commercial Debts (Interest) Act 1998

	2015-16 £000s	2014-15 £000s
Amounts included in finance costs from claims made under this legislation	17	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	17	0

12. Investment revenue

	2014-15 £000s	2013-14 £000s
Rental revenue		
PFI finance lease revenue (planned)	0	0
PFI finance lease revenue (contingent)	0	0
Other finance lease revenue	0	0
Subtotal	<u>0</u>	<u>0</u>
Interest revenue		
LIFT: equity dividends receivable	0	0
LIFT: loan interest receivable	0	0
Bank interest	18	23
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Subtotal	<u>18</u>	<u>23</u>
Total investment revenue	<u>18</u>	<u>23</u>

13. Other gains and losses

	2015-16 £000s	2014-15 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	1	(1)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0
Gain (Loss) on disposal of assets held for sale	132	0
Change in fair value of financial assets carried at fair value through the SoCI	0	0
Change in fair value of financial liabilities carried at fair value through the SoCI	0	0
Change in fair value of investment property	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	<u>133</u>	<u>(1)</u>

14. Finance costs

	2015-16 £000s	2014-15 £000s
Interest		
Interest on loans and overdrafts	185	0
Interest on obligations under finance leases	0	0
Interest on obligations under PFI contracts:		
- main finance cost	650	671
- contingent finance cost	392	384
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	17	0
Total interest expense	<u>1,244</u>	<u>1,055</u>
Other finance costs	0	0
Provisions - unwinding of discount	0	0
Total	<u>1,244</u>	<u>1,055</u>

15. Property, plant and equipment

15.1. Property, plant and equipment

2014-15

Cost or valuation:

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2015	18,976	102,509	570	28	23,192	32	5,605	699	151,611
Prior period adjustment	0	45	0	20	(920)	0	262	1	(592)
At 1 April 2015	18,976	102,554	570	48	22,272	32	5,867	700	151,019
Additions of Assets Under Construction				3,591					3,591
Additions Purchased	0	3,113	22		599	0	395	(7)	4,122
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	0
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	81	0	0	51	132
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	2,259	0	(2,259)	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	(17)	0	0	0	0	0	0	(17)
Disposals other than for sale	0	4,315	0	0	(1,050)	(5)	(573)	(65)	(1,693)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	4,315
Impairment/reversals charged to operating expenses	0	0	0	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	321	54	0	0	0	0	0	375
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption	0	0	0	0	0	0	0	0	0
Accounting	0	0	0	0	0	0	0	0	0
Accumulated Depreciation netted off following revaluation	0	(6,039)	(75)	0	0	0	0	0	(6,114)
At 31 March 2016	18,976	106,506	571	1,380	21,902	27	5,689	679	155,730

Depreciation

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2015	0	0	0		15,008	26	2,589	233	17,856
Reclassifications	0	0	0		0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		(1,044)	(5)	(573)	(65)	(1,687)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairment/reversals charged to operating expenses	0	2,096	6	0	0	0	0	0	2,102
Charged During the Year	0	3,943	69	0	2,436	6	1,019	73	7,546
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	(6,039)	(75)	0	0	0	0	0	(6,114)
Accumulated Depreciation netted off following revaluation	0	0	0	0	16,400	27	3,035	241	19,703
At 31 March 2016	18,976	106,506	571	1,380	5,502	0	2,654	438	136,027

Asset financing:

Owned - Purchased	18,376	81,975	571	1,380	5,020	0	2,651	329	110,302
Owned - Donated	600	9,691	0	0	482	0	3	109	10,885
Owned - Government Granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	14,840	0	0	0	0	0	0	14,840
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2016	18,976	106,506	571	1,380	5,502	0	2,654	438	136,027

Prior period adjustments relate to a reclassification of accruals from Plant and Machinery to other headings across note 15.1 and 16.1 which were made incorrectly at the end of 31st March 2015.

