Annual report and accounts

April 2016 – March 2017

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Welcome to our annual report for 2016-17

Every year, our annual report gives us the opportunity to look at how well we have performed over the last 12 months and what we have achieved, as well as the challenges we have faced.

It has been a successful year for the Trust and we are extremely proud of our staff for their achievements. This year has also been one of change, not just for us but for the whole of Devon.

This year has seen us working more closely with our partner organisations than ever before as part of Devon's Sustainability and Transformation Partnership (STP). This has given us a much needed opportunity to join together with other trusts, clinical commissioning groups, local authorities, the ambulance service, Healthwatch and other health providers to really look at how we can work better together across Devon to improve care for our patients.

The first priority within the STP was to look at how we care for people who are frail or elderly across Devon, and we are very proud that the STP is taking forward and learning from our model of integrated community services, which provide support and treatment to enable people to live independently in their own homes.

A review of acute services is also underway, and we know this has caused concern in local communities where people are worried about what this could mean for them. We are hugely grateful to local people who have continued to show such passion in supporting our staff and our services. We expect the next steps to be published in June 2017.

While much of the focus this year has been on what we can do together across Devon, we have continued to carve our own successful path as a trust making real advances, with innovations that improve patient care.

NHS staff in northern Devon have worked tirelessly all year to make sure that our urgent and emergency services are there when you need them. This is shown by the very small number of people waiting longer than four hours in our emergency department and this demonstrates how well we are moving people through all of our services and then getting them back home again with the right support. We topped the list for trusts of our kind on more than one occasion this year for performance against this target, and were singled out as one of eight providers delivering on all fronts in a speech by Jim Mackey, chief executive of the national NHS Improvement. Our successful patient flow initiatives were featured as a national case study, and the local ITV Westcountry spent some time with our teams to find out how we've achieved success in this area.

Our domiciliary care service, Devon Cares, launched in July 2016, making us the first NHS trust to enter into the domiciliary care market. Devon Cares works in partnership with high quality local care agencies to provide social care to people in their own homes. Our NHS community services (district nurses, physiotherapy, occupational therapy and social care workers) are already supporting around 2500 patients in their own home at any one time, and Devon Cares often provides care to the same people. We are working hard to join up health and social care, improving the way people get home from hospital or receive support to remain independent in their own homes.

Since launching Devon Cares, the number of people in northern and mid Devon waiting to have their care needs met is at a historic low. In November we were asked to showcase the initiative to other providers at the national NHS Providers Conference, as an example of innovative practice.

Recruitment and retention of staff continues to be one of our top priorities and 2016/17 saw us continue to reduce our spend on agency staff. We have also launched a number of initiatives which will help us combat some of the national skills shortages, by growing and developing our own workforce. These include developing our own Staff Bank to fill temporary shifts and leading the Devon Excellence Centre, which aims to improve the quality of the training available to health and social care support staff. We are also part of the pilot of the new nursing associate role, which provides a route into nursing for the healthcare assistant workforce, and we have continued to support our Care Academy and Project SEARCH partnerships with Petroc College.

In the most recent NHS staff survey, our staff voted us as the top NHS organisation to work for in the South West. We are particularly proud of the feedback from our staff that they feel able to contribute to improvements at work and feel their role makes a difference to patients.

This is reflected in all of our successes as a Trust, and it is clear that having happy staff leads to patients having a positive experience, and overall success as an organisation.

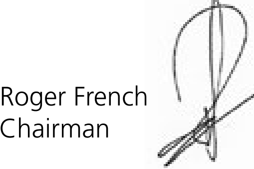
Our staff continue to inspire each other every day and their incredible commitment seems to increase year on year. As well as showing absolute dedication to our patients, many of our staff go over and above, coming up with innovative new ways to improve patient care and raising awareness of important issues.

In the past year, one of our ward sisters was invited to meet Prince Charles to talk about the work her team has been doing to improve patient safety. In November, a consultant microbiologist and his project team were shortlisted for a national award for their project to reduce unnecessary diagnostic testing and harm to patients. Our stroke therapy team has launched a website and app to help stroke patients find apps for rehabilitation following a stroke or brain injury, and the website is being used by people across the country, and even across the world. These are just a few examples of the inspirational work our staff are doing, and you will find many more within this report.

It is a real credit to our staff that, despite the challenges faced across Devon, we ended the 2016/17 financial year in surplus, money that we can invest in projects to improve care.

It hasn't all been easy and there have been times when we have had to make difficult decisions to ensure that we can continue to provide high-quality, safe services. In March, we made the decision to temporarily close the inpatient beds at Holsworthy Hospital due to significant safety concerns. We know this news came as a shock to the community and we will now be working with NHS partners, community leaders and clinical stakeholders to look at how we can solve the issue of low bed occupancy and staffing issues at the hospital with a view to trying to reopen the beds.

We are now heading into an exciting year where we will continue to work more closely with other organisations than ever before to solve the challenges we face and design clinically and financially sustainable services. We will continue to support staff with their ideas and innovations to improve care for our patients, and to celebrate when they gain well-deserved recognition for their efforts. We know that there will be some challenging times ahead, but with inspirational staff like ours, we have the best possible chance of a successful 2017/18.



Roger French
Chairman

Date: 1 June 2017

Alison Diamond
Chief Executive

Date: 1 June 2017

What we do

Across Devon, our teams of care professionals work with patients and their families to support people's independence, health and wellbeing. We provide support to avoid hospital admissions, and if an admission is necessary, we try to make each patient's stay in hospital as short and effective as possible before working with them on a safe discharge home.

In any 24 hours our health and social care community teams visit around 300 patients in their own homes to help them rehabilitate after illness or injury. At any one time, they are overseeing around 2500 people's care.

Our domiciliary care service, Devon Cares, works in partnership with high quality local care agencies to provide social care to people in their own homes.

We are working hard to join up health and social care, improving the way people get home from hospital or receive support to remain independent in their own homes.

Our values guide everything we do. At all times, we aim to:

- Demonstrate compassion
- Strive for excellence
- Respect diversity
- Act with integrity
- Listen and support others

A high-performing trust

In our most recent staff survey, our staff voted us in the top 10% of NHS provider organisations to work for and we also came out as the top provider in the South West. Our patients (through the Friends and Family Test) regularly report an average of over 95% satisfaction with our services.

The Care Quality Commission inspected our services in 2014 and found our community services to be 'close to outstanding' with inspectors wishing they lived in Devon. Our medical inpatient services at NDDH were the first to be judged as 'outstanding' by the CQC.

According to many clinical targets, we rate as one of the best performing non-foundation trusts in England, because we treat patients in line with national waiting time standards, have very few hospital-acquired infections and meet our four-hour waiting times for urgent care.

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

Highlights 2016/17

- We were the best performing trust in the country on more than one occasion for our emergency department performance this year, which is testament to the hard work of teams across the Trust. In November, the chief executive of NHS Improvement, Jim Mackey, highlighted NDHT at a national conference as one of eight providers 'delivering on all fronts'.
- We launched Devon Cares in July 2016, our domiciliary care service. Devon Cares works in partnership with high quality local care agencies to provide social care to people in their own homes. Since launching, the number of people in Northern and Mid Devon waiting to have their care needs met is at a historic low.
- We have completed an investment of just over £4 million into reducing energy costs and carbon across our sites, putting into place projects that will produce major financial savings for the Trust over the next 15 years. We expect our energy usage will decrease by at least 20%, placing us in line with the best performers in the NHS.
- 2016/17 saw teams across the Trust working extremely hard to prepare for the implementation of an electronic health record, which launched in April 2017. Having electronic health records brings benefits to patients, because staff have access to up-to-date, real-time information, allowing us to make more informed, holistic decisions about care. For example, information about an allergy will be readily available on the record, so we won't prescribe something we know a person will have a reaction to.

Freedom to Speak Up

NTROLLED
AREA
X-RAYS

North Devon District Hospital (NDDH), Barnstaple

In 2016/17, staff at Northern Devon Healthcare NHS Trust treated 28,122 inpatients, 21,804 day cases, 353,650 outpatients and delivered 1,548 babies. They also saw 45,050 people in our accident and emergency department, and 25,413 in our minor injuries units.

The populations of Torridge and North Devon account for 94% of patients to NDDH, with the remaining 6% coming from residents from the Cornish and Somerset borders or tourists to the area.

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

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

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

The Trust offers patients a choice of local, specialist services and invites consultants from other neighbouring Trusts to hold clinics in the area. We work with Musgrove Park in Taunton on a vascular network, Derriford on a neonatal network and the Royal Devon and Exeter on a cancer network. We also work with the RD&E to deliver ear, nose and throat services.

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

Integrated health and social care community services

Our teams of integrated health and social care community professionals across northern Devon work to rehabilitate patients, avoid admissions, and promote health, wellbeing and independence. The multidisciplinary teams include community nurses, social workers, physiotherapists, occupational therapists, community matrons and the voluntary sector.

The teams deliver care to around 2500 people, often with very complex needs, providing support and treatment to enable them to live independently in their own homes.

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

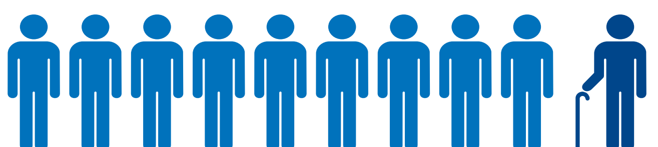
The Trust has five community hospitals and two resource centres, which provide a range of services that are easily accessible to the local population, including around forty inpatient beds, and rehabilitation and outpatient clinics.

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

No place like home

24 facts about our health and social care teams

1 Northern Devon has a population of 164,999, expected to **rise by 14.5% by 2026**.



An average of 10% of this population is **over 75 years old**.

2 Evidence shows that **we can provide better care for more people at home**, by freeing up our staff to **go out into the community**, rather than keeping them tied to a small number of beds.

3 Between October 2013 and October 2015, we **reduced our community hospital bed numbers** significantly, and **invested in our community health and social care teams.**

4 These teams are made up of **nurses, therapists and social care workers**. They look after people in their own homes, **promoting independence,** keeping them well and preventing admissions to hospital.

5 The teams take a strength-based approach, where they look at what people **can do first, along with their families and communities, and build care around that**.

6 The **teams prevented around**

H

2500

admissions to acute and community hospitals last year.

7 At any one time, the **teams are overseeing around**

people's care.

8 In any 24 hours, they **visit approximately**

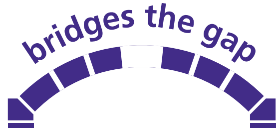
patients in their own home.

9 Our teams know the **best bed is your own bed**. Patients who need care in a hospital bed will **still be able to receive care in this way**, but the majority are **better off at home** with the right support and we know this is **where most people want to be**.

10 We have teams who can **respond quickly** if a patient needs **extra short-term support**, for example if they have had a fall.

11 And if a patient does need to come into hospital, our teams can **put the right care in place** so we can get them **back home again as soon as is safe**.

12 Our pathfinder team



between acute and community services. The team supports timely transfers of care from the acute hospital to community settings and **prevents admissions**.

13 We now have a **single point of access for people who need short term support** from our teams, which means the GP or community health professional requesting the care only needs to make one phone call.

14 Having **combined health and social care teams** makes sense, because many people have a combination of needs and we know **people find it easier when their care is more joined-up**.

15 We have also launched **Devon Cares**, where we work closely with our local domiciliary care providers to **arrange for people to receive social care at home**. This made us the first NHS Trust to enter to the domiciliary care market, and since taking over this function, we have **significantly reduced the number of people who are waiting to have their domiciliary care needs met**.

Devon Cares

We also have **specialist teams** for people with certain needs, such as:

16 The **lymphoedema service**, which provides on-going support for people with long-term cancer and non-cancer related lymphoedema and lipoedema.

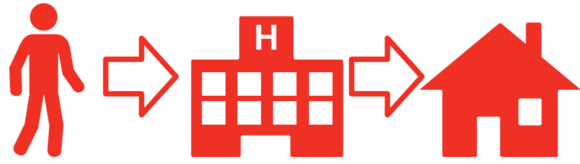
17 The **CREADO service**, which helps people to manage lung conditions and improve their quality of life.

18 The **speech and language therapy service**.

19 **Our care homes team provides free training for staff in nursing and residential homes** in order to reduce avoidable hospital admissions.

20 We **work in partnership** with independent providers, care homes and the voluntary sector.

21 **Our community teams have helped us to improve the movement of patients through our acute hospital and other services.**



This is because they have helped us to **reduce unnecessary admissions by keeping people well at home** and when people do need to be in hospital, we aren't keeping them there longer than they need to be.

22 We also have **one of the lowest rates of delayed transfers** of care in the country.

23 We know **patients are happy with our community services**, because they regularly receive **95%-100% satisfaction scores** across the whole North Devon community.

24 And our teams know that for most people, **there's no place like home**.

Specialist community services

The Trust is the main provider of specialist community healthcare services across North, East, Mid and South Devon, including podiatry, sexual health and the Sexual Assault Referral Centre (SARC). We also provide adult and paediatric bladder and bowel care services in these areas.

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

Healthy Teeth Devon

www.healthyteethdevon.nhs.uk

www.thecentresexualhealth.org

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

Improving patient, visitor and staff experience

We recognise that having a good experience of our services is about more than just the care you receive from a therapy, nursing or medical professional.

We work closely with Sodexo, our non-clinical support services partner, to ensure we provide the best services we possibly can to patients, visitors and staff.

Sodexo provides a range of services to the Trust, including catering, housekeeping and cleaning, portering, courier and post room, linen, car parking, reception management, security, waste management and retail.

Our aim is for a seamless service across all services, making the experience of our hospital as easy as possible, so that our patients, staff and visitors can focus on patient care.

Parking

It is free to park at a number of our sites, and there are spaces at all sites which allow free parking for blue badge holders.

In 2016/17, we invested in upgrading our car parking at the acute site and we continually try to improve our services. Our charges for visitors and patients needing to attend our services on a regular basis are some of the lowest in the NHS.

Food

We support healthy food in hospitals and work closely with Sodexo to ensure that staff, visitors and patients have healthy food options on our sites.

We have worked with Sodexo to ban price promotions and advertising of sugary drinks and foods high in fat, sugar and salt. Food retail areas have been rearranged so that healthy snacks and drinks are more prominent and vending machines have limited confectionery available.

We have also introduced a healthier vending machine in the main foyer of North Devon District Hospital, which has been stocked purely with healthy snacks, water and healthier drinks.

PLACE assessments

Patient-led assessments of the care environment were carried out over five days in March at North Devon District Hospital, and at Holsworthy, Bideford and South Molton Community Hospitals. Assessments take place every year and results are reported publicly to help drive improvements to the care environment.

The assessments see local people come into our hospitals as part of a team to assess how the environment supports patients' privacy and dignity, food, cleanliness and general building maintenance. This year, seven patient assessors were included in our inspections.

We work closely with Sodexo to review the patient feedback we receive as part of these assessments and where necessary, to make improvements.

NDHT's vision
Delivering high-quality and sustainable services that support your health and wellbeing

External factors

Success Regime Improving:
Population health
People's experience of

Five Year Forward View
Healthier populations
New ways of working and models of care

Sustainability and Transformation Plan (STP)
one system, one plan

Carter Review
Greater efficiency
Reduced variation

Drivers behind our plan

What we need to do

Our plan for 2016/17

We will take a place-based system approach to transforming our services to ensure they meet the changing needs of our patients. We will deliver safe and effective care within our budget and aim to deliver a surplus of £1.4M in order to be able to reinvest into services next year

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

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

We will deliver **integrated health and social care** seamlessly to meet the needs of individuals.

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

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

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

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

How we are going to do it

5 workstreams identified and agreed by the pan-Devon Success Regime:

1 Bed-based care
Ensuring patients' length of stay in hospital is appropriate to their needs. Shifting resources from acute care to out of hospital care
Fewer people in hospital when they could be at home. People retaining independence for longer

2 Planned care
Reducing the differences in levels of planned care. Follow up appointments based on clinical need not time
Reducing over-hospitalisation and unnecessary interventions

3 Continuing care
Optimising the amount of money being spent on continuing care. Better assessment and review
Changing the model of care from dependency to enablement

4 Procurement
Better buying decisions to get value for money from our buildings, clinical resources, equipment and utilities
More money to reinvest in services

5 Agency spend
Reduction in spending on agency staff through better processes for recruitment and deployment of staff
Safer patient care and more financially sustainable services

Additional priorities for 2016/17:

Devon Cares
Acting as "Prime Provider" for personal care across northern and mid Devon.
Providing a bridge between health and social care

Smartcare
Programme of transformational change to deliver more joined-up care. Going paperless, joining up care records and modernising clinical decision support tools

Workforce
Engaging our workforce, retaining our top spot within type of NHS provider (staff survey)
Improve health and well-being outcomes for staff

Quality
Quality improvement plan priorities:
Making the most of informal networks of care
Keeping hydrated
Mortality rate review
Focus on communication

Estates
Using our estates efficiently and effectively
Focus on energy efficiency and sustainability

Underpinned by our values

- Demonstrating compassion
- Striving for excellence
- Respecting diversity
- Acting with integrity
- Listening and supporting others

10 things you didn't know about research and development at NDHT

Clinical research is a vital part of our work, helping us to improve treatments for patients now and in the future.

747 The number of patients recruited to research in 2016/17, against a target of 500.

We have **38** principal investigators (lead researchers) across the Trust. These include doctors, nurses and allied health professionals (physiotherapists and occupational therapists).

26% of the 747 patients were recruited into interventional studies (where patients are offered a new treatment). This is an increase from 9% in 2015/16.

In 2016/17 we achieved a double first by opening our first research study with our sexual health service, and successfully recruiting the first patient in the UK to the study. The Safetxt study is testing whether text messages providing information and tips to increase safer sex helps young people adopt safer sex behaviours.

The department provides external training to the national research and development forum, which focuses on leading, shaping and influencing quality health research.

In June 2016, we held our **2nd** annual research symposium with speakers from across the region. The symposium also features a poster competition, open to all Trust staff and the wider research community and patients.

14 year old Ryan Fryer has been taking part in a clinical trial as part of his treatment for a kidney condition at North Devon District Hospital. Ryan shared his drug trial experience at the symposium and was presented with a framed copy of his story by the Trust chairman, Roger French.

The amount of money the department earned for conducting research studies from a mixture of commercial and non-commercial sponsors in 2016/17. This was in addition to funding from the clinical research network.

The date International Clinical Trials day is celebrated each year. In 2015 the research team worked in collaboration with Stagecoach to put research 'On the Buses' by taking over the number 19 service for the day to talk about research with patients, staff and the general public.

The year in pictures

2016

April

The chemotherapy and day treatment centre at North Devon District Hospital – the Seamoor Unit - celebrated a busy first year and its first birthday.

A new cohort of students started a 10-week rotational placement at NDDH as part of our Care Academy Partnership with Petroc.

May

The success of the Care Academy was highlighted in the House of Commons by North Devon MP Peter Heaton-Jones.

June

Tracey, clinical tutor and lead for QCF and care certificate, won a Medal for Excellence, awarded for her professionalism and support for learners over the past 18 years.

Staff showed their support for the armed forces community by saluting them on Armed Forces Day.

July

The Trust's Lundy Ward team were shortlisted in the Patient Safety Improvement category of the Nursing Times Awards 2016, for their work to educate and train staff to help patients avoid pressure ulcers and falls.

Staff nurse Siobhan Roissetter was awarded a Certificate of Recognition by Plymouth University after being nominated by one of her students.

Nine young people with learning disabilities celebrated graduating from the pioneering Project SEARCH internship scheme based at North Devon District Hospital.

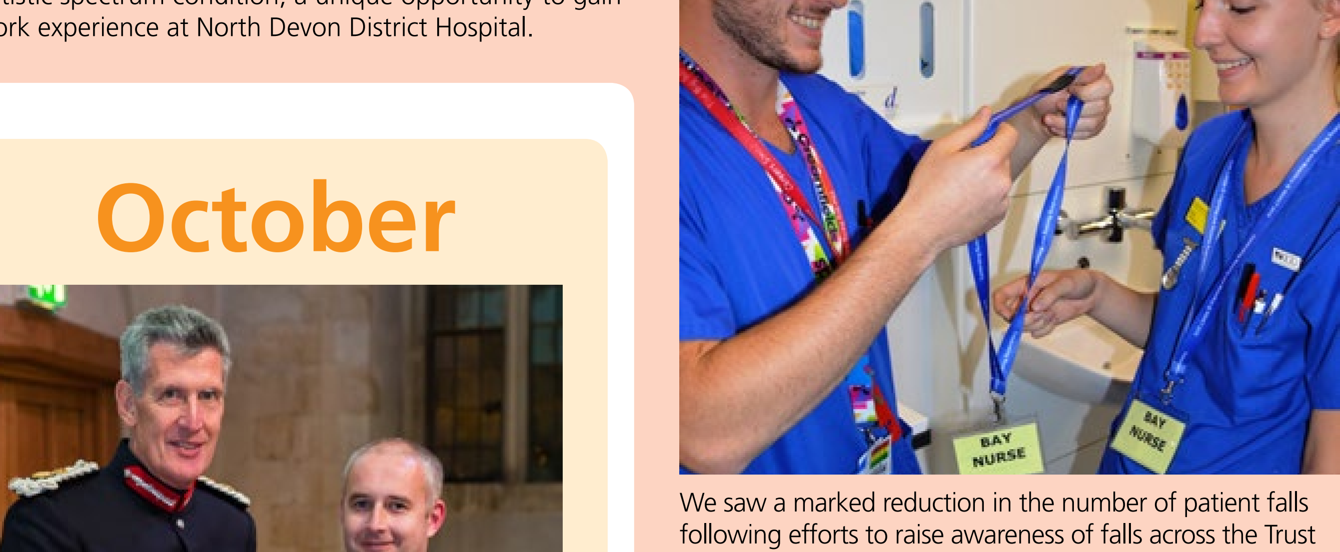
August

We held our second annual symposium to highlight research and development successes across the Trust.

The Seamoor Unit took first prize in the 2016 Michelmores Property Awards in the best building under £2 million category.

September

We welcomed a new intake of nine students as part of the Project SEARCH programme, which is run in partnership with Petroc college and Pluss, and gives young people aged 18-24, with learning disabilities or an autistic spectrum condition, a unique opportunity to gain work experience at North Devon District Hospital.



We saw a marked reduction in the number of patient falls following efforts to raise awareness of falls across the Trust and training on how to reduce the chance of a fall.

October

The Trust received a Silver Employer Recognition Award for demonstrating a commitment to supporting the armed forces community.

The Trust won the Responding to the Carter Challenge award at the national Allocate Awards, which recognises organisations that have risen to the workforce challenges set out in Lord Carter's 2016 report on productivity in NHS hospitals.

November

At the annual Queen's Nursing Institute Conference, the care homes team took first prize for the best poster presentation, which highlighted the improvements made in care homes over the past three years with their support.

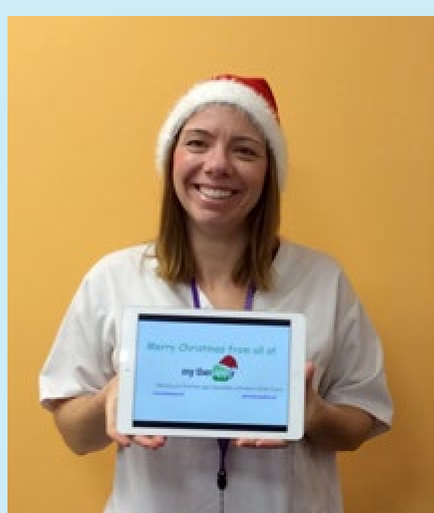
The facilities team was named Client of the Year at the National Construction Design and Management Awards, which recognise outstanding practice in health and safety risk management for construction projects.

The Trust launched the Devon Excellence Centre, which aims to improve the quality of training for support staff in health and social care and to make it more accessible through working with the National Skills Academy for Health.

Gemma Lilley, ward sister at Lundy Ward, was invited to meet HRH the Prince of Wales to talk about the innovative work the Trust is doing to improve patient safety, before representing the Trust at the Nursing Times Awards.

Devon Cares was one of twelve initiatives chosen to exhibit at the annual NHS Providers conference and exhibition.

December



We launched our first staff advent calendar, where we celebrated a different member of staff or volunteer each day, who are all part of making sure we deliver great patient care.

A conference organised by the Trust's care homes team to raise awareness of best practice in caring for older people was called 'inspiring' by those who attended.

Starlight Children's Foundation's pop-up pantomime visited the Caroline Thorpe children's ward and performed their version of the classic children's story Dick Whittington and His Cat.

2017

January

The trainee nursing associate programme launched on 20 January. At the end of the two-year programme, the candidates will be qualified band 4 nursing associates with a foundation degree. This is a fantastic opportunity for our staff to develop, offering a pathway for healthcare assistants to move into nursing roles

February

We launched a bowel scope screening service in the endoscopy unit as part of the NHS Bowel Cancer Screening Programme.

March

A celebration was held at the children's ward at North Devon District Hospital to mark the final donation from the Caroline Thorpe Children's Fund after 45 years of support.

Our staff rated us the top provider in the South West and in the top 10% of providers in England in the NHS staff survey, which asks NHS staff what they think about the organisation they work for.

The stroke therapy team were shortlisted for an Advancing Healthcare Award for entrepreneurship for developing their stroke rehabilitation app review website, the first website of its kind in the UK.

Project SEARCH intern Danielle Young became the first person in 2017 to gain employment at the Trust through the award-winning supported internship programme. Danielle was appointed to the new full-time role of radiology clinical support worker at North Devon District Hospital.

The Trust joined the global celebration of Nutrition and Hydration week, with plenty of activities to highlight the importance of good nutrition and hydration to both staff and patients.

News review

We published 121 news articles last year.

Of these articles:

26 were about campaigns and events we support and take part in

20 were about our workforce, including the achievements of individuals, and workforce projects

16 were about awards we have won and celebrations of our services

12 were publicising engagement with the public, including around the STP

10 were about innovative things happening at the Trust

9 were about service changes

9 were about our charitable efforts

8 were information (roadworks notices, cold weather alerts)

5 were updates about the STP

3 were advertising recruitment open days

3 were corporate updates, such as appointments

Our most read news

The most read articles on the Trust website were:

1. Wider Devon Sustainability and Transformation Plan (STP) latest submission released (4 November 2016)

Angela Pedder, lead chief executive of the Sustainability and Transformation Partnership, shares the latest submission of the Sustainability and Transformation Plan.

