NHS
Northern Devon Healthcare
NHS Trust

Annual report and accounts

April 2018 – March 2019

Contents

Chairman's Introduction

It is my pleasure to introduce our annual report and accounts for 2018/19

It has been another very challenging year for the NHS in England as we've continued to see demand outstripping resource. Nationally, the NHS recorded its poorest ever performance against the four hour A&E target and against waiting times for cancer treatment, and waiting lists for other care also continue to grow. Behind these numerical targets is a very human impact: more people are waiting longer to receive the care they need.

The national financial position adds to this picture, with providers forecast to end the year with a deficit of more than £500 million. This would be a worrying number if we were delivering the service expected of us, but it is even more concerning when you consider that we are continuing to overspend while collective performance is declining.

The national funding settlement of course brings welcome investment into the NHS, but will it be enough to help it recover its operational and financial position? Not in my view. We already have a significant financial challenge to address across the Devon Sustainability and Transformation Partnership, with a significant deficit for 2019/20. And in any case, I believe the most significant issue we face is not money, but workforce. We have a shortage of more than 100,000 staff across the NHS and providers are trying to plug the gap however they can to ensure we are delivering safe care. Often, this involves spending more money on fewer people through agencies.

The NHS needs to learn from these workforce challenges and whilst we need to continue to lobby centrally for solutions, I believe we can have a huge impact locally. We need to continue our focus on 'growing our own' workforce and being creative in finding solutions to workforce challenges. We've already seen this through successful initiatives like the trainee nursing associates programme, and we have recently worked with Petroc College and Bolton University to offer nursing degrees in Barnstaple. Closer working partnerships between NHS organisations, both across the Devon Sustainability and Transformation Partnership, and through the recent collaborative agreement between NDHT and the Royal Devon and Exeter NHS Foundation Trust (RD&E), allow us to share the workforce problem and come up with collective solutions. For example, we recently recruited three consultants in obstetrics and gynaecology to work across North Devon and Exeter, which is fantastic news and brings a wealth of experience to both communities.

With the EU Exit on the horizon, now more than ever we need to recognise the invaluable contribution of our EU workforce and indeed of those from outside of the EU. And whilst it has been an uncertain time, the NHS mustn't let the EU Exit become any sort of excuse for not delivering for our patients. Of course, there will be some things that are outside of the NHS' control, but we have and must continue to prepare where we can, and we must continue to support our EU colleagues and provide them with clear information if they wish to remain in the UK.

Workforce isn't the only thing the NHS needs to think differently about. I believe the NHS has traditionally underinvested in services for children and young people, and particularly mental health, choosing instead to invest in other areas, such as elderly care. This isn't easy, as of course we want to provide excellent care for everybody, but we must recognise that by underinvesting in services to care for people at the beginning of their lives, we may miss opportunities to ensure they are well later in life. We have taken direct action to address this: NDHT is part of an alliance of NHS providers who have taken on the provision of children's and young people's services in Devon, increasing access to the services by 20% on day one. This is corporately challenging, because demand is extremely high, creating a financial risk for the organisations involved, but we have all chosen to support this because we believe it is the right thing to do.

We know there are many areas across Devon with high levels of deprivation and within the Sustainability and Transformation Partnership we must take a lead and play our part in ensuring resources are shared fairly amongst our communities. When considering our commitments to respecting diversity, and promoting equality and inclusivity, we need to focus on deprivation in addition to the protected characteristics. To me, this is about focusing on equality of outcomes rather than simply equality of investment, because each community is different and has its own set of challenges and needs. There are many issues which the NHS can influence directly and the work NDHT has been doing with partner organisations as part of One Northern Devon - including health, education, police, fire, housing and voluntary services to name a few – shows what can be achieved when we come together with a shared vision.

With all this said, it is clear that there is no magic solution to help the NHS meet the demand it faces. Prevention and early intervention are extremely important and help people to lead healthy lives, but they don't stop people from getting ill eventually, nor do they address the fact that with an ageing population, people need care for longer. It is clear that, as demand continues to increase and we continue to experience workforce challenges, things are going to get tougher for the NHS.

So how is NDHT performing?

We are particularly challenged in northern Devon because of being so rural – in fact North Devon District Hospital is the most remote hospital in mainland England. 2018/19 has been a really significant year for the NHS in North Devon, as NDHT and the RD&E have entered into a unique collaborative agreement to support NDHT to address its challenges.

We have made significant progress since the outset of this agreement in June 2018, particularly in relation to stabilising services and improving performance, and you'll read more about this in the pages of this report. We are building the confidence our regulators have in us. In their last inspection in July 2018, the Care Quality Commission recognised the progress made in all areas as a result of the hard work of staff and they didn't issue any further warning notices. In March 2019, the Trust was notified that NHS Improvement no longer considered NDHT to be a 'challenged provider'. These improvements have happened over a short period time and I think we need to be realistic that there is more to do, but we are looking forward to continuing this journey of improvement.

Making these improvements to quality and performance has required investment, and this, along with our other challenges has led to us ending the 2018/19 financial year with a £17m deficit, with a plan to move towards financial balance in 2019/20. The Board's priority is to ensure that we deliver safe and high quality services, and our planning for 2019/20 has been focused on ensuring the financial plan and overall operational plan are aligned, and that we recover our financial position at the right pace.

As we go into 2019/20, we are looking to the longer term and considering what the best arrangements are for our hospital services going forwards and what the best organisational form would be to deliver that. The community are very well versed in how remote and rural northern Devon is, and to me it is inconceivable that you would ever not have a district general hospital in North Devon with services supporting it. What we do need to understand is how we deliver the services needed and how we ensure those services are safe, high quality and sustainable for years to come. This work, led by staff at NDHT, will need to link closely to the clinical services review work being undertaken for Devon and Cornwall by the STP.

For me, an important part of this will be to fully understand the challenges we face in northern Devon in relation to our remoteness, workforce and finance. We know some services cost more to provide in rural areas and we need to look closely at why that is so we can have that debate in order to ensure the cost of providing services in a remote area is fully allowed for.

It is really important to me that we have these conversations in an open way, involving staff, stakeholders and the community. There is an excellent staff culture at NDHT with a high level of transparency and an open leadership team. We are very fortunate to have the support of our local community, including some very passionate people who want to campaign for what they feel is right, in particular the local Save Our Hospital Services group.

Despite the risks and challenges relating to our workforce, the underlying demand for our services and the need to get back into financial balance, I feel extremely positive about the road ahead and the opportunity we have to set out a long term plan for services in northern Devon.

Finally, I'd like to take the opportunity to thank our staff, our volunteers, my Board colleagues, colleagues across the health and care system and our One Northern Devon partners for their efforts over the last 12 months. The NHS is operating in challenging circumstances, but the fantastic work detailed in this annual report shows what we can do when we work together. Thank you.

James Brent
Chairman

Performance report

Introduction by the Chief Executive

Welcome to the annual report and accounts for 2018/19

This year has been one of significant change for the Trust. In June 2018, we marked the beginning of a unique collaboration with the Royal Devon and Exeter NHS Foundation Trust (RD&E) which has seen NDHT receiving leadership support to help address some of the challenges it faces as a result of being so remote.

Without a doubt the most significant of these challenges is workforce. The NHS nationally is facing a huge workforce challenge and this has a heightened impact in remote areas. This in turn has led to increased pressure on the Trust's financial position and whilst money is also a challenge, more of it won't solve the problem because there simply aren't enough staff to fill the vacancies. This is unlikely to be resolved in the near future because it takes time to train staff. Therefore we need to think differently and make the most of opportunities to work together, both as part of the collaborative agreement and across the STP.

As a result of the collaborative agreement, there have been a number of changes to the leadership team, which now includes a joint chair and chief executive with the RD&E, as well as a joint medical director, chief operating officer and director of people.

At the outset of the agreement, we set some immediate priorities and implemented a plan to stabilise services, with additional clinical support going into some of the most vulnerable specialties.

One of our key areas of focus was maternity services. We focused on addressing the concerns raised by the CQC and we have appointed a substantive head of midwifery, as well as welcoming three new consultants in obstetrics and gynaecology. The consultants are joint posts with the RD&E and add to the growing team of senior consultants at NDDH, bringing additional expertise in outpatient hysteroscopy, fertility services, governance and teaching/simulation to North Devon. It is fantastic to see these tangible examples of progress which will really make a difference in people's lives.

Improving performance in the context of increased demand has also been a key area of focus, in particular managing our waiting lists for referral to treatment (RTT) and cancer. Thanks to the hard work of our teams, we have seen significant improvements in these areas. The number of patients waiting over 52 weeks has reduced from 107 in August 2018 to 16 in March 2019. The number waiting over 40 weeks has reduced from over 500 to under 200. Over the course of 2018/19, the Trust has reduced the number of patients waiting more than six weeks for a diagnostic test from 22.4% to 14.6%. Our performance in relation to diagnostic and cancer has improved above our trajectory, meaning we have done better than expected, and importantly, we are doing better for our patients.

We have carried out a review of governance, with a focus on ensuring the organisation has values and behaviours at its heart which help it to continuously learn and improve.

This progress has been recognised by our regulators and it is fantastic for us to be building the confidence they have in us. NHS Improvement no longer considers NDHT to be a 'challenged provider' and following their inspection in July 2018, the CQC recognised that, thanks to the hard work of staff across the organisation, we'd made progress in all areas.

Making these improvements to our services has required significant investment, and this, along with the impact of our other challenges, has seen us end the year with a £17m deficit. It is really important that we understand the drivers behind our deficit more fully and that we recover at the right pace. Our planning for 2019/20 focuses on returning to financial balance whilst ensuring the financial plan and overall operational plan are aligned.

One of the key areas we invested in in 2018/19 was our preparations for winter. Winter is always busy for the NHS, and this year we worked with staff, partner organisations and the community to pull together a wide-ranging plan. This included developing our acute medical unit to reduce the numbers going through the Emergency Department (A&E). We've also put in some additional long-term resource, with extra bed capacity and more staff. Alongside this, we carried out a large awareness campaign, asking people to make the best use of NHS resources and to help get their loved ones home from hospital when they are ready to be discharged.

All of this great work has happened thanks to our fantastic innovative teams. It was great to see some of our teams being recognised nationally for the work they have done to improve care for patients. Our Lundy Ward team won the Nursing Times award for Enhancing Patient Dignity for transforming a side room into a welcoming and private space for families when it is most needed. Staff have also been recognised for how well they've worked with partner organisations, with the waiting times app NHSquicker and the North Devon Integrated Diabetes Service being recognised in the prestigious Health Service Journal awards. Over the pages of this annual report, you will find many more examples of how staff at NDHT go above and beyond for patients every day.

Our staff are our greatest asset, and how they feel about work is really important to us. It was fantastic once again to see NDHT staff rating the Trust as a great place to work in the NHS Staff Survey, particularly as our services have continued to be very busy. Staff wellbeing has been a focus this year and we've been encouraging staff to talk about how they are feeling and to direct their colleagues to the appropriate support if they think anybody is finding things difficult. We signed the Time to Change employer pledge, through which we've committed to change the way we think and act about mental health at work. We are also really proud of the work we have been part of this year with our One Northern Devon partners to get individuals and organisations signing a Stop Suicide Pledge.

With all of this fantastic work behind us, we are looking forward with real positivity. 2018/19 focused on stabilising our services, and whilst there are many more improvements we'd like to make, we feel ready to welcome CQC inspectors back when they visit this year to show them some of the fantastic work we've been doing.

As we move into 2019/20, we'll be moving our focus to how we can secure the long term clinical sustainability of services in northern Devon. It will be really important to involve staff, stakeholders and the local community in this work, to ensure we have a shared understanding of the challenges we are facing in relation to our workforce and remoteness, and that we understand what is important to everybody about local healthcare services. This important piece of work will form the cornerstone of our plans for all of our services and will help us to make a decision on what form the organisation should take in the future.

The support of the community has always been important to staff at NDHT, whether it is your kind words making them smile, your incredible fundraising efforts for Over and Above, or the passion with which you talk about services. We hope you'll continue to support us as we head into this important year.

Suzanne Tracey
Chief Executive

About Northern Devon Healthcare NHS Trust

What we do

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

In any 24 hours our health and social care community teams visit around 450 patients in their own homes to help them rehabilitate after illness or injury. At any one time, they are overseeing around 8,850 people's care.

Our domiciliary care service, Devon Cares, is a partnership of high quality local care agencies who provide social care to people in their own homes.

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

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

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

North Devon District Hospital (NDDH), Barnstaple

In 2018/19, staff at North Devon District Hospital treated 31,332 inpatients, 20,322 day cases, 309,349 outpatients and delivered 1,285 babies. They also saw 47,672 people in our emergency department and 12,055 in our minor injuries units.

The populations of Torridge and North Devon account for 82% of patients to NDDH, with the remaining 18% coming from residents from the Cornish and Somerset borders or tourists to the area.

NDDH provides a 24/7 emergency service and is designated trauma unit operating within a trauma network serving the whole of Devon and Cornwall. This network ensures residents of northern Devon have access to trauma services.

The Trust offers a range of general medical services, including cardio-respiratory, stroke care and gastroenterology. General surgical services include orthopaedics, urology and colorectal specialities. We also run ophthalmology services, using the latest procedures and techniques to treat glaucoma and macular degeneration.

The Trust offers patients a choice of local, specialist services and invites consultants from other neighbouring NHS trusts to hold clinics in the area. We work with Musgrove Park in Taunton on a vascular network and Derriford on a neonatal network. We have worked with the Royal Devon and Exeter NHS Foundation Trust (RD&E) for a number of years to deliver various services to our patients. This partnership was formalised in 2018 with the formation of the collaborative agreement between NDHT and the RD&E.

Integrated health and social care community services

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

The teams deliver care to around 8,850 people at any one time, often with very complex needs, providing support and treatment to enable them to live independently in their own homes.

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

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

In 2016, we launched Devon Cares. We are the prime provider of domiciliary care services across northern and mid Devon and work in partnership with our local social care providers to arrange for people to receive social care at home. This made us the first NHS Trust to enter the domiciliary care market, and since taking over this function, the number of people waiting to have their care needs met has significantly reduced.

The Trust has five community hospitals and two resource centres, which provide local hubs of healthcare for their communities and a range of services that are easily accessible to the local population, including minor injuries units and local outpatient and self-referral services, such as sexual health clinics.

Specialist community services

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

NHS
Devon Salaried Dental Service

www.healthyteethdevon.nhs.uk

Devon & Cornwall SARC
Sexual Assault Referral Centres

sarchelp.co.uk

Devon Sexual Health
Contraception, Sexual Health & HIV service

www.devonsexualhealth.co.uk

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

Our year

Highlights of 2018/19:

- In our most recent staff survey NDHT was the fourth acute and community trust in the country for overall staff engagement – 7.29 out of 10 compared to the national average of 7.0.
- We appointed the first hospital based Admiral Nurse – dementia clinical nurse specialist in Devon as part of the Trust's drive to improve dementia care.
- The first wave of Nursing Associate recruits completed their training in January 2019. Devon is one of 11 first-wave Nursing Associate pilot sites and the only Sustainability and Transformation Partnership (STP)-wide site selected and funded by Health Education England (HEE). Nursing Associates are part of the frontline clinical workforce and help to bridge the gap between healthcare assistants and registered nurses.
- The Lundy Ward team were crowned the overall winners of the Enhancing Patient Dignity Award at the Nursing Times Awards for their work to create an adaptable and enhanced side room called 'The Snug'.
- Our Trust charity, Over and Above, has raised just over £800k of the £1.5m target for the Cancer and Wellbeing Centre appeal and we hope to start building the centre during the financial year 2019/2020.The space will support people and their loved ones with a cancer diagnosis and other illnesses, as well as providing overnight accommodation for relatives of very poorly patients to use.
- Our patients (through the Friends and Family Test) regularly report an average of over 96% satisfaction with our services.