Revaluation Reserve Balance for Property, Plant & Equipment

2014-15

	Land £000's	Buildings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
At 1 April 2015	6,874	22,738	201	0	123	0	0	4	29,940
Movements - DV Valuation	0	4,666	54	0	0	0	0	0	4,720
At 31 March 2016	6,874	27,404	255	0	123	0	0	4	34,660

Additions to Assets Under Construction in 2014-15

Land	£000's	0
Buildings excl Dwellings		3,448
Dwellings		0
Plant & Machinery		143
Balance as at YTD		3,591

15.2. Property, plant and equipment prior-year

2014-15

	Land £000's	Buildings excluding dwellings £000's	Dwellings £000's	Assets under construction & payments on account £000's	Plant & machinery £000's	Transport equipment £000's	Information technology £000's	Furniture & fittings £000's	Total £000's
Cost or valuation:									
At 1 April 2014	21,998	95,909	570	1,152	23,148	32	4,927	691	148,427
Additions of Assets Under Construction				2,292					2,292
Additions Purchased					2,663		842	26	7,539
Additions - Non Cash Donations (i.e. Physical Assets)	0	0	0	0	0	0	0	0	0
Additions - Purchases from Cash Donations & Government Grants	0	357	0	1,975	148	0	0	52	2,532
Additions Leased (including PFI/LIFT)	0	0	0						
Reclassifications	0	5,369	0	(5,391)	15	0	0	7	0
Reclassifications as Held for Sale and Reversals	(293)	(602)	0	0	0	0	0	0	(895)
Disposals other than for sale	0	0	0	0	(2,782)	0	(164)	(77)	(3,023)
Revaluation	661	5,396	0	0	0	0	0	0	6,057
Impairments/negative indexation charged to reserves	(1,850)	(2,515)	(105)	0	0	0	0	0	(4,470)
Reversal of Impairments charged to reserves	0	603	30	0	0	0	0	0	633
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0
Accumulated Depreciation netted off following revaluation	(1,540)	(5,916)	(25)	0	0	0	0	0	(7,481)
At 31 March 2015	18,976	102,509	570	28	23,192	32	5,605	699	151,611
Depreciation									
At 1 April 2014	0	0	0	0	15,072	18	1,862	240	17,192
Reclassifications	0	0	0						0
Reclassifications as Held for Sale and Reversals	0	(48)	0		0	0	0	0	(48)
Disposals other than for sale	0	0	0		(2,772)	0	(163)	(77)	(3,012)
Revaluation	0	0	0						0
Impairments/negative indexation charged to operating expenses	1,615	5,214	0	0	0	0	0	0	6,829
Reversal of Impairments charged to operating expenses	(75)	(3,459)	0	0	0	0	0	0	(3,534)
Charged During the Year	0	4,209	25		2,708	7	891	71	7,911
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0						0
Accumulated Depreciation netted off following revaluation	(1,540)	(5,916)	(25)	0	0	0	0	0	(7,481)
At 31 March 2015	0	0	0	0	15,008	25	2,590	234	17,857
Net Book Value at 31 March 2015	18,976	102,509	570	28	8,184	7	3,015	465	133,754
Prior period adjustment	0	45	0	20	(920)	(1)	263	2	(591)
Revised Total at 31 March 2015	18,976	102,554	570	48	7,264	6	3,278	467	133,163
Asset financing:									
Owned - Purchased	20,598	75,233	570	320	7,318	14	3,059	417	107,529
Owned - Donated	1,400	6,911	0	832	758	0	6	34	9,941
Owned - Government Granted	0	0	0	0	0	0	0	0	0
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	13,765	0	0	0	0	0	0	13,765
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2015	21,998	95,909	570	1,152	8,076	14	3,065	451	131,235

15.3. Property, plant and equipment

Various donors have funded assets during the year, including League of Friends of all hospitals and the Northern Devon Healthcare Trust Charitable Fund.

