

Compassion

Excellence

Annual Report

Integrity

Support

Diversity

2012/13

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Introduction

Welcome to our annual report for 2012/13, which sets out progress in our continuing drive to improve care for the people we serve.

Over the last 12 months, we have completed a systematic review of our governance arrangements. This is to ensure that we can demonstrate to the taxpayers, our regulators and our patients that we operate effectively, understand our risks and deliver high-quality care.

This review was commissioned both in response to the Francis report into failings at Mid Staffordshire NHS Foundation Trust and as part of our own NHS Foundation Trust application.

Where our systems were strong, they are now stronger. Where there were gaps, we have addressed them.

The Board receives a tremendous amount of data about its services, which allows us to maintain a keen oversight of the quality of care being delivered to patients. Care Quality Commission inspection reports, complaints, Patient-Led Assessments of Clinical Environments (PLACE), the patient safety walkabouts, the real-time patient experience data and our own staff feedback are all used to assess the quality of services.

We ensure as much data, decision-making and feedback as possible is reported publicly, taking to heart the duty of candour that was a recommendation from the Francis report. You will see examples of this in most of our corporate materials, from the 'being open' priority of the Quality Account, to the steadily-increasing amount of data being reported monthly on our website.

Taking meaning from the data has been another key priority of ours as we set the clinical and the performance data against what we know from patient and staff feedback through complaints and incident forms. Through this triangulation we have been able to expose areas of concern that needed immediate attention, and are proud that this ensures the Board can listen to the front line.

We are frequently tested on the quality of our services and you will read how well we responded to these tests throughout this annual report.

Over the last year, we had a big drive on patient documentation and clinical supervision, to reinforce their importance as fundamental to high-quality care.


You will read about our achievements in controlling infections within our hospitals – both MRSA and Clostridium Difficile. You will also read that NDDH was ranked 11th in the country in terms of meeting the standards of care that most mattered to patients (see page 11). We also worked with our partners and commissioners to trial new models of healthcare in our communities that see us leading the way in integrating care and fulfilling our vision of supporting people to live independently in their own homes.

All of this would not have been possible without the dedication and determination of our staff. Nothing typified the demands that are placed on our NHS staff more than our experiences over the 2012 winter. Staff pulled out all the stops to ensure continuity of care for patients during periods of unprecedented demand. We know from the letters we receive every week from patients, their friends and families, that we speak for many when we express our gratitude to our NHS staff for their hard work and compassion.

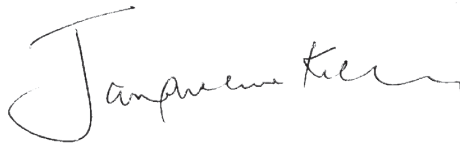
Looking forward to the coming year, we, along with all other NHS organisations, face the challenge of transforming services to ensure that we are ready to meet the changing demographics of our population whilst dealing with very constrained budgets. This will require the redesign of many services across northern and eastern Devon, and will involve many of our local communities to work in partnership and as critical friends with us as we consider how best to provide services which are sustainable, as well as providing equity of access and value for money.

We are also looking forward to working with our primary commissioners, Devon County Council and Northern, Eastern and Western Devon Clinical Commissioning Group, to develop and implement our shared vision for the future pattern and provision of community services across northern and eastern Devon.

We commit to sharing our ideas as they evolve, so you, as part of the community we serve, can play a full part in helping to shape local NHS care for the future.



Roger French
Chair



Jac Kelly
Chief Executive

What we do

Northern Devon Healthcare NHS Trust operates across 1,300 square miles, providing care for people from Axminster to Bude and from Exmouth to Lynton.

The Trust offers both acute services, centred on North Devon District Hospital (NDDH), and community services, which span a network of 17 community hospitals and nine clusters, across Torridge, North Devon, East Devon, Exeter, Mid Devon, Teignbridge and West Devon.



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

Integration - a 'joined up' approach – is essential to this way of working. The Trust was one of the first in England to integrate acute and community healthcare services, in 2006, adding adult community health and social care services in 2008.

At that stage, the Trust covered only northern Devon. However, the success at integrating care laid the groundwork for the transfer to the Trust of an additional 12 community hospitals and complex care teams, and all of the pan-Devon specialist community services, in April 2011.

At any one time, the Trust supports 6,000 patients in their own homes and 600 people in hospital beds. It employs more than 4,300 staff and serves a population of around 484,000, with a budget of £209 million.

From its headquarters in Barnstaple, the Trust is responsible for the management of, and services provided from, the following bases:

North Devon District Hospital, Barnstaple

In 2012/13, staff at North Devon District Hospital treated 46,237 inpatients, saw 192,949 outpatients and delivered 1,626 babies.

The populations of Torridge and North Devon account for 94 per cent of patients to North Devon District Hospital, with the remaining six per cent either residents from the Cornish and Somerset borders or tourists to the area.

North Devon District Hospital provides a 24/7 accident and emergency service. It was designated early in 2012 as a trauma unit within a trauma network serving the whole of Devon and Cornwall.

The Trust offers a range of general medical services including cardio-respiratory, stroke care and gastro-enterology. General surgical services include orthopaedics, vascular and colorectal specialties. NDDH is recognised by the Royal College of Surgeons as having some of the best (gold-standard) equipment available in the NHS.

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

The Trust has a strategy to repatriate appropriate services to northern Devon to meet the needs of the local community, so fewer people have to travel out of the area for treatment. Wet, age-related macular degeneration is one real success story as we brought the service to NDDH from South Devon. The team at NDDH now secures some of the best outcomes for eye patients in the South West.

The Trust offers patients a choice of local, specialist services and invites consultants from other neighbouring trusts to hold clinics in the area. The Trust works with Taunton on a vascular network, Derriford on a neonatal network and Royal Devon & Exeter (RD&E) on a cancer network.

As well as acute and community services, the Trust has a range of intermediary services which aim to control and facilitate the flow of patients to and from the acute hospital. The pathfinder team at NDDH and the onward care team at the RD&E organise timely and safe discharges for patients who require ongoing care or support after leaving hospital.

Community hospitals and resource centres

The Trust's 17 community hospitals provide local hubs of healthcare for their communities and a range of services that are easily accessible to the local population, including approximately 300 inpatient beds; the Trust actively flexes bed numbers up and down according to demand. In addition to the inpatient beds, we use these hubs as bases for rehabilitation and outpatient clinics with consultants visiting from NDDH and from hospitals in Exeter, Taunton or Plymouth.

Some hospitals also offer specialist services such as minor injury units and/or stroke rehabilitation and renal care.

The resource centres in Barnstaple and Lynton provide local residents with a range of local outpatient and self-referring services, such as family planning clinics.





Community teams

The role of the complex care teams is to provide local services which rehabilitate patients and promote their independence. The teams support 6,000 patients at any one time to live independently in their own homes.

The Trust's community nursing and therapy services are aligned into 17 complex care teams working across Exeter, east, mid and northern Devon. They provide integrated health and social care to support patients to live independently at home.

The teams serve those patients who need regular support from skilled professionals, including community nurses, social workers, physiotherapists, occupational therapists and community matrons.

Patients with long-term conditions, such as chronic obstructive pulmonary disease (COPD) or diabetes, or those who need rehabilitation following surgery, an illness or discharge from hospital, benefit from the support of these teams in their own homes.

Northern Devon Healthcare NHS Trust was one of the first in the country to launch these integrated teams, breaking down boundaries between different agencies so that patients don't get passed from one agency to the other.

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 do not require an appointment and are managed by specialist nurses who can provide treatment for minor injuries or illnesses such as sprains, cuts and minor infections.

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

Foundation Trust update

The Trust’s application to become an NHS Foundation Trust is now well under way. Some 5,000 residents of Exeter, north, east and mid Devon, as well as residents of Cornwall, Plymouth and Somerset, have signed up to support us as members.

We expect to be authorised as an NHS Foundation Trust in 2014.

Being a member of the Trust gives people a way of getting involved and having a say, with the chance to make a real difference to the way in which the Trust operates.

Local people and staff are eligible to become members of the Trust and take an active part in shaping the future. Members can do as much or as little as they want, from simply receiving information to attending focus groups.

Members are kept informed of developments within the Trust and their feedback will help shape Trust strategies.

There is an online application form on the Trust’s website (www.northdevonhealth.nhs.uk/ft) for anyone interested in becoming a member, or they can telephone the membership office on 01271 313971 for an application form to be sent in the post.

What does being a member involve?

Greater involvement, more say, better understanding.... Being a member really does make a difference.

Being a member is a way of supporting your local NHS services, getting involved, finding out more and helping to shape plans for the future.

The main benefit of being a member is that you can make your voice heard.

You can do as much or as little as you want, from receiving regular newsletters to being part of a focus group, or be a volunteer. It’s free to join (you don’t even need a stamp!).

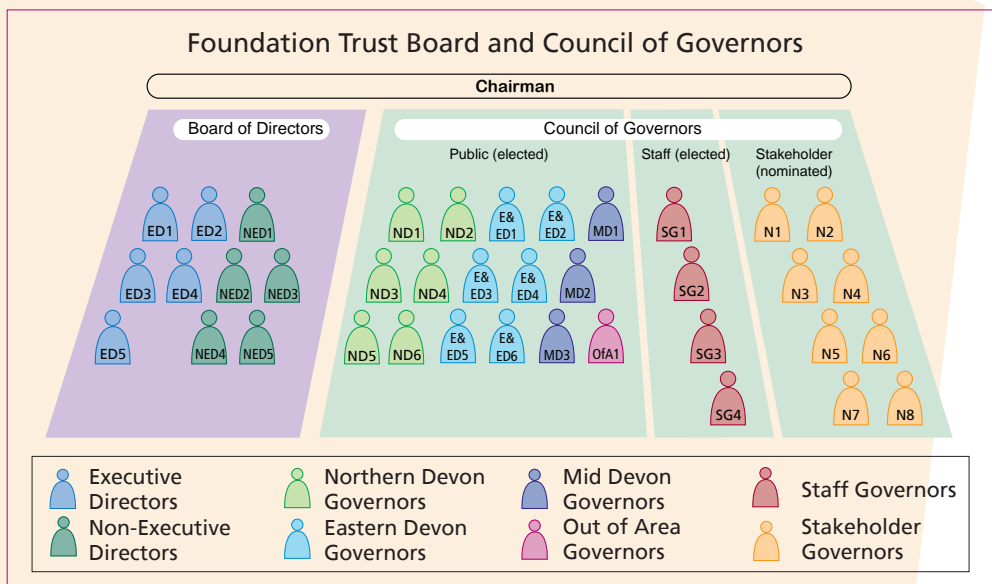
What is the role of Governors and the Council of Governors?

Be the voice of patients, carers, the public and stakeholders....

Governors are elected by members or nominated by some of our stakeholders and partners.

The Council of Governors is responsible for representing the interests and views of members and supporting the NHS Foundation Trust fulfil its duties.

The Council advises and influences on how the Trust develops to meet the needs of local people in the future.



Quality



We believe that if we live the values of the organisation, then we can be confident of providing the highest possible care to our patients.

Our values are:

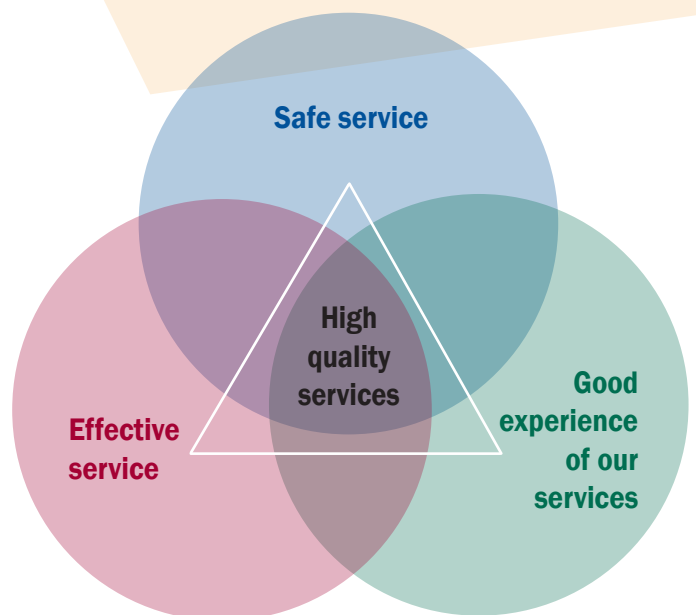
- Compassion
- Excellence
- Integrity
- Diversity
- Support

High-quality care consists of three components:

1. Our services are **safe**. We keep our patients free from avoidable harm or infection
2. The care we provide is **effective**. We provide good clinical outcomes for patients
3. The **experience** of patients meets their expectations. We explain what is going to happen and treat them with compassion and respect at all times

These dimensions help patients and healthcare staff understand how each element contributes to providing a high quality service to patients.

We have used these dimensions to structure this annual report.



Over the past year the Trust has made very good progress in a number of key areas to improve the quality of service offered to patients, namely:

- Making access to NDDH quicker and easier
- Enhancing and developing community services
- Increasing the amount of day case surgery so that patients are able to go home from hospital sooner
- Making significant progress in reducing avoidable harm and virtually eliminating the likelihood of patients catching MRSA in our hospitals
- Launching the Friends and Family Test to ask patients for immediate and honest feedback (see page 29)

These improvements made a huge difference to the experience and outcomes for patients using Trust services last year.

The Trust is proud of its achievements over the past year and hopes to build on them as the year progresses.

More information on our specific priorities for improving the quality of care can be found in the Trust's Quality Account, published annually.

The Trust's strategy for the next five years outlines the required fundamental redesign of services as we move care away from hospital settings and into community settings and patients' homes.

This transformation ensures that our services are ready for an increasing number of patients as the population ages, and remain value for money for the taxpayer.

This vision is shared by our commissioner, the Northern, Eastern and Western Devon Clinical Commissioning Group.

Where services are retained in hospitals, they must be delivered to the highest possible standards and be sustainable for future generations.

In January 2013, the Board was alerted to reports that the inpatient service provided at Moretonhampstead Community Hospital was not

consistently meeting the required standards of quality. The Board took the decision to temporarily close the inpatient beds until such time as we have tackled the patient safety and quality issues, and recruited sufficient staff to provide inpatient care at the hospital.

The decision centred on concerns over the limited opportunity for Moretonhampstead staff to maintain core clinical skills when they deal with so few patients – concerns that were also shared by the Care Quality Commission following an inspection in 2012.

Understandably, the decision caused concern amongst the local community and we have been working closely with local residents to keep them informed of our progress and ensuring they understand the reasons for the closure.

During the period of temporary closure, the Trust completed a number of key actions to address the safety and quality issues. For example:

- An on-site safety review was carried out by senior Trust clinicians
- The Trust recruited a new Band 7 team leader for the Moretonhampstead and Okehampton hospital cluster
- All staff in the Moretonhampstead and Okehampton cluster agreed to work in shifts which rotate between both hospitals, giving them greater experience of working with a larger number of patients
- The Trust launched a development programme with staff to assess and support training and skills

Other key actions were also being addressed, including the recruitment of sufficient registered nurses.

We remain committed to delivering high-quality care for our patients and will continue to take decisions that are in the best, long-term interests for patients.

End-of-year performance dashboard

In March 2013, MHP Health Mandate ranked all English NHS Trusts according to factors that were most important to patients.

The Northern Devon Healthcare NHS Trust was ranked 11th out of 146 trusts with a score of 7.28 in a report called the Quality Index. The report is the first-ever overall assessment of NHS hospital quality in England, and ranked trusts on 10 different indicators based on what patients said was most important to them.

The report found that of the 10 indicators, patient experience and waiting times matter most to the public. In a poll of the British public conducted by ComRes, nearly one quarter (23%) of respondents said the factor they considered to be most important when deciding which hospital to choose for an operation was the number of patients who said they had had a good experience of care at the hospital. One fifth of respondents (20%) placed greatest importance on how long they would have to wait for an operation.

The 10 factors on which trusts were judged and which were considered to have an impact on a person's choice of services were:

1. Risk of getting an infection from the hospital
2. The rate of recent (written) patient complaints about the hospital
3. The chance of your operation being cancelled at short notice
4. The number of patients who said they got better after being treated in hospital
5. The number of patients who said they had a good experience of care
6. Whether you would have to share a sleeping area or bathroom with someone of the opposite sex
7. How long you would have to wait for an operation
8. The risk you would be harmed during treatment
9. If you were involved in decisions about your care
10. The number of staff at the hospital who would recommend it to family and friends

Jac Kelly, chief executive of the Trust, said: "We are delighted that the excellent standard and quality of care that our Trust provides corresponds directly to what is most important to patients. Our staff are incredibly dedicated and the fact that their hard work has been recognised nationally is testament to their ongoing commitment and expertise.

"I am very proud of our success and am looking forward to building upon it throughout the coming year."

TV and rugby star opens new children's unit at NDDH

TV and rugby personality Matt Dawson performed the official opening of the new children's unit at NDDH in July last year.

Matt cut the ribbon at the children's unit before touring the ward to speak to patients and give out goody bags.

The state-of-the-art children's unit brings together Caroline Thorpe Ward and the Special Care Baby Unit (SCBU).

It includes a purpose-built children's assessment unit and high-dependency unit, a cardiac monitoring system, school, play and overnight family rooms, improved facilities for parents and a new resource room for doctor training.

The move represented the latest phase of a £1million project to bring together services for women, babies and children in the Ladywell Unit.

Jac Kelly, the Trust's chief executive, said: "We are delighted that Matt Dawson agreed to officially open our new children's unit, which will offer great benefits to families across North Devon.

"The unit provides a safe, modern and bright environment and features a number of facilities that will significantly enhance the experience of patients, their families and staff.

"With services for women, babies and children now housed under one roof, it will allow staff to share skills and best practice and help us achieve our long-term goal of improving quality of care for all patients."

Sidmouth Hospital set for £1.2million refurbishment

Plans to inject £1.2million into Sidmouth Hospital and transform it into a modern healthcare hub were unveiled in November 2012.

The Trust has been working on the plans with the Comforts Fund, the hospital's League of Friends. Under the proposals, the hospital will have a new physiotherapy department, rehabilitation unit and gym area as well as an improved front entrance, reception and waiting room.

Work was due to start in June 2013 and be completed by the summer of 2014.

It represents the fifth and final phase of a 23-year-old programme to upgrade the hospital.

Matron Emma Bagwell said: "This project sees the transition of Sidmouth from a cottage hospital into a vibrant, modern and professional hub of community health and social care.

"This is an exciting time for everyone involved in the project and the local community we serve – our patients will be the real winners."





Photo courtesy of Terry Ife, Sidmouth Herald.

Seaton home nursing team wins Healthcare Hero Awards

The Seaton home nursing team was named the winner of the Trust's first ever Healthcare Hero Awards.

Helen Wellstead, Caroline Shuttleworth, Eliz Livingstone and Caitlin Bodington received more than 20 nominations from people who were keen to tell us how the team had touched their lives.

The quartet offer shelter to patients and their families in and around Seaton who are experiencing the effects of a life-limiting illness.

They were described as 'Angels of Mercy' by some people and were widely praised for being kind, supportive, compassionate, understanding and knowledgeable.

The awards gave the public the opportunity to vote for any employee of the Trust – no matter what their job role – who had gone beyond the call of duty and made a positive impact on their lives.

Jac Kelly, chief executive, said: "We were overwhelmed by the nominations for the Seaton home nursing team – not just the amount but the heartwarming stories that accompanied them.

"They are very worthy winners and clearly live up to the title of Healthcare Hero to a number of patients and their families in East Devon."

The judging panel also announced a runner-up – Honiton community matron Becky Garnsworthy – while seven nominees were commended.

Clinical effectiveness

– How the Trust has developed its services to meet patient needs

Trust plays a leading role in the newly formed Academic Health Science Networks

Jac Kelly, chief executive of the Northern Devon Healthcare NHS Trust, is a member of the Board of the South West Peninsula Academic Health Science Network (AHSN).

The South West Peninsula AHSN is one of 15 designated across England with the task of bringing together the wealth of experience, knowledge and skills in the region to improve the health and wellbeing of the 2.2 million people living in Somerset, Devon, Cornwall and the Isles of Scilly.

Chairman Dr Andrew Vallance-Owen said: "Creation of this network presents a unique opportunity to pull together the inspiring and cutting-edge innovation and research in pockets across our region so that knowledge, skills and best clinical practice can be shared and adopted across the peninsula.

"Building on the successful partnerships within our region, we want to strengthen links with industry and develop a more systematic way of advancing health treatments, technologies, medicines and clinical care.

"The AHSN will provide an important mechanism for achieving a step-change in the way the NHS translates research and innovation into both best practice and cost-effective treatments and services for patients. We will also be promoting greater participation of patients in health research.

"Creation of this AHSN has been achieved by unprecedented high levels of co-operation between health organisations across the region and the universities in Exeter and Plymouth.

"We will also want to foster closer links with industry to be more effective at generating positive local economic benefits from research and innovation in health."

Development of AHSNs was recommended in the report 'Innovation, Health and Wealth' by NHS England Chief Executive Sir David Nicholson in December 2011. Sir David said: "The NHS is full of brilliant people with brilliant ideas. To spread ideas right across the NHS means working collaboratively with all those who have an interest."

Earl Howe, Health Minister, said: "Britain is one of the best research centres in the world and it is important that we harness the skills and creativity in this sector to really improve the lives of those who use the NHS. The new AHSNs will help us develop better technology and make better use of the skills of NHS staff. They will also help us get in a better position to tackle the changing needs of our population and ensure patients get the care they deserve."

The AHSNs are licensed and funded by NHS England. More information about the AHSN can be viewed at: www.swpahsn.co.uk

Mortality rates

Mortality ratios/indices are a very useful clinical tool for spotting areas of concern and scrutinising whether there is an underlying safety issue at hospital or ward level, or with regards to a particular clinician or team. Whilst it does not tell you where the area of concern is, mortality data is a useful early-warning indicator of possible concerns with health services.

All the national mortality ratios and indices for the Trust aggregate the data for NDDH and the 17 community hospitals, despite being very different clinical environments.

The Trust Board scrutinises mortality data every month and in October and December 2010 we noticed a trend which gave us cause for concern. This trend continued into January 2011 and the Medical Director immediately launched an investigation into what was causing the apparent rise in our mortality rates.

There were several strands to the investigation and our Trust's approach was to prioritise effort in the areas which posed the greatest potential harm to patients.

Two hundred sets of patient case notes were peer reviewed by senior consultants across acute and community. No areas of obvious concern were identified.

Mortality data is an index or ratio of several factors about clinical care and outcomes. Our patient safety strategy was to focus on the most likely causes of a higher mortality ratio – those areas where avoidable harm could be prevented. We took considerable action to ensure that there were no underlying clinical concerns.

The actions we took have combined to reduce our mortality rate; the rolling 12-month measure continues on a downward trajectory month by month.

Alison Diamond, medical director, said, "We continue to provide safe, high-quality healthcare, and this is proved by a range of measures.

"Our mortality rates are within the expected range according to the Summary Hospital-level Mortality Indicator (SHMI), the Department of Health's preferred measure. More people do not die in our hospitals.

"We are one of very few Trusts in the country with such a noticeable difference between SHMI and HSMR figures. This is because most Trusts only run acute hospitals, whereas we manage the acute North Devon District Hospital as well as 17 community hospitals.

"Community hospitals look after a larger proportion of patients at the end of their lives, so a higher mortality rate is to be expected.

"I would like to reassure the public that we have closely examined huge amounts of clinical information, including about 200 sets of patient notes, and have found no major cause for concern."

Supporting good communication skills across integrated services

Northern Devon Healthcare NHS Trust provides integrated care across a range of acute, community health settings and in the patient's own home.

This makes communication between healthcare professionals critical to the continuity of care for our patients as they cross between hospitals, communities and home.

We focus a great deal of effort on ensuring that all our staff and partners (such as GPs) meet the required standards of communication when discussing patients, providing advice to clinical teams or handing over patients either to another care setting or to another clinician.

The first area of focus was on SBAR

We use a technique called SBAR, which is an easy-to-remember mechanism used widely in medical environments to frame conversations requiring a clinician's immediate attention and action.

SBAR stands for:

- S** – Situation: What is happening at the present time?
- B** – Background: What are the circumstances leading up to this situation?
- A** – Assessment: What is the problem?
- R** – Recommendation: What should we do to correct the problem?

SBAR helps to prevent breakdowns in communication by creating a shared 'mental model' around all patient handovers and situations requiring escalation or critical exchange of information

Using SBAR helps to ensure effective escalation and increased patient safety.

The second area of focus was early warning scores

In a similar theme to SBAR, we also focus on supporting clinicians to identify acute illness in patients, consistently.

Again, one of the successful features of integrated health services is the use of a common language between primary care, community and acute clinicians. The early warning score (EWS) is a very simple score assigned to certain physiological observations that are already routinely undertaken when patients come to, or are being monitored in, hospital.

The national EWS was introduced by the Royal College of Physicians. The scoring system is made up of six simple physiological observations:

- Respiratory rate
- Oxygen saturations
- Temperature
- Systolic blood pressure
- Pulse rate
- Level of consciousness

A score is allocated to each as they are measured, with greater scores reflecting the potential for acute illness in the patient in our care. The score for all six measurements is then combined, to provide an overall early warning score for the patient.

The score then dictates the appropriate clinical action required and also defines how often the patient needs the observations checked, at two hours, six hours or 12 hours.

Shorter recovery time for patients through enhanced recovery programme

During 2012/13, NDDH saw a dramatic reduction in the average length of stay for patients undergoing knee and hip replacements.

The improvements have come as a result of the launch of the enhanced recovery programme, where patients take an active role in their own recovery process.

Fitter and better-educated about their condition, patients can recover faster from major surgery.

The hospital has set up a joint school: a therapy-led, pre-op session where patients can learn techniques for using crutches, sitting and other practical issues they will face following surgery.

Staff at the Trust have written an 80-page patient guide for knee and hip replacements, which was published last summer.

The handbook includes information about preparing for an operation, what to expect from a hospital stay and how to deal with the after-effects of surgery, as well as contact details if a patient has any concerns.

Gillian Taylor, the Trust's service manager, said: "The multi-disciplinary team has reviewed the whole patient pathway, developing clear, concise and consistent high-quality information for patients.

"The results over the last 12 months are outstanding and are testament to the commitment of a team who have placed the patient at the centre of the whole process."

Within 12 months, the average length of stay for patients having a knee replacement had dropped from 5.9 days to 3.8 days.

This compares with a national average of 5.5 days and puts the Trust in the top 25 per cent of trusts in the country.

There is a similar improvement for patients undergoing a hip replacement: they can expect to stay over one day less in hospital, as we have reduced the length of stay from six days to 4.9 within the last 12 months.

Innovative 'telehealth' support system for people with Chronic Obstructive Pulmonary Disease

In October 2012, in conjunction with local GPs and NHS Devon, the Trust launched a remote support service for patients with Chronic Obstructive Pulmonary Disease (COPD) called Telehealth.

Telehealth is used across the NHS to monitor and manage people's conditions remotely. It means that community respiratory nursing teams can provide treatment and care to patients at home.

Patient Chris Axford with Lesley Parsons, lead nurse for the respiratory service



Patients with a long-term condition take their daily health readings, such as oxygen levels, and transmit them to a clinician.

Trials undertaken in other parts of the country show that, if used correctly, Telehealth can deliver huge benefits for patients.

The programme was launched in Holsworthy and Torrington and is due to be rolled out to all COPD patients in North Devon.

Dr Paul Lovell, clinical lead for COPD in North Devon, said: "We hope Telehealth will transform the way patients with COPD receive care in North Devon by supporting patients to remain independent and having the tools to manage their own condition.

"Instead of waiting for a crisis to happen or a trip to A&E, Telehealth will alert clinicians to early signs of an imminent decline in a patient's condition and will allow us to intervene promptly to improve the patient's condition.

"This will avoid crises happening and improve the patient's quality of life."

Chris Axford from Holsworthy was one of the first patients to have the tele-monitoring equipment installed and said: "The weekend after we received the equipment and were trained in its use, my health took a turn for the worse.

"Ordinarily I'd have ended up phoning 999 for an ambulance and been admitted to hospital. But because we could see the readings ourselves and knew they'd be reviewed elsewhere I felt able to take my meds and rest - just as they would have told me to do in hospital.

"First thing on Monday morning a nurse was on the phone to check on my progress. Wonderful."

Audit Commission report rates Trust as one of best in country for day case surgery

For many patients, their surgery will increasingly be completed in one day and they will be back home from hospital by the evening.

The Audit Commission completed a report in October 2012 which reviewed day surgery rates nationally.

1st place

The Trust was ranked best in England on its record for performing hand and shoulder surgery on a day-case basis. Against 143 other hospitals, NDDH came top in those that perform specialist surgery to reduce pain in shoulder and hand joints, carrying out 94% and 91% (respectively) of all eligible procedures as day cases, compared to the national average of 67% and 77%.

Cheryl Baldwick, lead clinician in orthopaedics, said, "We know patients undergoing this type of surgery would rather go home the same day, and we have worked very hard to ensure we are able to grant this wish more often.

"Some magnificent teamwork behind the scenes, increased use of special anaesthetic techniques to numb the arm and investment in new equipment have enabled us to perform more of this sort of surgery as day cases."