The document is available on the Devon STP website www.devonstp.org.uk.

2. North Devon anaesthetists scoop national award (19 May 2016)

A team of anaesthetists from Northern Devon Healthcare NHS Trust scooped a prestigious national award in May as part of a South West research project. The South West Anaesthesia Research Matrix (SWARM) was named 'Anaesthesia Team of the Year' at the British Medical Journal (BMJ) Awards. Set up four years ago, SWARM is a trainee-led audit and research collaboration between NHS organisations. The network allows projects to be run at the same time at all the participating trusts. This results in better quality research that has a higher impact for patients across the South West.

3. Open letter from Dr Alison Diamond (1 November 2016)

Chief executive Dr Alison Diamond writes an open letter to staff, patients and the public in response to concerns about the Sustainability and Transformation Plan.

4. Trust to become first to enter home care market (18 April 2016)

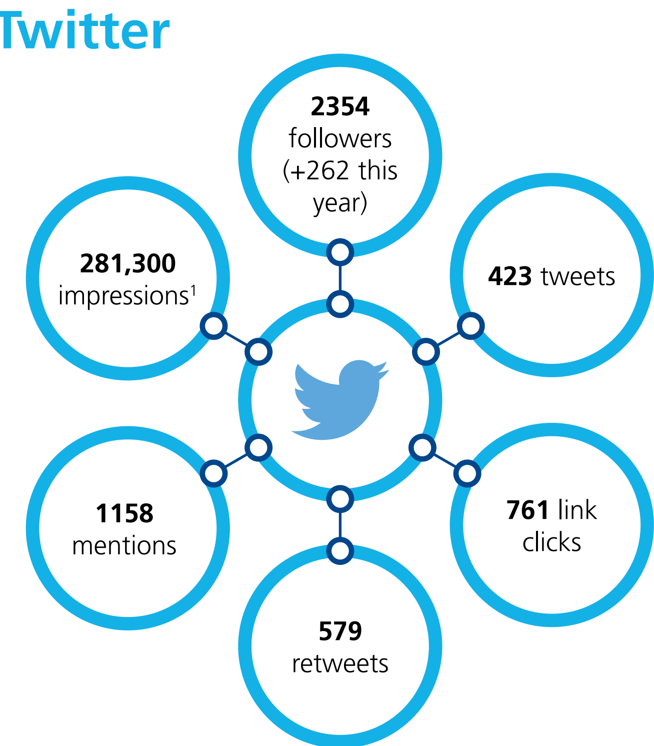
In April, we announced that the Trust was set to become the first NHS trust to enter the home care market by launching our own domiciliary care service.

We launched the service, Devon Cares, in July 2016. The service works with high quality local care providers to arrange social care packages for people in their own homes, and since launching, Devon Cares has reduced the amount of people waiting to have their care needs met in North and Mid Devon to a historic low.

Dr Guy Rousseau (second from left) with other members of SWARM at the event

Social media review

Twitter



[1] | times our tweets appeared in other users' feeds

Top tweets

1. Reached **7,305** people

Jun 24 To all our fantastic staff from the #EU. We really value your hard work & professionalism, & the care you give our patients #LoveOurEUStaff

2. Reached **3,802** people

Sep 11 We are supporting Organ Donation Week 2016 @NHSOrganDonor #yesidonate See: bit.ly/2csFovQ pic.twitter.com/6LxRlDBZR8

3. Reached **3,702** people

Aug 8 Affected by the way an #NHS trust has investigated a death? #CQCDeathsReview @CareQualityComm RT DEADLINE 14 Aug bit.ly/29R9fvP

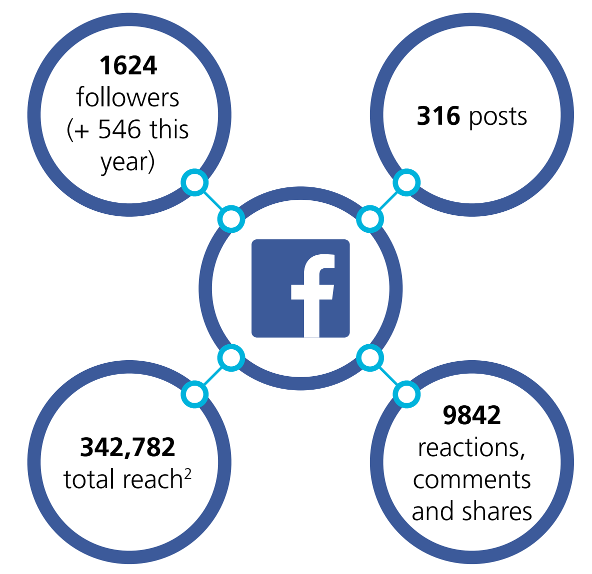
4. Reached **2,508** people

Jun 25 Proudly supporting Armed Forces Day #SaluteOurForces @ArmedForcesDay @ndht pic.twitter.com/EKPLczDt06

5. Reached **2,110** people

Feb 2 A patient said about #lundyward @ #nddh - "Treated as a person, not just a patient. Kind, caring, always listen" #ndhtexperience

Facebook



[2] | the number of times our posts appeared in other users' news feeds

Top Facebook posts

1. Reached **10,024** people

20/07/2016: A nurse from the Trust has been awarded a Certificate of Recognition by Plymouth University after being nominated by one of her students.

Siobhan Roissetter, a staff nurse for the Trust, received her certificate in recognition of her 'outstanding contribution to the support of practice learning.'

Siobhan, who is based in the day surgery unit at North Devon District Hospital (NDDH), has been a mentor for 10 years. She supports and educates nursing students through their eight-week placements at the hospital, which they undertake as part of their three years' training.

2. Reached **6,356** people

Invitation to our radiography open day in January for qualified radiographers, radiography students or anybody interested in a career in radiography.

3. Reached **6,085** people

18/07/2016: Northern Devon Healthcare NHS Trust has been shortlisted for another prestigious national award for its work to improve patient safety.

The Trust's Lundy Ward team, based at North Devon District Hospital (NDDH) have been shortlisted in the Patient Safety Improvement category of the Nursing Times Awards 2016, for their work to educate and train staff to help patients avoid pressure ulcers and falls.

4. Reached **5,749** people

03/11/2016: Dr Alison Diamond writes an open letter in response to your support for hospital services in North Devon.

The letter is available to read on the Trust website.

5. Reached **5,433** people

Invitation to meet the team at the Royal College of Nursing Jobs Fair in London (September 2016).

Top themes

Advent calendar

24 posts – 39,091 people reached, 1102 reactions, comments and shares.

Popular post:

Day 20 of our #Advent Calendar features Dave Parsley, post room porter -

www.northdevonhealth.nhs.uk/christmas-calendar/day-20-dave-parsley/

International women's day

5 posts – 12,621 people reached, 554 reactions, comments and shares

Popular post:

It's International Women's Day on 8 March 2017 and all this week we are celebrating some of the great work being done by women at the Trust.

This is Libby. She is a junior doctor on the acute stroke unit, and for International Women's Day she has organised a series of talks for staff about women in leadership roles and women's health.

Staff awards

3 posts – 6,487 people reached, 265 reactions, comments and shares

Popular post:

Congratulations to February's Staff Awards winners – Heather, Cher, Tamara and Emma from the Rapid Intervention Centre (RIC) team. The RIC coordinates urgent health and social care support in the community. They were nominated for their work to ensure the right care is provided at the right time, by the right person. Each month, their positive attitude is reflected in customer satisfaction scores, with 100% of service users saying they would recommend the service.

Patient experience comments

30 posts – 37,035 people reached, 1505 reactions, comments and shares

Popular post:

A patient on King George V ward was asked this question - "How likely are you to recommend our ward to friends and family if they needed similar care or treatment?"

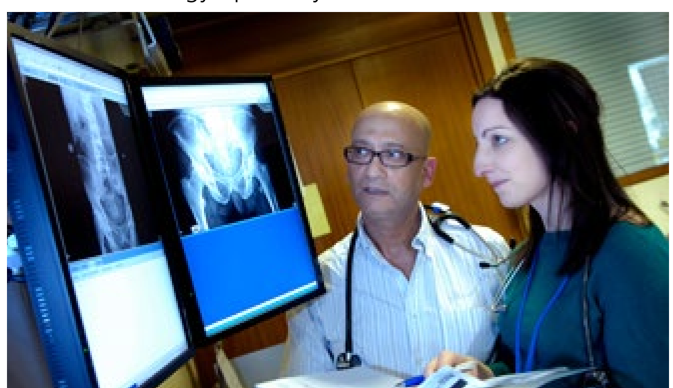
This was the main reason they gave the response of extremely likely - "It is the staff. All of them, from Sodexo to consultants. They all go the extra mile - nothing, absolutely nothing, is too much trouble for them."

Recruitment

104 posts – 107,857 people reached, 2478 reactions, comments and shares

Popular post:

Invite to radiology open day.



Involving you

The Trust is committed to giving patients and the general public a greater voice.

The NHS continues to face the challenge of driving up the quality of care and improving patient experience, whilst also facing rising demands for services and the need to make sure our services are efficient for the future. In this environment, good communication and engagement is crucial.

We are committed for all of our engagement work to be guided by legislation and driven by a genuine desire to work in partnership with local communities.

The acute services review and the temporary closure of inpatient beds at Holsworthy Hospital were the focus of much of our engagement during the year. In both cases, our aim was to keep people informed and to listen to feedback.

We also engaged on the proposal to co-locate the acute and rehabilitation stroke services at North Devon District Hospital through an online survey, through our links with the Stroke Association and through our VISTA patient and carer support group.

Learning from your experiences

Our communications and engagement teams continued to meet with patients and people with experiences of using our services to find case studies and stories to share with the Trust board and more widely. Talking to people about their experiences helps us to learn what we did well and what we could improve, and we share this learning widely across the Trust.

The care environment

We carried out four patient led assessments of the care environment at NDDH, Holsworthy, Bideford and South Molton Community Hospitals. The assessments saw seven patient assessors come into our hospitals as part of a team to assess food, cleanliness and maintenance, as well as how the environment supports patients' privacy and dignity. Our director of facilities also took part in a quality and safety walk-around accompanying a nurse visiting patients in their own homes.

Local Democracy Week

Chief executive Dr Alison Diamond took part in a Question Time event in October, where school children from Pilton and Braunton had the chance to ask local leaders questions about their local services. The panel included representatives from the NHS, Devon and Cornwall Police, and district and county councils, as well as the local MP Peter Heaton-Jones.

How did we involve you in 2016/17?

- **1** annual general meeting
- **3** patient experience focus groups with Healthwatch, to find out what is important to you
- **3** meetings to explain the STP and the acute services review
- **4** meetings building relationships with the local community and public and voluntary sector organisations as part of One Ilfracombe
- **5** Involving People Steering Group meetings, where we meet with representatives of community and patient groups to talk about our services and to get their views
- **5** meetings to explain the decision to temporarily close inpatient beds in Holsworthy
- **6** board meetings in public
- **6** Your Future Care roadshows, where we talked about the success of care at home in North Devon
- **11** meetings with MPs and local councils
- **40** executive roadshows for staff
- **250** letters received and responded to from members of the community, covering a range of issues, including the acute services review and the STP, our plan to co-locate stroke services at NDDH and the temporary closure of inpatient beds at Holsworthy Hospital

Key service updates

Acute services review

In November, NHS Northern, Eastern and Western Devon Clinical Commissioning Group announced that health and care partners in Devon would be undertaking a review of acute services.

Since this announcement, clinicians across Devon have been reviewing the high priority acute services – stroke services, maternity and paediatrics, and urgent and emergency care.

The aim of the review is to make sure Devon's acute hospital services are fit for the future and provide the best possible care for our patients.

We have held a number of public meetings to get people's feedback on the criteria that will be used when developing possible scenarios.

We expect the next steps of the acute services review to be announced in June 2017.

Temporary closure of inpatient beds at Holsworthy Community Hospital

In March, we announced that the inpatient beds in Holsworthy would be closed temporarily due to significant safety concerns.

In order for the beds to reopen, we need to address both the issue of staffing challenges and the low occupancy of the inpatient beds. Because the Trust determines its staffing needs based on the care that is provided, the issue of low bed occupancy needs to be addressed first.

We are currently doing some work to address these challenges and we will be working with the community to explore how we can best use the beds.

Co-location of stroke services at North Devon District Hospital

In November, we announced a proposal to co-locate the acute and rehabilitation stroke services at NDDH to allow us to deliver better, more joined-up care for stroke patients. The move, which takes place in summer 2017, means that the stroke teams can work more closely together and that they can give patients more direct clinical supervision, so we can make sure all stroke patients receive the specialist care they need, in the right environment.

Bowel cancer screening service

In February, the Trust launched a bowel scope screening service as part of the NHS Bowel Cancer Screening Programme. The screening takes place in the endoscopy unit at NDDH, with Invitations for screening being sent out to men and women after their 55th birthday.

Devon Cares

In July 2016, we launched Devon Cares, a new approach to home care, which brings together care providers and gives them the backing of the NHS.

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

Through the contract, we are 'prime provider' of home care in northern and mid Devon, which means we organise care. This benefits the Trust because it bridges the gap between health and social care and allows us to ensure care providers are working to support people's health and ability to live independently in their own homes.

Since launching Devon Cares, the number of people waiting to have their care needs met in north and mid Devon has reduced to a historic low.

Transforming community services

On 1 October 2016, we said farewell to our colleagues in Eastern Devon, as they joined the Royal Devon and Exeter NHS Foundation Trust.

This followed a decision by NHS Northern, Eastern and Western Devon Clinical Commissioning Group to award the contract for community services in eastern Devon to the RD&E.

We have run these services, which included community hospitals and community nursing and therapy teams, since April 2011. We achieved great successes together and the Trust would like to take this opportunity to thank all of our staff for making the partnership great and working hard to improve the care we provide. We wish those staff who have left us all the very best for the future.

The minor injuries services in eastern Devon have also transferred to other providers.

A community that goes Over and Above

Our charity continues to support our patients and staff to help us to provide the very best care we can offer. The charity fundraises to pay for things that are Over and Above what the NHS is able to provide, to make a real difference to our patients, their families and to our amazing staff.

Your Hospital Charity
supporting Northern Devon Healthcare NHS Trust
Registered Charity No. 1051463

SCBU appeal

In 2016/17, we completed the Special Care Baby Unit appeal, raising around £250,000, which allowed us to buy three state of the art Draeger neonatal ventilators costing almost £25,000 each. These have replaced the old machines, which were almost 25 years old.

Lead neonatal ward manager, Liz Mills, said: 'We are delighted to receive the new ventilators – it is a dream come true. With these we can provide the very best support to babies on the ward.

'The ventilators help a baby breathe by blowing oxygen-enriched air gently into their lungs. They have touch screens and are also connected wirelessly to the Trust's electronic healthcare records, meaning less administration time for our nurses and more time with the babies and new mums on the unit.'

Thanks to the appeal, we have also been able to buy:

- Neonatal incubators
- Phototherapy devices
- Hot cots with control units
- Developmental soothers
- Care aids
- Breast pumps on stands, as well as breast pumps for portable use which can be lent to new mums
- iPads which allow new mums to see their babies in the Special Care Baby Unit from their hospital bed
- Toys for the new baby's brothers and sisters to play with

As always, local people and organisations have been absolutely amazing in helping us to raise these funds and we would like to give our heartfelt thanks to anybody who has been part of this. This equipment really will help our doctors and nurses to support sick and vulnerable babies who are born early or with difficulties in North Devon.

Events

Scrumptious Croyde Trail

300 participants from across the UK walked or ran 10 miles in June 2016 with enticing tastes of local foods along the trail. Thanks to our local food and business sponsors for another successful event.

The Final Fling

VW Campers from across Devon turned out for this amazing event at Little Roadway Farm Campsite near Woolacombe.

Big Purple Day

Every July our supporters dress in purple, make purple cakes and do something daft to raise funds.

Jim's Journey

Former Trust staff member Jim Bray walked 630 miles along the entire South West Coast Path in summer 2016, raising more than £4000 for Over and Above.

Exmoor Ramble

Ivan Huxtable organised his third Exmoor Ramble to support the hospital charity.

Abseil and skydive

Our abseil at Heanton Punchardon Church is open to young and old – our youngest participant this year was 12 and the eldest was 89. The church family are renowned for their delicious cakes and refreshments which are available to purchase on the day. Our skydives continue to attract superheroes of all ages to jump 10,000 feet out of an aeroplane.

Clay pigeon shoot

The Tetcott and Luffincott Gun Club raised £1,800 for the stroke service in recognition on the excellent care one of their members received on our stroke rehabilitation unit.

A marathon effort

School teacher Duncan Hughes ran three marathons in three days in memory of his Dad, John. The 78.6 mile Atlantic Coast Challenge started at Constantine Bay in Padstow and finished at Land's End.

19 year old Petroc student Katie Baker took part in an amazing 20 runs in a year to raise funds for the Special Care Baby Unit Appeal.

Paul Bissett and Ian MacBeth of North Devon Road Runners and Bradworthy runner Kirsty Slade ran the London Marathon to raise funds for the Special Care Baby Unit and the Seamoor Chemotherapy Unit.

Caroline Reed, day surgery staff nurse, also ran the marathon for Over and Above. Caroline wants to use the money raise to make the day surgery unit friendlier for younger patients.

Siblings David and Catherine Pettett raised over £4,000 for the Seamoor Chemotherapy Unit, in memory of their mum Judith who lost her battle against cancer in August 2015. David took part in the River Dart 10k swim and Catherine completed a five day hike along the Great Wall of China.

Raffles

North Devon Tesco stores donate a wide range of gifts and hampers to raise funds through our regular raffles.

SCBU film

In August, staff took part in a spoof film of the Grease hit 'You're the One that I want' as part of the SCBU appeal. Baby Lifeline was so impressed with the film that they screened it at their appeal launch at the Royal College of Obstetrics and Gynaecologists in front of some well-known TV personalities.

Chopped hair for SCBU

Grace Bucknell, from Witheridge, raised over £670 by organising a sponsored hair cut for the Special Care Baby Unit Appeal. Her cut hair was donated to make wigs for children who have lost their hair through illness.

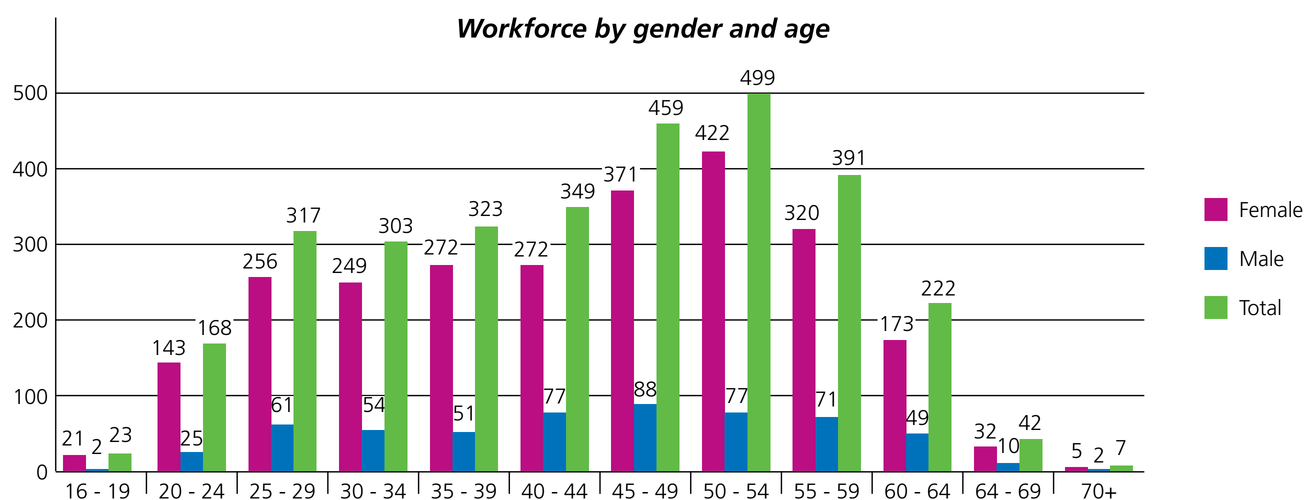
Christmas Jumper Day

The amazing support we receive from local people and businesses makes it possible for the charity to support the Trust to provide the very best patient care, so thank you.

All donations make a difference, no matter how small. To find out more, visit www.overandabove.org.uk.

Our workforce

At the close of 2016/17, Northern Devon Healthcare NHS Trust employed 3,103 staff.



The gender split of our workforce is roughly 82% female and 18% male. When compared with the NHS population as a whole, our figures are more in keeping (NHS – 77% female/23% male), although this is significantly different to the general population (2001 census identified 48% of working age population as female).

When compared to the rest of the NHS population, we employ lower numbers of staff within age bands 25-29, 30-34 and 35-39 and in contrast we employ higher numbers of staff within the 50-54, 55-59, 60-64 age bands. However, this distribution is reflective of the age profile of Devon as a region.

We continue to employ a significant number of young apprentices and this accounts for a high proportion of our band 2 post holders being under 20 years old. We have also seen under 20s staff holding band 3 positions which is a positive development for the younger workforce.

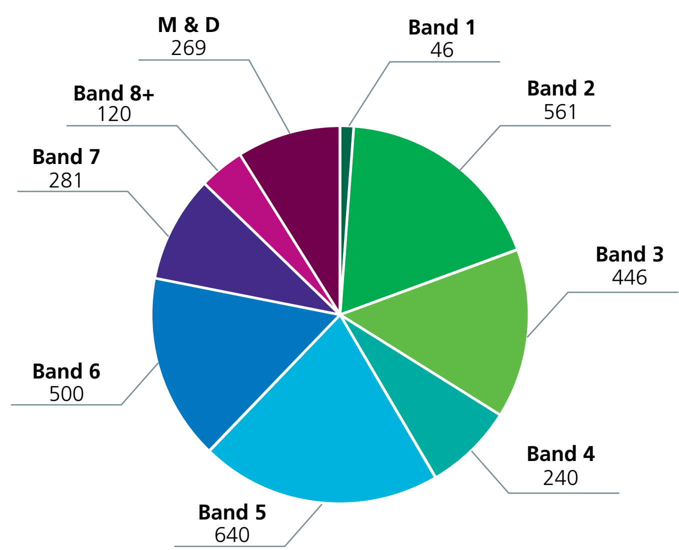
Equality and diversity are at the heart of our Trust strategy and values and we recognise that supporting, developing and enabling a diverse workforce enables us to continue to build on high standards of patient care.

The workforce and organisation development directorate continues to work collaboratively to support a large number of departments, offering operational advice and training on deaf/deaf-blind communication awareness, disability equality, equality impact assessment, human right and learning disability awareness.

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

Sickness absence

The Trust sickness absence figure for 2016/17 was 3.6% against a target of 3%. This was below the average sickness figure for the whole NHS, which was 4.24%.



Promoting communication and sharing ideas

Effective communication and consultation with our staff is a vital part of ensuring we deliver the highest quality services. During 2016/17 we held nearly 50 executive team roadshows across the Trust to ensure staff were kept up to date with the challenges and opportunities facing the Trust. The roadshows also give staff the opportunity to contribute their ideas as to how we can work effectively to deliver safe, high-quality care.

This year, we launched Staff Voice, an online platform where staff can discuss their views and ideas, and share best practice with one another.

SMITH

We have a high-reporting culture at the Trust and we actively encourage staff to raise any concerns they have through our online incident reporting forms. We have also introduced a network of Freedom to Speak Up guardians, who support staff in raising concerns and provide confidential advice.

We continue to embed the principles of Listening into Action into our everyday culture across the Trust, so that meaningful engagement with staff is at the centre of any changes to what we do.

This is reflected in our staff survey results again this year, with staff continuing to rate how involved they feel with change highly.

Staff survey results

The national NHS staff survey 2016, which sampled 1205 randomly-selected staff, was carried out between September and December 2016. 443 staff took part, meaning the Trust had a response rate of 37%. This is below average for trusts of our type and is lower than our response rate of 48% in 2015. We are looking at what may have caused the lower response rate and hope to improve our position in the next survey.

Our overall results in the staff survey were excellent, placing us top out of the 23 providers in the South West in the top 10% of all providers in England (17th out of 228).

Our top six results were all the highest ranking results for any trusts with acute and community services. These were:

- support from immediate managers
- feeling able to contribute to improvements at work
- agreeing that their role makes a difference to patients
- satisfaction with opportunities for flexible working patterns
- staff experiencing discrimination at work in the last 12 months (the Trust received the lowest score, which is better)
- staff attending work in the last three months despite feeling unwell, because they felt pressure from their manager, colleagues, or themselves (the Trust received the lowest score, which is better)

The Trust's score for overall staff engagement was 3.88, a slight decrease on 2015's score of 3.93. This score was above average when compared with trusts of a similar type – the average score was 3.80. Possible scores ranged from 1, indicating that staff are poorly engaged, to 5, indicating that staff are highly engaged.

The Trust's lowest scoring areas in the 2016 survey were:

- Communication between senior management and staff (just below the national average)
- Staff motivation at work (average score)

We are developing actions in these areas and hope future surveys will show progress.

Organisational change and employee consultations

2016/17 has been a busy and challenging year for the HR operations team with the team itself having faced significant change and restructuring as a result of the Transforming Community Services (TCS) implementation, which saw a number of the team transfer to the Royal Devon and Exeter NHS Foundation Trust (RD&E) along with the eastern community services.

The HR team has supported a number of organisational change and employee consultation programmes during 2016/2017. The largest change programme was the transfer of eastern community services to the RD&E as part of TCS. This saw around 1,400 staff transfer from the employment of NDHT to the RD&E under the Transfer of Undertakings (Protection of Employment) Regulations (TUPE). The impact of TCS on staff was of course wider than the staff who transferred. The roles and responsibilities of a number of staff who remained with NDHT also changed.