All land and buildings are restated to current modern equivalent asset value using professional valuations in accordance with IAS16 every five years and in the intervening years by annual desk top exercise undertaken by the District Valuer, an arm of the Valuation Office, which is an executive agency of HM Revenue and Customs. A professional valuation from the District Valuer has been undertaken at the end of the year and the revaluation has been applied to all land and buildings. The District Valuer undertook a full revaluation on 31st March 2015 of all land and buildings and the next full valuation will be due in five years time. Asset values have overall increased this year by £1.5million.

Economic lives of PPE

	Min life Years	Max life Years
Buildings exc dwellings	2	75
Dwellings	5	38
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	3	5
Furniture and Fittings	10	10

16. Intangible non-current assets

16.1. Intangible non-current assets

2015-16	IT - in-house & 3rd party software £000's	Computer Licenses £000's	Licenses and Trademarks £000's	Patents £000's	Development Expenditure - Internally Generated £000's	Total £000's
Cost or valuation						
At 1 April 2015	0	2,734	1,524	0	1,962	6,220
Prior period adjustment	0	534	57	0	0	591
At 1 April 2015	0	3,268	1,581	0	1,962	6,811
Additions Purchased	0	20	251	0	2,359	2,630
Additions Internally Generated	0	0	0	0	0	0
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0
Additions - Purchases from Cash Donations and Government Grants	0	0	0	0	0	0
Additions Leased (including PFI/LIFT)	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	(28)	0	0	(28)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0
Impairments/reversals charged to reserves	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2016	0	3,288	1,804	0	4,321	9,413
Amortisation						
At 1 April 2015	0	1,580	895	0	59	2,534
Reclassifications	0	0	0	0	0	0
Reclassified as Held for Sale and Reversals	0	0	0	0	0	0
Disposals other than by sale	0	0	(28)	0	0	(28)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairment/reversals charged to reserves		0	0	0	0	0
Impairments/reversals charged to operating expenses	0	0	0	0	0	0
Charged During the Year	0	493	205	0	15	713
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2016	0	2,073	1,072	0	74	3,219
Net Book Value at 31 March 2016	0	1,215	732	0	4,247	6,194
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	0	1,215	732	0	4,247	6,194
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0
Total at 31 March 2016	0	1,215	732	0	4,247	6,194

Prior period adjustments relate to a reclassification of accruals from Plant and Machinery to other headings across note 15.1 and 16.1 which were made incorrectly at the end of 31st March 2015.

Revaluation reserve balance for intangible non-current assets

There is no revaluation reserve relating to Intangible Assets.

16.2. Intangible non-current assets prior year

2013-14	IT - in-house & 3rd party software £000s	Computer Licenses £000s	Licenses and Trademarks £000s	Patents £000s	Development Expenditure - Internally Generated £000s	Total £000s
Cost or valuation:						
At 1 April 2014	0	2,525	1,225	0	421	4,171
Additions - purchased	0	244	302	0	1,541	2,087
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Prior period adjustment	0	0	0	0	0	0
Revised Total at 31 March 2015	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(35)	(3)	0	0	(38)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2015	0	2,734	1,524	0	1,962	6,220
Amortisation						
At 1 April 2014	0	1,191	492	0	59	1,742
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	(35)	(3)	0	0	(38)
Upward revaluation/positive indexation	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	0	424	406	0	0	830
Transfer (to)/from Other Public Sector bodies under Absorption Accounting	0	0	0	0	0	0
At 31 March 2015	0	1,580	895	0	59	2,534
Net book value at 31 March 2015	0	1,154	629	0	1,903	3,686
Prior period adjustment	0	534	57	0	0	591
Revised Total at 31 March 2015	0	1,688	686	0	1,903	4,277
Asset Financing: Net book value at 31 March 2016 comprises:						
Purchased	0	1,154	629	0	1,903	3,686
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Finance Leased	0	0	0	0	0	0
On-balance Sheet PFIs	0	0	0	0	0	0
Total at 31 March 2015	0	1,154	629	0	1,903	3,686
Prior period adjustment	0	534	57	0	0	591
Revised Total at 31 March 2015	0	1,688	686	0	1,903	4,277

16.3. Intangible non-current assets

Intangible assets are carried at cost.

