

Annual Report

2011 - 2012



Contents

Introduction	4
What we do	6
North Devon District Hospital, Barnstaple	6
Community hospitals and resource centres	7
Community teams	8
Specialist community services	8
Patient Experience	10
Improving the environment for patients.	10
National patient survey rates hospital among the best for quality of care.	11
Out-patient reminder scheme sees sharp fall in missed appointments.	12
New gynaecology unit opens at NDDH.	12
Chemotherapy appeal captures public imagination as fund tops £750,000	13
Patients and carers highlight areas for action to improve dementia care	13
Salaried dental service deemed 'excellent' by patients	14
Trust recognised for its 'baby friendly' approach	14
The Trust launched a series of initiatives to bring care closer to home.	15
Health staff go mobile with new technology	16
Revamped hospital gardens offer havens for patients and visitors.	17
Name-change at Whipton to reflect wider catchment area	17
Charity helps collect views to improve patient experience	18
Integration brings benefits on sexual health	18
Bishop of Crediton authorises Julie as Lead Chaplain	19
Greater awareness sees jump in PALS support for patients and families.	19
Ottery hospital wows visitors with brand new reception	20
New film for patients due to undergo surgery	20

Patient Safety and Quality . . . . .	.21
Tough approach helps drive down rates of key infections . . . . .	.21
High levels of incident-reporting contribute to patient safety . . . . .	.21
New initiatives to keep patients safe from falls . . . . .	.22
Hospital goes 'Smokefree' on No Smoking Day . . . . .	.23
Clinic opens in Exeter to help smokers give up . . . . .	.23
Involving patients and the public to improve care . . . . .	.24
Safeguarding vulnerable patients . . . . .	.25
Performance. . . . .	.26
Figures highlight short waiting times for Trust patients . . . . .	.26
Trust responds rapidly to Care Quality Commission inspections . . . . .	.26
National report highlights speedy care for hip-fracture . . . . .	.29
Dr Foster hospital guide provides assurance on standards at NDDH . . . . .	.29
Operating and Financial Review . . . . .	.30
Annual Governance Statement . . . . .	.45
Remuneration Report. . . . .	.62
Head of Internal Audit Opinion . . . . .	.66
Accounts. . . . .	.75

Introduction

Last year represented a real milestone for the Trust, as we took over responsibility for community and some specialist services across a large part of Devon.

That means we now serve nearly half a million people across a largely-rural area, with more than 4,500 staff and 17 community hospitals, in addition to North Devon District Hospital.

Our task has been to integrate the new services and, importantly, help new staff feel part of a single organisation that already spanned both acute and community care.

One of the keys to greater integration across our new and existing services is technology, which last year saw development of a pioneering system to support those community staff who go out to see patients. This enables us to provide nurses and therapists in the field with handheld computers to download their daily caseloads via the mobile phone and wi-fi networks, update records and then upload the data while in the field.

Known as ComPAS, this project has generated wide interest across the NHS as we spearhead the move towards a truly mobile workforce that can spend more time on the road seeing patients.

However, while this sort of innovation will pay long-term dividends, most of our work last year was about doing day-to-day things as well as possible for patients.

This included providing premises that are clean and safe. As a result, all our hospitals were rated as either 'good' or 'excellent' in annual inspections for issues such as hygiene standards and the quality of food. Infection rates were low.

Highlights in the community included the launch of a series of projects to bring care closer to home for patients, so they could come out of hospital earlier and, sometimes, avoid admission altogether. This is a pointer towards the shape of care to come for the NHS, as hospitals concentrate more on those patients who benefit most from specialist treatment.

At North Devon District Hospital, the overall standard of care was rated among the top 20% in the NHS by patients in a national survey published last year. Further assurance on standards came from Dr Foster, which drew on comparative data across the NHS to assess individual hospitals.

Waiting times for patients also continued to be among the shortest in the South West, with at least 19 out of 20 being treated within 18 weeks of being referred by their GP.

However, the big test last year came with visits by the Care Quality Commission (CQC), which oversees all NHS trusts. An initial unannounced visit to NDDH found high levels of patient satisfaction, with the hospital meeting nearly all standards but requiring to improve on personal records and the training and development of staff.



While confirming our considerable progress in these areas, the CQC subsequently raised concerns about procedures and safety checklists in our operating theatres. These concerns had been addressed by April 2012. Tiverton Hospital was also found to meet all relevant standards in a CQC visit last year.

Such rigorous assessments might be daunting, but they can only help as we constantly strive to improve. We are proud of the response of staff in addressing shortcomings and in making sure that we do the best for our patients.

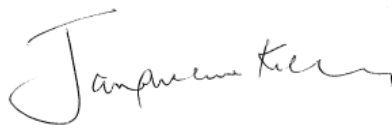
Against this background, we pressed ahead with our plans to become a Foundation Trust, which will give local people and our own staff a much greater say in our work and give us greater freedom to develop. We urge anyone with an interest in local healthcare to sign up as a member, so they can have a say in how we develop in future.

We also saw wonderful evidence of local support when we launched an appeal to raise £2.2m for a new chemotherapy unit at NDDH. By March 2012, the total in pledges and donations had reached £750,000, thanks to the efforts of hundreds of people.

Our thanks go to everyone who played a part in this effort. The end result should be a building that is a lasting tribute to the compassion and enthusiasm of local communities.



Roger French
Chairman



Jac Kelly
Chief Executive

Our vision

Our Trust will deliver safe and effective healthcare to the local population through a partnership with staff, patients, the public and other organisations.

Our values

Integrity - We will act with integrity and openness

Diversity - We will treat others fairly and equally and value diversity

Compassion - We will demonstrate care and compassion

Support - We will listen and support others and make time to do so

Excellence - We will strive for excellence in all that we do

What we do

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

We offer both acute and community services, centred on North Devon District Hospital and a network of 17 community hospitals, spanning Torridge, North Devon, East Devon, Exeter, Mid Devon, Teignbridge and West Devon.

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

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

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

Until March 2011, the Trust employed 2,600 staff, serving a population of 165,000 with a budget of £117 million. Now, we employ more than 4,500 staff and serve a population of around 484,000 with a budget of £209 million.

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



North Devon District Hospital, Barnstaple

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

North Devon District Hospital provides a 24/7 accident and emergency service, which was designated early in 2012 as a Trauma Unit within a network serving the whole of Devon and Cornwall.

We offer a range of general medical services including cardio-respiratory, stroke care and gastro-enterology. Our general surgical services include orthopaedics, vascular and colorectal specialties and are recognised by the Royal College of Surgeons as having some of the best (gold-standard) equipment in the NHS.

We also run very successful ophthalmology services, which use the latest procedures and techniques to treat glaucoma and macular degeneration.

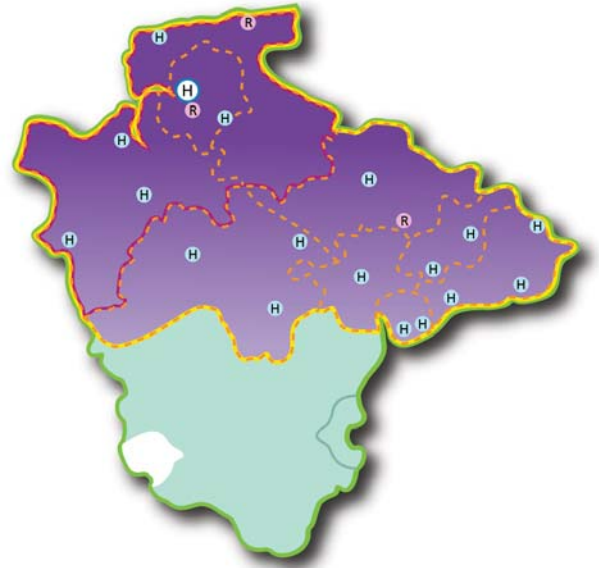
An increasing number of procedures are now carried out as day cases. Last year saw the opening of a gynaecological day-case unit, for example, which means that well over 75% of all surgical patients now never need to stay the night in hospital.

We have a strategy to repatriate appropriate services to northern Devon to meet the needs of our local community, so fewer people have to travel out of the area for treatment. Wet, age-related macular degeneration is one real success story, with our team at NDDH securing some of the best outcomes for eye patients in the South West.

Where it is not clinically or financially viable to manage a service directly, we work with neighbouring acute trusts to establish clinical networks. We work with Taunton on a vascular network, Derriford on a neonatal network and Royal Devon & Exeter on a cancer network.

In between our acute and our community services, we have a range of intermediary services which aim to control and facilitate the flow of patients to and from the acute. Our Pathfinder Team, for example, organises timely and safe discharges for patients who require ongoing care or support after leaving hospital.

In 2011/12, staff at North Devon District Hospital treated 22,791 inpatients, saw 151,003 outpatients and delivered 1,641 babies.



Community hospitals and resource centres

Our 17 community hospitals provide a range of services that are easily accessible to the local population, including inpatient beds, rehabilitation and outpatient clinics with consultants from NDDH and from hospitals in Exeter, Taunton or Plymouth.

Some hospitals also offer a minor injury unit and specialist services such as stroke rehabilitation and renal care.

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



Community teams

Our community nursing and therapy services are aligned into 17 complex care teams, providing integrated health and social care to help ensure that patients are supported in living independently in their own homes. These teams serve those patients who need regular support from skilled professionals, including district nurses, social workers, physiotherapists, occupational therapists, community nurses and community matrons. Patients might typically have long-term conditions, such as COPD or diabetes, or need rehabilitation following an illness.

The role of the complex care teams is to provide local services which rehabilitate patients and promote their independence.

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

Specialist community services

The Trust is the main provider of specialist community healthcare services in Devon, such as audiology, chiropody and sexual health.

More information is available on our website: www.northdevonhealth.nhs.uk



FT and membership

The Northern Devon Healthcare NHS Trust is planning to become an NHS Foundation Trust in 2013. Being an NHS Foundation Trust does not change our commitment to the standing principle that underpins the NHS, that of healthcare provided free at the point of delivery.

How does being a Foundation Trust benefit the local community?

NHS Foundation Trusts are designed to be more accountable to their local communities, through their membership and Council of Governors. For more information, please contact the membership office using the contact details overleaf.

What does being a member involve?

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

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

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

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

As a member you can:

- ▶ **Demonstrate** support to your local NHS
- ▶ **Challenge** the Trust to be accountable to local communities
- ▶ **Influence** future NHS developments
- ▶ **Represent** your community by ensuring there is a local focus
- ▶ **Vote** for Governors
- ▶ **Stand** as a Governor yourself
- ▶ **Receive** early information on potential changes to health services
- ▶ **Exchange** views and ideas
- ▶ **Access** to the NHS Discount Scheme

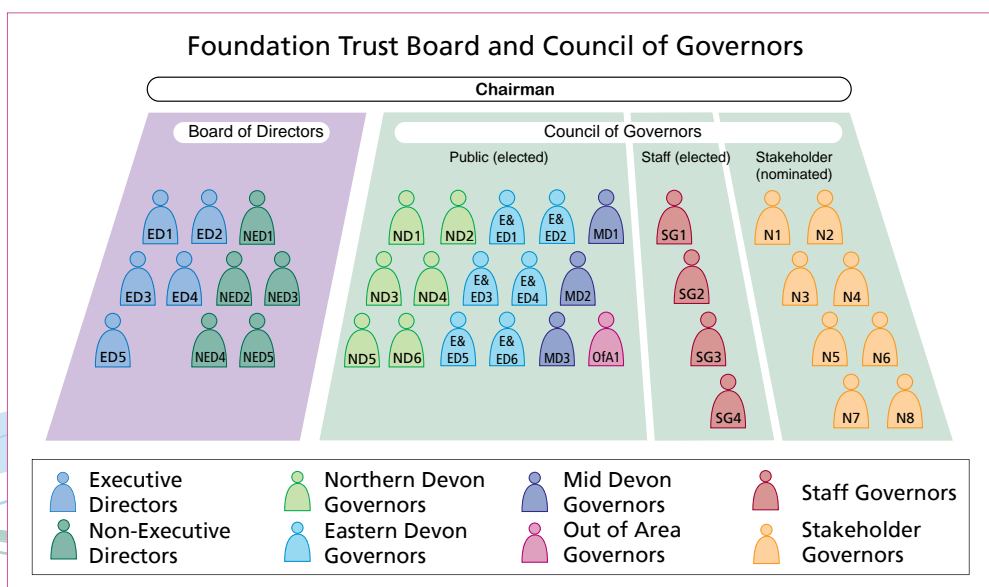
What is the role of Governors and the Council of Governors?

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

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

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

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



The public consultation, which formed part of the FT application process, was between 20th October 2011 and 16th January 2012. The report of all the comments received during this exercise is available on our website www.northdevonhealth.nhs.uk/ft.

Patient Experience

- how we have improved the patient's experience of using our services

Improving the environment for patients

North Devon District Hospital provides an excellent environment for patients according to the latest analysis published by the National Patient Safety Agency (NPSA) in its annual Patient Environment Action Team (PEAT) assessments.

Some of the highest possible were also awarded to our community hospitals across Exeter, Eastern, Mid and North Devon in an annual inspection.

The PEAT inspections check NHS hospitals in England for their standards in three areas of concern to patients – the environment (including cleanliness), food, and privacy and dignity. Inspections are carried out by NHS staff including matrons, facilities teams, infection control staff and patient representatives and members of the public.

All facilities run by the Northern Devon Healthcare Trust were included in the PEAT assessments, which took place between January and March 2011. The full scores are shown in the table below:

	Environment	Food	Privacy and Dignity
Axminster Hospital	Good	Excellent	Excellent
Bideford Hospital	Excellent	Good	Excellent
Budleigh Salterton Hospital	Good	Good	Good
Crediton Hospital	Excellent	Excellent	Excellent
Exmouth Hospital	Good	Excellent	Good
Holsworthy Hospital	Excellent	Excellent	Excellent
Honiton Hospital	Excellent	Excellent	Excellent
Ilfracombe (Tyrrell) Hospital	Excellent	Good	Excellent
Mortonhampstead Hospital	Excellent	Excellent	Excellent
North Devon District Hospital	Excellent	Excellent	Excellent
Okehampton Hospital	Excellent	Excellent	Excellent
Ottery St Mary Hospital	Excellent	Excellent	Excellent
Seaton Hospital	Good	Excellent	Excellent
Sidmouth Hospital	Good	Excellent	Excellent
South Molton Hospital	Excellent	Good	Excellent
Tiverton Hospital	Good	Excellent	Excellent
Torrington Hospital	Excellent	Good	Good
Exeter (Whipton) Hospital	Good	Good	Good

National patient survey rates hospital among the best for quality of care

The overall standard of care at North Devon District Hospital puts it among the top 20% of hospitals in the NHS, according a major survey of in-patients published in April 2011.

More than 450 people contributed to the local ratings, published by the Care Quality Commission (CQC) as part of its annual look at standards around the country.

The survey also puts NDDH in the top fifth of hospitals for issues such as the way doctors and nurses work together, and the level of respect and dignity for patients.

Nurses in particular are highlighted for the way they talk with patients and the confidence they inspire.

Other areas in which the hospital was rated among the top 20% include:

- ▶ Patients' involvement in decisions about both their care and their discharge
- ▶ Availability of someone to talk to about worries and fears
- ▶ Choice of admission dates
- ▶ Handwashing by both doctors and nurses
- ▶ Opportunity to talk with a doctor
- ▶ Staff doing everything to control pain
- ▶ Explanations of the risks and benefits of operations and procedures
- ▶ Numbers of people who want to complain about their care

The hospital was among the bottom 20% in five areas, including noise at night, mixed-sex accommodation and the numbers of patients asked about the quality of their care while in hospital.

Noise at night should reduce as more single rooms for patients are created during ward refurbishment. The increase in single rooms will also help the Trust place patients in single-sex areas. Following investment of nearly £1m, the Trust was able to all-but eliminate breaches of guidance on single-sex accommodation by spring 2012.



Out-patient reminder scheme sees sharp fall in missed appointments

A telephone reminder scheme saw sharp falls in the number of people who failed to turn up for out-patient clinics at North Devon District Hospital, following its introduction in April 2011.

The number of people not attending their appointments in August 2011 was nearly a third lower than in the same month the previous year, down from 6.7% to 4.6%. Some 107 extra patients were seen during the month – the equivalent of around five each day.

That means fewer patients are facing delays in their own diagnosis and treatment, while other patients can come off the waiting list more quickly. With staff wasting less time because of vacant clinic slots, the cash saving to the NHS is equivalent to £12,000-14,000 per month.

The system sees reminder calls made in the week before patients are due for their appointment.

For older patients, contact is made by a call-centre agent. They identify themselves clearly and make sure they are talking to the right person. Patients can then confirm that they are coming, cancel the appointment or ask for a new one.

For younger patients, the call is generally automated and comes in the early evening.

New gynaecology unit opens at NDDH

A new gynaecology day unit opened in early 2012 at NDDH, marking the completion of the first phase of the wider £1m refurbishment of the Ladywell Unit to create a modern centre for the women and children of northern Devon.

The new unit provides a welcoming and modern environment, with more single rooms, where more patients can be treated as daycases, avoiding the need for an overnight stay in hospital.

More than 100 patients are expected to be treated each month - a 10% increase on the previous year.

Jo Kerr, Ward Manager, said: "It is very bright and modern and it is good that we have theatres and recovery located in the same area which is much better for patients and staff. We have already had some excellent feedback from patients who have commented on how welcoming the unit is."

The full refurbishment will also see the creation of:

- ▶ A brand new Special Care Baby Unit (SCBU) with modern facilities and accommodation for families
- ▶ A new children's ward (Caroline Thorpe) alongside SCBU



Chemotherapy appeal captures public imagination as fund tops £750,000

The campaign to create a new £2.2m chemotherapy unit at North Devon District Hospital captured the imagination of people across the area last year.

Hundreds helped out by doing almost anything to raise cash, from running or selling cakes to knitting, slimming or parachute jumping.

By the end of March, the total in donations and pledges had reached £750,000 thanks to their efforts and to the generosity of thousands who handed over cheques or simply dropped a few coins in a collecting box.

The chemotherapy appeal will provide a new purpose-built environment for the 5,000 cancer patients that are seen at the hospital each year.

With one in three people being diagnosed with cancer at some point in their lifetime, it is a disease which affects nearly all families. There are more than 200 different types of cancer and 50 chemotherapy drugs. Some patients need a simple injection of a drug that can take a few minutes to complete, but many chemotherapy treatments require a drip that can take several hours.

Patient feedback tells us that the quality of nursing and consultant care and treatment is excellent. However, we know that the quality of the building lets us down.

For latest news about the appeal, details on forthcoming events and ideas for fundraising, visit www.northdevonhealth.nhs.uk/charity or contact the fundraising team on charity@ndevon.swest.nhs.uk or 01271 311772.



Patients and carers highlight areas for action to improve dementia care

The Trust held a series of focus groups last summer to gain the views of patients with dementia and of their carers.

The feedback was used to help shape a Trustwide action plan to improve care, linked to our wider dementia strategy.

Although the number of people taking part was fairly small, the quality and value of the feedback was high and everyone was pleased to have an opportunity to share their views and to meet others in a similar situation.

There were many instances of good practice, praise for individuals, services and wards, and some key areas for improvement.

These were the main themes for improvement:

- ▶ Overall, carers felt excluded from many decisions, and overlooked even though they knew so much about the individual with dementia and could provide valuable insights.
- ▶ Discharge sometimes seemed rushed, while staff sometimes referred to the wrong records or the wrong section of the record.
- ▶ Carers felt a lack of involvement in decisions and concern over the way in which the patient had - or had not - been assessed for capacity to make decisions.
- ▶ The level of care varied considerably, depending on which staff were on duty.
- ▶ Greater focus was needed on encouraging patients to eat.
- ▶ There seemed to be a lack of stimulation for patients, especially given that many would have difficulty working the bedside televisions or using the headphones.
- ▶ Information could be improved, especially on medication, who to contact after discharge, and support for carers. Full explanations of treatment needed to be repeated, as the patient might not remember.

A full report from the focus groups was shared with the Trust's Involving People Steering Group and the Learning from Patient Experience Group.

Salaried dental service deemed 'excellent' by patients

Some 98% of patients rated the overall quality of our salaried dental services as 'excellent', in a survey last year.

The Trust's salaried dental service provides around 22,000 appointments each year to urgent care and special needs patients in the two main dental access centres in Exeter and Barnstaple.

The survey highlighted that:

- ▶ Patients repeatedly referred to clinicians and other staff as 'excellent' and 'brilliant'.
- ▶ Overall, urgent care patients waited for less time on arrival than in 2009.
- ▶ Special care patients were similarly impressed with the service, with 74% of respondents scoring their individual experience as 'excellent' and a further 26% as 'good'.
- ▶ Over 81% of all Special Care patients waited less than 15 minutes to see their clinician, once they arrived in the department.

As well as the overwhelmingly positive feedback to the survey, a number of areas of improvement were identified from the patient's comments.

Two of the key themes were to:

- ▶ Improve communication with patients, both before their appointment and during their appointment
- ▶ Ensure prompt and efficient referral of patients back to general dental practitioners to reduce our waiting



Trust recognised for its 'baby friendly' approach

The Trust is on the way to becoming formally accredited as 'baby friendly', securing a certificate of commitment under a scheme launched by Unicef in the UK in 1994.

The initiative is designed to ensure a high standard of care for pregnant women and breastfeeding mothers and babies.

Sue Whitworth, senior midwife at North Devon District Hospital, said: "We are delighted to have achieved our certificate of commitment as it shows that we are really dedicated to becoming a baby-friendly accredited trust."



Bringing care closer to home

The Trust launched a series of initiatives to bring care closer to home

Reducing the wait to get the right community-based care

We have put a lot of effort into understanding the reasons why some people were waiting long periods for discharge into the community from the Royal Devon and Exeter Hospital (RD&E)

We therefore established a health and social care discharge team at the RD&E to focus on getting patients home wherever possible, with support from the appropriate services, or into a community hospital bed.

Decisions are all based on what a patient needs, drawing from the range of options available, as opposed to what we've always done in the past.

This Onward Care Team started at RD&E in November 2011 and has already reduced the number of people waiting for discharge.

As part of this work, we also invested in new IT links so that community-based teams could track 'their' patients in the RD&E, ensuring that planning for discharge could begin earlier.

The benefit for patients is that there is more continuity to their care – any hospital episodes are managed properly by those people who are responsible for their long-term care – and they don't spend any more time in hospital than needed.

Joined up health and social care

Sometimes, patients need more rehabilitation or recuperation time but they are not quite ready to go home. Previously this would have caused a delay to a patient leaving hospital whilst a care plan was put in place.

We have worked with NHS Devon to remove this blockage by giving our complex care teams the funds to book a bed in a care home at short notice.

In addition, increased investment in reablement across Exeter, east and mid Devon has meant that people can remain at home because our teams support them to live independently.

Our complex care teams are working to improve access to assessments for people with dementia to ensure that we are flexible and respond to their needs.

Lastly, we have developed the urgent care co-ordination service across eastern Devon. From October 2011, GPs and other community services can get immediate access to urgent care services for their patients.

This service is proving very successful at avoiding hospital admissions and keeping people safely at home. We are working in partnership with Devon Doctors to ensure that this service is available 24/7.

New home-based service to help patients stay out of hospital

The Trust launched a new service last year in the Exmouth area to provide care for people in their own homes.

Hospital at Home means fewer people – mainly older patients – will have to go into a care home or community hospital after discharge from acute hospital. In addition, some people are supported to remain at home, rather than being admitted unnecessarily.

The service is for patients aged over 18 who are registered with a GP in the Woodbury, Exmouth and Budleigh Salterton catchment area, and who have 'extended care' needs. This could mean patients recently discharged who require rehabilitation and support to regain independence after a fall or other medical issue, for example.

It is led by a team of Trust nurses, occupational therapists and community care workers, and overseen by doctors. It is supported by a team of specialist mental health staff from Devon Partnership NHS Trust.





Red Cross 'Home from Hospital' service launched

A partnership scheme launched last year by the Trust means Red Cross volunteers are providing help and support to patients discharged from hospital in northern Devon.

The 'Home from Hospital' service provides patients with support at home, helping them regain their confidence and independence, and preventing readmission to hospital.

The service will run initially for 12 months, with Red Cross volunteers on hand for a period of up to six weeks for each patient to assist with day-to-day tasks such as shopping, collecting prescriptions and generally helping to rebuild confidence after an accident or illness.

John Towers, Senior Service Manager at the Red Cross said: "Sometimes it's only something very small – such as making sure there's food in the cupboards, or having a chat and a cup of tea – that prevents re-admission to hospital."



Health staff go mobile with new technology

More than 800 community nurses and therapists across the Trust area are now using state-of-the-art computer technology as part of their patient visits, under a project known as ComPAS (Community Patient Administration System).

They are equipped with seven-inch Samsung tablet devices that download daily caseloads and can be used when out and about seeing patients, with the outcomes from visits then uploaded back to the central database.

The devices connect to the database via the 3G phone network or via wireless connection. This enables data to be shared more easily and quickly with other staff, so the whole team has access to the latest and fullest picture of each patient.

The Samsungs are also attractive, easy to use and give staff a host of additional benefits, including:

- ▶ Maps and Satnav
- ▶ NHS email and calendar
- ▶ Camera, so wounds could be shown to doctors at hospital for assessment, for example
- ▶ Integral phone with bluetooth capability and conferencing

Other benefits include improved governance – the system for safeguarding and improving standards - and the ability to compare our services with those of other providers.

A pilot project early in 2012 was followed by training and a staged rollout of the devices from March to April.

Keri Storey, Assistant Director of Health and Social Care, said: "This pioneering project represents our first step in our aspiration to create a mobile community workforce, including district nurses, physiotherapists and occupational therapists.

"We believe that ComPAS marks an important stage in our journey to use information to make a real difference to how we are able to care for patients and directly supports our vision to help people live healthily and independently in their own homes. This is all about using technology to make the most of our nurses' and therapists' time, so patients can gain the benefits."

Revamped hospital gardens offer havens for patients and visitors

Gardens and green space can play an important role in helping patients relax and recover, especially at community hospitals. Last year saw two main garden projects to improve the surroundings for both patients and their visitors.