Other organisational change and employee consultation processes included:

- The re-procurement of Health Promotion Devon Services. This saw services and staff TUPE transfer to two separate non-NHS providers.
- The re-procurement of eastern minor injury services. The minor injury units (MIUs) transferred to a number of different providers and staff TUPE transferred to the RD&E and to the Claremont Medical Practice in Exmouth.
- Stroke service co-location.
- Medical Records RIFD tagging.
- Rapid response service.
- Governance team restructuring.
- Operations directorate restructuring.
- IT/IM&T team restructuring.
- Electronic health record implementation.
- Workforce /HR directorate restructuring.
- The temporary closure of inpatient beds at Holsworthy community hospital and the temporary deployment of staff to other services.

In total, outside of TCS, there have been around 23 consultation processes supported by HR, involving more than 300 staff.

Employment advice and employee relations

The employee advice line has handled over 2,000 calls in 2016/17 supporting staff and managers with a wide range of queries and providing them with advice and guidance. The team has supported the management of 227 formal employee relations cases (excluding cases related to services that have now transferred to the RD&E).

We continue to work in partnership with our staff side and trade unions colleagues to ensure that staff are appropriately consulted and supported in the workplace.

We have a strong partnership with staff side, including a monthly partnership forum. This provides a forum for Trust management and trade unions to keep each other informed and a space for staff engagement, consultation and negotiation. The membership and operation of the partnership forum has had to go through a period of transformation following TCS. As well as impacting on the nature of the business dealt with by the partnership forum, TCS saw two longstanding staffside vice chairs transfer to the RD&E.

Recruitment and retention

The national picture remains challenging in relation to recruitment to a number of clinical professional posts. In the context of this challenging national picture, the Trust has been relatively successful in attracting staff to many of these hard to fill posts. The Trust held two open days in 2016/17, resulting in the recruitment of 15 nurses. We have also had a strong and successful presence at eight careers events in various locations across the country throughout the year.

In September 2016 we established our own Staff Bank, in partnership with NHS Professionals. We have focused our efforts on recruiting qualified nurses, HCAs and support staff to work in clinical areas, and this has generated a lot of interest from both existing staff interested in picking up extra bank shifts, as well as new staff wishing to work for the Trust a temporary worker. By having our own Staff Bank, we are able to offer bank workers the opportunity to pick up shifts as and when they want. This has proved to be an attractive option for staff who are retiring but would still like to work for the Trust on an ad-hoc basis. This has also helped us to reduce our dependence on agency staff, which is good for patient care and more cost effective. During the coming year, we will be looking to develop our medical and dental, and allied health professional bank.

In October 2016, we were awarded the 'Responding to the Carter Challenge' award at the National Allocate Awards. The award recognises organisations that have risen to the workforce challenges set out in Lord Carter's 2016 report on productivity in NHS hospitals and the work our eRoster Team, in collaboration with other departments, has done to improve the efficiency and effectiveness of our rosters. In January 2017 we commenced a challenging plan to roll out Healthroster to all remaining staff groups, including medical and dental rosters. This will also include the introduction of e-expenses which will further streamline the way staff claim for travel and expenses.

In May 2016, following lengthy negotiations between the BMA and the Government, the new junior doctors' contract was introduced and since then we have been transitioning junior doctors across onto the new contract arrangements in line with the NHS England implementation timeline. As part of this process, we have successfully appointed a guardian of safe working hours and introduced new exception reporting arrangements to monitor rota compliance. A junior doctors forum has also been established to support engagement with our junior doctors.

Developing our workforce

2016/17 saw us provide 103 people with work shadowing opportunities within the Trust across many disciplines.

- We began healthcare apprenticeship recruitment to help support the recruitment challenges into our nursing and therapy roles.
- We continued our Care Academy student programme with Petroc College, with 25 students taking part.
- We ran the Project SEARCH initiative, providing nine internships to students with learning disabilities. Three of these students have gone on to secure employment so far.
- 31 school age children took part in our work experience week finding out more about working within health care.

2016 also saw the launch of the Devon Excellence Centre, which is a network of training providers and health and care organisations working together to provide development initiatives particularly for support workers across the Devon system. We are working with colleagues within the STP on an apprenticeship rotation programme and the Trust has an action plan to ensure we make the most of the new apprenticeship standards.

We continue to identify new ways of developing our workforce to be confident and competent, and this has included blended learning using videos, e-learning and face to face training. The back care team have supported the spinal pathway guidance and the routes into nursing and therapy professions have been supported with cohorts of trainee assistant practitioners and trainee nursing associates.

Consultancy

In 2016/17, the Trust had no expenditure on consultancy services.

Staff pay benefits

Employee benefits and staff numbers

Employee benefits

Employee benefits - gross expenditure 2016-17	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**118,424**	107,413	11,011
Social security costs	**9,630**	9,630	0
Employer contributions to NHS BSA - pensions division	**13,115**	13,115	0
Other pension costs	**10**	10	0
Termination benefits	**0**	0	0
Total employee benefits	**141,179**	**130,168**	**11,011**
Employee costs capitalised	3,382	2,564	818
Gross employee benefits excluding capitalised costs	**137,797**	**127,604**	**10,193**

Employee benefits - gross expenditure 2015-16	Total £000s	Permanently employed £000s	Other £000s
Salaries and wages	**138,917**	121,697	17,220
Social security costs	**9,632**	9,632	0
Employer contributions to NHS BSA - pensions division	**14,742**	14,742	0
Other pension costs	**0**	0	0
Termination benefits	**0**	0	0
TOTAL - including capitalised costs	**163,291**	146,071	17,220
Employee costs capitalised	**3,742**	2,529	1,213
Gross employee benefits excluding capitalised costs	**159,549**	**143,542**	**16,007**

Staff numbers

	2016-17			2015-16
	Total number	Permanently employed number	Other number	Total number
Average staff numbers				
Medical and dental	**289**	248	41	298
Ambulance staff	**5**	5	0	4
Administration and estates	**532**	521	11	679
Healthcare assistants and other support staff	**1,108**	991	117	1,212
Nursing, midwifery and health visiting staff	**991**	923	68	1,210
Nursing, midwifery and health visiting learners	**0**	0	0	0
Scientific, therapeutic and technical staff	**476**	463	13	569
Social care staff	**0**	0	0	0
Healthcare science staff	**0**	0	0	0
Other	**0**	0	0	0
TOTAL	**3,401**	**3,151**	**250**	3,972
Of the above - staff engaged on capital projects	**367**	348	19	85

Staff sickness absence and ill health retirements

	2016-17 number	2015-16 number
Total days lost	27,864	29,412
Total staff years	3,434	3,702
Average working days lost	8.00	7.94

	2016-17 number	2015-16 number
Number of persons retired early on ill health grounds	**1**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**8**	196

Exit packages agreed in 2016-17

2016-17

Exit package cost band (including any special payment element)	*Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Number	£s	Number	£s	Number	£s	Number	£
Less than £10,000	37	76,862	0	0	**37**	**76,862**	0	0
£10,000-£25,000	0	0	0	0	**0**	**0**	0	0
£25,001-£50,000	1	30,000	0	0	**1**	**30,000**	0	0
£50,001-£100,000	0	0	0	0	**0**	**0**	0	0
£100,001 - £150,000	0	0	0	0	**0**	**0**	0	0
£150,001 - £200,000	0	0	0	0	**0**	**0**	0	0
>£200,000	0	0	0	0	**0**	**0**	0	0
Total	**38**	**106,862**	**0**	**0**	**38**	**106,862**	**0**	**0**

2015-2016

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

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

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

Other employee benefits include monies paid to agencies for posts that cannot be covered internally or appointed to on a permanent basis. The Trust uses an umbrella agency for most locum staff with some posts filled via personal service companies as detailed in the tables below.

Table 1: off-payroll engagements longer than six months

	Number
Number of existing engagements as of 31 March 2017	6
Of which, the number that have existed:	
for less than one year at the time of reporting	0
for between one and two years at the time of reporting	5
for between two and three years at the time of reporting	1
for between three and four years at the time of reporting	0
for four years or more at the time of reporting	0

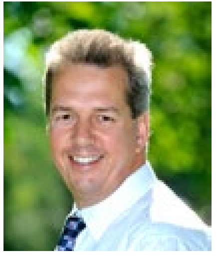
All of the above posts have been subject to risk-based assessment and assurance has been received that the individuals are paying the right amount of tax.

Table 2: New off-payroll engagements

	Number
Number of new engagements, or those that reached six months in duration, between 1 April and 31 March 2017	0
Number of new engagements which include contractual clauses giving Northern Devon Healthcare NHS Trust the right to request assurance in relation to income tax and national insurance obligations	0
Number for whom assurance has been requested	0
Of which:	
Assurance has been received	0
Assurance has not been received	0
Engagements terminated as a result of assurance not being received	0

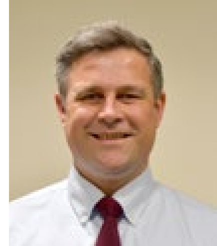
Executive team changes

Andy Robinson, director of finance and performance



In 2015/16, we said goodbye to Andy Robinson, director of finance and performance. Andy left the Trust in August 2016 to take up a role as director of finance for the system.

Colin Dart, acting director of finance



Colin Dart was appointed as acting director of finance in August 2016 and became an executive member of the Northern Devon Healthcare NHS Trust board.

Colin joined the Trust in March 2007 as the deputy director of finance. Prior to this, Colin gained extensive commissioning and provider expertise in his role as deputy director of finance and then acting director of finance with North Devon Primary Care Trust.

Colin is a qualified accountant and a fellow member of the Chartered Association of Certified Accountants (FCCA).

Rob Sainsbury, director of operations

Rob Sainsbury, director of operations, left the Trust in October 2016 for a new role as chief operating officer at NHS Northern, Eastern and Western Devon Clinical Commissioning Group.

Andy Ibbs, director of operations and strategy

Andy Ibbs was appointed as director of operations and strategy in November 2016. Andy was previously director of strategy and transformation.

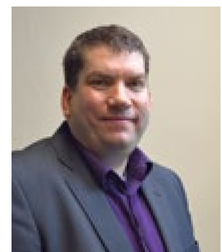
Dr Nicola Ryley, interim head of nursing

In April 2017, Dr Nicola Ryley left the Trust for new opportunities.

Darryn Allcorn, director of nursing, quality and workforce

Darryn was appointed director of nursing, quality and workforce in April 2017.

Board changes



Jonathan Broad, associate non-executive director, left the Board in February 2017, having served as a board member since January 2016.

In February 2017, the Trust confirmed three reappointments to the board.

Roger French was reappointed as Trust chairman for a further two years, until January 2019.

Robert Down was reappointed as a non-executive director for a further two years, until February 2019.

Pauline Geen was also reappointed as a non-executive director for a further two years, until March 2019. Pauline is also the senior independent director for the Trust.

Over and above
Your Local Hospital Charity

Patient experience

Patient experience is one of the three elements of high-quality care, alongside safety and clinical effectiveness, and organisations that are more patient-centred have better clinical outcomes. We are absolutely committed to collecting, analysing and learning from patient experience so we can ensure our patients have the best possible experience of our services.

Throughout 2016/17, the Trust's patient experience programme has continued to cover the majority of services provided by the Trust. This means that whether patients are in an inpatient care setting, clinic or in their own home, they have the opportunity to tell the Trust about their experience of the service they have received.

The Trust's director of nursing has responsibility at board-level for patient experience. This includes the delivery of the Trust's patient experience strategy and annual programme, compliance with the Friends and Family Test and demonstrating that the Trust has used patient experience feedback to improve the experience of care. Patient experience also features in the Trust's quality strategy, placing it firmly at the heart of the Trust's continuous drive to improve the quality of services provided.

At the start of each board meeting, either a patient story is presented or a member of staff presents a piece of work which has been developed to improve the experience of patient care. Patient stories are obtained either through the complaints process, service transformation projects, letters to the chief executive or from patients who have approached the Trust. This sometimes involves the patient being present to give a more detailed account, which allows the board to see and hear first-hand the impact of the Trust's work.

The Learning from Patient Experience Group is the forum where patient experience feedback is routinely triangulated with staff experience and other operational data, in recognition of the close links between staff experience, operational pressures and patient experience.

The Trust's patient experience data is routinely shared and welcomed by clinical and operational teams in the form of monthly or bi-monthly reports. In addition, it is shared with the patient safety and quality team in recognition of the importance of patient experience in assessing the quality of NHS services alongside effectiveness and safety.

The work of the Trust is always changing and patient experience data is sometimes requested to understand the impact on patients of various transformation programmes. There is a continued and growing focus across Devon and more widely on supporting people as much as possible in their own homes and so the experience of patients being cared for in their own homes is very important in building public confidence in this model of care.

The comprehensive patient experience survey programme includes a team of volunteer patient experience surveyors. This team routinely visits the inpatient wards at North Devon District Hospital to collect real-time patient feedback at the bedside. The aim is to visit each inpatient ward several times a month. In cases where the patient may be too ill to communicate with the volunteer, feedback is captured from relatives/carers where possible. The patient experience team provides a report to the acute/maternity ward and senior management within two-three hours of the feedback being collected by the volunteer. Selected patient comments are routinely posted on Twitter and Facebook, subject to patient consent. With an increasing reach, social media now forms another feedback channel together with mystery shopping, Patient Opinion, NHS Choices, postal surveys, focus groups, face-to-face engagement, PALS/customer relations and, of course, the Friends and Family Test.

In conjunction with Healthwatch Devon, a series of community-based focus groups have recently sought more detailed face-to face patient feedback around five key themes which had already been identified by the Trust through other feedback channels. The themes are:

- communication
- availability of staff
- co-ordination of care
- self-care
- encouraging patient feedback

The results were subsequently shared in group sessions with staff whose roles ranged from nursing, operations, workforce development and therapy, through to PALS/customer relations. The learning from this project will form the basis of the patient experience strategy going forward.

The introduction during 2016/17 of the patient experience module in the Meridian software system is enabling enhanced accessibility and analysis of patient experience feedback throughout the Trust.

The Trust routinely publishes the Friends and Family Test results and detailed feedback on its website: www.northdevonhealth.nhs.uk/patient-experience

The Friends and Family Test programme gathers feedback from the following services:

North Devon District Hospital

Acute inpatient wardsh
Emergency department
Maternity services
Outpatients
Day cases

Community

Community therapy
Community nursing
Community hospital inpatient wards
Community hospital outpatients
Community hospital day cases
Community children's nursing
Pathfinder urgent care
Rapid response service
Minor injury units
Walk-in centres

Specialist community services

Sexual health
Podiatry
Bladder and bowel
Dental
Chronic fatigue syndrome / ME (to 30 September 2016)

The patient experience strategy uses the following model:

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

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

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

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

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

You said we did

You said

I would like to be able to attend physiotherapy appointments before and after work.

We did!

We have used the Trust's flexible working policy to allow clinicians to alter their working hours, so they can offer early and late appointments for patients.

You said

The physiotherapy outpatients department could be nicer and more private.

We did!

The department has been refurbished and now has individual clinic rooms to improve privacy and dignity.

You said

Improving communication on discharge could help prevent avoidable readmissions.

We did!

We have set up a medicine support service where, with a patient's consent, we send a copy of their discharge summary to their community pharmacy. The pharmacist can then check the next prescription received from the patient's GP to make sure any changes made during hospital admission have been followed up.

You said

Communication between the wards and pharmacy could be improved.

We did!

We purchased enough bleeps so that each ward can have dedicated pharmacist and ward-based technician to contact should they require a prescription to be processed for discharge or urgent medication to be supplied.

You said

It can take too long to be discharged when waiting for a prescription from pharmacy.

We did!

Pharmacists and pharmacy technicians now check medications and prescriptions at ward level, and this has reduced the average time it takes pharmacy to process prescriptions for discharge. We have also introduced packs for items that are regularly required after surgery.

You said

Toys for younger children are needed in the waiting area (Litchdon House).

We did!

There is now a wooden toy table for children to play with.

More information on our patient experience, including more 'you said, we did' examples, can be found on the website: www.northdevonhealth.nhs.uk/patient-experience

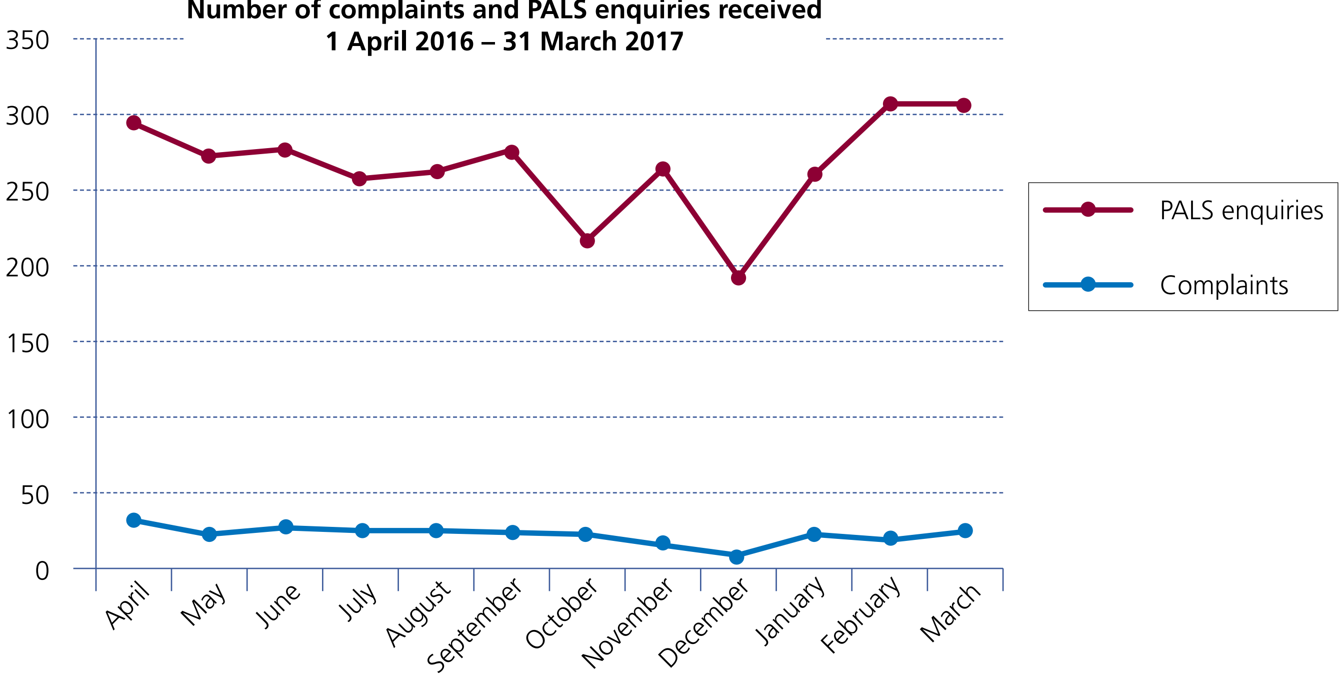
Complaints and patient feedback

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

During the year period, 264 complaints were received, which is a decreased level of activity on 2015/2016 (336) due to the transfer of eastern community services to another provider on 1 October 2016. 3188 PALS enquiries were received, which is an increase of 401 on 2015/2016.

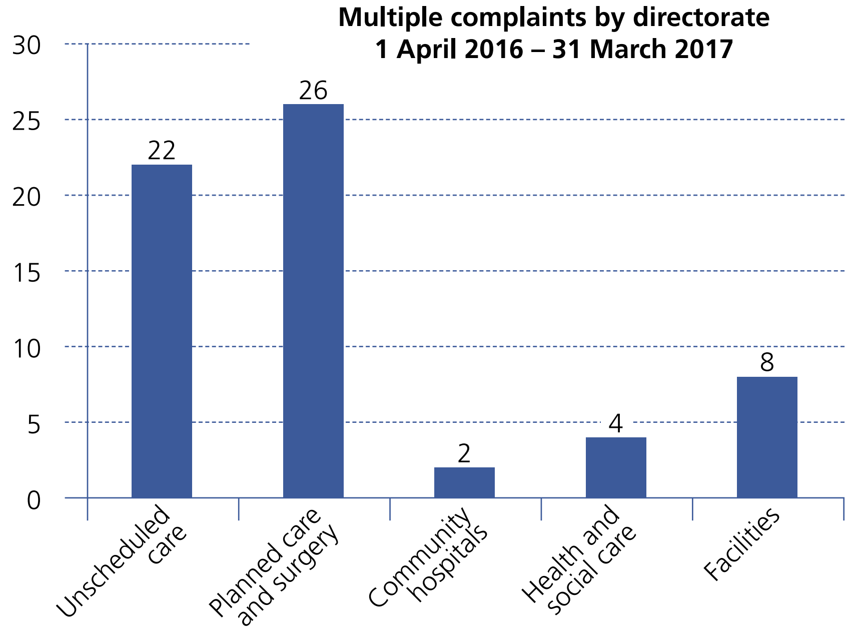
The combined complaints and PALS activity demonstrates a positive reflection on how patients and service users feel able to provide feedback on their experience, which the Trust welcomes and encourages. During the period, no complaints were received by the Care Quality Commission (CQC).

The top five complaint themes were clinical care and treatment (39%), communication (20%), access to clinical services (15%), attitude of staff (15%), and discharge arrangements (4%).



The division with the highest number of complaints for the financial year was unscheduled care, with 87 complaints. Planned care received 78 complaints, and there were 42 multiple complaints, where complaints related to more than one directorate.

The graph below shows the breakdown of complaints received by the service delivery unit.



The two complaints received for community hospitals were received for Holsworthy Hospital and Bideford Hospital.

All complaints are required to be acknowledged within three working days, in line with Trust policy. During the period, 94% of complaints were acknowledged within this timeframe.

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

Complaint response performance

During the period, 96% of complaints were responded to within the agreed timeframe or an agreed extension to the timeframe, which is an increase of 4% on the last reporting period (2015/2016). In order to monitor and prevent late responses to complainants, the Trust reviews the key performance indicator (KPIs) relating to the timeliness of investigations as part of the monthly performance review meetings with our service directorates and our commissioners, NHS Northern Eastern and Western Devon Clinical Commissioning Group (NHS NEW Devon CCG).

Outcomes and remedial actions from closed complaints

During the period, **290** complaints were closed following investigation. Of these closed complaints, 33 required action to be taken as a result of the concern raised. Of these **33**:

16 related to clinical care and treatment

4 related to communication

7 related to attitude of staff

2 related to accessing clinical services

1 related to discharge planning

1 related to patient property

1 related to information provision

1 related to quality of facilities

Service improvements

Examples of remedial actions undertaken are as follows:

- The cancer services team have changed their MDT (multi-disciplinary) agenda documentation to ensure the size of a lesion being reviewed within the meeting is contained within the agenda.
- A patient's experience was discussed at the dermatology department's governance meeting. Another complaint was also discussed at the pharmacy governance meeting to reinforce the importance of documenting conversations a pharmacist may have with a patient about their medication
- The pharmacy team have reviewed their internal procedural documents to include a section to make it clearer for pharmacy referrals.
- Service improvement work has been undertaken with the Clinical Commissioning Group on the continuing healthcare (CHC) assessment process to improve timeliness of assessments and the involvement/ communication with relatives and patients. A review of the correspondence sent by the CHC administration hub has been undertaken and additional letters introduced to explain the steps in the process.
- The divisional nurse for planned care and surgery will share a patient's experience anonymously with all ward managers on the surgical wards and surgical sisters at the team meeting. They will highlight the importance of contacting the liaison nurse when a patient has a purple sticker to flag the patient is under the care of the oncology service and awareness-raising around the purple sticker will be undertaken within the appropriate forums in the unscheduled care directorate.
- The divisional nurse for planned care and surgery will speak with ward mangers to discuss medication concerns that arose from a complaint.
- A consultant in emergency medicine has presented a power point presentation at the emergency department (ED) clinical governance meeting to include slides addressing the differences between the information from the ED notes and the timeline provided by a patient, highlighting the significances for discussion, reflection and learning.
- Staff have been reminded to always be courteous and respectful to patients and/or relatives that attend the emergency department.
- A ward manager discussed with their staff what patients should be offered in terms of food and fluids, when they are recognised to be coming to the end of their life, following a relative's experience.

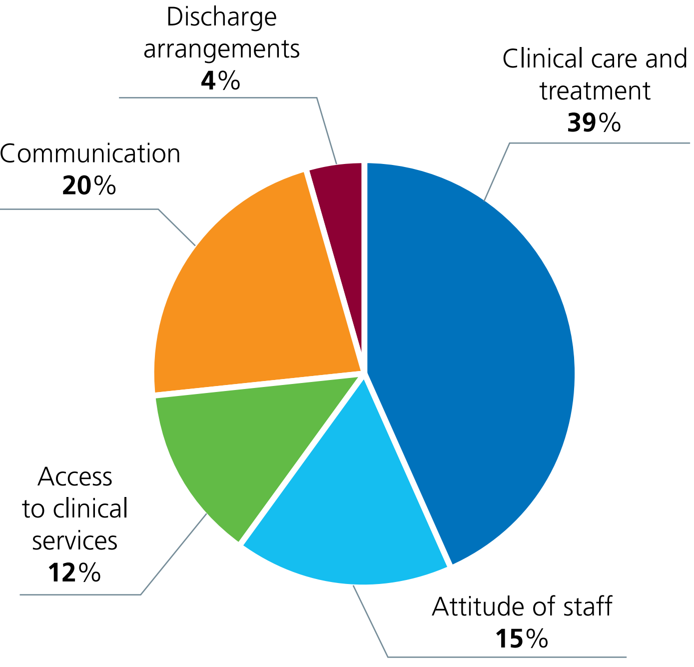
Service Improvements undertaken for the Eastern Community Services before the services were transferred to the new provider on 1 October 2016:

- Clarification was sought from an agency which provides temporary staff to work within the Rapid Response Service and Hospital at Home surrounding the level of training they receive. Assurance was sought from the agency that before allowing the staff member to conduct any Rapid Response or Hospital at Home shifts, they have to demonstrate to the manager that they are able to work under their own initiative, able to provide a high level of care with minimal information, able to identify risks and know how to report these risks, able to work under pressure and cope with short-notice changes whilst still remaining calm and professional, alongside established competences with medication.
- Considerable work was undertaken to improve the waiting time for initial musculoskeletal (MSK) appointments following referrals within the eastern area. This work was undertaken alongside our commissioners and included an increase in service capacity via additional clinics and staff, and reviewing appointment length of time.
- The management team at the Linden Day Centre at Ottery St Mary Community Hospital, which is a day centre for patients with dementia, undertook a number of action points to improve communication with relatives and carers, to include a review of their handover process to ensure relevant information is shared between staff, before the services transferred to the new provider.
- The community occupational therapy team undertook a piece of work with local care home providers within the Exeter locality to educate them on positioning and the use of equipment to help move and turn patients, to include a physiotherapy/occupational therapy action plan to be written into the care homes plan to improve communication amongst staff.