4th place

The Trust was ranked fourth in England on its record for performing gall bladder surgery on a day-case basis. Against a national target of 60%, NDDH performed 74% of all gall bladder surgery as day cases.

Surgeon Nick Markham led a project to review day case procedures and has been behind the development of laparoscopic gall bladder surgery at NDDH.

5th place

The Trust achieved similar success in general surgery, coming fifth out of 149 hospitals. Some 83% of patients in northern Devon who require surgery, such as a hernia operation, will have the procedure as a day case.

John Taylor, clinical director for surgery, put the Trust's success down to streamlined admission procedures, a standardised approach to treatment and recovery, and changes to anaesthetic practice.

Reduced waiting times for eye patients

Waiting times for eye patients at North Devon District Hospital have reduced dramatically over the past two years.

The figures were revealed following an external review into the Trust's wet age-related macular degeneration (WAMD) service.

Dramatic reductions have been seen since NDDH introduced a 'two-stop' service in 2011.

Patients now have two quick appointments rather than one longer one that could last for an unpredictable amount of time.

Patients are checked during a first appointment and, if they need an injection, will be booked in on a separate day. On that day, a dedicated doctor will be on hand to give injections only.

The WAMD review found that waiting times for patients and the duration of treatment had been reduced dramatically – by up to 71 per cent.

Improved approach to wound care

Last year, the Trust celebrated the development of a new, integrated pathway to treat patients with chronic ulcers.

Chronic ulcers can result in significant distress and social isolation for patients.

Often, the ulcer itself is treated without assessing the possible underlying cause. Trust clinicians recognised that if a patient is properly assessed by a nurse before starting treatment, most ulcers healed within 12 weeks.

The new pathway was developed by a range of professionals, including practice nurses, tissue viability nurses, GPs, microbiologists, vascular surgeons and podiatrists. Since its introduction, one surgery reported that practice nurses had carried out 35 per cent fewer ulcer appointments in one week and that healing rates appeared to be much higher.

This work demonstrates the benefits to patients of health professionals working across traditional boundaries to focus on delivering the right care to the right patient at the right time.

East Devon dementia service scoops national innovation award

An innovative Trust service that enhances the lives of older people with dementia in East Devon secured a prestigious national award.

The Rowan and Linden centres were among only eight winners of an Innovation and Best Practice in Community Hospitals Award for 2012.

The centres, based at Ottery St Mary, provide a safe haven and ongoing support for people with dementia, anxiety or depression, or who are socially isolated.



Gaynor Appleby (centre), team leader at the Rowan and Linden centres, and Yvonne Addington, community mental health nurse, collect their national award from Dr Andrew Crowther, president of the Community Hospitals Association.

The awards were organised by the Community Hospitals Association (CHA).

Chief executive Barbara Moore, who visited Ottery on a fact-finding mission, said: "The staff there are excellent and the service and care they provide for dementia patients is first class."

The Rowan centre provides a 12-week assessment for individuals, who take part in a variety of activities with help from key workers, while carers and loved ones are given one-to-one support.

The Linden day centre provides activities and ongoing support for individuals and respite for carers.

The centres provide a service to residents of Ottery, Honiton and Sidmouth.

Pathfinder – right care, right time, right place

Pathfinder is a dynamic, multi-disciplinary health and social care team based at NDDH. The team assesses people's health and social care needs in both acute and community settings so that the appropriate care, therapy or treatment can be provided.

Pathfinder aims to prevent unnecessary hospital or care home admission, and to promote early discharge from hospital. It also oversees the transfer process from the acute to community hospital settings.

Over the past year, the team has supported many individuals, empowering them to decide where they would like to receive their care. The team's innovative use of 'night sits' as part of their discharge planning has been a particular highlight and success story of the past year. This refers to the provision of overnight care support for people who need it, at the time when they may feel alone and anxious and be more likely to call the ambulance service. This extra support has meant that people can remain at home rather than coming into hospital unnecessarily, or be discharged earlier.

The 'night sits' have been accessed by both health and social care staff to prevent admission to hospital or care homes. They are run by the rapid response service, which provides care, therapy and support free of charge for up to seven days to help people in need during an acute illness or social care crisis. There are 18 rapid response support workers across Northern Devon.

Patient safety

– How the Trust has continued to reduce and eliminate events of avoidable harm and infections for patients

In October 2009, Northern Devon Healthcare NHS Trust embarked on a programme of patient safety improvement in collaboration with NHS South West and other regional acute trusts. The aims of the programme were ambitious – to achieve a dramatic reduction in adverse events, reduce mortality rates, and create a culture that puts patient safety at the heart of everything we do.

In November 2010, the programme was extended to include improvement aims for community health services. The Trust continues to be an active member of the South West Quality and Patient Safety Improvement Programme (SWQPSIP), which receives funding from the Department of Health following the reforms of the NHS in England in April 2013, and is hosted by the Royal United Hospital Bath NHS Trust.

Every year, the Trust Board receives an annual report on patient safety, which details our achievements, identifies where patient safety has improved and where further focus is required.

Highlights from this year include:

Assessing our 'safety culture': We asked our staff who deliver care how safe they felt the organisation was and whether they would recommend the service to their friends and family. The results of the survey demonstrated that staff are confident in knowing when and how to report concerns and incidents relating to patient safety, and that staff actively take personal responsibility for ensuring patient safety in their own areas of work.

Patient safety walkrounds: A robust programme of patient safety walkrounds commenced in October 2009, and has recently been extended to include community nursing teams and services.

Walkrounds allow staff the opportunity to raise patient safety issues directly with senior individuals in the Trust, and empower them to implement

change to solve these issues. As of April 2013, a total of 501 issues had been identified by staff, and 382 resolved (76.25%). For 2013/14, we aim to sustain a resolution rate of 80% of all patient safety issues raised during patient safety walkround.

Essential patient safety review training events:

The patient safety team has, in partnership with Workforce Development's clinical development facilitators, undertaken a complete review of the essential patient safety review (EPSR) training day.

This mandatory three-yearly training for registered nurses and midwives and for clinical support staff is now based on real case studies of adverse or patient harm events that have occurred in the Trust, and reinforces key patient safety messages throughout the day, providing clear guidance on professional and personal accountability, responsibility and delegation.

Attendees leave at the end of the day with a clear message about patient safety priorities within the Trust, and how they can personally contribute to patient safety improvement.

Reported patient safety incidents: Detailed analysis of all patient safety incidents continues, with quarterly thematic reports for clinical incidents, serious event audits (SEAs) and serious incidents requiring investigation (SIRIs) reviewed by various committees, including the Safer Care Delivery Committee and the Quality Assurance Committee.

The Patient Safety Operational Group reviews all clinical incidents on a monthly basis and the patient safety team additionally review all patient harm events weekly to ensure accurate grading of severity and to identify themes and trends requiring focus and action. This enables the patient safety team to agree remedial action with departmental and team leaders quickly, reducing the likelihood of error resulting in potential harm to patients.

Ongoing review also ensures that 'early warning' learning can be shared across the organisation, allowing a review of processes and procedures to make certain that appropriate controls are in place to reduce the risk of harm. Additionally, staff are encouraged to attend round-table reviews that take place as part of incident investigations, allowing learning to be discussed directly by frontline staff and taken back to the bedside.

In addition to this robust scrutiny of clinical incidents, patient stories are now presented bi-monthly at the Quality Assurance Committee and at Trust Board.

NHS Safety Thermometer

The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. Organisations use the NHS Safety Thermometer to survey all relevant patients one day each month.

It has been designed to be used by frontline healthcare professionals to secure a snapshot of harm from four high-volume patient safety issues - pressure ulcers, falls, urinary infection in patients with catheters, and treatment for venous thromboembolism (VTE). Participation in data collection using the NHS Safety Thermometer is an important step for NHS organisations in reducing harm.

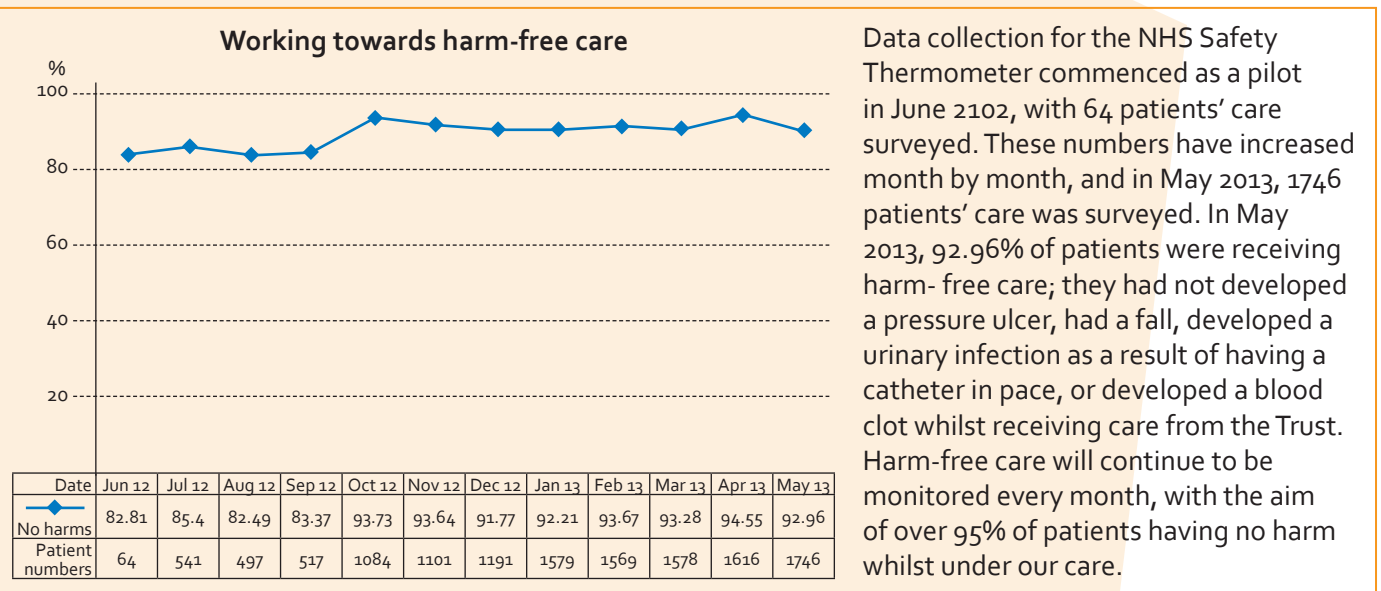
In January 2012, an NHS Safety Thermometer was published which showed that Northern Devon Healthcare NHS Trust had the fourth-most-improved performance in England in terms of reducing avoidable harm caused to patients. This achievement was featured in the Health Service Journal on 7 February 2013.

Hourly RU OK? checks provide extra reassurance for hospital patients

As of February 2013, patients are being checked to see if they are comfortable and safe at least once every hour as part of a new Trust-wide campaign.

The Trust made the commitment to every patient in NDDH and the 17 community hospitals it manages across the county.

The RU OK? campaign is in line with David Cameron's pledge for hourly rounds on wards as well as the 'six Cs' set out by England's chief nursing officer Jane Cummings – care, compassion, competence, communication, courage and commitment.



Assistant director of nursing Bev Cox, who is leading the campaign, said: "We want to be the best we can possibly be for our patients, their families and carers, and are always looking at ways to improve.

"RU OK? is a pledge we make to all our patients. Our clinical teams will check they are comfortable and safe at least once every hour and if any concerns or needs are identified, they can be dealt with promptly.

"This proactive approach helps us maintain the highest levels of patient safety and ensure those in our care have the best possible experience."

RU OK? is for all patients and builds on 'comfort rounding', which is aimed at inpatients at a high risk of suffering a harm event such as a fall.

Data collected through comfort rounding, RU OK? and matron walkrounds is collated by the Trust and used by managers and clinical teams to gain feedback from patients and carers.

This supports them in providing the best possible patient-centred care.

Reducing falls

Falls in hospital are a major cause of disability and mortality for older people in the UK, with 208,000 falls reported in acute hospitals and 38,000 in community hospitals every year. Every minor fall can cause distress, pain, injury, loss of confidence and loss of independence to the individual, as well as anxiety to carers and relatives.

We want to be sure that we have done everything possible to prevent patients from falling and injuring themselves whilst in our care.

At the start of the year, we aimed to ensure that 90% of patients assessed at risk of falling received regular comfort rounds in inpatient areas.

By January 2013, we were able to report that 95.83% of patients were receiving regular and appropriate comfort rounding.

As a result, the number of patients experiencing harm from falls continued to decrease across all inpatient areas in the Trust. Until the end of January 2013, there had been 12 harmful falls in wards within North Devon District Hospital, four in northern community hospitals and 15 in eastern community hospitals.

Matron walkrounds

Every month, 36 matrons' walkrounds are carried out by senior nurses in the Trust, including the director of nursing, assistant directors of nursing, the head of quality and safety and the head of midwifery. The focus is on reviewing whether 'comfort rounding' is in place when it should be, and on discussing the importance and use of comfort rounding with clinical staff and patients.

Following a number of small tests of change with clinical staff on the wards, a new assessment tool was designed and implemented. This is transforming the way in which we approach comfort rounding by supporting individualised and person-centred care. The tool will be monitored and reviewed regularly.



Where comfort rounding is in place for suitable patients, this is discussed immediately with ward staff at the time of the walkround, and any themes shared more widely with ward managers and senior nurses.

Benchmarking against other trusts has been undertaken. We believe our approach is unique, being highly individualised and patient-centred.

Reducing pressure ulcers for patients in our care, in hospital or at home

Pressure ulcers can occur in any patient, when pressure is placed on a particular part of the body, interrupting the blood supply. The body's natural defence against pressure ulcers is to keep moving – something that patients can't always do independently.

Avoidable pressure ulcers are a key indicator of the quality of nursing care; preventing them improves patient care. Pressure ulcers are recognised as having a detrimental effect on patients' health, wellbeing and recovery.

In 2012, we focussed on a thorough training and awareness programme with staff to ensure that they were aware how to prevent and treat pressure ulcers.

Our progress is monitored through NHS Safety Thermometer performance data and is presented monthly to the Trust Board.

MRSA

Our last case of MRSA was in February 2011.

C. Difficile infection

Clostridium Difficile (c.Diff) is an infection that can cause dangerous symptoms and even death. Although naturally present in some people, it can spread quickly in a confined environment like a hospital, where people are already unwell.

The NHS has been working hard to combat c.Diff, using different infection control techniques to keep patients safe.

Reflecting the significant advances in combatting infections, the target maximum for the 2012/13 financial year was 17. Against this target the Trust reported only 13 cases of clostridium Difficile.

A full review of the 13 cases provided more learning to allow us to reduce this rate even further next year.

This is a fantastic result and testament to the consistent fight against infection by our staff.

Reducing the number of infections after surgery

A surgical wound infection occurs after surgery, when germs from the skin or the environment enter the cut that the surgeon makes. A surgical wound infection can develop at any time from two to three days after surgery until the wound has healed (usually two to three weeks after the operation). Very occasionally, an infection can occur several months after an operation.

Surgical wound infections are uncommon. Most are limited to the skin, but can spread occasionally to deeper tissues. Infections are more likely to occur after surgery on parts of the body that harbour lots of germs, such as the gut. Procedures involving the lower abdomen may present a higher risk of the patient developing an infection.

We identified that rates of infection in abdominal surgery were higher than expected and sought to address the issue.

Over the last year, we achieved our aim of reducing cases of infection following abdominal surgery from 18.2% to 10.8%, which is 2% lower than the national average.

These efforts have directly benefitted patients as they spend less time in hospital.

Inspections by the Care Quality Commission

Northern Devon Healthcare NHS Trust participated in special reviews or investigations by the Care Quality Commission relating to the following areas during 2012/13.

July

CQC made an unannounced inspection of Ilfracombe Hospital in July 2012 to check the Trust's records, observe how people were being cared for, look at records for people who use the services and talk to staff. This inspection was part of a themed inspection programme to assess whether older people receiving care in NHS hospitals were treated with dignity and respect, and whether their nutritional needs were met.

The CQC's report showed that the Trust was meeting all the standards and no actions were required.

August

CQC made an unannounced inspection of Moretonhampstead Hospital in August 2012, observing how people were being cared for. The CQC's report showed that the Trust was not meeting all the standards inspected. Outcome 14 – Supporting Workers was judged to be non-compliant.

The CQC found that because not many people were being treated in the MIU and the inpatient beds, staff were not getting an opportunity to use or develop their skills and knowledge. This meant that clinical skills might not be maintained. The Trust has taken action to ensure that all of the CQC essential standards of quality and safety are complied with at all locations.

February

CQC made a scheduled inspection at NDDH in February 2013, observing how people were being cared for and checking each stage of their treatment and care. The CQC report showed that the Trust was meeting all the standards; no actions were required.

The CQC visited 10 of our wards, speaking to 68 patients, 63 staff and 18 visitors/carers. Their informal feedback was that they had received a warm welcome, with staff inviting the inspectors to come and see their wards or services.

The last day of the visit coincided with publication of the Francis report on Mid Staffordshire. The inspectors immediately took the opportunity to test awareness of the report and to ask staff how they would respond to some of the key issues, such as raising incidents of poor care within the Trust. The unanimous response from our staff, according to the inspectors, was that people wouldn't want patients at NDDH to be in the same situation as at Mid Staffs.

The inspectors advised us that we were fully compliant with all five outcomes.

Patient experience

– How the Trust has improved the patient's experience of using its services

Patients hold unique vantage points as expert witnesses to care.

We know that their judgements are informed as much by the care they witness others receiving as by the care they receive themselves.

The experience of a patient's loved ones, carer or family and friends clearly plays a significant part in the patient's well-being.

Our staff are proud of the high quality of services we provide. Our patients and their families frequently tell us how much they appreciate the care they received. But we know we can always do better.

As a Board, we are committed to fulfil our statutory duty to hold our organisation to account for improving the quality and responsiveness of services, and to demonstrate this accountability to our local communities. This, of course, is the right thing to do and the reason most NHS staff do their job so passionately.

We launched a refreshed patient experience strategy in 2013 and are really proud of our achievements so far in improving the experience of patients in our care.

Every day we ask patients for their feedback, whether they are in inpatient, an outpatient or receiving care in their own home from our community teams. On average, over 20% of patients are asked to answer six short questions on what they think of the care they received.

The feedback is returned directly to staff within a few hours of patients telling us their views, although this is slightly longer if we've asked patients to post their response.

If we spot problems, we are then able to do a 'deep dive' into services and teams to see what might have caused the feedback or comments to be given.

Asking patients to be 'mystery shoppers' is one way of getting under the skin of a service; this initiative was nominated for an award (see page 30).

Patients also give their feedback via complaints, social media, the media and letters to the chief executive.

All the feedback gets presented at the bi-monthly Learning from Patient Experience Group. The membership of this group consists of clinicians, senior nurses, service managers and patient safety, clinical effectiveness and patient experience leads.

Trends and interesting findings are discussed and triangulated. For example, we might look at sickness absence data, complaints, patient experience, patient safety as well as performance targets to build up a picture of whether that service is working well or needs some support.

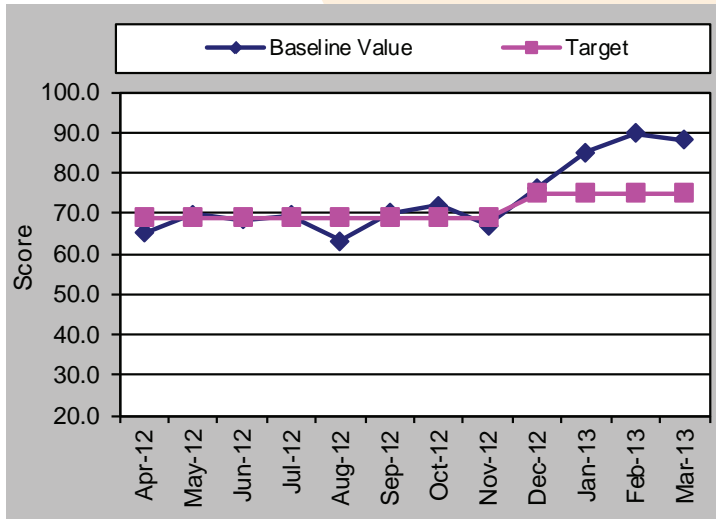
This approach means we can spot problems early and support clinicians and managers to understand how to improve patient care.

A snapshot of our data for the last 12 months is displayed in the next graphs.

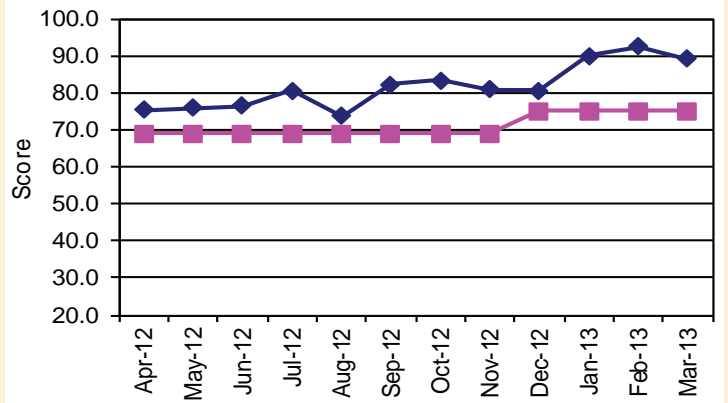
Graph 1 – Friends and Family Test scores for all wards

Graphs 2-6 – patient responses to key questions

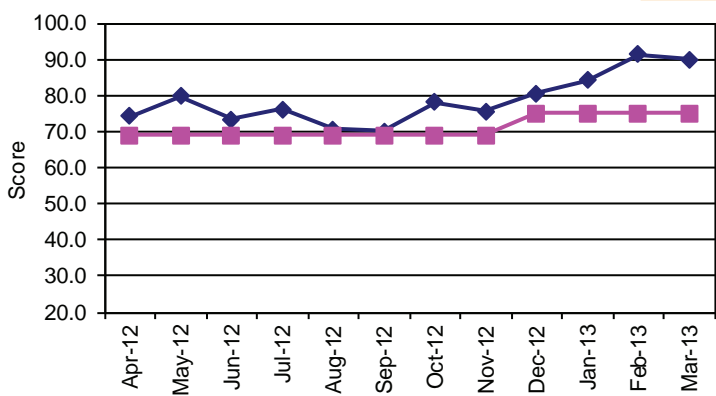
Graph 1 – “Would you recommend this service to your friends and family?”



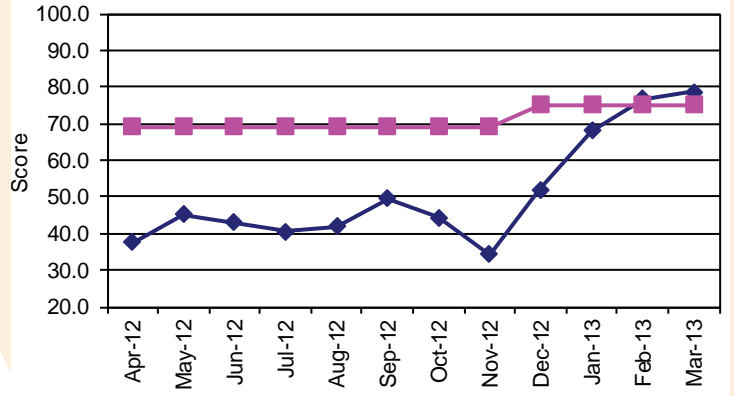
Graph 4 – “Were you given enough privacy?”



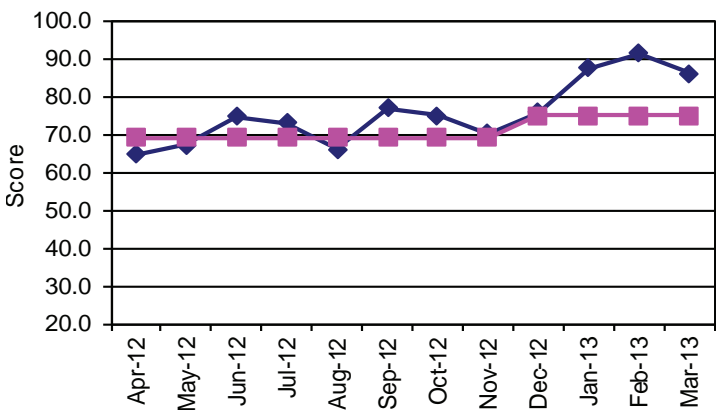
Graph 2 – “Were you as involved as you wanted to be?”



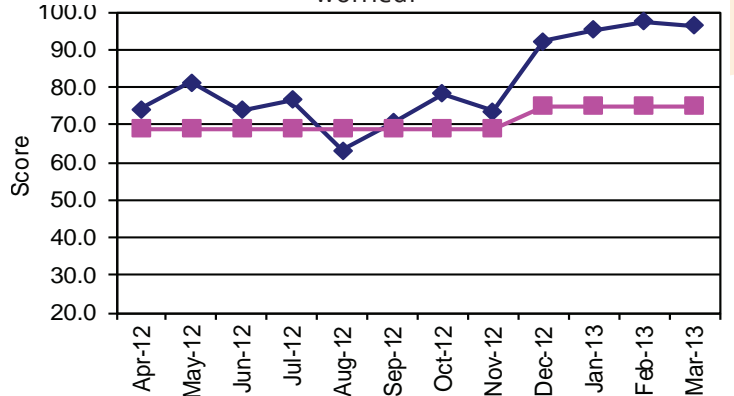
Graph 5 – “Were you told about medication side-effects to watch for?”



Graph 3 – “Did you find someone to talk to about worries and fears?”



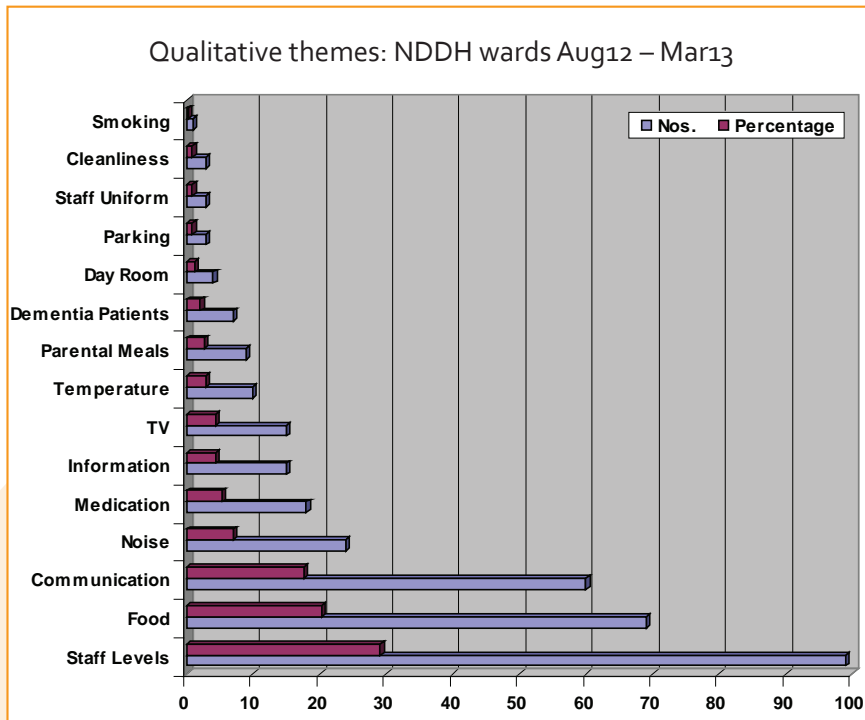
Graph 6 – “Were you told who to contact if you were worried?”



From collecting regular and real-time feedback from patients, we were able to quickly spot when there were issues being raised by patients which needed our attention. Patients not being told about medication side-effects was quickly revealed as an area needing improvement. Following concerted effort, we were able to make sure we improved our service by January 2013.

‘You said, we did’

Last year our patients gave us feedback on the following themes:



The top themes were:

- Perception of staffing levels on the wards
- The quality of food being served
- Communication between clinicians and patients

Our response to this feedback was as follows:

Staffing

We launched a ‘deep dive’ to understand why, when wards were fully staffed, patients still felt that our staff were under pressure.

This project has continued into the new financial year and the results will be reported in subsequent updates to the Board.

Food

The feedback on food was not being seen in complaint letters or enquiries, so we undertook to find out more.

We analysed the feedback which told us that some patients felt they received cold and/or unappetising food whilst an inpatient at NDDH.

The catering team responded by raising the temperature of the food by five degrees as it left the on-site kitchen.

We then looked at how the toast was being served on the wards in the morning and found that there was only one round. Again, the catering service responded by doing two toast rounds on each ward, instead of one, to ensure that patients received warm toast for breakfast.

Lastly, we asked our patient experience volunteers to do an unannounced tasting session on the wards where this feedback had been received. They took the last serving on that ward and reported back that the food was tasty and warm, with a good choice.

Communication

This area of feedback will again require more analysis as there was insufficient information in the feedback collected from patients for any specific area for us to look at.

We are piloting a range of patient experience survey techniques to establish the root cause of this feedback.

Trust launches Friends and Family Test

All NDDH inpatients, and patients who have received care in a ward, medical assessment unit or A&E department, now have the opportunity to provide immediate feedback about their experience.