Tiverton Hospital saw the opening of a new beach-themed garden to brighten an enclosed courtyard of paving slabs and low-maintenance ground cover. Support and funding came from the League of Friends.

The garden, complete with rowing boat, is also often used as a therapeutic resource for children attending speech and language therapy at the hospital.

It also boasts three model ducks, a lobster pot with life-sized crab and a lifebelt that was originally used as a film prop at Ealing Studios.

A tranquil new courtyard garden was also created at **Exeter Community Hospital (Whipton)**.

The hospital's League of Friends teamed up with local firm EDF Energy after staff, patients and visitors had decided the garden deserved a long-overdue facelift.

Volunteers flexed their green fingers and spent a day working on the garden as part of their Helping Hands programme in conjunction with the Time and Talent Network, a skills-based voluntary group supported by local employers.

The garden has been transformed from a drab area of paving to a relaxing environment where patients, visitors and staff can sit and reflect, chat, and enjoy the beauty of shrubs and plants.

Name-change at Whipton to reflect wider catchment area

Whipton Community Hospital has changed its name to Exeter Community Hospital (Whipton), in a move backed by three quarters of those who responded to a consultation last year.

The new identity – put forward by the League of Friends – reflects the fact that the hospital serves the wider Exeter community. The aim is then to remove the Whipton reference after a year, once the change is established with patients, NHS partners and other organisations.

The League of Friends hopes that its fundraising efforts will also be boosted by the realisation among the wider Exeter population that they are all served by the hospital.



Charity helps collect views to improve patient experience

The Trust launched a pioneering project last year with the Patients Association, a national charity, to gather independent feedback from patients while they are in hospital.

The aim is to use the information to improve services and enhance the experience for both patients and their carers.

The project has been in development for several months and it is hoped the approach will encourage patients to express their views freely.

Heather Eardley, South West Regional Manager of the Patients Association, and trained volunteers visited the wards of North Devon District Hospital and South Molton and Exmouth community hospitals during September and October, asking patients about their stay.

She said: "Our philosophy is listening to patients and speaking up for change. We have been setting up projects with a number of NHS trusts across the South West and are delighted to partner with the Northern Devon Healthcare. We hope this project will gather important patient feedback that will help shape service delivery and improve patient experience".



Integration brings benefits on sexual health

Last year saw a series of developments in sexual health services across Devon, following a comprehensive assessment of needs and the extent to which they were being met.

There was a drive to integrate contraception and genito-urinary medicine (GUM) clinics, offering a wider range of support under one roof. This saw combined clinics launched on a Saturday morning in Exeter and during the week in Tiverton and – from May 2012 - Exmouth. Increased access to services has seen a rise in activity of 14%.

Funds from NHS South West to increase access to long-acting reversible contraception mean 64 practices in Devon now offer a full range, including coils and contraceptive implants. Five nurses in the Exeter Walk-in Service are trained to fit contraceptive implants.

Although rates fluctuate, Devon currently has a lower rate of teenage conceptions to under 18 year olds than both the South West and England. Local sexual health service directories for young people identify services and promote key messages including the website www.nhs.uk/worhtalkingabout

A C-Card condom distribution scheme is available in many schools, colleges and youth settings, and has recently been extended to Barnstaple Health Centre. Free emergency hormonal contraception for women aged 13-19 is also provided in a number of community pharmacies.

The new annual diagnosis rate for Chlamydia screening reflects both coverage and positivity of testing at all sites among the 15-24-year-old population. A rate of 2,400 per 100,000 population is required to reduce the prevalence of Chlamydia. As of December 2011, Devon's annual diagnostic rate was 2,043 per 100,000 compared with a South West rate of 1979 and an England rate of 1964.

Bishop of Crediton authorises Julie as Lead Chaplain

The Reverend Julie Cartwright joined the Trust in November as Head of Spiritual Care. Her service of welcome and licensing, led by the Right Reverend Bob Evens, Bishop of Crediton, was held at North Devon District Hospital.

The service was held to welcome Julie as lead chaplain and give her licence to carry out her work, which is a legal requirement at the beginning of a new ministry.

Greater awareness sees jump in PALS support for patients and families

Last year saw an increase of over 80% in the number of patients and visitors contacting the Trust's Patient Advice and Liaison Service (PALS).

The rise, from 677 in 2010/11 to 1,239 in 2011/12, reflected greater awareness among both staff and the public of how PALS can support patients, carers and families. More staff training, the use of TV screens in patient waiting areas and an extra member of staff within the PALS team all played their part.

The range of issues and questions raised with PALS was huge, with many leading to changes in the way the Trust works. For example, following concerns from one patient who is a Jehovah's Witness, the Trust arranged for a trainer to work with midwifery staff on the needs of this community.

Staff from Customer Relations (Patient Experience) also ran several focus groups in the northern Devon community for people who have dementia and for their families and carers. The aim was to understand the experiences of dementia patients at both North Devon District Hospital and in the community hospitals run by the Trust, with the view of improving services.

The response was very positive. Following on from the groups, a patient experience/carer video was produced for staff training, to improve customer care in the area of dementia.



Ottery hospital wows visitors with brand new reception

Visitors to Ottery St Mary hospital are now greeted by a brand new reception area, following renovation work last summer.

Since the hospital was built 16 years ago, patient, visitor and staff numbers have increased, and more clinics and meetings are being held. Reception has necessarily become a multi-functional area for patient and visitor inquiries, answering telephones and emails, staff picking up post and general office admin tasks.

When the hospital shop closed earlier in the year, hospital staff seized the opportunity to give the reception area a facelift. The shop is now a photocopier and shredder room, meaning that the receptionist can take calls and deal with visitors without the interruption of noisy equipment.

The reception desk has been lowered to meet disability requirements and the whole area has been tidied to make an extremely welcoming, functional and smart area.

Sarah Dent, Northern Devon Healthcare Trust's locality business manager for Honiton and Ottery hospitals, said: "First impressions are so important and we wanted our reception area to reflect the excellent services that are provided in the rest of the hospital."



New film for patients due to undergo surgery

The Trust continues to produce information films for patients requiring surgery. The latest is 'Hernias and their treatments', a 15-minute guide on what hernias are, how they are treated and the recovery process after an operation. The Trust performs around 500 hernia operations each year.

Consultant Surgeon Nick Markham presents the film, with input from his patients. It follows on from his popular gallstones DVD, which received excellent feedback from patients and won accolades from the Royal College of Surgeons.

Nick Markham said: "For many people, having a condition such as a hernia and coming into hospital for an operation can be a nerve-wracking experience. This film explains what hernias are and now patients turn up well informed and ready for the op. Patients feel reassured because they know what to expect and when they will be able to resume normal day-to-day activities after a hernia operation, such as driving and playing sport."

As well as being given to patients on DVD, the film is available on the Trust's website.

www.northdevonhealth.nhs.uk



Patient Safety and Quality

- how we have improved the safety of our services and the quality of our care

Tough approach helps drive down rates of key infections

The Trust continued to drive down infection rates last year, with not a single hospital-acquired case of MRSA bacteraemia – one of the most-dangerous infections – and just 16 of C difficile all year.

Concerted efforts by staff meant we were within the limits set by the NHS for both infections.

We continued with our MRSA screening programme for patients. For elective patients, screening is carried out at pre-op clinic, so those who test positive can start suppression therapy with body washes and nasal ointments before admission to hospital.

For emergency surgical patients, we screen on admission and then immediately start suppression therapy; this can be stopped early if the test comes back negative. For emergency medical patients there is screening on admission, with suppression therapy starting if results come back positive.

We also monitor compliance with the screening programme every month, so our compliance is very high - much greater than the average identified through national audit.

With C difficile, we scrutinise every case. There has been an increase in the frequency of toilet cleaning routine at North Devon District Hospital from two to three times a day and every commode is disinfected with a product called Tristel after every use.

Most importantly there has been a lot of work on antibiotic usage, which has seen changes in formulary to drugs that lower the risk of C difficile infection. These changes have been made so there is no reduction in effectiveness for the original purpose of the antibiotic - for combating chest or urinary infection, for example.

High levels of incident-reporting contribute to patient safety

A national report into patient safety and the culture of incident-reporting in the NHS highlights the Trust as the highest reporter of incidents.

The National Patient Safety Agency notes the number and severity of all incidents reported by staff at similar sized NHS trusts. For the last two years the Trust has now been at the top or second from top.

The commentary accompanying the report states: "Scrupulous reporting and analysis of safety related incidents, particularly incidents resulting in no or low harm, provides an opportunity to reduce the risk of future incidents through learning."

The Trust encourages its doctors, nurses and managers to report any incidents or events which cause staff concern. By reporting these events, it enables the Trust to investigate both the infrequent, high-risk events and those commonly occurring, low risk events.

Staff are encouraged to make professional judgements about when and where patient safety could be improved and the Trust uses these reports to reduce risks across the organisation.

All incidents are reported nationally through the National Learning and Reporting Service. The main findings of the report show that:

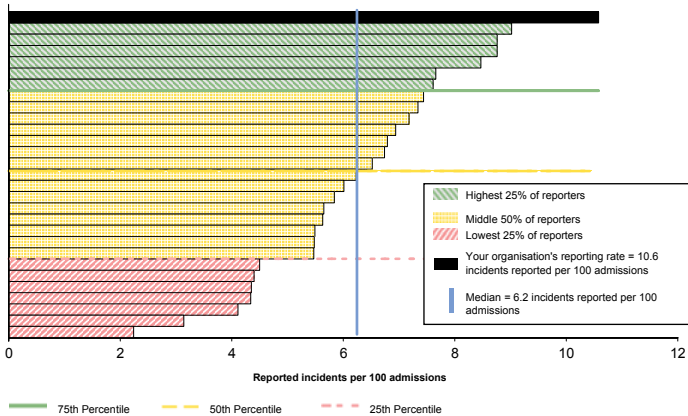
- ▶ Patient care and safety at the Trust has been greatly improved by a culture of reporting incidents as they happen
- ▶ Northern Devon has the highest rate of reporting incidents of any comparable trust, which means that our staff place emphasis on continuous learning and improvement
- ▶ The Trust's safety culture has ensured that during the past year there have been no incidents which have led to avoidable patient deaths

Carolyn Mills, director of nursing said: "It may seem counter-intuitive that a high number of incidents is seen as a good thing, but our patients expect us to learn from experience and continuously reduce the risks of healthcare provision. We are proud of our culture of open reporting and learning as it means we can continually improve patient care."

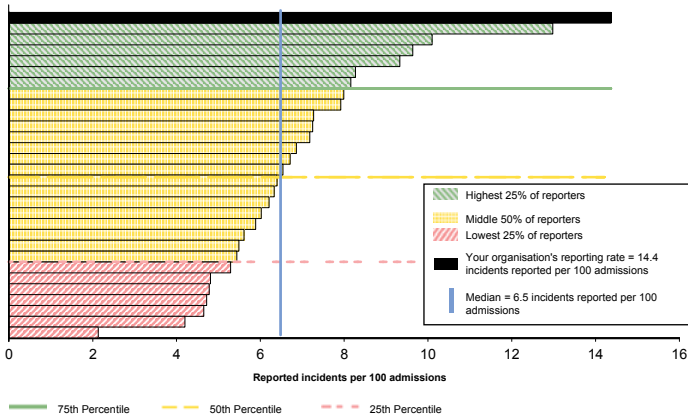
The Department of Health said: "There is strong evidence that high reporting levels reflect a strong safety culture, not poor performance. Where incidents are reported it gives clinical teams the information they need to address any underlying safety issues in order to further improve the quality and safety of the services they provide."

Comparative reporting rate

September 2011, per 100 admissions, for 29 small acute organisations.



March 2012, per 100 admissions, for 30 small acute organisations.



New initiatives to keep patients safe from falls

Falls are a major cause of injury, especially for older people, whether at home, in the street or in hospital.

Last year the Trust made significant progress as part of its wider patient safety programme to reduce harm from falls among inpatients by 30% from the previous year.

To facilitate this improvement there are two operational falls-prevention groups, covering our northern and eastern areas, with a strategic group overseeing overall progress, monitoring trends and ensuring action is taken to mitigate risks.

A Trust-wide Falls Prevention Policy covers all areas of inpatient, outpatient and domiciliary care, giving staff clear guidance on their roles and responsibilities in helping prevent patient falls, what documentation to use in assessing risks and what to do in the event of a patient falling.

All staff undertake basic training on preventing falls and we are investigating enhanced training for staff who work with high-risk patient groups.

The Trust has also been active in work across the South West, trialling a number of initiatives to help prevent harm from falls, As a result, we are now using:

- ▶ Non-slip slipper socks as a safe alternative for patients without suitable footwear
- ▶ Colour-coded walking equipment to highlight assistance required for safe mobilisation
- ▶ Sensor cushions to alert staff when a patient at high risk of falls has got out of bed or a chair
- ▶ Falls alert stickers in nursing notes to indicate when, where and why a patient fell and what action has been taken as a result



Hospital goes 'Smokefree' on No Smoking Day

North Devon District Hospital is now a smoke-free site. New signage was installed in March, with support available to staff, patients and visitors to help them stop smoking or manage their cravings whilst at the hospital. This includes on-site clinics and the prescription of nicotine-replacement therapy.

Patients are now advised at their pre-operative assessment of the smoke-free policy and referred to support via their GP.

Alison Diamond, Medical Director said: "Many visitors and patients have told us they would much prefer to visit a hospital site that is free of tobacco smoke, and object to walking through a cloud of smoke right outside the main entrance. Our doctors see people every day whose lives are being shortened by smoking and it contradicts everything we are trying to do if we continue to allow smoking on site."

NDDH is following the example of all other acute hospitals in the South West including the Royal Devon and Exeter Hospital and Derriford, which have gone smoke-free.

Clinic opens in Exeter to help smokers give up

Smokers in Exeter are now being offered a helping hand to give up at a new clinic that started last year.

The clinic, run by the Trust's countywide Stop Smoking Service, is held at Exeter Community Hospital (Whipton) on Friday mornings from 10am to 12pm.

Specialist advisers are also available across Devon to provide free help for anyone else who would like to quit. They are on hand for individual, group and family appointments, during the day and in the evening.

They can explain about the different types of medication that are available, including nicotine-replacement therapy and new drugs such as Champix. And they can advise on issues such as coping with cravings and what to do in tricky social situations.

Greg Price, who manages the Stop Smoking Service said: "We've got a flexible team who're just waiting to help. They'll see you face to face, talk on the phone or via email, and run clinics at different times of day to try and suit you.

"Giving up smoking can be hard, but it's a whole lot easier when you can turn to an expert who's helped dozens of other people quit cigarettes."

To find out about your local clinic or for advice, call the service direct on 01884 836024 or email: stopsmoking.devonpct@nhs.net



Involving patients and the public to improve care

The Trust is committed to involving patients, carers and the wider public, drawing on their knowledge and experience to help shape better services for the future.

This approach is in line with national legislation and the NHS Constitution, reflecting a wider commitment to the ethos that states: "No decision about me without me".

Involving People Steering Group (IPSG)

IPSG continued to meet every two months, bringing together individuals and groups to discuss important issues. The IPSG now receives the Trust's performance report, and has been engaged in the Foundation Trust application, with minutes fed into the Trust's Learning from Patient Experience Group (LPEG) for action.

Issues on last year's agenda included:

- ▶ The Trust's service development strategy
- ▶ What should be included on the TV screens in public areas at NDDH
- ▶ The development of easy-read materials
- ▶ The production of a customer care training DVD
- ▶ Dementia focus groups and resources for carers of people with dementia

Sensory Impairment Task Group

The Sensory Impairment task group meets quarterly to help improve access to Trust information and services for people with sensory impairments.

The Sensory Impairment Task Group includes service user perspectives from the SeeHear Centre and LINK Devon. Progress has been made towards identifying patients with a visual impairment, adding a sticker to their notes and highlighting them on computer systems so correspondence can be sent in large print or audio format.

PEAT inspections

The annual PEAT inspections were supported by patient representatives from LINK Devon and Living Options.

Dementia focus groups

Focus groups for patients with dementia or carers of people with dementia were held last summer. A total of about 26 people attended, providing valuable feedback for senior manager and for the Trust's Dementia Steering Group.

As a result of the events, three of the carers shared their stories both in a 'customer care' DVD and in face-to-face sessions to strengthen staff training in dementia. Two of the carers have also been involved in the Dementia Steering Group.

Patients with a learning disability

Patients with a learning disability had identified that appointment letters were not in an accessible format, resulting occasionally in missed hospital visits. As a result, although the Trust's current patient computer system cannot handle easy-read formats, a cover sheet is sent out with the appointment letter, so patients can get help directly from the Trust's learning disability liaison nurses.

Patient surveys

Three kiosks, based in the main foyer at NDDH, A&E and Ladywell Unit, have been operational and running an ongoing patient satisfaction survey since November 2011. Some 382 people have contributed their views by April 2012.

Volunteers

Volunteers play an important part in providing some of the 'extras' that the NHS cannot always provide itself. For example, Trust has recently recruited more volunteers to assist with the library trolley service, and a volunteer to assist with social activities for patients at South Molton Hospital. The Chaplain is also recruiting more volunteers to support the chaplaincy service.

Involving ethnic minority communities

One of the engagement events as part of the Trust's Foundation Trust application saw 19 people from the Asian, Chinese and Arabic communities come to the Exeter and Sidwell Community Centre.

The meeting was so successful that it was agreed it would be valuable to have similar meetings, possibly on a quarterly or six-monthly basis. It highlighted many health issues affecting minority communities, including:

- ▶ The need for sessions on healthy lifestyle
- ▶ The importance of physiotherapy support, especially in preventing falls
- ▶ Concern about that vitamin D deficiency in the Asian community
- ▶ Domestic violence and the need for women to understand that information shared with doctors is confidential
- ▶ Access to emergency services for people whose first language is not English

These concerns and suggestions will be followed up by the Trust's Equality and Diversity Lead. In addition, the Sahara Project was asked to provide a representative for the IPSTG.

LINK Devon

The Trust continued to work with LINK Devon, drawing on feedback about Trust services and requests for information, especially involving additional services at Okehampton Hospital and ophthalmology services closer to patients in Okehampton.

Following on from LINK Devon's 'Leaving Hospital' report, about discharge, the Trust has worked with LINK Devon volunteers to conduct a more detailed investigation so we can understand the obstacles to a smooth discharge.

Multifaith space

There was a very large response to a questionnaire about the multifaith space to replace the old chapel at NDDH. It generated 238 responses – one of the biggest responses the Trust had had to a consultation in recent times.

The results were sent to the group overseeing plans, which opted for a smaller place that could be further sub-divided as required for people of various faiths or none.

Safeguarding vulnerable patients

The Trust made real progress last year in strengthening the way it identified and protected vulnerable adults who might be at risk from abuse.

Following an inspection by the Care Quality Commission, there was a vast increase in the number of staff going through training programmes. This helped increase the reporting of potential 'safeguarding' incidents, where people might be at risk, and the number of applications to deprive people of liberty to protect their own interests.

Four serious incidents requiring investigation (SIRI) were also reported at NDDH last year, prompting the Trust to ask for CQC support and to take further action following a review of each case.



Performance

- how we have improved the safety of our services and the quality of our care

Figures highlight short waiting times for Trust patients

Trusts continue to be monitored to ensure that their waiting times for patients are managed well, with at least 95% treated within 18 weeks of their initial GP referral, in line with the NHS Charter.

Northern Devon performed well throughout the year, consistently showing some of the shortest waiting times in the South West, with well over 95% of people treated within the 18 weeks.

Figures released by NHS Devon for October 2011, for example, also revealed that we were the only Trust in Devon to meet the 18-week target for all specialities, from ophthalmology to orthopaedics.

In spring 2012, we were seeing 97.5% of cancer patients within the 14-day period for urgent referrals, compared to 95.7% nationally.

Jac Kelly, Trust Chief Executive, said: "We are committed to keeping waiting lists short to ensure our patients are seen and treated as quickly as possible. We review waiting lists on a weekly basis and aim to meet national standards and better them."

Trust responds rapidly to Care Quality Commission inspections

The Care Quality Commission (CQC) paid a series of unannounced visits to the Trust last year, as part of its role in monitoring standards across the NHS.

Tiverton Hospital and North Devon District Hospital both saw the arrival of inspectors to observe practice and talk with patients.

The Tiverton visit came after the CQC had been contacted by a visitor. The inspectors found that staff were meeting all relevant standards, adding: "We saw that people looked well cared for and the standard of personal care provided was high. The majority of the care we observed was kind, thoughtful and respectful. There was consistency in all the information the five care workers told us; staffing arrangements; about patients' individual needs and vulnerabilities; and how they are able to safeguard patients in their care from abuse."

Visits to NDDH highlighted in particular the high levels of patient satisfaction and overall compliance with requirements, as well as pointing to areas for improvement.

The first CQC report in May 2011 said in its summary of findings: "We observed care and treatment being delivered, by a cross-section of Trust staff, in a kind and respectful way."

The inspectors concluded: "Overall we heard very positive comments about individuals' experiences of using the hospital."

The CQC found that the hospital was meeting 14 key standards, such as:

- ▶ Treating people with respect, involving them in their care and enabling them to influence services
- ▶ Providing a clean environment and protecting people from infection
- ▶ Having enough staff

However, the inspectors called for action to meet two other standards, covering:

- ▶ Training, supervision and development of staff
- ▶ Maintenance of personal records

With a series of actions already under way at the Trust to address the CQC's findings, inspectors made a second unannounced visit in July to focus on just four of the 14 national standards.

The subsequent report called for improvements to documentation, consent procedures and wound-care plans. The inspectors said there was no evidence that "outcomes for people were poor, but we did find that wound care plans were not being reviewed and monitored sufficiently to ensure appropriate treatment was consistent."

When the CQC returned in November, inspectors found that significant progress had been made and "the Trust has invested a lot of time and effort to making sure they have reviewed the standard and quality of records relating to patient care".

During their visit, inspectors heard feedback from patients that was universally positive about the care they had received.

Measures taken by the Trust included the introduction of:

- ▶ New documentation to make it easier for staff to plan and monitor patient care
- ▶ More ward-based learning and greater supervision for staff
- ▶ A weekly monitoring report of compliance at ward level with requirements such as care-planning, risk-assessment and the securing of consent for treatment

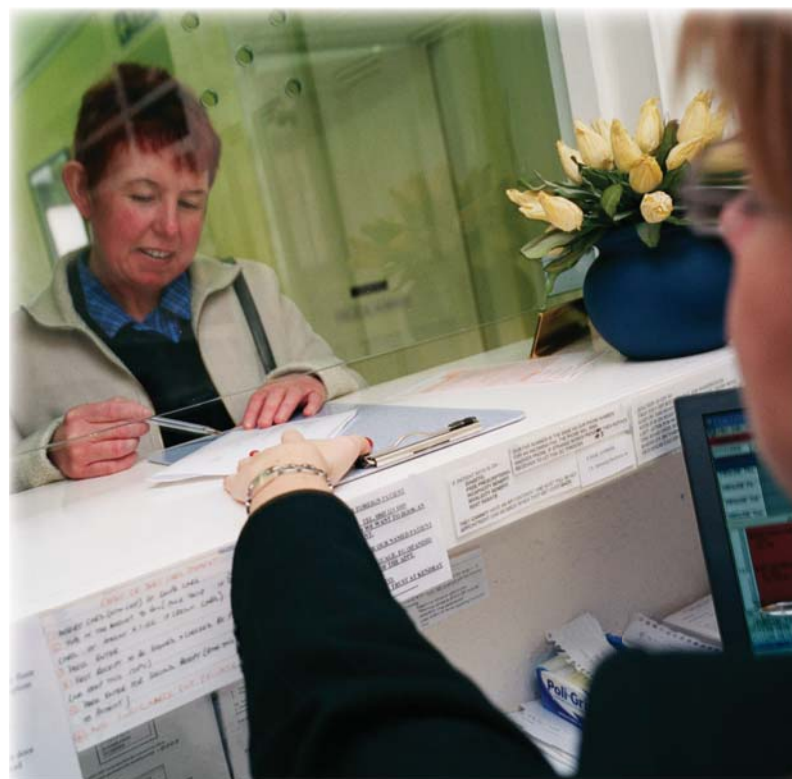
However, there were concerns relating to procedures and safety checklists in theatres, prompting immediate action to ensure. These included:

- ▶ Reviewing and introducing new, formalised briefings by surgeons to ensure all staff
- ▶ Introducing monthly quality audits with results being fed back to individual members of staff

When the CQC returned in early April 2012, inspectors reported that NDDH was now meeting all requirements for checking patients when they underwent surgery.

As a result, "care and treatment in theatres was planned and delivered in a way that ensured people's safety and welfare".

Dr Alison Diamond, the Trust's Medical Director, said: "The theatres teams have worked hard to make these changes. They were really upset when the last CQC report found shortcomings, even if there was no evidence that patients had been adversely affected. Now they're delighted they have been able to show patients that they're in the safest hands."



What patients told the CQC:

Hygiene

"The cleaning staff work hard and do a good job."

"It is kept very clean, I have no complaints."

Staff

"I don't need to ask questions because they explain it so well."

"You can't fault them [the staff]. They jolly you along and they are lovely about everything."

"I was admitted quickly via A&E who were fabulous, explained everything to me and even helped me to contact people to make sure my relative understood where I was being admitted to. On the ward nothing has been too much trouble and the doctors have explained everything to me."

"Been treated lovely, all the staff are very kind."

"We know xx very well in PALS, she has helped us a lot with various concerns we had."

"I've never been rushed...People [staff] have got time to talk to you."

"You've got to wait sometimes – but there's other patients they have to see."

The hospital

"Revamped over recent years, and is now a much better place to visit and be in."

"It runs pretty smoothly."

"I think patient care is really good here [acute surgical unit]. I chose to come here."

Food

"Some days it's alright."

"The porridge this morning was lovely, a big bowlful!"

"Best not to mention what I think about the food."

"It's safer to have sandwiches and it's jelly every day for tea time."

Medicines

"I'm very, very pleased with everything here."

"Quite happy, I get everything I need"

"Staff have been lovely and explained it all to me."