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.

Top five subject themes for complaints received 1 April 2016 – 31 March 2017



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

Clinical care and treatment – unscheduled care (**60**)

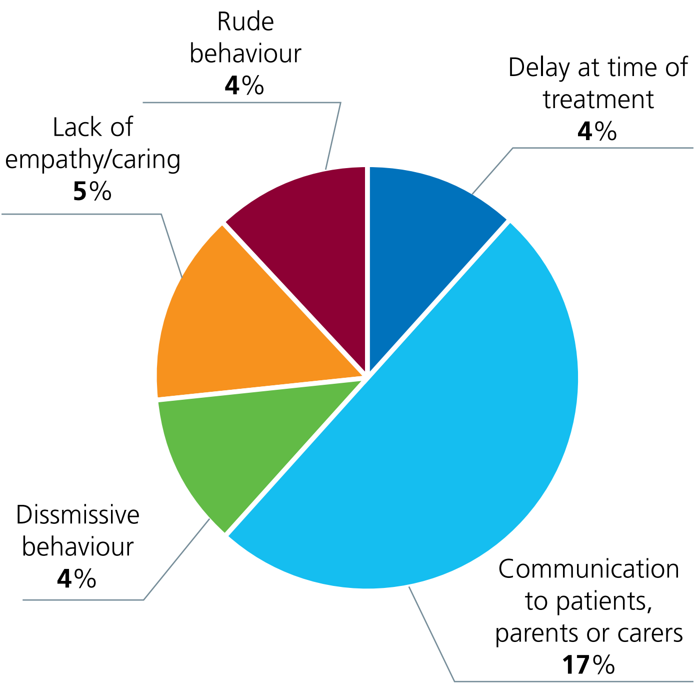
Attitude of staff – planned care and surgery division (**35**)

Access to clinical services – planned care and surgery division (**36**)

Communication – unscheduled care (**35**)

Discharge arrangements – multiple directorate complaint (**10**)

Complaints by sub-subject
1 April 2016 – 31 March 2017



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

Communication to patients, parents or carers – unscheduled care (**32**)

Delay at time of treatment – unscheduled care and planned care and surgery both (**13**)

Dismissive behaviour – planned care and surgery (**12**)

Inappropriate discharge – planned care and surgery (**7**)

Communication between staff regarding patients – planned care and surgery (**11**)

Parliamentary and Health Service Ombudsman complaints

Complaints referred by outcome	Apr	May	June	July	August	Sept	Oct	Nov	Dec	Jan	Feb	March	Total
Request received from Ombudsman	**1**	0	0	**1**	**1**	0	0	0	0	0	**1**	**2**	**6**
Issue not upheld with no further action	0	0	**1**	0	0	**1**	0	0	0	**2**	0	**2**	**6**
Issue upheld and recommendations made	**1**	0	0	0	0	0	0	0	0	0	0	0	**1**
Issue partially upheld	0	0	0	0	0	0	0	0	0	0	0	0	0

Please note the upheld outcome was part of referral activity reported in 2015/2016 due to the length of time an investigation takes.

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 (784), followed by clinical support and logistics service delivery unit (CSLSDU), clinical support services (731), and acute service delivery unit (ASDU) for medical specialities (643). The overall number of PALS contacts was 2787. The high number of enquiries received for clinical support services has been as a result of difficulties in contacting the central management centre, who manage referral bookings within the Trust.

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

The table below shows the number of PALS issues by subject matter/directorate for the year.

	2013/14	2014/15	2015/16	2016/17
Access to services - clinical	629	1001	954	**968**
Access to Services - physical	24	18	31	**78**
Admission arrangements	11	7	6	**10**
Attitude of staff	115	106	143	**134**
Benefits	11	5	3	**0**
Bereavement	9	7	2	**2**
Clinical care and treatment	213	246	204	**205**
Communication	218	260	569	**600**
Compliments	154	160	28	**18**
Confidentiality issues	6	14	3	**12**
Discharge arrangements	49	81	35	**59**
Equality and diversity	2	7	2	**1**
Quality of facilities	40	23	21	**56**
Hotel services	22	20	13	**12**
Information provision	1108	395	641	**882**
Medical records	32	45	61	**68**
Patient's property	17	31	16	**34**
Privacy and dignity	6	8	3	**2**
Security	8	8	2	**1**
Transport	103	62	50	**48**
Totals	**2777**	**2504**	**2787**	**3190**

PALS issue by service delivery unit:

	2015/16	2016/17	Total
Planned care and surgery	1442	1350	**2792**
Unscheduled care	863	1248	**2111**
Community hospitals	72	15	**87**
Health and social care	115	78	**193**
Specialist service	73	36	**109**
Director of nursing	209	133	**342**
Director of facilities	99	211	**310**
Director of finance	14	11	**25**
Medical director	7	1	**8**
Director of workforce and development	1	8	**9**
Strategy and transformation	3	8	**11**
Trust wide	54	91	**145**

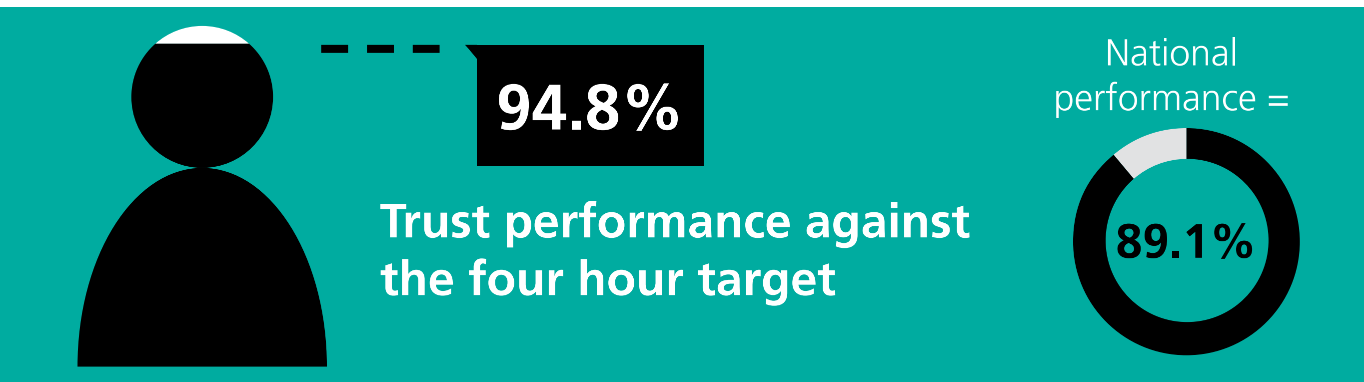
Our performance

It is really important that our patients have confidence in the quality of care provided by their local NHS. The Trust's performance is monitored against key national standards. In addition, the Trust board regularly reviews progress against a range of internal and external metrics.

Performance against national standards

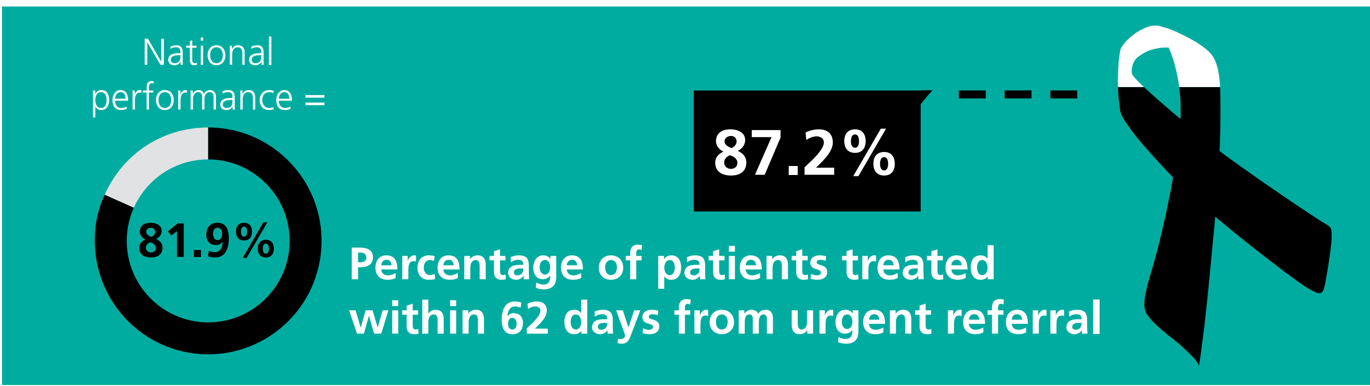
		Performance			Quarterly trend			
		Target	2015-16	**2016-17**	Q1	Q2	Q3	Q4
Infection control	C.difficile over three days – avoidable (NDDH)	0	1	**0** (green)	0	0	0	0
	C.difficile over three days (NDDH)	1	11	**6** (red)	4	1	0	1
Referral to treatment times	Percentage incomplete pathways less than 18 weeks	92.0%	94.8%	**92.4%** (green)	94.2%	93.1%	92.2%	90.2%
Waiting times	Percentage of ED, MIU and WIC attendances waiting less than 4 hours	95%	96%	**94.8%** (red)	95.2%	95.5%	94.6%	93.5%
Cancer access initial treatments	Percentage treated within 62 days of urgent GP referral	85%	89.2%	**91.1%** (green)	92.9%	86.8%	92.1%	92.7%
	Percentage treated within 62 days from urgent GP referral (open Exeter)	85%	84%	**87.2%** (green)	89.6%	83.5%	88%	84.7%
	Percentage of patients treated within 62 days from screening referral	90%	85.7%	**77.8%** (red)	100%	100%	100%	33.3%
	Percentage treated within 62 days following consultant decision to upgrade priority	90%	87.2%	**99.3%** (green)	100%	100%	97.9%	100%
	From diagnosis to first treatment within 31 days	96%	97.4%	**99.1%** (green)	99.2%	98.1%	99.7%	99.2%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	91.2%	**97.4%** (green)	95.6%	98%	98%	97.7%
	Drug treatments within 31 days	98%	99.3%	**99.6%** (green)	100%	100%	98%	100%
Cancer access initial appointments	Urgent referrals seen within 2 week wait	93%	93.9%	**90.5%** (red)	88.1%	84.6%	95.3%	94.3%
	Symptomatic breast patients seen within 2 week wait	93%	88.4%	**71.3%** (red)	69.4%	41.9%	95.8%	81.9%
Certification against compliance with requirements regarding access to healthcare for people with a learning disability	Yes / No	Yes	Yes	Yes (green)	Yes	Yes	Yes	Yes
Community care information completeness	Referral to treatment information completeness	50%	99.6%	**97.4%** (green)	99.57%	99.37%	93.03%	98%
	Referral information completeness	50%	100%	**98.23%** (green)	100%	99.1%	99.57%	100%
	Treatment information completeness	50%	99.64%	**96.8%** (green)	99.53%	98.93%	91.97%	95.8%

Performance was generally strong during 2016/17.

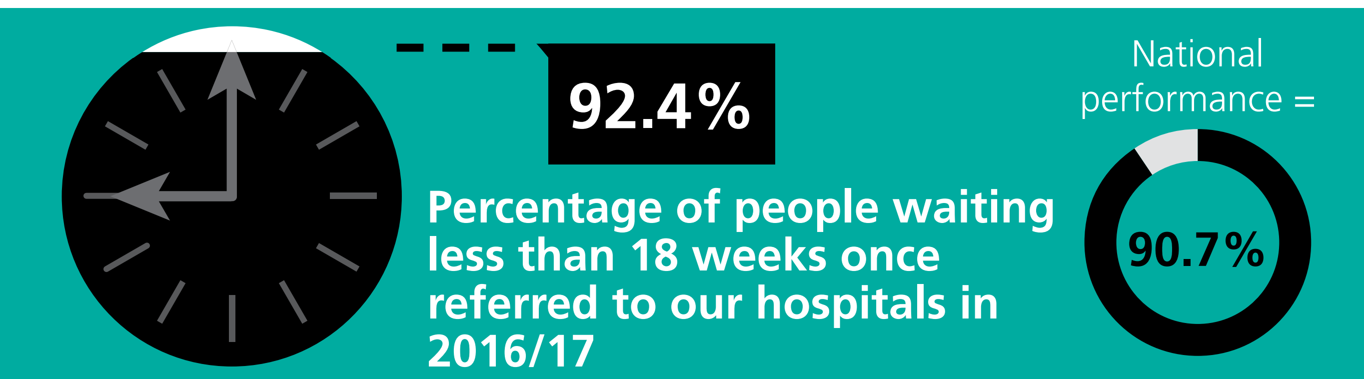


Attendance to our emergency department has continued to rise year on year, and in 2016/17, performance against the four-hour target was a challenge. We saw, admitted or treated 94.8% of patients within four hours during 2016/17, falling just shy of the national standard of 95%.

However, this was in the context of worsening performance across England, and despite not meeting the target, the Trust has consistently been in the top quartile nationally. We were also in the top ten for trusts of our kind against this standard for a number of months, and we were top in the country on a number of occasions. We recognise that meeting the four-hour target is not just the responsibility of our emergency department, but that it requires all of our teams across the Trust to work together to ensure timely treatments and discharges, and to prevent delays. Our performance against the four-hour target also depends on the support of our health and social care community teams and our social care service, Devon Cares. Our teams and the social care providers we work with play a fundamental role in keeping people independent and well at home, preventing hospital admissions and getting people back home as quickly as possible with the right support after a hospital stay.



Our performance against the various cancer targets improved steadily during the year, with almost consistent delivery against the two-week, 31-day and 62-day targets. There remain some issues with breaches caused by patient choice, or those shared with other providers, and these areas are more difficult to control, however progress has been made and we continue to explore ways to improve.



Over the year the Trust treated 92.4% of patients within 18 weeks, in excess of the national target of 92%. However, performance deteriorated over the year and we didn't achieve the target in the last quarter. This is because we switched resources to ensure that emergency and cancer care services were protected.

More information about our performance can be found on our website:
www.northdevonhealth.nhs.uk/about/performance

Sustainability statement

The Trust has a corporate duty to maintain safe and efficient services, but we recognise that as a large user of resources, we must also have practices in place that allow us to be environmentally sustainable in the services we provide. By delivering healthcare in this way, we ensure a minimal impact on the local community and infrastructures.

This approach also ensures the efficient use of Trust resources, supporting the Trust's aim to reduce operational costs. To support us in demonstrating this year on year, we have adopted the NHS software the Good Corporate Citizen guide (GCC). Within the GCC there are nine areas identified that trusts should focus on with each area requiring a score for compliance. These scores can then be benchmarked against other NHS organisations and against the Trust's previous scores annually, to demonstrate continuous improvement. These areas are:

1. Travel

As a healthcare provider with large distances between properties, the Trust faces ever increasing challenges in ensuring sustainable travel to its services for both the public and staff.

For the public and staff:

- The Trust advertises public transport access
- We encourage the use of public transport with staff subsidies for bus passes
- Through the Healthy Travel initiative, we offer a car parking charge claim back facility for staff who park in town and walk to site
- We encourage lift sharing where possible
- We offer access to the cycle to work scheme and provide onsite changing facilities at some of the Trusts sites for those wishing to participate

For staff business travel:

- We encourage the use of teleconferencing where possible.
- We have access to a newer, more efficient car fleet for business mileage, thereby reducing the grey fleet of inefficient private cars used in the past by staff.

2. Procurement

Procurement within the NHS has been identified as a key area in assisting trusts to achieve sustainability targets. The Trust's procurement team have planned and put in place a number of ideas and initiatives:

- The standardisation of goods to reduce the extensive range of goods/services we provide to deliver healthcare services.
- Partnerships with other NHS trusts to allow the formation of purchasing networks.
- A more sustainable approach with suppliers in the selection of goods and services, where practical. This has become a key factor of the purchase selection process.
- Reducing packaging of goods purchased.
- Energy and resource consumption is identified prior to purchase of equipment, often influencing purchase selection.
- The method of sustainable disposal of equipment at end of life is identified at purchase.
- Where possible the purchase of local services/goods to reduce carbon miles from transport.
- Innovative methods of delivery from the NHS Supply Chain fleet including early am deliveries to avoid traffic issues and assist in reducing fuel consumption.

Facilities

3. Energy

The Trust has in place a constant monitoring and targeting program for all its properties to ensure energy consumption is reduced. This will automatically bring a reduction in energy costs and carbon produced ($CO2$). To further support this, the Trust has just completed its Energy Performance Contract (EPC), an investment of some £4.3 million. Within the EPC, major projects have been put in place that will produce major financial savings for the Trust over the next 15 years and allow it to meet and better the national NHS $CO2$ target placed on the Trust. The EPC has provided a major investment in the Trust's infrastructures which, from savings made will allow a payback of the investment within seven years, releasing funds to support healthcare delivery and the development of healthcare facilities.

Now the EPC is completed the Trust's energy usage is expected to decrease by at least 20% of its present annual usage. It is anticipated that this energy reduction will place the Trust in line with the best performers within the NHS.

4. Waste

The Trust continues to be proactive in all areas of waste management, monitoring the contract with SRCL, Viridor and other waste contractors very closely. In order to achieve some form of benefit from the waste it produces, rather than seeing it go to landfill, the Trust is continually investigating the potential to recycle its waste streams. Innovative processes are identifying ways to bring this to areas where disposal was seen only as the only option. One such area is the recycling of needle collection bins which in the past were required to be incinerated. For waste that does have to be incinerated, the Trust is part of a consortium using a waste to heat incinerator thereby reclaiming the heat for use in another process. Success in its waste management has allowed the Trust to maintain quality and to continually improve standards. This has been through the development of partnerships within the consortium. The Trust has used the expertise of specialist contractors, particularly in tapping into new innovations. Within these contracts, we work with the contractors to look at improving effective segregation and increased recycling to reduce the waste volumes the Trust produces, while at the same time ensuring that any innovative techniques do not affect compliance to relevant legislation.

5. Workforce

The Trust is actively involved in the continual improvement of the working environment and facilities for our workforce. This is monitored closely through the use of staff surveys where there is the opportunity to feedback on all issues including sustainability. A key aim for 2017/18 will be:

- Raising awareness of the sustainability agenda throughout the Trust
- Engaging managers and staff within the Trust
- A comments process to allow all users of our sites the ability to engage and suggest ways the Trust could improve its sustainable reputation
- To possibly adopt new processes by changing the way we work and deliver services.

6. Community engagement

This area within the GCC relates to community engagement and the importance of how the Trust and its services assist the local population to build healthy, sustainable lives and communities. It looks at what facilities and support we make available to our staff i.e. childcare and carer support. It makes reference to how the Trust communicates sustainability to all staff, whether through training or communication packages. To achieve compliance, the Trust is also required to partner with local organisations, potentially sharing assets and resources with local communities, and to engage with service users about their experience of our services. This will be another key aim for 2017/18.

7. Buildings

A key aim for trusts is to provide buildings and facilities that are fit for purpose and functionally suitable. Another challenge for trusts is to use properties efficiently and effectively, disposing of potential redundant stock. Such building stock is often identified as requiring large capital investment thereby increasing trusts' outstanding backlog investments. In keeping with the Trust's sustainable agenda, there are key requirements for all projects and developments within the estate:

- To use sustainable products in all developments.
- To design such developments to reduce energy to a lower figure than is used at present.
- To design new properties to achieve an excellent rating for energy efficiency based on energy consumed per metre of area.

The most recent new development for the Trust was the Seamoor unit, providing chemotherapy services. This development was awarded the national standard of "Excellent" through the Building Research Establishment Environmental Assessment Methodology (BREEAM). In 2016, the Trust was commended as a finalist in the National Health Business awards, which recognises excellence in the provision of NHS facilities.

8. Adaptation

This section links in with the Trust's emergency planning, building design protocols and service planning. It challenges the Trust to consider how the potential effects of climate change can affect our ability to deliver healthcare services.

There must be due consideration in all of the areas above, addressing such potential influences as floods, extreme hot/cold temperatures, storms etc. Such planning is key to ensuring that any impact of climate change can be managed with a minimal effect on healthcare service delivery.

The Trust meets a great deal of this section through its processes for service and area development, through business case approval, then ultimately by the design and delivery of projects.

9. Models of care

The experts in any service provided by the Trust are those delivering the service. When we engage staff in discussions about how we can deliver services in a more environmentally sustainable way, they contribute practical and innovative suggestions. To support such involvement requires the Trust to educate clinical staff about how they can contribute to the delivery of sustainable healthcare and how they can try to reduce the carbon impact in some areas of the services they provide. This section also builds on the area of community engagement, by assessing the practical and sustainable approach the Trust takes in its service delivery.

An element of health education to staff, the public, and visitors around the benefits of healthy lifestyles also contributes to more environmentally sustainable models of care, particularly in relation to long term conditions, chronic disease or those who are vulnerable. Integrated care is a key factor in reducing duplication, unnecessary interactions and unnecessary tests, and when new models of integrated care are developed, consideration will be given as to whether they reduce environmental impact.

Staff involvement will be key to implementing:

- A reduction in waste from certain resources i.e. pharmaceutical waste
- The re-use of medicines, control and efficient stock management.

Such benefits can only be achieved through clinician engagement during patient care and treatment. A key aim is to deliver safe and effective care 'closer to home' and this has an indirect environmental impact by assisting in the reduction in vehicle-produced CO2, as patients and the public have fewer and shorter journeys when treated in their own home or local outpatient facilities. This also assists in reducing the impact of vehicle congestion on the NDDH acute site.

Emergency preparedness, resilience and response

The Civil Contingencies Act

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

- To assess the risks of an emergency occurring and use this information to inform contingency planning
- To put emergency plans in place
- To have business continuity arrangements in place
- To put in place arrangements to make information available to the public and maintain arrangements to warn, inform and advise the public in the event of an emergency
- To share information with other local responders to enhance coordination
- To cooperate with other local responders to enhance coordination and efficiency

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

NHS Core Standards

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

The Trust undertook a self-assessment against the named core standards in August 2016 and of the 51 applicable standards, the Trust identified as being:

- Fully compliant with 49 of the standards (green)
- Partially compliant with two of the standards (amber)

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

Incident response plan

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

Fraud policies and procedures

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

The Trust has support from an independent local counter fraud specialist (LCFS) to ensure risks are mitigated and systems are resilient to fraud and corruption. An annual anti-fraud work plan is approved by the audit committee.

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

The risk-based programme of anti-fraud work was delivered in 2016/17, addressing all strategic areas of the national counter-fraud strategy. The LCFS has developed key relationships across the Trust and this, coupled with the work undertaken by the LCFS, has resulted in the development of an anti-fraud culture within the Trust.

Health and safety

Twice a year, the Trust board receives a report from the internal health and safety committee in order to highlight the key issues, decisions taken and risks discussed over the previous six months.

Members of the committee include union appointed safety representatives, management representatives, specialist advisors and a non-executive director. The committee chair is the director of nursing, quality and workforce.

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

The Trust has duties under law including:

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

Over the last financial year, we had the following focus:

1. Receiving and responding to staff incident reporting:

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

All health and safety related incidents are reviewed by the health and safety manager and other specialists e.g. back care advisor, fire and security advisor or infection prevention and control nurse, to ensure managers have taken appropriate actions.

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

During the financial year (1 April 2016 to 31 March 2017), the following incidents relating to health and safety were reported and presented in the quarterly incident reports to the health and safety committee (see table 1 for the number and percentage per quarter of incidents).

The drop in the number of incidents reported when comparisons are made between Q2 and Q3 2016-17 occurred following Transforming Community Services and the transfer of a number of services to the Royal Devon and Exeter NHS Foundation Trust as of 1 October 2016 (at the end of the period covering Q2 2016-17).

Table 1

Incident category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Patient accidents (including falls)	397 (63%)	419 (64%)	218 (63%)	238 (62%)
Staff accidents	101 (16%)	95 (14%)	46 (13%)	58 (15%)
Violence and aggression	86 (14%)	104 (16%)	61 (18%)	73 (19%)
Fire	35 (6%)	26 (4%)	18 (5%)	14 (4%)
Visitor / contractor accidents	7 (1%)	9 (1%)	5 (1%)	3 (1%)
Total	626	653	348	386

Patient accidents, including falls are also reviewed by the head of physiotherapy and occupational therapy and are presented at the patient safety operational group to provide a Trust-wide approach to the management of patient accidents.

2. RIDDOR regulations:

Under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR), certain categories of incident are reported externally to the Health and Safety Executive (HSE). During the 2016-17 financial year, a total of 43 incidents were reported to the HSE under RIDDOR.

An example of an incident that meets RIDDOR reportable criteria would be a patient who suffers a fall and sustains a significant injury such as a hip fracture, where management, procedural and / or equipment failings are identified as contributory factors.

Under the memorandum of understanding that exists between the HSE and the Care Quality Commission (CQC), information contained within RIDDOR reports submitted to the HSE for patient accidents that meet the RIDDOR reporting criteria can be shared with the CQC (by the HSE). The CQC may then choose to lead on any subsequent externally-led investigation that may be deemed appropriate by either organisation.

- Quarter 1 2016-17, 13 incidents were reported under RIDDOR
- Quarter 2 2016-17, 14 incidents were reported under RIDDOR
- Quarter 3 2016-17, 10 incidents were reported under RIDDOR
- Quarter 4 2016-17, 6 incidents were reported under RIDDOR

The incidents reported to the HSE fell under the RIDDOR categories indicated in table 2. It can be noted that 10 RIDDORs submitted were following patient accidents.

Table 2

RIDDOR categories - reports submitted to HSE, 2016-17	Report of an injury	Report of a dangerous occurrence	Total
Bone fracture excluding finger, thumb or toe	4	0	4
Loss of consciousness due to head injury or asphyxia	2	0	2
Off work for more than 7 days	20	0	20
Light duties for more than 7 days	2	0	2
Member of public taken directly to hospital	2	0	2
Dangerous occurrence	0	3	3
Patient suffering specified injury	10	0	10
Total	40	3	43

More information on the Trust's approach to health and safety can be found in the bi-annual reports to the Northern Devon Healthcare NHS Trust board on the Trust website, www.northdevonhealth.nhs.uk.