Launched in April 2013, the Friends and Family Test comprises just one simple question: **How likely are you to recommend our ward/A&E department to friends and family if they needed similar care or treatment?**

All patient responses are entirely voluntary, anonymous and confidential.

Asked at the point of discharge and with a set of six response options ranging from 'extremely likely' to 'extremely unlikely', the Friends and Family Test is intended to capture as closely as possible the patient's feelings about their recent experience.

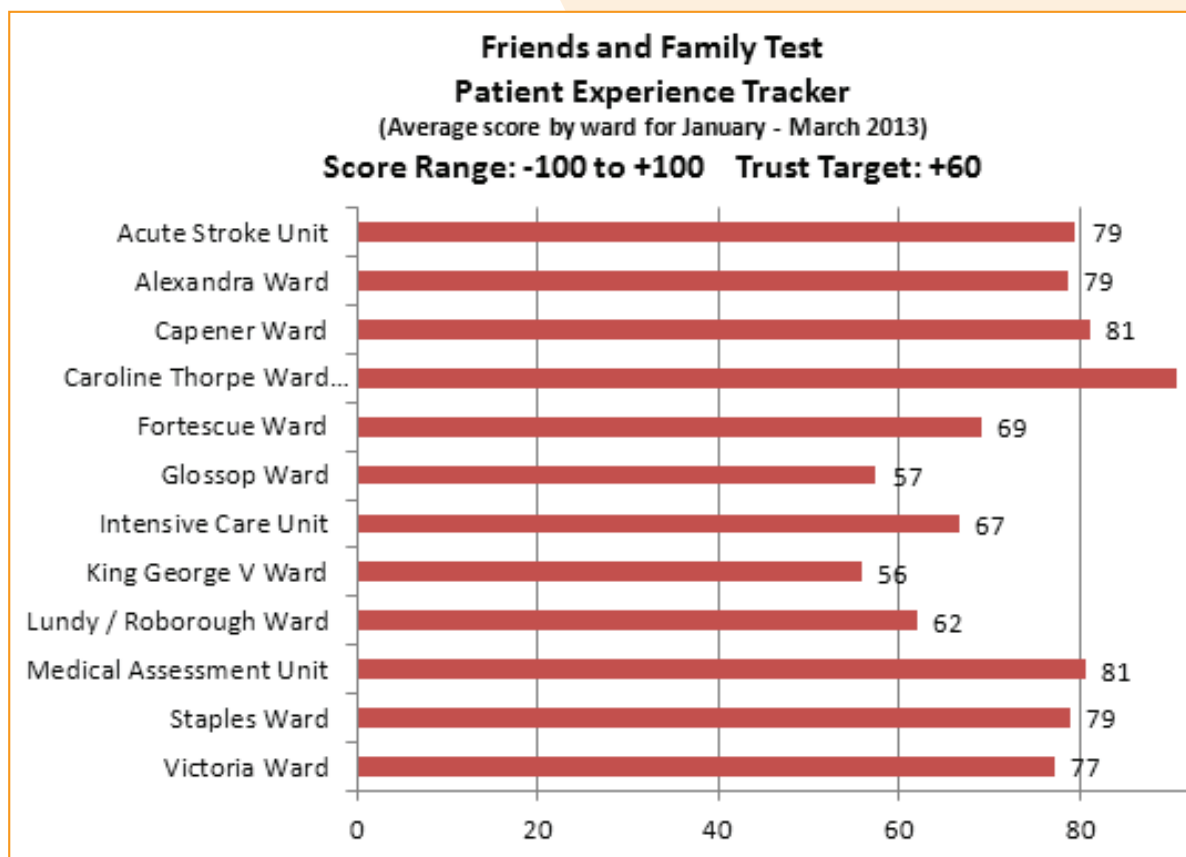
Patients will be invited to explain briefly why they responded in the way they did and to post their response into the letterboxes on each ward before they leave.

Carolyn Mills, director of nursing, said: "The feedback we get from patients is overwhelmingly positive and I would like the rest of the NHS to see the high standard of care we provide in our hospitals and patients' homes.

"The results are really valuable as they absolutely correlate to high staff satisfaction, well-performing services and low numbers of complaints.

"This means our clinicians can quickly spot where problems are occurring and act to put them right."

The table below shows the Friends and Family data that we collected from patients in the last four months of the financial year, ahead of the national launch.



Trust's 'mystery shoppers' give feedback on services

The Trust has been one of the first in the country to launch a 'mystery shopper' scheme for patients to give feedback about its services.

Working in partnership with an independent charity, the Patients Association, the Trust has been looking for current and prospective patients to evaluate their experience of using its services.

Patients are asked to record their thoughts and experience as they go through each stage of their care.

The feedback is collated by the Patients Association, and presented in an anonymous report to the Trust.

A Patients Association representative debriefs the mystery shopper, receives the feedback and ensures the right clinicians and teams in the Trust get to hear what the person thought of their service.

All patients are welcome to join in, whether they are an inpatient, day case, outpatient or receiving care from the Trust's community teams.

Carolyn Mills, the Trust's director of nursing, said: "We consider patients to be experts by experience.

"This mystery shopper scheme will be a very useful tool to gather patient feedback, which will help with our long-term aim to improve our services.

"We have teamed up with the Patients Association to reassure patients that their feedback will be anonymous, but also that the patient has an advocate they can trust who will ensure something is done with their feedback."

Mystery shoppers must be aged 18 or over, live in Devon, and be current or potential patients, carers, staff or users of health services from the Trust.

They are invited to attend network events, where they can find out what has happened as a result of their feedback.

Improving the experience of patients with dementia

In 2012, we were delighted to be selected by the King's Fund and Health Foundation on their patient and family-centred care programme.

This programme supports NHS organisations to focus on an aspect of care and evaluate the improvements made to the experience of patients, their carers and NHS staff.

Our project focuses on the pathway of care for dementia patients who access any service from North Devon District Hospital in Barnstaple and are discharged back to their usual place of residence.

This pathway involves acute clinicians, community teams including social care, GPs, the voluntary sector and carers. It is for this reason that our particular focus is on the experience during the multiple handovers between acute, community and primary care.

Throughout 2012, we used a variety of qualitative and quantitative methods of data collection to gain an understanding of the patient experience.

Continuing in 2013, we started to map this experience against the pathway of care to discover the service hotspots and where the greatest anxiety is caused to patients.

The overall aim is to **see the person in the patient**, so patients with dementia are cared for with dignity and compassion, in a safe environment with their carers feeling fully engaged in their care.

Our hopes and aspirations are to provide a service which:

- Manages patients safely in their usual place of residence
- Only admits patients when absolutely necessary
- Identifies patients with dementia early and ensures there is information available which improves safety and experience
- Involves patients and carers in clinical decisions
- Is supported by staff with the right skills, training and support
- Is integrated and co-ordinated
- Works across teams to support timely and safe discharges

The King's Fund and Health Foundation keep in fortnightly contact with the Trust team to ensure good progress is being made and that we are able to measure improvement to the experience of patients with dementia.

An evaluation of the success of the programme is being reported to the Board in the Autumn of 2013.

Rapid assessment at home launched in Exeter area

A pioneering new service in the Exeter area was launched in April 2012 to provide a rapid assessment service for people in their own homes.

Rapid assessment at home aims to help those patients whose health suddenly deteriorates, or after they have had a fall, and are at imminent risk of admission to hospital.

The rapid assessment at home team, based in Exeter, responds within two hours of receiving the referral, arriving at the patient's home to undertake a full health and social care needs assessment and create a care plan with the patient and their family or carers.

The assessment process can take up to five days, during which decisions are made to create an action plan to address essential health and social care needs.

In discussion with the GP, patient and family members, a plan is made to take forward the care at home while alternative options are considered.

The team consists of skilled professionals who are experts in helping people to remain independent in their own homes.

It includes a lead matron, community matrons, therapists, district nurses, psychiatric nurses, occupational therapists, night sitters and short-term carers, among others.

Georgie Adams, lead matron, said: "This is so much better for patients than a hospital bed because we find they respond in a positive way, and enabling them to remain in their own home, around friends and family, provides a supportive environment for care."

The service is available for referrals from Monday to Friday, 9am to 5pm.

All the local GPs, community teams and RD&E staff in A&E, medical triage and the acute medical unit are aware of how to contact the team.

Keri Storey, associate director of health and social care for Northern Devon Healthcare NHS Trust, said: "This scheme is another example of how the health and social care community staff are working together to wrap services around patients.

"We are changing the way we provide services to help patients remain independent in their own homes."

Barnstaple Leg Club offers vital support for patients

Healing rates for people suffering from serious leg conditions in Barnstaple are on the rise thanks to a leg club launched by the Trust in April last year.

The aim of the club, the first of its kind in the South West, is to provide care and support for people who have conditions such as a leg ulcer.

It encourages people to get out and about, despite their condition, which for many can be socially isolating.

More than 30 patients have been referred to the club by a GP or community nurse since the launch, with almost half having healed compared to an average of 10 per cent in a clinical setting.

The leg club is a nurse-led service provided by the Trust and run by volunteers.

Roy Pearce, who has a prosthetic left leg and severe leg ulcers on his right leg, was referred to the club by his GP.

He said: "Before I was referred to the club I had not left my house for three years.

"The nurses give you so much confidence and that can help you to heal quicker. I honestly believe that."

Meg Mew, lead community nurse, said: "Leg ulcers and other lower leg conditions are socially isolating and disabling and it is easy for sufferers to think it is just them, but in fact they are very common.

"We have found that at first patients are reluctant to attend the club but once they actually get here and meet with others suffering from similar problems they enjoy it and look forward to coming each week.

"The benefits for both staff and members are huge."

There are plans to open more clubs across North Devon.

Hospital at home scheme in East Devon 'fantastic'

A project run by the Trust to treat people in East Devon in their own home, rather than in hospital, has been described as 'fantastic' by patients.

Under the Hospital at Home scheme, patients are visited by nurses, occupational therapists, physiotherapists and other health and social care workers.

Patients can stay at home during their treatment, while still getting all the care they would receive on a conventional ward. Care can range from daily visits by the clinical team to more intensive support worker input and overnight assistance.

The scheme treats patients in the Exmouth area who have previously been in conventional hospitals, or who have been referred directly by GPs, to avoid unnecessary hospital admission.

It allows them to get out of hospital and back to familiar surroundings sooner, while freeing up hospital beds for other patients.

Hospital at Home was commissioned by the NHS Woodbury, Exmouth and Budleigh Salterton (WEB) locality group and is provided by the Trust's local integrated health and social care team.

Although the scheme started in December 2011 as an initial six month pilot, it was extended last year for a further period of evaluation.

It has a nominal 'ward' size of up to 21 patients who can be cared for at any one time.

Maria Dickson, therapy manager for the Trust, said: "This area has a very high elderly population, and for the elderly, particularly people with early dementia, hospital can be disorientating, with risk of infection.

"Looking after people in their own home is a much better way of doing things."

Nurse-led service for deep vein thrombosis improves patient experience

A nurse-led service for patients with deep vein thrombosis (DVT) has made receiving treatment for the condition quicker and easier.

The DVT clinics are based at NDDH and run from Monday to Friday. They receive referrals directly from GPs and the emergency department. The clinics are run by nurses, and patients can be seen quickly and treated as outpatients. Doctors are on hand for further advice if needed.

The service aims to support GPs in caring for patients within the community without the need for an acute admission. In addition, the clinic supports discharges from the medical assessment unit, providing follow-up appointments for monitoring and review.

Patients are assessed by doppler ultrasound and receive information leaflets about their condition and treatment, as well as contact details for any further enquiries they may have.

Last year the clinic reviewed on average 10 to 12 patients a day, with the majority being discharged straight home after treatment.

The Trust reviews the pathway for treatment regularly, making sure that current best practice is maintained in accordance with National Institute for Health and Care Excellence (NICE) guidelines.

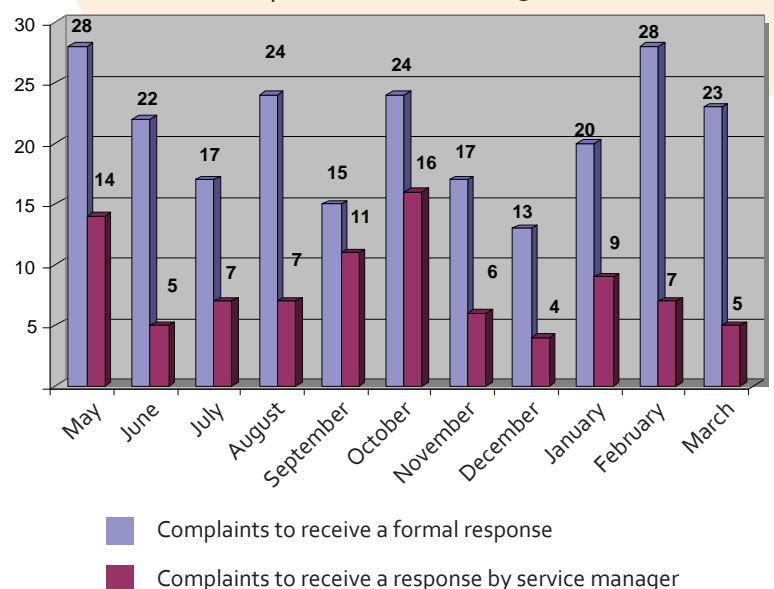
Complaints

Complaints continue to be a vital source of feedback from our service users, carers and relatives. 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 Patient Advice and Liaison Service (PALS).

During the year period, 358 complaints were received (an increase of 33 on 2011/2012) and 1,869 PALS enquiries were received (an increase of 608 on 2011/2012). This increase demonstrates a positive reflection on how patients and service users feel able to provide feedback on their experience, which the Trust welcomes and encourages. As such we would hope to see this patient feedback activity continually increase over time. During the period, no complaints were received by the Care Quality Commission (CQC).

The top five complaint themes were clinical care and treatment (45%), communication (17%), access to clinical services (15%), attitude of staff (15%), and discharge arrangements (8%).

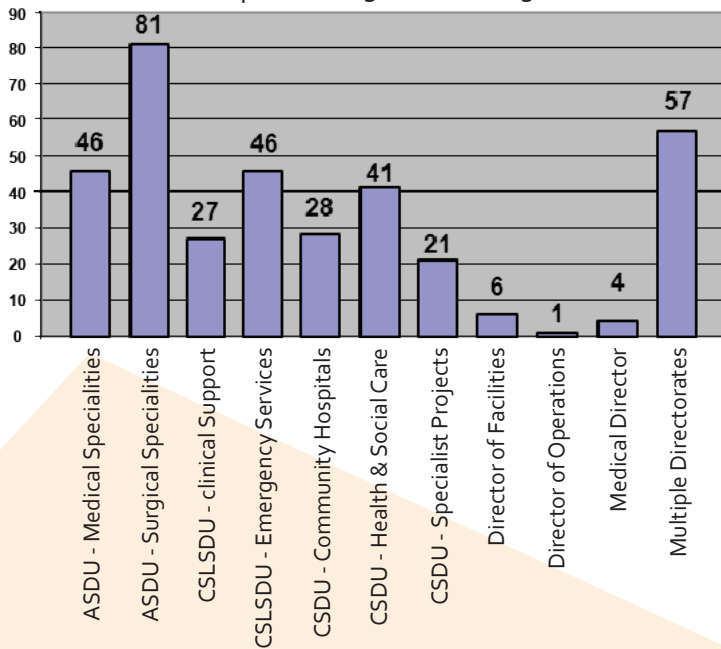
Number of complaints and concerns received April 2012 - March 2013



The division with the highest number of complaints for the financial year was the Acute Service Delivery

Unit (SDU) consisting of surgical specialties (81), followed by both the Acute SDU, medical specialties (46) and Clinical Support and Logistics SDU, Emergency Services (46), and then Community SDU, Health and Social Care (41).

Complaints and concerns received by directorate
1 April 2012 - 31 March 2013



Fifty-seven complaints were received within the period for multiple directorates. The graph below shows the breakdown of complaints received by Service Delivery Unit.

Out of the 28 complaints received for the community hospitals, Exmouth hospital received the highest with six, followed by Bideford and Seaton hospitals (three each).

Axminster, Crediton, Honiton, Moretonhampstead, Tiverton and Exeter hospitals all received two each, followed by Ottery, Sidmouth and Tyrrell hospitals with one. One complaint involved care at a patient's home

All complaints are required to be acknowledged within three working days, in line with Trust policy. During the period, 74% of complaints were acknowledged within this timeframe.

Since October 2012 the Trust has improved the process of acknowledging complaints. The

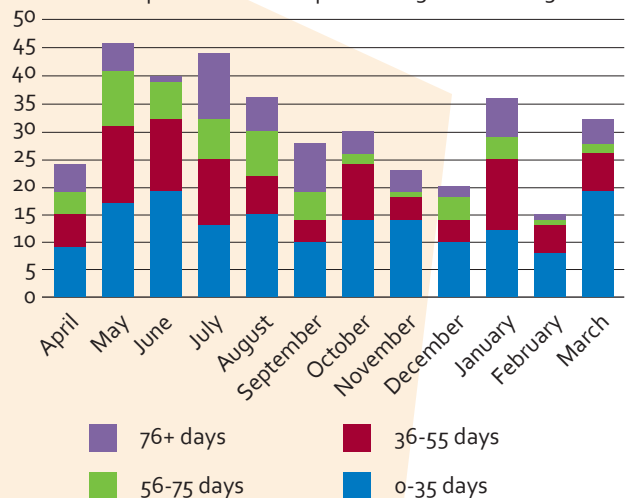
Customer Relations Manager now telephones complainants on receipt of their complaint (where contact details are available) to discuss and agree a way forward for managing their complaint, offering complainants the opportunity to attend a meeting with the relevant senior staff/clinicians involved in their complaint. Of the 172 complaints received since September 2012, 101 complainants were spoken to at the outset of their complaint, and offered a meeting.

During the period, 52 local resolution meetings took place. Feedback received during this time shows complainants are very grateful for the opportunity to meet with staff face to face. The complainant is sent summary notes of the meeting, issued from the chief executive.

Complaint response performance

During the period, 42% of complaints were responded to within 35 working days (or the timeframe agreed), which is an increase of 34% on the last reporting period (2011/12). The graph below shows the response performance by month; the table shows performance over the reporting period.

Complaints response time performance by month for complaints closed 1 April 2012 - 31 March 2013



Overall performance is improving and through the directorate performance reporting the customer relations team is continuing to work with the Service Delivery Units to improve performance, with particular focus around reducing the number of complaints responded to within 36-55 days to better improve the Trust's overall performance, as demonstrated in the table below:

Timeframe	% for April & May 2012	% for June & July 2012	% for Aug & Sept 2012	% for Oct & Nov 2012	% for Dec 2012 & Jan 2013	% for Feb & March 2013	Direction of travel
0 - 35 days	38%	38%	40%	53%	39%	57%	↑
36 - 45 days	13%	13%	8%	17%	20%	13%	↓
46 - 55 days	15%	17%	10%	9%	11%	11%	↔
56 - 75 days	20%	18%	21%	6%	14%	8%	↓
76+ days	14%	14%	22%	15%	16%	11%	↓
Number Closed	71	84	63	53	56	47	

Outcomes and remedial actions from closed complaints

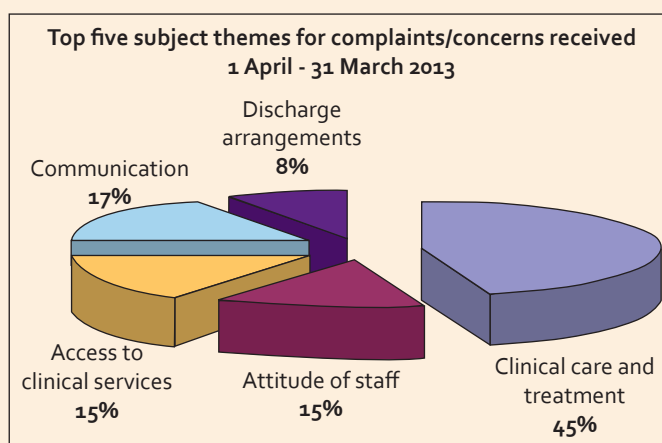
During the period, 374 complaints were closed following investigation. Of these closed complaints, 105 required action to be taken as a result of the concern raised. Of these 105:

- 46 related to clinical care and treatment
- 19 related to accessing clinical services
- 15 related to the attitude of staff and 11 to communication
- Six related to discharge arrangements and one to admission arrangements

- Three related to quality of facilities/hotel services
- Two related to confidentiality matters, and
- One related to information provision

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 subjects above were:

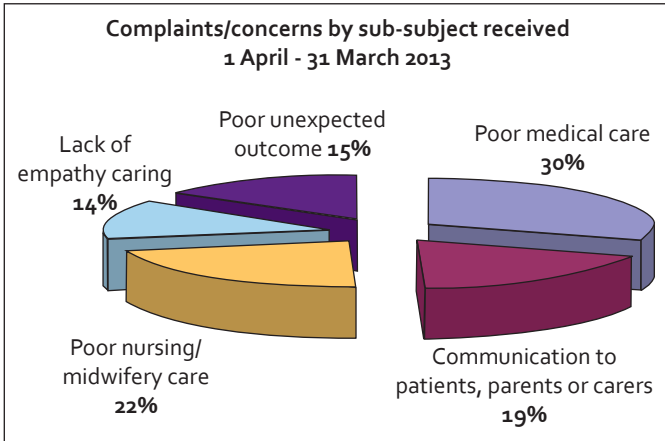
Clinical care and treatment - ASDU Surgical Specialities (86)

Attitude of staff - ASDU Surgical Specialities (16)

Access to clinical services - ASDU Surgical Specialities (32)

Communication - ASDU Surgical Specialities (12)

Discharge arrangements - ASDU - Medical Specialities (9)



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

- Poor medical care** - ASDU Surgical Specialities (30)
- Communication** - ASDU Surgical Specialities (15)
- Poor nursing/midwifery care** - ASDU Surgical Specialities (16)
- Lack of empathy** - ASDU Surgical Specialities (9)
- Poor unexpected outcome** - ASDU Surgical Specialities (10)

Parliamentary and Health Service Ombudsman complaints

In November 2012, the Parliamentary and Health Service Ombudsman issued their third annual report into complaint handling within the National Health Service. Within this report they identified two main themes – communication and the importance of embedding good complaint handling.

The Ombudsman continues to emphasise that when complaint handling is done well organisations can learn from complaints to continue to deliver high-quality, patient-centred care.

The report concludes that the NHS is still not handling complaints as it should. However, the table below and the Ombudsman report in relation to Northern Devon Healthcare NHS Trust shows the Trust performing well in term of resolving complaints received. Of the eight complaints closed within the financial year (2012/13), four were returned to the Trust for further local resolution and four complaints were closed by the Ombudsman's after a review of the complaint file as requiring no further action.

Within their annual report for 2011/12, the Ombudsman reported they had received 23 complaints surrounding the care and treatment the Trust provides. Two of these complaints were investigated by the Ombudsman's office, one being resolved via further intervention by the Trust, and one complaint being partially upheld. This latter complaint relates to a longstanding and historical complaint from 2009.

During this financial year (2012/13), the Trust received 11 new requests from the Ombudsman and one case previously referred to the Ombudsman's office was closed. Details of both the new and closed cases can be found in the table below.

Complaints referred by Outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Total
Request received from Ombudsman	0	1	1	0	0	0	2	1	0	0	4	1	10
Returned for local resolution (futher response or meeting)	0	0	0	1	0	0	2	0	1	0	0	0	4
Case closed with no further action	0	1	0	0	0	0	0	1	0	0	1	1	4
Issue upheld and recommendations made	0	0	0	0	0	0	0	0	0	0	0	0	0

Examples and remedial actions identified from complaint investigations

You said

'I am unhappy with the pain relief offered during my labour and the reluctance of staff to give me a specific pain relief identified in my birth plan'

We did

The maternity department has targeted further training at those staff who would benefit from increased knowledge of all the pain relief medication available during labour.

You said

'I am unhappy about the delay surrounding an occupational therapy assessment'

We did

The investigation identified improved information was required on referral forms to assist the outpatient clinics in arranging assessments and appointments in a timely manner.

You said

'I am concerned about the treatment my son received from the Emergency Department when they treated his head laceration'

We did

An explanation was given on the care and treatment provided and an apology was offered for the patient experiencing a known complication of the intervention. It was explained the matter had been discussed by the nurse practitioner with the Emergency Department consultant and senior nurse.

You said

'I am unhappy with the lack of advice and information provided to me when my daughter required emergency dental treatment'

We did

The investigation identified the need to review current information leaflets on stainless steel crowns, and to submit an article on this gold standard practice for distribution to all general dental practitioners.

You said

'I am concerned about the care and treatment I received from the Pain Clinic. I am also concerned about the way in which I was spoken to'

We did

As a result of the complaint the Consultant in question was spoken to about the patient's experience. Changes to the pain management service and the introduction of the new Integrated Persistent Pain service was explained to the patient via a meeting.

You said

'I am concerned about the miscommunication from the Bladder and Bowel Service'

We did

An apology and explanation was given. The investigation highlighted the need to involve parents in paediatric assessments, and recognised existing assessments needed to incorporate specific and/or complex needs of children.

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 Specialities (472), followed by ASDU Medical Specialities (389). The Trust-wide figure was 363.

The top five PALS themes continue to be the same as the previous year: information provision (45%), access to clinical services (16%), clinical care and treatment (9%) and communication (6%), and attitude (4%). The table below show the number of PALS issues by subject matter/directorate for the year. Information provision continues to be a large proportion of the work undertaken by PALS.

Top three divisions with the highest number of PALS issues	Top three areas of concern	
ADSDU – Surgery 472 issues	Difficulty in contacting department by phone/contact details	63
	Clinical information specific	47
	Contact information for departments	37
ASDU – Medicine 389 issues	Clinical information specific	88
	Difficulty in contacting department by phone/contact details	32
	Contact information for departments	23
Trust-wide 364 issues	Contact information for departments	67
	Information on healthcare services	52
	Clinical information specific	34

The table on the right shows the number of PALS issues by subject matter and directorate for the reporting period. You will note from the last table that information provision is a large proportion of the work undertaken by PALS; this continues to remain a strong trend.

PALS issues by directorate

ASDU - Medical Specialities	389
ASDU - Surgical Specialities	472
CSLSDU - Clinical Support Services	156
CSLSDU - Emergency Services, Logistics & Resilience	129
CSDU - Community Hospital	26
CSDU - Health & Social Care	111
CSDU - Specialist Service	43
Trust wide	364
Director of Facilities	142
Director of Nursing (e.g. Infection Control)	19
Director of Operations	1
Director of Finance	9
Director of HR	4
Commercial Directorate	1
Totals:	1869

PALS issues by subject matter

	Total 2012/13
Access to Services - Clinical	302
Access to Services - Physical	59
Admission arrangements	16
Attitude of Staff	83
Benefits	14
Bereavement	5
Clinical Care and Treatment	176
Communication	105
Confidentiality issues	6
Compliments	37
Discharge arrangements	48
Equality and Diversity	5
Quality of Facilities	46
Hotel Services	18
Information Provision	835
Medical Records	25
Patient's Property	22
Privacy and Dignity	4
Security	8
Transport	55
Totals:	1869

Serious incidents requiring investigations

The Trust continues to be a high reporter of patient safety incidents to the National Patient Safety Agency, compared with similar small acute trusts. As indicated by the high reporting figures, the organisation has robust incident-reporting processes embedded throughout and a culture which supports this.

Overall, 85% of the reported incidents resulted in no harm or minor harm; 99% of the reported incidents resulted in no, minor or moderate harm; and only around 1% of the reported incidents in major harm.

During the year, 4% of the reported incidents were escalated. This escalation is either self-imposed because we wish to learn from specific prioritised themes of incidents, or because we are required to escalate incidents that are highlighted as part of national patient safety campaigns.

Escalated incidents are subject to an initial significant event audit investigation, which is undertaken by clinical and management staff. The report is then presented to the executive team for a decision on whether it should be designated as a serious incident requiring investigation. The final decision is agreed by the executive directors group.

A total of 25 serious incidents were subject to a comprehensive formal investigation. The completed reports are reviewed by the executive team and presented to the Quality Assurance Committee and the Trust Board.

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.

Themes and trends from both significant event audits and serious incidents requiring investigation are reviewed quarterly and shared, to ensure that lessons are learned widely throughout the Trust.

Operating and Financial Review

1. Objective of the Operating and Financial Review

The objective of this Operating and Financial Review (OFR) is to prepare a balanced and comprehensive analysis to inform the reader of events that impacted on the Trust during the 2012/13 financial year. The Review is presented through the eyes of the Trust Board.

2. Trust Overview

Who we are

Northern Devon Healthcare NHS Trust (hereafter referred to as the Trust) provides a range of acute, community and pan-Devon healthcare services to a population of 484,000 people (65% of the population of Devon).



As part of the reconfiguration of the NHS, the Trust was awarded a three-year contract from 1 April 2011 to manage and transform a range of services that were previously provided by the provider arm of NHS Devon. There have been no service re-configurations affecting the services provided by the Trust within the last financial year.