Research and development at NDHT

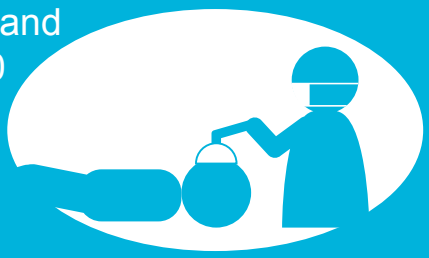
We are a research-active Trust and encourage our doctors, nurses and therapists to take part in clinical trials and research to improve patient care and our understanding of patients experience.
Here is an overview of research and development in 2018/19:

We have had over **1000** patients, staff and volunteers participate in research so far this year. This is well over our target and our best performance in over 5 years.

We have been awarded **extra funding** from the Clinical Research Network (South West Peninsula) to employ a therapy research fellow for one year. This post has made a real difference to the way we work and we have plans to do some home-grown research.

We have been delighted to be part of individuals' **learning and development** – including those from Project SEARCH, work experience for schools and PETROC

We work across several specialist teams who all work hard to make research happen at this trust. This year we worked in collaboration with a great team of trainee anaesthetists (South West Anaesthesia Research Matrix) and recruited over 160 patients having planned surgery.

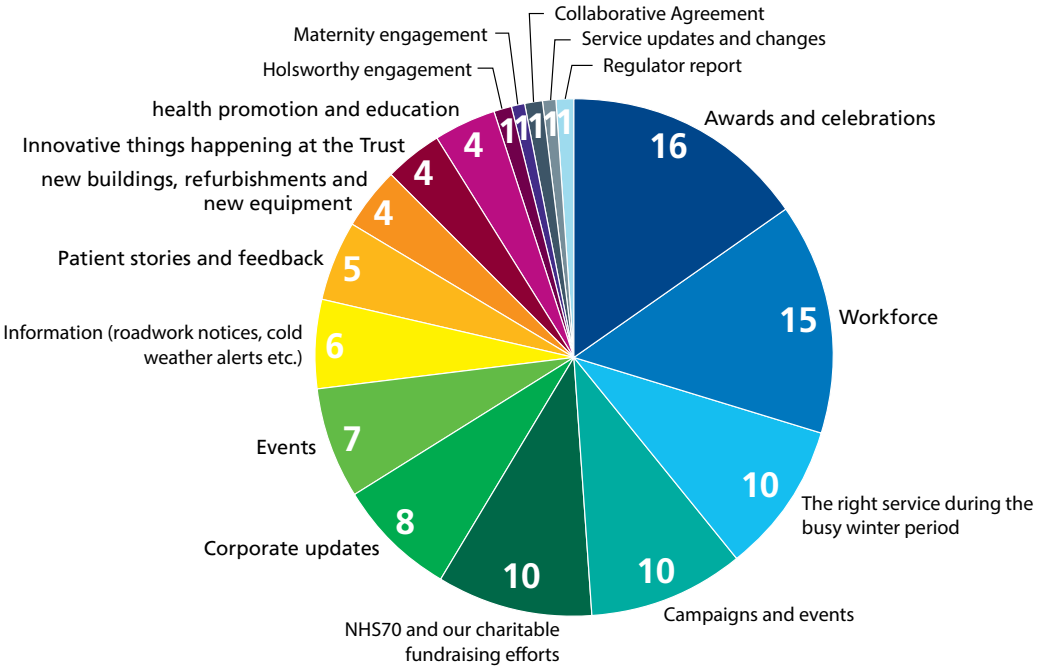


It has been great to have the opportunity to work with the **staff wellbeing** team. This year we took part in research investigating two online wellbeing interventions to reduce NHS staff stress and had over 50 recruits.

We have held our **4th annual research symposium** – we had a drop-in programme which made it possible for those working in the hospital to attend a session that they were interested in. Over 90% fed back that it was a positive experience.

News review

A wide range of news items were published on our website, promoted through our social media channels and the external press throughout the year highlighting the hard work of our staff in delivering improved care for patients. See below for the breakdown of news by topic.

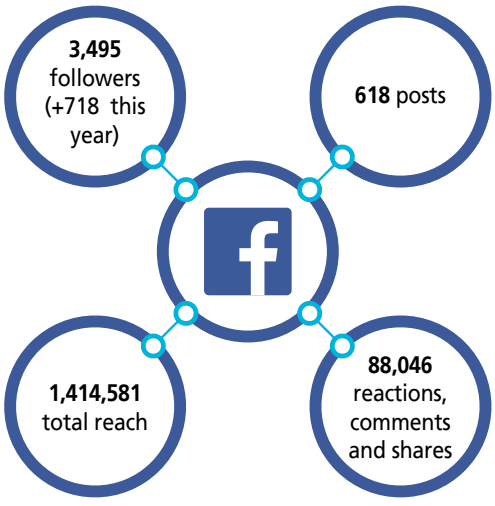


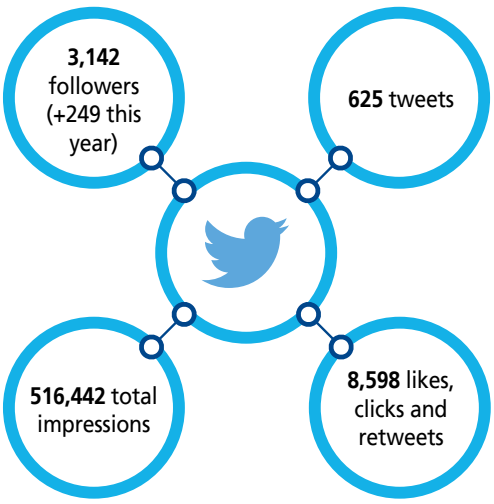
The most frequent news topic was awards and celebrations of our service. This included the national recognition for the team from Lundy Ward from the Nursing Times Awards for enhancing patient dignity for their work to create 'The Snug'.

The Trust has been looking at innovative ways to address workforce shortages, and this is reflected in the high number of news articles and social media posts that relate to our workforce. The Trust worked with BBC Spotlight in November 2018 to highlight the fantastic work of Project SEARCH, which aims to support young people with a learning disability or autism into the world of work.

We also ran a public awareness campaign across our website, social media channels and with the local press to help people understand what they could do to support their local NHS services during winter, and we shared news about our celebrations for the 70th anniversary of the NHS.

We have increased our Facebook followers by 718 this year to a total of 3495, which has helped promote our vacancies to a much wider audience and we have seen an increase in the sharing of recruitment posts. Our Twitter presence allows us to engage with national campaigns and share with our 3142 followers. It also supports the sharing of staff achievements as many of our staff tweet about conferences, awards, innovations and training that they attend.





(Total reach = the number of times our posts appeared in other users' news feeds)

The year in pictures

2018

April

Staff and patients took part in the national #EndPJparalysis campaign to help more patients get up, dressed and moving when in hospital.

NDHT was recognised by Devon and Somerset Fire and Rescue Service for referring more than 100 people to them for a free Home Fire Safety visit.

May

Gill Howard, senior healthcare assistant on Caroline Thorpe Ward, won the Outstanding Contribution to Children's Healthcare Award from North Devon children's charity Honey's Bravery Bags.

On global Hand Hygiene Day (5 May) we raised awareness of good hand hygiene practices with staff, patients and visitors.

We held our annual nursing and midwifery celebration event. Our celebrations included stories from patients and presentations about innovative ideas that have resulted in excellent care for patients and new mums in northern Devon and even further afield. There were awards and even some dancing!

2018

June

We celebrated both Reserves Day and Armed Forces Day in June. Our staff saluted our forces to say thank you and recognise the extraordinary commitment of armed forces personnel.

Our 2017/18 cohort of Project SEARCH students graduated and 100% of these students have since progressed on to employment. The students, their mentors and representatives from the Trust, Petroc and Pluss all came together to celebrate the significant achievements of all the students at a graduation ceremony.

July

2018 was a special year for the NHS, marking 70 years since the National Health Service began. We celebrated in lots of ways, including with open days at our hospitals, awards for staff, and cakes for our inpatients. Local campaigners came to NDDH with a banner and cake to wish the NHS a happy birthday.

2018

August

We launched a dementia support café to support those who care for people living with dementia and their loved ones. Carers and relatives can socialise with others in similar circumstances and learn more about dementia and the local services available whilst volunteers spend time with their loved one. The cafés are held twice a month.

September

A cubicle on the children's ward at NDDH was refurbished thanks to the fundraising efforts of Care for Kids North Devon, involving the local community.

Organisations across northern Devon joined together for a campaign that launched on World Suicide Prevention Day (10 September). One Northern Devon developed and signed the One Northern Devon Stop Suicide Pledge, which encourages people to talk about suicide and direct people to support. Other organisations and individuals were encouraged to sign the pledge.

October

Patient experience volunteer Roger Pullen was awarded a British Empire Medal (BEM) in the Queen's Birthday Honours List for 2018. Roger received his medal and certificate from the Lord Lieutenant of Devon on behalf of Her Majesty in recognition of his voluntary work for the Trust and for helping to raise thousands of pounds for local charities.

On World Mental Health Day (10 October), chief executive Suzanne Tracey renewed our pledge to the Time to Change movement, demonstrating our ongoing commitment to changing how we think and act about mental health in the workplace.

2018

November

November became awards season for the Trust. The diabetes specialist nurse team and pharmacy team came away from the Quality in Care (QiC) Diabetes Awards with a high commendation. The North Devon Integrated Diabetes Service was shortlisted in the HSJ Awards. Our senior nursing team, nurses on the wards, Staff Bank team and our eRoster team were shortlisted in the 'putting care needs first' category of the national Allocate Awards.

December

Sam Stacey, a patient services assistant at NDDH, won two awards at the annual Sodexo Service Excellence Awards following outstanding positive feedback from patients, colleagues and clinical staff.

We counted down the days until Christmas with our staff advent calendar.

2019

January

We worked with staff, stakeholders, and other organisations to develop a wide-ranging plan in preparation for the busy winter period. As well as many internal projects, our plan included a communications strategy to raise awareness of how the local community could support their local services during winter.

The theatres, pre-op and clinical audit teams received an award for the second year in a row from the National Joint Registry. The award recognises our significant contribution of high-quality data to this important national registry.

February

Plymouth's new Sexual Assault Referral Centre (SARC) was formally opened. The facility is a new, purpose-built environment that will provide support to people who have experienced rape or sexual assault.

March

During National Apprenticeship Week (4-8 March) we celebrated the fantastic contribution apprentices make to the Trust and we welcomed local schoolchildren to come and find out about apprenticeships with NDHT.

Andrea Beacham, partnerships and GP liaison lead, attended a meeting of the All-Party Parliamentary Group for Diabetes in the House of Commons to talk about the successes of the North Devon Integrated Diabetes Service.

NDHT staff helped to launch the nationally-acclaimed red bag scheme in North Devon. The scheme aims to make the transition smoother for people who are admitted to hospital from a care home by packing a red bag with essential items and information.

Key developments

Collaborative agreement with the Royal Devon and Exeter NHS Foundation Trust (RD&E)

In June 2018, NDHT entered into a collaborative agreement with the RD&E. Through this agreement, the RD&E is providing leadership support to NDHT to address the challenges we face in continuing to provide acute services.

In line with the agreement, Suzanne Tracey became the chief executive (and Accountable Officer in accordance with NHS legislation) of both the RD&E and NDHT on 18 June. From 1 July 2018 James Brent was appointed chair of NDHT as well as RD&E, although the organisations continue to have two separate Boards.

In the first six months of the agreement, we undertook a diagnostic piece of work to help us fully understand where we were as an organisation and we focused our efforts on stabilising services. We have made some really good progress in addressing some of our operational and performance challenges. We also identified a programme of governance development that aligns the RD&E and NDHT systems to facilitate further joint working and sharing of posts between the two organisations.

The next piece of work we committed to do under the collaborative agreement is a piece of work to develop our future plans for hospital services in northern Devon.

Our starting place is the outcome of the acute services review that there needs to be an A&E in North Devon. In developing the plan we are focusing on how to achieve clinically and financially sustainable acute services in northern Devon. Developing our future plans for hospital services in northern Devon will continue into 2019 and we will be seeking to involve staff, patients and the community in its creation to ensure we have a shared understanding of our challenges and how our services may adapt to meet those challenges.

NDHT extends its support to victims of sexual assault across Devon, Cornwall and the Isles of Scilly

From 1 October 2019 NDHT began running the sexual assault referral centres (SARCs) in Plymouth and Truro, adding to our already very successful Exeter SARC.

These additional centres allow greater numbers of those who have experienced sexual assault to access medical, practical and emotional support.

As part of this contract NDHT launched a new, purpose-built forensic facility in Plymouth, a new SARC website and a 24/7 helpline number. The Exeter SARC is being developed into a centre of excellence for paediatric forensics.

NDHT launches new sexual health service

On 1 July 2018, sexual health services across North, Mid, East and South Devon and Torbay were combined into a single service. The service is led by NDHT, working in partnership with Torbay and South Devon NHS Foundation Trust (T&SDFT) to provide the services in South Devon.

Over the next few years we will be introducing more and more digital sexual health services, including:

- Online appointment booking
- Online triage
- Online test ordering
- Online appointments with clinicians

Emergency department refurbishment completed

Following a £1m investment the emergency department was refurbished and opened in summer 2018 providing a better environment for staff and patients.

This investment enabled us to address the long-standing patient feedback that the chairs in the waiting area were uncomfortable. We replaced the wooden seating with wipeable cushioned seating, which is much more comfortable. We have also installed a couple of bariatric chairs, high chairs and low chairs so that patients can easily sit down and get up.

Contract for community services for children and young people awarded to Devon's NHS Alliance

In November 2018 the Devon Children and Families NHS Alliance was awarded the Devon contract for Community Health and Wellbeing Services for Children and Young People. The alliance is a partnership of all NHS providers in Devon, including NDHT and is led by Torbay and South Devon NHS Foundation Trust.

This new service is known as Children and Family Health Devon. The contract began on 1 April 2019 and will run for seven years, with a possible three-year extension.

The a lliance shares a vision for the future to provide the highest quality community services for children, young people and families in Devon, and it is great that we will be part of this opportunity to make these services the best they can be, improving and transforming lives.

Sustainability and Transformation Partnership

Review of the year

Three local authorities, seven NHS organisations and one Community Interest Company joined forces in October 2016 to create a single Devon Sustainability and Transformation Partnership (STP). Since the summer of 2018, Dame Suzi Leather has been the Devon STP independent chair.

The STP mission is to achieve the triple aim of improving:

1. Our population's health and wellbeing
2. The experience of care
3. The cost effectiveness of spending per head of population

In July 2018 it published a two year report highlighting the significant progress that has been achieved through joint working, noting in particular:

- Improved performance against national NHS standards, putting Devon in the top 30% nationally on urgent care and mental health
- Reduced delays in transferring patients out of hospital
- 86% of adult social care providers rated as either Outstanding or Good by the Care Quality Commission
- Enhanced community services
- Clinically appropriate referrals into hospitals
- New clinical networks supporting "Best Care for Devon" standards in
  - Urgent and emergency care
  - Stroke
  - Maternity services
- Innovative mental health services including
  - Liaison psychiatry in each acute hospital
  - Psychological support for people with long-term health conditions
  - Specialist support for women with postnatal depression
- More than 100 ambassadors trained to promote careers in health and social care in schools.
- Strengthening outcomes for children and young people, with children's community health services rated "Good" by the Care Quality Commission

In addition, historical overspending has been reduced from £95.4 million to £22.7 million in the past two years. The Devon system is aiming for financial balance in 2019/20.