National report highlights speedy care for hip-fracture

People admitted to North Devon District Hospital with fractured hips are getting rapid treatment, according to a national report published.

The National Hip Fracture Database analysis for 2011 shows that two-thirds of patients are placed on the orthopaedic ward – Capener – within four hours of arrival, compared to the national average of just under half.

Around 95% go on to have their operations within 48 hours and during normal working hours – the preferred time because all hospital support systems are fully operational – compared to the national average of 86%.

Patients typically stay in the hospital for around 11 days, well below the national average of over 16, which means they can go home, to a community hospital or into other forms of care more rapidly.

The audit also highlights good performance in cementing replacement joints and assessing patients to minimise the risk of falling.

Areas for improvement include the need to make sure patients have pre-operative assessments and are on medication at discharge, where rates are below the national average.

Dr Foster hospital guide provides assurance on standards at NDDH

The 2011 Dr Foster Hospital shows solid standards of care for patients at North Devon District Hospital.

The guide, which looks at progress across the NHS over the past 10 years, puts NDDH mortality rates at expected levels, including at weekends.

The Trust is also at the expected level for ensuring that patients with fractured hips have their surgery within two days, and has a readmission rate after hip replacement that is significantly better than average. Standards of care involving hip and knee surgery are highlighted by Dr Foster as key, given the ageing population.

Another theme of the guide is the need for hospitals to form networks, as not all can provide a full 24/7 range of services.

This is a strategy that the Trust has developed over recent years, working with other others in the South West including Musgrove Park in Taunton, the Royal Devon and Exeter Hospital, and Derriford Hospital in Plymouth.



Operating and Financial Review

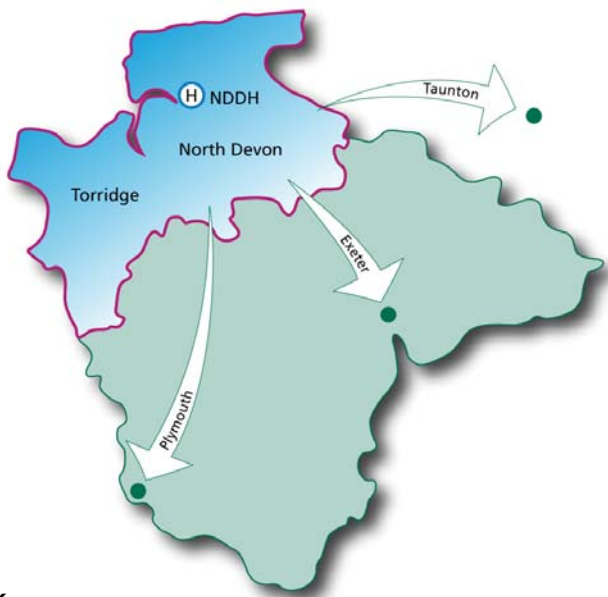
1. Objective of the Operating Financial Review

The objective of this OFR is to prepare a balanced and comprehensive analysis to inform the reader of events that impacted on the Trust during the 2011/12 financial year and is presented through the eyes of the Trust Board.

2. Trust Overview

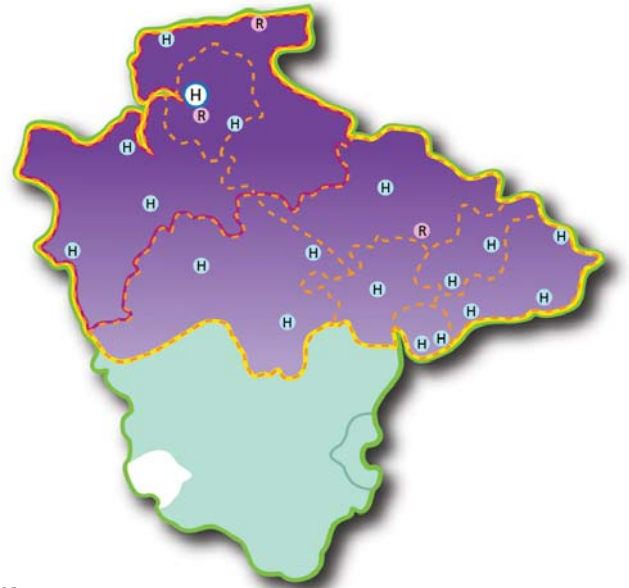
Who we are

Northern Devon Healthcare NHS Trust was created in 1991 and historically served a population of approximately 165,000 people within North Devon and the neighbouring towns and villages in North East Cornwall and Mid Devon and looked something like this:



Key
■ Northern Devon Healthcare Trust acute catchment
Ⓜ NDDH in Barnstaple

As part of the reconfiguration of the NHS, the Trust was awarded a 3 year contract from 1 April 2011 to manage and transform a range of services that were previously provided by the provider arm of NHS Devon.



Key
■ Area served by majority of Trust's services
■ Area served by Devon wide community services
 Edge of acute catchment
 Edge of all adult community health & social care services
 17 health and social care clusters
 Edge of Devon-wide specialist community services
Ⓜ NDDH in Barnstaple
Ⓜ Community hospitals
Ⓜ Resource centres

As a result, the Trust now provides a range of Acute, Community and Pan Devon Services and now serves a population of 484,000 people (65% of the population of Devon)

Trust at a glance

Staff working in acute services



Staff working in community



Acute beds



341 at NDDH

Community beds



303 across 17 community hospitals

96 CH beds in North

207 CH beds in East

14 complex care teams

We now provide services to over half of Devon

Population served: 484,000 (Devon total: 740,000)

Square miles covered: 1,300 (Devon total: 2,500)

Acute Services Provided

The Trust manages the North Devon District Hospital in Barnstaple and provides a full complement of adult and child secondary care services including:

- ▶ Outpatient care;
- ▶ Elective Inpatient and Day Case services;
- ▶ Emergency treatment and follow-up care;
- ▶ Diagnostics;
- ▶ Maternity services (including the Special Care Baby Unit);
- ▶ Intensive care; and Accident & Emergency services.

Community Services Provided in North and East Devon

The Trust provides an integrated model of care with some health services and social care services to provide integrated, high quality care and efficient care that treats the patient in the right place and increasing access to a broad range of services with minimal bureaucracy.

The Trust also has ownership and management responsibility for the provision of 5 Community Hospitals in North Devon.

Due to current NHS rules, the 12 Community Hospitals in East Devon remain under the ownership of NHS Devon and the Trust retains the management responsibility for services from these sites.

These services include:

12 Community Hospitals, including 7 Minor Injury Units * (MIU) located at:

- ▶ Axminster
- ▶ Budleigh Salterton
- ▶ Crediton
- ▶ Exmouth*
- ▶ Honiton*
- ▶ Moretonhampstead*
- ▶ Okehampton*
- ▶ Ottery St. Mary*
- ▶ Seaton
- ▶ Sidmouth*
- ▶ Tiverton*
- ▶ Whipton, Exeter

Nine Complex Care Teams



Pan Devon Services

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

- ▶ Bladder and Bowel Care
- ▶ Community Nursing
- ▶ Physiotherapy
- ▶ Occupational Therapy
- ▶ Radiology
- ▶ Speech and Language Therapy
- ▶ Continuing Healthcare
- ▶ Sexual Health services including Family Planning
- ▶ Podiatry

Stakeholders

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

- ▶ NHS South West Strategic Health Authority;
- ▶ NHS Devon Primary Care Trust;
- ▶ NHS Cornwall & Isles of Scilly Primary Care Trust;
- ▶ NHS Somerset Primary Care Trust;
- ▶ North & East Devon Clinical Commissioning Groups;
- ▶ Devon Partnership Mental Health NHS Trust;
- ▶ Royal Devon & Exeter NHS Foundation Trust;
- ▶ Plymouth Hospitals NHS Trust;
- ▶ Taunton Hospitals NHS Foundation Trust;
- ▶ South Western Ambulance Service NHS Trust;
- ▶ Devon County Council;
- ▶ Devon County Council Adult and Community (Social) Services;
- ▶ District and Parish Councils.

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

The Trust is continuing to develop its Estate Control Plan to prioritise future developments to maximise the efficiency of those services.

During the year, the Trust can demonstrate the following examples of system change that has been implemented during the current year:

- ▶ Building work to refurbish and expand the Day Surgery Unit at North Devon District Hospital from 14 to 20 bed spaces allowing an extra 1,000 patients per year can now be treated ;
- ▶ The overall standard of care at North Devon District Hospital puts it among the top 20% of hospitals in the NHS, according to the latest survey of in-patients, published in April 2011;
- ▶ A team of community matrons and IT colleagues won a national award for innovation and best practice at the annual Community Hospitals Association conference for work on the creation of a community hospital audit tool that assesses the safety and quality of care through peer assessment;
- ▶ The Trust has invested over £150,000 in new washing disinfector equipment for the Sterile Services Department (SSD);
- ▶ The NDDH's telephone reminder system for out-patients, introduced in April 2012, has seen 'do not attend' (DNA) rates fall by nearly a third in the eight specialities covered;
- ▶ A new Hospital at Home service provided by the Trust was launched in the Exmouth area to provide care for people in their own homes;
- ▶ Families across North Devon benefit from a refurbishment of the Ladywell Unit at North Devon District Hospital (NDDH). The £1m project creates a modern centre for women's and children's services which see and treat close to 3,000 children every year.

Other Highlights included:

- ▶ NDDH Consultant Surgeon Nick Markham was awarded first prize in a film competition run by the Association of Surgeons of Great Britain and Ireland (ASGBI) aimed at patients that undergo Gall Bladder surgery at the Trust;
- ▶ All hospitals run by the Trust scored well in the latest Patient Environment Action Team (PEAT) assessments. A number of sites recorded higher scores than last year, including North Devon District Hospital, which was rated 'excellent'. The community hospitals across northern, east and mid Devon all scored highly, achieving 'good' or 'excellent' ratings;
- ▶ A new electronic hoist is in operation at NDDH. The device was kindly funded by the League of Friends so larger patients could be moved comfortably and with dignity in most areas of the hospital;
- ▶ 98% of patients rate the overall quality of the Trust's salaried dental services as 'excellent' in a patient satisfaction survey;
- ▶ Figures released by NHS Devon revealed that the Trust was the only Trust in Devon to meet the 18 week referral to treatment target for all specialities in October 2011;

3. Trust Governance and Board Level Changes

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

The Trust Board is led by a Chairman together with a team of 5 Non-Executive Directors and 5 Executive Directors. The Non-Executive Directors have a part-time role, providing experience and expertise, usually gained from working in organisations outside the NHS.

The Executive and Associate Directors are led by the Chief Executive and combine their role as board members with regular management responsibility.

The Trust experienced the following Executive and Non-Executive Director movements during the financial year:

Mrs June Lake ceased her role of Non-Executive Director from 30 June 2011.

Mr Nick Lewis was appointed to the role of Non-Executive Director on 1 August 2011 for a period of 4 years.

Mr Chris Snow, CBE was appointed to the role of Non-Executive Director on 1 August 2011 for a period of 4 years.

Full details of these and any other Executive and Non-Executive directors are contained within the remuneration report.

The treatment of pension liabilities can be found on pages 24 of the accounts.

The Board has adopted Codes of Conduct and Accountability recommended by the NHS Executive. Audit, Risk, Clinical Governance and Remuneration and Terms of Service Committees and other sub-committees of the Board are well established.

Details of company directorships or other significant interests held by directors where those companies are likely to do business, or are possibly seeking to do business with the NHS where this may conflict with their managerial responsibilities are required to be disclosed in the Declaration of Members Interests. This is presented at each Board meeting and is updated as required.

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

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

4. Vision, Values and Strategic Objectives

During the year the Trust reviewed its vision, values and strategic objectives and from 2011/12 the Trust's vision is:

We will deliver local integrated health and social care to support people to live as healthily and independently as possible, recognising the differing needs of our local communities across Devon.

The four cornerstones we pursued as part of our turnaround strategy continue to be relevant and appropriate and will therefore be carried forward into our future plans over the next 5 years:

- ▶ Securing safe, sustainable hospital services;
- ▶ Integration of health and social care;
- ▶ Improving local access to services; and
- ▶ Building on strong governance

The Trust's strategic objectives are:

1. We will be recognised for delivering care of the highest quality, measured in terms of clinical effectiveness, patient safety and the patient experience.
2. We will ensure access to a sustainable range of services that are delivered locally through established partnerships, and clinical networks with other organisations where necessary
3. We will maximise the benefits derived from an integrated model of health and social care that provides the right care at the right time in the right place at the right level for the individual.
4. We will recruit and develop a flexible and multi-skilled workforce fully engaged in turning our vision into a reality.

5. We will efficiently and effectively run our services; generating surpluses to reinvest in services to benefit our local community and underpinning all we do with systems and processes which deliver safe, high quality services
6. We will be the local provider of choice; working in partnership with the public and commissioners to promote independence and well being and meet the needs of our community.

Delivering these objectives, and realising our vision will give the Trust the best chance to deal with the unprecedented challenges ahead, particularly coping with the large increase in older people and the harsh financial climate.

It is expected that the Trust will ensure that it will be able to manage with the anticipated 12% increase in demand for hospital services from older people over the next five years through strong financial management and the integrated networks it has and will continue to develop will ensure that patients are treated in the most appropriate place.

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

Our service development plan

Supporting Independent Living and Well-being

- protecting the rights of vulnerable people
- avoiding unnecessary hospital admissions
- creating a multi-skilled workforce
- whole pathway transformation

Adult health and social care:

- Development of Complex Care team's capacity and capability
- Introducing single point of access
- Extending the range of services available in the community

Responsive acute services:

- Developing the emergency hub
- Enhancing day surgery capacity
- Improving patient flow
- Extending acute and clinical expertise into the community

Networking and partnerships:

- Developing networks for clinical services
- Working with (other) agencies to provide care closer to home

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

5. Trust Operational Performance

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

- ▶ Control of Infection
- ▶ Cancer Access Targets
- ▶ Quality Indicators
- ▶ Patient Access Targets

Control of Infection

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

Control of Infection				
Indicator	Year Cumulative			
	Mth	Plan	Actual	
MRSA - Acute >2 Days	Mar	1	0	✓
Clostridium Difficile - Acute >3 Days	Mar	17	16	✓

Cancer Access Target

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

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

All NHS Trusts involved in the patients care review the reasons for delay so that improvements can be made.

Cancer Access Targets				
Indicator	Mth	Year Cumulative		
		Plan	Actual	
Cancer 14 Day - Urgent Referral	Mar	93%	97.7%	✓
Symptomatic Breast 14 Day	Mar	93%	95.1%	✓
Cancer 31Day Diagnosis to Treatment	Mar	96%	99.3%	✓
Cancer 31Day - Subsequent Surgery	Mar	94%	97.1%	✓
Cancer 31Day - Subsequent Drug	Mar	98%	100%	✓
62 Day Urgent Referral to Treatment within NDHT	Mar	85%	87.8%	✓
62 Day Urgent Referral to Treatment at other Hospital	Mar Cum	85%	58.6%	◆
62 Day Urgent Referral to Treatment Trust Overall	Mar Cum	85%	85.5%	✓
Cancer 62 Day Screening	Mar	90%	96.2%	✓

Quality Indicators

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

Never Events

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

Delayed Transfers of Care

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

The impact of delayed discharges affects the flow of patients through the hospital system and so has an impact on access targets such as the minimum 4 hour wait in A&E.

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

Stroke Pathways

The Trust has stroke pathways that involve patients being treated in both the acute hospital setting as well as in dedicated stroke rehabilitation services provided from its Community Hospitals that ensure that the most appropriate quality services are available to patients in the best setting of care – not solely in an acute hospital.

Key Quality Indicators				
Indicator	Year Cumulative			
	Mth	Plan	Actual	
Never Events	Mar	0	2	✘
Cancelled Operations as % of Elective Operations	Mar	<0.8%	0.69%	✓
Cancelled Operations <28 days (Cumulative)	Mar	>95%	100%	✓
Fractured Neck of Femur operated on within 24hrs	Mar	90%	91.8%	✓
Thrombolysis - Call To Needle	Mar	>68%	0% 0/1	✓
GUM Offer <48Hrs (East & North)	Mar	>98%	100%	✓
Delayed Transfer of Care (Acute)	Mar	<3.5%	1.8%	✓
Delayed Transfer of Care (North Community Hospitals)	Mar	<3.5%	12.6%	✘
Delayed Transfer Care (East Community Hospitals)	Mar	<3.5%	6.8%	✘
Stroke >90% stay North Acute	Mar	80%	67%	✘
Stroke >90% stay East Community	Mar	80%	76.8%	◆
Stroke Swallow Screening 4Hrs	Mar	95%	93.7%	◆
Stroke Swallow Assessment 24Hrs	Mar	95%	83.3%	✘
Women Seen by 12 Wks Pregnancy	Mar	90%	86%	◆
Smoking at Delivery	Mar	<20%	14.0%	✓
Breastfeeding Initiation	Mar	>71%	76.4%	✓
Reduce Elective Caesarean Sect.	Mar	<11.6%	10.5%	✓

Patient Access Targets

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

This becomes more impressive considering that the number of unscheduled emergency patients treated in 2011/12 increased by 2,530 (19%) above the agreed activity plan with NHS Commissioners.

During 2011/12 the Trust undertook in excess of 45,000 First Outpatients appointments and 22,000 Elective procedures.

Referral to Treatment (North) (Plan = national standards)					
Indicator	Mth	Plan	Actual	Variance	
18wk RTT Admitted Pathways	Mar	>90%	94.7%	n/a	✓
RTT Admitted Median - Weeks	Mar	<11.1	8.3	n/a	✓
RTT Admitted 95th Percentile - Weeks	Mar	<23.0	18.5	n/a	✓
18wk RTT Non-Admitted Pathways	Mar	>95%	99.4%	n/a	✓
RTT Non-Admitted Median Weeks	Mar	<6.6	3.0	n/a	✓
RTT Non-Admitted 95th Per - Weeks	Mar	<18.3	10.4	n/a	✓
RTT Incomplete Pathways <18 wks	Mar	92%	98.7%	n/a	✓
Outpatients GP Waiting >11 wks	Mar	0	1	+1 Gynaecology	✓
Elective patients Waiting >20 wks	Mar	0	1	+1 Colorectal Surgery	✓
Diagnostics Waiting >6 wks	Mar	0	0	0	✓

Indicators are taken from the May 2012 Performance report that details the reporting the Trust makes on a monthly basis to the Board.

The Board would like to take this opportunity to recognise the dedication and hard work of all staff that has made 2011/12 such a successful year.

6. Financial Performance

There are a number of targets set by the Department of Health and the Trust's 2011/12 performance against these targets is shown below:

Target	Actual Performance
To break even on income and expenditure taking one year with another	In year surplus of £1,719k before impairments achieved the Statutory duty.
To achieve a capital cost absorption rate of 3.5%	Rate of 3.5% achieved.
To operate within a Capital Resource Limit.	Achieved.
To pay 95% of non-NHS invoices within 30 days	94% of bills paid within target (volume). 95% of bills paid within target (value).

Financial Position

Activity

Before the start of each financial year, the Trust agrees with NHS Devon Primary Care Trust the planning assumptions regarding the number of patients we are expected to treat. During 2011/12 we experienced an overall increase of 7.5% in the number of patients that were referred to us.

Attendances at A&E were 1.6% lower than the Trust had planned with NHS Devon Primary Care Trust.

Total Emergency admissions were 19% higher than the Trust had planned with NHS Devon Primary Care Trust.

This meant that the number of patients we treated was significantly higher than we planned.

Section 5 highlights the Trust performance and highlights that we treated all of these patients with the minimum delay, to high standards in a clean environment.

Acute Contract Activity (Plan = contracted volumes)				
Indicator	Year Cumulative			
	Plan	Actual	Variance	
GP Referrals	27,942	30,196	+8.1%	✓
Other Referrals	16,997	18,133	+6.7%	✓
Total Referrals	44,940	48,330	+7.5%	✓
Outpatient First Attendances	42,923	45,268	+5.5%	◆
Outpatient Follow Up Attendances	83,243	92,794	+11.5%	◆
Elective DC Activity	18,004	19,119	+6.2%	✓
Elective IP Activity	4,353	675	-15.6%	✓
Elective Total Activity	22,357	22,794	+2.0%	◆
Day Case Rate Overall	80.5%	83.9%	+3.4%	✓
Non-elective (All inc Mat.)	17,719	20,651	+16.5%	◆
Non-elective (General & Acute)	13,339	15,869	+19.0%	◆
A&E Attends (NDDH)	40,233	39,574	-1.6%	✓

Financial Performance

2011/12 is the third year that the Trust has had to prepare its accounts and report financial performance under International Financial Reporting Standards (IFRS). Whilst this has not materially affected the Trust's underlying financial position, there is one fundamental change that continues to require clarification.

On the face of the main accounts, it would appear that the Trust has moved from having a financial surplus in 2008/09 that has turned into a financial deficit in subsequent years. The table below is an extract from the Statement of Comprehensive Income contained in page 3 of the accounts:

	2008/09 £'000	2009/10 £'000	2010/11 £'000	2011/12 £'000
Retained surplus/ (deficit) for the year	7,918	(5,086)	(93)	(5,724)

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

Impairments relate to the IFRS requirement to revalue assets to Modern Equivalent Asset Valuation.

Impairments are elements of capital expenditure that is incurred but does not add to the value of the asset.

Where an insufficient revaluation reserve balance exists for that asset, the remainder is charged to the Statement of Comprehensive Income.

The Impairment charge for the year is £7,328,000. This has no impact on the Trust's liquidity as it is a non-cash item.

The Trust has a statutory financial duty to break even. The table below is an extract from the Financial Performance Targets contained in note 39.1 on page 44 of the accounts:

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

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

Staff Sickness

The Trust has an overall sickness rate of 3.3% (at 31 March 2012).

The Trust continues to access benchmarking data that is utilised to make further improvements in sickness rates.

Savings and Efficiency

The Trust had a financial savings target for the year of £8.9million. The Trust achieved £9.4 million through cost reduction and efficiency improvements.

The ability of the Trust to deliver the full value of the above Continuous Improvement Programme has been severely affected by the following factors:

- ▶ Activity increases as a consequence of increased referrals to the Trust;
- ▶ Increased Emergency admissions.

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

The performance of savings and efficiency plans achieved during the year continued to be reported regularly to the Trust Board, Finance Committee and Clinical Services Executive Committee.

Trust Accounts

The Trust's accounts are audited annually by the Audit Commission, Unit 5-6 Blenheim Court, Matford Business Park, Lustleigh Close, Exeter, Devon, EX2 8PW. The fee for this work is detailed on page 23 of the accounts.

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

Alternatively they are available for download from our website at www.northdevonhealth.nhs.uk

7. Where our money comes from

The majority of the Trust's funding comes from contracts with Primary Care Trusts (PCTs), which purchase healthcare on behalf of their residents.

Total income received by the Trust in 2011/12 was £211.8 million (£134.7m 2010/11), a 55% increase on the previous year, as a result of the Trust taking on community services in East Devon.

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

Source:		Monetary Equivalent £m		Monetary Equivalent £m
	2010/11	2010/11	2011/12	2011/12
Primary Care Trusts	£0.93	£125.6	£0.92	£195.3
Other Income	£0.04	£5.3	£0.04	£8.3
Education, Training & Research	£0.02	£2.9	£0.02	£3.9
Other Patient Income	£0.01	£0.9	£0.02	£4.3
Total	£1.00	£134.7	£1.00	£211.8

8. What we spend money on

The largest component of our expenditure is on salaries and wages. The Trust employed an average of 3,708 whole time equivalent staff (2,285 2010/11) at an overall cost of £140.0 million (£91.5 million 2010/11).

Average staff numbers included 280 doctors (281 2010/11), 1,162 nursing staff (715 2010/11), 1,102 Healthcare Assistants and support staff (506 2010/11), 658 administration and estates staff (491 2010/11) and 506 scientific and technical and other staff (292 2010/11).

A further £25.4 million (£18.9 million 2010/11) was spent on clinical supplies such as drugs and consumables used in providing healthcare to patients.

The cost of running the premises and equipment amounts to £18.1 million (£6.4 million 2010/11) and general supplies and services which support the Trust's infrastructure cost £7.0 million (£6.1 million 2010/11).

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

Source:	Monetary Equivalent £m		Monetary Equivalent £m	
	2010/11	2010/11	2011/12	2011/12
Staff Pay (inc. Management)	£0.69	£91.5	£0.65	£140.0
Drugs & Clinical Supplies	£0.14	£18.9	£0.12	£25.4
Premises & Equipment	£0.05	£6.4	£0.08	£18.1
General Supplies & Services	£0.04	£6.1	£0.03	£7.0
Depreciation	£0.04	£5.0	£0.06	£12.4
Services from Other NHS Bodies	£0.01	£0.9	£0.04	£7.9
Other Expenses	£0.03	£3.6	£0.02	£4.5
Total	£1.00	£132.4	£1.00	£215.3

9. Better Payment Practice Code

Section 6 identifies a statutory requirement to pay 95% of non-NHS invoices within 30 days and details the Trust's performance against this.

The Confederation of British Industry (CBI) "Better Payments Practice Code" is a 4 point code that organisations should adopt to ensure prompt payment to suppliers. The points are:

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

Under the Late Payment of Commercial Debts (Interest) Act, all businesses are entitled to claim statutory interest and debt recovery compensation for the late payment of commercial debts.

Further details as provided on page 27 of the accounts are detailed below:

Note 13.1 Better Payment Practice Code - measure of compliance

	2011/12	
	Number	£000
Total Non-NHS trade invoices paid in the year	50,711	48,907
Total Non NHS trade invoices paid within target	47,695	46,250
Percentage of Non-NHS trade invoices paid within target	94%	95%

The Better Payment Practice Code requires the Trust to aim to pay all undisputed invoices by the due date or within 30 days of receipt of goods or a valid invoice, whichever is later.

Note 13.2 The Late Payment of Commercial Debts (Interest) Act 1998

	2011/12	2010/11
	£000	£000
Amounts included within Interest Payable (Note 13) arising from claims made under this legislation	0	0
Compensation paid to cover debt recovery costs under this legislation	0	0

There were no payments in respect of late payments on commercial debts.