Economic lives of Intangible assets	Min life Years	Max life Years
Software Licences	5	5
Licences and trademarks	5	5

17. Analysis of impairments and reversals recognised in 2015-16

	2015-16 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	2,102
Total charged to Annually Managed Expenditure	2,102
Total Impairments of Property, Plant and Equipment charged to SoCI	2,102
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Intangibles charged to SoCI	0
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	0
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	0
Total Impairments of Financial Assets charged to SoCI	0
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	30
Total charged to Annually Managed Expenditure	30
Total impairments of non-current assets held for sale charged to SoCI	30
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	2,132
Overall Total Impairments	2,132
Donated and Gov Granted Assets, included above	
PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	(12)
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

17. Analysis of impairments and reversals recognised in 2015-16 (Continued)

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non- Current Assets Held for Sale	Total
	£000s	£000s	£000s	£000s	£000s
Impairments and reversals taken to SoCI					
Loss or damage resulting from normal operations	0	0	0	0	0
Over-specification of assets	0	0	0		
Abandonment of assets in the course of construction	0	0	0		0
Total charged to Departmental Expenditure Limit	0	0	0	0	0
Unforeseen obsolescence	0	0	0		0
Loss as a result of catastrophe	0	0	0	0	0
Other	0	0	0	0	0
Changes in market price	2,102	0	0	30	2,132
Total charged to Annually Managed Expenditure	2,102	0	0	30	2,132
Total Impairments of Property, Plant and Equipment changed to SoCI	2,102	0	0	30	2,132

Donated and Gov Granted Assets, included above

PPE - Donated and Government Granted Asset Impairments:
amount charged to SOCI - DEL

£000s

(12)

Intangibles - Donated and Government Granted Asset
Impairments: amount charged to SOCI - DEL

0

18. Investment property

The Trust has no investment property.

19. Commitments

19.1. Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2016	31 March 2015
	£000s	£000s
Property, plant and equipment	2,682	0
Intangible assets	0	0
Total	2,682	0

19.2. Other financial commitments

The trust has not entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

20. Intra-Government and other balances

	Current receivables £000s	Non-current receivables £000s	Current payables £000s	Non-current payables £000s
Balances with Other Central Government Bodies	346	0	2,551	0
Balances with Local Authorities	1,463	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	8	0
Balances with NHS bodies inside the Departmental Group	4,367	0	2,227	4,667
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with Bodies External to Government	2,780	971	15,253	10,065
At 31 March 2016	8,956	971	20,039	14,732
prior period:				
Balances with Other Central Government Bodies	9	0	4,696	0
Balances with Local Authorities	1,324	0	40	0
Balances with NHS bodies outside the Departmental Group	0	0	0	0
Balances with NHS Trusts and FTs	6,850	0	3,031	0
Balances with Public Corporations and Trading Funds	0	0	1,969	0
Balances with Bodies External to Government	4,057	983	11,359	8,320
At 31 March 2015	12,240	983	21,095	8,320

21. Inventories

	Drugs £000s	Consumables £000s	Work in Progress £000s	Energy £000s	Loan Equipment £000s	Other £000s	Total £000s	Of which held at NRV £000s
Balance at 1 April 2015	1,268	1,753	0	111	0	0	3,132	0
Additions	14,354	16,079	0	40	0	0	30,473	0
Inventories recognised as an expense in the period	(14,541)	(15,547)	0	(21)	0	0	(30,109)	0
Write-down of inventories (including losses)	0	0	0	0	0	0	0	0
Reversal of write-down previously taken to SOCI	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0
Balance at 31 March 2016	1,081	2,285	0	130	0	0	3,496	0

22.