However, real challenges remain including health inequalities, social isolation, disadvantage for people with mental health problems, an ageing population and meeting the needs of carers.

Recruitment of staff remains challenging. Initiatives such as Proud to Care are showing the value of collaboration in this area. A campaign is under way with NHS England to promote the South West to prospective GPs. NHS England workforce trajectories indicate a gap of 62 GPs in Devon by 2020. A new academy of nursing was launched by four NHS Trusts in Devon and the University of Exeter putting local nurses at the forefront of regional, national and international advances in care.

The CCGs and local authority have been working together to implement reforms for services for children and young people with special educational needs and disabilities, which will be co-designed with children, young people and their families.

The STP has proposed taking a more focused approach on fewer priorities for 2019/20, to deliver high impact changes and make best use of resources. Over the next year, the STP focus will be on five areas:

- Accelerating the **digital opportunities** for the system
- Developing an **acute care strategy** for Devon and Cornwall
- **Addressing inequalitie**s by moving resources to where they will be more effective
- **Integrating mental health services**, alongside development of inpatient services
- Promoting **prevention and self-care**, helping more people live healthy, well lives at home.

These five priorities are accompanied by two other pieces of work that need to be accomplished:

- Implementation of the Integrated Care Model blueprint agreed in 2017
- Implementation of the workforce strategy

We will continue to review our key hospital services across Devon, so that they deliver the same high standards of care.

The STP-led acute services review confirmed that our four acute hospitals in Exeter, Barnstaple, Plymouth and Torquay are key in the provision of NHS services. Clinical services are now approached in a more collaborative way. This includes a ground-breaking agreement on mutual clinical support among the four hospitals, which has proved invaluable in addressing short-term service challenges due to medical staffing problems. The collaborative agreement between the Royal Devon and Exeter NHS Foundation Trust and Northern Devon Healthcare NHS Trust is also providing opportunities for joint working, including shared posts.

Mental health award

Devon Partnership NHS Trust was a winner at HSJ Value Awards 2018 for reducing the number of patients with mental health needs being treated outside the region.

Mental health support for students

An NHS community mental health team has established a base on the University of Exeter campus, to provide direct support to students. The initiative, one of the first of its kind at a UK university, is jointly funded by Devon Partnership NHS Trust, the university, the CCGs and Devon County Council.

Improving access to psychological therapies

Following the Depression and Anxiety Service's success in extending its services to people with long term conditions in the Northern, Eastern and Western localities, the service was implemented in South Devon and Torbay.

Eating disorder service

A new eating disorder service in the community was launched across Devon in February 2019 to provide dedicated support to people with mild to moderate eating disorders.

Returning to work

More than 1,000 people with mental health problems in Devon have received help and support to work towards getting back to paid employment. The New Leaf scheme in Exeter represents innovative working, helping to improve people's health and wellbeing, with a benefit to society.

New service providers for children's services

From 1 April 2019, children's health and wellbeing services will be provided by NHS providers, working together. In Devon and Torbay they will be provided by Devon Children and Families Alliance.

In Plymouth, children's health, wellbeing and special educational needs and disability services will be run by Livewell Southwest, in partnership with University Hospitals Plymouth NHS Trust, Plymouth City Council and a range of third sector organisations.

Learning disability services

New approaches have been tested in collaboration with local partners to ensure suitable accommodation for people with learning disabilities. The service secured £1.9million investment from NHS England to enable people to return to their own homes from hospital, with capital from NHS England enabling the purchase of houses across Devon.

Visit by Secretary of State

The Secretary of State for Health, Matt Hancock, visited Devon STP in September. After working a night shift at Derriford Hospital in Plymouth, he toured Budleigh Health Hub and Ottery St Mary Hospital. Sustainability and Transformation Partnership representatives explained how investment in digital technology is supporting new ways of providing care and outlined how community conversations were enabling local people to be involved in the development of new models of care.

Devon's charter to end loneliness

Representatives from Devon's Health and Wellbeing Board, which oversees the strategic delivery of health and social care services in the county, have signed an ambitious charter to end loneliness.

Maternity services

Hospitals in Torbay, Newton Abbot, Barnstaple, Exeter and Plymouth were highly rated in the Maternity Services Survey commissioned by the Care Quality Commission. Their performance was rated by hundreds of women who had given birth in February 2018 either at home or in hospital.

Digital strategy

During the year, STP colleagues agreed a Digital Blueprint for Devon, which envisages a fully integrated and interoperable clinical digital system, extending access to vital information across primary, secondary, community and social care and in to hospices and care homes.

Primary Care

GPs and their services in Devon are highly valued and once again, the results of the patient survey bore testimony to patients' satisfaction. Every one of our GP practices was rated as Outstanding or Good.

Improved access

Devon made great progress with the e-Consult programme during the year, meaning more than 600,000 patients in Devon now have 24-hour online access to their GP practice. A 500 per cent increase in online and phone consultations has put Devon in the lead in the south west and in second place nationwide for offering alternative ways of having a GP consultation.

The range of innovative self-help tools available in the service now includes symptom-checkers, instructive videos created by GPs, and advice about the various places a patient can get help, including pharmacies, the NHS 111 helpline or an available app.

Improved hours

Patients across Devon are now able to make routine GP appointments in the evenings and at weekends. From October, an improved access service made it easier for people to get an appointment at a convenient time. GPs from different practices have worked together to provide the improved-hours scheme.

Primary care development

The Devon CCGs have been supporting general practice with the development of primary care networks and federations, so that practices can benefit from working at scale and offer a wider range of services to patients. A Devon-wide learning event for GPs and practice staff on new primary care networks was well received and follow-up events are planned.

Winter

All parts of the system made detailed plans for responding to the increased demand on services that the NHS experiences every winter. The 2017/18 winter had been particularly difficult, with demand significantly exceeding local and national predictions. Service capacity was challenged across health and care services. Gastric illness and influenza had a real impact.

The system-wide winter plan focussed on maintaining the flow of patients through our hospitals. This requires all partners across health, social care and the voluntary sector working together to ensure that patients can be safely discharged from hospital at the appropriate time.

The four main hospitals were allocated national funding as follows:

- **Derriford Hospital, Plymouth**: £2.5million to press ahead with upgrading parts of the Emergency Department, in advance of a major rebuild.
- **Royal Devon and Exeter Hospital, Exeter**: £700,000 to improve the 'flow' of patients through the hospital and reduce demand on the Emergency Department
- **Torbay Hospital, Torquay**: £340,000 for key improvements to urgent and emergency care
- **North Devon District Hospital, Barnstaple**: £175,000 to provide increased bed capacity

Pharmacy First

In preparation for winter, the NHS publicised a scheme for people in Devon to get prescription medicines for a range of minor illnesses straight from a pharmacy, without the need to visit a doctor. Under the Pharmacy First scheme, trained pharmacists in participating branches can give out medication which normally has to be prescribed by a GP.

Integrated Care System/Devon Long Term Plan

The creation of one CCG for Devon is an important step in the journey to create a single strategic commissioner for the county, as partners in the Sustainability and Transformation Partnership design a new, more integrated care system.

Work has been progressing on how this Integrated Care System (ICS) for Devon should operate and improve outcomes for our population.

We have been supported nationally through being selected to take part in the Aspiring ICS programme, which was tailored locally to focus on specific areas including developing population health management, care redesign, financial planning and effective system governance.

Over the coming months we will:

- Develop a Devon five-year plan in response to the national NHS Long Term Plan, showing how we will work together across the NHS, local authorities and other partners to improve outcomes for our population.
- Design the most effective ways of working together both in local communities and places as well as across the wider Devon system, with the right system governance that allows for transparent and responsive decision making
- Engage with stakeholders and local communities in developing the plan and system working
- Publish the Devon Strategy in the Autumn 2019.


DANGER

Our charity supporters go Over and Above

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

Over and Above is the official NHS charity serving patients and staff who use the services of NDHT. Each year the charity invests in key areas such as equipment, patient and family support, capital projects, staff training and transforming our hospitals into more welcoming and comfortable environments.

The core mission of the charity is to enhance the care and treatment of patients within northern Devon, by supporting projects and services which are beyond the scope of government funding.

Over and Above achieve this by working with clinicians, staff and volunteers to deliver services and projects that will make a positive difference to our patients by:

- enhancing the quality of patient care
- improving the environment for patients and staff
- raising funds for equipment that will improve outcomes for the patient
- supporting staff development that will enable them to provide excellent clinical care
- supporting research projects that can improve patient outcomes

During the past year we have continued to raise funds to build a Cancer and Wellbeing Centre at North Devon District Hospital. The charity hopes to make this a reality by fundraising £1.5m. The centre will be a dedicated place for our cancer patients and their families to have access to information and support services to improve their wellbeing. The facility will offer a drop in service, providing information on cancer and other conditions, financial and benefits advice, counselling and psychological support, complimentary therapies, nutritional advice, hair loss support, health and wellbeing events and training and much more.

The centre will also provide overnight accommodation to inpatients loved ones whilst they are being treated at North Devon District Hospital. We know that our very poorly patients really benefit from having their loved ones close by.

The appeal total stands at just over £800k and we will start building the centre during the financial year 2019/2020. The charity will continue to fund this centre in future years so on-going public support will be vital.

Fundraising highlights

During the past year Tesco stores throughout North Devon have continued to support the charity. Tesco staff have held lots of events and have donated raffle prizes to help our appeal. In the last seven years they have helped us raised over £60,000 in various ways. Thanks to them and the support given by all their customers.

Owen Pryor and his Littleham Crealock Arms Darts fundraising team have raised thousands of pounds for our cancer services. In April they organised a fabulous ABBA night which raised almost £5,000 for our Cancer and Wellbeing Centre Appeal. Owen is a fantastic supporter of our charity and is a volunteer at the hospital helping cancer patients who visit the Seamoor Unit for their treatments.

Every June is our famous Scrumptious Croyde Trail. Both walkers and runners took part in this popular 10 mile route, which starts in Croyde and leads our participants to Saunton, Georgeham, Putsborough and back to Croyde. This scrumptious event offers food and drink tasters along the route kindly provided by local food producers. It sells out every year and fun and laughter are guaranteed.

Northam resident Kevin Reynolds challenge was more than a drop in the ocean! He swam the equivalent of 21 miles, equal to the length of the cross channel swim from the UK to France. He did this in Westward Ho!'s outdoor sea pool … this equates to 1,700 widths. He has raised over £1,600 which is phenomenal! Thank you!

A huge congratulations to Steve Hobbs and the Lynton Football Team who raised a phenomenal £2,115 for the Cancer and Wellbeing Centre Appeal. Steve and his team organised an 18 mile off road walking challenge from Lynton to NDDH. The event was mainly in memory of Steve's dad who passed away in April 2017, and he was also inspired by his girlfriend who had just been diagnosed with cancer. Well done to you all for completing this awesome challenge.

We would like to thank all the clubs and organisations who have brought in vital funds in the past year to help our charity make a real difference to enhance the quality of care given to our patients. Without your support we could not provide the vital services and equipment beyond the scope of NHS funding.

Do you want to make a REAL difference to the lives of our patients? Then why not leave Over and Above charity a Legacy in your will

We would like to thank those donors who have left our charity a lasting gift in their will during the past year and those who have pledged to do so. Leaving a gift in your will to charity is an incredibly generous way to make a donation. We understand loved ones come first, but leaving a gift in your will to the Over and Above official NHS charity can make a real difference to ensuring the best quality of care is provided to many patients.

If you would like to fundraise for our charity, the Over and Above team would be delighted to hear from you. We can offer you a fundraising pack with lots of ideas and you can find more information on our charity website www.overandabove.org.uk or on Facebook – Over and Above Hospital Charity

All your donations make a real difference, no matter how small. You can contact the charity team on 01271 311772 or by email at ndht.charity@nhs.net

Patient experience

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

Throughout 2018/19, the Trust's patient experience programme has continued to cover the majority of services provided by the Trust. This means that whether patients are in an inpatient care setting, clinic or in their own home, they have the opportunity to tell the Trust about their experience of the service they have received.

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

At the start of each board meeting, either a patient story is presented or a member of staff presents a piece of work which has been developed to improve the experience of patient care. Often patients attend the meeting themselves, giving them the opportunity to give direct feedback to Board members. Patient stories are obtained either through the complaints process, service transformation projects, letters from patients who have approached the Trust, or from staff who feel that one of their patients has had an experience which we can learn from and who ask patients if they would like to take part.

Our comprehensive patient experience survey programme is supported by a highly valued team of volunteer patient experience surveyors. This team routinely visits the inpatient wards at North Devon District Hospital to collect patient feedback at the bedside. The volunteers visit each inpatient ward several times a month. In cases where the patient may be too ill to communicate with the volunteer, feedback is captured from relatives/carers where possible. The patient experience team provides a report back to the acute/maternity ward and senior management within two to three hours of the feedback being collected by the volunteer, allowing teams to act on the feedback received quickly. Selected patient comments are routinely posted on Twitter and Facebook and are shared with staff in internal communications, subject to patient consent.

There is a continued and growing focus across Devon and more widely on supporting people as much as possible in their own homes and so the experience of patients being cared for in their own homes is very important in building public confidence in this model of care. We know patients are happy with our community services, because they regularly receive 95-100% satisfaction scores across the whole northern Devon community.

With an increasing reach, social media now forms another feedback channel together with Care Opinion, NHS Choices, postal surveys, focus groups, face-to-face engagement, PALS/customer relations and, of course, the Friends and Family Test.

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

The work of the Trust is always changing and patient experience data is sometimes requested to understand the impact on patients of various transformation programmes.

During the year, the Trust established a Patient Experience ommittee as part of its governance review. The purpose of the committee is to improve and sustain patient experience and, whenever appropriate, to promote co-design. Through its work the committee ensure that we are collecting and acting on patient feedback to continually improve the experience of care we offer.

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

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

North Devon District Hospital

Acute inpatient wards
Emergency department
Maternity services
Outpatients
Day cases

Community

Community therapy
Community nursing
Community hospital inpatient wards
Community hospital outpatients
Community hospital day cases
Community children's nursing
Pathfinder urgent care
Pathfinder complex discharge
Rapid response service
Minor injury units

Specialist community services

Sexual health
Podiatry
Bladder and bowel
Dental

The patient experience strategy uses the following model:

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

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

Celebrate and share positive patient feedback. Most of the feedback we receive indicates a positive patient experience, and we recognise that as well as learning from what we can do better, we can learn from what we do well.

Improve the experience by ensuring the feedback is heard and understood by the relevant clinical and managerial teams. Receiving, analysing and presenting feedback and then involving users and staff in developing the solution completes the 'you said, we did' governance cycle.

Share the improvements made. See page 26 for examples of how we have used patient feedback to make real changes.