Acute services, NDDH

The Trust provides acute services from North Devon District Hospital (NDDH) in Barnstaple and offers a full complement of adult and child secondary care services including:

- Outpatient care
- Elective inpatient and day case surgery services;
- Emergency treatment and follow-up care
- Diagnostics
- Maternity services (including the Special Care Baby Unit)
- Intensive care and Accident & Emergency services

Community hospitals and resource centres

The Trust's 17 community hospitals provide local hubs of healthcare for their communities and a range of services that are easily accessible to the local population, including approximately 300 inpatient beds, rehabilitation, and outpatient clinics with consultants from NDDH and from hospitals in Exeter, Taunton or Plymouth.

The resource centres in Barnstaple and Lynton provide local residents with a range of local outpatient and self-referring services, such as family planning clinics.

The Trust has ownership and management responsibility for five community hospitals in North Devon. Due to current NHS rules, in 2011/12 the 12 community hospitals in East Devon remained under the ownership of NHS Devon whilst the Trust retained the management responsibility for services from these sites.

These services include 12 community hospitals, seven Minor Injury Units and nine complex care teams.

Community health and social care teams

The role of the complex care teams is to provide local services which rehabilitate patients and promote their independence. They support 6,000 patients at any one time to live independently in their own homes.

The Trust's community nursing and therapy services are aligned into 17 complex care teams, providing integrated health and social care to help ensure that patients are supported to live independently at home. These teams serve those patients who need regular support from skilled professionals, including community nurses, social workers, physiotherapists, occupational therapists and community matrons.

Specialist community, pan-Devon services

The Trust is the main provider of specialist community healthcare services across North, East, Mid and South Devon, such as 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, based in Sidwell Street, Exeter and onsite at the Royal Devon & Exeter NHS Foundation Trust (RD&E). These services do not require patients to make an appointment and are managed by specialist nurses who can treat minor injuries or illnesses such as sprains, cuts and minor infections.

Pan-Devon services

The Trust provides a range of specialist community services across Devon including:

- Bladder and bowel care
- Community nursing
- Physiotherapy
- Occupational therapy
- Radiology
- Speech and language therapy
- Continuing healthcare
- Sexual health services including family planning
- Podiatry
- Cardiac rehabilitation/heart failure
- Parkinson's Disease
- ME (chronic fatigue syndrome)

Stakeholders

To meet local healthcare needs, we work closely with the following organisations:

- South West Strategic Health Authority*
- National Trust Development Authority
- Devon Primary Care Trust*
- Cornwall & Isles of Scilly Primary Care Trust*
- Somerset Primary Care Trust*
- Northern, Eastern and Western Devon Clinical Commissioning Group
- Devon Partnership NHS Trust (mental health)
- Royal Devon & Exeter NHS Foundation Trust
- Plymouth Hospitals NHS Trust
- Taunton Hospitals NHS Foundation Trust
- South Western Ambulance Service NHS Trust

- Devon County Council
- Devon County Council Adult and Community (Social) Services
- Parish, town and district councils

**NB: Since the implementation of the Health and Social Care Act in April 2012 the commissioning bodies no longer exist in their current form. However, we continue to work closely with the successor organisations, chiefly the National Trust Development Authority and the Northern, Eastern and Western Devon Clinical Commissioning Group.*

The Trust continually reviews services to ensure that they follow the latest guidelines in clinical best practice and policy, and is committed to involving service users, patients, carers and the public in planning, developing, delivering and improving healthcare services.

The Annual Report contains examples of system change that have been implemented during the year for the benefit of our patients. Examples include:

- The new women's and children's unit at NDDH
- Sidmouth Hospital's plans for a £1.2million refurbishment
- Seaton Home Nursing Team's win in Healthcare Hero Awards
- The Trust's leading role in the newly-formed Academic Health Science Network
- Shorter recovery time for patients through enhanced recovery programme
- Innovative 'telehealth' support for people with respiratory problems
- The Audit Commission's rating of the Trust as one of best in the country for day-case surgery
- Reduced waiting times for eye patients
- East Devon dementia service's national award
- The launch of hourly RU OK? checks
- Reducing falls

- Matron walkrounds
- Reducing pressure ulcers of patients in our service
- C.Difficile
- MRSA
- Reducing the number of infections after surgery

Other highlights:

- The Trust's launch of the Friends and Family Test to capture immediate feedback
- The Trust's use of 'mystery shoppers' to give feedback on services.
- Improving the experience of patients with dementia
- Launch of the Rapid Assessment at Home service in Exeter

3. Trust Governance and Board-level changes

The Trust is directed by the Trust Board, which meets regularly to determine strategy and receive information from those managing day-to-day operations.

The Trust Board is led by a Chairman, together with a team of five non-executive directors and five executive directors. The non-executive directors have a part-time role, providing experience and expertise, usually gained from working in organisations outside the NHS.

The executive and associate directors are led by the chief executive and combine their role as board members with regular management responsibility.

The Trust experienced the following non-executive director movements during the financial year:

- Dr Tim Douglas-Riley started on 1 July 2012
- Amelia Tucker Jones resigned on 1 February 2013

Full details of these and other executive and

non-executive directors are contained within the remuneration report. The treatment of pension liabilities can be found on page 109 of the accounts.

The Board has adopted codes of conduct and accountability recommended by the NHS Executive. Audit, Risk, Clinical Governance and Remuneration and Terms of Service Committees and other subcommittees of the Board are well established. Details of company directorships or other significant interests held by directors where those companies are likely to do business, or are possibly seeking to do business with the NHS where this may conflict with their managerial responsibilities, are required to be disclosed in the Declaration of Members' Interests. This is presented at each Board meeting and is updated as required.

The Declaration of Members' Interests is available for inspection from Corporate Affairs, Munro House, North Devon District Hospital, Raleigh Park, Barnstaple, North Devon. EX31 4JB.

The Board receives assurance from many sources and these are detailed in the Annual Governance Statement.

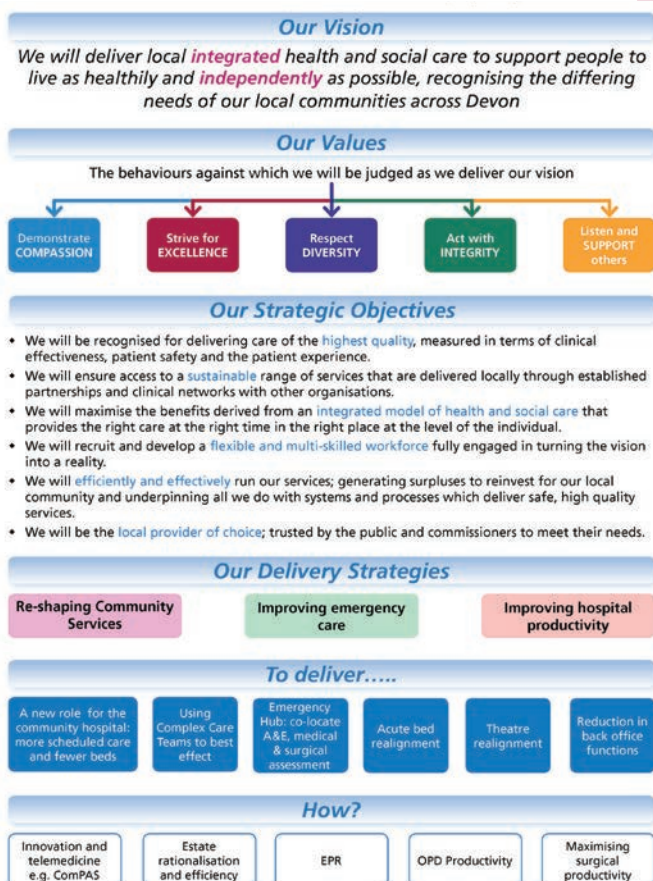
4. Vision, values and strategic objectives

Delivering our strategic objectives and realising our vision will give the Trust the best chance to face the unprecedented challenges ahead, particularly coping with the large increase in the number of older people and the constrained financial climate.

It is expected that the Trust will ensure that it will be able to manage with the anticipated 12% increase in demand for hospital services from older people over the next five years through the provision of safe, quality, integrated services supported by strong financial management.

In the future this will mean that more patients will be treated at home, with the consequence that those treated in hospital will be more complex than is currently the case.

The increased cost of this will be off set by increased efficiency across the service lines of the Trust. In addition, market opportunities to expand the footprint of the Trust, both geographically and into increased social care ,will be explored, as long as such opportunities make a positive contribution to overheads.



5. Trust operational performance

The Trust’s operational performance indicators are reported under the following categories:

- Control of infection
- Cancer access targets
- Quality indicators
- Patient access targets

Key to performance traffic lights

Key	Traffic light	Performance
●	Red	Worse than plan
▲	Amber	Close to plan
✓	Green	= to or better than plan

Control of infection

The Trust has had a very successful year in the management and control of infections against its thresholds.

	Last Full Year		Last 4 Quarters				Current Quarter			FOT
	2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	January 2013	February 2013	March 2013		
MRSA (Acute >2 Day) Annual threshold = 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	
MRSA (East CHs >2 Day) Annual threshold = 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	
MRSA (North CHs >2 Day) Annual threshold = 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	
MRSA Screening Acute Elective	●	✓	✓	✓	✓	✓	✓	✓	✓	
MRSA Screening Acute Non-Elective	●	●	●	▲	▲	▲	✓	✓	▲	
MSSA (Acute >2 Days) Annual threshold = 8	✓	✓	✓	✓	✓	✓	✓	✓	✓	
MSSA (East CHs >2 Days) Annual threshold = 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	
MSSA (North CHs >2 Days) Annual threshold = 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	
E.Coli (Acute >3 Days) Annual threshold = 21	✓	✓	▲	✓	✓	✓	✓	✓	✓	
E.Coli (East CHs >3 Days) Annual threshold = 2	✓	✓	✓	●	●	✓	▲	✓	✓	
E.Coli (North CHs >3 Days) Annual threshold = 1	✓	✓	✓	✓	✓	✓	✓	✓	✓	
C. Difficile (Acute only) Annual threshold 17	✓	✓	✓	✓	✓	✓	✓	▲	✓	
C.Difficile (East CH >3Day) Annual threshold = 32	▲	▲	✓	✓	✓	✓	✓	✓	✓	
C.Difficile (Nth CH >3 Days) Annual threshold = 4	✓	✓	✓	●	✓	✓	✓	✓	✓	

Cancer access target

Performance for patients accessing cancer services in a timely way was strong throughout the year.

The management of cancer for some patients can become very complex and requires the patient to be treated by another NHS hospital. This can result in some delays being incurred, which means that the 62-day access at another hospital can be missed.

All NHS trusts involved in the patient's care review the reasons for delay so that improvements can be made.

	Last Full Year		Last 4 Quarters					Current Quarter	
	2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	January 2013	February 2013	March 2013	FOT
Cancer 2-week wait from referral to date first seen	✓	✓	✓	✓	✓	✓	✓	✓	✓
2-week wait from referral to seen - breast symptomatic	✓	✓	✓	✓	△	✓	△	✓	✓
Cancer 31-day diagnosis to treatment	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cancer 31-day subsequent treatment - surgery	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cancer 31-day subsequent treatment - drug	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cancer 62-day urgent referral from GP	✓	✓	✓	✓	✓	✓	✓	✓	✓
Cancer 62-day referral from screening service	✓	✓	△	●	✓	✓	✓	✓	✓
Cancer 62-day consultant upgrade referral	✓	✓	✓	✓	✓	✓	✓	✓	✓
62 day urgent referral to treat at other hosp	●	●	△	●	●	●	●	●	●
62-day urg referral to treat Trust overall	✓	△	✓	✓	✓	✓	△	✓	✓

Quality indicators

There are a broad range of indicators that the Trust reports as an indication of the underlying quality of services.

	Last Full Year	Last 4 Quarters					Current Quarter		
	2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	January 2013	February 2013	March 2013	FOT
Cancelled operations As % of electives	✓	△	△	✓	△	△	✓	△	△
Cancelled operations rebooked <28 day	✓	✓	△	✓	✓	✓	✓	✓	✓
Fractured neck of femur operated on <48Hrs	✓	△	✓	△	△	△	✓	●	△
Delayed transfer of care (acute)	✓	✓	✓	✓	✓	✓	✓	✓	✓
Delayed transfer of care (Northern CHs)	●	●	●	●	✓	△	△	△	△
Delayed transfer of care (Eastern CHs)	●	●	●	●	●	△	△	△	△

Cancelled operations

Since 2008/09 the Trust has experienced unprecedented increases in the level of emergency admissions and A&E attendances. Despite best endeavours, continued pressure in these areas can impact on the ability to maintain elective operations.

Delayed transfers of care

Delayed transfers of care affect the efficiency of the Trust and impacts on the time a patient can either spend in a hospital bed or the time a patient can spend waiting to be admitted into a hospital bed.

The impact of delayed discharges affects the flow of patients through the hospital system and so has an impact on access targets such as the minimum four-hour wait in A&E.

Delays can be caused by processes that can be controlled or influenced by the Trust as well as others that are not in our control. Examples would be awaiting a social care assessment or care package, or waiting for a residential nursing home placement to become available.

'Never events'

Key quality & safety indicators	Last	Last 4 Quarters				Current			
	FY	4	1	2	3	J	F	M	FOT
Never Events	●	✔	●	✔	●	✔	✔	✔	✔

'Never events' by definition should not happen. The Trust has a stringent process including reporting, investigating and learning from errors that impact on patient safety, which is visible to those impacted and to the Trust Board.

Patient access targets

The Trust has maintained its achievement of treating patients within the required waiting times.

The following results were taken from the May 2013 Performance Report that detailed our performance against the patient access targets. These results are published monthly to the Board.

Indicator	Last Full Year	Last 4 Quarters					Current Target	Current Quarter					
	2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13	January 2013		February 2013		March 2013			
	Status	Status	Status	Status	Status	Status		Value	Status	Value	Status	Value	
18 wk RTT admitted	✔	✔	✔	✔	✔	>90%	✔	94.7%	✔	94.6%	✔	95.2%	
RTT admitted median – weeks	✔	✔	✔	✔	✔	<11.1	✔	10.10	✔	10.0	✔	9.0	
RTT admitted 95th per – weeks	✔	✔	✔	✔	✔	<23.0	✔	18.6	✔	18.4	✔	18.0	
18 wk RTT non-admitted	✔	✔	✔	✔	✔	>95%	✔	99.3%	✔	99.5%	✔	99.5%	
RTT non-admitted median – weeks	✔	✔	✔	✔	✔	<6.6	✔	3.1	✔	2.9	✔	2.9	
RTT non-admitted 95th per – weeks	✔	✔	✔	✔	✔	<18.3	✔	12.0	✔	11.6	✔	11.7	
18wk RTT incomplete pathways	✔	✔	✔	✔	✔	>92%	✔	98%	✔	97.8%	✔	97.9%	
Diagnostics waiting > 6 weeks	▲	▲	✔	✔	✔	>99%	✔	99.2%	✔	99.5%	✔	99.4%	

Indicator	Last Full Year	Last 4 Quarters				Current Target	Current Quarter					
	2011/12	Q4 2011/12	Q1 2012/13	Q2 2012/13	Q3 2012/13		January 2013		February 2013		March 2013	
	Status	Status	Status	Status	Status		Status	Value	Status	Value	Status	Value
18 wk RTT admitted	✓	✓	✓	✓	✓	>90%	✓	1007%	✓	100%	✓	100%
RTT admitted median – weeks	✓	✓	✓	✓	✓	<11.1	✓	6.0	✓	9.0	✓	5.0
RTT admitted 95th per – weeks	✓	✓	✓	✓	✓	<23.0	✓	8.75	✓	10.8	✓	11.6
18 wk RTT non-admitted	✓	✓	✓	✓	✓	>95%	✓	99.4%	✓	99.3%	✓	99.3%
RTT non-admitted median – weeks	✓	✓	✓	✓	✓	<6.6	✓	5.78	✓	7.0	✓	7.0
RTT non-admitted 95th per – weeks	✓	✓	✓	✓	✓	<18.3	✓	11.86	✓	12.0	✓	12.0
18wk RTT incomplete pathways	✓	✓	✓	✓	✓	>92%	✓	99.5%	✓	100%	✓	99.2%
Diagnostics waiting > 6 weeks	⚠	⚠	✓	✓	✓	>99%	✓	99.8%	✓	99.8%	✓	99.5%

The Board would like to take this opportunity to recognise the dedication and hard work of all staff that has made 2012/13 such a successful year.

6. Financial performance

There are a number of targets set by the Department of Health. The Trust's 2012/13 performance against these targets is shown below:

Target	Actual performance
To break even on income and expenditure taking one year with another	In year surplus of £2,206k before impairments achieved the statutory duty
To achieve a capital cost absorption rate of 3.5%	Rate of 3.5% achieved
To operate within a Capital Resource Limit.	Achieved
To pay 95% of non-NHS invoices within 30 days	95% of bills paid within target (volume) 96% of bills paid within target (value)

Financial position

Activity

Before the start of each financial year, the Trust agrees with its commissioners the planning assumptions regarding the number of patients we expect to treat and access our services.

Since 2008/09 the Trust has experienced:

- an overall increase of 16% in the number of patients that attend A&E.
- an overall increase of 19% in total Emergency admissions.

As seen from the previous tables, the Trust has demonstrated achievement of its patient access targets for the year.

Acute contract activity					
Indicator	Year Cumulative				
	Plan	Actual	Diff	%	
GP referrals	30660	30638	-22	-0.1%	✓
Other referrals	18181	18314	133	0.7%	✓
Total referrals	48841	48952	111	0.2%	✓
Outpatient first attends	46684	46305	-379	-0.8%	⚠
Outpatient follow-up attends	96090	95184	-906	-0.9%	✓
Outpatient waiting list	2599	2850	251	9.7%	●
Elective DC activity	18939	18854	-85	-0.4%	✓
Elective IP activity	3714	3412	-302	-8.1%	●
Elective total activity	22653	22266	-387	-1.7%	⚠
DC rate overall	83.6%	84.7%			✓
Elective waiting list	1449	1512	116	4.3%	●
Non-elective (all inc mat.)	20977	20970	-7	0.0%	✓
Non-elective (general & acute)	16240	16406	166	1.0%	✓
A&E attends (NDDH)	40107	40329	222	0.6%	✓

Financial performance

2012/13 is the fourth year that the Trust has had to prepare its accounts and report financial performance under International Financial Reporting Standards (IFRS). Whilst this has not materially affected the Trust's underlying financial position, there is one fundamental change that continues to require clarification.

On first glance at the main accounts, it would appear that the Trust has moved from having a financial surplus in 2008/09 to a financial deficit in subsequent years. The table below is an extract from the breakeven performance contained in page 130 of the accounts:

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Retained surplus/(deficit) for the year	7,902	(5,086)	(93)	(5,724)	(1,051)

Under IFRS, the Trust is required to include a technical accounting adjustment for impairments within the Statement of Comprehensive Income.

Impairments relate to the IFRS requirement to revalue assets to modern equivalent asset valuation. Impairments are elements of capital expenditure that are incurred but which do not add to the value of the asset.

Where an insufficient revaluation reserve balance exists for that asset, the remainder is charged to the Statement of Comprehensive Income. The impairment charge for the year is £3,288,000.

This has no impact on the Trust's liquidity as it is a non-cash item. The Trust has a statutory financial duty to break even. The table below is an extract from the Financial Performance Targets contained in note 43.1 on page 130 of the accounts:

Note 39.1	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000	2012/13 £'000
Retained surplus/(deficit) for the year	7,902	(5,086)	(93)	(5,724)	(1,051)
Adjustment for Impairments and donated assets	0	5,086	345	7,443	3,257
Break Even in-year Position	7,902	0	252	1,719	2,206

Therefore, the Trust is able to report breakeven at an operational level and achievement of its Statutory Breakeven Duty.

Savings and efficiency

The ability of the Trust to deliver the full value of its savings programme has been severely affected by:

- Activity increases as a consequence of increased referrals to the Trust
- Increased emergency admissions

This variability in demand above the initial agreed contract activity plan affected the ability of the Trust to realise the productivity and efficiency opportunities in a planned way.

The Trust had a financial savings target for the year of £12.7 million.

The Trust achieved £11.7 million through cost-reduction and efficiency improvements, and earned £1.0million income above its financial plan, which contributed to the achievement of the target surplus for 2012/13.

Cost reduction plans are subject to a quality impact assessment undertaken by the medical director and director of nursing to ensure that patient safety, clinical effectiveness and quality of care are not compromised.

The Trust has constituted a Cost Improvement Plan Steering Group with executive director membership that oversees the delivery of the savings programme. The performance of savings and efficiency plans achieved during the year continued to be reported regularly to the Trust Board and Finance Committee.

Trust accounts

The Trust's accounts are audited annually by Grant Thornton UK LLP, Unit 26-28 Basepoint, 1st Floor, Yeoford Way, Marsh Barton Trading Estate, Exeter, EX2 8LB. The fee for this work is detailed on page 107 of the accounts.

A copy of the accounts is available from Kate Winter, PA to the Director of Finance, Trinity Suite, Level 5, North Devon District Hospital, Raleigh Park, Barnstaple, Devon, EX31 4JB.

Alternatively the files are available for download from our website at: www.northdevonhealth.nhs.uk

7. Where our money comes from

In 2012/13, the majority of the Trust's funding came from contracts with Primary Care Trusts (PCTs), which purchased healthcare on behalf of their residents.

Total income received by the Trust in 2012/13 was £220.7 million (£211.0m in 2011/12), a 4.6% increase on the previous year.

The source of each pound the Trust receives, together with the monetary equivalent of total income, is summarised below:

Source:	Monetary equivalent £m		Monetary equivalent £m	
	2011/12	2011/12	2012/13	2012/13
Primary Care Trusts	£0.92	£195.3	£0.91	£200.7
Other patient income	£0.01	£3.6	£0.03	£7.1
Total income from patient care	£0.93	£198.9	£0.94	£207.8
Other income	£0.05	£8.2	£0.04	£8.3
Education, training & research	£0.02	£3.9	£0.02	£4.6
Total other operating income	£0.07	£12.1	£0.06	£12.9
Total income	£1.00	£211.0	£1.00	£220.7

8. What we spend money on

The largest component of our expenditure is on salaries and wages. Over the year, the Trust employed an average of 3,779 whole time equivalent staff (3,662 2011/12) at an overall cost of £146.0 million (£140.1 million 2011/12).

Average staff numbers included 284 doctors (280 2011/12), 1,162 nursing staff (1,149 2011/12), 1,168 healthcare assistants and support staff (999 2011/12), 644 administration and estates staff (742 2011/12) and 521 scientific and technical and other staff (492 2011/12).

A further £27.3 million (£24.6 million 2011/12) was spent on clinical supplies such as drugs and consumables used in providing healthcare to patients.

The cost of running the premises and equipment amounts to £19.7 million (£18.1 million 2011/12) and general supplies and services which support the Trust's infrastructure cost £7.0 million (£7.0 million 2011/12).

The consumption of each pound the Trust spends, together with the monetary equivalent of total expenditure, is summarised below:

Applications:	Monetary equivalent £m		Monetary equivalent £m	
	2011/12	2011/12	2012/13	2012/13
Staff pay (inc. management)	£0.65	£140.1	£0.66	£146.0
Drugs & clinical supplies	£0.12	£24.6	£0.13	£27.3
Premises & equipment	£0.08	£18.1	£0.09	£19.7
General supplies & services	£0.03	£7.0	£0.03	£7.0
Depreciation	£0.06	£12.4	£0.04	£8.5
Services from other NHS bodies	£0.04	£7.9	£0.03	£6.4
Other expenses	£0.02	£4.4	£0.02	£5.0
Total income	£1.00	£211.0	£1.00	£220.7

9. Better Payment Practice Code

The Trust has a statutory requirement to pay 95% of non-NHS invoices within 30 days and details the Trust's performance against this.

The Confederation of British Industry (CBI) Better Payments Practice Code is a four-point code that organisations should adopt to ensure prompt payment to suppliers. The points are:

1. Agree payment terms at the outset
2. Explain payment procedures to suppliers
3. Pay bills in accordance with the contract or legislation
4. Prompt communication of disputed invoices

Under the Late Payment of Commercial Debts (Interest) Act, all businesses are entitled to claim statutory interest and debt recovery compensation for the late payment of commercial debts. Further details as provided on page 112 of the accounts are detailed below:

Note 11.1 Better Payment Practice Code - measure of compliance		
	2012/123	
	Number	£000
Total Non-NHS trade invoices paid in the year	57,138	58,816
Total Non NHS trade invoices paid within target	54,253	56,543
Percentage of Non-NHS trade invoices paid within target	95%	96%
The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.		
Note 11.2 The Late Payment of Commercial Debts (Interest) Act 1998		
	2012/13	2011/12
	£000	£000
Amounts included within Interest Payable (Note 13) arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
There were no payments in respect of late payments on commercial debts.		

10. Capital investment

In 2012/13 capital expenditure totalled £7.8 million. This included:

- £4.3m on Estate developments
- £1.3m on operational medical equipment
- £1.5m on operational IT
- £1.1m on backlog maintenance

The Trust received £176k in donations towards capital spend and is grateful to the Leagues of Friends, volunteers and contributors to charitable funds for their invaluable contribution to the Trust.

The Trust sold one of its properties, Lynton Resource Centre, during the year realising a receipt of £302k.

11. International Financial Reporting Standards (IFRS)

The Accounts for 2012/13 have been prepared in accordance with International Financial Reporting Standards.

12. Breakeven duty and 2013/14 financial outlook

NHS trusts are required to break even, taking one year with another. In practice this duty must be delivered over a three-year period and can be extended to five years with the permission of the Department of Health, starting with first year the deficit arises.

The Trust achieved its financial targets and the table below illustrates the impact on the Trust's cumulative deficit.

	2010/11	2011/12	2012/13
	Actual	Actual	Actual
	£'000	£'000	£'000
Post 1997 cumulative surplus/(deficit) b/fwd	(93)	(5,724)	(1,052)
Adjustments for impairments and donations	345	7,443	3,257
Breakeven surplus/(deficit)	252	1,719	2,205

Breakeven duty year	1	2	3
Breakeven duty achieved?	Yes	Yes	Yes

The current economic climate remains challenging to all public sector bodies as the level of funding reduces from historical levels. In particular, the Devon health economy faces a significant financial challenge in 2013/14 and we will be a proactive contributor in the process.

The diverse range of services provided by the Trust gives us the critical mass and opportunity to have a positive impact on the health outcomes for our patients.

13. Foundation Trust status

NHS foundation trusts remain part of the NHS but are free from central government control. Within clearly-defined guidelines, an NHS foundation trust can raise capital funding and external borrowing and determine the services they wish to provide. The Trust has in place a formal tri-partite agreement setting a timetable with NHS South of England and the Department of Health.

The Trust has submitted its Integrated Business Plan and Long-Term Financial Model and expects to achieve NHS Foundation Trust status during the 2013/14 financial year.

14. Sustainability statement

Northern Devon Healthcare NHS Trust views the efficient use of its resources as key indicator of its ability to reduce costs and environmental impact.

As one of the largest employers in Devon, the Trust is aware that through its business of providing healthcare to an area of 1,400 square miles its operating protocols can have a big environmental impact on local resources. The NHS Good Corporate Citizen guide identifies six areas that Trusts should focus on. These are:

Energy:

The Trust's annual energy budget is £2.8 million, and with the spiralling cost of energy this has become a priority area.

Through the management of energy usage and investment in energy-saving schemes and processes, the Trust has achieved a reduction in utility consumption by a further 1.5% during 2012/13 financial year. This achievement resulted in a lower energy consumption of £390/m², in line with the best performers in the UK.

Waste:

Environmental impact and compliance with statutory waste regulations are key areas for the Trust. In the last financial year we have successfully reduced the volume of waste through efficient segregation and increased recycling.

The Trust continues to remain proactive in all areas of waste management and has extended its segregation programme. This ensures that the Trust remains compliant with legislation, that the environmental impact of our services is minimised and that the Trust manages the cost of producing waste.

Healthy travel:

The Trust promotes healthy travel within its workforce by advertising public transport access and cycle schemes.

In 2012 the Trust expanded its partnership with local bus services, reducing the cost of travel, encouraging more people to use public transport and leave their cars at home. There was a big emphasis on encouraging staff to share car transport. In support of the cycle-to-work scheme, changing facilities are maintained at all sites for those wishing to participate.

Also, for those who are required to do business journeys within their role, the Trust has entered into a contract with Enterprise car rentals in order to gain access to and utilise a newer, more-efficient car fleet.

Procurement:

Procurement of goods and services plays a big part in the sustainable approach the Trust has with its suppliers. Through such processes, the amount of packaging is reduced, local resources accessed and consideration given to the environmental impact of goods in their purchase, use and final disposal.

The Trust actively encourages the use of NHS Supply Chain for its consumable purchases in order to benefit from a one-vehicle delivery, as opposed to multi-vehicle deliveries.

Estate development:

The Trust's aim is to ensure that the properties within its estate are fit for purpose and support the delivery of a modern healthcare service. Key to this is a design and layout that should provide the right ambience and should support the efficient provision of healthcare services to ensure it does not impact on local or national resources. All development is specified with the use of sustainable products and energy efficiencies that meet Department of Health benchmarks.

Work force:

The Trust is actively involved in the continual improvement of the working environment and facilities for its workforce. Key is the provision of a safe and secure environment where employees are able to work without the threat of violence, aggression or abuse, but also in an ambience that supports and facilitates the delivery of their activity. The Trust ensures there is a continual monitoring of such environments and facilities through the use of staff surveys and feedback.