22.1. Trade and other receivables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS receivables - revenue	4,365	6,820	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	0	0	0
Non-NHS receivables - revenue	2,169	2,600	1,243	1,222
Non-NHS receivables - capital	87	347	0	0
Non-NHS prepayments and accrued income	1,783	1,624	0	0
PDC Dividend prepaid to DH	0	30		
Provision for the impairment of receivables	0	(3)	(272)	(239)
VAT	259	685	0	0
Current/non-current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	293	137	0	0
Total	8,956	12,240	971	983
Total current and non current	9,927	13,223		
Included in NHS receivables are prepaid pension contributions:	0			

The great majority of trade is with NHS Clinical Commissioning Groups (CCGs). As CCG's are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

22.2. Receivables past their due date but not impaired

	31 March 2016 £000s	31 March 2015 £000s
By up to three months	22	546
By three to six months	43	50
By more than six months	2,279	263
Total	2,344	859

22.3. Provision for impairment of receivables

	31 March 2016 £000s	31 March 2015 £000s
Balance at 1 April 2015	(242)	(192)
Amount written off during the year	0	0
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(30)	(50)
Transfers to NHS Foundation Trust on authorisation as FT	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0
Balance at 31 March 2016	(272)	(242)

23. NHS LIFT investments

The Trust has no LIFT investments.

24.

24.1. Other financial assets – current

The Trust has no other financial assets to report.

24.2. Other financial assets – non-current

The Trust has no other financial non current assets to report.

25. Other current assets

The Trust has no other current assets to report.

26. Cash and cash equivalents

	31 March 2016 £000s	31 March 2015 £000s
Opening balance	2,450	3,602
Net change in year	(1,159)	(1,152)
Closing balance	1,291	2,450
Made up of		
Cash with Government Banking Service	1,279	2,438
Commercial banks	0	0
Cash in hand	12	12
Liquid deposits with NLF	0	0
Current investments	0	0
Cash and cash equivalents as in statement of financial position	1,291	2,450
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	1,291	2,450
Third Party Assets - Bank balance (not included above)	0	4
Third Party Assets - Monies on deposit	0	0

27. Non-current assets held for sale

94

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2015	293	552	0	0	0	0	0	0	0	0	845
Plus assets classified as held for sale in the year	0	17	0	0	0	0	0	0	0	0	17
Less assets sold in the year	(220)	(411)	0	0	0	0	0	0	0	0	(631)
Less impairment of assets held for sale	0	(30)	0	0	0	0	0	0	0	0	(30)
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2016	73	128	0	0	0	0	0	0	0	0	201
Liabilities associated with assets held for sale at 31 March 2016	0	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2014	0	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	293	554	0	0	0	8	0	0	0	0	847
Less assets sold in the year	0	0	0	0	0	(8)	0	0	0	0	0
Less impairment of assets held for sale	0	(2)	0	0	0	0	0	0	0	0	(2)
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2015	293	552	0	0	0	0	0	0	0	0	845
Liabilities associated with assets held for sale at 31 March 2015	0	0	0	0	0	0	0	0	0	0	0

A small number of equipment items were sold in the year.

During 2014-15, 3 sites were identified as surplus to requirements and have been made available for sale. Woodcotes at Crediton Hospital and property at Whipton Barton Road, Exeter were sold during the year. The Gardeners' Cottage at East Budleigh Road remains held for sale.

28. Trade and other payables

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
NHS payables - revenue	1,569	2,749	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	300	282	0	0
Non-NHS payables - revenue	11,113	9,577	0	0
Non-NHS payables - capital	133	1,047	0	0
Non-NHS accruals and deferred income	3,195	3,167	0	0
Social security costs	1,290	1,314		
PDC Dividend payable to DH	110	0		
Accrued Interest on DH Loans	8			
VAT	0	0	0	0
Tax	1,261	1,372		
Payments received on account	0	0	0	0
Plus assets classified as held for sale in the year	363	1,295	0	0
Total	19,342	20,803	0	0
Total payables (current and non-current)	19,342	20,803		
Included above:				
to Buy Out the Liability for Early Retirements Over 5 Years	0	0		
number of Cases Involved (number)	0	0		
outstanding Pension Contributions at the year end	2,044	2,008		

29. Other liabilities

The Trust has no other liabilities to report.