You said we did

	You said	We did
1	At North Devon District Hospital, the menu choice for inpatients with coeliac disease is too limited.	We reviewed the menu options available for patients with coeliac disease and improved the range.
2	While waiting for treatment in the Seamoor Unit it would be good to be able to leave the unit to go for a coffee. However, due to poor telephone reception, this is not possible in case staff are unable to contact the patient.	We have introduced a bleep for patients. If there is a delay to the patient's treatment, they can leave the area and be bleeped when their treatment is ready.
3	In the outpatient waiting area at South Molton Community Hospital there are a number of contradictory signs directing patients.	We reviewed the signage and removed any unnecessary signs to prevent confusion.
4	I need to drink a bowel preparation to cleanse the colon ahead of my endoscopy procedure. The bowel prep tastes horrible and is too much to drink. (Endoscopy Suite – NDDH)	For most patients we have changed to a different bowel prep that is half the volume and is a different flavour (citrus). Some patients still require the original bowel prep.
5	The play area in the main eye clinic waiting area is too small and does not allow for paediatric patients to be separated out from the adults.	Paediatric patients attending the eye clinic are now sharing the play area previously used only by patients attending the Day Surgery Unit. This is located away from the main Eye Clinic waiting area and is equipped with a range of toys and seating for both parents and children. A lot of positive feedback has been received about the new arrangement.
6	Car parking at North Devon District Hospital needs to be improved.	We have developed a longer term traffic management plan, which includes creating over 100 new parking spaces during 2019, as well as plans to reduce the need to queue outside of the hospital. We have staff out in our car parks to manage the traffic and direct cars to available spaces.
7	Occasionally, bandages are not so good and some nurses would benefit from a refresher course in bandaging. (Leg Ulcer Service)	We provided training following the commencement of the leg ulcer service to ensure that all nurses are fully competent and confident in compression bandaging and leg ulcer management. Since July, 2018, 165 nurses have received formal training and more is planned.
8	Parents who cannot be on the ward (e.g. those with older siblings to care for) have said that they would like to keep in touch as closely as possible. (Special Care Baby Unit)	We have introduced computerised parent diaries using the Badger data entry system to allow parents who cannot be on the ward to view updates on their baby's care and view daily photographs of their baby.
9	Mothers have said they receive inconsistent advice from staff in respect of breastfeeding. (Special Care Baby Unit)	We have achieved the Baby Friendly Initiative Stage 1 award and are moving towards gaining Stage 2 by the end of 2019. Specialised training has been developed. This will enable staff to empower mothers by teaching them more about expressing breast milk, responsive feeding and the importance of feeding in the development of a bond between mother and baby.
10	The parents of a patient with special needs requested more suitable communication methods for their daughter, explaining that their child was working with the Widgit word symbols. (Caroline Thorpe Ward)	We acquired the Widgit software and produced bespoke phrases for the patient in order to meet her communication requirements and thereby enhance her understanding of the hospital experience. This method of communication is now being used on an ongoing basis, as appropriate.

Complaints and patient feedback

The Trust strives to provide the best care; however when we do not get this right complaints from our service users, carers and relatives are a vital source of feedback.

In line with Trust policy, a complaint becomes formal in accordance with the complainant's wishes and a complaint may originate from a concern (written or verbal) which was impossible to resolve through the Patient Advice and Liaison Service (PALS).

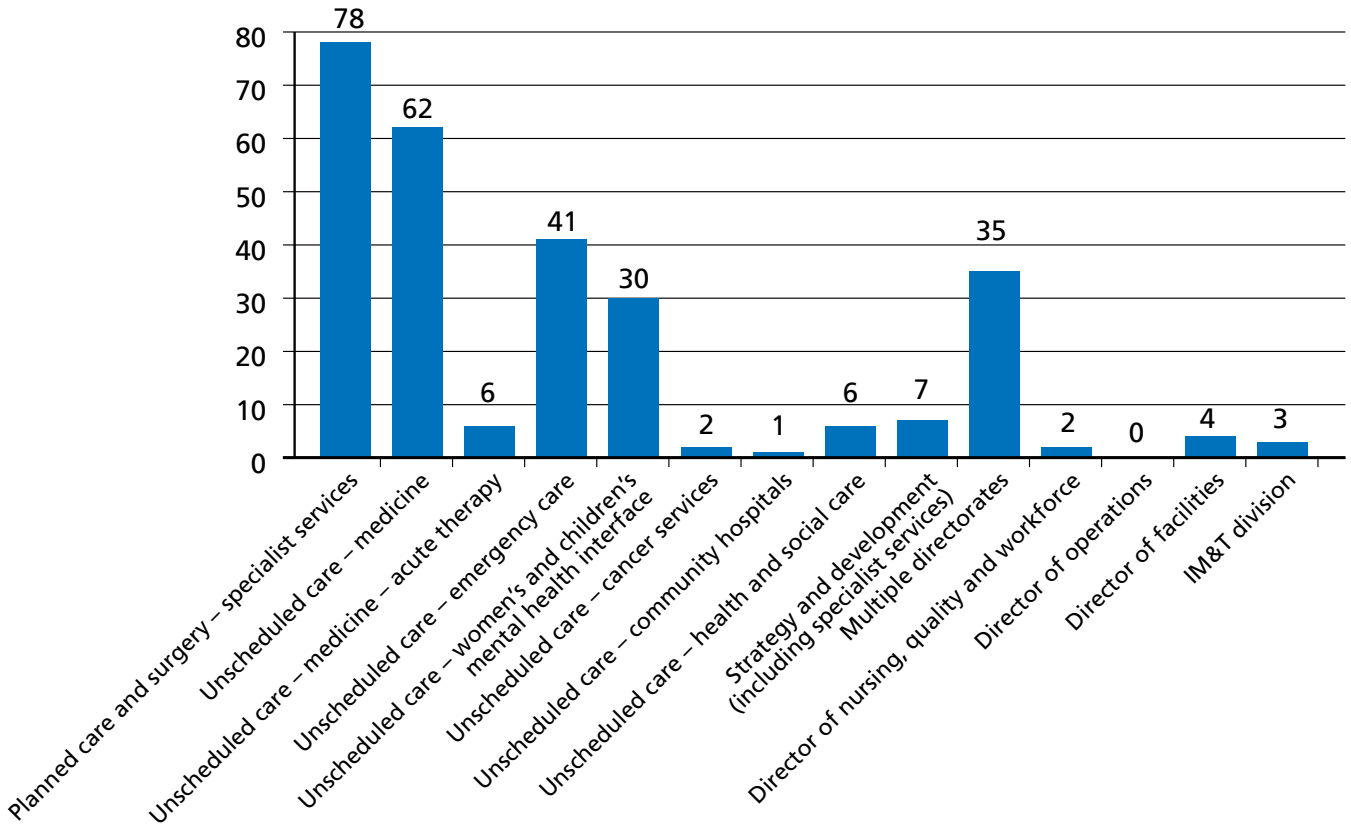
During the year (2018/19), 277 complaints were received, which is a 9% increase on 2017/2018 (255). The majority of complaints related to acute or inpatient services with low numbers of complaints received in relation to community services.

3265 PALS enquiries have been received this year, which is a decrease of 516 on 2017/2018. During the year the PALS service experienced a vacant position which affected its operating hours for a short period of time. A decrease in the number of issues raised through PALS was noticed during this period which may have contributed to the decrease in overall numbers from the previous year.

The combined complaints and PALS activity is a positive reflection on how patients and service users feel able to provide feedback on their experiences, which the Trust welcomes and encourages.

The division with the highest number of complaints for the financial year was the planned care division with 78 complaints. The graph below shows the breakdown of complaints received by division, and associated specialities within the unscheduled care division.

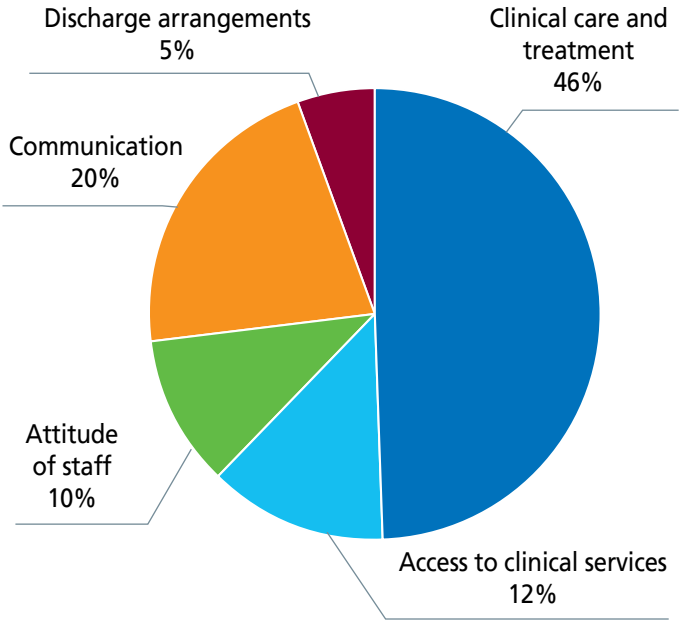
Breakdown of complaints received in 2017/18 by division



Breakdown of complaints by the top five subject matters

The top five complaint themes were clinical care and treatment (46%), communication (20%), access to clinical services (12%), attitude of staff (11%) and discharge arrangements (5%).

Top five subject themes for complaints received 1 April 2017 – 31 March 2018



Examples of issues raised under these headings are:

- clinical care and treatment – poor medical/nursing/midwifery care; delay in diagnosis, complications of treatment, delay in treatment, drug/medication errors, equipment errors/misuse, hospital acquired infection, injury through treatment
- communication – communication to patients, carers or service users, communication between staff, lack of signposting, signage, interpreting services
- access to clinical services – length of wait for inpatient/outpatient/surgery, waiting time in A&E, unnecessary appointment, cancellation of appoints, difficulty in contacting departments via phone, difficulty booking appointment, cancelled clinic/operation
- attitude of staff – lack of empathy/caring, dismissive behaviour, rude/inappropriate behaviour, poor body language, aggressive behaviour
- discharge arrangements – inappropriate discharge, medication issue, transfer between hospital, social care provision, transport issues, aids and equipment, aftercare information, failure to follow procedures

Key performance metrics

All complaints are required to be acknowledged within three working days in line with Trust policy and statutory legislation. During the year 99% of complaints were acknowledged within this timeframe, with only two cases being acknowledged outside the three day time period.

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

Complaint response and investigation performance

During the year 96% of complaints were responded to within either the agreed timeframe or within an agreed extension to the initial timeframe, which is static with the performance for the previous financial year (2017/2018).

In order to monitor and prevent late responses to complainants, the timeliness of investigations is monitored via the monthly performance review meetings with Divisions and by the Trust's Patient Experience Group.

During the year 79% of complaint investigations were returned to the customer relations team within the assigned timeframe to meet the response time to the person raising the issue. This performance does not meet the Trust's or Clinical Commissioning Group's target of 95% and 85% respectively and work was undertaken during the year to improve the timeliness of investigations. An improvement was seen in Q4 with 97% of investigations returned on time, although the aggregated percentage for the year sits at 79%. This improvement is expected to continue into the 2019/20 reporting period and will be monitored by the organisation on a quarterly basis.

Closed complaints

During the year 280 complaints were closed following investigation. Actions that arise from complaints are monitored by the divisions and reported to the Trust's Patient Experience Group.

Parliamentary and Health Service Ombudsman complaints

Where the person raising the complaint is either unhappy with their complaint response or the way their complaint has been handled, they have the right of redress to raise their dissatisfaction with the Parliamentary and Health Service Ombudsman (PHSO) who will review their concerns and the Trust's management of their complaint to include the outcome of the Trust's investigation.

Where possible, and in line with the complainant's wishes, the Trust will undertake many attempts of resolution to try and resolve outstanding dissatisfaction. A complainant can approach the Ombudsman after this process or as soon as they receive their complaint response. The table below shows the number of cases the Ombudsman contacted the Trust about this financial year (nine), alongside outcomes of their review concluded within the year (which could relate to cases from previous financial years).

The table below shows the Trust has a good reputation with cases referred to the Ombudsman with ten cases they formally investigated NOT being upheld and four cases being determined as not requiring formal investigation. The Ombudsman's formal investigation involves expert clinical advisors who review the patient's care and treatment alongside the concerns raised, and the Ombudsman's investigation outcome is final.

Concerns raised directly to the Care Quality Commission

During the year, nine concerns were raised directly to the Care Quality Commission (CQC). Seven related to issues relating to clinical care and treatment, one related to attitude of staff and one related to hospital facilities. On each occasion the CQC contacted the Trust with details of the concerns and following investigation by the organisation, the CQC was satisfied with the sequence of events for each case and did not determine any further action was necessary.

Complaints referred by outcome	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	**Total**
Request received from Ombudsman	0	0	2	0	3	1	1	2	0	0	0	0	**9**
Issue NOT upheld with no further action	1	1	1	-	2	-	1	2	2	-	-	-	**10**
Issue upheld and recommendations made	-	-	-	-	-	-	-	-	-	-	-	-	**0**
Issue partially upheld	-	-	-	-	-	-	1	-	-	-	-	-	**1**
Decision by Ombudsman NOT to investigate	-	-	-	-	-	-	-	2	2	-	-	-	**4**

Summary of main themes of PALS issues/matters

The overall number of PALS contacts received in the year was 3265.

The division and specialities with the highest amount of PALS feedback was planned care (1581), followed by unscheduled care – medicine (964), unscheduled care – acute therapy (195), Director of Nursing, Quality and Workforce (120), and unscheduled care – women and children's mental health interface (103).

The top five PALS themes were access to clinical services (39%), communication (26%), information provision (22%), clinical care and treatment (4%), and attitude of staff (2%). The type of issues within these subject categories are the same as those used for complaints, as described previously.

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

	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
Access to services - clinical	629	1001	954	968	1590	**1262**
Access to Services - physical	24	18	31	78	97	**41**
Admission arrangements	11	7	6	10	8	**3**
Attitude of staff	115	106	143	134	110	**73**
Benefits	11	5	3	0	0	**0**
Bereavement	9	7	2	2	4	**4**
Clinical care and treatment	213	246	204	205	186	**130**
Communication	218	260	569	600	913	**843**
Compliments	154	160	28	18	57	**28**
Confidentiality issues	6	14	3	12	4	**10**
Discharge arrangements	49	81	35	59	50	**37**
Equality and diversity	2	7	2	1	0	**1**
Quality of facilities	40	23	21	56	49	**23**
Hotel services	22	20	13	12	8	**10**
Information provision	1108	395	641	882	861	**732**
Medical records	32	45	61	68	61	**33**
Patient's property	17	31	16	34	22	**21**
Privacy and dignity	6	8	3	2	1	**0**
Security	8	8	2	1	0	**13**
Transport	103	62	50	48	50	**16**
Totals	2777	2504	2787	3190	4071	**3265**

Improving patient, visitor and staff experience through our non-clinical support services

We recognise that having a good experience of our services is about more than just the care you receive from a therapy, nursing or medical professional. Within the healthcare settings we have a variety of key services which contribute to the overall patient experience, many of these are called 'hotel services'.

The Trust operates services across the whole of North Devon, at community hospitals, in community settings and at the main acute hospital site. These services cover switchboard, estates, medical records, sterile services, medical equipment and capital developments.

In addition we work closely with Sodexo, our non-clinical support services partner, to ensure we provide the best services we possibly can to patients, visitors and staff. Sodexo provides a range of services to the Trust, including catering, housekeeping and cleaning, portering, courier and post room, linen, car parking, reception management, security, waste management and retail. Sodexo also support the Trust in the management of the 'hotel services' at other community sites.

We carefully analyse Trust patient experience surveys and any feedback we receive via PALs or through the complaints department so that we can address issues and improve our service.

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

Parking

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

We continue to monitor and invest wherever possible in our car park and transport links to the main NDDH site. In recent months the Trust has been putting on more clinics to help us see patients as quickly as possible and reduce our waiting lists which is really good thing for patients. This increased activity has led to a lack of available parking spaces and difficulty in keeping cars moving through the hospital site.

Additional spaces are currently being built which will ease this pressure however we will also have to develop other plans to try and ensure that we can address the queue of traffic outside the hospital site and this work is currently in progress. During this difficult period the porters have offered fantastic support in the car parks to direct patients and visitors to available spaces.

Our charges for visitors and patients continue to be some of the lowest in the south west and some of the lowest in the NHS.

Food

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

In line with Government policy we have worked with Sodexo to ban price promotions and advertising of sugary drinks and foods high in fat, sugar and salt. Food retail areas have been rearranged so that healthy snacks and drinks are more prominent and vending machines have limited confectionery available, but instead provide a range of healthy alternatives.