Actions taken by the Trust to improve the time taken to pay suppliers includes:

- ▶ Review of processes to minimise delays;
- ▶ Implement electronic scanning and authorisation solution
- ▶ Improve the process for receipting goods;
- ▶ Review the frequency of payment runs.

10. Capital Investment

In 2011/12 capital expenditure totalled £5.3 million. This included:

- ▶ £2.1m on Estate developments;
- ▶ £1.6m on operational medical equipment;
- ▶ £1.1m on operational IT;
- ▶ £0.5m on backlog maintenance.

The Trust received £36k in donations towards capital spend and is grateful to the Leagues of Friends, Volunteers and contributors to Charitable Funds for their invaluable contribution to the Trust.

11. International Financial Reporting Standards (IFRS)

The Accounts for 2011/12 have been prepared in accordance with International Financial Reporting Standards.

12. Breakeven Duty and 2012/13 Financial Outlook

NHS Trusts are required to break-even taking one year with another. In practice this must be delivered over a 3 year period and can be extended to 5 years with the permission of the Department of Health and starts with first year the deficit arises.

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

	2010/11	2011/12
	Actual	Actual
	£'000	£'000
Post 1997 Cumulative Surplus/(Deficit) b/fwd	(93)	(5,724)
Adjustments for Impairments and donations	345	7,443
Breakeven Surplus/(Deficit)	252	1,719
Break Even Duty Year	1	2
Breakeven Duty Achieved?	Yes	Yes

The current economic climate will prove challenging to public sector bodies as the level of investment reduces. In particular, the Devon health economy faces a significant financial challenge in 2012/13 and we will be a proactive contributor in the process.

Transforming Community Services affords the Trust critical mass and opportunity to positively impact on patient care across a wider geographic area.

However, the corrective actions required places a risk on the Trust that has resulted in a savings target of £12.7 million being incorporated in financial plans for 2012/13.

13. Foundation Trust Status

NHS Foundation Trusts remain part of the NHS but are free from central government control. Within clearly defined guidelines, a NHS Foundation Trust can raise capital funding and external borrowing and determine the services they wish to provide.

The Trust has in place a formal Tri-partite agreement setting a timetable with NHS South of England and the Department of Health that will see Foundation Trust status achieved in the 2012/13 financial year.

14. Sustainability Statement

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

As one of the largest employers in Devon the Trust is aware that through its business of providing healthcare to an area of 1400 square miles its operating protocols can have a big environmental impact on local resources. The NHS Good Corporate Citizen guide identifies six areas that Trusts should focus on. These include:-

Energy:

The Trust's annual energy budget is £2.8 million per annum, with the spiralling cost of energy this has become a priority area. Through the management of its energy usage the Trust has achieved a reduction in utility consumption by a further 1.5% for the year 2011 – 2012. This brings the Trust down to an energy consumption of £390/m², in line with the best performers in the UK.

Waste:

Environmental impact and compliance to statutory waste regulations are key areas for the Trust. In the year 2011 – 2012 through efficient segregation and increased recycling waste volumes have reduced. The Trust continues to remain proactive in all areas of waste management, ensuring costs are managed, that we remain compliant to legislation, and that environmental impact is minimised.

Green Travel:

The Trust promotes green travel within its workforce by advertising public transport access and the encouragement of lift sharing. In supporting of the cycle to work scheme onsite changing facilities are maintained at all sites for those wishing to participate.

Procurement:

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

Estate development:

The Trust's aim is to ensure that the properties within its estate are fit for purpose and support the delivery of a modern healthcare service. Key to this is a design and layout that should provide the right ambience, but withstanding that in its production and running it must not impact on local or national resources. All development is specified with the use sustainable products and energy efficiencies that meet Department of Health bench marks.

Work force:

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

15. Emergency Planning

Introduction

The Civil Contingencies Act 2004 outlines a single framework for civil protection in the United Kingdom. Part 1 of the Act establishes a clear set of roles and responsibilities for those involved in emergency preparation and response at local level.

The Act divides local responders into two categories, imposing a different set of duties on each. Category 1 responders are those organisations at the core of the response to most emergencies, and are subject to the full set of civil protection duties. Northern Devon Healthcare NHS Trust incorporating community services in Exeter, East and Mid Devon is a Category 1 responder. Category 2 responders have a lesser set of duties and are required to co-operate and share relevant information with other Category 1 and 2 responders.

As a Category 1 Responder, the Trust has the following duties:

- ▶ To assess the risk of emergencies occurring and use this to inform contingency planning;
- ▶ To put emergency plans in place;
- ▶ To put business continuity management

arrangements in place;

- ▶ To have arrangements to make information available to the public about civil protection matters 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 co-ordination;
- ▶ To cooperate with other local responders to enhance co-ordination and efficiency.
- ▶ Organisational structure for emergency planning and resilience

The Director of Operations has strategic responsibility for emergency planning and resilience across the Trust and for providing assurance to Trust Board that the organisation meets its statutory and legal requirements. This role is supported by a Non-Executive Director champion for emergency planning and resilience.

Operational responsibility for coordinating and delivering the emergency planning and resilience programme for the North Devon District Hospital, 17 Community Hospitals, 9 Minor Injury Units, 2 Walk In Centres, 17 Complex Care Teams and 12 Devon wide specialist community services sits with the Divisional General Manager for Emergency Services, supported by the Trust Risk Manager and the Trust Emergency Planning Group.

Major Incident Plan

The Trust reviews and updates its Major Incident Plan and publishes it on its Intranet on an annual basis. The plan fully complies with national guidance for emergency preparedness.

Following the Transforming Community Services project, from April 2011, the Trust acquired additional sites and services from Devon Provider Services. This has necessitated a review and rewrite of the Major Incident Plan to reflect the structure and purpose of the new organisation and to fit with the plans of Devon County Council where Health and Social Care staff provide joint services.

Business Continuity Strategy and Plans

During 2011- 2012, the Trust developed and approved its Business Continuity Strategy. It also reviewed and amended its Core Services Prioritisation Summary following the Transforming Community Services project. The Business

Continuity Strategy details the actions that the Trust will take to ensure resilience of its Core Services and plans for recovery should a Business Continuity incident occur. The Core Services Prioritisation Summary details those services which must remain functioning and those services which could be considered for temporary reduction or stand down, depending on the identified threat, or incident.

Other Trust Emergency Plans

- ▶ Chemical Biological Radiological and Nuclear Plan – this plan details the roles, responsibilities and actions that Trust staff need to undertake to respond to patients attending Trust sites who have been involved in a Chemical Biological Radiological and Nuclear or Hazardous Materials incident. The plan is undergoing further review and amendment to include the role of Minor Injury Unit and Walk In Centre staff. This plan is supported by lockdown arrangements for Trust sites which are aimed to protect staff and patients from hazards associated with Chemical Biological Radiological and Nuclear or Hazardous Materials incidents.
- ▶ Pandemic Influenza Plan – this plan details the Trust arrangements for the protection of staff and operational contingency arrangements in the event of large numbers of staff being affected should a pandemic influenza outbreak occur. It also details the Trust's response to the provision of antiviral treatments from designated Trust sites across North and East Devon. This plan was approved in 2009 and is now due to be reviewed and amended following the recent review and amendment of national guidance for Pandemic Influenza planning in 2012.
- ▶ Heatwave and Cold Weather Plans – these plans detail how the Trust will implement the Heatwave and Cold Weather plans for England, which aim to enhance resilience in the event of severe hot or cold weather. These plans are an important component of overall Trust capacity planning and wider health promotion activity and are reviewed on an annual basis.

Partnership Working

Collaboration with partner organisations and other stakeholders is a duty under the Civil Contingencies Act 2004. Working closely with our partners is fundamental to the Trust's ability to respond to a major incident and the organisation has continued to work with individual external agencies throughout 2011 - 2012 to ensure all emergency plans are mutually supportive and support a whole health community response.

The Trust is a member of the Devon, Cornwall and Isles of Scilly Local Resilience Forum and Local Resilience Health Emergency Planning Group and regularly attends the scheduled meetings. This ensures that the Trust receives all the relevant information on emerging issues and is involved with the development of emergency plans across the Devon, Cornwall and Isles of Scilly area. It is also an opportunity to network with emergency planning and resilience colleagues from other NHS organisations to share planning arrangements, documents and expertise.

During 2011 – 2012, the Trust has worked in partnership with other Category 1 and Category 2 Health organisations in Devon, Cornwall and Isles of Scilly, to develop a Mass Casualties Plan, which would be invoked in the event of a mass casualty incident. Collaborative work with Local Authority partners is planned for 2012 – 2013 to further develop facilities for the treatment of large numbers of walking wounded resulting from a mass casualty incident.

Exercise and Testing

During 2011 - 2012 the Trust participated in a number of external exercises:

- ▶ 'Alarm Call' communications cascade exercises – these took place in September 2011 and March 2012 and were coordinated by the South West Ambulance Service NHS Foundation Trust. On each occasion, there was a prompt response from Trust staff to the cascade calls across the Trust;
- ▶ 'Exercise Nordic', September 2011 – this was a Devon County Council rest centre exercise in Chulmleigh, North Devon. Participation enabled Trust Health and Social Care staff to work in collaboration with the emergency services, voluntary and voluntary first aid organisations, local authority and Devon County Council staff to set up and work in the rest centre;

- ▶ 'Exercise Diaspora' September 2011 – this was a large scale multi agency command and control exercise run by the Health Protection Agency to test the response to a mass casualty incident across NHS organisations in the South West Peninsula. Participation enabled the Trust to exercise the incident control team and clinical teams in response to a number of scenarios involving increased demands on services.

During 2011 - 2012, the Trust's Business Continuity plans were implemented and tested in response to planned industrial action by a number of healthcare unions and professional bodies. Core services were maintained and disruption to patients attending Trust sites was minimised.

In March 2012, Business Continuity plans were reviewed to ensure that Trust Managers and staff developed contingency plans to maintain core services if fuel supplies were seriously disrupted as a result of planned industrial action by tanker drivers in England. Although the planned disruption was averted, the planning enabled the Trust to identify its essential users of fuel and develop other contingency plans to maintain services in a fuel shortage situation.

External assessment and assurance

During 2011 – 2012, the Trust's emergency planning and resilience arrangements including the Chemical Biological Radiological and Nuclear plan were assessed by the Strategic Health Authority and found to be fit for purpose and complied with the requirements of the Civil Contingencies Act 2004. Where recommendations were made to strengthen plans, these will be included in the 2012 – 2013 emergency planning and resilience programme.



Annual Governance Statement

1. Scope of responsibility

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

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

Internal Reporting –

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

Stakeholder Reporting -

- ▶ Attendance at the Northern and Eastern Devon Clinical Commissioning Group meetings when required
- ▶ Attendance at the LINKs meetings and the Overview and Scrutiny Committee when required
- ▶ Additionally, the Trust Executive Team have attended Devon Health Community meetings when they have been convened

Networking Meetings -

- ▶ Chief Executive Director and Chairman
- ▶ Director of Finance
- ▶ Medical Director
- ▶ Director of Nursing

- ▶ Director of HR
- ▶ League of Friends

2. The governance framework of the organisation

2.1. Board composition

During 2011/12, the membership of the Trust Board changed as two new Non-Executive Directors were appointed following the resignation of one Non-Executive Director at the end of March 2011 and the end of the second term of office of another Non-Executive Director at the end of June 2011 (Table 1). The new Non-Executive Directors were appointed by the Appointments Commission in accordance with good practice. The interim Chief Executive was made substantive in January 2012, following a robust recruitment process led by the Strategic Health Authority.

Table 1 – Board membership for 2011/12

Non-Executive Directors		
Name	Role	Comment
Roger French	Chairman	
Pauline Geen	Non-Executive Director	
June Lake	Non-Executive Director	Second term of office completed in June 2011
Nick Lewis	Non-Executive Director	First term of office started 1 August 2011
Jane Reynolds	Non-Executive Director	
Chris Snow	Non-Executive Director	First term of office started 1 August 2011
Amelia Tucker-Jones	Non-Executive Director	
Executive Directors		
Jac Kelly	Chief Executive	Interim position made substantive in January 2012
Alison Diamond	Medical Director	
Kate Lyons	Director of Operations	
Carolyn Mills	Director of Nursing	
Andy Robinson	Director of Finance & Performance	

Board meetings are also attended by the Director of Personnel & Development, Director of Facilities and the Head of Corporate Governance. Since April 2011, the Associate Director of Health & Social Care also attends Board meetings to reflect the Trust's provision of adult community services.

2.2. Board committee structure

During 2011/12, the Trust Board reviewed the Board's committee structure. In November 2011, it was agreed to establish a Finance Committee as a sub-committee of the Trust Board. The role of the Finance Committee is to maintain robust financial management by monitoring financial performance and making recommendations to the Executive Team or to the Trust Board as appropriate.

In January 2012, the role and membership of the Clinical Governance Committee was reviewed. It was agreed to re-name the Committee as the Quality Assurance Committee and to establish a core membership of three Non-Executive Directors, the Medical Director, the Director of Nursing and senior clinicians. The core membership is supported by specialist advisers who attend the Committee meetings. A Non-Executive Director has been nominated as the Chair of the Committee. The role of the Quality Assurance Committee is to provide leadership and assurance that the Northern Devon Healthcare NHS Trust's clinical governance systems and processes are in place and are effective in providing safe high quality care.

The sub-committees of the Trust Board comprise:

- ▶ Audit & Assurance Committee
- ▶ Charitable Funds Committee
- ▶ Finance Committee
- ▶ Foundation Trust Application Steering Group
- ▶ Quality Assurance Committee
- ▶ Remuneration and Terms of Service Committee

Membership of each sub-committee includes Non-Executive and Executive Directors, as well as other staff who may be full members, act as specialist advisers or be in attendance. Each sub-committee is chaired by a Non-Executive Director. The Terms of Reference and membership of the sub-committees are reviewed on an annual basis and, following approval by the relevant sub-committee, are presented to the Board for ratification.

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

2.3. Trust Board meetings

In 2011/12, the Trust Board met ten times in public. Each meeting was quorate and attendance of the members of the Trust Board is shown in Table 2 below.

Table 2 – Board attendance 2011/12

	Attendance	26.04.11	24.05.11	28.06.11	26.07.11	27.09.11	25.10.11	22.11.11	10.01.12	28.02.12	27.03.12
R French	10/10 100%	X	X	X	X	X	X	X	X	X	X
P Geen	9/10 90%	-	X	X	X	X	X	X	X	X	X
J Lake	2/3 67%	X	-	X	/	/	/	/	/	/	/
N Lewis	6/6 100%	/	/	/	/	X	X	X	X	X	X
J Reynolds	10/10 100%	X	X	X	X	X	X	X	X	X	X
C Snow	6/6 100%	/	/	/	/	X	X	X	X	X	X
A Tucker-Jones	7/10 70%	X	X	-	X	-	-	X	X	X	X
J Kelly	9/10 90%	-	X	X	X	X	X	X	X	X	X
A Diamond	8/10 80%	X	X	X	X	X	-	X	X	-	X
K Lyons	9/10 90%	X	X	-	X	X	X	X	X	X	X
C Mills	9/10 90%	X	X	X	-	X	X	X	X	X	X
A Robinson	9/10 90%	X	X	X	X	-	X	X	X	X	X

Throughout the year and following an informal Board observation in November 2011 by representatives of the Strategic Health Authority as part of the Foundation Trust application, the agenda for the Board meetings was reviewed to ensure that the Board considered:

- ▶ Quality issues as the first item on the agenda
- ▶ Emerging issues as potential risks or opportunities to the organisation
- ▶ Addressing the balance between strategic issues and operational detail

- ▶ Reports that required the whole Board's input and/or decision rather than reports that had already been discussed and/or agreed at the sub-committee level
- ▶ Questions from the public at the end of the Open Board meeting.

The Board agenda will continue to be kept under review.

The function of the Board Briefing Programme and information contained in the routine Board Briefing packs were reviewed to ensure the Board had sufficient opportunity to discuss and consider the business details to support the informed decision-making process of the Board. In addition, it was agreed to instigate a process for disseminating Flash Reports to Board members between Board meetings.

2.4. Key Issues of Board reports 2011-12

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

- ▶ Approval of Annual Business Plan including Financial Plans and Budgets (IBP and LTFM)
- ▶ Approval of the Tripartite Formal Agreement to achieve Foundation Trust status.
- ▶ Approval of the Devon County Council Memorandum of Understanding for integrated adult health and social care services 2011-14
- ▶ Regular updates were provided regarding the proposals to address issues around breaches of Mixed Sex Accommodation
- ▶ Approval of the Trust's Corporate Objectives 2011-12
- ▶ Approval of the Trust's Vision, Strategic Objectives and Values
- ▶ Receipt of the Staff Survey 2010 and 2011 and supporting action plan
- ▶ Receipt of the Patient Survey 2010 and supporting action plan
- ▶ Approval of the Trust's application to be designated as a Trauma Unit
- ▶ Approval of the Organisational Development Framework
- ▶ Approval of key Foundation Trust documents that form part of the application for Foundation Trust status
- ▶ Approval of the Quality & Patient safety Strategy 2011-14
- ▶ Approval of the Informatics and IM&T Strategy
- ▶ Approval of the Workforce Development Strategy 2012
- ▶ Approval of the Patient Experience Strategy 2011-14
- ▶ Approval of the Risk Management Strategy
- ▶ Approval of the Trust's Smokefree policy and agreement to support the Smokefree Hospital Initiative
- ▶ Agreement to support the Trust's designation as a Trauma Unit at North Devon District Hospital
- ▶ Approval of the Responsible Officer for medical validation

2.5. Key issues from Board sub-committee reports 2011-12

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

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

Audit & Assurance Committee

- ▶ Statement on Internal Control – the Committee reviewed the Statement on Internal Control for the period 1st April 2010 to 31st March 2011 and confirmed that it was consistent with the view of the Committee on the Trust's system of internal control.
- ▶ Head of Audit Opinion – the Committee received the Head of Audit Opinion 2010/11 and Internal Audit Annual Report 2010-11 and noted its conclusions of significant assurance in respect of the system of internal control.

- ▶ Annual Audit Letter – the Committee received the Annual Audit Letter prepared by the Audit Commission.
- ▶ Annual Governance Report – the Committee received the Annual Governance Report prepared by the Audit Commission and noted that the Trust had received an unqualified opinion for value for money.
- ▶ In-depth Risk Reports – following the receipt of routine reports of the Trust's high level (15+) risks, the Committee requested that an in-depth review be undertaken on three ongoing risks related to maternity services (Risk ID 1008), standardisation of equipment (Risk ID 477) and ventilation issues in a shower room (Risk ID 510) to identify barriers to the implementation of its mitigating actions. This provided additional assurance that the risks were being managed effectively. The in-depth reports were also presented to the Risk Management Committee and to the Trust Board to note.
- ▶ Committee Compliance Reports – the Committee received the annual Risk Management Committee Compliance Report 2009/10 and noted that the Risk Management Committee was meeting its Terms of Reference. The Committee received the annual Clinical Governance Committee Compliance Report 2009/10 and noted that the Clinical Governance Committee was meeting its Terms of Reference
- ▶ ALE Recommendations Report – following the demise of the Auditors' Local Evaluation Assessment (ALE) programme at the end of 2009/10, the Committee requested that a regular update on the progress made by the Trust against the recommendations identified in the Audit Commission's final ALE report be presented to the Committee. It was noted that a number of the recommendations had already been completed or already formed part of the Trust's ongoing work.
- ▶ Transforming Community Services programme – following the proposals for the transfer of community services in Exeter, East and Mid Devon to the Trust, the Committee requested that an update of the Transforming Community Services be provided as a standing agenda item. The Committee repeatedly reviewed the progress of the Due Diligence Report and the outstanding issues from the exercise.

Charitable Funds Committee

- ▶ It was agreed that an overarching Fundraising Strategy should be developed.
- ▶ A Board Briefing session is to be scheduled in 2012-13 to enable the Trustees to prioritise the future fundraising priorities and to consider the role of the Fundraising Office.
- ▶ It was agreed that the Head of Communications and the Fundraising Manager should continue to attend Committee meetings and to provide regular update reports.
- ▶ Investment Policy – the Committee approved the policy and agreed that the review interval could be increased to three years.
- ▶ Reserves Policy – the Committee approved the policy and agreed that the review interval could be increased to three years.

Finance Committee

Routine Review Areas

During the year, the Committee received routine reports to gain assurance that an accurate Financial position was being reported including:

- ▶ Monthly financial reports.
- ▶ Monthly Activity and QIPP reports.
- ▶ Monthly Financial and Performance Dashboard Reports.
- ▶ Monthly update reports on the Continuous Improvement Programme.
- ▶ Monthly Capital programme reports.
- ▶ Ad-hoc and exception reports will be received as and when required.
- ▶ The Annual Finance Committee Compliance Report will be received.

Principal Review Areas and Key Outputs

The principal review areas and key outputs are as follows:

- ▶ Updates on the 2012/13 contracting process with NHS Devon.
- ▶ Annual Trust budgetary position - the Committee reviewed the documents and recommended approval to the Trust Board.

Foundation Trust Application Steering Group

- ▶ Foundation Trust Application Report and Timeline – the Steering Group received regular reports from the Corporate Project Manager on the progress of the Foundation Trust application.
- ▶ Project Risk Log – the Steering Group regularly received and reviewed the project risk log.
- ▶ Strategic Health Authority Iterative Reviews – the Steering Group received and noted the minutes of Strategic Health Authority iterative reviews,
- ▶ Commissioner Convergence – the Steering Group received frequent verbal updates on the progress made by the Trust towards achieving commissioner convergence.
- ▶ Membership update – the Steering Group received regular membership updates from the Head of Communications.
- ▶ Draft Constitution proposals – the Steering Group reviewed the draft constitution proposals and recommended referral to Executives for further discussion.
- ▶ Membership Strategy – the Steering Group reviewed and noted the Membership Strategy,
- ▶ Consultation and Summary Consultation Documentation – The Steering Group reviewed and noted the Foundation Trust Consultation and recommended approval to the Trust Board.
- ▶ Rebranding Report – the Steering Group reviewed the Rebranding Report and recommended presentation to the Board for further discussion.
- ▶ Marketing Strategy – the Steering Group reviewed and noted the Marketing Strategy recommending that it should be presented to the Board.
- ▶ Foundation Trust Communications Strategy – the Steering Group reviewed and noted the Communication Strategy recommending that it be presented to the Board for final approval.
- ▶ Foundation Trust project Structure – the Steering Group reviewed noted the Foundation Trust project structure.

- ▶ Integrated Business Plan and Long Term Financial Model – the Steering Group noted the updates received,
- ▶ Monitor’s Quality Governance Framework – the Steering Group noted the requirements of the framework.
- ▶ Organisational Name – the Steering Group noted the revised organisational name that would come into being once the Trust obtains Foundation Trust status.

Quality Assurance Committee (formally Clinical Governance Committee)

- ▶ An in-depth risk report for Risk ID 1008 relating to identified risks in maternity services following a serious incident investigation was received by the Committee.
- ▶ An in-depth risk report for Risk ID 477 relating to the potential risk of harm to patients from the incorrect administration of medicines, fluids or enteral feeds via an infusion pump or syringe driver was received by the Committee.
- ▶ The Committee supported proposals to introduce a system of taking two blood samples for patients with no historical blood sample to reduce the risk of transfusing mismatched blood. Errors in transfusion mismatched blood is classified as a National Patient Safety Agency “Never Event”.
- ▶ Following discussion of a serious incident investigation report, the Committee requested that an additional action be added to raise awareness amongst ward staff on the procedure for obtaining pressure-relieving mattresses. The Committee also requested that a statement should be included in the report to clarify that community hospital beds are not booked ahead, even for long term rehabilitation patients.
- ▶ Following discussion of a serious incident investigation report, the Committee requested that safety checks will be implemented to reduce the risk of a similar incident re-occurring in relation to protocols for repeated medication loading doses.

- ▶ Four serious incident investigation reports were not approved by the Committee as there were concerns that the action plans were not sufficiently robust or detailed to mitigate the risk of an incident re-occurring. The serious investigation reports were subsequently re-submitted and approved.
- ▶ The Committee approved the Restraint Policy.
- ▶ The Committee approved the Claims Handling Policy.
- ▶ The Committee approved the Patient Experience Strategy.
- ▶ The Committee approved the Being Open Policy.
- ▶ The Committee approved the Procedural Document Development, Implementation and Management Policy.
- ▶ The Quality and Patient Safety Improvement Strategy for 2011–14 was approved. It reflects the Trust's commitment to delivering harm free care and to continue to embed patient safety across all levels of the organization. The supporting workplan will be reviewed on a routine basis by the Patient Safety Operational Group.

Remuneration and Terms of Service Committee

- ▶ The Committee reviewed the remuneration of Chief Executive, Executive Directors and other Directors following the transfer of Devon Provider Services to the Trust.
- ▶ Agree any variation of contract for Chief Executive
- ▶ The committee noted changes to national pay scales for staff on Agenda for Change Terms and Conditions of Service.
- ▶ The Committee reviewed and acted on guidance issued by the Secretary of State relating to pay increased for very senior managers.
- ▶ The Committee considered salary survey benchmark reports.
- ▶ The Committee agreed the Chief Executive's recruitment process.

- ▶ The Committee supported the development of a framework to which bonus payment or increases to salary will be paid, taking into account the current economic climate.
- ▶ The Committee agreed a framework to approve arrangements for payments to staff that fall under the following categories that are not a contractual entitlement, i.e. redundancy, compromise and severance payments for all staff.

2.6. Board performance and effectiveness

Trust Board

In 2011/12, a gap analysis of the Board members' skills and knowledge was led by the Director of Personnel & Development. The findings were reported to the Board and will form the basis of a Board Development Programme to support the Board's continuing development to meet the requirements of a Foundation Trust Board.

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

Audit & Assurance Committee

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

2.7. Compliance with the Corporate Governance Code

Throughout 2011-12, the Board has continued to build on the principles of good corporate governance. Corporate governance is the way in which organisations are directed, controlled and led. It defines relationships and the delegation of roles and responsibilities of those who work within the organisation, determines the rules and procedures through which the organisation's strategic objectives are set, and provides the means of attaining those strategic objectives and monitoring performance. Most importantly, it defines where accountability lies throughout the organisation.