30. Borrowings

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Bank overdraft - Government Banking Service	0	0		
Bank overdraft - commercial banks	0	0		
Loans from Department of Health	0	0	4,667	0
Loans from other entities	0	0	0	0
PFI liabilities:				
Main liability	341	292	7,980	8,320
Lifecycle replacement received in advance	0	0	0	0
LIFT liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	0	0	0	0
Other (SALIX loan)	356	0	2,085	0
Total	697	292	14,732	8,320
Total borrowings (current and non-current)	15,429	8,612		

The Trust has no other financial liabilities to report.

Borrowings / Loans - repayment of principal falling due in:

	31 March 2016		
	DH £000s	Other £000s	Total £000s
0-1 Years	0	697	697
1 - 2 Years	0	1,053	1,053
2 - 5 Years	0	1,990	1,990
Over 5 Years	4,667	7,022	11,689
TOTAL	4,667	10,762	15,429

31. Other financial liabilities

The Trust has no other financial liabilities to report.

32. Deferred income

	Current		Non-current	
	31 March 2016 £000s	31 March 2015 £000s	31 March 2016 £000s	31 March 2015 £000s
Opening balance at 1 April 2015	832	944	0	0
Deferred revenue addition	1,953	716	0	0
Transfer of deferred revenue	(1,497)	(828)	0	0
Current deferred Income at 31 March 2016	1,288	832	0	0
Total deferred income (current and non-current)	1,288	832		

33. Finance lease obligations as lessee

The Trust has no current lease obligations as a lessee.

34. Finance lease receivables as lessor

The Trust has no current lease obligations as a lessor.

35. Provisions

	Total £000s	Comprising: Early Departure Costs £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay (incl. Agenda for Change) £000s	Other £000s	Redundancy £000s
Balance at 1 April 2015	89	0	89	0	0	0	466	0
Arising during the year	35	0	35	0	0	0	0	0
Utilised during the year	(34)	0	(34)	0	0	0	0	0
Reversed unused	(30)	0	(30)	0	0	0	(466)	0
Unwinding of discount	0	0	0	0	0	0	0	0
Change in discount rate	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts on being authorised as FT	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies under absorption accounting	0	0	0	0	0	0	0	0
Balance at 31 March 2016	60	0	60	0	0	0	0	0
Expected Timing of Cash Flows:								
No Later than One Year	30	0	30	0	0	0	0	0
Later than One Year and not later than Five Years	30	0	30	0	0	0	0	0
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at 31 March 2016

60,977

As at 31 March 2015

33,370

Legal claims relates to provisions for the member's excess due in Employer Liability cases as notified by the NHS Litigation Authority.

The provision reflects the excess due by the Trust since the NHS Litigation Authority make the majority of the payments and recharge the Trust in due course. The associated contingent liability is in note 36 below.

36. Contingencies

	31 March 2016 £000s	31 March 2015 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	(16)	0
Employment Tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	(48)
Net value of contingent liabilities	(16)	(48)
Contingent assets		
Contingent assets	0	0
Net value of contingent assets	0	0

37. PFI and LIFT - additional information

The information below is required by the Department of Health for inclusion in national statutory accounts.

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI	2014-16 £000s	2013-15 £000s
Total charge to operating expenses in year - Off SoFP PFI	0	0
Service element of on SOFP PFI charged to operating expenses in year	394	371
Total	394	371

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI	2014-16 £000s	2013-15 £000s
No Later than One Year	345	337
Later than One Year, No Later than Five Years	354	1,434
Later than Five Years	5,642	6,022
Total	6,341	7,793

Plus assets classified as held for sale in the year.