We have met the national targets of:

- 70% of drinks stocked must be sugar free
- 60% of confectionary and sweets do not exceed 250 calories
- 60% of sandwiches and other pre-packed meals contain 400 calories or less per serving.

The same principles of healthy eating apply to our patient meals and there has been a reduction in salt, fat and sugar content which has resulted in some of our patients stating that our food is bland. Feedback about our food is variable, at the same food service a patient can rate it as excellent but another states it is poor.

We have ensured that wards have access to 'dietary' menus, allergen information and also that condiments are supplied with the food service. Menus continue to be improved taking into account comments made in our patient surveys.

In line with our environmental responsibilities Sodexo has introduced wooden cutlery to replace plastic wherever possible and Trust and Sodexo staff continue to recycle as much waste as possible across all sites.

PLACE Assessments

Patient-led assessments of the care environment (PLACE) are a national requirement on an annual basis in the NHS and give a snapshot of how a hospital is performing against a range of non-clinical activities which impact on the patient's experience of care. The assessments in May 2018 were carried out at sites with inpatient beds which included North Devon District Hospital and South Molton Community Hospitals.

The assessments see local people come into our hospitals as part of a team to assess how the environment supports patients' privacy and dignity, dementia and disability needs in addition to inspecting the other services which includes food and hydration, cleanliness and general condition of buildings, appearance and their maintenance.

We work closely with our nursing colleagues, community hotel service teams, Sodexo and estates to review the patient feedback we receive as part of these assessments and where necessary, to make improvements. Ward food service and hydration are two key areas where we will be concentrating our efforts to improve patient experience.

Hospital results are reported publicly to help drive improvements to the care environment. Our scores remain high but have dipped due to having to inspect the 'older' parts of the hospital.

We continue to address any areas where improvements can be made such as offering patients a quiet time to get prepared and enjoy their meals. The percentage scores falling short of the national average will be reviewed again to see if we can make any immediate improvements within the funding available.

Improving the Environment

The Trust through its estates capital team work to improve its buildings and grounds to make the patient experience as pleasant as possible.

The opening of the new Emergency Department (ED) front entrance not only looks aesthetically pleasing, presenting a more modern outlook but also provides for a better patient experience.

Re-provision and additional car park management will assist in the building of the new Cancer and Wellbeing Centre to be constructed during the spring/summer 2019.

	Cleanliness		Food & Hydration overall		Organisational Food		Ward Food		Privacy, Dignity & Wellbeing		Condition, Appearance & Maintenance		Dementia		Disability	
	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017	2018	2017
National average	98.47	98.38	90.17	89.68	89.97	88.80	90.52	90.19	84.16	83.68	94.33	94.02	78.89	76.71	84.19	82.56
Trust Score	97.77	99.63	85.87	94.06	91.72	87.49	83.76	97.11	81.61	85.89	94.96	97.87	79.76	93.59	89.28	93.91

Our strategy and corporate objectives

As outlined in the key developments section of this report, the Trust entered into a collaborative agreement with the Royal Devon and Exeter NHS Foundation Trust in June 2018. This agreement is currently for two years until June 2020 and its objectives inform the Trust's organisational strategy.

The purpose of the collaborative agreement is to:

- In the short to medium term, improve and sustain service delivery across Devon, but particularly to meet the health needs of the population of northern Devon and north-east Cornwall based on the STP principles of need and equity of access
- Enable NDHT, RD&E and the wider Devon system to plan medium-term resource deployment, particularly to NDHT, in a planned and managed way
- Carry out a piece of work to determine the most appropriate arrangements and organisational form to ensure that the health needs of the population of northern Devon can best be met over the longer term.

In the first six months of the agreement, the focus was on carrying out an initial diagnostic piece of work to fully understand where we were as an organisation and to stabilise our services in the short to medium term. We have made a lot of progress in a relatively short period of time thanks to the hard work of teams across the Trust. You can read more about the improvements we have made to quality and performance within the pages of this report.

For 2019/20, our focus is on carrying out the piece of work to develop the long term plan for our services, working alongside staff, stakeholders and the community, and this piece of work will inform our strategy going forwards.

As we do this important work we continue to keep our vision and values in mind, placing patients and their families firmly at the centre.

Vision

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

Our values

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

Key risks and issues

NDHT operates in a challenging and demanding environment. There are a number of risks that the Trust faces now and will continue to face in the future. The Trust manages its strategic risks through its enhanced governance structure which is being developed throughout the organisation and the reporting of risks through the corporate risk register. This is regularly reviewed and updated and reported to the Board via the governance committee. The formal reporting route to the Board is through a Board Assurance Framework (BAF). During 2018/19 the BAF format and report has been part of the overall governance review process to ensure that it is fit for purpose and meets the organisation's needs.

Operational

Workforce

Workforce remains the Trust's greatest asset but the significant shortages in workforce nationally mean that it is also one of our greatest risks. Being a small District General Hospital and the most remote hospital in mainland UK, we are competing for the same scarce workforce pool as larger teaching and research institutions. Therefore we need to continue to think innovatively regarding our workforce models and consider workforce availability in everything we do.

Demand

We have worked hard this year to develop our demand and capacity modelling to ensure that we understand the drivers of our operational challenge. Whilst we would intend to deliver against the NHS constitutional standards, the level of demand in some areas is too high to enable us to achieve the level of performance recovery required in order to meet the standards in one year. We saw significant demand in referrals in 2018/19 particularly in cancer specialties and ophthalmology and this is set to continue based on current referral patterns and pathways into 2019/20.

This creates an operational risk on delivery driven by the availability of workforce to build in additional capacity where it is needed. We continue to work across the Devon system on network solutions for specialities where there is a clear capacity shortage.

Finance

The Trust's 2019/20 plan has been established in the context of the wider plan established for the whole Devon population, driven by the Devon Sustainability and Transformation Plan (STP). The STP for Devon seeks to respond to some of the key challenges facing the county, primarily the ability to continue to deliver financially and clinically sustainable services in the face of increasing demand from a growing and ageing population. The Devon STP aims to address the financial challenge whilst improving health outcomes for people in an equitable way through shifting our model of care to provide more effective joined up services in, or closer to, people's homes and thereby reducing reliance on bed-based care.

The 2019/20 financial environment of the NHS will be extremely challenging and the above average level of demand in North Devon and workforce shortages compound this financial pressure. The Trust will need to continue to deliver operational productivity and cost efficiency to manage our financial position, whilst recognising the financial constraints that also exist in the wider Devon system.

The Trust fell short of its Cost Improvement Programme target for 2018/19 and ended the year off plan with a year end deficit of £16.6m. This was partly driven by operational pressures and historic budget management processes which have been addressed for the coming year.

The Trust Board has signed off a plan for 2019/20 that delivers against the breakeven control total expectation of the regulators following receipt of national money against the financial recovery fund and provider sustainability fund. However, to achieve this there is a cost improvement expectation of £10m which is over 4% of the planned cost base for the year. This is to be expected given the shortfall on recurrent delivery in 2018/9 but poses a risk to deliver in year.

Quality

CQC

In February 2018, the Care Quality Commission published a report following their visit in October 2017, which rated the Trust as 'requires improvement'. They also issued the Trust with a warning notice highlighting that the internal controls for the management of maternity, emergency department, outpatients and end of life services did not meet the CQC compliance standards.

The Trust submitted an action plan to address the CQC's concerns with the majority of actions complete in March 2018. There were a number of areas which were more complex and likely to take longer to address, and the Board made these areas priorities for improvement in 2018/19 within the Trust's quality account. The quality account for 2018/19 gives more details of the progress made against these priorities.

In July 2018, the CQC visited again and recognised that progress had been made in all areas. The CQC did not issue any further warning notices, but said that more work needed to be done to improve the quality of the Trust's services.

Addressing the CQC's findings and ensuring improvements are embedded has been a key area of focus throughout the collaborative agreement between NDHT and the RD&E, which commenced in June 2018. We expect to welcome CQC inspectors back in 2019/20 and we are confident that they will see further improvements. We recognise that moving our overall rating from 'requires improvement' to 'good' and eventually to 'outstanding' is a significant step forward and may take longer, and we are committed to continuing our journey of continuous improvement as we go into 2019/20.

Challenged provider status

In 2018, NDHT was deemed to be a 'challenged provider' by our regulators, NHS Improvement, meaning that we would receive additional support and oversight. In recognition of the improvements made to our quality and performance, NHS Improvement confirmed in 2019 that NDHT was no longer considered to be a challenged provider.

External Factors

EU Exit

Through the continued uncertainty about the EU Exit and the possibility of a 'no deal', Trust staff have worked hard to prepare our business continuity arrangements.

The Trust is part of a national and regional network of EU Exit teams and we have been working closely with our partners to prepare. Key members of staff from across the organisation have led on EU Exit preparations structured around nine domains identified by the Department of Health and Social Care:

1. Medicines and vaccines
2. Medical devices and clinical consumables
3. Non-clinical consumables, goods and services
4. Workforce
5. Reciprocal healthcare
6. Research and clinical trials
7. Data sharing, processing and access
8. Blood and transplant
9. Vaccines and other public health issues

The Trust has carried out risk assessments and reviewed our well-rehearsed incident plans, which will help us to ensure that we continue to provide safe and high-quality care to our patients and service users.

Performance analysis

Our performance

It is really important to the Trust that our patients have confidence in the quality of care provided, that they receive timely care and that the Trust do everything we can to ensure we meet our targets.

The Trust's performance is monitored against key national standards, and the Trust board regularly reviews progress against a range of internal and external metrics.

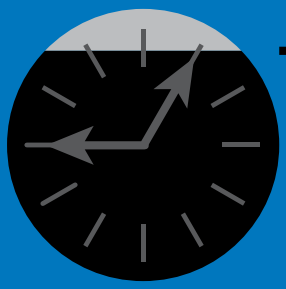
2018/19 was a challenging year with increasing referrals, a rise in acute inpatient demand and increased attendances to our emergency department. The Trust put in place multiple improvement plans and our clinical and operational teams worked hard throughout 2018/19 to deliver against these plans.

Those improvement actions have begun to deliver the desired performance improvements against standards for patient flow, elective access wait times and diagnostics.

As always, we are focused on providing the best possible care to our patients and we will continue to work to do this and deliver against improvement plans throughout 2019/20, addressing the performance challenges we are facing.

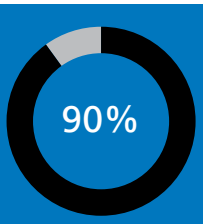
		Performance			Quarterly trend 2018-2019			
		Target	2017-18	**2018-19**	Q1	Q2	Q3	Q4
Infection control	C.difficile over three days – avoidable (NDDH)	0	0	**0**	0	0	0	0
	C.difficile over three days (NDDH)	6	13	**4**	1	3	0	0
Referral to treatment times	Percentage incomplete pathways less than 18 weeks	92.0%	83.1%	**78.4%**	77.7%	77.7%	79.7%	79.1%
Over 52 week waits	Patients waiting more than 52 weeks without treatment	0	132	**933**	238	307	255	133
40-51 week waits	Patients waiting 40-51 weeks without treatment	No national target	1502	**3848**	1137	1325	730	656
Diagnostics	Percentage of patients waiting more than 6 weeks for a diagnostic test	1%	13.7%	25.4%	27.3%	29.8%	24.6%	18.7%
Waiting times	Percentage of ED, MIU and WIC attendances waiting less than 4 hours	95%	90.1%	**84.6%**	86.0%	86.0%	85.7%	82.2%
Cancer access initial treatments	Percentage treated within 62 days of urgent GP referral	85%	83.9%	**82.3%**	86.3%	76.7%	85.7%	80.5%
	Percentage treated within 62 days from urgent GP referral (including shared pathways)	85%	78.7%	**78.0%%**	82.5%	71.2%	83.0%	74.2%
	Percentage of patients treated within 62 days from screening referral	90%	70.6%	**77.3%**	66.7%	71.4%	100%	100%
	Percentage treated within 62 days following consultant decision to upgrade priority	90%	90.6%	**86.9%**	94.6%	90.0%	80.9%	84.4%
	From diagnosis to first treatment within 31 days	96%	98.4%	**97.0%**	100%	97.1%	96.2%	95.8%
Cancer access subsequent treatments	Surgical treatments within 31 days	94%	97.3%	**96.7%**	100%	95.7%	89.7%	88.3%
	Drug treatments within 31 days	98%	98.8%	**99.6%**	100%	100%	100%	97.4%
Cancer access initial appointments	Urgent referrals seen within 2 week wait	93%	91.6%	77.8%	93.3%	69.6%	68.7%	90.6%
	Symptomatic breast patients seen within 2 week wait	93%	88.9%	82.8%	94.9%	91.7%	69.4%	82.8%

Trust's performance against the four-hour target



84.6%

Our agreed trajectory =



Percentage of patients we saw, admitted or treated within four hours

2018/19 was an extremely busy year for our emergency department and urgent care services with more people coming through the doors than ever before. The Trust saw 47,671 patients, compared to 45,294 in 2017/18, an increase of 5.2% and saw, admitted or treated and discharged 84.6% of these patients within four hours. This is below the 90% trajectory set as part of the national planning process.

Although the Trust is not where we want to be against this trajectory or the national standard, we know that our staff worked incredibly hard to plan and prepare for our busiest time of year. This ensured performance over the winter months was significantly better than last year and has made a huge difference in our ability to deliver care to some very poorly patients during periods of huge demand.

In the emergency department we launched the primary care streaming service, which helped to make the best use of our resources by establishing a pathway for patients who need a primary care service, such as a GP, rather than the emergency department. We also developed a different pathway for patients who are urgently referred to us by their GP, where they were seen, admitted or treated and discharged by a dedicated GP referrals team, instead of waiting to be seen in the emergency department alongside walk-in patients.

Meeting the four-hour target is not just the responsibility of our emergency department teams, but requires all of our teams across the Trust to ensure patient flow through the hospital is efficient and avoids delays.

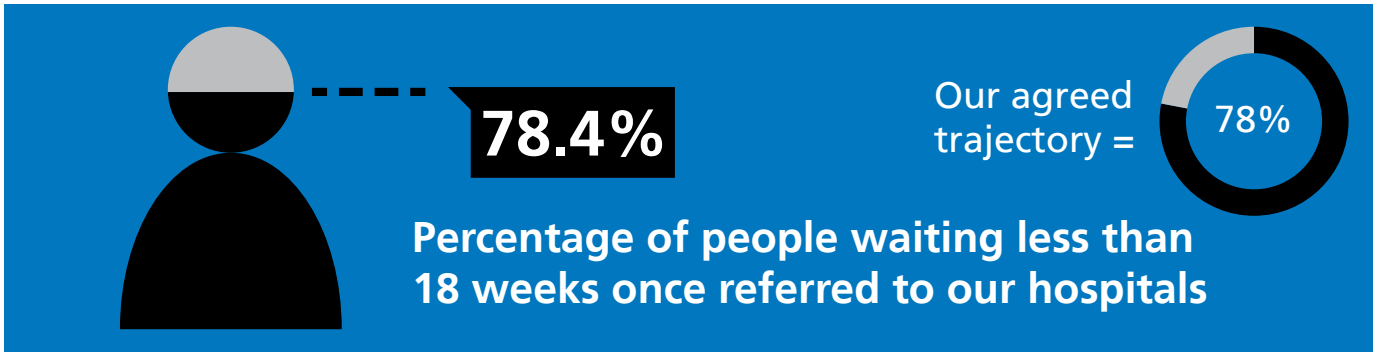
As part of our comprehensive winter plan, we increased the number of beds available to care for patients, invested in additional staff, and developed new and existing ideas to help people regain their independence and get home from hospital as soon as possible. We delivered internal and external campaigns to encourage timely discharges, and our pharmacy and phlebotomy teams delivered enhanced services during weekends to support this.