15. Emergency preparedness, resilience and response

The Trust's director of operations has strategic responsibility for emergency preparedness, resilience and response across the Trust and for providing assurance to Trust Board that the organisation meets its statutory and legal requirements. The director is supported by the divisional general manager for emergency services who has operational lead responsibility for emergency preparedness, resilience and response.

Major Incident Plan

The Trust regularly reviews and updates its Major Incident Plan, which is published permanently on the staff intranet. The plan complies fully with national guidance for emergency preparedness, resilience and response. This ensures that should a major incident occur which requires a response from healthcare organisations, the Trust has the necessary systems and processes in place for staff to take appropriate action.

The Civil Contingencies Act (2004) ensures that the United Kingdom is prepared to deal with major disruptive challenges, however they might occur. Under the Act, the Trust is classed as a Category 1 responder with responsibilities including:

- Assessment of the risks of an emergency occurring and using this to inform contingency planning
- Putting emergency plans in place
- Having business continuity arrangements in place
- Putting 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
- Sharing information with other local responders to enhance co-ordination
- Co-operating with other local responders to enhance co-ordination and efficiency

Working closely with our partners and other stakeholders is fundamental to the Trust's ability to respond to a major incident and maintain business continuity of core services and critical functions.

The Trust is a member of the Devon, Cornwall and Isles of Scilly Local Resilience Forum. The forum, which is hosted by Devon and Cornwall Police, enables Category 1 and 2 emergency responders and specific supporting agencies to consult, collaborate and disclose information with each other to facilitate planning and response to emergencies, and produce a Community Risk Register.

Business continuity

NHS organisations and providers of NHS-funded care must have suitable, up-to-date plans which set out how they will:

- Maintain continuous service when faced with disruption from identified local risks
- Resume key services which have been disrupted by, for example, severe weather, IT failure, an infectious disease, a fuel shortage or industrial action

The Trust's Business Continuity Strategy was approved by the Trust Board in May 2012. A business impact analysis was completed and all Trust core services and supporting critical functions were identified. Operational leads identified a number of

risks to the delivery of these, and business continuity (contingency) plans have been under development.

Business continuity planning is supported by the Trust's capacity and escalation plan, which is reviewed on an annual basis.

The Trust planned for a severe winter, tracking an increase in admissions and activity back to October 2012 and taking in to account potential and actual outbreaks of infection. The winter vomiting disease, Norovirus, struck earlier than usual this year.

Exercise and testing

In March and October 2012, the Trust's communications cascade arrangements were successfully tested by our external partners, South Western Ambulance Service NHS Foundation Trust.

To ensure that all of our acute, community and specialist services were prepared for winter, an emergency planning exercise was staged in November 2012, dubbed 'Winter Wonderland'. This exercise successfully tested the Trust's integrated response to severe weather events affecting the delivery of Trust core services in hospitals and community services.

Response to incidents

In early 2012, the Trust was fully involved in the Devon and Cornwall multi-agency preparation for the Olympics and the Olympics torch relay. This work was coordinated by the police and local authorities.

Extra staff resources were made available in Exeter Sidwell Street Walk-in Centre and in the Emergency Department of North Devon District Hospital. This was to support the emergency and voluntary services response to the large numbers of spectators on the route and large numbers of participants in activities which were planned to coincide with the relay.

The torch relay passed through Devon, and all scheduled activities took place, without incident, on 20 and 21 May 2012.

Over the past year, the Trust has opened its Incident Control Room and convened an Incident Response Team on four occasions; once to manage an internal incident affecting several key departments, and three times to mitigate the health and safety and business continuity impacts of severe flooding, ice and snow across Devon in November and December 2012 and in January 2013.

Annual Governance Statement

I. Scope of responsibility

The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

With regard to the accountability arrangements for the Trust, the following routine meetings are attended by the Chief Executive and/or executive directors:

Internal reporting:

- Weekly Executive Directors Group meetings
- Monthly performance meetings with the Director of Finance and Performance and the Director of Operations with general managers
- Monthly Finance Committee
- Monthly Clinical Services Executive Committee meetings
- Monthly Heads of Department meetings
- Quarterly Strategic Workforce Development Committee meetings
- Board meetings, at least ten times a year

Stakeholder reporting:

- Attendance at the Northern, Eastern and Western Devon Clinical Commissioning Group meetings when required
- Attendance at the Local Involvement Network (LINK) meetings and the Overview and Scrutiny Committee when required
- Additionally, the Trust Executive team have attended Devon health community meetings when they have been convened

Networking meetings:

- Chief Executive Director and Chairman
- Director of Finance
- Medical Director
- Director of Nursing
- Director of HR
- League of Friends

2. The Governance Framework of the Organisation

2.1 Board composition

During 2012/13, the membership of the Trust Board changed following the resignation of one non-executive director at the end of January 2013 (Table 1). The appointment of a new non-executive director is ongoing in accordance with the requirements of the NHS Trust Development Authority.

Table 1 – Board membership for 2012/13

Non-Executive Directors		
Name	Role	Comment
Roger French	Chairman	
Pauline Geen	Non-Executive Director	
Nick Lewis	Non-Executive Director	
Jane Reynolds	Non-Executive Director	
Chris Snow	Non-Executive Director	
Amelia Tucker-Jones	Non-Executive Director	Resigned end of January 2013, appointment process ongoing.
Executive Directors		
Jac Kelly	Chief Executive	
Alison Diamond	Medical Director	
Kate Lyons	Director of Operations	
Carolyn Mills	Director of Nursing	
Andy Robinson	Director of Finance & Performance	

In July 2012, an associate non-executive director with a clinical background was appointed in order to reflect best practice. The Associate Non-Executive Director attends Board meetings but does not have voting rights. He is a member of some of the sub-committees of the Board.

Board meetings are also attended by the Director of Workforce & Organisational Development, Director of Facilities, Commercial Director and Head of Corporate Governance. The Associate Director of Health & Social Care also attends Board meetings to reflect the Trust's provision of adult community services.

2.2 Board committee structure

During 2012/13, the Trust Board reviewed the Board's committee structure. In October 2012, the Board agreed to dis-establish the Foundation Trust Application Steering Group as a significant amount of work had been completed. This also reduced duplication of effort as the routine updates of outstanding issues relating to the Foundation Trust application process were being presented to both the Foundation Trust Application Steering Group and the Board.

In November 2012, it was agreed to review the role and functions of the Strategic Workforce Development Committee with a view to establishing it as a sub-committee of the Board. The Committee currently reports directly to the Director of Workforce & Organisational Development. The role of the new committee would be to provide leadership and assurance that Northern Devon Healthcare NHS Trust's workforce management and processes are in place and effective and to support the Organisational Development programme of work. A decision on the future role of this committee will be made in 2013/14.

In 2012/13, the sub-committees of the Trust Board comprised:

- Audit & Assurance Committee
- Charitable Funds Committee
- Finance Committee
- Foundation Trust Application Steering Group – dis-established in October 2012
- Quality Assurance Committee
- Remuneration and Terms of Service Committee

Membership of each sub-committee includes non-executive and executive directors, as well as other staff who may be full members, act as specialist advisers or be in attendance. Each sub-committee is chaired by a Non-Executive Director. The terms of reference and membership of the sub-committees are reviewed on an annual basis and, following

approval by the relevant sub-committee, are presented to the Board for ratification.

Attendance by Board members at the relevant Board sub-committees is shown in Appendix 1.

2.3 Trust Board meetings

In 2012/13, the Trust Board met ten times in public. Each meeting was quorate and attendance of the members of the Trust Board is shown in Table 2 below.

Table 2 – Board attendance 2012/13

	Attendance	24.04.12	22.05.12	26.06.12	24.07.12	25.09.12	23.10.12	27.11.12	22.01.13	26.02.13	26.03.13
Non-executive directors											
R French	10/10 100%	X	X	X	X	X	X	X	X	X	X
P Geen	10/10 100%	X	X	X	X	X	X	X	X	X	X
N Lewis	10/10 100%	X	X	X	X	X	X	X	X	X	X
J Reynolds	8/10 80%	X	X	X	X	X	-	X	-	X	X
C Snow	10/10 100%	X	X	X	X	X	X	X	X	X	X
A Tucker-Jones	8/8 100%	X	X	X	X	X	X	X	X		
Executive directors											
J Kelly	9/10 90%	X	X	X	-	X	X	X	X	X	X
A Diamond	8/10 80%	X	-	X	X	X	X	X	X	X	-
K Lyons	10/10 100%	X	X	X	X	X	X	X	X	X	X
C Mills	8/10 80%	X	X	X	-	X	X	X	X	X	-
A Robinson	9/10 90%	X	X	-	X	X	X	X	X	X	X

Throughout the year, the agenda for the Board meetings was reviewed to ensure that the Board considered:

- Quality issues as the first item on the agenda
- Patient stories to provide the Board with direct feedback on patients’ experience
- Emerging issues as potential risks or opportunities to the organisation
- The balance between strategic issues and operational detail
- Reports that required the whole Board’s input and/or decision rather than reports that had already been discussed and/or agreed at the sub-committee level, and
- Questions from the public at the end of the Open Board meeting

The Board agenda will continue to be kept under review.

The function of the Board Briefing programme and information contained in the routine Board Briefing packs have been reviewed to ensure the Board had sufficient opportunity to discuss and consider the business details to support the informed decision-making process of the Board. In addition, a process for disseminating flash reports to Board members continued between Board meetings to ensure information is shared between Board members in a timely way.

2.4 Key issues of Board reports 2012/13

A summary of the key issues reported to the Board is set out below:

- Approval of the Trust’s Vision, Strategic Objectives and Values
- Approval of the Trust’s Annual Corporate Objectives 2012/13
- Approval of the iterations of the Integrated Business Plan and Long-Term Financial Model

- Approval of key Foundation Trust documents that form part of the application for Foundation Trust status
- Approval of the Annual Accounts 2011/12
- Ratification of the Charitable Funds Annual Report and Accounts 2011/12
- Approval of the Budget 2012/13
- Approval of the Board Governance Memorandum
- Approval of the Board Quality Governance Statement and Memorandum
- Approval of the Quality Account 2011/12
- Receipt of the Staff Survey 2012
- Receipt of the National Patient Survey 2011
- Receipt of the Liaison Psychiatric Annual Report 2011/12
- Ratification of the Clinical Audit and Effectiveness Strategy 2012-15
- Ratification of the Quality Improvement Strategy 2012-15
- Approval of the Business Continuity Strategy
- Approval of the Employee Engagement Strategy
- Approval of the Equality Objectives
- Approval of the Information Governance Strategy
- Approval of the Trust's membership as a voting member of the South West Peninsula Academic Science Network
- Ratification of the Trust's membership of the Peninsula Pathology consortium that comprises four NHS Trusts in Devon and Cornwall and has been established to deliver the benefits outlined in the Carter report into Pathology Services.
- Approval of the collaborative procurement of a clinical information system for acute and community hospitals with Gloucestershire Hospital NHS Foundation Trust and Yeovil District Hospital NHS Foundation Trust

- Approval of the Trust's withdrawal from membership of the South West Pay Consortium and rejection of the Consortium's proposals with a re-iteration of the Trust's commitment to staff that it would not initiate any negotiation that removed Trust staff from national pay, terms and conditions.

2.5 Key issues from Board sub-committee reports 2012/13

An annual committee compliance report for each sub-committee is published which details the sub-committee's activity, routine business and key outputs, areas of development and members' attendance. The annual committee compliance report is presented to the relevant sub-committee for approval before ratification by the Board.

A summary of the principal review areas, key outputs and main areas of development undertaken by each of the sub-committees to improve the sub-committee's effectiveness and to enhance the assurance process is set out below.

Audit & Assurance Committee

The principal review areas and key outputs include:

- Internal Audit Plan 2012/13 – The committee reviewed and approved the annual plan.
- Counter Fraud Plan 2012/13 – The committee reviewed and approved the annual plan.
- Scheme of Delegation, Standing Orders and Standing Financial Instructions – The committee reviewed the amended documents and recommended approval to the Trust Board.
- Principal Risk and Assurance Register – The committee reviewed the Register and supporting action plan. This report is also presented to the Trust Board to note.

- Annual Governance Statement 2011/12 – The committee reviewed and approved the Annual Governance Statement for the period 1 April 2011 to 31 March 2012 and confirmed that it was consistent with the view of the Committee on the Trust’s system of internal control.
- Head of Audit Opinion – The committee received the Head of Audit Opinion 2011/12 and Internal Audit Annual Report 2011/12 and noted its conclusions of significant assurance in respect of the system of internal control.
- Annual Accounts – The committee reviewed and approved the Annual Accounts and Financial Statements for 2011/12 and recommended them for Board approval.
- Annual Governance Report 2011/12 – The committee received the Annual Governance Report prepared by the Audit Commission.
- Annual Audit Letter 2011/12 – The committee received the Annual Governance Report prepared by the Audit Commission and noted that the Trust had received an unqualified opinion for both the financial statements and for value for money.
- Counter Fraud Annual Report 2011/12 – The committee received the annual report prepared by the Local Counter Fraud Specialist.
- Audit South West Annual Report 2011/12 – The committee received the annual report prepared by the internal auditors.

Main areas of development include:

- Transforming Community Services Due Diligence Process

Following the exercise transferring community services in Exeter, East and Mid Devon to the Trust, the committee requested that an update of the Transforming Community Services be provided as a standing agenda item. The committee repeatedly reviewed the progress of the Due Diligence Report and the outstanding issues from the exercise, in particular the transfer of assets and premises.

The standing item was removed from the committee’s agenda when the issues were transferred for oversight and monitoring by the Finance Committee, another sub-committee of the Trust Board.

- Internal audit reports

During the year, the Committee identified a number of high-risk internal audit reports that related to quality and safety and it was agreed that the Chair of the Audit and Assurance Committee would request the Chair of the Quality Assurance Committee to seek additional assurance that the recommendations from these internal audit reports were being actioned.

- In-depth risk reports

At the request of the committee, an in-depth review was undertaken on a high-score risk to highlight the barriers to progressing the mitigation of the risk and provided assurance that action was being taken to manage the risk effectively.

The committee also received a second in-depth review of a high-score risk that had been identified by the Risk Management Committee.

- Stock-control process

The committee noted the issues that had been raised by the external auditors in terms of stock control processes and that action was being taken to address the issues, in particular to ensure there is an accurate stock valuation. Relevant members of staff were requested to attend the committee meeting to provide assurance that effective action was being taken.

Charitable Funds Committee

The principal review areas and key outputs include:

The Committee approved:

- The Charitable Funds Annual Accounts 2011/12
- The Charitable Funds Annual Report 2011/12
- The Fundraising Strategy
- The Fundraising Policy

The Committee received:

- Progress reports on the Chemotherapy Appeal
- Reports on the transfer of charitable funds from NHS Devon for Eastern Community Hospitals and Services
- Reports on the transfer of charitable funds to Devon Partnership Trust charitable funds, and
- Guidance on the regulation and governance of NHS Charities

Main areas of development include:

- The representatives from Barclays were changed and their specialty covers third sector not-for-profit organisations, and
- A survey had been undertaken asking fund holders what their annual plans were for using the available charitable funds. No large schemes had been identified.

Finance Committee

The principal review areas and key outputs are as follows:

- Monthly financial reports are made in anticipation of the Trust becoming an NHS Foundation Trust with an emphasis on Financial Risk Ratings. These include the Capital Programme.
- Updates on the 2012/13 contracting issues with NHS Devon
- 2012/13 contract heads of terms

- CQUIN Indicators for 2012/13
- Continuous Improvement Programme governance process and procedures, including Quality Impact Assessments
- Continuous Improvement Programme performance
- Approval of PACS Business Case
- Post Project Review – Children’s services
- Eastern Charitable Funds transfer
- Budgeting

Main areas of development include:

- A presentation on the implementation of service line reporting.
- Understanding and challenge of the financial risk rating and indicators of future financial risk.
- A presentation on the Quality Impact Assessment process used to support the Cost Improvement Programme implementation.

Foundation Trust Application Steering Group

The principal review areas and key outputs are as follows:

- Foundation Trust Application Report and Timeline – the Steering Group received regular reports from the Corporate Project Manager on the progress of the Foundation Trust application.
- Monitor’s Financial and Governance Risk Ratings – The Steering Group received regular reports from the Corporate Project Manager on the Trust’s position.
- Project Risk Log – the Steering Group regularly received and reviewed the project risk log.
- Commissioner Convergence – the steering group received frequent verbal updates on the progress made by the Trust towards achieving commissioner convergence.
- Membership update – the steering group received regular membership updates from the Head of Communications.

- Integrated Business Plan and Long Term Financial Model – The steering group received regular reports from the FT Project Director on the progress of the Integrated Business Plan.
- Long Term Financial Model – The steering group received regular reports from the Director of Finance & Performance on the progress of the Long Term Financial Model.
- Draft Constitution proposals – the steering group reviewed the draft constitution proposals and the legal implications of the Health and Social Care Act 2012.
- Historical Due Diligence Stage 2 Report – The steering group received the independent external assessor's report.
- Monitor's Quality Governance Framework Review – The steering group received the independent external assessor's report.
- Board Governance Memorandum Review – The steering group received the independent external assessor's report.
- Quality Review Assessment feedback – The steering group received the Strategic Health Authority's review report.
- Code of Conduct for Governors – The steering group approved Code of Conduct for Governors.

Main areas of development include:

- Following discussion at the Trust Board meeting in October 2012, it was agreed to dis-establish the steering group to avoid duplication of work.

Quality Assurance Committee

The principal review areas and key outputs are as follows:

- Following discussion of a serious incident investigation report, the committee requested that the action plan be expanded to include the details of what intermediate actions had been implemented to address the issues identified by the investigation as root causes
- Following discussion of a serious incident investigation report, the committee requested that a Trust-wide risk be recorded on the Corporate Risk Register relating to patients who are not medically fit being transferred to community hospitals
- Following discussion of a serious incident investigation report, the committee requested an additional action to be added to the action plan for the learning from the incident to be rolled out specifically to other areas where conscious sedation is used
- Following discussion of a serious incident investigation report, the committee requested an additional action to be added to the action plan regarding the trial of a new system which ensures urgent, unexpected findings from radiological diagnostic reports are notified to the referrer by email
- Following discussion of a serious incident investigation report, the committee requested an additional action to be added to the action plan regarding an audit of compliance with relevant National Patient Safety Agency and NICE guidance to be signed off by the Medical Director and Director of Nursing
- Following discussion of a serious incident investigation report, the committee requested that a risk recorded on the Corporate Risk Register relating to the reviewing of histology test results be reviewed to ensure that all mitigation actions have been implemented and whether the risk should be reviewed to include all test results not just histology
- Following discussion of a serious incident investigation report, the committee requested that the full report and supporting action plan be brought to the Trust Board's attention for further discussion to consider the wider issue strategic issue of the difficulties of staff in small isolated community hospitals being able to maintain their skills and competencies

The Committee approved:

- The Quality Account 2011/12
- The Quality Improvement Strategy 2012-15;
- The Clinical Audit and Effectiveness Strategy
- The Incident Management and Investigations Policy
- The Clinical Audit and Effectiveness Programme 2012/13

The Committee received:

- The Safeguarding Adults annual report 2011/12
- The controlled drugs annual report 2011/12
- The controlled drugs assurance report
- The Patient and Public Involvement annual report 2011/12
- The Organ and Tissue Donation annual Report 2011-12 and plan for 2012/13
- The Infection Prevention and Control Committee annual report 2011/12
- The revalidation of doctors annual report
- Monitor's Quality Governance Framework and updates
- The Board Statement and Memorandum of Quality Governance updates
- The Quality Account 2011/12 external audit report;
- The NICE quality standards assurance route
- The National Inpatient survey 2011
- The thematic review of South of England never events 2011/12
- The Midlands and East Quality Observatory report
- A number of multi-agency serious incident investigation reports

- Care Quality Commission Hospital Standardised Mortality Ratio COPD review report
- The Doctor Foster Hospital Guide 2012
- A report on the NHS Commissioning Board National Dataset
- The Trust's action plan to deliver improvement in the Trust's Hospital Standardised Mortality ratios and Summary Hospital-level Mortality Indicator
- An update on progress of the Clinical Audit and Effectiveness Programme, and
- A report on the Mid Staffordshire NHS Foundation Trust Public Inquiry

Main areas of development include:

- Patient stories

In May 2012, the committee agreed that each committee meeting should start with a patient story to highlight true patient and carers' voices and to support the momentum for changes that would not have come from patient satisfaction surveys or other patient feedback routes.

The patient stories are also presented to the Learning from Patient Experience Group and the Trust Board, and shared with local teams.

- NICE guidance

It was agreed that quarterly reports on NICE guidance should be presented to the Committee to provide assurance that the NICE guidance was being implemented.

- Quality-assessment process for Continuous Improvement Projects

It was agreed that the committee would receive the details of any Continuous Improvement Projects or cash-releasing efficiency savings schemes for higher-rated quality impact assessments.

- Patient Experience Quarterly Report

It was agreed by the Committee that the Patient Experience Quarterly report should be presented to the Learning from Patient Experience Group

rather than to the Committee. Any key risks or opportunities will be highlighted via the minutes.

■ Internal audit reports

During the year, the Audit & Assurance Committee identified a number of high-risk internal audit reports that related to quality and safety and it was agreed that the Chair of the Audit and Assurance Committee would request the Chair of the Quality Assurance Committee to seek additional assurance that the recommendations from the internal audit reports were being actioned.

As a consequence, a section on the internal audit reports related to quality and safety was included in the Trust Compliance Report. In addition, the relevant specialist sub-groups of the Quality Assurance Committee were required to review the internal audit reports and ensure that any key risks or opportunities were brought to the attention of the committee via the sub-groups' minutes.

■ Maternity Services Patient Safety Forum

In November 2012, it was agreed that the minutes, annual Committee Compliance Report and the terms of reference for the Maternity Services Patient Safety Forum should be presented to the Committee on a routine basis to ensure oversight by a sub-committee of the Trust Board.

■ Assurance from specialist sub-groups of the Committee and other specialist groups

As set out in the committee's terms of reference, a number of sub-groups and other specialist groups should present information in the form of minutes, terms of reference, annual Committee Compliance Report and Annual Report. In a number of cases, some of the scheduled information was not received by the Committee. In 2013/14, a schedule will be established to ensure that the required information is presented to the relevant sub-group and scheduled for the next available committee meeting. Where an item is deferred by the sub-group, this will

be highlighted by the Committee Chair and the Committee will agree whether the deferral is acceptable or not.

Remuneration and Terms of Service Committee

The principal review areas and key outputs are as follows:

- Chief Executive's recruitment
- Mutually Agreed Resignation Scheme – discussed at Remuneration and Terms of Service Committee; decision not to proceed taken at Trust Board.

Main areas of development include:

- Development of a framework to which bonus payment or increases to salary will be paid, taking into account the current economic climate;
- Receipt of information on salary of senior managers reporting to the Chief Executive and all Directors reporting to the Chief Executive, and
- Agreement of a framework to approve arrangements for payments to staff that fall under the following categories that are not a contractual entitlement:
 - Compromise agreements
 - Severance payments for all staff
 - Redundancy payments.

2.6 Board performance and effectiveness

Trust Board

In March 2012, the Board completed the Board Governance Assurance Framework for Aspirant Foundation Trusts, which is part of the Foundation Trust application process. The Board Governance Assurance Framework enabled the Board to make a self-assessment of its current capacity and capability supported by appropriate evidence that was externally validated by an independent supplier in April 2012. A number of areas of development were identified as part of this process which have been implemented in 2012/13, led by the Chairman.

Members of the Board participated in three externally-facilitated Board development days to develop skills and strategies to successfully participate in forthcoming board-to-board assessment with the NHS Trust Development Authority and Monitor as part of the Foundation Trust application process.

In July 2012, the Board approved the role of Non-Executive Champions to act as an independent advocate for a specific area and to challenge and raise awareness of that area at Board level. Non-Executive Champions were nominated for:

- Emergency Planning
- Quality & Safety
- Safeguarding – Adults and children
- Workforce – including security management

In January 2013, a Boardroom Bulletin was included in the Trust's bimonthly newsletter for staff and friends of the Trust. Compiled by the Chairman, it provides an update with the news to come out of the regular Trust Board meetings

Audit & Assurance Committee

The Audit and Assurance Committee has reviewed its own effectiveness against the self-assessment checklist from the Audit Committee Handbook (2011) to ensure it continues to provide assurance to the Board in line with best practice. A programme of Audit and Assurance Committee briefings continues to be undertaken in order to support the members. In addition, members of the committee attended a number of events arranged by external bodies, eg Audit Commission.

2.7 Compliance with the Corporate Governance Code

Throughout 2012/13, the Board has continued to build on the principles of good corporate governance. Corporate governance is the way in which organisations are directed, controlled and led. It defines relationships and the delegation of roles and responsibilities of those who work within the organisation, determines the rules and procedures through which the organisation's strategic objectives are set, and provides the means of attaining those strategic objectives and monitoring performance. Most importantly, it defines where accountability lies throughout the organisation.

To support the ongoing strengthening of corporate governance within the Trust, the Board has based its improvements on a number of key documents including:

- Standards of business conduct (Department of Health, 1993)
- Code of conduct for NHS managers (Department of Health, 2002)
- Building an assurance framework: a practical guide for NHS Boards (Department of Health, 2003)
- Code of conduct and accountability in the NHS (Department of Health, 2004)

- Integrated governance handbook (Department of Health 2006)
- Introductory guide – NHS Governance (Healthcare Financial Management Association 2011)
- Code of governance for NHS Foundation Trusts (Monitor, 2010)
- Audit committee handbook (Healthcare Financial Management Association 2011)
- Board governance assurance framework for aspirant Foundation Trusts (Department of Health, 2011)
- Integrated governance (Healthcare Financial Management Association 2011)
- Corporate governance in central government departments: Code of good practice (HM Treasury, 2011)

The Board complies with the Corporate Governance Code. All Board members follow the Nolan Principles on conduct in public life. In addition, where relevant, Board members also work within the requirements of their professional regulatory bodies.

In 2012/13, the Board formally, collectively affirmed and documented its understanding of the organisation's purpose and document the Board's role and responsibilities in a Board Operating Framework. The Board approved the re-appointment of a non-executive director as Vice-Chairman for a period of two years. The Director of Finance & Performance was formally re-confirmed as the Deputy Chief Executive. One of the non-executive directors was appointed as Senior Independent Director for a period of two years.

2.8 Compliance with the statutory requirements

Arrangements are in place for the discharge of the Trust's statutory functions and compliance is checked through a variety of external independent assessments including:

- The Trust commissions a comprehensive annual Internal Audit programme
- The Trust commissions a comprehensive Counter-Fraud programme of work
- Violence and aggression and security issues are supported by the Trust's Local Security Management Specialist
- The Trust is registered with the Care Quality Commission with no conditions
- The Trust reports RIDDORs to the Health & Safety Executive, and
- The Trust is subjected to external assessments and inspections, eg Information Commission and Care Quality Commission

Where partial or non-compliance is identified, supporting action plans are developed and performance monitored via the Trust's risk management arrangements.

The Trust also has a range of internal processes that require staff to ensure that they carry-out their duties in line with legislative and regulatory requirements, including:

- Register of Interests
- Standing Orders
- Standing Financial Instructions
- Scheme of Delegation, and
- Code of Conduct

In addition, staff are required to work to the regulatory requirements of their professional bodies.

No reports have been received to indicate that the Trust is not legally compliant.

3. Risk assessment

3.1 System of internal control

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

- Identify and prioritise the risks to the achievement of the organisation’s policies, aims and objectives
- Evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically

The system of internal control has been in place in Northern Devon Healthcare NHS Trust for the year ended 31 March 2013 and up to the date of approval of the annual report and accounts.

In making this statement, reference must also be made to the Head of Internal Audit Opinion which provided an overall opinion of ‘Significant assurance’ on the effectiveness of the organisation’s internal control systems and financial governance.

3.2 Capacity to handle risk

The Board and senior management are committed to risk management, as this is an integral part of achieving the Trust’s objectives and of being accountable to the public.

The Chief Executive has overall responsibility for risk management within the Trust. The Commercial Director has been nominated as the lead Director for risk management. Each director has responsibility for leading and reporting on the risk management plans for risks identified within their directorates. The directors are accountable to the Chief Executive in this role.

The line management and professional structures within the Trust ensure that responsibility for the implementation of risk management procedures and control of risks are in line with the scheme of delegation for their areas of responsibility. Support is provided by members of the Corporate Governance team to enable staff to identify and assess risks and to develop action plans to manage them. The Trust’s risk management arrangements have been embedded throughout the organisation, resulting in shared good practice.

Following the incorporation of community services as part of the Transforming Community Services initiative in April 2011, the Trust’s risk-management processes were rolled-out across the Eastern part of the Trust. The transferred risks were reviewed and either accepted as being no longer applicable, merged with existing risks as they represented duplication, or added to the Corporate Risk Register as new risks. A detailed audit trail has been kept. Any ongoing open risks continue to be managed via the Trust’s embedded risk management arrangements.

Statutory health and safety training is provided to all staff. Generic risk-assessment training is provided to the relevant staff. Further risk-management training, such as managing the Corporate Risk Register and the Principal Risk and Assurance Register, is targeted to the appropriate staff. This has enabled staff to manage risk in a way appropriate to their authority and duties. Training will continue to be provided over the next year.