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

- ▶ Standards of business conduct (Department of Health, 1993)
- ▶ Code of conduct for NHS managers (Department of Health, 2002)
- ▶ Building an assurance framework: a practical guide for NHS Boards (Department of Health, 2003)
- ▶ Code of conduct and accountability in the NHS (Department of Health, 2004)
- ▶ Integrated governance handbook (Department of Health 2006)
- ▶ Introductory guide – NHS Governance (Healthcare Financial Management Association 2011)
- ▶ Code of governance for NHS Foundation Trusts (Monitor, 2010)
- ▶ Audit Committee Handbook (Healthcare Financial Management Association 2011)
- ▶ Board governance assurance framework for aspirant Foundation Trusts (Department of Health, 2011)
- ▶ Integrated governance (Healthcare Financial Management Association 2011)
- ▶ Corporate governance in central government departments: Code of good practice (HM Treasury, 2011)

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

In 2012-13, the Board will formally collectively affirm and document its understanding of the organisation's purpose and document the Board's role and responsibilities in a Board Operating Framework.

3. Risk assessment

3.1. System of internal control

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

- ▶ identify and prioritise the risks to the achievement of the organisation's policies, aims and objectives,
- ▶ evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically.

The system of internal control has been in place in Northern Devon Healthcare NHS Trust for the year ended 31 March 2012 and up to the date of approval of the annual report and accounts.

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

3.2. Capacity to handle risk

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

The Chief Executive has overall responsibility for risk management within the Trust. The Director of Finance and Performance has been nominated as the lead Director for risk management. Each Director has responsibility for leading and

reporting on the risk management plans for risks identified within their directorates. The Directors are accountable to the Chief Executive in this role.

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

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

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

3.3. Risk profile

As at 31 March 2012, there were 368 open risks recorded on the Corporate Risk Register (Table 3). During 2011/12, 359 new risks were recorded and 363 risks were accepted as the mitigating actions had been completed and the risk re-scored.

Table 3 – Risk profile of open risks as at 31 March 2012 (n = 368)

Category	Risk score	Number	% of Total
Low	1 - 6	52	14
Medium	8 - 12	243	66
High	15 - 25	73	20

4. The risk and control framework

4.1. Risk Management Strategy

The Risk Management Strategy was reviewed in order to reflect the developments in risk management throughout the year and the impact of the incorporated community services as part of Transforming Community Services. It also included a new section on risk appetite. The Risk Management Strategy was approved by the Trust Board in February 2012. It was agreed that the Risk Management Strategy will be reviewed within the first half of 2012/13 to include the ongoing developmental work around the Strategic Risks.

The Risk Management Strategy includes the following:

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

It also includes a description of the whole risk management process and requires all risk to be recorded, when identified, in a standard format risk register and prioritised using a standard scoring methodology. The Corporate Risk Register includes all recorded risk, both clinical and non-clinical, for the organisation.

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

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

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

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

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

4.2. Assurance Framework

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

- ▶ Principal objectives
- ▶ Principal risks
- ▶ Key Controls
- ▶ Assurances on Controls
- ▶ Gaps in Assurance

- ▶ Gaps in Control
- ▶ Principal Risk Action Plan

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

High scoring risks, i.e. with scores of 15 or more, recorded on the Corporate Risk Register are discussed at the Risk Management Committee to assess if they represent an example of a principal organisation-wide risk. These risks are recorded on the Principal Risk and Assurance Register, together with a description of existing controls and related assurances and any gaps. Where gaps have been identified, action is agreed to manage the gaps and the information is set out in the Principal Risk Action Plan. This is presented to the Executive Directors Group, the Audit and Assurance Committee and the Trust Board for information. The Principal Risk and Assurance Register is monitored by the Audit and Assurance Committee and presented to the Trust Board for approval once year.

During 2010/11, the Trust Board completed a comprehensive exercise to review the Corporate Risk Register to identify the strategic risks to the organisation which represent the risks identified at Executive Director and Non-Executive Director level. In 2011/12, further work has been undertaken to develop an assurance framework for the management of the strategic risks facing the organisation – those risks that, if they materialised, would have a detrimental impact on the achievement of the strategic objectives and could lead to organisational failure or significant lost opportunities.

In 2012/13, further work will be undertaken by the Board to assess the strategic risks to the achievement of the strategic objectives, derived from SWOT and PESTLE analyses of the Trust's business. Where gaps in controls or assurance are identified, actions will be developed to mitigate the gaps. These actions will then form the annual corporate objectives for the Trust which will translate into personal performance objectives for the Board Directors and the annual work programmes for the Board sub-committees.

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

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

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

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

4.3. Management of key risks

Data security risks

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

In October 2011, a follow-up audit was undertaken by the Information Commissioner's Office to assess the progress made by the Trust on the Data Protection Compliance Audit carried out in October 2010. The follow-up audit stated that the Information Commissioner's Office had reasonable assurance that the Trust's processes and procedures to mitigate risks of non-compliance with the Data Protection Act are in place. In February 2012, an Internal Audit report on the Trust's Information Governance toolkit found that overall, there was potentially a medium potential adverse impact on the Trust's objectives. The report's recommendations and supporting action plan have been recorded onto the Trust's Corporate Risk Register and will performance monitored via the organisation's risk management arrangements.

In 2011/12, no serious data security incidents were reportable to the Information Commissioner's Office. One data security incident was formally investigated by the Trust.

Performance risks

Throughout the year the Trust handled a higher than expected demand on emergency services. General and Acute emergency admissions were 8% higher than the previous year and 19% higher than the contracted activity plan. There have also been a number of occasions during the winter period where it has been necessary to close beds to support infection control measures. Contingency action including the opening of additional beds in accordance with Winter Pressure Plans and cancellation of some non-urgent elective surgery. However the consequent pressure on bed availability over extended periods adversely impacted on the Trust's ability to maintain the 95% A&E 4 hour standard.

Early in 2011, the Trust's performance tracking processes picked up an increase in the Hospital Standardised Mortality Ratio. A thorough investigation, including external support and detailed clinical review, highlighted shortfalls in the processes for recording and coding of clinical information. Further information is included within Section 5.2

The Trust's local analysis indicates under-achievement for the following indicators:

- ▶ A&E waiting times – in 2011/12, levels of emergency demand have been higher than forecast plans throughout the year.
- ▶ Mixed Sex Accommodation – there have been periods during the year when pressure on bed capacity and the clinical need to admit resulted in breaches of Mixed Sex Accommodation standards.
- ▶ Never Events – there were two events recorded during 2011/12.
- ▶ Delayed Transfer of Care – has been under pressure at Community Hospitals resulting in non-achievement of the contracted standard.
- ▶ Stroke Service Indicators – a contributing factor in underachievement of the 90% of stay indicator has been pressure on emergency admissions and periods where Stroke Unit beds were closed for infection control requirements.

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

- ▶ Monthly Directorate Performance meetings
- ▶ Monthly Finance Committee meetings
- ▶ Routine reports to the Trust Board

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

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

There is currently uncertainty around the implications of QIPP programme for 2012/13 and the resulting impact on the Trust's workforce plans. This issue is being monitored by the Director of Operations and the Director of Personnel and Development.

Serious incidents requiring investigations risks

The Trust continues to be a high reporter of patient safety incidents reported to the National Patient Safety Agency compared with similar small acute trusts. The organisation has robust incident reporting processes embedded throughout the organisation as indicated by the high incident reporting culture. During 2010/11, the process was further strengthened for escalating reported incidents for a decision on whether they should be designated as a serious incident requiring investigation and formally investigated. Incidents may be escalated if the outcome actually or potentially had a severe or catastrophic level of harm or if the incident represents a significant risk to the organisation. Escalated incidents are subjected to an initial Significant Event Audit investigation and the report is presented to the executive team for a decision on whether it should be designated as a serious incident requiring investigation. The final decision is agreed by the Executive Directors Group.

On completion of the comprehensive formal investigation of serious incidents, the reports are reviewed by the executive team and presented to the Quality Assurance Committee and the Trust Board. Actions highlighted in both the Significant Event Audit reports and the serious incident investigation reports are recorded on the Corporate Risk Register and performance monitored and reported via the Trust's risk management systems.

5. Review of effectiveness of risk management and internal control

5.1. Effectiveness of risk management and internal control

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

My review has also been informed by:

- ▶ Audit Commission reports
- ▶ Internal Audit reports
- ▶ Assessments by external agencies, e.g. Information Commission consensual visit
- ▶ Care Quality Commission planned and responsive inspections
- ▶ Internal management reports

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Risk Management Committee, the Quality Assurance Committee, the Audit and Assurance Committee, the Clinical Services Executive Committee, the Finance Committee and the Trust Board. A plan to address weaknesses and ensure continuous improvement of the system is in place.

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

- ▶ The Board receives the following reports that provide it with assurance on how the controls within the organisation are working:
- ▶ Reports from other committees of the organisation
- ▶ Reports from Executive Directors and key managers
- ▶ Reports from external reviewers, when received
- ▶ The Audit and Assurance Committee receives reports from Internal and External Audit on the work conducted by them during the year.
- ▶ Minutes from the Board sub-committees are presented to the Board to note.
- ▶ Executive Directors and key managers may present reports to the Board to note or to approve.
- ▶ The Director of Internal Audit has provided a Head of Internal Audit Opinion commenting on the current status of the Assurance Framework and the effectiveness of the Systems of Internal Control reviewed by Internal Audit. This has been used to aid in the preparation of this Statement.
- ▶ The reporting structure described in the Assurance Framework is used to monitor the systems of internal control and make reports to the Board.
- ▶ The Assurance Framework is independently reviewed by Internal Audit on an annual basis.
- ▶ The Trust registered its locations, service types, regulated activities and a named manager for each location with the Care Quality Commission. The Trust received confirmation that the Trust had been successfully registered without any location or service specific conditions.

Issues of Significant Internal Control identified by the Executive Directors will be reported immediately to the Chief Executive. Reports will also be made to the next Executive Group meeting and to the next Board meeting. Where necessary, a Flash report will be disseminated to the Board with a description of the issue and the action taken and/or proposed. If required, the issue will be escalated to the relevant group, e.g. Audit and Assurance Committee or Quality Assurance Committee.

Disclosure of a significant internal control issue may contain a description of the weakness and its impact to provide context for the actions taken to manage it. In such cases, the Trust may exercise discretion when disclosing a significant internal control issue in order to avoid further adverse impacts or exploitation of the weakness.

5.2. Significant Issues

Non-compliance with Care Quality Commission's Essential Standards

Throughout 2011-12, the Trust received six final reports of the Care Quality Commission inspections.

Three inspections were carried out at North Devon District Hospital in February 2011, July 2011 and November 2011. On each occasion, a number of Compliance Actions were identified including lack of staff supervision, non-compliance with the WHO surgical checklist and poor documentation. In each case, an action plan was developed to achieve compliance and was submitted to the care Quality Commission. The action plans were recorded on the Corporate Risk Register and performance monitored via the Trust's risk management processes. The Care Quality Commission was informed once the action plans had been completed. North Devon District Hospital was inspected in March 2012 as a follow-up compliance review and was assessed as being fully compliant as it was found to be meeting all the essential standards of quality and safety inspected.

A responsive inspection was undertaken at Tiverton Hospital following information received by the Care Quality Commission from a member of the public. One Improvement Action was identified.

As part of a national review of arrangements related to Termination of Pregnancy services, the Trust was assessed as being fully compliant with the essential standards inspected.

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

A&E Department Review

An allegation was made by a member of staff in the A&E Department that there had been manipulation of A&E waiting times and bullying of staff. The Board approved an investigation into the allegations by an independent external reviewer.

The investigation included face to face interviews with current and previous members of staff in the A&E department, including managers, clinicians and admin staff. A range of data was also reviewed. The conclusion of the report was that discharge and transfer times of patients in A&E had been back-timed, in most cases legitimately. There was no adverse impact on patient safety. No evidence was found of any one individual being victimised as a result of raising concerns, although there was evidence that some staff had been subject to unacceptable behaviour from peers and senior staff due to the pressure to achieve the A&E waiting time target.

A development plan was implemented to address team morale and improve leadership within the A&E Department, as well as to manage the implementation of new clinical indicators.

The Board was briefed on the issue and progress by the Chief Executive at the routine monthly Board meetings.

Safeguarding Adults Review

A concern was raised about the Trust's adult safeguarding arrangements and processes following a police investigation and report. An allegation was made that there were systemic failures and that criminal proceedings may be instigated for corporate manslaughter by clinical negligence.

An independent external review was commissioned by the Trust to re-examine a number of adult safeguarding serious incident investigations. The review concluded that the Trust has reasonably sound processes in place. A number of recommendations were made to improve the arrangements and these were incorporated into an overarching action plan.

In addition, the Trust contacted the Care Quality Commission to ask for a responsive review at North Devon District Hospital. One area of concern was highlighted relating to the lack of documentation recording care provided in patients' records. An action plan was implemented and a follow-up visit was made by the Care Quality Commission and the Trust was reported as compliant.

The Trust was informed by the Crown Prosecution Service that there was no case against a single individual and that it was satisfied that the Trust's governance arrangements were robust.

The Board was briefed on the issue and progress by the Director of Nursing at the routine monthly Board meetings.

Hospital Standardised Mortality Review

During the winter of 2010, the Performance Team made the Medical Director aware that the Hospital Standardised Mortality Ratio (HSMR) had dipped for three months. This was reported to the Trust Board as part of the March and April 2011 performance reports. A further variable was introduced following the incorporation of community services in Exeter, East and Mid Devon as the eastern figures were reported separately from the northern figures. The picture was further complicated by the annual re-basing process undertaken by Dr Foster in September 2011 that identified the Trust as a regional outlier.

A review of around 170 case notes of patients who had died within a set timeframe was undertaken by consultant clinicians and it was shown that the patients' care had not been compromised. The root causes for the HSMR figures included co-morbidity coding negatively impacting on expected death rate, changes in coding guidance being applied without clinical engagement and there was a disconnect between the understanding of the clinicians and the coders. An action plan was developed in October 2011 to improve the monthly HSMR date for both the acute and community hospitals. Implementation of the action plan is ongoing.

The Board was briefed at the routine monthly Board meetings and additional assurance was provided by external support provided by the Dr Foster team.

Service Level Agreement Review

Following the incorporation of community services in Exeter, East and Mid Devon in April 2011 as part of the Transforming Community Services programme, 136 Service Level Agreements were transferred to the Trust. Each Service Level Agreement (SLA) has been allocated to a nominated Lead Executive Director and a Lead Manager. A programme of review and risk assessment has been implemented in order to review and clarify or remove each SLA. Progress has been monitored by the Executive Team on a monthly basis with reports being presented to the Executive Directors Group.

Currently, 51 SLAs continue to be monitored on a monthly basis.

Progress reports have been made to the Foundation Trust Application Steering Group, Audit & Assurance Committee and Trust Board by the Director of Facilities and the Director of Finance & Performance.

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

Signature:



Date: June 2012

APPENDIX 1

Attendance at Board sub-committees

1. Audit & Assurance Committee

	Attendance	12.04.11	7.06.11	9.08.11	11.10.11	13.12.11	14.02.12
P Geen	5/5 (100%)	-	X	X	X	X	X
N Lewis	3/3 (100%)			-	X	X	X
J Reynolds	6/6 (100%)	X	X	X	X	X	X
A Tucker-Jones	3/3 (100%)	X	X	X	-	-	-

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

2. Charitable Funds Committee

	Attendance	17.05.11	21.07.11	19.01.12
J Lake	1/1 (100%)	X		
J Reynolds	3/3 (100%)	X	X	X
C Snow	1/1 (100%)			X
A Tucker-Jones	3/3 (100%)	X	X	X
C Mills	1/3 (33%)	-	-	X
A Robinson	3/3 (100%)	X	X	X

3. Finance Committee

	Attendance	21.11.11	23.01.12	27.02.12	26.03.12
R French	4/4 (100%)	X	X	X	X
P Geen	4/4 (100%)	X	X	X	X
N Lewis	3/4 (75%)	X	-	X	X
J Reynolds	4/4 (100%)	X	X	X	X
A Diamond	4/4 (100%)	X	X	X	X
J Kelly	4/4 (100%)	X	X	X	X
K Lyons	4/4 (100%)	X	X	X	X
A Robinson	4/4 (100%)	X	X	X	X

4. Foundation Trust Application Steering Group

	Attendance	16.05.11	27.06.11	26.07.11	22.08.11	19.09.11	24.10.11	21.11.11	23.01.11	27.02.11	26.03.11
R French	9/9 (100%)	X	X	Canx	X	X	X	X	X	X	X
P Geen	8/9 (89%)	-	X	Canx	X	X	X	X	X	X	X
J Reynolds	8/9 (89%)	X	X	Canx	-	X	X	X	X	X	X
A Diamond	7/0 (78%)	-	-	Canx	-	X	X	X	X	X	X
C Mills		-	X	Canx	-	-	-	X	-	X	X
J Kelly	8/9 (89%)	X	X	Canx	-	X	X	X	X	X	X
K Lyons	5/9 (56%)	X	-	Canx	-	X	X	-	-	X	X
A Robinson	8/9 (89%)	X	X	Canx	X	-	X	X	X	X	X

Joint members: A Diamond and C Mills

Canx – meeting cancelled due to number of apologies.

5. Quality Assurance Committee (formerly Clinical Governance Committee)

Clinical Governance Committee – Membership between 1 April 2011 – 29 February 2012

	Attendance	10.05.11	12.07.11	13.09.11	08.11.11	10.01.12
P Geen J Lake	2/2 (100%)	X X	X			
C Snow A Tucker-Jones	3/3 (100%)			X	X X	X
A Diamond	3/5 (60%)	X			X	X
C Mills	5/5 (100%)	X*	X	X	X	X

Joint members: P Geen and J Lake, C Snow and A Tucker-Jones

X* - Deputy attended in absence

Quality Assurance Committee – Membership changed for March 2012

	Attendance	13.03.12
P Geen	1/1 (100%)	X
C Snow	1/1 (100%)	X
A Tucker-Jones	0/1 (0%)	-
A Diamond	1/1 (100%)	X
C Mills	1/1 (100%)	X

6. Remunerations & Terms of Service Committee

Attendance 19.05.11 15.06.11 13.10.11 13.12.11

	Attendance	19.05.11	15.06.11	13.10.11	13.12.11
R French	4/4 (100%)	X	X	X	X
P Geen	4/4 (100%)	X	X	X	X
J Lake	1/2 (50%)	-	X		
N Lewis	2/2 (100%)			X	X
J Reynolds	4/4 (100%)	X	X	X	X
C Snow	1/2 (50%)			X	-
A Tucker-Jones	3/4 (75%)	X	-	X	X



Remuneration Report

Introduction

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a remuneration report containing information about directors' remuneration. In the NHS, the report will be in respect of the senior managers of the NHS body. The definition of a senior manager is:

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

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

Remuneration report

Details of senior managers' remuneration and pensions follow.

A) Remuneration

Name and Title	2011-12			2010-11		
	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100	Salary (bands of £5000) £000	Other Remuneration (bands of £5000) £000	Benefits in Kind Rounded to the nearest £100
J Kelly - Interim Chief Executive	140-145			125-130		
C Mills - Director of Nursing	95-100			85-90		
A Robinson - Director of Finance and IMT	130-135			120-125		
K Lyons - Director of Operations	105-110			80-85		
A Diamond - Medical Director	105-110			100-105		
I Roy - Director of Facilities	85-90			80-85		
M Bignell - Associate Director of Organisational Development	90-95			70-75		
R French - Chairperson	15-20			0-5		
J Lake - Non-executive Director (1)	0-5			5-10		
A Tucker Jones - Non-executive Director	5-10			5-10		
J Reynolds - Non-executive Director	5-10			5-10		
P Geen - Non-executive Director	5-10			0		
C Snow - Non-executive Director (2)	0-5					
N Lewis - Non-executive Director (2)	0-5					

(1) The Non-executive Director's term of office ceased on 30 June 2011

(2) The Non-executive Director was appointed on 1 August 2011

B) Pension Benefits

Name and title	2011-12						2010-11								
	Real increase in pension at age 60 (bands of £2500 £000)	Real increase in lump sum at age 60 (bands of £2500 £000)	Total accrued pension at age 60 at 31 March 2012 (bands of £5000 £000)	Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5000 £000)	Cash Equivalent Transfer Value at 31 March 2012 £000	Cash Equivalent Transfer Value at 31 March 2011 £000	Real increase in pension at age 60 (bands of £2500 £000)	Real increase in lump sum at age 60 (bands of £2500 £000)	Total accrued pension at age 60 at 31 March 2010 (bands of £5000 £000)	Lump sum at age 60 related to accrued pension at 31 March 2010 (bands of £5000 £000)	Cash Equivalent Transfer Value at 31 March 2010 £000	Cash Equivalent Transfer Value at 31 March 2009 £000	Real Increase in Cash Equivalent Transfer Value £000	To nearest £100	
C Mills - Director of Nursing	2.5-5	10-15	30-35	90-95	373	500	35	2.5-5	5-7.5	25-30	70-75	383	372	(6)	
A Robinson - Director of Finance and IMT	0-2.5	5-7.5	30-35	95-100	527	626	25	2.5-5	7.5-10	25-30	75-80	512	343	1	
K Lyons - Director of Operations	(0-2.5)	(5-10)	25-30	80-85	343	396	13			25-30	85-90		634		
A Diamond - Medical Director	7.5-10	20-25	45-50	150-155	634	873	66	0-2.5	2.5-5	40-45	120-125	695	502	(24)	
I Roy - Director of Facilities	2.5-5	7.5-10	30-35	100-105	502	619	30	0-2.5	5-7.5	25-30	85-90	507	235	(5)	
M Bignell - Associate Director of Organisational Development	2.5-5	10-15	15-20	45-50	235	343	30	0-2.5	2.5-5	10-15	30-35	223	223	2	

Notes

- (1) The Chief Executive does not receive pensionable remuneration.
- (2) As Non-Executive members do not receive pensionable remuneration, there will be no entries in respect of pensions for Non-executive members.
- (3) For directors employed during the year, there is no corresponding data for the previous year to reflect movements.
- (4) A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme. A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies. The CETV figures, and from 2004-05 the other pension details, include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS pension scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost. CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.
- (5) Real Increase in CETV - This reflects the increase in CETV effectively funded by the employer. It takes account of the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period.
- (6) The Trust pension values are recorded using Consumer Price Index (CPI) rather than Retail Price Index (RPI) in previous years.

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

The banded remuneration of the highest paid director in Northern Devon Healthcare Trust in the financial year 2011-12 was £140,000-£145,000 (2011-12 £125,000-£130,000) This was 5.8 (2011-12 5.2) times the median remuneration of the workforce which was £25,000 (2011-12, £25,000)

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

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

Non-executive directors

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

Name	Appointment start date	Appointment end date
Roger French (Chairman)	01/02/11	31/01/15
June Lake (NED)	01/07/07	30/06/11
Amelia Tucker-Jones (NED)	11/12/10	10/12/14
Jane Reynolds (NED)	01/06/07	31/05/15
Pauline Geen (NED)	03/12/11	02/02/15
Chris Snow (NED)	01/08/11	31/07/16
Nick Lewis (NED)	01/08/11	31/07/16

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

Executive directors and associate directors

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



Head of Internal Audit Opinion

DRAFT 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 2012

Roles and Responsibilities

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

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

- ▶ how the individual responsibilities of the Accountable Officer are discharged with regard to maintaining a sound system of internal control that supports the achievement of policies, aims and objectives;
- ▶ the governance framework of the organisation including the board's committee structure, the structure and use of the Board Assurance Framework, an 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 and risk management including any disclosures of significant control deficiencies together with assurances that actions are or will be taken where appropriate to address issues arising.

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

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

The opinion does not imply that Internal Audit have reviewed all risks and assurances relating to the organisation. The opinion is substantially

derived from the conduct of risk-based plans generated from a robust and organisation-led Assurance Framework. As such, it is one component that the Board of Directors takes into account in making its Annual Governance Statement.

The Head of Internal Audit Opinion

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

My opinion is set out as follows:

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

My **overall opinion** is that

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

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

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

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

From 1st April 2011, Northern Devon Healthcare Trust has increased its service provision through the acquisition of community services based in Eastern Devon. The addition of 12 Community Hospitals and activity with a total value of £65m has resulted in Northern Devon's forecasted income for the year increasing to £206m. The increase in size of the organisation has brought increased risk in the provision of services, and in ensuring consistency of practice across the Trust. The Trust implemented and performed a robust Due Diligence process to enable it to assess the clinical and operational risks arising from the new services.

Our audit plan for the year has been split into two parts. The first part focussed on the Trust's structure and operations before 1st April 2011. In addition, we agreed an additional audit plan to address the new risks arising from the transfer of the eastern community services. Where appropriate we have broadened existing reviews to include the whole Trust to ensure that our audits have been as effective and efficient as possible.

During the year, the Trust has had two visits from the CQC resulting in corrective action plans being implemented. The first of these, surrounding Safeguarding practices, is an area that we have reviewed during the year. The Trust has made progress against the recommendations raised in our report and the actions arising from the CQC visit. The second review identified inconsistent application of the World Health Organisation's Surgical Checklist. We have included a review of this area in our 2012/13 Audit Plan to provide assurance that appropriate action has been taken to mitigate the issues identified.

Our audits this year have confirmed that core corporate and financial systems continue to operate effectively, and have adapted to the changing environment within the Trust. We have completed a number of reviews of clinical systems and practices within the Trust which have identified a significant concern about whether staff within the Trust have received the necessary training to enable them to perform their roles in a safe and effective manner. The issues have been identified across the Trust, with poor record keeping being identified both in the community setting as well as in the main hospital wards. We are due to have a meeting with the

Director of Nursing and Director of Personnel and Development to discuss the necessary action and we will continue to work with the Trust to ensure that these are implemented.

This lack of robust practices and records surrounding the training of staff represents a significant risk to the Trust which should be resolved as soon as is practicable.

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.