Imputed "finance lease" obligations for on SOFP PFI contracts due	2014-16 £000s	2013-15 £000s
No Later than One Year	969	942
Later than One Year, No Later than Five Years	3,248	3,416
Later than Five Years	11,574	12,375
Subtotal	15,791	16,733
Less: Interest Element	(7,470)	(8,120)
Total	8,321	8,613

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	2014-16 £000s	2013-15 £000s
No Later than One Year	341	292
Later than One Year, No Later than Five Years	958	1,047
Later than Five Years	7,022	7,274
Total	8,321	8,613

Number of on SOFP PFI Contracts

Total Number of on PFI contracts	1	1
Number of on PFI contracts which individually have a total commitments value in excess of £500m	0	0

Number of off SOFP PFI Contracts

Total Number of off PFI contracts	0	0
Number of off PFI contracts which individually have a total commitments value in excess of £500m	0	0

38. Impact of IFRS treatment - current year

	2015-16 Income	Expenditure	2014-15 Income	Expenditure
The information below is required by the Department of Health for budget reconciliation purposes	£000s	£000s	£000s	£000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)				
Depreciation charges		357		337
Interest Expense		1,043		1,055
Impairment charge - AME		0		0
Impairment charge - DEL		0		0
Other Expenditure		394		382
Revenue Receivable from subleasing	(638)		(633)	
Impact on PDC dividend payable		235		153
Total IFRS Expenditure (IFRIC12)	(638)	2,029	(633)	1,927
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		928		996
Net IFRS change (IFRIC12)		463		298
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
Capital expenditure 2015-16		0		0
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		170		164

	2015-16 Income/ Expenditure IFRIC 12 YTD £000s	2015-16 Income/ Expenditure ESA 10 YTD £000s
Revenue costs of IFRS12 compared with ESA10		
Depreciation charges	357	
Interest Expense	1,043	
Impairment charge - AME	0	
Impairment charge - DEL	0	
Other Expenditure		
Service Charge	394	1566
Contingent Rent	0	
Lifecycle	0	
Impact on PDC Dividend Payable	235	
Total Revenue Cost under IFRIC12 vs ESA10	2,029	1,566
Revenue Receivable from subleasing	(638)	(638)
Net Revenue Cost/(income) under IDRIC12 vs ESA10	1,391	928

39. Financial Instruments

39.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with the CCG and the way those CCG'S are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trusts treasury activity is subject to review by the Trusts's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2016 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament. The Trusts funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

39.2. Financial assets

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0			0
Receivables - NHS		4,365		4,365
Receivables - non-NHS		2,198		2,198
Cash at bank and in hand		1,291		1,291
Other financial assets	0	0	0	0
Total at 31 March 2016	0	7,854	0	7,854
Embedded derivatives	0			0
Receivables - NHS		6,789		6,789
Receivables - non-NHS		2,594		2,594
Cash at bank and in hand		2,450		2,450
Other financial assets	0	2,575	0	2,575
Total at 31 March 2015	0	14,408	0	14,408

39.3. Financial liabilities

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0		0
NHS payables		1,678	1,678
Non-NHS payables		8,931	8,931
Other borrowings		8,108	8,108
PFI & finance lease obligations		8,321	8,321
Other financial liabilities	0	1,947	1,947
Total at 31 March 2016	0	28,985	28,985
Embedded derivatives	0		0
NHS payables		2,732	2,732
Non-NHS payables		6,600	6,600
Other borrowings		0	0
PFI & finance lease obligations		8,612	8,612
Other financial liabilities	0	9,603	9,603
Total at 31 March 2015	0	27,547	27,547

40. Events after the end of the reporting period

The Trust's NEW Devon CCG contract for a range of community services is planned to cease during the financial year ending 31st March 2017. On transfer services and staff will transfer to the Royal Devon and Exeter Foundation Trust (RD&EFT).

The estimated annual financial reduction in income will be approximately £52m with a matched reduction in expenditure.