Disclosure of personal data related incidents

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

For the 2016/17 financial year, the Trust reported:

Zero information governance SIRIs.

Zero cyber security SIRIs.

Annual governance statement 2016/17

1. Scope of responsibility

1.1 As accountable officer, I have responsibility for maintaining a sound system of internal control that supports achievement of the organisation's policies, aims and objectives, whilst safeguarding quality standards, public funds and departmental assets for which I am personally responsible in accordance with the responsibilities assigned to me.

1.2 I am also responsible for ensuring that the organisation is administered with propriety, prudently and economically and that resources are applied efficiently and effectively. I acknowledge my responsibilities as set out in the accountable officer memorandum for chief executives of NHS trusts.

1.3 In the delivery of my responsibilities and objectives, I am accountable to the board and my performance is reviewed regularly and formally by the chairman on behalf of the board.

2. The governance framework of the organisation

Trust board

2.1 The Trust board has overall responsibility for the strategy, activity and integrity of the Trust. During 2016/17, the Trust secretary role was part of the portfolio of the director of strategy and transformation until October 2016 when this transferred to the director of workforce and development. Both directors provided senior leadership in corporate governance.

2.2 The Trust board met on six occasions during the 2016/17 financial year on the following dates:

- 5 April 2016
- 7 June 2016
- 2 August 2016
- 4 October 2016
- 6 December 2016
- 7 February 2017

Figure 1 – Attendance at Trust Board

Name	Role	Attendance
Non-executive directors		
Roger French	Chairman	6/6
Tim Douglas-Riley	Non-executive director	6/6
Robert Down	Non-executive director	6/6
Pauline Geen	Non-executive director	6/6
Nick Lewis	Non-executive director	5/6
Tony Neal	Non-executive director	4/6
Executive directors		
Alison Diamond	Chief executive	5/6
Colin Dart	Acting director of finance (from October 2016)	3/3
Andy Ibbs	Director of operations and strategy (from December 2016)	2/2
Nicola Ryley	Interim director of nursing	5/6
Andy Robinson	Director of finance and performance, deputy chief executive (until August 2016)	3/3
Robert Sainsbury	Director of operations (until October 2016)	3/3
George Thomson	Medical director	4/6
In attendance		
Jonathan Broad	Associate non-executive director (until February 2017)	6/6
Andy Ibbs	Director of strategy and transformation (until October 2016)	4/4
Darryn Allcorn	Director of workforce and development	5/6
Iain Roy	Director of facilities	4/6

2.3 The board conducts its business in accordance with the Standing Orders and Standing Financial Instructions. The papers of the Trust board are published on the Trust website.

2.4 The Trust board consists of the chairman, five non-executive directors and five executive directors (including the chief executive). The director of workforce and development, director of facilities, and the director of strategy and transformation also attend the Trust board meetings. During 2016/17, an associate non-executive director was also in attendance at board meetings.

Board briefings

2.5 The Trust board meets in between board meetings for board briefings where issues are discussed in detail prior to being presented at Trust board.

Ten board briefings were held through the 2016/17 financial year where items were discussed, updated and challenged. These are the large operational and financial issues that affect the daily function of the trust, including:

- Lord Carter Report
- Whistleblowing
- Agency spending caps
- Quality account
- Strategic and corporate objectives
- Place based approach to service and community development
- Board assurance framework
- Contract negotiations
- Domiciliary care – Devon Cares
- Mortality review for acute kidney injury
- Electronic healthcare record
- Success Regime
- Sustainability and Transformation Plan
- Community transfer of services
- Appointment of external auditors
- Revalidation for nurses and midwives
- Acute services review
- Operational plan 2017/18 and 2018/19
- Length of stay and bed reductions
- Care Quality Commission – update on inspections
- Delivery of performance targets
- Review of themes arising from incidents, SEAs, SIRIs and complaints
- Briefing on Care Quality Commission review of how NHS trusts review and investigate the death of patients
- Promoting independence
- Engagement strategy
- Stroke services
- Managing conflicts of interest in the NHS
- Devon Excellence Centre
- Flexible workforce
- Quality improvement strategy
- Patient flow
- Vision and values

Going Concern Opinion on the 2016/17 statutory accounts

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

Board strategy and development days

2.7 Four board strategy and development days have been held during the year. One board away day has also been held. These days are used to assess the performance of the board as well as its effectiveness. The NHS Leadership Academy supported a session with the full Trust board exploring board autonomy and system governance in relation to statutory requirements and working across the wider system through developing Sustainability and Transformation Plans. The session also explored how the board can be assured of safe, effective care considering pace of change and working within the wider system.

Sub-committees of the Trust board

2.8 The Trust board is supported by sub-committees whose membership includes non-executive directors. For some sub-committees, the membership only includes non-executive directors and executive directors (these are marked '*' below). Others have members of staff who act as specialist advisors (marked '#' below). The sub-committees are:

- Audit and assurance committee *
- Charitable funds committee #
- Finance committee
- Quality assurance committee #
- Remuneration and terms of service committee *
- Workforce and organisational development committee #

2.9 Non-executive directors also sit on the risk management committee which reports to both the audit and assurance, and quality assurance committees.

2.10 The board has overall responsibility for the effectiveness of the governance framework and requires that each of its sub-committees has agreed terms of reference which describe their duties, responsibilities and accountabilities together with the process for assessing and monitoring effectiveness. All the sub-committees have at least one non-executive member. The sub-committee chairs are all non-executive directors. The chairs of the sub-committees routinely present written and verbal reports to the board highlighting key issues and decisions at their meetings.

2.11 A formal compliance report for each sub-committee is reported to board annually, outlining the activity undertaken during the year against the individual committee's terms of reference.

Audit and assurance committee

2.12 The audit committee has provided the board with assurance on the key aspects of their work, including:

- An effective system of internal control and risk management
- An effective internal audit function that meets NHS internal audit standards
- Reviewing the findings of the external auditor and other significant assurance functions
- Reviewing and reporting on the annual report and financial statements

Charitable funds committee

2.13 The charitable funds committee manages and monitors all aspects concerned with the charitable funds within Northern Devon Healthcare NHS Trust. The committee's main functions include:

- Approving charitable funds policies and procedures
- Considering and monitoring the risk profile of charitable funds investments
- Receiving spending plans for each charitable fund and approving them on behalf of the Trust board
- Supporting and monitoring fundraising on behalf of the Trust's charities

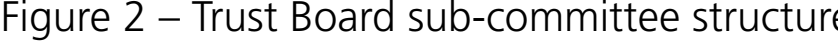


Figure 2 – Trust Board sub-committee structure

Trust board

- Audit and assurance committee
  - Risk management committee
- Quality assurance committee
  - 5 advisory groupsv
  - 11 specialist sub-groups
- Finance committee
- Workforce and organisational development committee
  - Organisational development committee
  - Planning, education and recruitment committee
  - Partnership forum
- Charitable funds committee
- Remuneration and terms of service committee

Finance committee

2.14 The finance committee maintains robust financial management by monitoring financial performance and making recommendations to the executive team or to the Trust board as appropriate. The committee's main functions include:

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

Quality assurance committee

2.15 The quality assurance committee provides leadership and assurance that clinical governance systems and processes are in place and effective in providing safe, high quality care. The committee's main functions include:

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

Remuneration and terms of service committee

2.16 The remuneration and terms of service committee determines the remuneration and conditions of service of the chief executive, executive directors, other directors who report to the chief executive and staff not on national terms and conditions of service, ensuring that it complies with current statutory and NHS requirements. The committee's main functions include:

- Determination of appropriate remuneration and terms of service for the chief executive, executive and other directors who report to the chief executive and staff not on national terms and conditions
- Determination of performance awards
- Determination of contractual arrangements

Workforce and organisational development committee

2.17 The workforce and organisational development committee provides advice and assurance to the Trust Board on all matters relating to the workforce, including workforce strategy and planning, and pay and rewards. It also has responsibility for organisational development, including health and wellbeing, and equality and diversity. The committee's main functions include:

- Approving the workforce and organisational development strategies and action plans
- Approving pay and reward strategies
- Approving a strategic workforce plan
- Providing assurance on the delivery of the workforce strategic and corporate objectives and performance against key performance indicators
- Receiving assurance on the management and mitigation of workforce risks

Corporate governance

2.18 The UK Corporate Governance Code sets out standards of good practice in relation to board leadership and effectiveness, remuneration, accountability and relations with stakeholders. Although compliance with the Code is not required by NHS trusts, best practice principles of good governance are applied to the function and effectiveness of the Trust board, namely accountability, transparency, probity and a focus on the sustainable success of the organisation over the longer term.

The Trust board carried out a robust assessment of the principal risks facing the organisation through the annual SWOT and PESTLE exercise which informs the annual operating cycle, strategic and corporate objectives, and board assurance framework.

Risk management and internal control systems are monitored through the audit and assurance committee.

The Trust board has carried out assessments of its own corporate governance arrangements and effectiveness through four board strategy and development days and one board away day held during the year.

At the board development day on 5 July 2016 the board received a presentation on the well-led governance framework self-assessment aligned with the Care Quality Commission fundamental standards and the Trust's responses to the following key lines of enquiry:

- Is there a clear vision and a credible strategy to deliver good quality?
- Does the governance framework ensure that responsibilities are clear and that quality, performance and risks are understood and managed?
- How does the leadership and culture reflect the vision and values, encourage openness and transparency and promote good quality care?
- How are people who use the services, the public and staff engaged and involved?
- How are services continuously improved and sustainability ensured?

Quality governance

2.19 by listening to patient experience and understanding safety alongside delivering and maintaining services. This approach has been formally identified through Trust values and strategic objectives with executive leadership and board ownership.

Most committees have executive or senior leaders as core members enabling a robust structure of information dissemination, enquiry and assurance. These committees provide robust oversight of relevant issues to focus on quality and safety agendas determined locally or nationally.

'Ward to board' quality feedback is delivered by the quality assurance committee, which is chaired by a non-executive director. The safer care delivery committee and the mortality review committees are both chaired by a clinical executive director with membership including senior clinical leaders.

The chief executive and Trust board have multiple forms of communication with the organisation and its workforce including weekly electronic bulletins, a live chat forum for open dialogue, and a scheduled executive walk-around programme continues this supportive listening approach.

Quality improvement (QI) strategies have been developed to support the delivery of the Patient Safety Improvement Plan. The strategy emphasises the close association with patient experience and the importance of education in quality improvement, celebrating success locally and through national award schemes.

Use of QI methodologies such as root cause analysis, continuous improvement processes and run charts explore improvements or concerns in quality and safety. Such data is readily accessible to clinical and management teams through various platforms and is presented through established meeting structures for dissemination.

External stakeholders such as NHS NEW Devon Clinical Commissioning Group and NHS Improvement have structured reporting formats for quality reporting so there is scrutiny and oversight of contractual quality indicators.

Quality account

2.20 The quality account is published annually adhering to guidance issued by NHS England. The content is co-ordinated by the head of quality and safety within the Trust.

The content is carefully considered and informed from various internal and external intelligence sources including patient feedback obtained from national and local surveys, friends and family tests, themes from investigations and complaints, direct contributions and suggestions from patients, service users and patient engagement events, emerging issues from committees, direct staff contributions, and national and local quality improvement projects.

An external audit organisation is required to review the quality account and key quality indicators as outlined by the national guidance. The Trust audit and assurance committee has oversight of the audit findings and document.

The progress of any outlined improvement commitments within the quality account are monitored through various Trust meetings within the identified quality agenda sections: quality assurance committee, patient safety operational group and senior nurse forum.

As part of the prescribed content of the quality account progress is also described on the subsequent quality account published the following year. The quality account content and progress is presented to the public at the Trust annual general meeting.

Clinical audit

2.21 The clinical audit team are managed by the Trust head of quality and safety to reinforce the pivotal function of clinical audit in the delivery of quality care.

The deputy medical director with responsibility for clinical effectiveness has key responsibilities for ensuring the compliance of the organisation in the delivery of NICE standards and NICE compliance.

Audit programme progress and compliance is reported bi-monthly at the Trust quality assurance committee. The clinical audit programme is published within the annual quality account.

Research and development

2.22 The research and development department is managed by a team of director, manager and lead nurse with oversight by the Trust head of quality and safety. The research director is a senior consultant with the responsibility to support and lead collaborative, multi-disciplinary research activity and innovation within the Trust. The leadership reinforces the pivotal function of research in the delivery of quality care and its association to clinical effectiveness.

Research recruitment progress and time to target compliance is reported bi-monthly at the Trust quality assurance committee.

Research has strict governance regulations that are monitored closely by its regulators (MHRA and HRA). All research conducted at the Trust follows research protocols that have received a favourable ethical opinion from a research ethics committee (REC). These are monitored internally by research management, governance, and clinical and nursing staff, and externally by sponsors and MHRA.

Medicines governance

2.23 The Trust chief pharmacist is the designated medication safety officer and is supported by the Trust governance pharmacist to comply with the NHS England safety directive. As a Trust we are fully engaged with regional and national networks of medication safety officers to support local medication error reporting and learning and act as the main contact for NHS England and MHRA (Medicines and Healthcare products Regulatory Agency).

The Trust medicines governance group is a multi-professional group that meets to regularly review medication incidents, to identify any organisational specific patterns within incidents and to make suggestions for learning and improvement. It also acts as an advisory group for local implementation of national alerts and other recommendations.

A six monthly report provides the Trust drugs and therapeutics committee with an overview of medicines governance and safety, concerns, and actions being taken to mitigate against identified risks. The key performance indicators included in this report are produced and reported to the senior pharmacy team monthly. The report describes current medicines safety performance in relation to:

- Medicines reconciliation completed within 24 hours of admission
- Omitted doses of high risk medicines
- INRs (international normalised ratio) results over 6
- Number of medication incidents reported
- Percentage of medication incidents reported
- Percentage of medication incidents causing no obvious harm loss or damage
- Never events – medication
- Patient experience – medication

Dissemination to the multi-professional teams is a vital component for information and focus on improvement using forums and committees, intranet and various multi-media platforms. The report is shared at the bi-monthly Trust quality assurance committee.

Never events

2.24 Incidents identified as potential never events are escalated to the serious incident review group (SIRI review group) for review and a decision on whether they meet the criteria of a reportable incident under the NHS England revised never events policy and framework published in March 2015.

The purpose of the SIRI review group is to provide assurance that serious incident processes are robust, effective and delivering learning and improvement to support safe, high quality care. The SIRI review group reports to the quality assurance committee (QAC), a sub-committee of Trust board.

Following escalation, identified potential never events are reported to our commissioners who confirm whether the incident meets the criteria. Three never events were reported in 2016/17 - two meeting the criteria of wrong route administration of medication, and the third under the category of wrong site surgery.

SIRIs

2.25 The Trust continues to be a high reporter of patient safety incidents reported to the National Reporting and Learning System (NRLS) compared with similar small acute trusts. Robust incident reporting, management and investigation processes are embedded throughout the organisation, including a process for escalating reported incidents through the SIRI review group for a decision on whether they should be designated as a serious incident requiring investigation (SIRI) and formally investigated.

During the year, eight SIRIs were reported to our commissioners via STEIS, of which three were categorised as never events as detailed above.

There is a strong assurance route to board as described below. Reports that have been reviewed by the SIRI review group and formally approved at QAC are presented to the Trust Board as a summary of the SIRI investigation for ratification of the approval decision.

Actions to address the recommendations in each SIRI report are recorded on the corporate risk register and monitored to completion through established risk management processes. On completion of the action plan, the divisional team evaluates whether a clinical audit should be added to the annual programme to measure and demonstrate the impact of implementation on reducing the risk of recurrence.

Quarterly SIRI analysis reports (including never event investigations) are presented to QAC which include quantitative and qualitative data, identified themes, and Trust-wide actions underway or planned to address areas of learning.

Discharge of statutory functions

2.26 gements are in place for the discharge of statutory functions, that they have been checked for irregularities, and that they are legally compliant.

The Standing Orders and Standing Financial Instructions and Reservation of Powers and Scheme of Delegation clearly set out the rules by which the board and its committees conduct their business and the Trust discharges its statutory functions. Both documents are based on the Department of Health model for Standing Financial Instructions.

The documents are amended as legislation changes and are approved by the Trust board through the finance committee which has delegated authority. They are also reviewed on an annual basis and appropriate amendments made as required.

3. Risk assessment

3.1 The processes for risk assessment and management are set out in the Trust's risk management policy which reflects changes in process and includes guidance on SMART actions.

3.2 It is recognised that risk may be identified through a number of different routes, including alert notices from external agencies, internal audit reviews; external inspections, incidents and near misses, workplace risk assessments and regulation-specific risks.

3.3 Once a risk has been identified, a risk assessment is completed to create an auditable record, identify scoring and control measures in place, and set out the proposed treatment and actions to reduce the risk. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to risks. All risks are given a numerical risk rating based on a 5 x 5 risk matrix multiplying the potential consequence (impact) of the risk by its likelihood. The maximum score based on the risk matrix is 25.

3.4 All risks are recorded on the corporate risk register which is held on the DATIX risk module and performance-monitored to completion of actions through established risk management processes.

3.5 Risk actions are updated on a monthly basis and all exceptions are reported to the risk management committee, including action plan due date extensions, changes to risk score, and no responses to update requests. Exceptions for risks with a score of 15+ are routinely discussed in detail by the committee.

Risk profile

3.6 As at 31 March 2017 there were 89 open risks recorded on the corporate risk register (Figure 3). During the year from 1 April 2016 – 31 March 2017, 78 new risks were recorded and 96 risks were accepted as the mitigating actions had been completed and the risk re-scored.

3.7 The numbers of new and accepted risks are less than previous years, as the risk management committee agreed that a trial of recording investigation reports (SEAs and SIRIs), internal audits, NPSA notices and business continuity plans on DATIX as action plans rather than risks had been successful and should be formally adopted.

Figure 3 - Risk profile of open risks as at 31 March 2017

Risk score	No. of risks
High (15+)	23
Moderate (8-12)	59
Low (1-6)	7
Totals	89

3.8 In a number of cases, following review and triangulation of individual risks, risks have been be cross-referenced, merged and/or a Trust-wide risk has been recorded on the corporate risk register. When a new risk supersedes an old risk it was agreed by the committee that the score of the old risk would be changed to zero and the risk accepted. The committee continued its plan to create Trust-wide risks for ophthalmology, falls, maternity, and caring for children and adolescents with mental health and social issues.

High level risks

3.9 Major risks are monitored through the principal risk map, a listing of the high-scoring risks (15+) linked to each principal risk. Principal risks are risks which might prevent the Trust strategic objectives being achieved. The principal risk map is routinely presented to the risk management committee and the audit and assurance committee.

3.10 The high-level risks recorded on the corporate risk register as at 31 March 2017 include the following key areas:

- Recognition of risks to achieving the Trust's strategic objectives in the current financial and political environment, particularly relating to ensuring access to a sustainable range of services, and delivering services efficiently and effectively
- Managing patients with mental health or social issues in the safest and most appropriate way when they are inpatients for medical reasons
- Identified risks to delivering the best possible care and experience for patients using maternity services
- Achievement of the statutory performance targets in some service areas, particularly the 18-week referral to treatment and 52-week treatment targets
- Maintaining adequate clinical staffing levels in some service areas and the potential impact on the ability to provide safe, high quality care
- Recognised IM&T risks which may result in service disruption

3.11 All identified risks have clearly articulated controls and action plans in place to mitigate the risk. Completion of actions within deadlines is monitored through the risk management committee, with exceptions followed-up as appropriate.

Data security breaches and lapses

3.12 No data security breaches or lapses occurred during 2016/17 (1 April 16 to 31 March 17) and no issues were reported to the Information Commissioner's Office.

4. The risk and control framework

4.1 ty for risk management within the Trust and this is incorporated into the risk management strategy 2016/19. From April 2016 until October 2016 I delegated responsibility to the director of strategy and transformation, the lead director for risk management over that period. In October 2016, I transferred this responsibility to the director of workforce and development who became the lead director for risk management on an interim basis.

4.2 The Trust recognises the need for a robust focus on the identification and management of risks, and therefore this is an integral part of our overall approach to quality and safety. The risk management strategy sets out the key responsibilities for managing risk within the organisation, including the ways in which risks are identified, evaluated and controlled. A risk assessment matrix is used to ensure a consistent approach is taken to assessing and responding to organisational risks. This determines the Trust's approach to risk with clear processes for the management and monitoring of risk assessments as defined within the risk management strategy and risk management policy.

4.3 Line management and professional structures ensure that responsibility for the implementation of risk management procedures and prevention and control of risks are in line with the scheme of delegation. All staff have a responsibility for the management of clinical and non-clinical risks according to their roles and duties within the Trust.

4.4 All risks recorded on the corporate risk register have been categorised against one of the six Trust strategic objectives. All high scoring risks, i.e. with a risk score of 15+, are reviewed at the risk management committee to assess whether the individual high-scoring risk represents an example of a principal risk to the organisation. This process has been developed to allocate high scoring risks to 'themes'. To date, twelve principal risks have been identified. Individual high-scoring risks may be allocated to one or more of the principal risks.

4.5 The Trust has a strong track record in the identification, prevention and mitigation of risks. The processes are embedded in the culture of the organisation and through other robust systems such as the 'ward to board' assurance process and discussion of incidents and risk assessments at relevant groups such as the drugs and therapeutics committee and maternity services patient safety forum.

4.6 4As part of the 2016/17 annual audit plan as approved by the audit and assurance committee, a review of risk management arrangements within the Trust was carried out. Internal audit returned an overall assurance opinion of 'significant'.

4.7 The table below (Figure 4) shows the risks that have been accepted and closed during the year 2016/17 and demonstrates the effectiveness of processes to manage and mitigate risks.

System of internal control

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

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

The system of internal control has been in place in Northern Devon Healthcare NHS Trust for the year ended 31 March 2017 and up to the date of approval of the annual report and accounts.

Board assurance framework

4.9 A board assurance framework (BAF) has been in place throughout the year which is designed and operating to meet the requirements of Department of Health guidelines and the annual governance statement.

Figure 4 - Accepted and closed risks by initial risk score and current risk score

Initial risk score	Initial number of risks	Outcome / final risk score			
		No risk	Low	Medium	High
Low (1 – 6)	29	3	26	0	0
Medium (8 – 12)	54	18	15	21	0
High (15+)	13	4	6	2	1
Totals	96	25	47	23	1

The BAF provides a structure for the Trust board to be assured that the systems, policies and procedures in place are operating in a way that is effective and focussed on the key principal risks which might prevent the Trust strategic objectives being achieved.

The board recognises that an effective risk management process must be in place to ensure efficient and timely delivery of the Trust's five year strategy. In 2016/17, the board made the process of capturing the evidence of delivering the strategy more comprehensive, so that it aligns with external reporting requirements. The process requires:

- An agreed set of strategic objectives aligned to advancing the strategic vision;
- An assessment of the principal risks to the achievement of the strategic objectives, derived from the annual analysis of both SWOT (strengths, weaknesses, opportunities and threats) and PESTLE (political, economic, social, technological, legal and environmental)
- An annual review of existing controls and assurance mechanisms in place to manage the strategic risks and ensure delivery of the strategic objectives.

Managing the gaps in the controls and the established assurance systems, and the identified steps required to deliver the strategic objectives make up the annual corporate objectives for the Trust, which in turn are translated into personal performance objectives for directors and the annual work programmes for the board's sub-committees. Progress reports against the suite of corporate objectives are presented to the Trust board four times a year, to the first meeting after the quarter-end. In addition, progress reports on individual corporate objectives are presented to the board throughout the year. This ensures the controls and assurances remain valid and any identified gaps are mitigated by timely implementation of clearly defined actions with explicit timescales for delivery.

Counter fraud and security management arrangements

4.10 The Trust aims to reduce fraud to a minimum and employs the services of a local counter fraud specialist (LCFS) in line with the NHS directions on counter fraud arrangements. The LCFS routinely reports counter fraud activity and progress against the agreed work plan to the audit and assurance committee. These reports form part of the evidence supplied to NHS Protect and the external audit review of arrangements.

In addition, the Trust employs a local security management specialist (LSMS), in line with the NHS Protect national framework, to reduce issues relating to security. Their role is to work within the national legal framework for tackling violence and security management, providing advice and guidance to ensure an environment that is safe and secure and supports delivery of high standards of clinical care. The LSMS routinely reports security management activity to the security incident review group and the health and safety committee.

Committee structure

4.11 The audit and assurance committee and quality assurance committee, which are both sub-committees of Trust board and the risk management committee, are the three main committees for risk-related matters. Other committees/groups are responsible for the oversight of specific risk management areas such as health and safety and medicines management.

The audit and assurance committee is responsible for scrutinising the overall systems of internal control and for ensuring the provision of effective independent assurance via internal audit and external audit. It has a role in monitoring the management of high-scoring risks. High-level clinical risks are monitored by the quality assurance committee. The terms of reference of the two board sub-committees reflect these functions.

Training

4.12 Risk management training requirements are documented in the risk management policy and included on the Trust induction days and annual refresher training. Practical risk assessment courses are also delivered and are bookable through the staff training access resource (STAR).

Elective waiting time data

4.13 The Trust has a number of controls in place to maintain and assure the quality and accuracy of elective waiting time data, including on-going validation of referral to treatment time (RTT) pathway data, training in RTT pathway management (mandatory for key staff to update every three years), attendance at clinical governance events to update clinical staff, regular audits of data quality, and tailored support for areas where issues have been identified. An annual review is undertaken by internal audit in quarter 2 every year as part of the audit programme which provides additional assurance on the effectiveness of the processes in place and data accuracy.

Weekly meetings are held with key operational and performance staff to discuss patient pathways and manage any identified longer waiters. The Trust's patient access policy was revised in 2016/17 following changes to the national RTT rules and is published on the Trust's website.

A 'deep dive' visit was undertaken by NHS Improvement in September 2016 to review RTT management and reporting, and as a result of this an action plan was implemented, covering areas such as review of the Trust's internal 18 week database, and inclusion of RTT in the Trust's induction programme.

The forthcoming introduction of the TrakCare system in April 2017 has incentivised the Trust to review its current RTT processes in planning how these will flow in TrakCare, and training on the new system will refresh staff knowledge, as all those using it in areas that impact on RTT will require specific training.