We worked with our partners to arrange support with staffing challenges, which included medical consultants from the Royal Devon and Exeter NHS Foundation Trust providing additional support at weekends.

Whilst admissions to hospital have been high, increasing by 5.1% compared to 2017/18, our delayed transfers of care rate and average length of stay have remained low. We have also cancelled fewer operations during times of exceptionally high demand than last year.

The four hour target is being reviewed nationally by NHS England during 2019/20 to ensure targets set for trusts across the country continue to support a focus on the best interests of patients.

Referral to treatment targets



The Trust experienced data quality issues following the implementation of our electronic health record (EHR) in April 2017 and we were unable to have confidence in the performance figures relating to referral to treatment (RTT). This resulted in the Trust suspending national reporting of RTT performance in July 2017. Following a programme implemented to review and resolve the data quality issues, RTT data submissions recommenced in June 2018 with May 2018 data.

There have been significant improvements with reducing the percentage of patients waiting to start treatment within 18 weeks. 78.4% of patients in 2018/19 started treatment within this target which is above our trajectory of 78%.

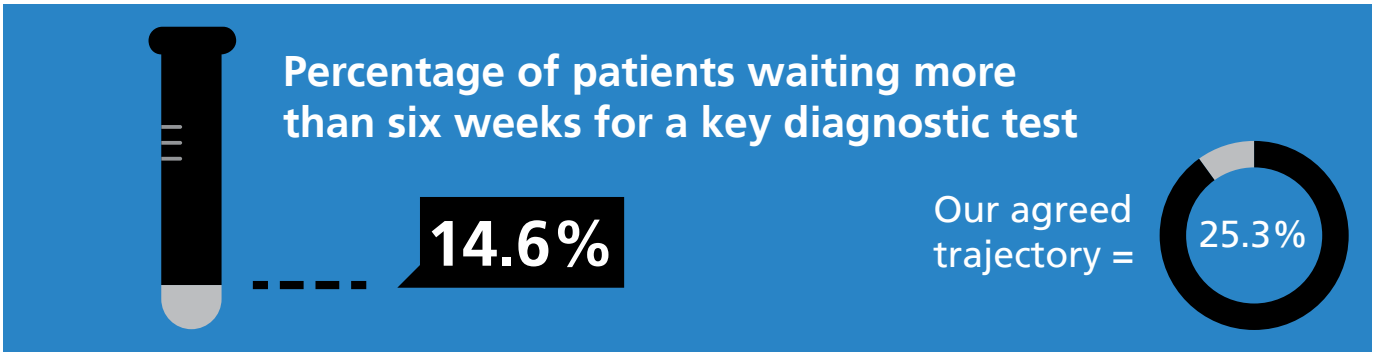
We closely monitored our patients who had been waiting for treatment for longest. In March 2018, 48 patients had been waiting over 52 weeks for treatment, and this peaked at 107 patients in August 2018. The national directive from NHS England set us a target of halving the long waiting patients to 24 by March 2019. There were difficulties with all specialties, but the biggest challenges were in orthopaedics and neurology.

We put together a wide-ranging plan to address our waiting lists and have reduced the number of patients waiting over 52 weeks to 16 at year end, a fantastic achievement that has required a huge commitment from teams across the Trust. The Trust is committed to continuing our efforts to reduce this number to zero in Quarter 1 of 2019/20.

The number of patients waiting over 40 weeks has also reduced from over 500 to fewer than 200 and the Trust is committed to continuing this hard work and maintaining our current performance.

All staff have played a part in this, both patient facing and non-patient facing teams. To deliver these improvements our plans included extra theatre sessions, additional outpatient clinics and extra diagnostics lists, including out of hours and at weekends.

Diagnostics



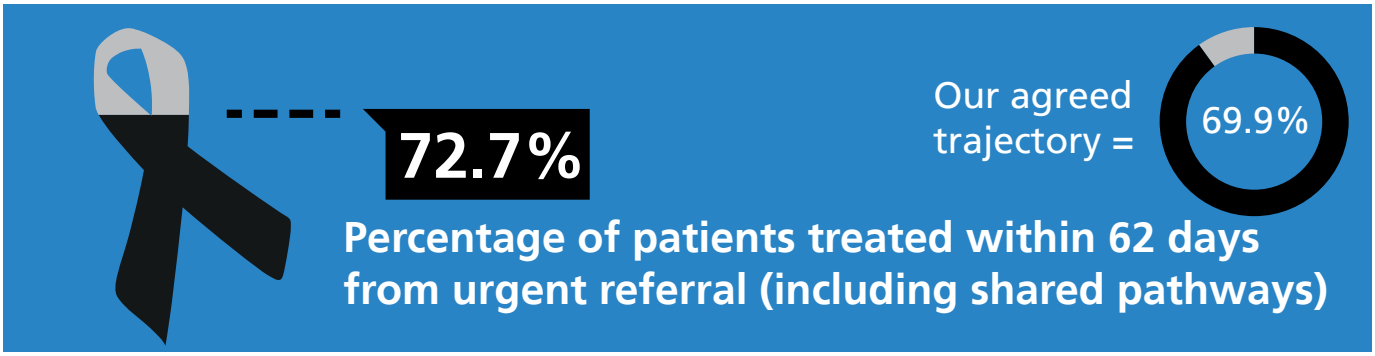
The Trust began 2018/19 in a challenging position, with 22.4% of patients waiting more than six weeks for a key diagnostic test. Over the year we have reduced this figure to 14.6% of patients against an agreed trajectory of 25.3%

A huge amount of work has taken place during the year to improve our position, which has clearly had a positive impact on wait times for planned treatment. We invested in mobile MRI and CT scanners and ran additional endoscopy, ultrasound and DEXA sessions, including at the weekend.

Our staff were supported to deliver these extended hours by independent companies, this has also provided opportunities for learning to further improve the service delivered.

Demand for endoscopy, MRI and CT scans continues to increase and we will continue to utilise these mobile scanners and run additional sessions. The Trust have secured funding for a second mobile CT scanner and we are aiming to have this operational in 2020/21.

Cancer treatment standards



The Trust saw an average 20% increase in the number of patients being referred to our cancer services, with an increase in the number of people being diagnosed at an earlier stage. Whilst this has increased demands on our services, particularly in diagnostic services, colorectal, dermatology and urology specialties, it is hugely positive that our patients have been diagnosed earlier.

Currently 72.7% of patients are starting treatment within 62 days of referral, against an agreed trajectory of 69.9%. As in 2017/18, we continue to perform above target once a decision about surgical and drug treatment has been made.

Cancer care can be complex and can require a number of diagnostics services and involve a number of different providers. The challenges we have experienced in our diagnostics provision has impacted on this performance and we expect an improvement when the full benefit of our additional diagnostic capacity filters through. The Trust is pleased to have secured funding that will assist us to look at different models of care for cancer patients. We will work with our partner providers to understand how we can see patients earlier in the cancer pathway.

Financial performance

The Trust finished the year with a financial deficit of £17m following a very difficult year. This deficit reflects the operational pressure the Trust faced with a deterioration of performance starting to materialise from 2017/18 which needed to be stabilised and improvements required in key areas such as diagnostics and cancer. In addition, the Trust has reviewed the bed capacity, investing in additional beds to ease the flow pressures within the hospital to maintain availability of beds for planned activity and reduce the number of short term cancelations.

Whilst the latter was reflected in the financial plan for the year the increase in demand above expectation on our A&E services and referrals into our planned care specialities resulted in a need for above planned levels of investment in additional capacity to manage the overall cohort of activity.

The financial position also demonstrates the pressure created by workforce shortages and the need to contract with temporary staff to ensure staffing levels are safe for our patients.

The focus going forward is to understand the key drivers of the financial deficit to support the on-going work of the RD&E collaboration ensuring that plans to deliver clinical sustainability and financial sustainability are joined up. A financial recovery plan will be required to demonstrate an improving financial trajectory going forward. This commences with a challenging financial position to breakeven in 2019/20 with support from the national financial recovery fund and provider sustainability fund of £14.1m

Going concern

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

The Directors, having made appropriate enquiries, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future and there are no material uncertainties that may cast significant doubt on this assessment. As directed by the 2018/19 Department of Health and Social Care Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

Sustainability statement

The Trust has a corporate duty to maintain safe and efficient services, but recognises that as a large user of resources it must also adopt practices that allow it to be environmentally sustainable in the services it provides. By delivering healthcare in an environmentally sustainable way, it ensures there is minimal impact on the local community and infrastructures. In addition, adopting an environmentally sustainable approach can ensure the efficient use of resources, supporting the Trust's aim to reduce operational costs.

In recognition of the need to target all healthcare activity, NHSI have now issued the 'Sustainable Development Assessment Tool' (SDAT). Within SDAT, there are ten domains identified that trusts should focus on, with each domain requiring a score for compliance. The benefit of using this approach is that the Trust can demonstrate improvement each year and the scores achieved can also be used as a performance indicator to benchmark the Trust against other NHS organisations. This is a new program and the Trust is in the process of applying SDAT to its business activity. Listed below are the domains and the Trust's expected status at present:

1. Corporate approach

This requires the Trust to demonstrate a culture of environmental sustainability in all of its activities, with clear lines of responsibilities and support from all levels of management. This includes policies and reporting, and through the application of benchmarking, we can demonstrate a compliance level.

Our status:

The Trust is committed to reducing its environmental impact and has an executive lead that champions this approach. Throughout 2019/20, this approach will be more formalised and documented to ensure that we can demonstrate an improved compliance level to this domain.

2. Asset management and utilities

The Trust is required to demonstrate that all utility services, including water, are monitored and managed to avoid waste and that where possible the Trust invests in technology that allows local generation of heat, electricity and the efficient use of utilities. An assessment of the estate is required to ensure that all areas are used effectively and efficiently, and that building development is carried out with an environmentally sustainable approach, adopting not only improved controls and design, but also using sustainable and renewable materials.

Our status:

The Trust has declared in its 2018 Estates Strategy where it is in relation to the above domain. A partnership with a technology specialist Veolia resulted in a £4.6m investment in energy projects. This investment was part funded by SALIX, a government-backed organisation, with payback anticipated in less than 8 years. The Trust is looking at further development using SALIX funding to procure greater savings. Within the 2018 Estates Strategy, the estate has been assessed and future plans declared to support the Trust's anticipated future services. This will support the changing delivery of healthcare services. The Trust has also applied for and been granted further funding from NHSI for a second round of LED lighting to replace old lights and further enhance our energy saving schemes as well as improving the look of the hospital helping to enhance the patient experience.

3. Travel and logistics

The Trust is required to consider transport costs and the implications of service delivery based on travel and access. In addition, through logistics, it must consider the impact of need to do journeys both in the form of goods deliveries to its estate and the attendance of appointments/delivery of services to remote locations.

Clear policies and their adoption are two key requirements, as well as partnering with like organisations to share resources in promoting our services to service users and staff.

Our status:

The Trust has in place many initiatives for both the staff and public and is committed to reducing its environmental impact through transport and travel. Throughout 2019/20, this approach will be more formalised and documented to ensure that we can demonstrate an improved compliance level to this domain.

4. Adaptation

This is a domain that includes the Trust's emergency planning, building design protocols and service planning. It challenges the Trust to consider how the potential

effects of climate change can affect our ability to deliver healthcare services.

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

Our status:

The Trust meets a great deal of this requirement through its processes for service and area development, through business case approval, then ultimately by the design and delivery of projects. The reference to emergency planning has been covered, but will be more formalised and documented in 2019/20 to ensure that we can demonstrate an improved compliance level to this domain.

5. Capital projects

This domain requires trusts to develop estates with buildings and facilities that are fit for purpose and functionally suitable. It also requires us to consider all stakeholders in the specification process when developing the estate either through new builds or refurbishment.

We must ensure we are not only designing services in an environmentally sustainable way but that we are also ensuring local social values are maintained through the use of engagement with the public.

Our status:

The Trust meets a great deal of this domain already. Development of the estate is carried out with key stakeholders in place to ensure developments are fit for purpose. For example, the Trust was awarded the national standard of "Excellent" through the Building Research Establishment Environmental Assessment Methodology (BREEAM) for its Chemotherapy build. The key aim throughout 2019/20 will be to ensure this is more formalised and documented so we can demonstrate an improved compliance level to this domain.

6. Green space and biodiversity

This domain has a wider remit as it assesses the Trust's ability to manage the impact of the provision of all of its services on the local biodiversity and what mitigating actions we have put in place to reduce these impacts.

Our status:

The Trust ensures its new builds and developments are sensitively designed when using green spaces with a preferred option to use of brown field development. Consideration is given to the potential impact of our day to day services, and this is strictly controlled to ensure the Trust stays within guidelines and statutory requirements. One example of success has been the Trust's management of its waste streams, where it continues to be proactive in waste management. The key aim throughout 2019/20 will be to address all the remits within the Trust's business activity to ensure we can demonstrate an improved compliance level to this domain.

7. Sustainable care models

This domain relates to how the Trust and its services assist the local population to build healthy, sustainable lives and communities. It relates to what partnerships we have formed with local organisations, what potential there is to share assets and resources with local communities, and how we engage with service users about their experience of our services.

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

Our status:

Staff involvement will be key to implementing a more sustainable model of care where we can introduce:

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

This will only be achievable through patient-clinician engagement during patient care and treatment.

Another key aim of the Trust is to deliver safe and effective care 'closer to home' and this has an indirect environmental impact by assisting in the reduction in vehicle-produced CO2, as patients and the public have fewer and shorter journeys when treated in their own home or local outpatient facilities. This also assists in reducing the impact of vehicle congestion on the NDDH acute site.

A more formalised and documented approach in 2019/2020 will allow the Trust to demonstrate an improved compliance level to this domain.

8. Our people

This domain looks at the Trust's most valuable asset, its staff, their involvement and the support we give them. It encourages focussed training, staff surveys, and education on sustainability at induction and as part of annual with healthy options, such as fitness, smoking cessation, food choices, carers and child care. It requires good communication that highlights the Trust's sustainable goals, and that encourages staff through to be sustainable in their approach within their own specialisms. It also looks for support from the Trust Board in promoting a more sustainable approach to the services we provide.

Our status:

The Trust has many support mechanisms and feedback routes available for staff, and monitors and treats staff welfare as a key area to ensuring an efficient and satisfied workforce. Improved communication and the cultural element will be two areas that will be tackled in 2019/20 to ensure the sustainable message is communicated to all. In the first instance the aim will be to ensure that staff apply sustainability within their specialisms. In 2019/20 we will produce an action plan to address the many issues of this domain, such as:

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

9. Sustainable use of resources

This domain looks at how the Trust directly and indirectly impacts on the use of resources and the production of carbon. For example, does the Trust have good sustainable purchasing, medicine management, food management, energy management and waste management? In some cases, this would involve partner organisations as they are essential to both supporting and validating our progress. This domain also asks how we treat items that are surplus to requirements, such as through reusing or disposal. It also identifies the need to purchase fresh local produce, saving road miles. It also requires us to understand our carbon footprint and to highlight the importance of sustainability amongst staff, so they take good practice home with them, thereby living a more environmentally friendly life.

Our status:

The Trust already tackles many activities where there is a clear link between carbon production and the service provided. Utility consumption, travel, food preparation, and waste management are all areas where the Trust has excelled in the past. This will be built on in 2019/20 to improve compliance.

10. Carbon / GHGs

This domain requires the Trust to have a target in place and a monitoring program for all its properties across all utilities, to ensure that they are managed and not wasted. It requires us to be aware of consumption and cost in all areas, thereby identifying potential waste. This will then allow investment and resources to be allocated to the most beneficial areas. From this approach there will be a reduction in costs and the CO2 produced. It is important that this CO2 footprint is communicated to all staff to allow them to apply sustainability to their areas.