Property will be transferring to NHS Property Services and other assets will transfer to RD&EFT, with a total asset reduction of £66m. The due diligence process for the transfer is currently ongoing.

41. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Devon Healthcare NHS Trust.

The Department of Health is regarded as a related party. During the year Northern Devon Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

NEW Devon CCG	Royal Devon & Exeter NHS Foundation Trust
NHS England and Local Area Teams	South Devon Healthcare Foundation Trust
Kernow CCG	South West Ambulance Service NHS Foundation Trust
NHS South Devon and Torbay CCG	North Bristol NHS Trust
NHS Litigation Authority	Devon Partnership Trust
NHS Supplies Authority	NHS Professionals
NHS Pensions Agency	National Blood Authority
Northern Devon Healthcare Trust Charitable Fund	

In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

- ▶ Devon County Council in respect of Public Health Services;
- ▶ North Devon Council in respect of business rates;
- ▶ Inland Revenue in respect of tax and national insurance; and
- ▶ HMRC in respect of VAT payable and recoverable.

42. Losses and special payments

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	12,813	60
Special payments	47,198	28
Total losses and special payments	60,011	88

The total number of losses cases in 2014-15 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	14,053	23
Special payments	34512	27
Total losses and special payments	48,565	50

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

43.1. Breakeven performance

Not relevant for trust.

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Turnover	89,547	118,418	128,855	128,509	134,710	211,041	220,680	225,787	234,685	233,235
Retained surplus/(deficit) for the year	(6,924)	7,602	7,902	(5,086)	(93)	(5,724)	(1,052)	1,141	714	(7,671)
Adjustment for:										
Timing/non-cash impacting distortions:										
Pre FDL(97)24 agreements	0	0	0	0	0	0	0	0	0	0
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0								
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0	5,086	345	7,328	3,288	1,340	3,297	2,132
Adjustments for impairments						92	(53)	(408)	(1,972)	429
Adjustments for impact of policy change re donated/government grants assets										
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	23	22	167	298	463
Absorption accounting adjustment							0	0	0	0
Other agreed adjustments	0	0	0	0	0	0	0	0	0	0
Break-even in-year position	(6,924)	7,602	7,902	0	252	1,719	2,205	2,240	2,337	(4,647)
Break-even cumulative position	(15,253)	(7,651)	251	251	503	2,222	4,427	6,667	9,004	4,357

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07	2007-08	2008-09	2009-10	2010-11	2011-12	2012-13	2013-14	2014-15	2015-16
	%	%	%	%	%	%	%	%	%	%
Materiality test (i.e. is it equal to or less than 0.5%):										
Break-even in-year position as a percentage of turnover	-7.73	6.42	6.13	0.00	0.19	0.81	1.00	0.99	1.00	-1.99
Break-even cumulative position as a percentage of turnover	-17.03	-6.46	0.19	0.20	0.37	1.05	2.01	2.95	3.84	1.87

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have not been restated to IFRS and remain on a UK GAAP basis.

43.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2015-16 £000s	2014-15 £000s
External financing limit (EFL)	5,711	1,825
Cash flow financing	5,675	1,315
Finance leases taken out in the year	0	0
Other capital receipts	0	0
External financing requirement	5,675	1,315
Under/(over) spend against EFL	36	510

43.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2015-16 £000s	2014-15 £000s
Gross capital expenditure	10,475	14,452
Less: book value of assets disposed of	(638)	0
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(132)	(2,531)
Charge against the capital resource limit	9,705	11,921
Capital resource limit	9,725	11,923
(Over)/underspend against the capital resource limit	20	2

44. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2016 £000s	31 March 2015 £000s
Third party assets held by the Trust	0	4

Northern Devon Healthcare NHS Trust
Raleigh Park
Barnstaple
Devon
EX31 4JB

t. 01271 322577

e. ndht.contactus@nhs.net

w. www.northdevonhealth.nhs.net