Assurance Framework - Corporate Governance and Risk Management

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

Audit	Assurance Rating	Impact Assessment
Principal Risk and Assurance Register	Ongoing	Ongoing
Risk Management	Green	Low
Performance Management and Data Quality	Ongoing	Ongoing
Clinical Governance	Green	Low
Care Quality Commission	Green	Low

In relation to the reviews notes above the following comments are made.

Principal Risk and Assurance Register – April 2012

This work is currently ongoing and this opinion will be updated once this work is complete. However, we do not anticipate any significant issues arising from this which would impact upon this opinion.

Risk Management – March 2012

We can confirm from our review of the Trust's Risk Management Strategy and Policy that both are fit for purpose and have been appropriately reviewed. The results of our work indicate that the Risk Management Committee, the Quality Assurance Committee, the Audit and Assurance Committee, and the Board are presented with sufficient and appropriate information to be able to monitor and manage risk within the Trust.

The current Risk Management process focus on operational risks which drive the Trust's Principal Risks. We understand that the Trust is developing a risk management process to monitor and manage strategic risk at a Board level to ensure that there is appropriate focus on the key issues.

We found that new risks were appropriately identified, recorded and reviewed in accordance with Trust policy. This was found to be the case with both NDHT and the transferred eastern sites.

Care Quality Commission (CQC) Compliance – December 2011

We visited 12 community hospitals (including seven Eastern sites) and through staff interviews, documentation review and observation tested compliance against four Outcomes specified by the Trust, these being outcomes 1,6,14 and 16. Good practice was noted throughout these hospitals, however we did find that improvement was needed in the completion of Do Not Attempt Resuscitation Forms/ Care Plans and Consent Forms.

Financial Assurance

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

Audit	Assurance Rating	Impact Assessment
Financial Planning – Part One	Amber	Medium
Financial Planning – Part Two	Draft report	Draft report
Budgetary Control	Green	Low
Debtors	Green	Low
Creditors	Green	Low
Payroll	Ongoing	Ongoing
Cash and Bank	Green	Low
Capital Accounting	**	**
Governance of Fundraising	Amber	Low
Charitable Funds	Ongoing	Ongoing

** this review was rescheduled by the finance team in March 2012

Audit work has been undertaken during the year on the core financial systems of the Trust to meet the requirements of the Trust's external auditors, the Audit Commission. Although not all these audits have been finalised at the date of this

statement, these reviews have concluded, overall, that the current systems in place represent a low risk to the Trust and that positive assurance can be provided that the systems in place are operating satisfactorily.

The following sections discuss the findings of our audit reports where the Impact Assessment has been determined as being Medium or High. The date that our audit report was issued as a final is included for information. The Trust has put in place actions to address our recommendations from these reviews. We have not validated progress made against the recommendations made following our reviews during the year, however, all high risk reviews are included in our 2012/13 Internal Audit plan. As such, all recommendations generated from high risk reports will be followed up during these reviews.

Financial Planning – Medium – November 2011

During the initial review, we noted that the overall process for identifying and monitoring the 2011/12 CRES programme was considered to be appropriate. At the time of the review, The Trust had identified that there was a slippage of £933k within the phased financial plan. This was made up of cumulative slippage in CRES plans of £743k. £508k of the cumulative CRES slippage is a result of underachievement of pay budgets.

We are currently in the process of finalising our second review of Financial Planning within the Trust which has considered delivery of the 2011/12 financial position and planning for the 2012/13 financial year.

ESR 3rd Party Assurance

When we receive the 3rd party assurance report on the ESR system, we will provide this to Management and we will update this opinion accordingly.

Corporate Assurance

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

Audit	Assurance Rating	Impact Assessment
Information Governance	Draft Report	Draft Report
Network Security / Integrity	Ongoing	Ongoing
Emergency Preparedness	Amber	High
Safeguarding Adults	Red	High
Safeguarding Children	Ongoing	Ongoing
Patient Safety	Amber	High
Medical Equipment Training Records	Draft Report	Draft Report
Medicines Management	Amber	Medium
Tissue Viability	Amber	Medium
Estates Productivity	Green	Low
Hotel Services	Green	Low
Medical Devices - Inventory	Draft Report	Draft Report
Induction and Training	Amber	Medium
Clinical Records Management	Amber	Medium
Sickness Management	Amber	Low
Fixed Term Contracts	Green	Low
Private Patients	Amber	Low
Dietetics	Red	Medium
Workforce Planning	Draft Report	Draft Report
Minor Injury Units	Draft Report	Draft Report
Outpatient Clinics in the Community	Draft Report	Draft Report
Community Hospital Visits	Ongoing	Ongoing
Incident Reporting	Ongoing	Ongoing
Use of NHS Resources	**	**
TCS Follow Up Review	Amber	Medium
Estates Transfer	***	***

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

*** This has been postponed due to the delay in the national timetable and will be completed during 2012/13

The following sections discuss the findings of our audit reports where the Impact Assessment has been determined as being Medium or High. The date that our audit report was issued as a final is included for information. The Trust has put in place actions to address our recommendations from these reviews. We have not validated progress made against the recommendations made following our reviews during the year, however, all high risk reviews are included in our 2012/13 Internal Audit plan. As such, all recommendations generated from high risk reports will be followed up during these reviews.

Safeguarding Adults – High – October 2011

Our review found that the design of the system and processes is based on sound principles and provides staff with sufficient guidance to ensure safe arrangements for safeguarding within the Trust. The main policies and procedures are up to date or are in the process of being reviewed and harmonised across the Eastern and Northern elements of the organisation.

There were, however, some significant weaknesses in the operation of these controls. While all Safeguarding Adults Group meeting have been quorate, attendance at these meetings has been poor during the past 12 months. The Eastern Safeguarding Adults Group has not met since April 2011, and the Safeguarding Lead has not attended the Northern team meetings. This represents a significant gap in the reporting and learning from incidents.

Our review of the Trust's Training Needs Analysis identified that there is no requirement for all roles with patient contact to undertake even basic training. Also, there is no requirement for those charged with overseeing and implementing Safeguarding processes to undertake training, including the Chief Executive and Non Executive Board members. As at the end of July 2011, 26% of all staff (including those without patient contact) had completed the compulsory basic e-learning for safeguarding adults. The Trust's target is 80% compliance.

Patient Safety – High – February 2012

From our review of the Patient Safety system and operational practices we can confirm that the design of the system and processes is based on sound principles. Overall, the review confirmed that Patient Safety is visible and embedded at a corporate level with managers and staff having sufficient guidance for ensuring Patient Safety within the Trust. Our findings at an operational level indicate, however, that these processes are still far from being embedded at all locations.

We identified significant concerns about the level of non-mandatory training that was outstanding on staff members training records. This was found across the Trust and within all Community locations. In some locations there was a lack of understanding of the required levels of training / competency required. There was also an inconsistent approach to the recording of training at a local level. At the time of our review, we were not able to provide assurance that staff had received the necessary ongoing training to enable them to safely perform their duties.

We also identified that there was a lack of consistency in core patient safety policies across the whole of the organisation. It should be noted, however, that staff were able to identify the policies that they were working to. We also identified that Terms of Reference and reporting structures for committees were not consistently in place. These weaknesses combined with our findings in respect of training records raised significant concerns about the effectiveness of the patient safety processes in place within the Trust.

Emergency Planning – High – March 2012

From our review of Emergency Planning, we are able to report that since 2010/11 a significant amount of work has been completed across the organisation to ensure that appropriate emergency plans are in place. During the year, each directorate has completed a Business Impact Assessment. Internal contingency plans should, however, also be in place for directorates, divisions and community hospitals to ensure that continuity of service is planned for. We were advised that these are held locally, however, none were provided when we requested them from the Emergency Planning Leads for each area.

Training for clinical staff has improved during the year because the Workforce Development Team has taken it into their remit to ensure that this is delivered. A programme of Chemical, Biological, Radiological and Nuclear (CBRN) training using the Health Protection Agency 'train the trainer' method to cascade information is currently being implemented. A review of emergency planning training provided to Duty Managers concluded, however, that it is not sufficiently comprehensive to ensure that a major incident or business continuity incident would be effectively managed.

Medicines Management – Medium – November 2011

This review followed up previous recommendations and in addition reviewed the Medicine Reconciliation processes. We identified that there are still inconsistent Medicines Management practices within the Trust. Our review of Medical Reconciliations found that only 50% of patient admissions reviewed had a reconciliation completed, and only 15% could be confirmed as having a reconciliation completed with 24 hours. We are undertaking a further review of this area during 2012/13.

Tissue Viability – Medium – March 2012

Whilst the system for reporting pressure ulcers is in line with NICE guidance, there are concerns over the accuracy of data, noticeably within the northern services where the same ulcer may be recorded more than once. This is an issue which the Trust is looking into. The referral process, based on documented guidance, appears sufficient and testing has been completed to review the operation of these processes and whether the Tissue Viability Service does/can respond and provide specialist support as appropriate.

There were concerns raised during the year by the CQC over the robustness of care plans and the completion of paperwork. Following this, the Tissue Viability Service implemented a new wound management form and this is an area which the Tissue Viability Service has been reviewing for compliance.

Based on our findings, we conclude that the Eastern area TV Service has a sound process for the management of referrals received which meets their requirements at present. The Northern area's processes, although robust in terms of data collection methods, could be streamlined

to provide the TV Service with a more proactive approach to ensure that all necessary information is collected and considered to determine the appropriateness of referrals and underlying reasons for inappropriate referrals.

Induction and Training – Medium – February 2012

Due to ongoing concerns about the completion and recording of training information within the Trust we reviewed the processes in place for Mandatory Training and Induction. At the time of the review, 73% of staff within the Eastern Services area were complaint with their training requirements, with the figure for the northern element of the Trust being 59%. Work based inductions were highlighted as an area where improvements in monitoring are needed. It was found that the method of reporting relied on Line Managers returning induction paperwork which was failing to occur. Testing identified a weakness in the process for the HR department notifying Workforce Development of new starters to the Trust (Northern staff only). As a result, staff are not booked to attend induction training.

Clinical Records Management – Medium – October 2011

Our review found that access to records requests are well-managed and that the filing of Healthcare Records within the HRD was logical, well ordered and accurate. We found that although there is sufficient training at induction, current update training requirements need to be revisited. Our testing identified that 31% of visits to A&E during 2010/11 resulted in the generation of a duplicate set of notes. Finally, we identified that from a sample of 60 self audits conducted by the Trust, only 23 self audits resulted in all of the notes sampled being in the recorded location.

Dietetics – Medium – February 2012

Our testing identified that patients are generally being seen within the required timescales by a member of the Dietetics team, although the Trust is not meeting the timescales for seeing patients. We did, however identify significant concerns about the administration and management systems in place within the Dietetics team which results in poor performance and poor management information being produced from the department to monitor whether the service is being delivered effectively. The lack of an effective

administrative system also meant that for a number of cases in our sample we were unable to review the referral documentation as it could not be located. In the event of a patient incident, the Trust may struggle to locate this information.

TCS Follow Up Review – April 2012

The objective of this audit review was to provide assurance to the Audit Committee regarding the clearance of outstanding issues arising from the due diligence process undertaken by the Trust around the Transforming Community Services process. Due to the timing of work around the asset transfer, our audit work on this area will commence in April 2012.

Our review concluded that the majority of matters flagged up as outstanding have been dealt with by the Trust. The main area where work is still required is in relation to policies, IM&T arrangements and service level agreements.

Policies - Work on aligning and updating policies is ongoing and the Trust has taken the view that core patient safety policies should be considered corporately as a priority. As such, all policies relating to areas covered by the NHSLA assessment process have been prioritised and updated. Although some individual teams have been updating policies in relation to their own areas of operation, the corporate approach has been necessarily limited to the alignment of policies in relation to NHSLA areas. Although it would have been ideal to align all policies as quickly as possible, the Trust has taken a pragmatic and realistic view of what is achievable while also setting staffing structures in place.

We understand that it is planned to set up a programme in April, after the NHSLA assessment, to highlight other high risk policies to managers and to ask them to consider whether they are still relevant and up to date and to ensure that they are updated as necessary.

IM&T - We also identified that work is ongoing around the rationalisation of IT infrastructure, in particular around IM&T contracts and storage area networks. We understand that arrangements are in hand to address these items.

The Trust has maintained a monthly review process over the status of SLAs since the start of the TCS process. This has been updated and monitored by the Trust Executive team on a monthly basis. Each SLA has been clearly identified, with an Executive Director lead and an operational lead in place.

Service Level Agreements - There are a number of SLAs where further work is required by the Trust to clarify the arrangements for the future. The prioritisation of the rationalisation of SLAs has been undertaken at Executive level. As such, and given lead manager priorities, a view has been taken in relation to some of the instances noted above that there are other work areas that are more of a priority than rationalising these SLAs at this point in time. This position is being reviewed, however, on a monthly basis.

Further to this, we understand that the Trust was sent an updated SLA schedule, supported by a proposed Model C form of contract for 2011/12 on the 19th March 2012 by the RD&E. We further understand that the Trust is currently reviewing this document to compare the detail with that currently held by the Trust.

Discussions with the Director of Facilities have also indicated that it may be beneficial to standardise the content / form of SLAs to ensure a consistent level of documentation of the key elements of the specification of each SLA.

Asset Transfer - The latest indication is that this transfer will take place as of 31st October 2012, though clearly there will be substantial work required to ensure that this transfer is appropriately handled. There is a clear understanding of the work required and the issues that need to be addressed prior to the transfer taking place. The Deputy Director of Finance is liaising with his counterpart in NHS Devon and also with the Audit Commission to ensure that this is appropriately managed. Areas for consideration are the progress being made by NHS Devon on the completeness and accuracy of the asset register and the need for a physical verification of assets, the condition and value of assets and the ongoing maintenance costs of estates assets being transferred.

As reported to the February meeting of the audit committee, this work is to commence in early 2012/13.

Information Governance – April 2012

The Trust has completed a self assessment of compliance against version 9 of the Information Governance Toolkit. We have audited the self assessment with reference to the mandated audit framework as set out in "A Question of Balance". This included:

- ▶ a review of the approach to delivering information governance within the corporate governance framework;
- ▶ an evidence based review of the Trust's toolkit self assessment and improvement planning; and
- ▶ an evidence based review of the organisation's toolkit self assessment and improvement planning.

This review is currently at draft report stage and this opinion statement will be updated to reflect the agreed outcome of this review.

Other Work

In respect of the remaining reviews noted in the Corporate Assurance section, recommendations have been agreed with management to address gaps in controls and assurance. Internal audit has monitored the status of these recommendations over the year working proactively with the Audit and Assurance Committee to identify and follow up any outstanding matters. No fundamental matters have been brought to the Trust's attention in respect of these areas.

Closure of these audits require management action to agreed recommendations but the issues raised are not considered to be significant and have been taken into account in the formulation of this opinion.

In addition to the reviews noted above, at the date of this opinion a number of audits are being competed, due to the audit year still being in progress, as follows:

Audits at draft report stage:

- ▶ Information Governance
- ▶ Medical Equipment Training Records
- ▶ Medical Devices Inventory
- ▶ Workforce Planning
- ▶ Minor Injury Units
- ▶ Outpatient Clinics in the Community
- ▶ TCS Follow Up Review

Audits in progress:

- ▶ Principal Risk and Assurance Register
- ▶ Performance Management and Data Quality
- ▶ Payroll
- ▶ Charitable Funds
- ▶ Network Security
- ▶ Safeguarding Children
- ▶ Community Hospital Visits
- ▶ Incident Reporting

Whilst a small number of control issues and recommendations may be reported as a result of these reviews we do not envisage any fundamental matters that may impact upon this opinion statement at this time.

Jenny McCall
Director of Audit
Audit South West
April 2012





Accounts

Data entered below will be used throughout the workbook:

Entity name:	Northern Devon Healthcare NHS Trust Q39_RBZ
This year	2011-12
Last year	2010-11
This year ended	31 March 2012
Last year ended	31 March 2011
This year commencing:	1 April 2011

Forward to the accounts

These accounts for the year ended 31 March 2012 have been prepared by the Northern Devon Healthcare NHS Trust under section 232 (Schedule 15, 3(1)) of the National Health Service Act 2006 in the form which the Secretary of State has, with the approval of the Treasury, directed.

Independent Auditor's Report to the Directors of Northern Devon Healthcare NHS Trust

I have audited the financial statements of Northern Devon Healthcare Trust for the year ended 31 March 2012 under the Audit Commission Act 1998.

The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes.

These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- ▶ the table of salaries and allowances of senior managers and related narrative notes; and
- ▶ the table of pension benefits of senior managers and related narrative notes.

This report is made solely to the Board of Directors of Northern Devon Healthcare Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

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 Trust; and the overall presentation of the financial statements.

I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- ▶ give a true and fair view of the state of Northern Devon Healthcare NHS Trust's affairs as at 31 March 2012 and of its income and expenditure for the year then ended; and
- ▶ have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion:

- ▶ the part of the Remuneration Report to be audited subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- ▶ the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

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

Trust's responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Basis of conclusion

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

- ▶ securing financial resilience; and
- ▶ challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself 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 2011.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I 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.

Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, I am satisfied that, in all significant respects, Northern Devon Healthcare Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2012.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust's annual quality accounts. I am satisfied that this work does not have a material effect on the financial statements.

Wayne Rickard
District Auditor
Units 3-4, Blenheim Court,
Matford Business Park,
Lustleigh Close,
Exeter EX2 8PW

7 June 2012

Statement of Comprehensive Income for year ended 31 March 2012

	NOTE	2011-12 £000	2010-11 £000 (restated)
Employee benefits	10.1	(140,068)	(91,710)
Other costs	8	(74,475)	(41,020)
Revenue from patient care activities	5	198,860	126,491
Other Operating revenue	6	12,181	8,416
Operating surplus/(deficit)		(3,502)	2,177
Investment revenue	12	22	12
Other gains and (losses)	13	(20)	4
Finance costs	14	(23)	(32)
Surplus/(deficit) for the financial year		(3,523)	2,161
Public dividend capital dividends payable		(2,201)	(2,436)
Retained surplus/(deficit) for the year		(5,724)	(275)
Other Comprehensive Income			
Impairments and reversals	17	(11,564)	(1,578)
Net gain/(loss) on revaluation of property, plant & equipment		104	5,518
Net gain/(loss) on revaluation of intangibles		0	0
Net gain/(loss) on revaluation of financial assets		0	0
Net gain/(loss) on other reserves		0	0
Net gain/(loss) on available for sale financial assets		0	0
Net actuarial gain/(loss) on pension schemes		0	0
Reclassification adjustment on disposal of available for sale financial assets		0	0
Total comprehensive income for the year		(17,184)	3,665
Financial performance for the year			
Retained surplus/(deficit) for the year		(5,724)	
Prior period adjustment to correct errors		0	
IFRIC 12 adjustment	38	23	
Impairments	17	7,328	
Adjustments iro donated asset/gov't grant reserve elimination		92	
Adjusted retained surplus/(deficit)		1,719	
PDC dividend: balance receivable/(payable) at 31 March 2012		358	

The notes on pages 7 to 46 form part of this account.

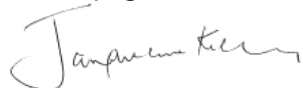
Statement of Financial Position as at 31 March 2012

	NOTE	31 March 2012 £000	1 April 2011 (restated) £000	Merger adjustments £000	31 March 2011 (restated) £000	31 March 2010 (restated) £000
Non-current assets:						
Property, plant and equipment	15	56,232	75,001	0	75,001	71,496
Intangible assets	16	833	629	0	629	583
Investment property		0	0	0	0	0
Other financial assets	24	0	0	0	0	0
Trade and other receivables	22.1	872	683	0	683	575
Total non-current assets		57,937	76,313	0	76,313	72,654
Current assets:						
Inventories	21	2,601	2,705	0	2,705	2,519
Trade and other receivables	22.1	11,121	4,481	0	4,481	6,062
Other financial assets	24	0	0	0	0	0
Other current assets	25	0	0	0	0	0
Cash and cash equivalents	26	3,467	950	0	950	419
Total current assets		17,189	8,136	0	8,136	9,000
Non-current assets held for sale	27	300	302	0	302	0
Total current assets		17,489	8,438	0	8,438	9,000
Total assets		75,426	84,751	0	84,751	81,654
Current liabilities						
Trade and other payables	28	(17,412)	(9,060)	0	(9,060)	(9,072)
Other liabilities	29	0	0	0	0	0
Provisions	35	(37)	(16)	0	(16)	(46)
Borrowings	30	(16)	(16)	0	(16)	(519)
Other financial liabilities		0	0	0	0	0
Working capital loan from Department		0	0	0	0	0
Capital loan from Department	30	(500)	(500)	0	(500)	0
Total current liabilities		(17,965)	(9,592)	0	(9,592)	(9,637)
Non-current assets plus/less net current assets/liabilities		57,461	75,159	0	75,159	72,017
Non-current liabilities						
Trade and other payables	28	0	0	0	0	0
Other Liabilities	31	0	0	0	0	0
Provisions	35	0	0	0	0	(10)
Borrowings	30	(17)	(33)	0	(33)	(1,546)
Other financial liabilities		0	0	0	0	0
Working capital loan from Department		0	0	0	0	0
Capital loan from Department	30	(500)	(1,000)	0	(1,000)	0
Total non-current liabilities		(517)	(1,033)	0	(1,033)	(1,556)
Total Assets Employed:		56,944	74,126	0	74,126	70,461
FINANCED BY:						
TAXPAYERS' EQUITY						
Public Dividend Capital		57,717	57,717	0	57,717	57,717
Retained earnings		(4,246)	1,478	0	1,478	1,753
Revaluation reserve	15.1	3,473	14,931	0	14,931	10,991
Other reserves		0	0	0	0	0
Total Taxpayers' Equity:		56,944	74,126	0	74,126	70,461

The notes on pages 7 to 46 form part of this account.

The financial statements on pages 3 to 46 were approved by the Board on 7 June 2012 and signed on its behalf by:

Chief Executive:



Date: 11 June 2012

Statement of Changes in Taxpayers' Equity for the year ended 31 March 2012

	Public Dividend capital £000	Retained earnings £000	Revaluation reserve £000	Other reserves £000	Total reserves £000
Balance at 1 April 2011	57,717	1,478	14,931	0	74,126
Opening balance adjustments		0	0	0	0
Adjustments for Transforming Community Services transactions		0	0	0	0
Restated balance at 1 April 2011	<u>57,717</u>	<u>1,478</u>	<u>14,931</u>	<u>0</u>	<u>74,126</u>
Changes in taxpayers' equity for 2011-12					
Retained surplus/(deficit) for the year		(5,724)			(5,724)
Net gain / (loss) on revaluation of property, plant, equipment			104		104
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale			0		0
Impairments and reversals			(11,564)		(11,564)
Movements in other reserves				0	0
Transfers between reserves		0	0	0	0
Release of reserves to SOCI			2		2
Transfers to/(from) other bodies within the Resource Account boundary	0	0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution	0	0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	0				0
PDC Repaid In Year	0				0
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension	0			0	0
Net recognised revenue/(expense) for the year	<u>0</u>	<u>(5,724)</u>	<u>(11,458)</u>	<u>0</u>	<u>(17,182)</u>
Balance at 31 March 2012	<u>57,717</u>	<u>(4,246)</u>	<u>3,473</u>	<u>0</u>	<u>56,944</u>
Included above:					
Transfer from revaluation reserve to retained earnings in respect of impairments		<u>0</u>	<u>0</u>		<u>0</u>

Changes in taxpayers' equity for 2010-11

Balance at 1 April 2010	57,717	1,753	10,991	0	70,461
Retained surplus/(deficit) for the year		(275)			(275)
Net gain / (loss) on revaluation of property, plant, equipment			5,518		5,518
Net gain / (loss) on revaluation of intangible assets			0		0
Net gain / (loss) on revaluation of financial assets			0		0
Net gain / (loss) on revaluation of assets held for sale					0
Impairments and reversals			(1,578)		(1,578)
Movements in other reserves				0	0
Transfers between reserves		0	0	0	0
Reclassification adjustment on disposal of available for sale financial assets			0		0
Reserves eliminated on dissolution		0	0	0	0
Originating capital for Trust established in year	0				0
New PDC Received	0				0
PDC Repaid In Year	0				0
PDC Written Off	0				0
Transferred to NHS Foundation Trust	0	0	0	0	0
Other Movements in PDC In Year	0				0
Net Actuarial Gain/(Loss) on Pension		0		0	0
Net recognised revenue/(expense) for the year	0	(275)	3,940	0	3,665
Balance at 31 March 2011	57,717	1,478	14,931	0	74,126
Included above:					
Transfer from revaluation reserve to retained earnings in respect of impairments		0	0		0

Statement of Cash Flows for the year ended 31 March 2012

	NOTE	2011-12 £000	2010-11 £000
Cash Flows from Operating Activities			
Operating Surplus/Deficit		(3,502)	2,177
Depreciation and Amortisation		5,037	5,013
Impairments and Reversals		7,328	445
Other Gains / (Losses) on foreign exchange		0	0
Donated Assets received credited to revenue but non-cash		(36)	(70)
Government Granted Assets received credited to revenue but non-cash		0	0
Interest Paid		0	(32)
Dividend paid		(2,584)	(2,375)
Release of PFI/deferred credit		0	0
(Increase)/Decrease in Inventories		104	(186)
(Increase)/Decrease in Trade and Other Receivables		(6,466)	1,412
(Increase)/Decrease in Other Current Assets		0	0
Increase/(Decrease) in Trade and Other Payables		8,068	698
(Increase)/Decrease in Other Current Liabilities		0	0
Provisions Utilised		(5)	(41)
Increase/(Decrease) in Provisions		26	1
Net Cash Inflow/(Outflow) from Operating Activities		7,970	7,042
CASH FLOWS FROM INVESTING ACTIVITIES			
Interest Received		22	12
(Payments) for Property, Plant and Equipment		(4,550)	(5,852)
(Payments) for Intangible Assets		(450)	(242)
(Payments) for Investments with DH		0	0
(Payments) for Other Financial Assets		0	0
(Payments) for Financial Assets (LIFT)		0	0
Proceeds of disposal of assets held for sale (PPE)		5	17
Proceeds of disposal of assets held for sale (Intangible)		0	0
Proceeds from Disposal of Investment with DH		0	0
Proceeds from Disposal of Other Financial Assets		0	0
Proceeds from the disposal of Financial Assets (LIFT)		0	0
Loans Made in Respect of LIFT		0	0
Loans Repaid in Respect of LIFT		0	0
Rental Revenue		0	0
Net Cash Inflow/(Outflow) from Investing Activities		(4,973)	(6,065)
NET CASH INFLOW/(OUTFLOW) BEFORE FINANCING		2,997	977
CASH FLOWS FROM FINANCING ACTIVITIES			
Public Dividend Capital Received		0	0
Public Dividend Capital Repaid		0	0
Loans received from DH - New Capital Investment Loans		0	0
Loans received from DH - New Working Capital Loans		0	0
Other Loans Received		0	0
Loans repaid to DH - Capital Investment Loans Repayment of Principal		(500)	(500)
Loans repaid to DH - Working Capital Loans Repayment of Principal		0	0
Other Loans Repaid		0	0
Cash transferred to NHS Foundation Trusts		0	0
Capital Element of Payments in Respect of Finance Leases and On-SoFP PFI and LIFT		(16)	(16)
Capital grants and other capital receipts		36	70
Net Cash Inflow/(Outflow) from Financing Activities		(480)	(446)
NET INCREASE/(DECREASE) IN CASH AND CASH EQUIVALENTS		2,517	531
Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		950	419
Opening balance adjustment - TCS transactions		0	
Restated Cash and Cash Equivalents (and Bank Overdraft) at Beginning of the Period		950	419
Effect of Exchange Rate Changes in the Balance of Cash Held in Foreign Currencies		0	0
Cash and Cash Equivalents (and Bank Overdraft) at year end		3,467	950

Notes to the accounts

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2011-12 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which is judged to be most appropriate to the particular circumstances of the trust for the purpose of giving a true and fair view has been selected. The particular policies adopted by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

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

1.3 Transforming Community Services (TCS) transactions

"Under the TCS initiative, services historically provided by PCTs have transferred to other providers - notably NHS Trusts and NHS Foundation Trusts. Such transfers fall to be accounted for by use of merger accounting. The Treasury FREM provides that where a transfer takes place in 2011-12, the recipient of the transfer will account for transferred activity in full for the period (and the original provider for none) to reflect the position had the transfer always applied.