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

5.1 As accountable officer, I have responsibility for reviewing the effectiveness of risk management arrangements and the system of internal control. My review is informed by the work of the internal auditors, clinical audit and the executive directors within the Trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the content of the quality report attached to this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit and assurance committee, and a plan to address weaknesses and ensure continuous improvement of the system is in place.

5.2 A full programme of reviews has been carried out by internal audit during the year, aligned to the Trust's strategic risk assessment and the Audit South West local risk assessment. The internal audit plan for 2016/17 took into account the risk and assurance framework, discussions with executive directors to identify key areas for review, and working within the Devon Sustainability and Transformation Plan (STP) partnership. Delivery and outcomes have been monitored through the audit and assurance committee.

Quarterly liaison meetings between internal audit and key staff at the Trust were held to review the audit programme, to ensure that there was clear understanding of the risks facing the organisation, and to maintain oversight of the board and committee agendas. The plan was updated as different risks emerged, and approved through the audit and assurance committee.

5.3 Of the 13 internal audit reviews completed at the date of publication of this statement, seven returned an overall assurance opinion of green/ significant, and six of amber/satisfactory. An amber rating is defined by internal audit as, 'there are some weaknesses in the design and/or operation of controls which could impair the achievement of the objectives of the system, function or process.' A satisfactory rating is defined as 'controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.' None of the reviews returned a red/limited/no overall assurance opinion.

The following reviews received an amber/satisfactory assurance rating:

Figure 5 – Internal audit assurance ratings (amber/satisfactory)

Report title	Assurance	Impact
Complaints	Amber/green	Low
Local Induction	Amber	Low
Theatre Stock management	Amber	Low
Infection Control (inoculation injuries)	Amber	Low
Security - Violence & Aggression / Use of Restraint	Amber	Medium
Payroll	Satisfactory*	

*Following feedback from audit committees and chief officers, Internal Audit South West reviewed the system for grading internal audit reports to provide better clarity on the level of risk posed to organisations from review findings. The new system provides a single assurance opinion in line with industry best practice (see table below) and came into effect for all draft reports issued after 1 January 2017.

5.4 Robust action plans have been put in place to address the recommendations, and these are monitored to completion through established risk management processes. Updates on progress against action plans are presented to the audit and assurance committee in the regular internal audit reports to the committee.

Head of internal audit opinion

5.5 In accordance with NHS internal audit standards, the head of internal audit is required to provide an annual opinion statement to the Trust, based on the work performed on the overall adequacy and effectiveness of the organisation's risk management, control and governance processes. This is achieved through a risk-based plan of work agreed with Trust management and approved by the audit and assurance committee.

The head of internal audit provided an overall opinion of 'significant assurance' on the effectiveness of the organisation's internal control systems and financial governance.

Figure 6 – Grading of internal audit reports from 01.01.17

Assurance level	Description
Significant	Controls are well designed and are applied consistently. Any weaknesses are minor and are considered unlikely to impair the effectiveness of controls to eliminate or mitigate any risk to the achievement of key objectives. Examples of innovation and best practice may be in evidence.
Satisfactory	Controls are generally sound and operating effectively. However, there are weaknesses in design or inconsistency of application which may impact on the effectiveness of some controls to eliminate or mitigate risks to the achievement of some objectives.
Limited	There are material weaknesses in the design or inconsistent application of some controls that impair their effectiveness to eliminate or mitigate risks to the achievement of key objectives.
No	There are serious, fundamental weaknesses due to an absence of controls, flaws in their design or the inconsistency of their application. Urgent corrective action is required if controls are to effectively address the risks to the achievement of key objectives.

The director of internal audit has provided a head of internal audit opinion commenting on the current status of the board assurance framework and the effectiveness of the systems of internal control reviewed by internal audit. This has been used in the preparation of this statement.

6. Significant issues

Success Regime / Sustainability and Transformation Plan

6.1 In June 2015 NHS England, the Trust Development Authority and Monitor announced that the NEW Devon health system would be one of the first three Success Regimes which has now evolved through 2016/17 to a Devon-wide Sustainability and Transformation Plan (STP) footprint that includes South Devon.

Next year (the 2017/18 financial year) there will be a pan-Devon shared saving requirement of £144m to achieve the STP's financial objective. This means that individual organisations will continue to transform services together to ensure our collective efforts work towards clinically and financially sustainable health and social care services for Devon.

Currently the system is undertaking a review of acute services including:

- Paediatrics, neonates and midwifery
- Stroke
- Urgent and unscheduled care

The outcomes of each review are likely to require service transformation and potentially wider consultation.

Transforming Community Services (eastern)

6.2 In October 2016, the transfer of a large part of the eastern community services to the Royal Devon and Exeter NHS Foundation Trust (RD&E) was completed.

The rationale for transferring services was to further integrate the excellent community health and social care services across East Devon with the acute services in the RD&E.

The Tiverton PFI contract has yet to transfer to NHS Property Services. The Department of Health is working with legal advisers to determine the appropriate deed of transfer.

Transforming Community Services (northern)

6.3 In November 2014, NHS NEW Devon CCG confirmed that the Trust was its preferred provider of community services in the northern locality.

The Trust has completed a strategic due diligence process with the CCG, and a new contract for the continued provision of these services has been awarded.

Investing in community services

6.4 In line with the CCG strategy of Care Closer to Home and their consultation on the number of community hospital beds required, the Trust continued to invest in community services to enable more people to be looked after at home.

Temporary closure of inpatient beds in Holsworthy Community Hospital

6.5 Due to issues with safe staffing and bed occupancy, Holsworthy inpatient community beds closed temporarily at the end of March 2017.

Junior doctors' contract

6.6 The Trust continues to implement the new junior doctor contract and will become lead employer for GP trainees in the northern locality from April 2017.

Agency spend

6.7 NHS Improvement continues to update strict guidance and reducing caps on the amount each Trust can spend on agency staff. There is specific challenge in medical spend which will require further actions to deliver sustainability. From April 2017, IR35 rules and additional restrictions on engagement of agency will be introduced.

Staff bank

6.8 In July 2016 the Trust reviewed and revised its bank staffing provision, entering into a partnership with NHS Professionals, rather than NHS Professionals being the lead provider of bank staff. All bank staff are now engaged by the Trust and the provision aims to further reduce reliance on agency and further address agency spend.

Devon Cares

6.9 Following a competitive tendering exercise, Devon County Council awarded the primary contract for the delivery of domiciliary care services in North Devon, Torridge and Mid Devon to the Trust's Devon Cares service. We have been working with a number of established domiciliary care providers to develop a new approach to delivering care across Devon.

This five-year contract supports our vision of health and social care working better together to improve the lives of patients. We also believe that a more integrated service would benefit the Trust by helping us get people out of hospital more quickly when they are ready to go home, and reducing the number of people who are admitted in the first place.

Smartcare – electronic health record

6.10 Smartcare, the major development being undertaken by the Trust to revolutionise its patient computer systems, has been a significant project during the year – involving clinical staff throughout the Trust in its development, design and training. The programme launched a new inpatient electronic health record (TrakCare) in April 2017 and we expect to have a new community system (RiO) in place later in 2017.

Performance

6.11 Performance has generally been strong during 2016/17. Our performance against the various cancer targets improved steadily during the year, with almost consistent delivery against the 2-week, 31-day and 62-day targets. There remain some issues with breaches caused by patient choice, or those shared with other providers, but progress has been made in each area.

Performance against the ED four-hour flow target has been a challenge, with 94.26% of patients seen, admitted or treated and discharged within four hours over the year, against a national standard of 95%. However, this needs to be set against a national backdrop of worsening performance. The Trust has consistently been in the best quartile nationally, and for a number of months over the winter was in the top five-ten.

Performance against the referral to treatment target of 92% within 18 weeks has steadily deteriorated over the year, with the target being missed for the last four months of the year. The reasons for this are two-fold: demand (i.e. referrals) failed to reduce as anticipated (they increased), and resources were switched to ensure that emergency and cancer care services were protected.

Dr Alison Diamond, chief executive
Northern Devon Healthcare NHS Trust

Remuneration report

Introduction

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

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

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

A) Remuneration

2016-17

Name and title	(a)	(b)	(c)	(d)	(e)	(f)
	Salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	Performance pay and bonuses (bands of £5,000)	Long term performance pay and bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (a to e)
A Diamond – chief executive	170-175				30-32.5	200-205
A Robinson – director of finance and performance [1]	50-55				60-62.5	115-120
C Dart - acting director of finance [2]	55-60				47.5-50	100-105
R Sainsbury – director of operations [3]	55-60				87.5-90	145-150
G Thomson – medical director	195-200				52.5-55	250-255
N Ryley – director of nursing	100-105				150-152.5	250-255
I Roy – director of facilities	90-95				30-32.5	120-125
D Allcorn – director for workforce and development	100-105				30-32.5	130-135
A Ibbs – director of operations and strategy	105-110				7.52-30	135-140
R French – chairperson	15-20					15-20
P Geen – non-executive director	5-10					5-10
N Lewis – non-executive director	5-10					5-10
T Douglas-Riley – non-executive director	5-10					5-10
R Down – non-executive director	5-10					5-10
Tony Neal – non-executive director	5-10					5-10
Jonathan Broad – non-executive director	5-10					5-10

(1) The director of finance and performance left 26 August 2016
(2) The acting director of finance commenced on 1 September 2016
(3) The director of operations left 7 October 2016

Policy for remuneration of directors

The Trust's remuneration policy for executive directors observes the Department of Health's pay framework for very senior managers (VSMs) and all Trust VSM executive director salaries reflect the framework. There were no performance pay awards.

2015-16

Name and title	(a) Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500)	(f) TOTAL (a to e)
A Diamond – chief executive	165-170				75-77.5	245-250
A Robinson – director of finance and performance	130-135				27.5-30	160-165
R Sainsbury – director of operations	110-115				55-57.5	165-170
G Thomson – medical director	190-195				195-197.5	390-395
N Ryley – director of nursing (1)	45-50				112.5-115	160-165
I Roy – director of facilities	85-90				17.5-20	105-110
D Allcorn – director for workforce and development	100-105				142.5-145	240-245
A Ibbs – director of strategy and transformation	100-105				25-27.5	130-135
R French – chairperson	15-20					15-20
P Geen – non-executive director	5-10					5-10
N Lewis – non-executive director	5-10					5-10
T Douglas-Riley – non-executive director	5-10					5-10
R Down – non-executive director	5-10					5-10
Lesley Crawford (2)	0-5					0-5
Tony Neal (3)	0-5					0-5
Jonathan Broad (4)	0-5					0-5

(1) The director of nursing commenced 19 October 2015
(2) The non-executive left in October 2015
(3) The non-executive commenced in January 2016
(4) The non-executive commenced in February 2016

B) Pension Benefits

Name and title	2016-17								2015-16							
	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2017	Lump sum at age 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2016	Lump sum at age 60 related to accrued pension at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2016	Cash Equivalent Transfer Value at 31 March 2015	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
A Diamond - chief executive	0-2.5	5-7.5	30-35	9095	637	556	57	0	2.5-5	7.5-10	25-30	85-90	556	481	45	0
A Robinson - director of fnance and performance	2.5-5	7.5-10	40-45	125-130	931	841	82	0	0-2.5	2.5-5	40-45	120-125	841	799	13	0
C Dart - acting director of finance	0-2.5	2.5-5	15-20	45-50	278	228	43									
R Sainsbury - director of operations	0-2.5	2.5-5	25-30	65-70	357	300	49	0	2.5-5	0-2.5	20-25	60-65	300	271	12	0
Dr G Thomson - medical director	2.5-5	0-2.5	70-75	195-200	1,273	1,191	52	0	7.5-10	15-17.5	65-70	195-200	1,191	1,038	112	0
N Ryley - director of nursing	5-7.5	20-22.5	45-50	145-150	1,060	879	166	0	2.5-5	12.5-15	40-45	125-130	879	744	51	
I Roy - director of facilities	0-2.5	5-7.5	40-45	120-125	855	792	47	0	0-2.5	2.5-5	35-40	115-120	792	760	12	0
D Allcorn - director for workforce and development	0-2.5	0-2.5	25-30	70-75	391	359	18	0	5-7.5	12.5-15	25-30	70-75	359	273	69	0
A Ibbs - director of strategy and transformation	0-2.5	0-2.5	30-35	90-95	590	548	27	0	0-2.5	(0-2.5)	30-35	90-95	548	525	3	0

Notes:

(1) As non-executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for non-executive members.

(2) A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

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

(4) The Trust pension values are recorded using Consumer Price Index (CPI) rather than Retail Price Index (RPI) in previous years.

(5) For directors employed during the year, prior year figures not available.

(6) NHS Pensions have used existing factors effective on 15 March 2016 to calculate CETVs.

C) Fair pay multiples

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

The banded remuneration of the highest paid director in Northern Devon Healthcare NHS Trust in the financial year 2016-17 was £170,000 – £175,000 (2015-16 £170,000 – £175,000). This was 6.51 (2015-16 7.06) times the median remuneration of the workforce which was £26,302 (2015-16, £24,063).

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.

In 2016/17 0 (2016/16 0) employees received remuneration in excess of the highest paid director. Remuneration ranged from £15,000 – £175,000 (2015/16 £15,000 – £175,000).

During the year, the Trust's headcount reduced following the transfer of community services in eastern Devon to the Royal Devon and Exeter NHS Foundation Trust. A larger proportion of the staff transferred were lower paid staff and therefore the average salary this year is higher than last, hence the change in multiple.

D) Non-executive directors

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

Name	Appointment start date	Appointment end date
Roger French (chairman)	01.02.11	31.01.19
Nick Lewis^ (NED)	01.08.11	31.07.17
Pauline Geen* (NED)	03.03.11	02.03.19
Tim Douglas-Riley (NED)	28.05.13	27.05.17
Robert Down (NED)	09.02.15	08.02.19
Tony Neal (NED)	05.01.16	04.01.18
Jonathan Broad* (Associate NED)	01.02.16	31.01.18

^ Audit committee chair
* Audit committee member

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

E) Executive directors

Name	Position	Contract Type	Start date	Employment status
Alison Diamond	Chief executive	Permanent	01.05.14	
Andy Robinson	Director of finance and performance	Permanent	15.11.06	Left Trust 26.08.16
Colin Dart	Acting director of finance	Permanent	01.09.16	
Rob Sainsbury	Director of operations	Permanent	03.11.14	Left Trust 07.10.16
George Thomson	Medical director	Permanent	03.11.14	
Nicola Ryley	Director of nursing	Interim	19.10.15	Fixed term to 18.04.17
Iain Roy	Director of facilities	Permanent	19.04.99	
Darryn Allcorn	Director for workforce and development	Permanent	11.02.15	
Andy Ibbs	Director of strategy and transformation	Permanent	01.10.12	

Head of internal audit opinion

on the effectiveness of the system of internal control at Northern Devon Healthcare NHS Trust for the year ended 31 March 2017

Roles and responsibilities

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

The annual governance statement is an annual statement by the accounting officer, on behalf of the board, setting out:

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

The organisation's assurance framework should bring together all of the evidence required to support the annual governance statement requirements.

In accordance with Public Internal Audit Standards and the Core Principles for the Professional Practice of Internal Auditing, 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 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
The purpose of my annual HoIA opinion is to contribute to the assurances available to the accounting officer and the board which underpin the board's own assessment of the effectiveness of the organisation's system of internal control. This pinion will, in turn, assist the board in the completion of its annual governance statement, and may also be taken into account by the Care Quality Commission in relation to compliance with outcomes.

My opinion is set out as follows:

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

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

1. An assessment of the design and operation of the
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.

My **overall opinion** is that

Significant assurance can be given that, in general, there is a sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently. However, some weaknesses in the design and/or inconsistent application of controls put the achievement of particular objectives at risk.

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

In relation to this opinion, we have carefully considered:

- The significance of the 'assurance ratings' given in internal audit reports.
- The Trust's response to its latest CQC inspection. The Trust was rated as "requires improvement" in the November 2015 inspection. All actions arising from that report have completed by the Trust.

Internal audit's work has been taken forward in three broad categories. The following summarises the opinions and assurances from the reviews undertaken in these areas. We have included those audits for which we have issued a draft report and are awaiting responses from Trust management, as our work has concluded. The gradings provided for these reviews will not change and, therefore, there will be no change to the opinion on issuing these reports as final.

From 1st January 2017, we introduced a single revised assurance opinion rating more in line with the head of internal audit opinion statement ratings. As a result, some audits are reported under the previous ratings, whilst more recent reports will have just the single rating as indicated in the tables below.

Assurance framework – corporate governance and risk management

The table below details the work completed by internal audit on the Trust's risk management and corporate governance systems.

Audit	Assurance Rating	Impact Assessment
Risk Management	Significant	n/a
Board Assurance Report (BAR)	Significant	n/a

Risk management

The Trust's risk management arrangements have been developed into a strategy and a range of robust policies to provide a structure that is, in the main, aligned to national guidance. The Trust has a very good compliance rate for risk training across the Trust (95%). The Trust should undertake the self-assessment of compliance with mandatory NHS Digital standards for the TrakCare system. Work is still on-going within the Trust risk action plans, to include capturing "SMART" actions, improve the information reported to committees and to review risk monitoring arrangements.

Board assurance report (BAR)

The BAR links to Trust objectives and risks, and identifies gaps in assurance to delivering strategic objectives. The board receives timely BAR updates and assurances of the management of these risks.

Care Quality Commission actions

The Trust's methodology going forward to ensure preparedness for future CQC inspections has been modified to enable a more robust record of compliance throughout each core service area with the five CQC key questions (compliance register). Once complete, the outcomes from the self-assessments from wards, services and community sites and local service inspections contributing to the compliance register, should provide all the information required to demonstrate a level of compliance with regulations when inspected by CQC.

Financial assurance

The table below details the work completed by internal audit on the Trust's financial management systems.

Audit	Assurance rating	Impact assessment
CIP (cost improvement programme) (2015/16)	Green	Medium
High level financial controls	Green	Low
Cash and bank	Green	Low
Charitable funds	Green	Low
Payroll	Satisfactory	n/a

Cost improvement programme – August 2016

Overall, appropriate arrangements were in place with respect to most of the areas we reviewed regarding CIP. There was a consistent method for accounting for CIP savings and these had been reconciled and agreed to the general ledger. There was clear evidence of ownership of 2016/17 CIP. The landscape of governance around financial planning, delivery and transformational change is undergoing fundamental overhaul across the Devon health economy. Clearly considerable commitment will be necessary to deliver the challenging targets. There is clear evidence of this commitment, both at an operational and corporate level.

Cost improvement programme – (draft report)

Through appropriate management leadership and staff engagement, improved documentation and reporting processes, the Trust has appropriate governance arrangements in place which should assist with the delivery of its CIP for 2017/18. Weekly triumvirate (Tri-U) meetings feed into weekly executive meetings, which are supported by monthly budget performance meetings and formal fortnightly reporting to the executive meeting. The scheme lead and executive sponsor are being held responsible for 2017/18 CIP and the underlying divisional detail. A condensed project initiation document (PID) and quality impact assessment (QIA) have been developed to enhance and improve the process of summarising and controlling the scheme.

Devon STP Partnership – audit assurance

The Trust is a member of the Devon STP Partnership, the aim of which is to facilitate the 'creation of a clinically socially and financially sustainable health and care system that will improve health, wellbeing and care of the population' across Devon.

We were commissioned by the programme delivery executive group (PDEG) of the Devon STP Partnership to undertake a review to provide assurance as to the overall high level governance and reporting arrangements in place at the level of the Devon STP Partnership to progress this aim.

We concluded that these governance arrangements as at the end of February 2017 were, overall, fit for purpose. We suggested enhancements to the governance and risk management arrangements to support the work of the Devon STP Partnership moving forward and ensure these arrangements remain fit for purpose, continue to be effective and enable delivery of the STP plan supported by appropriate capacity.

In addition to the audit work above, we have undertaken a high level desktop review of how the Trust's arrangements for the delivery of savings plans align with the work of Devon STP Partnership. This focused on whether the Trust board is appropriately sighted on the work of the Devon STP Partnership, risk management arrangements, reporting of STP activity and alignment of delivery and savings plans with STP agreed plans.

This work concluded that the Trust board has been provided with regular briefings regarding the work carried out by the STP Partnership and in its governance arrangements and ratified the STP memorandum of understanding at the February board meeting. While a generic risk is recorded in the corporate risk register that the Trust may not meet its CIP savings targets, there is scope to consider how specific STP related risks are identified, captured and recorded within the corporate risk register.

While there is no formal reporting from the STP partnership to the Trust, regular STP updates have been provided to the board and other meetings. There is scope for the Trust to enhance the co-ordination of reports and assurances into the Trust to ensure that there is a formalised and co-ordinated view of the reporting of progress, assurances and risks.

The Trust's delivery and savings plans for 2016/17 aligned with STP and STP work streams.

ISAE3402 Third party assurance report in respect of IT general controls in respect of the Electronic Staff Record (ESR)

Awaiting the 2016/17 independent service auditor's report in respect of the general control operated by IBM in relation to the national Electronic Staff Record.

Corporate assurance

The table below details the work completed by internal audit on the Trust's corporate systems.

Audit	Assurance rating	Impact assessment
Medical devices (2015/16)	Amber	Medium
Violence and aggression	Amber	Medium
Local induction	Amber	Low
Theatre stock	Amber	Low
Infection control (inoculation injuries)	Amber	Low
Community services (Holsworthy Hospital, 2015/16)	Amber	Low
Complaints	Amber Green	Low
Dental service (2015/16)	Green	Low
Ward level drugs management	Satisfactory	
IGT requirement 604	Significant	
Duty of candour	Limited (draft)	
Senior doctor job planning	Satisfactory (draft)	

Medical devices – June 2016

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

Violence and aggression – February 2017

The Trust's arrangements for the management of violence and aggression have been developed over the previous four years by the local security manager (LSMS), supported by the health and safety manager and clinical staff. A range of Trust related policies have been developed to provide a structure that is, in the main, aligned to national guidance and the requirements of NHS Protect. Some improvements to the Trust's arrangements are required to include security training for volunteers and contractors, regular violent warning marker review, policy updates and security risk assessment reviews.

Ward level drugs management – May 2017

The Trust has completed all of the recommendations from our previous report within their detailed medicines management action plan. Improvements need to be made, that mainly apply to non-general wards (ED, maternity and theatres), re the security of drugs and storage of drugs ready for disposal.

Duty of candour (DoC) – (draft report)

Overall, the Trust's duty of candour policy is in line with national guidance. Documentation for DoC incidents has not been maintained, as required in respect of initial contact, follow-up meetings and investigation reports. Additionally, due to inadequate key data prompted on Datix, the Trust is unable to accurately report on the compliance, monitoring and evaluation of DoC incidents.

Senior doctor job planning – (draft report)

The Trust's senior doctor job planning policy is fit for purpose, however, arrangements for supporting job plans and confirming work undertaken is in line with jobs plans could be improved.

Other work

Information Governance (IG) Toolkit V14

This was a compliance review of the Trust's evidence to support the Information Governance Toolkit V14 self-assessment and no assurance rating was provided, however, the review provided an assessment of the evidence presented at a point in time, (February 2017), for 14 toolkit requirements.

We confirmed that the Trust's information governance (IG) team has a structured approach to reviewing and updating the evidence in the IG Toolkit. The quality of the underlying evidence being submitted was generally of a standard that would be compliant with the toolkit requirements by the required submission date.

Training in practice

In the areas we visited, Trust staff were aware of key elements of mandatory/statutory training, which have been put into practice within their work areas. We identified a small number of training areas where clarification may be required to improve staff understanding or staff implementation of training requirements.

Follow-up of recommendations

In respect of all reviews undertaken during the year, recommendations have been agreed with management to address gaps in control and assurance. We have monitored the status of these recommendations over the year and can report that recommendations are positively accepted and implemented. The audit committee and assurance committee has been informed of those recommendations which are outstanding.

Jenny McCall
Director of audit
Audit South West

Accounts

Statement of the chief executive's responsibilities as the accountable officer of the Trust

The chief executive of the NHS Trust Development Authority has designated that the chief executive should be the accountable officer to the Trust. The relevant responsibilities of accountable officers are set out in the accountable officers memorandum issued by the chief executive of the NHS Trust Development Authority. These include ensuring that:

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

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

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

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

NB: sign and date in any colour ink except black

Signed ....
Chief executive

Date 25/5/17

Statement of directors' responsibilities in respect of the accounts

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

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

The directors are responsible for keeping proper accounting records which disclose with reasonable accuracy at any time the financial position of the Trust and to enable them to ensure that the accounts comply with requirements outlined in the above mentioned direction of the Secretary of State. They are also responsible for safeguarding the assets of the Trust and hence for taking reasonable steps for the prevention and detection of fraud and other irregularities.

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

By order of the board

NB: sign and date in any colour ink except black

25/5/17 Date

.... Chief executive

25.5.17 Date

.... Finance director

INDEPENDENT AUDITOR'S REPORT TO THE BOARD OF DIRECTORS OF NORTHERN DEVON HEALTHCARE NHS TRUST

We have audited the financial statements of Northern Devon Healthcare NHS Trust for the year ended 31 March 2017 on pages 4 to 35 under the Local Audit and Accountability Act 2014. These financial statements have been prepared under applicable law and the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to NHS Trusts in England. We have also audited the information in the Remuneration and Staff Report that is subject to audit.

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

Respective responsibilities of Directors, the Accountable Officer and auditor

As explained more fully in the Statement of Directors' Responsibilities set out on page 72 , the Directors are responsible for the preparation of financial statements which give a true and fair view. Our responsibility is to audit, and express an opinion on, the financial statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require us to comply with the Auditing Practices Board's Ethical Standards for Auditors.

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

We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Scope of the audit of the financial statements

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

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

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2016, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Opinion on financial statements

In our opinion the financial statements:

- ive a true and fair view of the financial position of the Trust as at 31 March 2017 and of the Trust's expenditure and income for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the

Opinion on other matters

In our opinion:

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

Matters on which we are required to report by exception

We are required to report to you if:

- in our opinion the governance statement does not comply with the Department of Health Group Accounting Manual 2016/17; or
- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014; or
- we are not satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2017.