3.3 Risk profile

As at 31 March 2013, there were 255 open risks recorded on the Corporate Risk Register (Table 3). During 2011/12, 325 new risks were recorded and 436 risks were accepted as the mitigating actions had been completed and the risk re-scored.

Table 3 – Risk profile of open risks as at 31 March 2012 (n = 255)

Category	Risk score	Number	% of Total
Low	1 - 6	30	12
Medium	8 - 12	173	68
High	15 - 25	52	20

4. The Risk and Control Framework

4.1 Risk Management Strategy

The Risk Management Strategy was reviewed in order to reflect the developments in risk management throughout the year and the impact of the incorporated community services as part of Transforming Community Services. It also included a new section on risk appetite. The Risk Management Strategy was approved by the Trust Board in February 2012.

The Risk Management Strategy includes the following:

- Details of the aims and objectives for risk management in the organisation
- A description of the relationships between various committees with a role in risk management
- Descriptions of the responsibilities of all levels of management and their levels of authority in respect of managing risk and operating a suitable system of internal control
- Summaries of the role of key individuals with responsibility for advising on and co-ordinating risk management activities
- A description of the tools that the organisation uses to review risk management performance and for gaining assurance about the management of risk
- The definitions of risk management, risk and other key terms
- Guidance on what is an acceptable risk to the organisation

It also includes a description of the whole risk-management process and requires all risk to be recorded, when identified, in a standard format risk register and prioritised using a standard scoring

methodology. The Corporate Risk Register includes all recorded risk, both clinical and non-clinical, for the organisation.

The Risk Management Strategy clearly states that it is the responsibility of all staff to identify risks and communicate those risks to the most appropriate person and/or committee. The Trust's risk-management arrangements ensure that all identified risks are assessed and validated and that actions are agreed to mitigate, minimise or accept the risk. Risks are performance-monitored and reviewed at regular intervals and the management of the risk may be challenged at any stage.

The Risk Management Committee was established in December 2006 to monitor and manage both clinical and non-clinical risks. Minutes of the Risk Management Committee meetings are presented to the Audit and Assurance Committee and the Quality Assurance Committee for information and challenge.

The role of the Audit and Assurance Committee has been expanded to monitor the management of high-scoring risks and to approve the management of the Principal Risk and Assurance Register. High-level clinical risks are monitored by the Quality Assurance Committee. The Terms of Reference of the two Board sub-committees reflect these functions.

All identified risks, including risks to data security, are entered onto the Corporate Risk Register, with supporting action plans to mitigate the risk. A robust system for validating the risk assessments and their scores and for performance monitoring the progress of the action plans has been put in place, supported by the Risk Team. Routine reports of new risks, exception reports and those risks that have been accepted are presented to the Risk Management Committee on a monthly basis for discussion and challenge.

The reporting schedule of risks has been reviewed to ensure the appropriate level of detail is presented to the relevant committees.

4.2 Board Assurance Framework

The Board Assurance Framework is monitored by the Audit and Assurance Committee. Key elements of the Board Assurance Framework are:

- Principal objectives
- Principal risks
- Key controls
- Assurances on controls
- Gaps in assurance
- Gaps in control
- Principal Risk Action Plan

In formulating the Board Assurance Framework, the Board has reviewed its strategic objectives. The Trust's vision and strategic objectives were reviewed in 2011/12 and approved by the Board in February 2012. The strategic objectives are used to confirm the Board agenda. The purpose of the Board Assurance Framework is to document the above and is used to examine the level of assurance on the effective operation of controls.

High scoring risks, ie with scores of 15 or more, recorded on the Corporate Risk Register are reviewed by the Risk Management Committee to allocate them into specific themes represented by a number of over-arching principal risks. To date, 12 principal risks have been identified. Individual high-scoring risks may be allocated to more than one principal risk.

The principal risks form the Board Assurance Framework and are recorded on the Principal Risk and Assurance Register, together with a description of existing controls and assurances and any gaps in controls or assurances. Where gaps have been identified, action is agreed by the Executive Team to manage the gaps and the information is set out in the Principal Risk Action Plan. The Principal Risk and Assurance Register and supporting action plan are monitored by the Audit and Assurance Committee and presented to the Trust Board for approval on a quarterly basis.

During 2012/13, further work has been undertaken to develop the Board Assurance Framework for the management of the Principal Risks facing the organisation – those risks that, if they materialised, would have a detrimental impact on the achievement of the strategic objectives and could lead to organisational failure or significant lost opportunities. The Board recognises that an effective risk management system process must be in place to ensure efficient and timely delivery of the Trust's 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 SWOT and PESTLE analyses
- A review of existing controls and assurance mechanisms in place to manage the Principal Risks and ensure delivery of the strategic objectives, and
- A process for identifying gaps in the controls and assurance and identifying the actions required to mitigate the gaps

The action identified to mitigate the gaps in the controls and assurance systems between them make up the annual corporate objectives for the Trust which translate into personal performance objectives for the Board directors and the annual work programmes for the Trust Board sub-committees. This ensures that the Trust Board is focussed on risks at a strategic rather than an operational level.

The principal risks are managed in accordance with the Trust's risk-management arrangements. In addition, the Board will review the principal risks on a routine basis through a quarterly Board Assurance Report to gain assurance that the agreed actions are being implemented and are effective. Where new principal risks are identified during the course of the year, they will be agreed by the Board and added to the risk management and reporting process.

In order to support the Trust Board's role in identifying risks to the delivery of the Trust's strategic objectives, the agenda for the Board meeting includes a standing agenda item for both executive directors and non-executive directors to raise emerging issues which may represent a risk or an opportunity to the organisation. This ensures that the Trust Board is made aware of emerging issues at an early stage and has an opportunity to discuss the potential impact on the Trust. In addition, key issues raised during the meetings of the sub-committees of the Trust Board are routinely highlighted and reported at the Board meeting by the sub-committees' chairs.

The Board Assurance Framework clearly states that the context for risk management should incorporate consideration of the organisation's stakeholders, including:

- Patients
- Public interests
- Service user interests
- Commissioners
- Ministers and the Department of Health
- Wider societal interests
- Risk aspects of relationships inside and outside of the NHS, including key suppliers of goods and services to incorporate:
- Ways in which the behaviour of 'partners' affects the Trust
- Ways in which the behaviour of the Trusts affects the partners
- The risk priorities of partners

4.3 Management of key risks

Data security risks

With regard to risks to information, the Trust recognises the need for an appropriate balance between openness and confidentiality in the management and use of information. Information is a vital asset, both in terms of the clinical management of individual patients and the effective control of services and resources. It plays a major part in clinical governance, service planning and performance management. Control measures have been put in place to ensure information is appropriately managed, and policies, clear procedures and accountability provide a robust governance framework for information management. These include controls to ensure confidentiality and appropriate security arrangements to safeguard personal information about patients, staff and commercially sensitive information. Other control measures ensure adherence to the requirements of the Freedom of Information Act and NHS Information Governance toolkit and controlled sharing of information with other agencies and health organisations through appropriate information-sharing protocols.

In February 2012, an internal audit report on the Trust's information governance toolkit found that, overall, there was potentially a medium potential adverse impact on the Trust's objectives. The report's recommendations and supporting action plan have been recorded onto the Trust's Corporate Risk Register and will be performance monitored via the organisation's risk-management arrangements.

In 2012/13, one serious data security incident was reported to the Information Commissioner's Office and formally investigated by the Trust. The Trust has provided additional information to the Information Commissioner's Office on request and is currently awaiting the office's conclusions.

Performance risks

The Trust handled further increased demand on emergency services with general and acute emergency admissions 3% higher than the previous year. On a number of occasions throughout the year, it has also been necessary to close beds to support infection control measures. Additional beds were opened as contingency, in accordance with Winter Pressure Plans, and some non-urgent elective surgery had to be cancelled during periods of peak demand. Consequent pressure on bed availability over extended periods has adversely impacted on the Trust's ability to achieve some Key Performance Indicators including the A&E four-hour standard, mixed-sex accommodation and some stroke standards.

Analysis of the Trust's Hospital Standardised Mortality Ratio (HSMR) has continued during the year, with further clinical review and detailed investigation. This work has contributed to a significant improvement in the rolling 12-month HSMR which is now within the normal expected range.

The Trust's local analysis indicates under-achievement for the following indicators at some points during the year:

- A&E waiting times – in 2012/13, levels of emergency demand have continued to include periods of peak pressure on the department and bed capacity.
- Mixed-sex accommodation – there have been periods during the year when pressure on bed capacity and the clinical need to admit necessitated proactive decision to breach mixed-sex accommodation standards in order to deliver prompt and appropriate care
- 'Never events' – one 'Never event' was recorded during 2012/13
- Stroke service indicators – contributing factors in underachievement of the 90% of stay indicator have been a 14% increase in stroke admissions and general pressure on emergency demand

Achievement of indicators has been monitored by the Trust throughout the year via:

- Monthly directorate performance meetings
- Routine reports to the Trust Board

Where potential under-achievement has been identified, action plans have been developed, implemented and monitored as part of the monthly monitoring arrangements to reduce the impact.

The other key indicators are currently expected to be achieved. The Trust continues to undertake robust internal performance monitoring in accordance with the organisation's Performance Management Framework.

A comprehensive performance reporting system was introduced during 2012/13. With completion of this project, performance achievement and alerts will be available online to managers and clinicians across the Trust. This system will contribute to identification and management of performance risks.

There is currently uncertainty around the implications of QIPP programme for 2013/14 and the resulting impact on the Trust's workforce plans. This issue is being monitored by the Director of Operations and the Director of Workforce and Organisational Development.

Serious incidents requiring investigations risks

The Trust continues to be a high reporter of patient safety incidents reported to the National Patient Safety Agency 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. Incidents may be escalated if the outcome actually or potentially had a severe or catastrophic level of harm or if the incident represents a significant risk to the organisation. Escalated incidents are subjected to an initial

Significant event audit investigation and the report is presented to the Executive team for a decision on whether it should be designated as a serious incident requiring investigation. The final decision is agreed by the Executive Directors Group.

On completion of the comprehensive formal investigation of serious incidents, the reports are reviewed by the Executive team 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. 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.

5. Review of effectiveness of risk management and internal control

5.1 Effectiveness of risk management and internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Board Assurance Framework and on the controls reviewed as part of the Internal Audit's work. The overall level of the Head of Internal Audit Opinion is significant assurance. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The Board Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation

achieving its principal objectives have been reviewed and are effective.

My review has also been informed by:

- External Audit reports
- Internal Audit reports
- Assessments by external agencies, e.g. Information Commission consensual visit
- Care Quality Commission planned and responsive inspections
- Internal management 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 Risk Management Committee, the Quality Assurance Committee, the Audit and Assurance Committee, the Clinical Services Executive Committee, the Finance Committee and the Trust Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

The main mechanism for this is the Board Assurance Framework and the agreed supporting committee and reporting structures that have been fully embedded throughout the organisation. The Terms of Reference for the key committees are reviewed on an annual basis to reflect any changes in organisational structure.

- The Board receives the following reports that provide it with assurance on how the controls within the organisation are working:
- Reports from other committees of the organisation
- Reports from Executive Directors and key managers
- Reports from external reviewers, when received
- The Audit and Assurance Committee receives reports from Internal and External Audit on the work conducted by them during the year.
- Minutes from the Board sub-committees are presented to the Board to note.

- Executive directors and key managers may present reports to the Board to note or to approve.
- 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 to aid in the preparation of this Statement.
- The reporting structure described in the Board Assurance Framework is used to monitor the systems of internal control and make reports to the Board.
- The Assurance Framework is independently reviewed by Internal Audit on an annual basis.
- The Trust registered its locations, service types, regulated activities and a named manager for each location with the Care Quality Commission. The Trust received confirmation that the Trust had been successfully registered without any location or service specific conditions.

5.2 Significant issues

Non-compliance with Care Quality Commission's Essential Standards

During 2012/13, the Trust was inspected on four occasions by the Care Quality Commission.

A planned review was carried out at North Devon District Hospital in April 2012 to check the Trust's compliance with ensuring the WHO surgical safety checklist was being completed in theatres and that compliance was being monitored. This inspection followed an unannounced inspection in November 2011 which had identified a concern regarding the consistency in completion of the WHO surgical safety checklist. The team of inspectors who visited in April 2012 observed checks in theatres and the Trust was found to be fully compliant with all the essential standards of quality and safety inspected.

In July 2012, a review of compliance was undertaken at the Tyrell Community Hospital as part of the Care Quality Commission's routine planned reviews. The

Trust was found to be fully compliant with all the essential standards of quality and safety inspected.

An announced inspection was undertaken at Moretonhampstead Community Hospital in August 2012 as concerns were identified. The Trust was found not to be meeting the essential standard of quality and safety relating to staff should be properly trained and supervised and have the chance to develop and improve their skills. The Care Quality Commission judged this as having a moderate impact on people who use the service as staff were not able to receive appropriate professional development. An action plan was developed to achieve compliance and was submitted to the Care Quality Commission. The action plan was recorded on the Corporate Risk Register and performance monitored via the Trust's risk management processes. The Care Quality Commission will be informed once the action plan has been completed.

In February 2013, a routine inspection was carried out at North Devon District Hospital as part of the Care Quality Commission's routine planned reviews. The Trust was found to be fully compliant with all the essential standards of quality and safety inspected.

The Board was briefed on each inspection and provided with update reports by the Director of Nursing at the routine monthly Board meetings.

Hospital Standardised Mortality Ratio

The Trust has been an outlier for Dr Foster Hospital Standardised Mortality Ratio for the previous year and has made significant improvements over the year. This was at odds with the Summary Hospital-level Mortality Indicator where the position was better than the average benchmark.

In September 2012, the Trust had a notification from Dr Foster that it was an outlier in mortality for Chronic Obstructive Pulmonary Disease. This was also followed by a letter in November 2012 from the Care Quality Commission requesting a report and an audit.

The audit showed no areas of clinical concern and many areas of good practice. The Care Quality Commission has reported:

“Alert relating to ‘chronic obstructive pulmonary disease and bronchiectasis’, raised by the Dr Foster Unit at Imperial College London in September 2012 and closed on 12 March 2013.

“In this case, the trust had reviewed their practice and identified areas where quality of care could be improved. The Care Quality Commission were assured by the plans they had in place to address these areas and, where appropriate, these plans were passed to the Care Quality Commission regional team for follow up. However, this does not suggest that the areas identified were necessarily responsible for the alert.”

In December 2012, the Trust received notification from the Bone Registry to say it was an outlier for mortality for patients having surgery for fractured neck of femur. In view of this, the Trust is currently undertaking a review of all the patients who died within the February 2011 – February 2012 timeframe to understand if there is any learning.

The Board receives monthly updates for the Hospital Standardised Mortality Ratio and the Summary Hospital-level Mortality Indicator position and has been fully briefed on the audit and actions following review of the Chronic Obstructive Pulmonary Disease patients.

Temporary closure of Moretonhampstead Community Hospital

In January 2013, following discussion of a serious incident investigation report that had been presented in full on the recommendation of the Quality Assurance Committee, the Board considered the wider issue relating to the consistency in the safety and quality of services provided at Moretonhampstead Community Hospital. The report raised not only local issues for the staff involved, but wider strategic issues for the Trust around the difficulties for staff in small, isolated community hospitals being able to maintain their skills and competencies. These findings from the serious incident investigation reflected the concerns raised by the Care Quality Commission in August 2012.

The Board agreed that it was not assured that under the existing circumstances that the community hospital was providing safe, high-quality care. It was agreed that the community hospital would be closed temporarily from 31 January 2013 for three months in the first instance with a review at the end of that period. The temporary closure would provide an opportunity to consider the alternatives that might be available for future service provision at the site. Arrangements were put in place to transfer existing patients appropriately, as well as to provide extra community service support. A communications plan was implemented to ensure good communications with both service users and staff.

Update reports have been provided to the Board by the Director of Nursing and the Director of Operations.

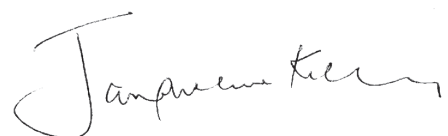
Payment by Results Data Assurance Framework Assurance

In the Annual Audit Letter 2011/12 provided by the Audit Commission, the external auditors were not able to provide adequate assurance to the commissioners on the progress made by the Trust in implementing the recommendations from the most recent clinical coding audit, the outpatients data quality review and the reference costs review. These reviews form part of the Trust’s Payment by Results Data Assurance Framework which focuses on the accuracy of clinical coding data and all data items that affect the price the commissioners pay the Trust for a spell under Payment by Results rules.

The Board was briefed by the Director of Finance & Performance and was advised that the report did not reflect the Trust’s position and that 19 of the 20 recommendations had been completed.

Accountable Officer: Jac Kelly, Chief Executive
Organisation: Northern Devon Healthcare NHS Trust

Signature:



Date: 6 June 2013

APPENDIX I

Board Members' Attendance at Board sub-committees

1. Audit & Assurance Committee

	Attendance	10.04.12	07.06.12	14.08.12	09.10.12	11.12.12	12.02.13
P Geen	5/6 83%	-	X	X	X	X	X
N Lewis	5/6 83%	X	X	X	X	X	X
J Reynolds	6/6 100%	X	X	X	X	X	X

The Audit and Assurance Committee is also attended by the Director of Finance & Performance.

2. Charitable Funds Committee

	Attendance	17.02.12	29.01.13
J Reynolds	2/2 100%	X	X
C Snow	2/2 100%	X	X
A Tucker-Jones	2/2 100%	X	X
C Mills	0/2 0%	-	-
A Robinson	2/2 100%	X	X

3. Finance Committee

	Attendance	24.04.12	21.05.12	25.06.12	23.07.12	24.09.12	22.10.12	26.11.12	21.01.13	25.02.13	25.03.13
R French	9/10 90%	X	-	X	X	X	X	X	X	X	X
N Lewis	10/10 100%	X	X	X	X	X	X	X	X	X	X
J Reynolds	7/10 70%	X	X	X	-	X	-	X	-	X	X
A Diamond	9/10 90%	X	-	-	X	X	-	X	X	X	-
C Mills	9/10 90%	X	X	X	-	X	X	X	X	-	-

	Attendance	24.04.12	21.05.12	25.06.12	23.07.12	24.09.12	22.10.12	26.11.12	21.01.13	25.02.13	25.03.13
J Kelly	7/10 70%	X	X	X	-	-	X	X	-	X	X
K Lyons	7/10 70%	X	-	X	X	X	X	X	-	-	X
A Robinson	9/10 90%	X	X	-	X	X	X	X	X	X	X

4. Foundation Trust Application Steering Group

	Attendance	23.04.12	21.05.12	25.06.12	23.07.12	24.09.12
R French	4/5 80%	X	-	X	X	X
N Lewis	5/5 100%	X	X	X	X	X
J Reynolds	4/5 80%	X	X	X	-	X
A Diamond	5/5 100%	X	-	X	X	X
C Mills	5/5 100%	X	X	X	-	X
J Kelly	3/5 60%	X	X	X	-	-
K Lyons	4/5 80%	X	-	X	X	X
A Robinson	4/5 80%	X	X	-	X	X

Joint members: A Diamond and C Mills

The meetings were occasionally attended by other Non-Executive Directors.

5. Quality Assurance Committee

	Attendance	08.05.12	10.07.12	11.09.12	13.11.12	08.01.13	12.03.13
P Geen	1/2 50%	-	X				
C Snow	5/6 80%	X	X	X	-	X	X
A Tucker-Jones		X	X	X	X	-	
A Diamond	6/6 100%	X	X*	X*	X	X	X
C Mills	6/6 100%	X*	X	X	X	X	

X* - Deputy attended in absence

Joint members: P Geen and C Snow until September 2012

6. Remunerations & Terms of Service Committee

	Attendance	25.06.12	24.09.12	04.12.12	26.02.13
R French	4/4 100%	X	X	X	X
P Geen	4/4 100%	X	X	X	X
N Lewis	4/4 100%	X	X	X	X
J Reynolds	4/4 100%	X	X	X	X
C Snow	4/4 100%	X	X	X	-
A Tucker-Jones	2/3 66%	X	X	X	

Remuneration Report

Introduction

Section 234B 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 directing 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, executive directors and associate directors.

Remuneration report

Details of Board directors' remuneration and pensions follow.

A) Remuneration

Name and Title	2012-13			2011-12		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
J Kelly - Interim Chief Executive	135-140			140-145		
C Mills - Director of Nursing	90-95			95-100		
A Robinson - Director of Finance and IMT	130-135			130-135		
K Lyons - Director of Operations	105-110			105-110		
A Diamond - Medical Director	105-110			105-110		
R French - Chairperson	15-20			15-20		
A Tucker Jones - Non-executive Director (1)	5-10			5-10		
J Reynolds - Non-executive Director	5-10			5-10		
P Geen - Non-executive Director	5-10			5-10		
C Snow - Non-executive Director	5-10			0-5		
N Lewis - Non-executive Director	5-10			0-5		
Dr T Douglas-Riley - Non-Executive Director (2)	0-5					

(1) The non-executive director's term of office ceased on 1 February 2013

(2) The non-executive director was appointed on 1 July 2012

B) Pension benefits

Name and title	2012-13							2011-12								
	Real increase in pension at age 60 (bands of £2500) £000	Real increase in lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2013 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2013 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2013 £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Real increase in Cash Equivalent Transfer Value £000	To nearest £100 Pension Employers Contribution to Stakeholder	Real increase in pension at age 60 (bands of £2500) £000	Real increase in lump sum at age 60 (bands of £2500) £000	Total accrued pension at age 60 at 31 March 2012 (bands of £5000) £000	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5000) £000	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real Increase in Cash Equivalent Transfer Value £000	To nearest £100 Pension Employers Contribution to Stakeholder
C Mills - Director of Nursing	0-2.5	2.5-5	30-35	95-100	545	500	9		2.5-5	10-15	30-35	90-95	500	373	35	
A Robinson - Director of Finance and IMT	0-2.5	2.5-5	30-35	100-105	683	626	11		0-2.5	5-7.5	30-35	95-100	626	527	25	
K Lyons - Director of Operations	0-2.5	0-2.5	25-30	85-90	429	396	6		(0-2.5)	(5-10)	25-30	80-85	396	343	13	
A Diamond - Medical Director	0-2.5	2.5-5	50-55	155-160	943	873	13		7.5-10	20-25	45-50	150-155	873	634	66	

Notes:

- (1) The Chief Executive does not receive pensionable remuneration.
- (2) As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-Executive members.
- (3) For directors employed during the year, there is no corresponding data for the previous year to reflect movements
- (4) 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.
- (5) 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.
- (6) The Trust pension values are recorded using Consumer Price Index (CPI) rather than Retail Price Index (RPI) in previous years.
- (7) Prior year figures not available

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 2012-13 was £135,000-£140,000 (2011-12 £125,000-£140,000-£145,000) This was 5.6 (2011-12 5.8) times the median remuneration of the workforce which was £25,000 (2011-12, £25,000)

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.

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 (Chairman)	01.02.11	31.01.15
Amelia Tucker-Jones (NED)	11.12.10	10.12.14
Jane Reynolds (NED)	01.06.07	31.05.15
Pauline Geen (NED)	03.12.11	02.02.15
Chris Snow (NED)	01.08.11	31.07.16
Nick Lewis (NED)	01.08.11	31.07.16

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 Appointments Commission.

Executive directors and associate directors

Name	Position	Contract Type	Start Date	Employment status
Jac Kelly	Chief Executive	Fixed Term	16.10.06	Contract was made substantive with effect from 09.01.12
Andy Robinson	Director of Finance and Performance	Permanent	15.11.06	
Carolyn Mills	Director of Nursing	Permanent	08.08.05	
Alison Diamond	Medical Director	Permanent	01.10.06	
Kate Lyons	Director of Operations	Permanent	01.06.10	
Ian Roy	Director of Facilities	Permanent	19.04.99	
Maureen Bignell	Associate Director of Organisational Development	Permanent	01.10.06	
Andy Ibbs	Commercial Director	Permanent	01.10.12	

Head of Internal Audit Opinion

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 Accountable Officer, on behalf of the Board, setting out:

- how the individual responsibilities of the Accountable 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 NHS 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. Overall opinion;
2. Basis for the opinion;
3. Commentary.

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.

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.

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

During the year, the Trust has had two visits from the CQC. The first in March 2012 confirmed that the Trust complies with the WHO (World Health Organisation) Surgery Checklist and termination services. We were asked to undertake a review of the scheduling of private patient procedures in theatres following this visit. The second review in August 2012 identified gaps in maintaining competencies for clinical staff at Moretonhampstead Community Hospital. We identified the competencies issue in July 2012 as part of our review of community MIU (Minor Injuries Unit) review. The Trust took the decision to close the community hospital for a period of three months to address this issue.

Our audits this year have confirmed that core corporate and financial systems continue to operate effectively, and have adapted to the changing environment within the Trust. This year's audit plan included a review of training records following a recurring trend in weaknesses in this area identified in a number of clinical reviews in 2011/12.

Our review concluded that a number of training standards remain below target, although all mandatory training elements have shown increased compliance in year. 65% of all mandatory training standards remain below target, compared to 80% in 2012. 18% remain below 60% (Red) compliance compared to 53% in 2012. Despite the organisation putting in place a logbook to record competencies at departmental level, the recording at manager level has shown little improvement since implementation in Q3 of 2012/13. The formal training compliance action plans remain open and additional actions have been added throughout the year to continue to deliver training compliance improvements to target. We were also asked to undertake a review of supervision and appraisal, which identified further issues in documenting supervision.

Internal Audit's work has been taken forward in three broad categories. The following summarises the opinions and assurances from reports of the reviews undertaken in these areas at the time of testing. Action plans have been agreed to address issues raised within each area and completion of these is monitored throughout the year.

Assurance Framework - corporate governance and risk management

Internal Audit completed reviews on the following Assurance Framework areas of the Trust:

Audit	Assurance Rating	Impact Assessment
Serious Incidents	Green	Low
Alerts and CAS	Green	Low
Principal Risk and Assurance Register	Green	Low
Risk Management	Green	Low
Performance Management	Draft Report/ Green	Draft Report/ Low
Care Quality Commission	Draft Report/ Green	Draft Report/ Low

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

Serious Incidents – February 2013

The processes documented within the Incident Management and Investigation Policy for investigating Serious Incidents are detailed, appropriate and were found to have been consistently applied for the six SIRIs we tested during our review. We identified two low-risk recommendations.

Alerts and CAS – July 2012

Overall, we have no concerns on the current process and procedure for the management of alerts received by the Trust. We are satisfied that adequate processes are in place to ensure that alerts are managed to minimise the potential risks to patients and staff and that alerts are, where relevant to the Trust, dealt with promptly and within the timeframes detailed on alert notices.

Principal Risk and Assurance Register – May 2013

The Trust's PRAR has been developed in line with the Department of Health guidelines as prescribed in 'Building the Assurance Framework: A practical guide for NHS Boards'. The Register is presented at Board and core committees alongside the PRAR Action Plan. There has been robust challenge of the content of both documents during the meetings.

Risk Management – May 2013

We can confirm from our review of the Trust's Risk Management Strategy and Policy that both are fit for purpose and have been appropriately reviewed. Additionally, the Trust's risk management arrangements meet the requirements of the NHSLA's Level 1 risk management standards, in respect of risk management strategy, process, committees and risk registers.

Performance Management (Draft, awaiting management comments)

This year we specifically reviewed the validation of ambulance handover times. Overall, our testing confirmed that the reported handover data was reliable. Our analysis of ambulance handovers in the region showed that, in 2012/13, the Trust exceeded the 15 minute target for 38% of all handovers, placing the Trust at 10th in the list of 13 regional trusts. Key reasons for breaches were no physical capacity and insufficient staff to complete handover. Financial penalties for breaching the 15 minute target (based on the 2012/13 contract) ranged between £10 - £2,200. We have made a number of recommendations around improving bed management.

Care Quality Commission (CQC) Compliance (Draft)

As a result of the three CQC visits between July and December 2011, 28 recommendations were made. We obtained satisfactory evidence of the completion of all 28 recommendations with the exception of two (regarding the storage of medicines outside of the Pharmacy). We acknowledge that guidance from the CQC and Monitor regarding evidencing compliance with assurance requirements is in development. It would be beneficial to the Trust to consider establishing some basic assurance from Trust sites/ departments that CQC Outcomes and Regulations are reviewed regularly and that they are complied with.

Financial assurance

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

Audit	Assurance Rating	Impact Assessment
Financial Planning – Part One	Amber	High
Budgetary Control	Green	Low
Capital Accounting	Green	Low
Payroll	Green	Low
Financial Controls (Debtors/ Creditors/ Cash & Bank)	Green	Low
Governance of Fundraising	Green	Low
Charitable Funds	Green	Low

Audit work has been undertaken during the year on the core financial systems of the Trust. Although not all these audits have been finalised at the date of this statement, reviews have concluded, overall, that the current systems in place represent a low risk to the Trust and that positive assurance can be provided that the systems in place are operating satisfactorily.

The following sections discuss the findings of our audit reports where the Impact Assessment has been determined as being Medium or High. The date that our audit report was issued as a final is included for information. The Trust has put in place actions to address our recommendations from these reviews. We have not validated progress made against the recommendations made following our reviews during the year, however, all high risk reviews are included in our 2013/14 Internal Audit plan. As such, all recommendations generated from high risk reports will be followed up during these reviews.