For TCS transactions specifically, it is impracticable to adjust the prior period's revenue account in each body and so restatement is effected by an adjustment to 1 April 2011 opening balances rather than by full restatement of comparators."

As part of the reconfiguration of the NHS, the Trust was awarded a 3 year contract from 1 April 2011 to manage and transform a range of services that were previously provided by the provider arm of NHS Devon. Further details are given in note 45.

1.4 Care Trust designation

Northern Devon Healthcare NHS Trust is not designated as a Care Trust

1.5 Pooled Budgets

Following changes under Transforming Community Services, the Trust no longer contributes to a pooled budget arrangement.

1.6 Critical accounting judgements and key sources of estimation uncertainty

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

1.6.1 Critical judgements in applying accounting policies

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

1.6.2 Key sources of estimation uncertainty

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

1. Accounting Policies (Continued)

1.7 Revenue

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

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

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

1.8 Employee Benefits

Short-term employee benefits

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

Retirement benefit costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is not designed to be run in a way that would enable NHS bodies to identify their share of the underlying scheme assets and liabilities.

Therefore, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

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

1.9 Other expenses

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

1.10 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- ▶ it is held for use in delivering services or for administrative purposes;
- ▶ it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- ▶ it is expected to be used for more than one financial year;
- ▶ the cost of the item can be measured reliably; and
- ▶ the item has cost of at least £5,000; or
- ▶ Collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control; or
- ▶ Items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

All property, plant and equipment are measured initially at cost, representing the cost directly attributable to acquiring or constructing the asset and bringing it to the location and condition necessary for it to be capable of operating in the manner intended by management. All assets are measured subsequently at fair value.

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

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

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

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

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

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure

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

1. Accounting Policies (Continued)

1.11 Intangible assets

Recognition

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

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

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

Measurement

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

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

1.12 Depreciation, amortisation and impairments

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

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

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

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

decrease previously charged there and thereafter to the revaluation reserve.

Impairments are analysed between Departmental Expenditure Limits (DEL) and Annually Managed Expenditure (AME) from 2011-12. This is necessary to comply with Treasury's budgeting guidance. DEL limits are set in the Spending Review and Departments may not exceed the limits that they have been set.

AME budgets are set by the Treasury and may be reviewed with departments in the run-up to the Budget. Departments need to monitor AME closely and inform Treasury if they expect AME spending to rise above forecast. Whilst Treasury accepts that in some areas of AME inherent volatility may mean departments do not have the ability to manage the spending within budgets in that financial year, any expected increases in AME require Treasury approval.

1.13 Donated assets

"Following the accounting policy change outlined in the Treasury FREM for 2011-12, a donated asset reserve is no longer maintained. Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to Income. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations, impairments and sales are as described above for purchased assets. Deferred income is recognised only where conditions attached to the donation preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated."

A donated reserve of £1,137k was redistributed between revaluation reserve and retained earnings.

1.14 Government grants

"Following the accounting policy change outlined in the Treasury FREM for 2011-12, a government grant reserve is no longer maintained. The value of assets received by means of a government grant are credited directly to income. Deferred income is recognised only where conditions attached to the grant preclude immediate recognition of the gain.

This accounting policy change has been applied retrospectively and consequently the 2010-11 results have been restated."

A government grant reserve of £80k was redistributed between revaluation reserve and retained earnings.

1.15 Non-current assets held for sale

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

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

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

The Trust is holding Lynton Hospital as an asset held for sale pending the sale which is currently being processed.

1. Accounting Policies (Continued)

1.16 Leases

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

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

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

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

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

The trust as lessor

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

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

1.17 Inventories

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

1.18 Cash and cash equivalents

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

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

1.19 Going Concern

The Secretary of State has directed that, where Parliamentary funding continues to be voted to permit the relevant services to be carried out elsewhere in the public sector, this is normally sufficient evidence of going concern

As a result, the board of Northern Devon Healthcare Trust have prepared these financial statements on a going concern basis.

1.20 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms (2.8% for employee early departure obligations).

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

1.21 Clinical negligence costs

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

1.22 Non-clinical risk pooling

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

1.23 EU Emissions Trading Scheme

The Trust is not required to register for the EU Emissions Trading Scheme due to the low level of emissions.

1.24 Contingencies

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

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

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

1.25 Financial assets

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

Financial assets are initially recognised at fair value.

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

Financial assets at fair value through profit and loss

The Trust has no material contracts that contain embedded derivatives

Held to maturity investments

The Trust has no held to maturity investments

Available for sale financial assets

The Trust has no available for sale financial assets

1. Accounting Policies (Continued)

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible.

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

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

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

1.26 Financial liabilities

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

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

Financial guarantee contract liabilities

The Trust has no financial guarantee contract liabilities.

Financial liabilities at fair value through profit and loss

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

Other financial liabilities

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

1.27 Value Added Tax

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

1.28 Foreign currencies

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

1.29 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in Note 44 to the accounts.

1.30 Public Dividend Capital (PDC) and PDC dividend

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

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

1.31 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

1.32 Subsidiaries

For 2010-11 and 2011-12 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the corporate trustee.

1.33 Associates

The Trust has no associates

1.34 Joint ventures

The Trust has no joint ventures

1.35 Joint operations

The Trust has no joint operations

1.36 Research and Development

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

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

The Treasury FReM does not require the following Standards and Interpretations to be applied in 2011-12. The application of the Standards as revised would not have a material impact on the accounts for 2011-12, were they applied in that year:

IAS 1 Presentation of financial statements (Other Comprehensive Income) - subject to consultation

IAS 12 - Income Taxes (amendment) - subject to consultation

IAS 19 Post-employment benefits (pensions) - subject to consultation

IAS 27 Separate Financial Statements - subject to consultation

IAS 28 Investments in Associates and Joint Ventures - subject to consultation

IFRS 7 - Financial Instruments: Disclosures (annual improvements) - effective 2012-13

IFRS 9 Financial Instruments - subject to consultation - subject to consultation

IFRS 10 Consolidated Financial Statements - subject to consultation

IFRS 11 Joint Arrangements - subject to consultation

IFRS 12 Disclosure of Interests in Other Entities - subject to consultation

IFRS 13 Fair Value Measurement - subject to consultation

IPSAS 32 - Service Concession Arrangement - subject to consultation"

2. Community Equipment Store Pooled Budget

The Trust no longer contributes to the pooled budget following changes under Transforming Community Services.

3. Operating segments

The Trust has determined only one segment to be reported, that being healthcare activities.

	Healthcare		Total	
	2011-12 £000	2010-11 £000	2011-12 £000	2010-11 £000
Income	<u>211,041</u>	<u>134,907</u>	<u>211,041</u>	<u>134,907</u>
Surplus/(Deficit)				
Segment surplus/(deficit)	0	0	0	0
Common costs	<u>(214,564)</u>	<u>(132,746)</u>	<u>(214,564)</u>	<u>(132,746)</u>
Surplus/(deficit) before interest	<u>(3,523)</u>	<u>2,161</u>	<u>(3,523)</u>	<u>2,161</u>
Net Assets:				
Segment net assets	<u>56,944</u>	<u>74,126</u>	<u>56,944</u>	<u>74,126</u>

4. Income generation activities

The trust undertakes income generation activities with an aim of achieving profit, which is then used in patient care.

The Trust does not undertake any activities where the full costs exceed £1m.

5. Revenue from patient care activities

	2011-12 £000	2010-11 £000
Strategic health authorities	0	0
NHS trusts	0	0
Primary care trusts - tariff	77,027	75,528
Primary care trusts - non-tariff	116,841	48,943
Primary care trusts - market forces factor	1,418	1,177
Foundation trusts	483	0
Local authorities	1,581	0
Department of Health	0	0
NHS other	0	0
Non-NHS:		
Private patients	437	463
Overseas patients (non-reciprocal)	0	0
Injury costs recovery	679	333
Other	394	47
	<u>198,860</u>	<u>126,491</u>

Injury cost recovery income is subject to a provision for impairment of receivables of 10.45% to reflect expected rates of collection.

6. Other operating revenue

	2011-12 £000	2010-11 £000
Recoveries in respect of employee benefits	291	657
Patient transport services	0	0
Education, training and research	3,876	2,527
Charitable and other contributions to expenditure	165	38
Receipt of donations for capital acquisitions	36	70
Receipt of Government grants for capital acquisitions	0	0
Non-patient care services to other bodies	3,760	2,441
Income generation	1,139	879
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Other revenue	2,914	1,804
	<u>12,181</u>	<u>8,416</u>
Total operating revenue	<u>211,041</u>	<u>134,907</u>

7. Revenue

	2011-12 £000	2010-11 £000
	2011-12	2010-11
From rendering of services	209,902	134,028
From sale of goods	1,139	879

8. Operating expenses (excluding employee benefits)

	2011-12 £000	2010-11 £000
Services from other NHS trusts	90	437
Services from PCTs	168	95
Services from other NHS bodies	0	0
Services from foundation trusts	7,644	322
Purchase of healthcare from non NHS bodies	0	0
Trust chair and non executive directors	49	50
Supplies and services - clinical	24,633	18,887
Supplies and services - general	7,014	6,097
Consultancy services	301	53
Establishment	3,858	1,909
Transport	985	648
Premises	13,313	3,815
Impairments and Reversals of Receivables	57	6
Inventories write down	0	0
Depreciation	4,790	4,817
Amortisation	247	196
Impairments and reversals of property, plant and equipment	7,328	340
Impairments and reversals of intangible assets	0	0
Impairments and reversals of financial assets [by class]	0	0
Impairments and reversals of non current assets held for sale	0	105
Impairments and reversals of investment properties	0	0
Audit fees	164	123
Other auditor's remuneration [detail]	0	0
Clinical negligence	2,376	2,198
Research and development (excluding staff costs)	0	15
Education and Training	409	361
Other	1,049	546
	<u>74,475</u>	<u>41,020</u>
Employee benefits		
Employee benefits excluding Board members	139,148	90,877
Board members	920	833
Total employee benefits	<u>140,068</u>	<u>91,710</u>
Total operating expenses	<u>214,543</u>	<u>132,730</u>

9. Operating Leases

Trust as lessee

	Land	Buildings	Other	2011-12 Total	2010-11
	£000	£000	£000	£000	£000
Payments recognised as an expense					
Minimum lease payments				4,721	191
Contingent rents				0	0
Sub-lease payments				0	0
Total				<u>4,721</u>	<u>191</u>
Payable:					
No later than one year	0	4,385	156	4,541	158
Between one and five years	0	4,385	155	4,540	118
After five years	0	0	0	0	0
Total	<u>0</u>	<u>8,770</u>	<u>311</u>	<u>9,081</u>	<u>276</u>
Total future sublease payments expected to be received:				<u>0</u>	<u>0</u>

Trust as lessor

The Trust has no lessor agreements

10. Employee benefits and staff numbers

Employee benefits

	Total £000	Permanently employed £000	Other £000
Employee Benefits 2011-12 - gross expenditure			
Salaries and wages	118,487	110,967	7,520
Social security costs	9,048	8,786	262
Employer contributions to NHS Pensions scheme	13,431	13,042	389
Other pension costs	58	58	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	0	0	0
Total employee benefits	<u>141,024</u>	<u>132,853</u>	<u>8,171</u>
Less recoveries in respect of employee benefits (table below)	(291)	(291)	0
Total - Net Employee Benefits including capitalised costs	<u>140,733</u>	<u>132,562</u>	<u>8,171</u>
Employee costs capitalised	956	956	0
Net Employee Benefits excluding capitalised costs	<u>140,068</u>	<u>131,897</u>	<u>8,171</u>
Employee Benefits 2011-12 - income			
Salaries and wages	244	244	0
Social Security costs	19	19	0
Employer Contributions to NHS BSA - Pensions Division	28	28	0
Other pension costs	0	0	0
Other Post Employment Benefits	0	0	0
Other Employment Benefits	0	0	0
Termination Benefits	0	0	0
TOTAL excluding capitalised costs	<u>291</u>	<u>291</u>	<u>0</u>
	Total £000	Permanently employed £000	Other £000
Employee Benefits 2010-11 - net expenditure			
Salaries and wages	78,031	72,602	5,429
Social security costs	5,251	5,113	138
Employer contributions to NHS Pensions scheme	8,786	8,555	231
Other pension costs	25	25	0
Other post-employment benefits	0	0	0
Other employment benefits	0	0	0
Termination benefits	96	96	0
Total employee benefits	<u>92,189</u>	<u>86,391</u>	<u>5,798</u>
Employee costs capitalised	479		
Net Employee Benefits excluding capitalised costs	<u>91,710</u>		

Staff Numbers

	2011-12			2010-11
	Total Number	Permanently employed Number	Other Number	Total Number
Average Staff Numbers				
Medical and dental	280.16	252.00	28.16	280.78
Ambulance staff	0.00	0.00	0.00	0.00
Administration and estates	741.80	726.60	15.20	490.91
Healthcare assistants and other support staff	999.20	923.20	76.00	505.77
Nursing, midwifery and health visiting staff	1,149.40	1,077.60	71.80	715.16
Nursing, midwifery and health visiting learners	0.00	0.00	0.00	0.00
Scientific, therapeutic and technical staff	492.40	481.80	10.60	292.40
Social Care Staff	0.00	0.00	0.00	0.00
Other	0.00	0.00	0.00	0.00
TOTAL	<u>3,662.96</u>	<u>3,461.20</u>	<u>201.76</u>	<u>2,285.02</u>
Of the above - staff engaged on capital projects	22.64	22.64	0.00	15.00

Staff Sickness absence and ill health retirements

	2011-12 Number	2010-11 Number
Total Days Lost	16,387	27,452
Total Staff Years	<u>2,200</u>	<u>2,171</u>
Average working Days Lost	<u>7.45</u>	<u>12.64</u>

Exit Packages agreed in 2011-12

Exit package cost band (including any special payment element)	2011-12			2010-11		
	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number	*Number of compulsory redundancies Number	*Number of other departures agreed Number	Total number of exit packages by cost band Number
Less than £10,000	1	0	1	4	0	4
£10,001-£25,000	0	0	0	1	0	1
£25,001-£50,000	0	0	0	2	0	2
£50,001-£100,000	0	0	0	0	0	0
£100,001-£150,000	0	0	0	0	0	0
£150,001-£200,000	0	0	0	0	0	0
>£200,000	0	0	0	0	0	0
Total number of exit packages by type (total cost)	<u>1</u>	<u>0</u>	<u>1</u>	<u>7</u>	<u>0</u>	<u>7</u>
Total resource cost (£000s)	3	0	3	96	0	96

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

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

Pension costs

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

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

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates.

The last formal actuarial valuation undertaken for the NHS Pension Scheme was completed for the year ending 31 March 2004. Consequently, a formal actuarial valuation would have been due for the year ending 31 March 2008. However, formal actuarial valuations for unfunded public service schemes have been suspended by HM Treasury on value for money grounds while consideration is given to recent changes to public service pensions, and while future scheme terms are developed as part of the reforms to public service pension provision. Employer and employee contribution rates are currently being determined under the new scheme design.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period. Actuarial assessments are undertaken in intervening years between formal valuations using updated membership data are accepted as providing suitably robust figures for financial reporting purposes. However, as the interval since the last formal valuation now exceeds four years, the valuation of the scheme liability as at 31 March 2012, is based on detailed membership data as at 31 March 2010 updated to 31 March 2012 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year. From 2011-12 the Consumer Price Index (CPI) will be used to replace the Retail Prices Index (RPI).

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the employer.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11. Better Payment Practice Code

Measure of compliance

	2011-12 Number	2011-12 £000	2010-11 Number	2010-11 £000
Non-NHS Payables				
Total Non-NHS Trade Invoices Paid in the Year	50,771	48,907	37,418	40,934
Total Non-NHS Trade Invoices Paid Within Target	47,695	46,250	35,768	40,049
Percentage of NHS Trade Invoices Paid Within Target	93.94%	94.57%	95.59%	97.84%
NHS Payables				
Total NHS Trade Invoices Paid in the Year	2,045	78,617	1,189	46,431
Total NHS Trade Invoices Paid Within Target	2,017	78,596	1,151	46,224
Percentage of NHS Trade Invoices Paid Within Target	98.63%	99.97%	96.80%	99.55%

The Better Payment Practice Code requires the Trust to aim to pay all valid invoices by the due date or within 30 days of receipt of a valid invoice, whichever is later.

The Late Payment of Commercial Debts (Interest) Act 1998

	2011-12 £0000	2010-11 £0000
Amounts included in finance costs from claims made under this legislation	0	
Compensation paid to cover debt recovery costs under this legislation	0	

12. Investment Income

	2011-12 £000	2010-11 £000
PFI finance lease revenue (planned)	0	0
PFI finance lease revenue (contingent)	0	0
Other finance lease revenue	0	0
Subtotal	0	0
Interest Income		
LIFT: equity dividends receivable	0	0
LIFT: loan interest receivable	0	0
Bank interest	22	12
Other loans and receivables	0	0
Impaired financial assets	0	0
Other financial assets	0	0
Subtotal	22	12
Total investment income	22	12

13. Other Gains and Losses

	2011-12 £000	2010-11 £000
Gain/(loss) on disposal of property, plant and equipment	(20)	4
Gain/(loss) on disposal of intangible assets	0	0
Gain/(loss) on disposal of financial assets	0	0
Gain/(loss) on foreign exchange	0	0
Change in fair value of financial assets carried at fair value through the SoCI	0	0
Change in fair value of financial liabilities carried at fair value through the SoCI	0	0
Change in fair value of investment property	0	0
Recycling of gain/(loss) from equity on disposal of financial assets held for sale	0	0
Total	(20)	4

14. Finance Costs

	2011-12 £000	2010-11 £000
Interest		
Interest on loans and overdrafts	22	30
Interest on obligations under finance leases	1	2
Provisions - unwinding of discount	0	0
Interest on obligations under PFI contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on obligations under LIFT contracts:		
- main finance cost	0	0
- contingent finance cost	0	0
Interest on late payment of commercial debt	0	0
Other interest expense	0	0
Total interest expense	23	32
Other finance costs	0	0
Total	23	32

15. Property, plant and equipment

Property, plant and equipment

2011-12	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation:									
At 31 March 2011	12,776	51,579	1,330	0	17,955	12	3,872	294	87,818
Prior period adjustments	0	(6)	6	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0	0	0
At 1 April 2011 restated	12,776	51,573	1,336	0	17,955	12	3,872	294	87,818
Additions Purchased	0	1,684	34	1,297	1,430	0	344	16	4,805
Additions Donated	0	0	0	0	28	0	0	0	28
Additions Government Granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	1,302	1	(1,314)	11	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	0	0	0	0	0
Disposals other than for sale	0	0	0	0	(817)	0	0	0	(817)
Upward revaluation/positive indexation	40	65	0	0	0	0	0	0	105
Impairments/negative indexation	(2,869)	(9,008)	(400)	(41)	0	0	0	0	(12,318)
Reversal of Impairments	0	696	0	58	0	0	0	0	754
Transfers (to)/from NHS Bodies									
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	0
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	9,947	46,312	971	0	18,607	12	4,216	310	80,375
Depreciation									
At 31 March 2011	0	0	0		10,291	8	2,415	103	12,817
Prior period adjustments	0	0	0		0	0	0	0	0
Merger adjustments	0	0	0		0	0	0	0	0
At 1 April 2011 restated	0	0	0		10,291	8	2,415	103	12,817
Reclassifications					0	0	0	0	0
Reclassifications as Held for Sale	0	0	0		0	0	0	0	0
Disposals other than for sale	0	0	0		(792)	0	0	0	(792)
Upward revaluation/positive indexation	0	0	0		0	0	0	0	0
Impairments	3,592	3,826	0	0	0	0	0	0	7,418
Reversal of Impairments	(25)	(65)	0	0	0	0	0	0	(90)
Charged During the Year	0	2,043	21		1,944	1	742	39	4,790
Transfers to NHS Bodies									
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	0
Cumulative dep'n adjustment following revaluation	0	0	0	0	0	0	0	0	0
At 31 March 2012	3,567	5,804	21	0	11,443	9	3,157	142	24,143
Net book value at 31 March 2012	6,380	40,508	950	0	7,164	3	1,059	168	56,232
Purchased	6,380	39,826	950	0	6,962	3	1,055	160	55,336
Donated	0	682	0	0	202	0	4	8	896
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2012	6,380	40,508	950	0	7,164	3	1,059	168	56,232
Asset financing:									
Owned	6,380	40,508	950	0	7,119	3	1,055	168	56,183
Held on finance lease	0	0	0	0	45	0	4	0	49
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	0	0	0	0	0	0	0	0	0
Total	6,380	40,508	950	0	7,164	3	1,059	168	56,232

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 31 March 2011	2,911	10,011	747		1,251	0	0	11	14,931
Prior period adjustments	0	(228)	231		(3)	0	0	0	0
Merger adjustments	0	0	0		0	0	0	0	0
At 1 April 2011 restated	2,911	9,783	978	0	1,248	0	0	11	14,931
Upward revaluation/ positive indexation	40	66	0	0					106
Impairments/ negative indexation	(2,869)	(9,008)	(400)	(41)					(12,318)
Reversal of Impairments	0	696	0	58					754
At 31 March 2012	82	1,537	578	17	1,248	0	0	11	3,473

Property, plant and equipment

2010-11	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Cost or valuation:									
At 1 April 2010	12,906	48,321	1,322	0	17,012	12	4,316	295	84,184
Additions - purchased	0	1,222	0	1,090	2,222	0	535	3	5,072
Additions - donated	0	2	0	0	68	0	0	0	70
Additions - government granted	0	0	0	0	0	0	0	0	0
Reclassifications	0	0	0	(10)	4	0	6	0	0
Reclassified as held for sale	(130)	(275)	0	(2)	(523)	0	0	0	(930)
Disposals other than by sale	0	0	0	0	(828)	0	(985)	(1)	(1,814)
Revaluation & indexation gains	0	5,469	42	7	0	0	0	0	5,518
Impairments	0	(1,174)	0	(1,155)	0	0	0	(3)	(2,332)
Reversals of impairments	0	715	39	0	0	0	0	0	754
In-year transfers to/from NHS bodies	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	0
At 31 March 2011	12,776	54,280	1,403	(70)	17,955	12	3,872	294	90,522
Depreciation									
At 1 April 2010	0	0	0	0	9,815	7	2,793	73	12,688
Reclassifications	0	0	0	0	0	0	0	0	0
Reclassifications as Held for Sale	0	0	0	0	(523)	0	0	0	(523)
Disposals other than for sale	0	0	0	0	(816)	0	(985)	0	(1,801)
Upward revaluation/positive indexation	0	0	0	0	0	0	0	0	0
Impairments	0	888	0	43	0	0	0	0	931
Reversal of Impairments	0	(478)	0	(113)	0	0	0	0	(591)
Charged During the Year	0	2,291	73	0	1,815	1	607	30	4,817
Transfers to NHS Bodies	0	0	0	0	0	0	0	0	0
Transfers to Foundation Trusts	0	0	0	0	0	0	0	0	0
At 31 March 2011	0	2,701	73	(70)	10,291	8	2,415	103	15,521
Net book value	12,776	51,579	1,330	0	7,664	4	1,457	191	75,001
Purchased	12,776	50,695	1,330	0	7,396	4	1,446	183	73,830
Donated	0	884	0	0	268	0	11	8	1,171
Government Granted	0	0	0	0	0	0	0	0	0
Total at 31 March 2011	12,776	51,579	1,330	0	7,664	4	1,457	191	75,001
Asset financing:									
Owned	12,776	51,579	1,330	0	7,619	4	1,457	191	74,956
Held on finance lease	0	0	0	0	45	0	0	0	45
On-SOFP PFI contracts	0	0	0	0	0	0	0	0	0
PFI residual: interests	12,776	51,579	1,330	0	7,664	4	1,457	191	75,001

Revaluation Reserve Balance for Property, Plant & Equipment

	Land	Buildings	Dwellings	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
At 1 April 2010 restated	0	0	0	0	0	0	0	0
Movements (specify)	0	0	0	0	0	0	0	0
At 31 March 2011	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>0</u>

Property, plant and equipment

Various donors have funded assets during the year.