Our status:

The Trust has recently invested £4.3 million in schemes to reduce (CO2), with more planned as new technologies become available. Past investment by the Trust will ensure it meets and betters the national NHS CO2 target placed on the NHS. To date, with the schemes completed, the Trust's energy usage is expected to decrease by at least 20% of its present annual usage. It is anticipated that this energy reduction will place the Trust in line with the best performers within the NHS. Proof of this will be by benchmarking with other NHS organisations of a similar size.

It is also recognised that the Trust has other activities that influence the amount of CO2 produced and these need to be challenged, such as procurement routes, clinical services, food preparation, waste disposal, private and business travel, isolation of power-using equipment when not in use, new builds/refurbishments and their design, procurement of services and materials and so on.

The Trust recognises that carbon reduction involves everybody and this will be a key driver in 2019/20 as we address this domain.

Environment, employee matters, social, community and human rights issues

The Trust takes its responsibilities towards the community it serves very seriously. We recognise the responsibility we have to:

- Meet the acute health needs of the population we serve as safely, effectively and efficiently as possible.
- Ensure that in designing and delivering health services we fully take into account, and are influenced by, the views and opinions of our patients and patients to be.
- Take into account the impact we have on the environment because this will ultimately have an effect on the communities we serve. The sustainability report section within this report gives details of the steps we are taking to reduce our environmental impact.
- Take into account our status as the largest employer in Barnstaple and surrounding area. This means that decisions we make may well have an impact on the local economy and the health and wellbeing not only of our staff but their families and communities as well.
- Take into consideration our responsibilities, as an ethical organisation, to respect human rights and to ensure that our actions or decisions do not have an adverse impact on upholding human rights.
- Uphold the tenets of the NHS Constitution which brings together in one place details of what staff, patients and the public can expect from the NHS.
- Uphold the legal framework that exists to promote equality and diversity.
- Take very seriously our commitment to ensuring that staff feel motivated, empowered and are clear about the difference they are making to patient care.
- Ensure that the Trust is a positive place to work and that staff are supported appropriately. The Trust has a support programme which brings together our approach to equality and diversity, training and development, staff engagement, and support for health and wellbeing through occupational health, and access to counselling, staff physio and exercise classes. This year we have placed a particular focus on mental health through signing the Time to Change pledge and encouraging staff to look out for their colleagues.
- Uphold the legal framework in terms of the Bribery Act 2010 by providing staff with a robust and detailed "Standards of Business Conduct" policy and ongoing engagement, support and monitoring by Audit South West (Internal Audit, Counter Fraud and Consultancy Services).

Accountability report

Directors report

As a Board of a public service body, the Trust Board forms the collective strategic and operational leadership of the Northern Devon Healthcare NHS Trust and brings together its Executive Directors with independent Non-Executive Directors from outside the organisation to retain full and effective control over the Trust's business.

Trust Board members have corporate responsibility for

- Being responsible for managing the Trust on a day-to-day basis.
- Setting the strategic direction of the Trust within the policy and funding framework laid down by Parliament.
- Defining annual and longer term objectives and agreeing plans to achieve them.
- Overseeing the delivery of planned results by monitoring performance against agreed objectives and targets, ensuring corrective action is taken when necessary.
- Ensuring the organisation develops in line with the needs of the Commissioners, the stakeholder community and wider NHS.
- Establishing an effective system of corporate governance.
- Safeguarding the public reputation of the Trust.

Members of the Board of Directors and changes during 2018/19

Board members' details, together with declarations of their relevant interests and committee membership, are detailed on the following pages. Directors must comply with the Trust's Standards of Business Conduct and are required to declare any interests that are relevant and material on appointment or which may arise during the course of their term of office. A register of Board members' interests is maintained by the corporate office and is included with every set of public Trust Board papers.

On 18 June 2018, NDHT entered into a collaborative agreement with the Royal Devon and Exeter NHS Foundation Trust, which resulted in a number of changes to the executive team.

These pages show what the executive team and Board looked like before the collaborative agreement and after, as well as any further changes/updates since last year.

Executive directors

Executive team before the start of the collaborative agreement

Andy Ibbs
Interim Chief executive

George Thomson
Medical director (until December 2018)

Darryn Allcorn
Director of nursing, quality and workforce

Iain Roy
Director of facilities

Angela Hibbard
Director of finance

Jill Canning
Interim Director of operations

Executive team since the start of the collaborative agreement

Suzanne Tracey
Chief executive (joint post)

Suzanne joined the NHS in 1993 having qualified as an accountant with Price Waterhouse. She held the post of director of finance/deputy chief executive at Yeovil District Hospital NHS Foundation Trust from 2002 before joining the Royal Devon and Exeter NHS Foundation Trust to take up the role of director of finance in 2008 and subsequently deputy chief executive/chief financial officer. She was appointed as chief executive of the Royal Devon and Exeter in 2016. Under a collaborative agreement, agreed by the Boards of both the Royal Devon and Exeter and Northern Devon Healthcare NHS Trust in June 2018, Suzanne became chief Executive of both Trusts on 18 June 2018.

Pete Adey
Chief operating officer (joint post)

Pete qualified as a nurse in 1988, subsequently working at Hammersmith Hospital on a number of medical specialty wards prior to progressing to senior nurse. He joined the Royal Devon and Exeter NHS Foundation Trust in 1995 and undertook roles as divisional manager in a number of services including Child and Women's Health, Cancer Services, Radiology and Pathology prior to his appointment as deputy chief operating officer in 2012. Pete was appointed as executive director of operations in 2016 at the Royal Devon and Exeter NHS Foundation Trust, formally took up his position on the Board in March 2016 and assumed the role of chief operating officer from March 2017.

Pete joined the Northern Devon Healthcare NHS Trust as chief operating officer in August 2018 under a collaborative agreement between the Trust and the Royal Devon and Exeter NHS Foundation Trust.

Angela Hibbard
Director of finance and performance

Angela joined the NHS in 2003 as a management accountant in South Devon and Torbay NHS Trust (now Torbay and South Devon NHS Foundation Trust). Angela initially supported the Women's and Children's directorate before expanding her portfolio to include the medical directorate. Following a restructure of clinical services Angela took on a role overseeing the management accounts functions across all clinical services which gave her a really strong grounding in the delivery of front line hospital services. In 2008 Angela joined the Royal Cornwall NHS Trust to lead on their medium term financial planning and Cost Improvement Planning. During this time Angela supported a number of major service redesign programmes of work.

After 18 months in role Angela took an opportunity to join the South West Specialised Commissioning team to understand more about complex service provision for larger patient populations. During her time here Angela oversaw the transition into the new commissioning structures as part of the NHS reorganisation in 2012. As part of this process Angela transitioned into a role of head of finance for NHS England leading the finance function for the commissioning of primary care and supporting the CCG assurance process. This role opened up an opportunity in 2014 to join Northern, Eastern and Western Devon CCG as deputy chief finance officer overseeing the CCG's finance function for financial reporting and operational planning. Angela quickly started to fill the space required as part of the Success Regime and later the STP to bring the finance network of organisations together within Devon.

Angela has lived in Devon for the majority of her life and currently resides in Exeter with her husband and daughter.

Adrian Harris
Medical director (joint post, interim at NDHT until December 2018)

Adrian trained originally as a GP before spending 22 years as a consultant emergency physician, including directing the Emergency Departments of Northern Devon Healthcare NHS Trust, Yeovil District Hospital and the Royal Devon and Exeter NHS Foundation Trust. He is an honorary associate professor in Healthcare Leadership and Management at the University of Exeter Medical School. He has been executive medical director at the Royal Devon and Exeter NHS Foundation Trust since April 2015 and under a collaborative agreement joined the Northern Devon Healthcare NHS Trust as interim medical director in June 2018 and became medical director in December 2018.

Andy Ibbs
Executive director of strategic development

Andy joined the NHS in September 1990 where he worked at the Royal London Hospital with responsibility for improving immunisation and developmental check rates amongst children in one of the most deprived areas of the country. He moved to Dartford in June 1991 to become head of information management and technology for a new community and mental health services NHS Trust where he installed the first desktop computers and local area network. In January 1994 he moved to Somerset and over the next five years had a variety of roles with Somerset Health Authority, culminating as head of acute commissioning and leading

the county-wide acute services review. In July 1999 he took on the post of head of service development at Plymouth Hospitals NHS Trust and in April 2001 was promoted to director of planning, with responsibility for strategic, service and capital planning. He was project director for the construction of the South West Cardiothoracic Centre and the Peninsula Medical and Dental Schools. In July 2007 he started working with NHS South West undertaking a number of time-limited projects, including the evaluation of the business case for a £450 million new hospital built under the Private Finance Initiative, the establishment of a new international healthcare benchmarking system, and the programme of independent investigations into mental health homicides. He was also the regional lead for competition and system management.

Andy joined the Trust in February 2012 initially on secondment as foundation trust programme director. In October 2012 he took up the substantive post as commercial director and subsequently became director of strategy and transformation. He was appointed to the role of director of operations and strategy in November 2016. Andy was appointed to the role of interim chief executive from 1 April 2018 to 18 June 2018 and then commenced a 12-month secondment as executive director of strategic development to lead the Options Appraisal to identify the best means of ensuring the long-term sustainability of clinical services in northern Devon.

Julie Cooper
Interim director of people (joint post) from August 2018

Julie joined the NHS in 1990, working in community trusts in the midlands before becoming director of HR in 2003 at the Walsall provider of community and mental health services. During her time there, the Trust rose to the top ten of the NHS league table for staff survey results and finished first in the region for the Improving Working Lives initiative. As director of workforce and OD in a Birmingham PCT, she saw the Trust win the HSJ Workforce Development Award in 2010 for its apprenticeship scheme.

A spell at the Department of Health followed, where she contributed to the development of the governance framework and role outlines for the governing body of CCGs. In recent years, Julie has worked as an independent consultant, managing a portfolio of assignments and supporting numerous NHS organisations in senior interim roles and with specialist consultancy services throughout the country including Gloucestershire, Liverpool, Manchester and Leeds.

Darryn Allcorn
Chief nurse

Darryn qualified as a registered Nurse in 1995 and started his career in acute medical nursing, undertaking a variety of nursing roles before developing an interest in education and organisational development. Initially this transition was as a clinical educator both within the NHS and university arenas, the passion for organisational development continued and he was appointed as head of education and staff development in 2005. In 2010 he was appointed assistant director for workforce at Northern Devon Healthcare NHS Trust. During this time he led a number of service developments and changes in processes that have enhanced staff experience and access to development, whilst supporting a portfolio of organisational development and implementing a process that enabled detailed workforce planning, and enhanced the cohesion of workforce systems but maintained his passion and skills around nursing. Since 2014 Darryn has undertaken varied Board roles including workforce director and a joint role including nursing, workforce and quality. In July 2016 Darryn also undertook the role of senior responsible officer for workforce as part of the Devon STP and is now the chief nurse. Darryn was appointed Honorary Associate Professor with the University of Exeter.

Iain Roy
Director of facilities

Iain started his NHS career in 1983 as an apprentice tradesman in West Hertfordshire and has developed this career across a number of sites ranging from Southampton in the South, Bedford in the North, Canterbury in the East. He joined the Trust in April 1999 as director of facilities. Over the years the directorate has developed to include services such as procurement, central services sterile department and in 2012 healthcare records. Iain was until recently a member of the Chartered Quality Institute and has a particular interest in environmental management, the development of quality systems and the continuous improvement on partnership working both within the NHS and the private sector. He is responsible for delivering the Trust's sustainability strategy and its estate strategy.

Non-executive directors

Chairman and non-executive directors before collaborative agreement

Roger French
Chairman (Retired 30 June 2018)

Tim Douglas-Riley
Non-executive director

Tony Neal
Non-executive director

Robert Down
Non-executive director

Pauline Geen
Non-executive director

Judy Jones
Non-executive director (from Sep 2017, resigned 30 June 2018)

Current chairman and non-executive directors

James Brent
Chairman
(Joined the Trust from 1 July 2018)

James was a merchant and investment banker for twenty-five years and established the Akkeron Group, of which he is chairman, which has key business activities in hotels, urban regeneration, retail and leisure (including Plymouth Argyle Football Club). He has combined his commercial ventures with a desire to contribute in a range of public sector settings as well, for example previously as chairman of Plymouth City Development Company and chairman of Plymouth University.

James became chairman of the Royal Devon and Exeter NHS Foundation Trust in May 2012 and under a collaborative agreement became chairman of the Northern Devon Healthcare NHS Trust in July 2018.

Robert Down
Non-executive director

Robert has a background in the oil and gas industry, managing and leading the technical and financial activities of a large, complex multinational company and working in operations and project management.

Since 2015, Robert has been a Board member of Anchorwood Ltd, where he is currently chairman.

He is also a director of UNESCO North Devon Biosphere Foundation.

He joined the Trust in February 2015 as a non-executive director. His term of office was due to end in February 2019, but he was reappointed for a further two years.

Tim Douglas-Riley
Non-executive director

A qualified doctor, Tim spent his entire professional career as a medical officer in the Royal Navy. He held a wide variety of clinical and administrative post in the UK and operational settings ranging from base ports and training establishments through to Northern Ireland, the Falklands, the Royal Yacht, 22 Special Air Service Regiment and as the medical commander in Afghanistan. He gained a Royal Marines Green Beret, was a qualified parachutist and sports diver and has had additional training in diving, aviation and nuclear safety medicine as well as attending senior level staff courses.

In the last decade of his service career, he held a variety of Ministry of Defence and Navy Command positions where he was involved in the strategic planning of personnel policy, workforce structures, operational requirements and organisational change. His final position was the director of the Royal Naval Medical Service where he was responsible for the entire spectrum of health care delivery across the Royal Navy.

Tim was awarded a CBE in 2009 for his leadership of the Royal Naval Medical Service and his contribution to strategic change programmes within the Defence Medical Service Department. Additionally he was made an officer brother in the Order of St John for his services to the Royal Naval and Defence Medical Services. He is an associate member of the Chartered Management Institute.

He joined the Trust in July 2012 as an associate non-executive director to provide clinical experience within the Non-Executive team. He was appointed as a non-executive director in May 2013. His current term of office was due to end in May 2019, but he was reappointed for a further two years.

Pauline Geen
Non-executive director

Pauline has worked for more than 30 years in the public and private sector, with key roles in administration, facilities management and customer service.

Pauline's career began in 1976 with the Central Electricity Generating Board in the company secretariat. She progressed into facilities management and property services. She was the senior facilities manager for Severn Trent Water for eight years. During this time, she engaged with key stakeholders to develop a facilities management strategy and new service model which delivered cost efficiencies and improvements in customer service. She worked for the National Policing Improvement Agency as service delivery lead overseeing a large property portfolio including national police training centres, offices and data centres.

She has received awards from the British Institute of Facilities Management in customer service and the British Safety Council for excellence in health and safety.

She joined the Trust in March 2011 as a non-executive director. Her term of office was due to end in February 2019, but she was reappointed for a further two years.

Tony Neal
Non-executive director

Tony has a background as a management consultant in IT and business consultancy with a particular focus on organisational visioning, development and change with previous extensive Board level experience with BT and Fujitsu.

He has worked locally with each of the South West Local Authorities and a number of third sector organisations, chiefly as an interim manager and leading/supporting business turn around and change.

Tony joined the Board in January 2016 as a non-executive director and his current term of office will run to January 2020.

Mike Tucker
Non-executive director
(left in January 2019)

Mike has held the roles of senior commercial director and senior finance director across multiple organisations and trade sectors with an extensive background managing technical and strategic change across all levels of a business, by building and developing high performance teams.