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

Certificate

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

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

30 May 2017

Northern Devon Healthcare NHS Trust - Annual Accounts 2016-17

Statement of Comprehensive Income for year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Gross employee benefits	9.1	**(137,797)**	(159,549)
Other operating costs	7	**(77,260)**	(76,503)
Revenue from patient care activities	4	**198,749**	219,045
Other operating revenue	5	**18,831**	14,190
Operating surplus/(deficit)		**2,523**	(2,817)
Investment revenue	11	**12**	18
Other gains and (losses)	12	**2**	133
Finance costs	13	**(1,199)**	(1,244)
Surplus/(deficit) for the financial year		**1,338**	(3,910)
Public dividend capital dividends payable		**(2,941)**	(3,761)
Transfers by absorption - (losses)		**(51,526)**	0
Net Gain/(loss) on transfers by absorption		**(51,526)**	0
Retained surplus/(deficit) for the year		**(53,129)**	(7,671)

Other Comprehensive Income

	2016-17 £000s	2015-16 £000s
Impairments and reversals taken to the revaluation reserve	**504**	375
Net gain/(loss) on revaluation of property, plant & equipment	**555**	4,315
Total comprehensive income for the year	**(52,070)**	(2,981)

Financial performance for the year

Retained surplus/(deficit) for the year		**(53,129)**	(7,671)
IFRIC 12 adjustment (including IFRIC 12 impairments)	38	**1,702**	463
Impairments (excluding IFRIC 12 impairments)	17	**1,950**	2,132
Adjustments in respect of donated gov't grant asset reserve elimination		**183**	429
Adjustment re absorption accounting		**51,526**	0
Adjusted retained surplus/(deficit)		**2,232**	(4,647)

The notes on pages 8 to 35 form part of this account.

On 1st October 2016 communtiy services in Eastern Devon transferred to Royal Devon and Exeter Foundation Trust. The transfer was cost neutral to the Trust, however income and expenditure will have an equal reduction of £47.4m per annum.

Northern Devon Healthcare NHS Trust - Annual Accounts 2016-17

Statement of Financial Position as at 31 March 2017

	NOTE	**31 March 2017** £000s	31 March 2016 (restated) £000s
Non-current assets:			
Property, plant and equipment	15	**83,955**	136,027
Intangible assets	16	**8,052**	6,194
Trade and other receivables	21.1	**1,110**	971
Total non-current assets		**93,117**	143,192
Current assets:			
Inventories	20	**3,094**	3,496
Trade and other receivables	21.1	**11,062**	8,956
Cash and cash equivalents	25	**1,602**	1,291
Sub-total current assets		**15,758**	13,743
Non-current assets held for sale	26	**0**	201
Total current assets		**15,758**	13,944
Total assets		**108,875**	157,136
Current liabilities			
Trade and other payables	27	**(19,083)**	(19,342)
Provisions	34	**(19)**	(30)
Borrowings	29	**(1,052)**	(697)
Total current liabilities		**(20,154)**	(20,069)
Net current assets/(liabilities)		**(4,396)**	(6,125)
Total assets less current liabilities		**88,721**	137,067
Non-current liabilities			
Borrowings	29	**(9,669)**	(10,065)
DH revenue support loan	29	**(6,517)**	(4,667)
Total non-current liabilities		**(16,186)**	(14,762)
Total assets employed:		**72,535**	122,305
FINANCED BY:			
Public Dividend Capital		**55,040**	52,740
Retained earnings		**3,370**	34,418
Revaluation reserve		**14,125**	35,147
Total Taxpayers' Equity:		**72,535**	122,305

The notes on pages 8 to 35 form part of this account.

The financial statements on pages 4 to 6 were approved by the Board on 25th May 2017 and signed on its behalf by

Chief Executive: [signature] Date: 25/5/17

Statement of Changes in Taxpayers' Equity
For the year ending 31 March 2017

	Public Dividend capital	Retained earnings	Revaluation reserve	Other reserves	Total reserves
	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**52,740**	**34,418**	**35,147**	**0**	**122,305**
Changes in taxpayers' equity for 2016-17					
Retained surplus/(deficit) for the year		(53,129)			**(53,129)**
Net gain / (loss) on revaluation of property, plant, equipment			555		**555**
Impairments and reversals			504		**504**
Transfers between reserves		41	(41)	0	**0**
Reclassification Adjustments					
Transfers between Reserves in respect of assets transferred under absorption	0	22,040	(22,040)	0	**0**
Temporary and permanent PDC received - cash	2,948				**2,948**
Temporary and permanent PDC repaid in year	(648)				**(648)**
Net recognised revenue/(expense) for the year	**2,300**	**(31,048)**	**(21,022)**	**0**	**(49,770)**
Balance at 31 March 2017	**55,040**	**3,370**	**14,125**	**0**	**72,535**
Balance at 1 April 2015	**55,040**	**40,356**	**32,190**	**0**	**127,586**
Changes in taxpayers' equity for the year ended 31 March 2016					
Retained surplus/(deficit) for the year		(7,671)			(7,671)
Net gain / (loss) on revaluation of property, plant, equipment			4,315		4,315
Impairments and reversals			375		375
Transfers between reserves		1,733	(1,733)	0	0
Reclassification Adjustments					
PDC repaid in year	(2,300)				(2,300)
Net recognised revenue/(expense) for the year	**(2,300)**	**(5,938)**	**2,957**	**0**	**(5,281)**
Balance at 31 March 2016	**52,740**	**34,418**	**35,147**	**0**	**122,305**

The accompanying notes form part of these financial statements.

Northern Devon Healthcare NHS Trust - Annual Accounts 2016-17

Statement of Cash Flows for the Year ended 31 March 2017

	NOTE	**2016-17 £000s**	2015-16 £000s
Cash Flows from Operating Activities			
Operating surplus/(deficit)		**2,523**	(2,817)
Depreciation and amortisation	7	**7,396**	8,259
Impairments and reversals	17	**1,950**	2,132
(Increase)/Decrease in Inventories		**297**	(364)
(Increase)/Decrease in Trade and Other Receivables		**(2,332)**	3,036
Increase/(Decrease) in Trade and Other Payables		**(624)**	(547)
Provisions utilised		**(13)**	(34)
Increase/(Decrease) in movement in non cash provisions		**(28)**	5
Net Cash Inflow/(Outflow) from Operating Activities		**9,169**	9,670
Cash Flows from Investing Activities			
Interest Received		**12**	18
(Payments) for Property, Plant and Equipment		**(6,410)**	(8,388)
(Payments) for Intangible Assets		**(2,458)**	(3,120)
Proceeds of disposal of assets held for sale (PPE)		**0**	1,010
Net Cash Inflow/(Outflow) from Investing Activities		**(8,856)**	(10,480)
Net Cash Inflow / (outflow) before Financing		**313**	(810)
Cash Flows from Financing Activities			
Gross Temporary and Permanent PDC Received		**2,948**	0
Gross Temporary and Permanent PDC Repaid		**(648)**	(2,300)
Loans received from DH - New Revenue Support Loans		**8,984**	16,667
Other Loans Received		**404**	2,441
Loans repaid to DH - Working Capital Loans/Revenue Support Loans		**(7,134)**	(12,000)
Other Loans Repaid		**(104)**	0
Cash transferred to NHS Foundation Trusts or on dissolution		**(3)**	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		**(341)**	(292)
Interest paid		**(1,185)**	(1,245)
PDC Dividend (paid)/refunded		**(2,923)**	(3,620)
Net Cash Inflow/(Outflow) from Financing Activities		**(2)**	(349)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		**311**	(1,159)
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		**1,291**	2,450
Cash and Cash Equivalents (and Bank Overdraft) at year end	**25**	**1,602**	1,291

The accompanying notes form part of these financial statements.

Northern Devon Healthcare NHS Trust - Annual Accounts 2016-17

Information on reserves

1 **Public dividend capital**
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities. Additional PDC may also be issued to NHS trusts by the Department of Health. A charge, reflecting the cost of capital utilised by the NHS Trust, is payable to the Department of Health as the public dividend capital dividend.

2 **Income and expenditure reserve**
The balance of this reserve is the accumulated surpluses and deficits of the NHS trust.

3 **Revaluation Reserve**
Increases in asset values arising from revaluations are recognised in the revaluation reserve, except where, and to the extent that, they reverse impairments previously recognised in operating expenses, in which case they are recognised in operating income. Subsequent downward movements in asset valuations are charged to the revaluation reserve to the extent that a previous gain was recognised unless the downward movement represents a clear consumption of economic benefit or a reduction in service potential.

4 **Other reserves**
The Trust has no other reserves.

Northern Devon Healthcare NHS Trust - Annual Accounts 2016-17

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the Department of Health Group Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the DH Group Manual for Accounts 2016-17 issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items

1.1 Accounting convention

These accounts have been prepared under the historical cost convention modified to account for the revaluation of property, plant and equipment, intangible assets, inventories and certain financial assets and financial liabilities.

1.2 Acquisitions and discontinued operations

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

1.3 Movement of assets within the DH Group

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

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

1.4 Charitable Funds

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

1.5 Pooled Budgets

The Trust does not have any pooled budget arrangements.

1.6 Critical accounting judgements and key sources of estimation uncertainty

In the application of the NHS trust’s accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and

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.
Property is valued by the District Valuer using his professional judgement as detailed in note 1.10 and note 15.

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

NOTES TO THE ACCOUNTS

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total length of stay/costs incurred to date compared to total expected costs.

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

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

1.8 Employee Benefits

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

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. The schemes are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, the schemes are accounted for as though they were defined contribution schemes: the cost to the NHS body of participating in a 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 NHS 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 NHS trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and either
- the item cost at least £5,000; or
- Collectively, a number of items have a total 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.
- 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

NOTES TO THE ACCOUNTS

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. Assets that are held for their service potential and are in use are measured subsequently at their current value in existing use. Assets that were most recently held for their service potential but are surplus are measured at fair value where there are no restrictions preventing access to the market at the reporting

Revaluations of property, plant and equipment 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. Current values in existing use are determined as follows:
● Land and non-specialised buildings – market value for existing use.
● Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

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 cost. Software that is integral to the operation 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
● 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

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.

NOTES TO THE ACCOUNTS

Following initial recognition, intangible assets are carried at current value in existing use by reference to an active market, or, where no active market exists, at the lower of amortised replacement cost (modern equivalent assets basis) and value in use where the asset is income generating. 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, assets under construction or development, and assets held for sale are not depreciated/amortised.

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

At each financial year-end, the NHS trust checks whether there is any indication that its property, plant and equipment or intangible non-current assets have suffered an impairment loss. If there is indication of such an impairment, 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 at the financial year end.

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 are 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

1.13 Donated assets

Donated non-current assets are capitalised at current value in existing use if they will be held for their service potential, or otherwise at 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 treated in the same way as for purchased assets. Deferred income is recognised only where conditions attached to the donation

1.14 Government grants

Government grant funded assets are capitalised at current value in existing use if they will be held for their service potential, or otherwise at fair value on receipt, with a matching credit to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

1.15 Non-current assets held for sale

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

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

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

1.16 Leases

NOTES TO THE ACCOUNTS

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 of interest on the remaining balance of the liability. Finance charges are recognised in

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

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

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

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

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

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

The annual unitary payment is separated into the following component parts, using appropriate estimation techniques where necessary:
a) Payment for the fair value of services received;
b) Payment for the PFI asset, including finance costs; and
c) Payment for the replacement of components of the asset during the contract 'lifecycle replacement'.

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

PFI Asset
The PFI assets are recognised as property, plant and equipment, when they come into use. The assets are measured initially at fair value or, if lower, at the present value of the minimum lease payments, in accordance with the principles of IAS 17. Subsequently, the assets are measured at current value in existing use.

1.17 Private Finance Initiative (PFI) transactions continued

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

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

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

NOTES TO THE ACCOUNTS

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

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

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

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

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

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

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

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

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

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

Early retirement provisions are discounted using HM Treasury's pension discount rate of positive 0.24% (2015-16: positive 1.37%) in real terms. All other provisions are subject to three separate discount rates according to the expected timing of cashflows from the Statement of Financial Position date:
• A short term rate of negative 2.70% (2015-16: negative 1.55%) for expected cash flows up to and including 5 years including 10 years
• A long term rate of negative 0.80% (2015-16: negative 0.80%) for expected cash flows over 10 years.

All percentages are in real terms.

NOTES TO THE ACCOUNTS

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

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

1.21 Clinical negligence costs

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

1.22 Non-clinical risk pooling

The NHS trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the NHS trust pays an annual contribution to the NHS Litigation Authority and, in return, receives assistance with the costs of claims arising. The annual membership contributions, and any excesses payable in respect of particular claims are charged to operating expenses as and when they become due.

1.23 Carbon Reduction Commitment Scheme (CRC)

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

1.24 Contingencies

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

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

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

1.25 Financial assets

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

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

Financial assets at fair value through profit and loss

The Trust has no material contracts that contain embedded derivatives.

1.25 Financial assets continued

Held to maturity investments

The Trust has no held to maturity investments.

NOTES TO THE ACCOUNTS

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 NHS trust assesses whether any financial assets, other than those held at 'fair value through profit and loss' are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced

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

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

Financial guarantee contract liabilities
The trust has no financial guarantee liabilities.

Financial liabilities at fair value through profit and loss
The Trust has no material contract liabilities that contain embedded derivatives.

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

1.27 Value Added Tax
Most of the activities of the trust are outside the scope of VAT and, in general, output tax does not apply and input tax on purchases is not recoverable. Irrecoverable VAT is charged to the relevant expenditure category or included in the capitalised purchase cost of fixed assets. Where output tax is charged or input VAT is recoverable, the amounts are

1.28 Foreign currencies
The NHS trust's functional 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

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

1.30 Public Dividend Capital (PDC) and PDC dividend

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

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

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

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 the NHS trust not been bearing its own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

The Trust has no subsidiaries.

1.33 Associates

The Trust has no associates.

1.34 Joint arrangements

The Trust has no joint ventures.

1.35 Research and Development

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

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

The HM Treasury FReM does not require the following Standards and Interpretations to be applied in 2016-17. These standards are still subject to HM Treasury FReM interpretation, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 still subject to HM Treasury consideration.

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

1.37 Gifts

The Trust has no gifts.

1.38 Going Concern

These accounts have been prepared on a going concern basis

NOTES TO THE ACCOUNTS

The Trust achieved a surplus of £2.232m this year (2016: £4.647m deficit) and its net current liabilities are £4.396m as at 31.03.17 (2016: Net current liabilities £6.125m) which demonstrates the Trust's strong financial controls in improving its position and achieving its control total.

The most significant future risk to the Trust is the unknown impact of the strategic collaborative programme of work through the System Transformation Partnership (STP) in Devon and the pace to which the STP organisations are required to respond to meet the control totals issued through the NHS mandate for 2017/18.

It is reasonable to assume that the STP organisations will make sufficient cash management plans such that the individual organisations will be able to meet their current liabilities, and therefore supports the Trust view that the accounts are prepared on a going concern basis.

Therefore, there are material uncertainties related to external events or conditions that may cast significant doubt about the Trust's ability to continue as a going concern but the going concern basis remains appropriate.

2. Pooled budget

The Trust has no pooled budgets.

2.1 Operating segments

The Trust has considered the requirements in IFRS8 for segmental analysis. Having reviewed the operating
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 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	
	2016-17	2015-16	**2016-17**	2015-16
	£000s	£000s	**£000s**	£000s
Income	**217,580**	233,235	**217,580**	233,235
Surplus/(Deficit)				
Common costs	**(216,242)**	(237,145)	**(216,242)**	(237,145)
Surplus/(deficit) before interest	1,338	(3,910)	**1,338**	(3,910)
Net Assets:				
Segment net assets	**71,906**	122,305	**71,906**	122,305

3. Income generation activities

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

4. Revenue from patient care activities

	2016-17	2015-16
	£000s	£000s
NHS Trusts	**96**	78
NHS England	**18,327**	17,578
Clinical Commissioning Groups	**166,623**	187,566
Foundation Trusts	**229**	330
Department of Health	**26**	0
Additional income for delivery of healthcare services	**0**	2,300
Non-NHS:		
Local Authorities	**12,496**	10,054
Private patients	**437**	322
Overseas patients (non-reciprocal)	**27**	12
Injury costs recovery	**334**	732
Other Non-NHS patient care income	**154**	73
Total Revenue from patient care activities	**198,749**	219,045

5. Other operating revenue

	2016-17	2015-16
	£000s	£000s
Recoveries in respect of employee benefits	**751**	1,153
Patient transport services	**20**	279
Education, training and research	**4,347**	5,221
Charitable and other contributions to revenue expenditure -non- NHS	**223**	241
Receipt of charitable donations for capital acquisitions	**219**	132
Non-patient care services to other bodies	**3,894**	4,692
Sustainability & Transformation Fund Income	**4,415**	0
Income generation (Other fees and charges)	**948**	952
Other revenue	**4,014**	1,520
Total Other Operating Revenue	**18,831**	14,190
Total operating revenue	**217,580**	233,235

6. Overseas Visitors Disclosure

2016-17	2015-16
£000s	£000s

Income recognised during 2016-17 (invoiced amounts and accruals)	**27**	**12**
Cash payments received in-year (re receivables at 31 March 2016)	**2**	**9**
Cash payments received in-year (iro invoices issued 2016-17)	**14**	**11**
Amounts written off in-year (irrespective of year of recognition)	**6**	**3**

7. Operating expenses

	2016-17 £000s	2015-16 £000s
Services from other NHS Trusts	**199**	776
Services from CCGs/NHS England	**33**	67
Services from NHS Foundation Trusts	**3,022**	3,580
Total Services from NHS bodies*	**3,254**	4,423
Purchase of healthcare from non-NHS bodies	**332**	48
Purchase of Social Care	**4,401**	**0**
Trust Chair and Non-executive Directors	**57**	49
Supplies and services - clinical	**32,635**	32,206
Supplies and services - general	**6,926**	7,225
Consultancy services	**0**	86
Establishment	**4,301**	5,505
Transport	**115**	329
Service charges - ON-SOFP PFIs and other service concession arrangements	**375**	394
Business rates paid to local authorities	**1,142**	1252
Premises	**6,887**	8,606
Hospitality	**66**	63
Insurance	**148**	2
Legal Fees	**334**	345
Impairments and Reversals of Receivables	**64**	30
Depreciation	**6,645**	7,546
Amortisation	**751**	713
Impairments and reversals of property, plant and equipment	**1,924**	2,102
Impairments and reversals of intangible assets	**26**	0
Impairments and reversals of non current assets held for sale	**0**	30
Internal Audit Fees	**156**	110
Audit fees	**48**	57
Other auditor's remuneration [Quality Account]	**12**	12
Clinical negligence	**4,871**	3,967
Education and Training	**1,031**	990
Other	**759**	413
Total Operating expenses (excluding employee benefits)	**77,260**	76,503
Employee Benefits		
Employee benefits excluding Board members	**136,626**	158,293
Board members	**1,171**	1,256
Total Employee Benefits	**137,797**	159,549
Total Operating Expenses	**215,057**	236,052

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

8. Operating Leases

8.1. Northern Devon Healthcare NHS Trust as lessee

	Land £000s	**Buildings £000s**	**Other £000s**	**2016-17 Total £000s**	2015-16 £000s
Payments recognised as an expense					
Minimum lease payments				**334**	456
Total				**334**	456
Payable:					
No later than one year	0	0	151	**151**	329
Between one and five years	0	0	149	**149**	238
After five years	0	0	0	**0**	0
Total	**0**	**0**	**300**	**300**	567

8.2. Northern Devon Healthcare NHS Trust as lessor

The trust has no lessor agreements.

9. Employee benefits

9.1. Employee benefits

	2016-17 Total £000s	2015-16 Total £000s
Employee Benefits - Gross Expenditure		
Salaries and wages	**118,424**	138,917
Social security costs	**9,630**	9,632
Employer Contributions to NHS BSA - Pensions Division	**13,115**	14,742
Other pension costs	**10**	0
Termination benefits	**0**	0
Total employee benefits	**141,179**	163,291
Employee costs capitalised	**3,382**	3,742
Gross Employee Benefits excluding capitalised costs	**137,797**	159,549

9.2. Retirements due to ill-health

	2016-17 Number	2015-16 Number
Number of persons retired early on ill health grounds	**1**	4
	£000s	£000s
Total additional pensions liabilities accrued in the year	**8**	196

9.3 Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State in England and Wales. They are not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities. Therefore, each scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in each scheme is taken as equal to the contributions payable to that scheme for the accounting period.

In order that the defined benefit obligations recognised in the financial statements do not differ materially from those that would be determined at the reporting date by a formal actuarial valuation, the FReM requires that “the period between formal valuations shall be four years, with approximate assessments in intervening years”. An outline of these follows:

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary’s Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and are accepted as providing suitably robust figures for financial reporting purposes. The valuation of scheme liability as at 31 March 2017, is based on valuation data as 31 March 2016, updated to 31 March 2017 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the scheme actuary report, which forms part of the annual NHS Pension Scheme (England and Wales) Pension Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation
The purpose of this valuation is to assess the level of liability in respect of the benefits due under the schemes (taking into account their recent demographic experience), and to recommend contribution rates payable by employees and employers.

The last published actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2012. The Scheme Regulations allow for the level of contribution rates to be changed by the Secretary of State for Health, with the consent of HM Treasury, and consideration of the advice of the Scheme Actuary and appropriate employee and employer representatives as deemed appropriate.

The next actuarial valuation is to be carried out as at 31 March 2016. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this ‘employer cost cap’ assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health after consultation with the relevant stakeholders.

10. Better Payment Practice Code

10.1. Measure of compliance

	2016-17 Number	**2016-17 £000s**	2015-16 Number	2015-16 £000s
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	**67,509**	**77,983**	62,322	73,561
Total Non-NHS Trade Invoices Paid Within Target	**46,701**	**62,345**	50,707	62,144
Percentage of NHS Trade Invoices Paid Within Target	**69.18%**	**79.95%**	81.36%	84.48%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	**1,807**	**74,936**	2,143	**85,636**
Total NHS Trade Invoices Paid Within Target	**1,055**	**68,904**	1,597	**78,928**
Percentage of NHS Trade Invoices Paid Within Target	**58.38%**	**91.95%**	74.52%	92.17%

The Better Payment Practice Code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later. Trusts are expected to achieve a 95% compliance with this policy.

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

	2016-17 £000s	2015-16 £000s
Amounts included in finance costs from claims made under this legislation	**6**	17
Total	**6**	17

11. Investment Revenue

	2016-17 £000s	2015-16 £000s
Interest revenue		
Bank interest	**12**	18
Subtotal	**12**	18
Total investment revenue	**12**	18

12. Other Gains and Losses

	2016-17 £000s	2015-16 £000s
Gain/(Loss) on disposal of assets other than by sale (PPE)	**2**	**1**
Gain (Loss) on disposal of assets held for sale	**0**	**132**
Total	**2**	133

13. Finance Costs

	2016-17 £000s	2015-16 £000s
Interest		
Interest on loans and overdrafts	**159**	**185**
Interest on obligations under PFI contracts:		
- main finance cost	**628**	**650**
- contingent finance cost	**406**	**392**
Interest on obligations under LIFT contracts:		
Interest on late payment of commercial debt	**6**	**17**
Total interest expense	**1,199**	1,244
Total	**1,199**	1,244

14. Auditor Disclosures

14.1. Other auditor remuneration

	2016-17 £000s	2015-16 £000s
Other auditor remuneration paid to the external auditor:		
Other non-audit services	**12**	12
Total	**12**	**12**

This relates to the quality account audit with year

14.2. Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2016/17 or 2015/16.