All land and buildings are restated to current modern equivalent asset value using professional valuations in accordance with IAS16 every five years and in the intervening years by annual desk top exercise undertaken by the District Valuer. A professional valuation from the District Valuer has been undertaken at the end of the year and the revaluation has been applied to all land and buildings. In 2011/12, the District Valuer undertook an exercise to revalue the North Devon District Hospital site on a Modern Equivalent Asset (MEA) basis incorporating an asset in Barnstaple utilising significantly less space than the current site (and incorporates a Health Centre). This has resulted in a downward valuation of approximately £19m.

Of the land value £1.106m relates to land associated with dwellings.

Economic lives of fixed assets

	Min life Years	Max life Years
Software Licences	5	5
Licences and trademarks	5	5
Buildings exc dwellings	12	62
Dwellings	10	57
Plant & Machinery	5	15
Transport Equipment	7	7
Information Technology	5	5
Furniture and Fittings	10	10

Intangible non-current assets

2010-11	Software internally generated	Software purchased	Licences & trademarks	Patents	Development expenditure	Total
	£000	£000	£000	£000	£000	£000
Cost or valuation:						
At 1 April 2010	1,378	0	0	0	0	1,378
Additions - purchased	242	0	0	0	0	242
Additions - internally generated	0	0	0	0	0	0
Additions - donated	0	0	0	0	0	0
Additions - government granted	0	0	0	0	0	0
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation & indexation gains	0	0	0	0	0	0
Impairments	0	0	0	0	0	0
Reversal of impairments	0	0	0	0	0	0
Transferred to Foundation Trusts	0	0	0	0	0	0
At 31 March 2011	1,620	0	0	0	0	1,620
Amortisation						
At 1 April 2010	795	0	0	0	0	795
Reclassifications	0	0	0	0	0	0
Reclassified as held for sale	0	0	0	0	0	0
Disposals other than by sale	0	0	0	0	0	0
Revaluation or indexation gains	0	0	0	0	0	0
Impairments charged to operating expenses	0	0	0	0	0	0
Reversal of impairments charged to operating expenses	0	0	0	0	0	0
Charged during the year	196	0	0	0	0	196
Transfers to Foundation Trusts	0	0	0	0	0	0
At 31 March 2011	991	0	0	0	0	991
Net book value at 31 March 2010	629	0	0	0	0	629
Net book value at 31 March 2010 comprises:						
Purchased	629	0	0	0	0	629
Donated	0	0	0	0	0	0
Government Granted	0	0	0	0	0	0
Total at 31 March 2011	629	0	0	0	0	629

Intangible assets are not revalued.

Intangible assets are assigned a 5 year life.

17. Analysis of impairments and reversals recognised in 2011-12

	2011-12 Total £000
Property, Plant and Equipment impairments and reversals taken to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	7,328
Changes in market price	0
Total charged to Annually Managed Expenditure	7,328
Property, Plant and Equipment impairments and reversals charged to the revaluation reserve	
Loss or damage resulting from normal operations	0
Over Specification of Assets	11,564
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for PPE charged to reserves	11,564
Total Impairments of Property, Plant and Equipment	18,892
Intangible assets impairments and reversals charged to SoCI	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Intangible Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	0
Over-specification of assets	0
Abandonment of assets in the course of construction	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total impairments for Intangible Assets charged to Reserves	0
Total Impairments of Intangibles	0
Financial Assets charged to SoCI	
Loss or damage resulting from normal operations	0
Total charged to Departmental Expenditure Limit	0
Loss as a result of catastrophe	0
Other	0
Total charged to Annually Managed Expenditure	0
Financial Assets impairments and reversals charged to the Revaluation Reserve	
Loss or damage resulting from normal operations	0
Loss as a result of catastrophe	0
Other	0
TOTAL impairments for Financial Assets charged to reserves	0
Total Impairments of Financial Assets	0
Non-current assets held for sale - impairments and reversals charged to SoCI.	
Loss or damage resulting from normal operations	0
Abandonment of assets in the course of construction	0
Total charged to Departmental Expenditure Limit	0
Unforeseen obsolescence	0
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total impairments of non-current assets held for sale	0

17. Analysis of impairments and reversals recognised in 2011-12 (Continued)

	2011-12 Total £000
Investment Property impairments charged to SoCI	
Loss as a result of catastrophe	0
Other	0
Changes in market price	0
Total charged to Annually Managed Expenditure	0
Total Investment Property impairments charged to SoCI	0
Total Impairments charged to Revaluation Reserve	11564
Total Impairments charged to SoCI - DEL	0
Total Impairments charged to SoCI - AME	7,328
Overall Total Impairments	18,892
Of which:	
Impairment on revaluation to "modern equivalent asset" basis	0
Donated and Gov Granted Assets, included above	
Donated Asset Impairments: amount charged to SOCI - DEL	0
Donated Asset Impairments: amount charged to SOCI - AME	0
Donated Asset Impairments: amount charged to revaluation reserve	0
Total Donated Asset Impairments	0
Government Granted Asset Impairments: amount charged to SoCI - DEL	0
Government Granted Asset Impairments: amount charged to SoCI - AME	0
Government Granted Asset Impairments: amount charged to revaluation reserve	0
Total Gov Granted asset Impairments	0
TOTAL DONATED/GOVERNMENT GRANTED ASSET IMPAIRMENTS	0

The District Valuer's MEA valuation as described in Note 15.3 has resulted in a net impairment of approximately £19m.

18. Investment property

The Trust has no investment property.

19. Commitments

Capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2012	31 March 2011
	£000	£000
Property, plant and equipment	1,221	0
Intangible assets	0	0
Total	1,221	0

Other financial commitments

The trust has entered into non-cancellable contracts (which are not leases or PFI contracts or other service concession arrangements), for The payments to which the trust is committed are as follows.

	31 March 2012	31 March 2011
	£000	£000
Not later than one year	0	0
Later than one year and not later than five year	0	0
Later than five years	0	0
Total	0	0

20. Intra-Government and other balances

	Current receivables £000s	Non- current receivables £000s	Current payables £000s	Non- current payables £000s
Balances with other Central Government Bodies	5,536	0	5,084	0
Balances with Local Authorities	744	0	0	0
Balances with NHS Trusts and Foundation Trusts	502	0	2,728	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	4,339	872	9,600	0
At 31 March 2012	11,121	872	17,412	0
prior period:				
Balances with other Central Government Bodies	2,895	0	3,576	0
Balances with Local Authorities	15	0	0	0
Balances with NHS Trusts and Foundation Trusts	422	0	412	0
Balances with Public Corporations and Trading Funds	0	0	0	0
Balances with bodies external to government	1,149	683	5,072	0
At 31 March 2011	4,481	683	9,060	0

21. Inventories

	Drugs £000	Consumables £000	Energy £000	Work in progress £000	Loan Equipment £000	Other £000	Total £000
Balance at 1 April 2011	754	1,749	202	0	0	0	2,705
Prior period adjustment	0	0	0	0	0	0	0
Merger adjustment	0	0	0	0	0	0	0
Restated at 1 April 2011	754	1,749	202	0	0	0	2,705
Additions	7,506	13,604	75	0	0	0	21,185
Inventories recognised as an expense in the period	(7,414)	(13,799)	(76)	0	0	0	(21,289)
Write-down of inventories (including losses)	0	0	0	0	0	0	0
Reversal of write-down previously taken to SoCI	0	0	0	0	0	0	0
Transfers (to)/from other bodies	0	0	0	0	0	0	0
Transfers (to) Foundation Trusts	0	0	0	0	0	0	0
Balance at 31 March 2012	846	1,554	201	0	0	0	2,601

22. Trade and other receivables

Trade and other receivables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
NHS receivables - revenue	5,614	3,092	0	0
NHS receivables - capital	0	0	0	0
NHS prepayments and accrued income	0	0	0	0
Non-NHS receivables - revenue	3,806	433	974	740
Non-NHS receivables - capital	0	0	0	0
Non-NHS prepayments and accrued income	831	674	0	0
Provision for the impairment of receivables	(16)	(4)	(102)	(57)
VAT	424	225	0	0
Current part of PFI and other PPP arrangements prepayments and accrued income	0	0	0	0
Interest receivables	0	0	0	0
Finance lease receivables	0	0	0	0
Operating lease receivables	0	0	0	0
Other receivables	462	61	0	0
Total	11,121	4,481	872	683
Total current and non current	11,993	5,164		
Included in NHS receivables are prepaid pension contributions:	0	0		

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

Receivables past their due date but not impaired

	31 March 2012 £000	31 March 2011 £000
By up to three months	141	54
By three to six months	18	14
By more than six months	52	86
Total	211	154

Provision for impairment of receivables

	2011-12 £000	2010-11 £000
Balance at 1 April 2011	(61)	(55)
Adjustments	0	0
Restated balance at 1 April 2011	(61)	(55)
Amount written off during the year	0	0
Amount recovered during the year	0	0
(Increase)/decrease in receivables impaired	(57)	(6)
Transfer to NHS Foundation Trust	0	0
Balance at 31 March	(118)	(61)

Injury cost recovery income is subject to a provision for impairment of receivables of 10.5% to reflect expected rates of collection.

23. NHS LIFT investments

The Trust has no LIFT investments.

24. Other financial assets

The Trust has no other financial assets to report.

25. Other current assets

The Trust has no other current assets to report.

26. Cash and Cash Equivalents

	31 March 2012 £000	31 March 2011 £000
Opening balance at	950	419
Opening balance adjustment	0	
Merger adjustments	0	
Restated	950	419
Net change in year	2,517	531
Closing balance	3,467	950
Made up of		
Cash with Government Banking Service	3,457	944
Commercial banks	0	0
Cash in hand	10	6
Current investments	0	0
Cash and cash equivalents as in statement of financial position	3,467	950
Bank overdraft - Government Banking Service	0	0
Bank overdraft - Commercial banks	0	0
Cash and cash equivalents as in statement of cash flows	3,467	950
Patients' money held by the Trust, not included above	1	2

27. 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	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Balance at 1 April 2011	130	172	0	0	0	0	0	0	0	302
Merger adjustments	0	0	0	0	0	0	0	0	0	0
Restated at 1 April 2011	130	172	0	0	0	0	0	0	0	302
Plus assets classified as held for sale in the year	0	0	0	0	0	0	0	0	0	0
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	0	(2)	0	0	0	0	0	0	0	(2)
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0
Transfers (to)/from other bodies	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2012	130	170	0	0	0	0	0	0	0	300
Liabilities associated with assets held for sale at 31 March 2012	0	0	0	0	0	0	0	0	0	0
Balance at 1 April 2010	0	0	0	0	0	0	0	0	0	0
Plus assets classified as held for sale in the year	130	277	0	0	0	0	0	0	0	407
Less assets sold in the year	0	0	0	0	0	0	0	0	0	0
Less impairment of assets held for sale	0	(105)	0	0	0	0	0	0	0	(105)
Plus reversal of impairment of assets held for sale	0	0	0	0	0	0	0	0	0	0
Less assets no longer classified as held for sale, for reasons other than disposal by sale	0	0	0	0	0	0	0	0	0	0
Balance at 31 March 2011	130	172	0	0	0	0	0	0	0	302
Liabilities associated with assets held for sale at 31 March 2011	0	0	0	0	0	0	0	0	0	0

Lynton Hospital has been reclassified as an asset held for sale pending the completion of the sale to the local GP practice.

28. Trade and other payables

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Interest payable	0	0		
NHS payables - revenue	3,418	1,010	0	0
NHS payables - capital	0	0	0	0
NHS accruals and deferred income	0	0	0	0
Family Health Services (FHS) payables	-	-	-	-
Non-NHS payables - revenue	5,829	2,325	0	0
Non-NHS payables - capital	1,208	924	0	0
Non-NHS accruals and deferred income	1,050	818	0	0
Social security costs	1,303	855		
VAT	0	0	0	0
Tax	1,365	991		
Payments received on account	0	0	0	0
Other	3,239	2,137	0	0
Total	17,412	9,060	0	0
Total payables (current and non-current)	17,412	9,060		
Included above:				
outstanding Pension Contributions at the year end	1726	1131		

29. Other liabilities

The Trust has no other liabilities to report.

30. Borrowings

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Bank overdraft - Government Banking Service	0	0	0	0
Bank overdraft - commercial banks	0	0	0	0
Loans from Department of Health	500	500	500	1,000
Loans from other entities	0	0	0	0
PFI liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
LIFT liabilities:				
Main liability	0	0	0	0
Lifecycle replacement received in advance	0	0	0	0
Finance lease liabilities	16	16	17	33
Other (describe)	0	0	0	0
Total	516	516	517	1,033
Total other liabilities (current and non-current)	1,033	1,549		

Loans - repayment of principal falling due in:

	31 March 2012		
	DH £000	Other £000	Total £000
0-1 years	500	0	500
1 - 2 Years	500	0	500
2 - 5 Years	0	0	0
Over 5 Years	0	0	0
Total	1,000	0	1,000

31. Other financial liabilities

The Trust has no other financial liabilities to report.

32. Deferred income

	Current		Non-current	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Opening balance at 01/04/11	59	64	0	0
Deferred income addition	601	56	0	0
Transfer of deferred income	(45)	(61)	0	0
Current deferred Income at 31 March 2012	615	59	0	0
Total other liabilities (current and non-current)	615	59		

33. Finance lease obligations as lessee

Amounts payable under finance leases (Other)	Minimum lease payments		Present value of minimum lease payments	
	31 March 2012 £000	31 March 2011 £000	31 March 2012 £000	31 March 2011 £000
Within one year	17	18	16	16
Between one and five years	17	34	17	33
After five years	0	0	0	0
Less future finance charges	(1)	(3)		
Present value of minimum lease payments	33	49	33	49
Included in:				
Current borrowings			16	16
Non-current borrowings			17	33
			33	49
Finance leases as lessee			31 March 2012 £000	31 March 2011 £000
Future Sublease Payments Expected to be received			0	0
Contingent Rents Recognised as an Expense			0	0

34. Finance lease receivables as lessor

The Trust has no finance lease receivables.

35. Provisions

	Comprising:									
	Total £000s	Pensions to Former Directors £000s	Pensions Relating to Other Staff £000s	Legal Claims £000s	Restructuring £000s	Continuing Care £000s	Equal Pay £000s	Agenda for Change £000s	Other £000s	Redundancy £000s
Balance at "01/04/11"	16	0	0	16	0	0	0	0	0	0
Prior period adjustment	0	0	0	0	0	0	0	0	0	0
Merger adjustments	0	0	0	0	0	0	0	0	0	0
Restated Balance 01/04/11	16	0	0	16	0	0	0	0	0	0
Arising During the Year	30	0	0	30	0	0	0	0	0	0
Utilised During the Year	(5)	0	0	(5)	0	0	0	0	0	0
Reversed Unused	(4)	0	0	(4)	0	0	0	0	0	0
Unwinding of Discount	0	0	0	0	0	0	0	0	0	0
Change in Discount Rate	0	0	0	0	0	0	0	0	0	0
Transfers to NHS Foundation Trusts (for Trusts becoming FTs only)	0	0	0	0	0	0	0	0	0	0
Balance as at "31/03/12"	37	0	0	37	0	0	0	0	0	0

Expected Timing of Cash Flows:

No Later than One Year	37	0	0	37	0	0	0	0	0	0
Later than One Year and not later than Five Years	0	0	0	0	0	0	0	0	0	0
Later than Five Years	0	0	0	0	0	0	0	0	0	0

Amount Included in the Provisions of the NHS Litigation Authority in Respect of Clinical Negligence Liabilities:

As at "31/03/12"	19,279
As at "31/03/11"	18,711

Legal Claims - relates to provisions for the member's excess due in Employer Liability cases as notified by the NHS Litigation Authority. The provision reflects the excess due by the Trust since the NHS Litigation Authority make the majority of payments and recharge the Trust in due course. An associated contingent liability of £32,000 is shown in note 36 (2010/11 £17,000).

36. Contingencies

	31 March 2012 £000	31 March 2011 £000
Contingent liabilities		
Equal Pay	0	0
Other	(32)	(17)
Amounts Recoverable Against Contingent Liabilities	0	0
Net Value of Contingent Liabilities	<u>(32)</u>	<u>(17)</u>
Contingent Assets		
Contingent Assets	0	0
Net value of contingent assets/(liabilities)	<u>(32)</u>	<u>(17)</u>

£32,000 (2010/11 £17,000) contingency reflects the potential liability relating to Employer's liability cases as notified by the NHS Litigation Authority. An associated provision is shown in note 35.

37. PFI and LIFT - additional information

The Trust has no PFI or LIFT contracts to report on.

38. Impact of IFRS treatment - current year

	Total £000
The information below is required by the Department of Health for budget reconciliation purposes	
Revenue costs of IFRS: Arrangements reported on SoFP under IFRIC12 (e.g. PFI / LIFT)	
Depreciation charges	21
Interest Expense	2
Impairment charge - AME	0
Impairment charge - DEL	0
Other Expenditure	0
Revenue Receivable from subleasing	0
Impact on PDC dividend payable	0
Total IFRS Expenditure (IFRIC12)	<u>23</u>
Revenue consequences of PFI / LIFT schemes under UK GAAP / ESA95 (net of any sublease income)	0
Net IFRS change (IFRIC12)	<u>23</u>
Capital Consequences of IFRS : LIFT/PFI and other items under IFRIC12	
Capital expenditure 2011-12	0
Average net assets relating to IFRIC12 schemes - IFRS	0
Average net assets relating to IFRIC12 schemes - UKGAAP	0
UK GAAP capital expenditure 2011-12 (Reversionary Interest)	0
Revenue costs of IFRS: all other expenditure associated with IFRS (e.g. finance leases)	
Depreciation charge	0
Interest expense	0
Impairment charge - AME	0
Impairment charge - DEL	0
Other expenditure	0
Impact on PDC dividend payable	0
Total IFRS expenditure (non IFRIC12)	0
Revenue consequences under UK GAAP	0
Net IFRS change (non IFRIC12)	0
Capital consequences of IFRS all other expenditure associated with IFRS	
Capital expenditure 2011-12	0
Net assets relating to non-IFRIC12 IFRS - IFRS basis	0
Net assets relating to non-IFRIC12 IFRS - UKGAAP basis	0
UK GAAP capital expenditure 2011-12 (Reversionary Interest)	0

39. Financial Instruments

Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with primary care trusts and the way those primary care trusts are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. Trust treasury activity is subject to review by the trust's internal auditors.

Currency risk

The trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The trust has no overseas operations. The trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The trust borrows from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 20XX are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The trust's operating costs are incurred under contracts with primary care trusts, which are financed from resources voted annually by Parliament. The trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The trust is not, therefore, exposed to significant liquidity risks.

Financial Assets

	At 'fair value through profit and loss' £000	Loans and receivables £000	Available for sale £000	Total £000
Embedded derivatives	0	0	0	0
Receivables - NHS	0	5,614	0	5,614
Receivables - non-NHS	0	3,807	0	3,807
Cash at bank and in hand	0	3,467	0	3,467
Other financial assets	0	1,363	0	1,363
Total at 31 March 2012	0	14,251	0	14,251
Embedded derivatives	0	0	0	0
Receivables - NHS	0	3,092	0	3,092
Receivables - non-NHS	0	433	0	433
Cash at bank and in hand	0	950	0	950
Other financial assets	0	1,639	0	1,639
Total at 31 March 2011	0	6,114	0	6,114

Financial Liabilities

	At 'fair value through profit and loss' £000	Other £000	Total £000
Embedded derivatives	0	0	0
NHS payables	0	3,418	3,418
Non-NHS payables	0	7,037	7,037
Other borrowings	0	1,000	1,000
PFI & finance lease obligations	0	33	33
Other financial liabilities	0	4,341	4,341
Total at 31 March 2012	0	15,829	15,829
Embedded derivatives	0	0	0
NHS payables	0	1,010	1,010
Non-NHS payables	0	3,249	3,249
Other borrowings	0	1,500	1,500
PFI & finance lease obligations	0	49	49
Other financial liabilities	0	4,801	4,801
Total at 31 March 2011	0	10,609	10,609

40. Events after the end of the reporting period

There are no events after the reporting period to be included.

£000

0

41. Related party transactions

Northern Devon Healthcare NHS Trust is a body corporate established by order of the Secretary of State for Health.

During the year none of the Board Members or members of the key management staff or parties related to them has undertaken any material transactions with Northern Devon Healthcare NHS Trust.

The Department of Health is regarded as a related party. During the year Northern Devon Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent Department. These entities are:

NHS Devon	Royal Devon & Exeter NHS Foundation Trust
NHS South of England	South Devon Healthcare Foundation Trust
NHS Cornwall & Isles of Scilly	South West Ambulance Service NHS Foundation Trust
NHS Plymouth	North Bristol NHS Trust
Portsmouth Hospitals NHS Trust	Devon Partnership Trust
NHS Litigation Authority	NHS Torbay
NHS Supplies Authority	NHS Professionals
NHS Pensions Agency	National Blood Authority

In addition, the trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with:

- ▶ North Devon District Council in respect of business rates;
- ▶ Inland Revenue in respect of tax and national insurance;
- ▶ Customs and Excise in respect of VAT payable/recoverable;
- ▶ Devon County Council in respect of the provision of a joint community equipment store.

The trust has also received revenue and capital payments from a number of charitable funds, certain of the trustees for which are also members of the NHS trust board.

During the year the charity has contributed £123,000 towards NHS activities .

42. Losses and special payments

The total number of losses cases in 2011-12 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	12,588	29
Special payments	55,877	23
Total losses and special payments	68,465	52

The total number of losses cases in 2010-11 and their total value was as follows:

	Total Value of Cases £s	Total Number of Cases
Losses	8,837	17
Special payments	53,049	30
Total losses and special payments	61,886	47

Details of cases individually over £250,000

There were no cases individually exceeding £250,000.

43. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

Breakeven performance

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000	2011-12 £000
Turnover	77,056	89,547	118,418	128,855	128,509	134,710	211,041
Retained surplus/(deficit) for the year	(7,961)	(6,924)	7,602	7,902	(5,086)	(93)	(5,724)
Adjustment for:							
Timing/non-cash impacting distortions:							
Use of pre - 1.4.97 surpluses [FDL(97)24 Agreements]	0	0	0	0	0	0	0
2006/07 PPA (relating to 1997/98 to 2005/06)	0						
2007/08 PPA (relating to 1997/98 to 2006/07)	0	0					
2008/09 PPA (relating to 1997/98 to 2007/08)	0	0	0				
Adjustments for Impairments				0	5,086	345	7,328
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*				0	0	0	23
Adjustments for impact of policy change re donated/ government grants assets							92
Other agreed adjustments	0	0	0	0	0	0	0
Break-even in-year position	(7,961)	(6,924)	7,602	7,902	0	252	1,719
Break-even cumulative position	(8,329)	(15,253)	(7,651)	251	251	503	2,222

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS Trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance. Other adjustments are made in respect of accounting policy changes (impairments and the removal of the donated asset and government grant reserves) to maintain comparability year to year.

If anticipated financial year of recovery is more than two years state the period agreed with SHA

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %	2011-12 %
Materiality test (i.e. is it equal to or less than 0.5%):							
Break-even in-year position as a percentage of turnover	-10.33	-7.73	6.42	6.13	0.00	0.19	0.81
Break-even cumulative position as a percentage of turnover	-10.81	-17.03	-6.46	0.19	0.20	0.37	1.05

The amounts in the above tables in respect of financial years 2005/06 to 2008/09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

Capital cost absorption rate

Until 2008/09 the trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009/10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

External financing

The trust is given an external financing limit which it is permitted to undershoot.

	2011-12	2010-11
£000	£000	£000
External financing limit	(1,149)	(767)
Cash flow financing	(2,997)	(977)
Finance leases taken out in the year	0	0
Other capital receipts	(36)	(70)
External financing requirement	(3,033)	(1,047)
Undershoot/(overshoot)	<u>1,884</u>	<u>280</u>

Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2011-12	2010-11
	£000	£000
Gross capital expenditure	5,284	5,384
Less: book value of assets disposed of	(25)	(13)
Less: capital grants	0	0
Less: donations towards the acquisition of non-current assets	(36)	(70)
Charge against the capital resource limit	5,223	5,301
Capital resource limit	5,230	5,304
(Over)/underspend against the capital resource limit	<u>7</u>	<u>3</u>

44. Third party assets

The Trust held cash and cash equivalents which relate to monies held by the NHS Trust on behalf of patients or other parties. This has been excluded from the cash and cash equivalents figure reported in the accounts.

	31 March 2012	31 March 2011
	£000s	£000s
Third party assets held by the Trust	<u>1</u>	<u>2</u>

Transforming community services

As part of the reconfiguration of the NHS, the Trust was awarded a 3 year contract from 1 April 2011 to manage and transform a range of services that were previously provided by the provider arm of NHS Devon.

The Trust received income from NHS Devon for these services of £64.368m in 2011/12.

There were no transfers of assets or liabilities that existed at 31 March 2011.

These services transferred include:

Community Services (East Devon, Exeter and Mid Devon)

- ▶ 12 Community Hospitals, including 7 Minor Injury Units
- ▶ Nine Complex Care Teams

Due to current NHS rules, the 12 Community Hospitals in East Devon remain under the ownership of NHS Devon and the Trust retains the management responsibility for services from these sites.

Pan Devon Services

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

- ▶ Bladder and Bowel Care
- ▶ Community Nursing
- ▶ Physiotherapy
- ▶ Occupational Therapy
- ▶ Radiology
- ▶ Speech and Language Therapy
- ▶ Continuing Healthcare
- ▶ Sexual Health services including Family Planning
- ▶ Podiatry

As a result, the Trust now provides a range of Acute, Community and Pan Devon Services and now serves a population of 484,000 people (65% of the population of Devon).