Financial Planning – High – November 2012

On review of the financial reporting process, we are satisfied that the process is robust, with no cause for concern.

When considering the current position regarding the identification and delivery of CRES savings, we concluded that there were significant issues which needed addressing by the Trust if it was to achieve its budgeted surplus position of £2.2m by year-end. This is as a result of:

- the current level of identified savings which, once non-recurrent savings are removed, is only slightly above the required target, leaving very little headroom; and
- the Trust was forecasting, as at Month 3, a £5m year-end shortfall against its CRES plan with £2.7m achieved to date. However, £1.2m of this saving has been delivered through non-recurring savings from reserves.

We are currently undertaking our second review of Financial Planning within the Trust which considers the delivery of the final 2012/13 financial position and planning for the 2013/14 financial year. This work is due for completion in June 2013.

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 in relation to the ESR.

We are satisfied that the 2012/13 Independent Service Auditor's report provided by PricewaterhouseCoopers, dated 8th May 2013, provides reasonable assurance in respect of the IT general controls operated by McKesson 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 overall conclusion from their audit opinion was that for the period 1 April 2012 to 31 March 2013, 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. Detailed testing identified a small number of areas where controls were either not designed or operating efficiently, however these did not adversely impact upon the overall control environment as appropriate mitigating controls were in place.

Corporate assurance

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

Audit	Assurance Rating		Impact Assessment	
Supervision and Appraisal	Red	Amber	High	Low
Safeguarding Adults	Amber		Medium	
Patient Safety	Amber		Medium	
Service Level Agreements	Amber		Medium	
Home Access – e-Rostering	Amber		Medium	
Information Governance	Amber		Medium	
IG Toolkit Requirement 604	Amber		Medium	
Local Inductions	Amber		Medium	
Access Controls – CompAS	Amber		Medium	

Audit	Assurance Rating	Impact Assessment
Medicines Reconciliations	Amber	Medium
Community Outpatients	Draft Report/ Amber	Draft Report/ Medium
Emergency Planning	Draft Report/ Amber	Draft Report/ Medium
Hotel Services Procurement	Green	Low
Dietetics	Green	Low
Private Patients	Draft Report/ Amber	Draft Report/ Low
Community Travel Claims	Draft Report/ Amber	Draft Report/ Low
Asset Transfer – Due Diligence	n/a*	n/a*
Pharmacy Stock	n/a*	n/a*

* No opinion was presented for this review due to the nature of the work completed.

The following sections discuss the findings of our audit reports where the Impact Assessment has been determined as being Medium. The date that our audit report was issued as a final is included for information.

Supervision & Appraisal – High/ Low – January 2013

We reviewed the supervision and appraisal records for a sample of five patients at seven locations/ teams - Okehampton Hospital, Seaton Hospital, Community Nursing Team at Seaton Hospital, Ilfracombe Hospital, Lundy/ Roborough Ward – NDDH, Caroline Thorpe Ward – NDDH and Barnstaple Health Centre.

In general, we found a lack of evidence of supervision taking place across all areas. We identified inconsistencies across the Trust with the quality of supervision taking place:

- supervision was not evidenced as taking place at a minimum six-weekly intervals (as required by the Trust);

- no summary information available;
- evidence of limited types of review;
- inconsistent filing. The format of files varied across the Trust. Some were clearly indexed and others were not. Some areas held numerous files with information;
- non-standard documents in use. Documents from various trusts were in use; and
- disparity of central monitoring taking place.

Whilst we acknowledge the evidence of supervision taking place is poor, we are aware that team meetings, ward handovers, one- to- one meetings and working together does take place. However, this information is not being captured by the majority of managers we visited within this review.

Although we found that the completion of and completeness of staff appraisals were better evidenced than for supervision, we still found instances where these were not properly evidenced.

Safeguarding Adults – Medium – October 2012

Despite many improvements made since our previous review in June 2011, there were still three outstanding recommendations and five recommendations from the previous report which were re-opened. The completion of essential safeguarding training, although improved, is still under the Trust's target (80%), which is a risk to the Trust.

Patient Safety – Medium – October 2012

We reviewed several wards/ units across the Trust and found that patients are assessed regularly (however, not always in accordance with requirements) by trained staff to ensure prompt identification of possible deterioration with observations of patients recorded by both registered and unregistered staff. Risk assessments were being completed more completely than care plans.

We identified inconsistencies with the use and completion of patient documentation:

- inconsistent filing. The format of files varied across the Trust, some were clearly indexed and others were not;
- non-standard documents in use. Documents from various trusts in use including a care plan from a GP practice;
- Risk Assessment Booklets and care plans not fully completed; and
- poor review and evaluation of care plans. Some files did not hold care plans, and some care plans were evaluated within the patient notes, rather than on the care plan itself. Many did not show evidence of review or evaluation.

We acknowledge that the Trust assumed the responsibility for the additional services 18 months ago, however the required documentation is available Trust-wide on BOB and should be rolled out to all locations.

Service Level Agreements – Medium – March 2013

At the time of testing, the Trust maintained a register of all SLAs which is updated by SLA Leads and it was provided to the Executive Group monthly. Our review reflects the status of the management of SLAs during the period October – December 2012.

Although the SLA Register is presented to the Executive Group monthly, it is not clear from the meeting minutes what level of scrutiny it receives. We also found that half of the SLAs we reviewed had not been updated and several more were no longer relevant.

From our review, it was clear that the Trust should decide whether there should be central management of the SLAs in the form of a register. We have been informed that subsequent to this review, the SLA Register is no longer maintained by Facilities and has not been presented to the Trust Executive in the past few months. The Trust should also decide whether a formal process should be in place to review both the financial and non-financial aspects at least annually.

Home Access – e-Rostering – Medium – December 2012

Overall, we found that the controls were operating in the East effectively for home/ remote access e-Rostering.

We identified the following weaknesses in the operation of the control environment which require further management action:

- written and tested procedures and processes should be recorded for the IT provision of the day-to-day management of e-Rostering;
- a penetration test against the e-Rostering web application should be undertaken to provide management with assurance of any application security vulnerabilities that may be identified; and
- a thorough review of SLA, technical specifications and licence agreements should be undertaken including a risk assessment, in line with Information Governance Requirements (313, 314 and 323).

Information Governance – Medium – March 2013

We reviewed 14 of the 45 requirements of the Information Governance Toolkit, as agreed with the IG Manager and found that there was still a moderate amount of work to be completed by the Trust to ensure that Level 2 is met.

A significant challenge to the maintenance of the Information Governance Toolkit is the linking and management of the various IGT Requirements to the most up to date supporting documentation.

Our review identified the following difficulties to be addressed by the Information Governance Management Team:

- in some instances incorrect versions of policy documentation have been referenced by the Toolkit when newer versions are available;
- other supporting documentation is not up to date; and

- a process should be considered where all supporting documentation is maintained in a restricted access folder, which the Head of Information Governance can use to store up to date documentation. If a standardised naming convention is used, this would negate the need for constantly updating the Toolkit links when new documentation is provided.

IG Toolkit Requirement 604 – Medium – February 2013

We performed a review of the IGT Requirement 604, using the standard auditing template provided within the Toolkit to review a sample of manual and electronic records within the following four corporate departments:

- Estates/ Facilities;
- Personnel/ Human Resources;
- Information (Communications); and
- Complaints.

It was apparent that department heads were unaware of the Information Governance Toolkit's requirement for an Information Asset Inventory of all manual and electronic records held by their departments.

We are aware that a project is about to be initiated to construct and populate a Trust-wide Information Asset Inventory. However, until this has been completed and records management processes improved, the Trust does not comply with the requirements of the Information Governance Toolkit 604 Level 2, the Care Quality Commission Outcome 21 (Records) and potentially the Data Protection Act.

The management of retention periods for manual records and their disposal processes were well-established. However, the majority of electronic records were not subject to the same consistent level of process for identifying retention periods and the deletion of records. We recommended the following:

- As part of the project to implement an Information Asset Inventory, the Trust must perform its own audit to identify all corporate records held by all departments to ensure its accuracy.
- Consideration should be given to the necessity of retaining manual records when electronic records exist which can be printed if a hardcopy of the record is required in the future.
- The Trust should review the use of open cardboard boxes to store manual records containing personal data in shared archive stores, as this is insecure.
- The Trust should develop a process to ensure all electronic records are managed to the same level of consistency as manual records.

Access Controls (COMPAS) – Medium – April 2013

We have undertaken a review of the access controls relating to the COMPAS (Community Patient Administration System) tablet devices at the request of the IT Services Manager.

The remote management of access controls for 800 devices can be a difficult process to successfully establish, but must also comply with Information Governance Requirement 305. This requires that access to information systems and assets is controlled, with registration, change and revocation of access dealt with under formal procedures.

The risk to the transient data held on the tablets is minimal, but the efficiencies and financial benefits that could reasonably be expected from the use of tablets may be diminished. It is also apparent that the IT resource overheads required to manually rectify the disparity between the versions of software on all the tablets and the Secure Device Manager will be significant.

Local Inductions – Medium – May 2013

We found the harmonised Induction Policy appropriate and fit for purpose. This outlines a system where Workforce Development monitors compliance with the policy, with reminders sent electronically to individuals and their managers when appropriate training has not been completed.

Our review of a sample of 25 new staff identified non-compliance with the Trust's Induction Policy for all. This causes uncertainty for new staff members, but more importantly, places the Trust at risk of harm to staff, patients and visitors, if staff have not received an appropriate full induction.

We found that delays frequently occurred in attending the three strands that make up local induction:

- Trust-wide induction – although 23 of the 25 tested in our sample completed this, only nine were within their first month;
- work-based induction – only four staff in our sample completed this induction and returned their checklist to WFD, however none were completed within the target eight weeks; and
- manual handling for new starters – 11 of the 25 new staff tested completed this training.

Training supervisors were often not the line manager and the location of training information within personal files was difficult to find for the sample tested. Staff supervisors need to be reminded of their responsibility to ensure that appropriate information is given to new staff and that training is provided from an appropriate source.

In view of the lack of compliance with policy, the Trust Board should be provided with information to monitor the situation and increase the profile and importance of local induction.

Medicines Reconciliations – Medium - May 2013

Our findings from this review show an improvement on the 2011/12 figures (overall 50% completion), however 2012/13 figures still indicate improvement is required to comply with Trust policy. From our sample of nine wards/ hospitals, the following was found:

- 77% had a completed reconciliation (Level 1);
- 52% received a medicine reconciliation within 24 hours of their admission (Level 1);
- 34% were signed by a doctor or nurse (Level 1);

- 92% had the Drug Allergy section completed (Level 1); and
- the medication was adequately verified for 53% as required by the Medical Reconciliation Policy.

In addition, different documentation was found in use across the different areas we visited, rather than that specified in the trust policy and these were filed in various locations in the patient notes.

Community Outpatients (Draft) – Medium

Most of the NDHT clinics are booked centrally through the Central Management Centre (CMC), which we found fit for purpose. As the RD&E books the eastern community clinics, the Trust does not have control over this process or the number of clinics booked and consequently, performance monitoring for these clinics is not routinely monitored and reported. Our findings indicate that there is scope to monitor and investigate the levels of cancelled clinics to identify whether there is potential for savings from improved clinic management. Our review indicates that there is scope to undertake more review and investigation of DNAs to understand the reasons and consider whether system improvements can be made.

Emergency Planning (Draft) – Medium

There are a number of plans that require annual review. We have been informed that all community hospital emergency plans should be completed by the end of September 2013. The required six-monthly communications cascaded exercises were completed correctly and a 'Winter Wonderland' table-top exercise was completed. Reporting emergency preparedness issues is appropriate.

Other work

At the date of this opinion, a number of audits are at draft report stage.

Audits at draft report stage

- Care Quality Commission;
- Performance Management;
- Private Patients (Theatre Lists);

- Community Travel Claims;
- Community Outpatients (Unit Audits);
- Emergency Preparedness.

The assurance rating and impact assessment have been taken into account in making this opinion:

Audits being completed

- Training Records;
- Workforce Planning;
- Financial Planning 2;
- Community Services;
- Safeguarding Children; and
- SLAs (Community Maternity and Theatres).

Whilst a small number of control issues and recommendations may be reported as a result of these reviews, we do not envisage any fundamental matters that may impact upon this opinion statement.

Jenny McCall
Director of Audit
Audit South West

Accounts 2012/13

Data entered below will be used throughout the workbook:

Trust name	Northern Devon Healthcare NHS Trust
This year	2012-13
Last year	2011-12
This year ended	31 March 2013
Last year ended	31 March 2012
This year commencing:	1 April 2012
Last year commencing:	1 April 2011

Foreword to the accounts

These accounts for the year ended 31 March 2013 have been prepared by the Northern Devon Healthcare NHS Trust under section 232 (Schedule 15, 3(1)) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Statement of Comprehensive Income for year ended 31 March 2013

	NOTE	2012-13 £000	2011-12 £000
Gross employee benefits	10.1	(146,009)	(140,068)
Other costs	8	(73,902)	(74,475)
Revenue from patient care activities	5	207,834	198,860
Other Operating revenue	6	12,846	12,181
Operating surplus/(deficit)		769	(3,502)
Investment revenue	12	16	22
Other gains and (losses)	13	0	(20)
Finance costs	14	(15)	(23)
Surplus/(deficit) for the financial year		770	(3,523)
Public dividend capital (PDC) dividends payable		(1,822)	(2,201)
Net Gain/(loss) on transfers by absorption		0	
Retained surplus/(deficit) for the year		(1,052)	(5,724)
Other Comprehensive Income		2012-13 £000	2011-12 £000
Impairments and reversals		69	(11,564)
Net gain/(loss) on revaluation of property, plant & equipment		141	104
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Movements in Other Reserves eg. Non NHS Pensions Scheme		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net Gain / (loss) on Assets Held for Sale		0	
Net actuarial gain/(loss) on pension schemes		0	0
Reclassification Adjustments			
On disposal of available for sale financial assets		0	0
Total comprehensive income for the year*		(842)	(17,184)

* This sums the rows above and the surplus / (deficit) for the year before adjustments for PDC dividend and absorption accounting

Financial performance for the year

Retained surplus/(deficit) for the year	(1,052)	(5,724)
Prior period adjustment to correct errors	0	0
IFRIC 12 adjustment	22	23
Impairments	3,288	7,328
Adjustments iro donated asset/gov't grant reserve elimination	(53)	92
Adjustment re Absorption accounting	0	
Adjusted retained surplus/(deficit)	2,205	1,719

PDC dividend: balance receivable/(payable) at 31 March 2013

90

PDC dividend: balance receivable/(payable) at 1 April 2012

358

The notes on pages 94 to 131 form part of this account.

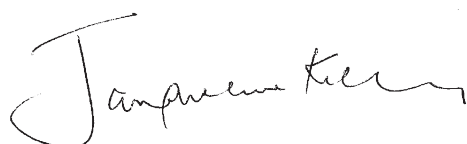
Statement of Financial Position as at 31 March 2013

		31 March 2013	31 March 2012
	NOTE	£000s	£000s
Non-current assets:			
Property, plant and equipment	15	55,367	56,232
Intangible assets	16	1,680	833
Investment property	18	0	0
Other financial assets	24	0	0
Trade and other receivables	22.1	973	872
Total non-current assets		58,020	57,937
Current assets:			
Inventories	21	2,676	2,601
Trade and other receivables	22.1	13,809	11,121
Other financial assets	24	0	0
Other current assets	25	0	0
Cash and cash equivalents	26	3,786	3,467
Total current assets		20,271	17,189
Non-current assets held for sale	27	0	300
Total current assets		20,271	17,489
Total assets		78,291	75,426
Current liabilities			
Trade and other payables	28	(21,341)	(17,412)
Other liabilities	29	0	0
Provisions	35	(331)	(37)
Borrowings	30	(17)	(16)
Other financial liabilities	31	0	0
Working capital loan from Department	30	0	0
Capital loan from Department	30	(500)	(500)
Total current liabilities		(22,189)	(17,965)
Non-current assets plus/less net current assets/liabilities		56,102	57,461
Non-current liabilities			
Trade and other payables	28	0	0
Other Liabilities	31	0	0
Provisions	35	0	0
Borrowings	31	0	(17)
Other financial liabilities	30	0	0
Working capital loan from Department	30	0	0
Capital loan from Department	30	0	(500)
Total non-current liabilities		0	(517)
Total Assets Employed:		56,102	56,944
FINANCED BY:			
TAXPAYERS' EQUITY			
Public Dividend Capital		57,717	57,717
Retained earnings		(5,298)	(4,246)
Revaluation reserve		3,683	3,473
Other reserves		0	0
Total Taxpayers' Equity:		56,102	56,944

The notes on pages 94 to 131 form part of this account.

The financial statements on pages 90 to 131 were approved by the Board on 06/06/2013 and signed on its behalf by

Chief Executive:



Date: 6 June 2013

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2013

	Public Dividend capital £000s	Retained earnings £000s	Revaluation reserve £000s	Other reserves £000s	Total reserves £000s
Balance at 1 April 2012	57,717	(4,246)	3,473	0	56,944
Changes in taxpayers' equity for 2012-13					
Retained surplus/(deficit) for the year		(1,052)			(1,052)
Net gain / (loss) on revaluation of property, plant, equipment			141		141
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			69		69
Movements in other reserves				0	0
Transfers between reserves		0	0	0	0
Release of reserves to Statement of Comprehensive Income			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 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	0
Originating capital for Trust established in year	0				0
New PDC Received	0				0
PDC Repaid In Year	0				0
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension		0		0	0
Net recognised revenue/(expense) for the year	0	(1,052)	210	0	(842)
Balance at 31 March 2013	57,717	(5,298)	3,683	0	56,102
Balance at 1 April 2011	57,717	1,478	14,931	0	74,126
Changes in taxpayers' equity for the year ended 31 March 2012					
Retained surplus/(deficit) for the year		(5,724)			(5,724)
Net gain / (loss) on revaluation of property, plant, equipment			104		104
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			(11,564)		(11,564)
Movements in other reserves				0	0
Transfers between reserves		0	0	0	0
Release of reserves to Statement of Comprehensive Income			2		2
Reclassification Adjustments					
Transfers to/(from) Other Bodies within the Resource Account Boundary	0	0	0	0	0
On Disposal of Available for Sale financial Assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	0				0
PDC Repaid In Year	0				0
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension		0		0	0
Net recognised revenue/(expense) for the year	0	(5,724)	(11,458)	0	(17,182)
Balance at 31 March 2012	57,717	(4,246)	3,473	0	56,944

Statement of Cash Flows for the year ended 31 March 2013

	NOTE	2012-13 £000s	2011-12 £000s
Cash Flows from Operating Activities			
Operating Surplus/Deficit		769	(3,502)
Depreciation and Amortisation		5,201	5,037
Impairments and Reversals		3,288	7,328
Other Gains / (Losses) on foreign exchange		0	0
Donated Assets received credited to revenue but non-cash		0	(36)
Government Granted Assets received credited to revenue but non-cash		0	0
Interest Paid		(15)	0
Dividend (Paid) / Refunded		(1,554)	(2,584)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		(75)	104
(Increase)/Decrease in Trade and Other Receivables		(2,789)	(6,466)
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		4,327	8,068
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(22)	(5)
Increase/(Decrease) in Provisions		316	26
Net Cash Inflow/(Outflow) from Operating Activities		9,446	7,970
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		16	22
(Payments) for Property, Plant and Equipment		(7,696)	(4,550)
(Payments) for Intangible Assets		(1,231)	(450)
(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)		300	5
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		(8,611)	(4,973)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		835	2,997
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		0	0
Public Dividend Capital Repaid		0	0
Loans received from DH - New Capital Investment Loans		0	0
Loans received from DH - New Revenue Support Loans		0	0
Other Loans Received		0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		(500)	(500)
Loans repaid to DH -Revenue Support Loans		0	0
Other Loans Repaid		0	0
Cash transferred to NHS Foundation Trusts		0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(16)	(16)
Capital grants and other capital receipts		0	36
Net Cash Inflow/(Outflow) from Financing Activities		(516)	(480)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		319	2,517
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		3,467	950
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		3,786	3,467

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 NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2012-13 NHS Trusts Manual for Accounts 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 NHS Trusts 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 Transforming Community Services (TCS) transactions

Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers 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 SOCNE, and is disclosed separately from operating costs.

1.4 Care Trust designation

Northern Devon Healthcare Trust is not designated as a Care Trust

1.5 Pooled Budgets

The Trust does not have any pooled budget arrangements.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the Trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. 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 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 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 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. The cost of leave earned but not taken by employees at the end of the period is recognised in the financial statements to the extent that employees are permitted to carry forward leave into the following period.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 trust'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
- Specialised buildings – depreciated replacement cost

Notes to the Accounts - 1. Accounting Policies (Continued)

Valuation cont'd

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. 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.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new 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
- the ability to measure reliably the expenditure attributable to the intangible asset during its development

Notes to the Accounts - 1. Accounting Policies (Continued)

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 Trust expects to obtain economic benefits or service potential from the asset. This is specific to the 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 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.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set. AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.14 Government grants

The Trust has no government granted assets on its balance sheet.

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. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then 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 trust as lessor

Amounts due from lessees under finance leases are recorded as receivables at the amount of the 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.17 Private Finance Initiative (PFI) transactions

The Trust does not have any PFI transactions

1.18 Inventories

Inventories are valued at the lower of cost and net realisable value using the first-in first-out 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 Trust's cash management.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the 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.

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 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 Trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to the 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 EU Emissions Trading Scheme

The Trust is not required to register for the EU Emissions Trading Scheme due to the low level of emissions.

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 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.

Notes to the Accounts - 1. Accounting Policies (Continued)**Contingencies cont'd**

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 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 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 initially recognised at fair value.

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. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

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 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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.26 Financial liabilities

Financial liabilities are recognised on the statement of financial position when the 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 contract 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.

Notes to the Accounts - 1. Accounting Policies (Continued)

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 Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets.

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 trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

Material entities over which the Trust has the power to exercise control so as to obtain economic or other benefits are classified as subsidiaries and are consolidated. Their income and expenses; gains and losses; assets, liabilities and reserves; and cash flows are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust's or where the subsidiary's accounting date is before 1 January or after 30 June.

Subsidiaries that are classified as 'held for sale' are measured at the lower of their carrying amount or 'fair value less costs to sell'

For 2011-12 and 2012-13 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the Northern Devon Healthcare NHS Trust Charitable Fund for which it is the corporate trustee.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.33 Associates

The Trust has no associates

1.34 Joint ventures

The Trust has no joint ventures

1.35 Joint operations

The Trust has no joint operations

1.36 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 Statement of Comprehensive Income 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.

1.37 Accounting Standards that have been issued but have not yet been adopted

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2012-13. The application of the Standards as revised would not have a material impact on the accounts for 2012-13, were they applied in that year:

IAS 1 Presentation of financial statements, on other comprehensive income (OCI) - subject to consultation

IAS12 Income Taxes Amendment - subject to consultation

IAS 19 (Revised 2011) Employee Benefits - subject to consultation

IAS 27 Separate Financial Statements - subject to consultation

IAS 28 Investments in Associates and Joint Ventures - subject to consultation

IAS 32 Financial Instruments: Presentation - amendment - subject to consultation

IFRS 7 Financial Instruments: Disclosures - amendment - subject to consultation

IFRS 9 Financial Instruments - subject to consultation - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation

IFRS 11 Joint Arrangements - subject to consultation

IFRS 12 Disclosure of Interests in Other Entities - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IPSAS 32 - Service Concession Arrangement - subject to consultation

2 Community Equipment Store Pooled Budget

The Trust no longer contributes to the pooled budget following changes under Transforming Community Services

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 Segments, they are similar in each of the following aspects:

- The nature of the products and services;
- The nature of the production processes;
- 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	
	2012-13 £000	2011-12 £000	2012-13 £000	2011-12 £000
Income	<u>220,680</u>	<u>211,041</u>	<u>220,680</u>	<u>211,041</u>
Surplus/(Deficit)				
Segment surplus/(deficit)	0	0	0	0
Common costs	<u>(219,910)</u>	<u>(214,564)</u>	<u>(219,910)</u>	<u>(214,564)</u>
Surplus/(deficit) before interest	<u>770</u>	<u>(3,523)</u>	<u>770</u>	<u>(3,523)</u>
Net Assets:				
Segment net assets	<u>56,102</u>	<u>56,944</u>	<u>56,102</u>	<u>56,944</u>

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 the full costs exceed £1m.

5. Revenue from patient care activities	2012-13 £000s	2011-12 £000s
Strategic Health Authorities	0	0
NHS Trusts	759	0
Primary Care Trusts - tariff	79,509	77,027
Primary Care Trusts - non-tariff	119,624	116,841
Primary Care Trusts - market forces factor	1,541	1,418
NHS Foundation Trusts	513	483
Local Authorities	4,313	1,581
Department of Health	0	0
NHS other	0	0
Non-NHS:		
Private patients	363	437
Overseas patients (non-reciprocal)	0	0
Injury costs recovery	568	679
Other	644	394
Total Revenue from patient care activities	<u>207,834</u>	<u>198,860</u>

6. Other operating revenue	2012-13 £000s	2011-12 £000s
Recoveries in respect of employee benefits	746	291
Patient transport services	0	0
Education, training and research	4,582	3,876
Charitable and other contributions to revenue expenditure - NHS	0	0
Charitable and other contributions to revenue expenditure -non- NHS	148	165
Receipt of donations for capital acquisitions - NHS Charity	176	36
Receipt of Government grants for capital acquisitions	0	0
Non-patient care services to other bodies	3,658	3,760
Income generation	1,070	1,139
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Other revenue	2,466	2,914
Total Other Operating Revenue	<u>12,846</u>	<u>12,181</u>
Total operating revenue	<u>220,680</u>	<u>211,041</u>

7. Revenue	2012-13 £000	2011-12 £000
From rendering of services	219,610	209,902
From sale of goods	1,070	1,139

8. Operating expenses (excluding employee benefits)	2012-13	2011-12
	£000s	£000s
Services from other NHS trusts	602	90
Services from PCTs	127	168
Services from other NHS bodies	0	0
Services from foundation trusts	5,652	7,644
Purchase of healthcare from non NHS bodies	0	0
Trust Chair and Non-executive Directors	54	49
Supplies and services - clinical	27,301	24,633
Supplies and services - general	7,034	7,014
Consultancy services	510	301
Establishment	4,224	3,858
Transport	1,040	985
Premises	14,478	13,313
Impairments and Reversals of Receivables	27	57
Inventories write down	0	0
Depreciation	4,817	4,790
Amortisation	384	247
Impairments and reversals of property, plant and equipment	3,288	7,328
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets [by class]	0	0
Impairments and reversals of non current assets held for sale	0	0
Impairments and reversals of investment properties	0	0
Audit fees	88	164
Other auditor's remuneration	0	0
Clinical negligence	2,597	2,376
Research and development (excluding staff costs)	0	0
Education and Training	492	409
Change in Discount Rate	0	
Other	1,187	1,049
Total Operating expenses (excluding employee benefits)	<u>73,902</u>	<u>74,475</u>
Employee benefits		
Employee benefits excluding Board members	145,069	139,148
Board members	940	920
Total employee benefits	<u>146,009</u>	<u>140,068</u>
Total operating expenses	<u><u>219,911</u></u>	<u><u>214,543</u></u>

9 Operating Leases

9.1 Trust as lessee

	Land £000s	Buildings £000s	Other £000s	2012-13 Total £000s	2011-12 £000s
Payments recognised as an expense					
Minimum lease payments				4,932	4,721
Contingent rents				0	0
Sub-lease payments				0	0
Total				4,932	4,721
Payable:					
No later than one year	0	0	30	30	4,541
Between one and five years	0	0	184	184	4,540
After five years	0	0	0	0	0
Total	0	0	214	214	9,081
Total future sublease payments expected to be received:				0	0

The main element of payments recognised as an expense relates to properties being rented from Devon Primary Care Trust under the Transforming Community Services agreement. The Trust assumed ownership of these properties on 1 April 2013, as detailed in note 40, and consequently the payable figures above reduce in future years.