15.1. Property, plant and equipment

2016-17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	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
Cost or valuation:									
At 1 April 2016	18,976	106,506	571	1,380	21,902	27	5,689	679	**155,730**
Additions of Assets Under Construction				3,031					**3,031**
Additions Purchased	0	2,680	7		572	0	146	0	**3,405**
Additions - Non Cash Donations (i.e. physical assets)	0	0	0	0	0	0	0	0	**0**
Additions - Purchases from Cash Donations & Government Grants	0	16	0	0	203	0	0	0	**219**
Additions Leased (including PFI/LIFT)	0	0	0		0	0	0	0	**0**
Reclassifications	0	1,171	0	(1,183)	12	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	(2,363)	(15)	(424)	(19)	**(2,821)**
Revaluation	0	(3,045)	(37)	0	0	0	0	0	**(3,082)**
Impairments/reversals charged to operating expenses	0	(1,667)	(17)	0	(404)	0	0	(7)	**(2,095)**
Impairments/reversals charged to reserves	0	504	0	0	0	0	0	0	**504**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0	0	0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	(11,446)	(39,068)	0	0	(1,495)	0	(206)	(43)	**(52,258)**
At 31 March 2017	**7,530**	**67,097**	**524**	**3,228**	**18,427**	**12**	**5,205**	**610**	**102,633**
Depreciation									
At 1 April 2016	0	0	0		16,400	27	3,035	241	**19,703**
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		(2,363)	(15)	(424)	(19)	**(2,821)**
Revaluation	0	(3,568)	(69)		0	0	0	0	**(3,637)**
Impairment/reversals charged to reserves	0	0	0		0	0	0	0	**0**
Impairments/reversals charged to operating expenses	0	0	0		(165)	0	0	(6)	**(171)**
Charged During the Year	0	3,568	69		1,958	0	983	67	**6,645**
Transfers to NHS Foundation Trust on authorisation as FT	0	0	0		0	0	0	0	**0**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	0	0		(905)	0	(126)	(10)	**(1,041)**
At 31 March 2017	**0**	**0**	**0**	**0**	**14,925**	**12**	**3,468**	**273**	**18,678**
Net Book Value at 31 March 2017	**7,530**	**67,097**	**524**	**3,228**	**3,502**	**0**	**1,737**	**337**	**83,955**
Asset financing:									
Owned - Purchased	7,530	49,703	524	3,228	3,152	0	1,735	259	**66,131**
Owned - Donated	0	2,926	0	0	350	0	2	78	**3,356**
Owned - Government Granted	0	0	0	0	0	0	0	0	**0**
Held on finance lease	0	0	0	0	0	0	0	0	**0**
On-SOFP PFI contracts	0	14,468	0	0	0	0	0	0	**14,468**
PFI residual interests	0	0	0	0	0	0	0	0	**0**
Total at 31 March 2017	**7,530**	**67,097**	**524**	**3,228**	**3,502**	**0**	**1,737**	**337**	**83,955**

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	Assets under construction & payments on account	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 2016	6,874	27,404	255	0	123	0	0	4	**34,660**
Valuation changes	(6,373)	(14,046)	(60)	0	(54)	0	0	(2)	**(20,535)**
At 31 March 2017	**501**	**13,358**	**195**	**0**	**69**	**0**	**0**	**2**	**14,125**

Additions to Assets Under Construction in 2016-17

Buildings excl Dwellings	3,031
Balance as at YTD	**3,031**

15.2. Property, plant and equipment prior-year

2015-16

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	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
Cost or valuation:									
At 1 April 2015	18,976	102,554	570	48	22,272	32	5,867	700	**151,019**
Additions of Assets Under Construction				3,591					**3,591**
Additions Purchased	0	3,113	22		599	0	395	(7)	**4,122**
Additions - Purchases from Cash Donations & Government Grants	0	0	0	0	81	0	0	51	**132**
Reclassifications as Held for Sale and Reversals	0	(17)	0	0	0	0	0	0	**(17)**
Disposals other than for sale	0	0	0	0	(1,050)	(5)	(573)	(65)	**(1,693)**
Revaluation	0	(1,724)	(75)	0	0	0	0	0	**(1,799)**
Impairments/reversals charged to operating expenses	0	321	54	0	0	0	0	0	**375**
At 31 March 2016	**18,976**	**106,506**	**571**	**1,380**	**21,902**	**27**	**5,689**	**679**	**155,730**
Depreciation									
At 1 April 2015	0	0	0		15,008	26	2,589	233	**17,856**
Disposals other than for sale	0	0	0		(1,044)	(5)	(573)	(65)	**(1,687)**
Revaluation	0	(6,039)	(75)		0	0	0	0	**(6,114)**
Impairments/reversals charged to operating expenses	0	2,096	6		0	0	0	0	**2,102**
Charged During the Year	0	3,943	69		2,436	6	1,019	73	**7,546**
At 31 March 2016	**0**	**0**	**0**	**0**	**16,400**	**27**	**3,035**	**241**	**19,703**
Net Book Value at 31 March 2016	**18,976**	**106,506**	**571**	**1,380**	**5,502**	**0**	**2,654**	**438**	**136,027**
Asset financing:									
Owned - Purchased	18,376	81,975	571	1,380	5,020	0	2,651	329	**110,302**
Owned - Donated	600	9,691	0	0	482	0	3	109	**10,885**
On-SOFP PFI contracts	0	14,840	0	0	0	0	0	0	**14,840**
Total at 31 March 2016	**18,976**	**106,506**	**571**	**1,380**	**5,502**	**0**	**2,654**	**438**	**136,027**

16. Intangible non-current assets

16.1. Intangible non-current assets

2016-17	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated	Intangible Assets Under Construction	Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
At 1 April 2016	**0**	**3,288**	**1,804**	**0**	**4,321**	**0**	**9,413**
Additions Purchased	0	171	51	0	2,413	0	**2,635**
Disposals other than by sale	0	(90)	0	0	(23)	0	**(113)**
Impairments/reversals charged to operating expenses	0	(26)	0	0	0	0	**(26)**
At 31 March 2017	**0**	**3,343**	**1,855**	**0**	**6,711**	**0**	**11,909**
Amortisation							
At 1 April 2016	**0**	**2,073**	**1,072**	**0**	**74**		**3,219**
Disposals other than by sale	**0**	**(90)**	**0**	**0**	**(23)**		**(113)**
Charged During the Year	**0**	**510**	**233**	**0**	**8**		**751**
At 31 March 2017	**0**	**2,452**	**1,346**	**0**	**59**	**0**	**3,857**
Net Book Value at 31 March 2017	**0**	**891**	**509**	**0**	**6,652**	**0**	**8,052**
Asset Financing: Net book value at 31 March 2017 comprises:							
Purchased	0	891	508	0	6,652	0	**8,051**
Donated	0	0	1	0	0	0	**1**
Total at 31 March 2017	**0**	**891**	**509**	**0**	**6,652**	**0**	**8,052**

16.2. Intangible non-current assets prior year

2015-16	IT - in-house & 3rd party software	Computer Licenses	Licenses and Trademarks	Patents	Development Expenditure - Internally Generated		Total
	£000's	£000's	£000's	£000's	£000's	£000's	£000's
Cost or valuation:							
At 1 April 2015	0	3,268	1,581	0	1,962	0	**6,811**
Additions - purchased	0	20	251	0	2,359	0	**2,630**
Disposals other than by sale	0	0	(28)	0	0	0	**(28)**
At 31 March 2016	**0**	**3,288**	**1,804**	**0**	**4,321**	**0**	**9,413**
Amortisation							
At 1 April 2015	0	1,580	895	0	59	0	**2,534**
Disposals other than by sale	0	0	(28)	0	0	0	**(28)**
Charged during the year	0	493	205	0	15	0	**713**
At 31 March 2016	**0**	**2,073**	**1,072**	**0**	**74**	**0**	**3,219**
Net book value at 31 March 2016	**0**	**1,215**	**732**	**0**	**4,247**	**0**	**6,194**
Net book value at 31 March 2016 comprises:							
Purchased	0	1,215	732	0	4,247	0	**6,194**
Total at 31 March 2016	0	1,215	732	0	4,247	0	**6,194**

16.3. Intangible non-current assets

Intangible assets are carried at cost

Economic lives of Intangible assets	**Min life Years**	**Max life Years**
Software Licences	5	5
Licences and trademarks	5	5

15.3. (cont). Property, plant and equipment

Transfer by absorption costing relates to the transfer of community services in Eastern Devon to the Royal Devon and Exeter Foundation Trust. Services transferred with effect from 1st October 2016 and the property subsequently transferred to NHS Property Services Ltd on 1st December 2016. Tiverton Hospital remains on the Trust's balance sheet due to the nature of the PFI liability and is expected to transfer during 2017/18.

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

All land and buildings are restated to current modern equivalent asset value using professional valuations in accordance with IAS16 every five years and in the intervening years by annual desk top exercise undertaken by the District Valuer, an arm of the Valuation Office, which is an executive agency of HM Revenue and Customs. A professional valuation from D Corbett MRICS, District Valuer has been undertaken at the end of the year and the revaluation has been applied to all land and buildings. The District Valuer undertook a full revaluation on 31st March 2015 of all land and buildings and the next full valuation will be due on 31st March 2020. Asset values have overall increased this year by £959,000.

Economic lives of PPE	**Min life Years**	**Max life Years**
Software Licences	5	5
Licences and trademarks	5	5
Development Expenditure	5	5
IT - in house & 3rd Party Software	5	5
Buildings excl dwellings	2	75
Dwellings	5	38
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	3	5
Furniture and Fittings	10	10

20. Inventories

	Drugs	Consumables	Work in Progress	Energy	Loan Equipment	Other	Total	Of which held at NRV
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	**1,081**	**2,285**	**0**	**130**	**0**	**0**	**3,496**	0
Additions	15,285	14,841	0	47	0	0	**30,173**	0
Inventories recognised as an expense in the period	(15,158)	(15,224)	0	(88)	0	0	**(30,470)**	0
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	0	(105)	0	0	0	0	**(105)**	0
Balance at 31 March 2017	**1,208**	**1,797**	**0**	**89**	**0**	**0**	**3,094**	**0**

21.1. Trade and other receivables

	Current		Non-current	
	31 March 2017	31 March 2016	**31 March 2017**	31 March 2016
	£000s	£000s	**£000s**	£000s
NHS receivables - revenue	**6,555**	4,365	**0**	0
Non-NHS receivables - revenue	**2,234**	2,169	**1,441**	1,243
Non-NHS receivables - capital	**0**	87	**0**	0
Non-NHS prepayments and accrued income	**1,707**	1,783	**0**	0
PDC Dividend prepaid to DH	**0**	0	**(331)**	(272)
Provision for the impairment of receivables	**(5)**	0	**0**	0
VAT	**393**	259	**0**	0
Other receivables	**178**	293	**0**	0
Total	**11,062**	8,956	**1,110**	971
Total current and non current	**12,172**	9,927		

The great majority of trade is with NHS Clinical Commissioning Groups (CCGs). As CCG's are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary

21.2. Receivables past their due date but not impaired

	31 March 2017	31 March 2016
	£000s	£000s
By up to three months	**322**	22
By three to six months	**61**	43
By more than six months	**1,734**	2,279
Total	**2,117**	2,344

21.3. Provision for impairment of receivables

	2016-17	2015-16
	£000s	£000s
Balance at 1 April 2016	**(272)**	(242)
(Increase)/decrease in receivables impaired	**(64)**	(30)
Balance at 31 March 2017	**(336)**	(272)

22. NHS LIFT investments

The Trust has no LIFT investments.

23.1. Other Financial Assets - Current

The Trust has no other financial assets to report.

23.2. Other Financial Assets - Non Current

The Trust has no other financial non current assets to report.

24. Other current assets

The Trust has no other current assets to report.

25. Cash and Cash Equivalents

	31 March 2017	31 March 2016
	£000s	£000s
Opening balance	**1,291**	2,450
Net change in year	**311**	(1,159)

17. Analysis of impairments and reversals recognised in 2016-17

	2016-17 Total £000s
Property, Plant and Equipment impairments and reversals taken to SoCI	
Changes in market price	1,924
Total charged to Annually Managed Expenditure	**1,924**
Total Impairments of Property, Plant and Equipment changed to SoCI	**1,924**
Changes in market price	26
Total charged to Annually Managed Expenditure	**26**
Total Impairments of Intangibles charged to SoCI	**26**
Total Impairments charged to SoCI - AME	**1,950**
Overall Total Impairments	**1,950**

	Property Plant and Equipment	Intangible Assets	Financial Assets	Non-Current Assets Held for Sale	Total £000s
Impairments and reversals taken to SoCI					
Changes in market price	1,924	26	0	0	**1,950**
Total charged to Annually Managed Expenditure	**1,924**	**26**	**0**	**0**	**1,950**
Total Impairments of Property, Plant and Equipment changed	**1,924**	**26**	**0**	**0**	**1,950**

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 2017 £000s	31 March 2016 £000s
Property, plant and equipment	**462**	2,682
Total	**462**	2,682

19.2. Other financial commitments

The trust has not entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements).

Closing balance	**1,602**	1,291
Made up of		
Cash with Government Banking Service	**1,593**	1,279
Cash in hand	**9**	12
Cash and cash equivalents as in statement of financial position	**1,602**	1,291
Cash and cash equivalents as in statement of cash flows	**1,602**	1,291

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26. Non-current assets held for sale

	Land	Buildings, excl. dwellings	Dwellings	Asset Under Construction and Payments on Account	Plant and Machinery	Transport and Equipment	Information Technology	Furniture and Fittings	Intangible Assets	Financial Assets	Total
	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s	£000s
Balance at 1 April 2016	73	128	0	0	0	0	0	0	0	0	**201**
Transfers (to)/from Other Public Sector Bodies under Absorption Accounting	(73)	(128)	0	0	0	0	0	0	0	0	**(201)**
Balance at 31 March 2017	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Balance at 1 April 2015	293	552	0	0	0	0	0	0	0	0	**845**
Plus assets classified as held for sale in the year	0	17	0	0	0	0	0	0	0	0	**17**
Less assets sold in the year	(220)	(411)	0	0	0	0	0	0	0	0	**(631)**
Less impairment of assets held for sale	0	(30)	0	0	0	0	0	0	0	0	**(30)**
Balance at 31 March 2016	**73**	**128**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**201**

27. Trade and other payables

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
NHS payables - revenue	**3,004**	1,569	**0**	0
NHS accruals and deferred income	**300**	300	**0**	0
Non-NHS payables - revenue	**7,457**	11,120	**0**	0
Non-NHS payables - capital	**498**	133	**0**	0
Non-NHS accruals and deferred income	**5,390**	3,195	**0**	0
Social security costs	**1,219**	1,290		
PDC Dividend payable to DH	**129**	110		
Accrued Interest on DH Loans	**14**	8		
Tax	**991**	1,261		
Other	**81**	356	**0**	0
Total	**19,083**	19,342	**0**	0
Total payables (current and non-current)	**19,083**	**19,342**		
Included above:				
Outstanding Pension Contributions at the year end	**1,551**	2,044		

28. Other liabilities

The Trust has no other liabilities to report.

29. Borrowings

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Loans from Department of Health	**0**	0	**6,517**	4,667
PFI liabilities - main liability	**341**	341	**7,639**	7,980
Other (SALIX loan)	**711**	356	**2,030**	2,085
Total	**1,052**	**697**	**16,186**	**14,732**
Total other liabilities (current and non-current)	**17,238**	**15,429**		

Borrowings / Loans - repayment of principal falling due in:

	31 March 2017		
	DH £000s	**Other £000s**	**Total £000s**
0-1 Years	0	1,052	**1,052**
1 - 2 Years	0	711	**711**
2 - 5 Years	6,517	1,319	**7,836**
Over 5 Years	0	7,639	**7,639**
TOTAL	**6,517**	**10,721**	**17,238**

The Revolving Working Capital Facility with the Department of Health was transferred to a Single Currency Interim Revenue Support Loan on 25th January 2017 which is repayable on 18th January 2020. The Trust drew down a further £1,850,000 in year.
The interest rate is 1.5% payable.

The SALIX loan was signed on 14th August 2015 with a final repayment of date of 1st April 2020. There is zero interest payable on this loan.

30. Other financial liabilities

The Trust has no other financial liabilities to report.

31. Deferred income

	Current		Non-current	
	31 March 2017 £000s	31 March 2016 £000s	**31 March 2017 £000s**	31 March 2016 £000s
Opening balance at 1 April 2016	**1,288**	832	**0**	0
Deferred revenue addition	**4,361**	1,953	**0**	0
Transfer of deferred revenue	**(2,134)**	(1,497)	**0**	0
Current deferred Income at 31 March 2017	**3,515**	1,288	**0**	0
Total deferred income (current and non-current)	**3,515**	1,288		

32. Finance lease obligations as lessee

The Trust has no current lease obligations as a lessee.

33. Finance lease receivables as lessor

The Trust has no current lease obligations as a lessor.

34. Provisions

	Total	Comprising: Early Departure Costs	Legal Claims	Restructuring	Continuing Care	Equal Pay (incl. Agenda for Change	Other	Redundancy
	£000s	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**	**£000s**
Balance at 1 April 2016	**60**	0	60	0	0	0	0	0
Arising during the year	**6**	0	6	0	0	0	0	0
Utilised during the year	**(13)**	0	(13)	0	0	0	0	0
Reversed unused	**(34)**	0	(34)	0	0	0	0	0
Balance at 31 March 2017	**19**	**0**	**19**	**0**	**0**	**0**	**0**	**0**
Expected Timing of Cash Flows:								
No Later than One Year	**19**	0	19	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 2017	71,196
As at 31 March 2016	60,977

Legal claims relates to provisions for the member's excess due in Employer Liability cases as notified by the NHS Litigation Authority.
The provision reflects the excess due by the Trust since the NHS Litigation Authority make the majority of the payments and recharge the Trust in due course.
The associated contingent liability is in note 35 below.

35. Contingencies

	31 March 2017 £000s	31 March 2016 £000s
Contingent liabilities		
NHS Litigation Authority legal claims	**(7)**	(16)
Net value of contingent liabilities	**(7)**	(16)

36. Analysis of charitable fund reserves

	31 March 2017 £000s	31 March 2016 £000s
Restricted / Endowment Funds	562	595
Non-Restricted Funds	1,499	1,514
	2,061	2,109

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

37. PFI and LIFT - additional information

The information below is required by the Department of Heath for inclusion in national statutory accounts

Charges to operating expenditure and future commitments in respect of ON and OFF SOFP PFI

	2016-17 £000s	2015-16 £000s
Service element of on SOFP PFI charged to operating expenses in year	375	394
Total	375	394

Payments committed to in respect of off SOFP PFI and the service element of on SOFP PFI

	2016-17 £000s	2015-16 £000s
No Later than One Year	354	345
Later than One Year, No Later than Five Years	1,507	354
Later than Five Years	5,250	5,642
Total	7,111	6,341

Imputed "finance lease" obligations for on SOFP PFI contracts due

	2016-17 £000s	2015-16 £000s
No Later than One Year	944	969
Later than One Year, No Later than Five Years	3,066	3,248
Later than Five Years	10,813	11,574
Subtotal	14,823	15,791
Less: Interest Element	(6,843)	(7,470)
Total	7,980	8,321

Present Value Imputed "finance lease" obligations for on SOFP PFI contracts due Analysed by when PFI payments are due	2016-17 £000s	2015-16 £000s
No Later than One Year	341	341
Later than One Year, No Later than Five Years	848	958
Later than Five Years	6,791	7,022
Total	7,980	8,321

Number of on SOFP PFI Contracts

	2016-17	2015-16
Total Number of on PFI contracts	1	1

38. Impact of IFRS treatment - current year

The information below is required by the Department of Heath for budget reconciliation purposes	**2016-17 Income £000s**	**2016-17 Expenditure £000s**	2015-16 Income £000s	2015-16 Expenditure £000s
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)				
Depreciation charges		**372**		357
Interest Expense		**628**		1,043
Other Expenditure		**781**		394
Revenue Receivable from subleasing	**(643)**		(638)	
Impact on PDC dividend payable		**266**		235
Total IFRS Expenditure (IFRIC12)	**(643)**	**2,047**	**(638)**	**2,029**
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease revenue)		**(298)**		928
Net IFRS change (IFRIC12)		**1,702**		**463**
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12				
UK GAAP capital expenditure 2015-16 (Reversionary Interest)		175		170

	2016-17 Income/ Expenditure IFRIC 12 YTD £000s	**2016-17 Income/ Expenditure ESA 10 YTD £000s**	2015-16 Income/ Expenditure IFRIC 12 YTD **£000s**	2015-16 Income/ Expenditure ESA 10 YTD **£000s**
Revenue costs of IFRS12 compared with ESA10				
Depreciation charges	**372**		357	
Interest Expense	**628**		1,043	
Other Expenditure				
Service Charge	**345**	**345**	394	1,566
Contingent Rent	**406**		0	
Lifecycle	**30**		0	
Impact on PDC Dividend Payable	**266**		235	
Total Revenue Cost under IFRIC12 vs. ESA10	**2,047**	**345**	**2,029**	**1,566**
Revenue Receivable from subleasing	**(643)**	**(643)**	**(638)**	**(638)**
Net Revenue Cost/(income) under IDRIC12 vs. ESA10	**1,404**	**(298)**	**1,391**	**928**

39. Financial Instruments

39.1. Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with the CCG and the way those CCG'S are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's 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 NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust's has low exposure to credit risk. The maximum exposures as at 31 March 2017 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament . The 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

	At 'fair value through profit and loss'	Loans and receivables	Available for sale	Total
	£000s	£000s	£000s	£000s
Receivables - NHS		5,926		**5,926**
Receivables - non-NHS		2,911		**2,911**
Cash at bank and in hand		1,602		**1,602**
Total at 31 March 2017	**0**	**10,439**	**0**	**10,439**
Receivables - NHS		4,365		4,365
Receivables - non-NHS		2,198		2,198
Cash at bank and in hand		1,291		1,291
Total at 31 March 2016	0	7,854	0	7,854

39.3. Financial Liabilities

	At 'fair value through profit and loss'	Other	Total
	£000s	£000s	£000s
NHS payables		3,004	**3,004**
Non-NHS payables		7,799	**7,799**
Other borrowings		9,258	**9,258**
PFI & finance lease obligations		7,980	**7,980**
Total at 31 March 2017	**0**	**28,041**	**28,041**
NHS payables		1,678	1,678
Non-NHS payables		8,931	8,931
Other borrowings		8,108	8,108
PFI & finance lease obligations		8,321	8,321
Other financial liabilities	0	1,947	1,947
Total at 31 March 2016	0	28,985	28,985

40. Events after the end of the reporting period

With the transfer of services to Royal Devon and Exeter NHS Foundation Trust on 1st October 2016,

associated properties were transferred to NHS Property Services on 1st December 2016.

However due to legalities over the nature of the PFI contract, the transfer of Tiverton Hospital was unable to be transacted during the financial year.

We are therefore holding the asset on the balance sheet at 31st March 2017 at a valuation of £15.721m, with an associated PFI liability of £7.980m.

Negotiations are ongoing and once settled the property will be transferred under absorption cost accounting.
A date for transfer has yet to be agreed.

41. Related party transactions

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Devon Healthcare NHS Trust

The Department of Health is regarded as a related party. During the year Northern Devon Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. For example :

	2016-2017		2015-2016	
	Income	**Expenditure**	**Income**	**Expenditure**
	£000	**£000**	**£000**	**£000**
NEW Devon CCG	157,720	41	177,967	55
NHS England and Local Area Teams	22,687	17	0	18,801
NHS Kernow CCG	6,508	0	6,551	12
NHS South Devon and Torbay CCG	1,535	0	1,739	0
Royal Devon & Exeter NHS Foundation Trust	2,979	6,410	2,249	7,197
Torbay and South Devon NHS Foundation Trust	35	284	9	295
North Bristol NHS Trust	0	123	2	104
Devon Partnership Trust	2,520	165	2,442	146
NHS Pensions Agency	0	13,115	0	24,899
Health Education England	4,126	56	3,675	4
NHS Litigation Authority	0	5,033	0	3,967
NHS Blood and Transplant	21	542	0	624

	2016-2017		2015-2016	
	Debtors	**Creditors**	**Debtors**	**Creditors**
	£000	£000	£000	£000
NEW Devon CCG	1,044	300	1,374	589
NHS England and Local Area Teams	2,862	5		
NHS Kernow CCG	0	0	283	12
NHS South Devon and Torbay CCG	0	0	53	0
Royal Devon & Exeter NHS Foundation Trust	1,845	2,636	607	916
Torbay and South Devon NHS Foundation Trust	284	41	4	37
North Bristol NHS Trust	0	42	2	25
Devon Partnership Trust	313	9	256	73
NHS Pensions Agency	0	1,551	0	2,044
Health Education England	5	1	2	0
NHS Litigation Authority	0	0	0	0
NHS Blood and Transplant	3	51	0	8

In addition, the trust has had a number of material transactions with other government departments, other central and local government bodies plus its linked charity, as referred to it note 36.

	2016-2017		2015-2016	
	Income	**Expenditure**	**Income**	**Expenditure**
	£000	£000	£000	£000
Most of these transactions have been with:				
Devon County Council in respect of Public Health Services and Domiciliary Care	1,405	12,395	0	0
Inland Revenue in respect of tax and national insurance; and	0	31,346	0	31,664
HMRC in respect of VAT payable and recoverable.	4,310	0	6,140	0
NHS Professionals	0	4,734	0	9,541
NHS Supplies Authority	0	3,590	0	4,511
Northern Devon Healthcare Trust Charitable Fund	402	0	229	

42 Losses and special payments

The total number of losses cases in 2016-17 and their total value was as follows:

	Total Value of Cases	**Total Number of Cases**
	£s	
Losses	12,431	57
Special payments	118,290	31
Total losses and special payments and gifts	130,721	88

The total number of losses cases in 2015-16 and their total value was as follows:

	Total Value of Cases	**Total Number of Cases**
	£s	
Losses	12,813	60
Special payments	47,198	28
Total losses and special payments	60,011	88

Details of cases individually over £300,000
There are none to report

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

	2006-07 £000s	2007-08 £000s	2008-09 £000s	2009-10 £000s	2010-11 £000s	2011-12 £000s	2012-13 £000s	2013-14 £000s	2014-15 £000s	2015-16 £000s	2016-17 £000s
Turnover	89,547	118,418	128,855	128,509	134,710	211,041	220,680	225,787	234,685	233,235	217,580
Retained surplus/(deficit) for the year	(6,924)	7,602	7,902	(5,086)	(93)	(5,724)	(1,052)	1,141	714	(7,671)	(53,129)
Adjustment for:											
Timing/non-cash impacting distortions:											
Adjustments for impairments	0	0	0	5,086	345	7,328	3,288	1,340	3,297	2,132	1,950
Adjustments for impact of policy change re donated/government grants assets						92	(53)	(408)	(1,972)	429	183
Consolidated Budgetary Guidance - adjustment for dual accounting under IFRIC12*				0	0	23	22	167	298	463	1,702
Absorption accounting adjustment							0	0	0	0	51,526
Break-even in-year position	**(6,924)**	**7,602**	**7,902**	**0**	**252**	**1,719**	**2,205**	**2,240**	**2,337**	**(4,647)**	**2,232**
Break-even cumulative position	**(15,253)**	**(7,651)**	**251**	**251**	**503**	**2,222**	**4,427**	**6,667**	**9,004**	**4,357**	**6,589**

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, Northern Devon Healthcare NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %	2012-13 %	2013-14 %	2014-15 %	2015-16 %	2016-17 %
Materiality test (I.e. is it equal to or less than 0.5%):											
Break-even in-year position as a percentage of turnover	-7.73	6.42	6.13	0.00	0.19	0.81	1.00	0.99	1.00	-1.99	1.03
Break-even cumulative position as a percentage of turnover	-17.03	-6.46	0.19	0.20	0.37	1.05	2.01	2.95	3.84	1.87	3.03

The amounts in the above tables in respect of financial years 2006/07 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

43.2. Capital cost absorption rate

The dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets based on the pre audited accounts and therefore the actual capital cost absorption rate is automatically 3.5%.

43.3. External financing

The Trust is given an external financing limit which it is permitted to undershoot.

	2016-17 £000s	2015-16 £000s
External financing limit (EFL)	4,157	5,711
Cash flow financing	3,795	5,675
External financing requirement	**3,795**	5,675
Under/(over) spend against EFL	**362**	36

43.4. Capital resource limit

The Trust is given a capital resource limit which it is not permitted to exceed.

	2016-17 £000s	2015-16 £000s
Gross capital expenditure	9,290	10,475
Less: book value of assets disposed of	0	(638)
Less: donations towards the acquisition of non-current assets	(219)	(132)
Charge against the capital resource limit	**9,071**	9,705
Capital resource limit	9,076	9,725
(Over)/underspend against the capital resource limit	**5**	20

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, the balances held currently are less than £1,000.

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