9.2 Trust as lessor

The Trust has no lessor agreements

10 Employee benefits and staff numbers

10.1 Employee benefits

	2012-13		
	Total £000s	Permanently employed £000s	Other £000s
Employee Benefits - Gross Expenditure			
Salaries and wages	125,595	115,285	10,310
Social security costs	8,001	7,775	226
Employer Contributions to NHS BSA - Pensions Division	13,944	13,550	394
Other pension costs	36	36	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	19	19	0
Total employee benefits	147,595	136,665	10,930
Less recoveries in respect of employee benefits (table below)	(746)	(746)	0
Total - Net Employee Benefits including capitalised costs	146,849	135,919	10,930
Employee costs capitalised	1,586	1,545	41
Gross Employee Benefits excluding capitalised costs	146,009	135,120	10,889

Employee Benefits 2012-13 - income

Salaries and wages	628	628	0
Social Security costs	48	48	0
Employer Contributions to NHS BSA - Pensions Division	70	70	0
Other pension costs	0	0	0
Other Post Employment Benefits	0	0	0
Other Employment Benefits	0	0	0
Termination Benefits	0	0	0
TOTAL excluding capitalised costs	746	746	0

	2012-13			2011-12		
	Total £000s	Permanently employed £000s	Other £000s	Total £000s	Permanently employed £000s	Other £000s
Gross Employee Benefits & Net expenditure 2011-12						
Salaries and wages	118,487	110,967	7,520			
Social security costs	9,048	8,786	262			
Employer Contributions to NHS BSA - Pensions Division	13,431	13,042	389			
Other pension costs	58	58	0			
Other post-employment benefits	0	0	0			
Other employment benefits	0	0	0			
Termination benefits	0	0	0			
TOTAL - including capitalised costs	141,024	132,853	8,171			
Less recoveries in respect of employee benefits	(291)	(291)	0			
Total - Net Employee Benefits including capitalised costs	140,733	132,562	8,171			
Recognised as						
Employee costs capitalised	956					
Net Employee Benefits excluding capitalised costs	140,068					

10.2 Staff Numbers

	2012-13			2011-12	
	Total Number	Permanently employed Number	Other Number	Total Number	
Average Staff Numbers					
Medical and dental	284	251	33	280	
Ambulance staff	0	0	0	0	
Administration and estates	644	632	12	742	
Healthcare assistants and other support staff	1,168	1,030	138	999	
Nursing, midwifery and health visiting staff	1,162	1,085	77	1,149	
Nursing, midwifery and health visiting learners	0	0	0	0	
Scientific, therapeutic and technical staff	521	512	9	492	
Social Care Staff	0	0	0	0	
Other	0	0	0	0	
TOTAL	3,779	3,510	269	3,662	
Of the above - staff engaged on capital projects	41	41	0	23	

10.3 Staff Sickness absence and ill health retirements

	2012-13 Number	2011-12 Number
Total Days Lost	30236	16,387
Total Staff Years	3344	2,200
Average working Days Lost	9.04	7.45

	2012-13 Number	2011-12 Number
Number of persons retired early on ill health grounds	5	5
Total additional pensions liabilities accrued in the year	£000s 240	£000s 554

10.4 Exit Packages agreed in 2012-13

Exit package cost band (including any special payment element)	2012-13			2011-12		
	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	Number	Number	Number	Number	Number
Less than £10,000	1	0	1	1	0	1
£10,001-£25,000	1	0	1	0	0	0
£25,001-£50,000	0	0	0	0	0	0
£50,001-£100,000	0	0	0	0	0	0
£100,001 - £150,000	0	0	0	0	0	0
£150,001 - £200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	2	0	2	1	0	1
Total resource cost (£s)	18,857	0	18,857	3,000	0	3,000

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 taken by staff leaving 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 Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP 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.

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 the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2013, is based on the valuation data as 31 March 2012, updated to 31 March 2013 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, published annually. These accounts can be viewed on the NHS Pensions website. 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 scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes were suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision due in 2015.

The Scheme Regulations were changed to allow contribution rates to be set 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.

The next formal valuation to be used for funding purposes will be carried out at as at March 2012 and will be used to inform the contribution rates to be used from 1 April 2015.

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

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 the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11 Better Payment Practice Code**11.1 Measure of compliance**

	2012-13 Number	2012-13 £000s	2011-12 Number	2011-12 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	57,138	58,816	50,771	48,907
Total Non-NHS Trade Invoices Paid Within Target	54,253	56,543	47,695	46,250
Percentage of NHS Trade Invoices Paid Within Target	<u>94.95%</u>	<u>96.14%</u>	<u>93.94%</u>	<u>94.57%</u>
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,380	84,137	2,045	78,617
Total NHS Trade Invoices Paid Within Target	2,315	83,774	2,017	78,596
Percentage of NHS Trade Invoices Paid Within Target	<u>97.27%</u>	<u>99.57%</u>	<u>98.63%</u>	<u>99.97%</u>

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

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

	2012-13 £000s	2011-12 £000s
Amounts included in finance costs from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0
Total	<u>0</u>	<u>0</u>

12 Investment Income	2012-13	2011-12
	£000s	£000s
Rental Income		
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 Income		
LIFT: equity dividends receivable	0	0
LIFT: loan interest receivable	0	0
Bank interest	16	22
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Subtotal	<u>16</u>	<u>22</u>
Total investment income	<u>16</u>	<u>22</u>
13 Other Gains and Losses	2012-13	2011-12
	£000s	£000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	0	(20)
Gain/(Loss) on disposal of assets other than by sale (intangibles)	0	0
Gain/(Loss) on disposal of Financial Assets other than held for sale	0	0
Gain (Loss) on disposal of assets held for sale	0	0
Gain/(loss) on foreign exchange	0	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>0</u>	<u>(20)</u>
14 Finance Costs	2012-13	2011-12
	£000s	£000s
Interest		
Interest on loans and overdrafts	14	22
Interest on obligations under finance leases	1	1
Interest on obligations under PFI contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	<u>15</u>	<u>23</u>
Other finance costs	0	0
Provisions - unwinding of discount	0	0
Total	<u>15</u>	<u>23</u>

15.1 Property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account £000's	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
2012-13	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:									
At 1 April 2012	6,380	40,508	950	0	18,607	12	4,216	310	70,983
Additions of Assets Under Construction				451					451
Additions Purchased	0	4,114	4		914	0	1,281	90	6,403
Additions Donated	0	51	0	14	111	0	0	0	176
Additions Government Granted	0	0	0	0	0	0	0	0	0
Additions Leased	0	0	0		0	0	0	0	0
Reclassifications	0	393	0	(393)	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(857)	0	(1,872)	(23)	(2,752)
Upward revaluation/positive indexation	120	21	0	0	0	0	0	0	141
Impairments/negative indexation	(30)	(662)	(349)	(48)	0	0	0	0	(1,089)
Reversal of impairments	0	1,117	0	41	0	0	0	0	1,158
At 31 March 2013	6,470	45,542	605	65	18,775	12	3,625	377	75,471
Depreciation									
At 1 April 2012	0	0	0	0	11,443	9	3,157	142	14,751
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(857)	0	(1,872)	(23)	(2,752)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	3,395	0	0	0	0	0	0	3,395
Reversal of Impairments	(100)	(7)	0	0	0	0	0	0	(107)
Charged During the Year	0	2,113	35	0	2,024	1	612	32	4,817
At 31 March 2013	(100)	5,501	35	0	12,610	10	1,897	151	20,104
Net Book Value at 31 March 2013	6,570	40,041	570	65	6,165	2	1,728	226	55,367
Purchased	6,570	39,397	570	51	5,944	2	1,728	219	54,481
Donated	0	644	0	14	221	0	0	7	886
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	6,570	40,041	570	65	6,165	2	1,728	226	55,367
Asset financing:									
Owned	6,570	40,041	570	65	6,165	2	1,728	226	55,367
Held on finance lease	0	0	0	0	0	0	0	0	0
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2013	6,570	40,041	570	65	6,165	2	1,728	226	55,367

Due to the nature of the District Valuer's valuation which is applied on 31st March each year, the opening balances in year for land, buildings and dwellings are the closing net book value of the prior year. Cumulative depreciation for these categories of assets are netted off to create the current opening balances.

	Land	Buildings	Dwellings	Assets under construction & payments on account £000's	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2012	82	1,537	578	17	1,248	0	0	11	3,473
Adjustments	0	56	2	(58)	0	0	0	0	0
Restated as at 1 April 2012	82	1,593	580	(41)	1,248	0	0	11	3,473
Upward Revaluation / Positive indexation	120	21	0	0	0	0	0	0	141
Impairment/ Negative Indexation	(30)	(661)	(350)	0	0	0	0	0	(1,041)
Reversal of Impairment	0	1,117	0	(7)	0	0	0	0	1,110
At 31 March 2013	172	2,070	230	(48)	1,248	0	0	11	3,683

These adjustments relate to incorrect categorisation of assets under construction, buildings and dwellings values in closing 2011/12 balances.

15.2 Property, plant and equipment prior-year

2011-12

Cost or valuation:

	Land £000s	Buildings excluding dwellings £000s	Dwellings £000s	Assets under construction & payments on account £000s	Plant & machinery £000s	Transport equipment £000s	Information technology £000s	Furniture & fittings £000s	Total £000s
At 1 April 2011	12,776	51,573	1,336	0	17,955	12	3,872	294	87,818
Additions - purchased	0	1,684	34	1,297	1,430	0	344	16	4,805
Additions - donated	0	0	0	0	28	0	0	0	28
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,302	1	(1,314)	11	0	0	0	0
Reclassifications as Held for Sale and reversals	0	0	0	0	0	0	0	0	0
Disposals other than by sale	40	65	0	0	(817)	0	0	0	(817)
Revaluation & indexation gains	(2,869)	(9,008)	(400)	(41)	0	0	0	0	(12,318)
Impairments	0	696	0	58	0	0	0	0	754
Reversals of impairments	0	0	0	0	0	0	0	0	0
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	9,947	46,312	971	0	18,607	12	4,216	310	80,375
Depreciation	0	0	0		10,291	8	2,415	103	12,817
At 1 April 2011					0	0	0	0	0
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		(792)	0	0	0	(792)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	3,592	3,826	0	0	0	0	0	0	7,418
Reversal of Impairments	(25)	(65)	0	0	0	0	0	0	(90)
Charged During the Year	0	2,043	21	0	1,944	1	742	39	4,790
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0	0	0	0
Cumulative dep netted off cost following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	3,567	5,804	21	0	11,443	9	3,157	142	24,143
Net book value at 31 March 2012	6,380	40,508	950	0	7,164	3	1,059	168	56,232
Purchased	6,380	39,826	950	0	6,962	3	1,055	160	55,336
Donated	0	682	0	0	202	0	4	8	896
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	6,380	40,508	950	0	7,164	3	1,059	168	56,232
Asset financing:									
Owned	6,380	40,508	950	0	7,119	3	1,055	168	56,183
Held on finance lease	0	0	0	0	45	0	4	0	49
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	6,380	40,508	950	0	7,164	3	1,059	168	56,232

15.3 (cont). Property, plant and equipment

Various donors have funded assets during the year

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 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. In 2012/13, the District Valuer undertook a desk top exercise on all land and buildings and this has resulted in a downward valuation of approximately £3m.

Of the land value £1.106m relates to land associated with dwellings.

Economic lives of fixed assets

	Min life Years	Max life Years
Software Licences	5	5
Licences and trademarks	5	5
Development Expenditure	5	5
Buildings exc dwellings	12	62
Dwellings	10	57
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	3	5
Furniture and Fittings	10	10

16.1 Intangible non-current assets

2012-13	Software internally generated £000's	Software purchased £000's	Licences & trademarks £000's	Patents £000's	Development expenditure £000's	Total £000's
At 1 April 2012	0	1,354	396	0	0	1,750
Additions - purchased	0	614	525	0	0	1,139
Additions - internally generated	0	0	0	0	92	92
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Additions - leased	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	(262)	(112)	0	0	(374)
Revaluation & indexation gains	0	0	0	0	0	0
Impairments charged to reserves	0	0	0	0	0	0
Reversal of impairments charged to reserves	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0
At 31 March 2013	0	1,706	809	0	92	2,607
Amortisation						
At 1 April 2012	0	730	187	0	0	917
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	(262)	(112)	0	0	(374)
Revaluation or indexation gains	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	283	97	0	4	384
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Transfer (to)/from Other Public Sector bodies	0	0	0	0	0	0
At 31 March 2013	0	751	172	0	4	927
Net Book Value at 31 March 2013	0	955	637	0	88	1,680
Net book value at 31 March 2013 comprises:						
Purchased	0	955	632	0	88	1,675
Donated	0	0	5	0	0	5
Government Granted	0	0	0	0	0	0
Total at 31 March 2013	0	955	637	0	88	1,680
Revaluation reserve balance for intangible non-current assets						
At 1 April 2012	£000's	£000's	£000's	£000's	£000's	£000's
Movements	0	0	0	0	0	0
At 31 March 2013	0	0	0	0	0	0

16.2 Intangible non-current assets prior year

2011-12	Software internally generated £000s	Software purchased £000s	Licences & trademarks £000s	Patents £000s	Development expenditure £000s	Total £000s
Cost or valuation:						
At 1 April 2011	1,299	0	0	0	0	1,299
Additions - purchased	0	324	119	0	0	443
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	8	0	0	8
Additions - government granted	0	0	0	0	0	0
Reclassifications	(1,299)	1,030	269	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Less cumulative depreciation written down on revaluation	0	0	0	0	0	0
At 31 March 2012	<u>0</u>	<u>1,354</u>	<u>396</u>	<u>0</u>	<u>0</u>	<u>1,750</u>
Amortisation						
At 1 April 2011	670	0	0	0	0	670
Reclassifications	(670)	536	134	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	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	194	53	0	0	247
Transfer to NHS Foundation Trust	0	0	0	0	0	0
Less cumulative depreciation written down on revaluation	0	0	0	0	0	0
At 31 March 2012	<u>0</u>	<u>730</u>	<u>187</u>	<u>0</u>	<u>0</u>	<u>917</u>
Net book value at 31 March 2012	0	624	209	0	0	833
Net book value at 31 March 2012 comprises:						
Purchased	0	624	203	0	0	827
Donated	0	0	6	0	0	6
Government Granted	0	0	0	0	0	0
Total at 31 March 2012	<u>0</u>	<u>624</u>	<u>209</u>	<u>0</u>	<u>0</u>	<u>833</u>

17 Analysis of impairments and reversals recognised in 2012-13

2012-13
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	3,288
Changes in market price	0
Total charged to Annually Managed Expenditure	3,288

Property, Plant and Equipment impairments and reversals charged to the revaluation reserve

Loss or damage resulting from normal operations	0
Over Specification of Assets	(69)
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for PPE charged to reserves	(69)
Total Impairments of Property, Plant and Equipment	3,219

Total Impairments charged to Revaluation Reserve

Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	3,288
Overall Total Impairments	3,219

Of which:

Impairment on revaluation to "modern equivalent asset" basis	0
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Donated and Gov Granted Assets, included above

PPE - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0
Intangibles - Donated and Government Granted Asset Impairments: amount charged to SOCI - DEL	0

The other impairment relates to the valuation of the Estate supplied by the District Valuer at year end as detailed in note 15.3.

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 2013 £000s	31 March 2012 £000s
Property, plant and equipment	0	1,221
Intangible assets	0	0
Total	0	1,221

19.2 Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service

	31 March 2013 £000s	31 March 2012 £000s
Not later than one year	0	0
Later than one year and not later than five year	0	0
Later than five years	0	0
Total	0	0

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	7,620	0	8,990	0
Balances with Local Authorities	813	0	0	0
Balances with NHS bodies outside the Departmental Group	0	0	71	0
Balances with NHS Trusts and Foundation Trusts	1,238	0	2,788	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,138	973	9,492	0
At 31 March 2013	13,809	973	21,341	0
prior period:				
Balances with other Central Government Bodies	5,536	0	5,084	0
Balances with Local Authorities	744	0	0	0
Balances with NHS Trusts and Foundation Trusts	502	0	2,728	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,339	872	9,600	0
At 31 March 2012	11,121	872	17,412	0

21 Inventories

	Drugs £000s	Consumables £000s	Energy £000s	Work in progress £000s	Loan Equipment £000s	Other £000s	Total £000s
Balance at 1 April 2012	846	1,554	201	0	0	0	2,601
Additions	10,825	14,273	68	0	0	0	25,166
Inventories recognised as an expense in the period	(10,751)	(14,243)	(97)	0	0	0	(25,091)
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to SoCI	0	0	0	0	0	0	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	0
Transfers (to) / from other Public Sector Bodies	0	0	0	0	0	0	0
Balance at 31 March 2013	920	1,584	172	0	0	0	2,676

22.1 Trade and other receivables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	31 March 2013 £000s	31 March 2012 £000s
NHS receivables - revenue	8,566	5,614	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	0	0	0
Non-NHS receivables - revenue	3,097	3,806	1,111	974
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	1,594	831	0	0
Provision for the impairment of receivables	(7)	(16)	(138)	(102)
VAT	291	424	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	268	462	0	0
Total	13,809	11,121	973	872
Total current and non current	14,782	11,993		
Included in NHS receivables are prepaid pension contributions:	0	0		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts 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 2013 £000s	31 March 2012 £000s
By up to three months	2,053	141
By three to six months	89	18
By more than six months	643	52
Total	2,785	211

22.3 Provision for impairment of receivables

	2012-13 £000s	2011-12 £000s
Balance at 1 April 2012	(118)	(61)
Amount written off during the year	0	0
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(27)	(57)
Transfer to NHS Foundation Trust	0	0
Balance at 31 March 2013	(145)	(118)

Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection.

23 NHS LIFT investments

The Trust has no LIFT investments.

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.

24.3 Other Financial Assets - Non Current - Capital Analysis

The Trust has no other financial non-current capital assets to report.

25 Other current assets

The Trust has no other current assets to report.

26 Cash and Cash Equivalents

	31 March 2013 £000s	31 March 2012 £000s
Opening balance	3,467	950
Net change in year	<u>319</u>	<u>2,517</u>
Closing balance	<u>3,786</u>	<u>3,467</u>
Made up of		
Cash with Government Banking Service	3,775	3,457
Commercial banks	0	0
Cash in hand	11	10
Current investments	<u>0</u>	<u>0</u>
Cash and cash equivalents as in statement of financial position	<u>3,786</u>	<u>3,467</u>
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	<u>0</u>	<u>0</u>
Cash and cash equivalents as in statement of cash flows	<u>3,786</u>	<u>3,467</u>
Patients' money held by the Trust, not included above	<u>2</u>	<u>1</u>

27 Non-current assets held for sale

	Land £000s	Buildings, excl. dwellings £000s	Dwellings £000s	Asset Under Construction and Payments on Account £000s	Plant and Machinery £000s	Transport and Equipment £000s	Information Technology £000s	Furniture and Fittings £000s	Intangible Assets £000s	Total £000s
Balance at 1 April 2012	130	170	0	0	0	0	0	0	0	300
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	(130)	(170)	0	0	0	0	0	0	0	(300)
Less impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Plus reversal of impairment of assets held for sale	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
Transfers to Foundation Trust	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0
Revaluation	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	0	0	0	0	0	0	0	0	0	0
Liabilities associated with assets held for sale at 31 March 2013	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2011	130	172	0	0	0	0	0	0	0	302
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	0	(2)	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
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
Balance at 31 March 2012	130	170	0	0	0	0	0	0	0	300
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0

Lynton Hospital was sold at the end of March

28 Trade and other payables

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	31 March 2013 £000s	31 March 2012 £000s
Interest payable	0	0		
NHS payables - revenue	6,729	3,418	0	0
NHS payables - capital	23	0	0	0
NHS accruals and deferred income	0	0	0	0
Non-NHS payables - revenue	7,075	5,829	0	0
Non-NHS payables - capital	787	1,208	0	0
Non_NHS accruals and deferred income	954	1,050	0	0
Social security costs	1,275	1,303		
VAT	0	0	0	0
Tax	1,387	1,365		
Payments received on account	0	0	0	0
Other	3,111	3,239	0	0
Total	21,341	17,412	0	0
Total payables (current and non-current)	21,341	17,412		

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	1,841	1,726

29 Other liabilities

The Trust has no other liabilities to report.

30 Borrowings

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	31 March 2013 £000s	31 March 2012 £000s
Bank overdraft - Government Banking Service	0	0		
Bank overdraft - commercial banks	0	0		
Loans from Department of Health	500	500	0	500
Loans from other entities	0	0	0	0
PFI liabilities:				
Main liability	0	0	0	0
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	17	16	0	17
Other (describe)	0	0	0	0
Total	517	516	0	517
Total other liabilities (current and non-current)	517	1,033		

Loans - repayment of principal falling due in:

	31 March 2013		
	DH £000s	Other £000s	Total £000s
0-1 years	500	17	517
1 - 2 Years	0	0	0
2 - 5 Years	0	0	0
Over 5 Years	0	0	0
TOTAL	500	17	517

31 Other financial liabilities

The Trust has no other financial liabilities to report

32 Deferred income

	Current		Non-current	
	31 March 2013 £000s	31 March 2012 £000s	31 March 2013 £000s	31 March 2012 £000s
Opening balance at 1 April 2012	615	59	0	0
Deferred income addition	354	601	0	0
Transfer of deferred income	(621)	(45)	0	0
Current deferred income at 31 March 2013	348	615	0	0
Total deferred income (current and non-current)	348	615		

33 Finance lease obligations as lessee

Amounts payable under finance leases (Other)

	Minimum lease payments		Present value of minimum lease	
	31 March 2013 £000s	31 March 2012 £000s	31 March 2013 £000s	31 March 2012 £000s
Within one year	17	17	17	16
Between one and five years	0	17	0	17
After five years	0	0	0	0
Less future finance charges	0	(1)		
Present value of minimum lease payments	17	33	17	33
Included in:				
Current borrowings			17	16
Non-current borrowings			0	17
			17	33

Finance leases as lessee

Future Sublease Payments Expected to be received
Contingent Rents Recognised as an Expense

	31 March 2013 £000s	31 March 2012 £000s
Future Sublease Payments Expected to be received	0	0
Contingent Rents Recognised as an Expense	0	0

34 Finance lease receivables as lessor

The Trust has no finance lease receivables

35 Provisions

	Comprising:									
	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at 1 April 2012	37	0	0	37	0	0	0	0	0	0
Arising During the Year	319	0	0	57	0	0	0	0	0	262
Utilised During the Year	(22)	0	0	(22)	0	0	0	0	0	0
Reversed Unused	(3)	0	0	(3)	0	0	0	0	0	0
Unwinding of Discount	0	0	0	0	0	0	0	0	0	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	0	0	0	0	0	0	0	0	0	0
Transferred (to)/from other public sector bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2013	331	0	0	69	0	0	0	0	0	262
Expected Timing of Cash Flows:										
No Later than One Year	331	0	0	69	0	0	0	0	0	262
Later than One Year and not later than Five Years	0	0	0	0	0	0	0	0	0	0
Later than Five Years	0	0	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 2013

As at 31 March 2012

20,066

19,279

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 payments and recharge the Trust in due course. An associated contingent liability of £26,000 is shown in note 36 (2011/12 £32,000).

36 Contingencies

	31 March 2013 £000s	31 March 2012 £000s
Contingent liabilities		
Equal Pay	0	0
Other [give details]	(26)	(32)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	(26)	(32)
Contingent Assets		
Contingent Assets [give details]	0	0
Net Value of Contingent Assets	0	0

The contingency reflects the potential liability relating to Employer's liability cases as notified by the NHS Litigation Authority. An associated provision in the Balance Sheet of £69,000 (2011/12 £37,000) is shown in note 35.

37.1 PFI and LIFT - additional information

The Trust has no PFI or LIFT contracts to report on.

37.2 Other financial Commitments

The Trust has no other financial commitments.

38 Impact of IFRS treatment - current year

**Total
£000s**

The information below is required by the Department of Health for budget reconciliation purposes

Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g PFI / LIFT)

Depreciation charges	21
Interest Expense	1
Impairment charge - AME	0
Impairment charge - DEL	0
Other Expenditure	0
Revenue Receivable from subleasing	0
Impact on PDC dividend payable	0
Total IFRS Expenditure (IFRIC12)	22
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease income)	0
Net IFRS change (IFRIC12)	22

Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12

Capital expenditure 2012-13	0
UK GAAP capital expenditure 2012-13 (Reversionary Interest)	0

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 primary care trusts and the way those primary care trusts 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. Trust treasury activity is subject to review by the trust'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 income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2013 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 primary care trusts, which are financed from resources voted annually by Parliament. The trust 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

Embedded derivatives
Receivables - NHS
Receivables - non-NHS
Cash at bank and in hand
Other financial assets
Total at 31 March 2013

	At 'fair value through profit and loss' £000s	Loans and receivables £000s	Available for sale £000s	Total £000s
Embedded derivatives	0			0
Receivables - NHS		8,566		8,566
Receivables - non-NHS		3,097		3,097
Cash at bank and in hand		3,786		3,786
Other financial assets	0	1,141	0	1,141
Total at 31 March 2013	0	16,590	0	16,590

Embedded derivatives
Receivables - NHS
Receivables - non-NHS
Cash at bank and in hand
Other financial assets
Total at 31 March 2012

Embedded derivatives	0			0
Receivables - NHS		5,614		5,614
Receivables - non-NHS		3,807		3,807
Cash at bank and in hand		3,467		3,467
Other financial assets	0	1,363	0	1,363
Total at 31 March 2012	0	14,251	0	14,251

The financial assets consist of the financial element of trade and other receivables (Note 22.1) and cash at bank and in hand (Note 26)

39.3 Financial Liabilities

Embedded derivatives
NHS payables
Non-NHS payables
Other borrowings
PFI & finance lease obligations
Other financial liabilities
Total at 31 March 2013

	At 'fair value through profit and loss' £000s	Other £000s	Total £000s
Embedded derivatives	0		0
NHS payables		6,752	6,752
Non-NHS payables		7,862	7,862
Other borrowings		500	500
PFI & finance lease obligations		17	17
Other financial liabilities	0	1,073	1,073
Total at 31 March 2013	0	16,204	16,204

Embedded derivatives
NHS payables
Non-NHS payables
Other borrowings
PFI & finance lease obligations
Other financial liabilities
Total at 31 March 2012

Embedded derivatives	0		0
NHS payables		3,418	3,418
Non-NHS payables		7,037	7,037
Other borrowings		1,000	1,000
PFI & finance lease obligations		33	33
Other financial liabilities	0	4,341	4,341
Total at 31 March 2012	0	15,829	15,829

The financial liabilities consist of the financial element of trade and other payables (Note 28), plus current and non-current borrowings (Note 30)

40 Events after the end of the reporting period

On the 1st April 2013 the Trust assumed ownership of the properties it was previously renting under the agreement for Transforming Community Services. The value of £67.5m represents the assets at fair value which are transferring from Devon Primary Care Trust.

41 Related party transactions

Northern Devon Healthcare NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to 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. These entities are:

NHS Devon	Royal Devon & Exeter NHS Foundation Trust
NHS South of England	South Devon Healthcare Foundation Trust
NHS Cornwall & Isles of Scilly	South West Ambulance Service NHS Foundation Trust
NHS Plymouth	North Bristol NHS Trust
Portsmouth Hospitals NHS Trust	Devon Partnership Trust
NHS Litigation Authority	NHS Torbay
NHS Supplies Authority	NHS Professionals
NHS Pensions Agency	National Blood Authority

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:

- North Devon District Council in respect of business rates;
- Inland Revenue in respect of tax and national insurance;
- Customs and Excise in respect of VAT payable/recoverable;
- Devon County Council in respect of the provision of a joint community equipment store.

The trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also During the year the charity has contributed £150,000 towards NHS activities .

42 Losses and special payments

The total number of losses cases in 2012-13 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	13,024	19
Special payments	66,148	34
Total losses and special payments	79,172	53

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	12,588	29
Special payments	55,877	23
Total losses and special payments	68,465	52

Details of cases individually over £250,000

There were no cases individually exceeding £250,000.

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

	2005-06 £000s	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s
Turnover	77,056	89,547	118,418	128,855	128,509	134,710	211,041	220,680
Retained surplus/(deficit) for the year	(7,961)	(6,924)	7,602	7,902	(5,086)	(93)	(5,724)	(1,052)
Adjustment for:								
Timing/non-cash impacting distortions:								
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	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					
Adjustments for impairments								
Adjustments for impact of policy change re donated/government grants assets				0	5,086	345	7,328	3,288
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*							92	(53)
Adsorption Accounting Adjustment							23	22
Other agreed adjustments								0
Break-even in-year position	<u>(7,961)</u>	<u>(6,924)</u>	<u>7,602</u>	<u>7,902</u>	<u>0</u>	<u>252</u>	<u>1,719</u>	<u>2,205</u>
Break-even cumulative position	<u>(8,329)</u>	<u>(15,253)</u>	<u>(7,651)</u>	<u>251</u>	<u>503</u>		<u>2,222</u>	<u>4,427</u>

* 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.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %
Materiality test (i.e. is it equal to or less than 0.5%):	-10.33	-7.73	6.42	6.13	0.00	0.19	0.81	1.00
Break-even in-year position as a percentage of turnover	-10.81	-17.03	-6.46	0.19	0.20	0.37	1.05	2.01

The amounts in the above tables in respect of financial years 2005/06 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 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.

	£000s	2012-13 £000s	2011-12 £000s
External financing limit		(711)	(1,149)
Cash flow financing	(835)		(2,997)
Finance leases taken out in the year	0		0
Other capital receipts	0		(36)
External financing requirement		<u>(835)</u>	<u>(3,033)</u>
Undershoot/(overshoot)		<u>124</u>	<u>1,884</u>

43.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

		2012-13 £000s	2011-12 £000s
Gross capital expenditure		8,263	5,284
Less: book value of assets disposed of		(302)	(25)
Less: capital grants		0	0
Less: donations towards the acquisition of non-current assets		<u>(176)</u>	<u>(36)</u>
Charge against the capital resource limit		<u>7,785</u>	<u>5,223</u>
Capital resource limit		<u>7,801</u>	<u>5,230</u>
(Over)/underspend against the capital resource limit		<u>16</u>	<u>7</u>

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 2013 £000s	31 March 2012 £000s
Third party assets held by the Trust	<u>2</u>	<u>1</u>