As senior commercial director of Perrigo UK he was responsible for managing all consumer healthcare commercial activities of the CHC – Over the Counter (OTC) Store Brand (Retail) and Contract Manufacturing business unit for Perrigo UK, who are the largest store brand/own label supplier of OTC Medicines in the UK, with overall responsibility for business growth and development both in the UK and Europe.

Mike joined the Board in July 2018 as a non-executive director and his current term of office will run to June 2020.

Board meetings

The Trust Board met on eight occasions during 2018/19 on the following dates:

- 3 April 2018
- 5 June 2018
- 7 August 2018
- 2 October 2018
- 4 December 2018
- 3 January 2019
- 14 February 2019 (confidential agenda only)
- 7 March 2019

The Board conducts its business in accordance with the Standing Orders and Standing Financial Instructions. Papers for the Trust Board meetings are published on the Trust's public website.

Membership of the Board consists of the chairman, five non-executive directors and five executive directors, including the chief executive. The director of facilities and the director of people also attends Trust Board meetings. The director of IM&T attended at the start of the year until the responsibility transferred to the medical director on the retirement of the post holder.

Figure 1 – Attendance at Trust Board

Name	Role	Attendance
Non-Executive Directors		
Roger French[1]	Chairman	2/2
James Brent2	Chairman	6/6
Tim Douglas-Riley	Non-Executive Director	8/8
Robert Down	Non-Executive Director	7/8
Pauline Geen	Non-Executive Director	8/8
Judy Jones[3]	Non-Executive Director	2/2
Tony Neal	Non-Executive Director	7/8
Mike Tucker[4]	Non-Executive Director	3/3
Executive Directors		
Suzanne Tracey	Chief Executive (deputy attended one meeting on her behalf)	6/6
Pete Adey[5]	Chief Operating Officer	5/5
Darryn Allcorn	Director of Nursing, Quality and Workforce (until August 2018)/ Chief Nurse (from August 2018)	8/8
Chris Bowman[6]	Interim Medical Director	2/2
Jill Canning[7]	Interim Director of Operations	2/3
Adrian Harris[8]	Medical Director	6/6
Angela Hibbard	Director of Finance (deputy attended one meeting on her behalf)	7/8
Andy Ibbs[9]	Director of Operations and Strategy/Interim Chief Executive/ executive Director of Strategic Development	4/8
In attendance		
Katherine Allen[11]	Interim Director of Strategy	2/3
Julie Cooper[12]	Director of People	4/5
Jenny Nash[13]	Director of IM&T	1/1
Iain Roy	Director of Facilities	8/8
Geoff Smith[14]	Interim Director of IM&T	1/2

1. Roger French left the Trust in June 2018
2. James Brent joined the Trust in July 2018
3. Judy Jones left the Trust in June 2018
4. Mike Tucker joined the Trust in August 2018 and left in January 2019
5. Pete Adey joined the Trust in August 2018
6. Chris Bowman acted as Interim Medical Director until July 2018
7. Jill Canning acted as Interim Director of Operations from April-August 2018
8. Adrian Harris joined the Trust in July 2018.
9. Andy Ibbs was Interim Chief Executive from April-June, Director of Operations and Strategy between July-August and took on the role of Executive Director of Strategic Development from September 2019.
10. Katherine Allen acted as Interim Director of Strategy from April-August 2018
11. Julie Cooper was appointed as Director of People in August 2018
12. Jenny Nash left the Trust in April 2018
13. Geoff Smith was Interim Director of IM&T from June-August 2018

Board briefings

From April to December 2018 the Board attended Board Briefings, held in between formal Board meetings, where issues were discussed in detail prior to being presented to Board. From January 2019, Board Briefings were removed from the Board's meeting schedule as part of the review of the Board's programme of work as detailed below to allow for more focused assurance at formal Board meetings.

Three Board Briefings were held between April and December 2018 where the following operational and financial issues affecting the daily function of the Trust were discussed:

- Strategic Objectives
- Capital Plan 2018-19
- Financial Plan 2018-19 with supporting CIP plan
- Quality Account Priorities for 2018-19
- Operational Plan 2018-19
- Bed Capacity
- Performance
- Smartcare Programme Progress
- One Northern Devon
- Briefing on changes to Tariff

Board development days

Three Board development days were held during the year which are used in part to assess the Board's performance and effectiveness.

Sub-committees of the Trust Board

During the course of 2018/19 a governance review commenced which includes a review of committee structures as well as overall Executive portfolio responsibility. Corporate governance has historically sat under the portfolio of the former director of IM&T until May 2018. Under the new arrangements the chief nurse holds the portfolio for clinical governance reporting through the governance committee and the director of finance maintains the link for corporate governance through to the audit committee.

As part of the wider on-going review of governance, the Board's meeting schedule has been reviewed and there is agreement to remove Board briefings from the schedule and to hold ten formal Board meetings per annum. In addition, the Trust Board plans to hold three Board development days.

As a result, the sub-committees of the Trust Board have been revised with effect from 1 January 2019. Outlined below are the sub-committees in place from April – December 2018 and the new governance structure in place from January 2019.

April – December 2018

Audit and assurance committee

Charitable funds committee

Finance committee

Quality outcomes and assurance committee

Remunerations and terms of service committee

From 1 January 2019

Audit committee

Charitable Funds Committee

Finance committee

Remuneration and terms of service committee

Governance committee – five sub-committees reporting into governance which are clinical effectiveness committee, Integrated safeguarding committee, patient experience committee, safety and risk committee and workforce governance committee.

As part of this review the extent to which the Board has oversight of the Trust's overall performance has also been reviewed. The integrated performance report has been evaluated and refined to improve the quality of the information presented to the Board, allowing for more rigour in the Board's assessment of delivery of plan and performance against key national standards. This has enabled a more robust and informed debate at Board on the key challenges faced and the recovery actions being taken.

Audit committee

The audit committee ensures that an effective system of internal controls is in place and maintained. Independently of the Trust Board, it reviews and scrutinises the Trust's objectives and the associated risks and controls set out in the Board Assurance Framework. The committee comprised of three non-executive directors, chaired initially by Judy Jones, and passing to Mike Tucker until his resignation. Pauline Geen has acted as interim chair whilst recruitment of a replacement non-executive takes place. The directors of finance and performance and the chief nurse regularly attend and all other members of the executive team routinely receive papers and attend when the agenda demands.

Register of interests

The Board regularly updates its register of directors' interests to ensure that each member discloses any outside interests such as company directorships or other material interests which may conflict with their management responsibilities. Board members also have the opportunity at the start of each meeting to declare any interest which may impact on their ability to take part in discussions or to declare at any point in the agenda and potential conflict that arises based on nature of discussions.

The full register of interests for board members can be found on the Trust website www.northdevonhealth.nhs.uk/about/who-we-are/trust-board

Signed _____
Chief Executive

Date: 23 May 2019

Governance statement

Scope of responsibility

As accountable officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the NHS trust's policies, aims and objectives, whilst safeguarding the public funds and departmental assets for which I am personally responsible, in accordance with the responsibilities assigned to me. I am also responsible for ensuring the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The purpose of the system of internal control

The system of internal control is designed to manage risk to a reasonable level rather than to eliminate all risk of failure to achieve policies, aims and objectives; it can therefore only provide reasonable and not absolute assurance of effectiveness. The system of internal control is based on an ongoing process designed to identify and prioritise the risks to the achievement of the policies, aims and objectives of Northern Devon Healthcare NHS Trust, to evaluate the likelihood of those risks being realised and the impact should they be realised, and to manage them efficiently, effectively and economically. The system of internal control has been in place in Northern Devon Healthcare NHS Trust for the year ended 31 March 2019 and up to the date of approval of the annual report and accounts.

Capacity to handle risk

The chief nurse has overall oversight and leadership of risk, supported by a risk manager and governance roles within the division. These roles are further supported by electronic reporting systems and robust governance structures to oversee, scrutinise and gain assurance on identified risks within the parameters of the risk appetite that has been reviewed and agreed by the Trust Board.

Staff are trained or equipped to manage risk in a way appropriate to their authority and duties. This is provided through the training strategy and further supported through specialty risk surgeries.

The risk and control framework

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 identification of risk

It is every employee's responsibility to identify and escalate risks. Staff will be supported by training, locally based to the appropriate level of autonomy. Risk assessments are a key feature of all normal management processes. All divisions, departments and specialties must have an on-going programme of proactive risk assessments.

Incident reporting

Incident reporting provides an important prompt for risk assessment. Incidents and near misses are reported through DATIX in accordance with Trust policies and procedures.

Incidents are recorded on DATIX and the recorded incident report information provides data for analysis to the safety and risk committee and incident review group, dashboards and services teams as required. This includes information governance incidents and risks.

The assessment of risk

Key leaders and managers are able to fully assess and analyse a wide range of risks and recommend the priorities for action. Outcomes and actions arising within divisions from risk assessments will be reported through the divisional governance structure and supported through divisional risk surgeries.

The Trust has set its risk appetite and scores risks according to the likelihood and consequence with a maximum continued score of 25. Risks scoring 15 in addition to those risks that have a Trust-wide impact are managed and assured through the safety and risk committee. Those risks scoring above 8 but less than 15 are managed at divisonal level and the divisions supported to manage these through risk surgeries. Risks of less than 8 are tolerated.

The Control of Risk

The responsibility for implementing control measures devolved to divisions/specialties, with appropriate support of the Risk Lead, and those which have Trust-wide implications and require a corporate response will be referred to the safety and risk committee for assurance.

Risk appetite

The Trust risk appetite was reviewed and confirmed by the Trust Board in November 2018 where the levels were agreed upon as detailed above.

Risk management policy

The key objectives of the Risk Management Policy include:

- Defined clear lines of accountability and responsibility
- A systematic approach to the identification, assessment and prioritisation of risks
- Effective system for controlling and reducing risks
- A robust reporting and monitoring system for identified risks
- Risk management training for staff identified as having a key role in risk management

Quality governance

Quality governance arrangements are assessed through the governance framework, which sits alongside the performance assurance framework. The governance framework ensures the Trust Board receives assurance from the governance committee who are responsible for ensuring that governance is embedded in the organisation, the Trust operates within the law, complies with its regulators and delivers safe, quality and effective care. It will provide assurance to the Trust Board that the Trust has effective systems of internal control in relation to risk management and governance.

Five committees report to the governance committee:

- Integrated safeguarding committee
- Clinical effectiveness committee
- Workforce governance committee
- Safety and risk committee
- Patient experience committee

A range of specific groups report into these committees, reporting key issues upwards to provide the assurance that risks and issues are managed and mitigated.

As part of the governance review this reporting tool has been suspended to enable the review of all Trust risks to be complete.

The Trust underwent a Care Quality Commission Well-Led assessment in October 2017 and is due to undergo a further inspection in quarter 1 or 2 of 2019/20. The principles of Well-Led are measured and included in the Care Quality Commission Self Assessments undertaken Trust-wide.

Principal risks

The principal risks are monitored via the safety and risk committee. As part of the governance review the committee is reviewing all trust risks and scoring in order to clearly inform the corporate risk register and ensure that the Board assurance framework is fit for purpose. The current reporting under review is based on the key principles risks which are:

- PR1 – Financial Planning and Management
- PR2 – Strategic and Business Planning
- PR3 – Workforce Numbers
- PR4 – Workforce Skills
- PR5 – Procedural Management
- PR6 – Equipment and Facilities Arrangements
- PR7 – Clinical Records Management
- PR8 – Leadership and Management
- PR9 – Unsafe Behaviour
- PR10 – External Demands
- PR11 – Partnership Arrangements
- PR12 – Communications

Effectiveness of governance structures

As part of the Collaborative Agreement between NDHT and the RD&E, we identified a programme of governance development that aligns the RD&E and NDHT systems to facilitate further joint working and sharing of posts between the two organisations. The effectiveness of the governance structure will be measured continually, with a set reporting structure through sub-groups and committees and a planned internal audit review which will be presented to the Trust Board.

Reporting lines and accountabilities between the board, its sub-committee and the executive team

The responsibilities of each committee within the governance structure are clearly defined within their terms of reference which include the purpose, duties and responsibilities and defined membership. All of the Trust Board members have defined portfolios identifying their individual responsibilities.

Reporting lines and accountabilities from the sub-groups through to Board are clearly defined and visualised within the Trust structures through the terms of reference and each reporting structure and work plan.

Compliance with the Care Quality Commission licence and regulations is assessed regularly. Recent CQC inspections are detailed below.

- 2015 – Inspection of Urgent and Emergency Services, Maternity and Gynaecology, End of Life Care and Community End of Life Care
- 2017 – Urgent and Emergency Care, Maternity, End of Life Care and Outpatients
- 2018 – Re-inspection of Urgent and Emergency Care, Maternity, End of Life Care and Outpatients

After each inspection an action plan has been developed to ensure each recommendation is actioned to return to compliance. The Trust is currently working to a Trust-wide quality improvement plan to ensure all recommendations are met and are sustainable and improved.

The Trust Board has detailed oversight of the overall performance of all services. A full Integrated Performance Report is presented to each Trust Board meeting with dedicated operational meetings reviewing any areas requiring monitoring or improvements.

All CIPs have a Quality Impact Assessment undertaken which is reviewed by the clinical Executives.

Incident reporting is encouraged at all staff levels and the Trust has been a consistently high reporter for many years. The Trust uses the DATIX system and this is available to all staff.

Compliance with CQC Registration Requirements

The last Care Quality Commission Inspection visit was October 2017 when four core services were inspected, these were:

- Urgent and emergency care
- Maternity
- End of life care and
- Outpatients.

For the questions ‘are services safe, effective, responsive and well-led?’ the outcome was ‘requires improvement’. For the question ‘are services caring?’ the outcome was ‘good’. This provided an overall rating of ‘requires improvement’ for the Trust. The Trust was served with a Section 29A Warning Notice for improvement in the four core services, actions were taken and evidence of this was submitted to the CQC within the timescales. The Trust was re-inspected in July 2018 focused solely on the improvements required as detailed within the warning notice. There was evidence of improvements made in many areas and some embedding of new processes required and the Trust remained rated requires improvement. The Trust provided the CQC with an overall Quality Improvement Plan to ensure all the actions implemented provide the improvements required and were sustainable overall. The Trust has now reverted to normal CQC reporting.

The Trust is using the services of internal audit to provide assurance on our internal response to the CQC recommentations. This has taken the form of a review of evidence obtained from the action owner for each Warning Notice action. Internal audit were satisfied that the actions had been adequately addressed by the Trust where reported as completed.

Workforce strategies and staffing systems

The Trust has systems and processes in place to assess whether there are sufficient suitably qualified competent staff to meet the treatment needs of our patients safely and effectively. The Trust benchmarks staffing and effectiveness against the model hospital data with both staffing establishments and safe staffing data being reviewed and monitored by the Trust and the Board in the integrated performance report on a monthly basis.

The demand and capacity planning undertaken to inform the Trust operational plan identifies the broad workforce priorities and involves full clinical engagement with robust exploration of assumptions and appropriate challenge.

The Trust needs however to improve its longer term workforce planning approach and is currently identifying its preferred model to support this work.

The review of the People Strategy will see the development of a comprehensive implementation plan to address the workforce challenges for the future but there are a number of systems in place that support the Trust now in ensuring the appropriate utilisation of its current workforce.

The Trust has 89% of all staff on an electronic rota and has been assessed independently as having effective rotas, utilising a full suite of rostering tools to support the deployment of staff at the right place and time. It continues to improve its ability to optimise staff utilisation with the addition of electronic job planning for medics; this is linked to both establishment and financial systems.

The Salford Safer Care Nursing tool is used to undertake a census three times a day to assess the acuity and care hours per patient per day and this data is reviewed by the senior nursing team to inform their decision-making on staffing. The staffing tactical meetings which also happen daily are supported further by an additional assessment in the afternoon to plan nightime staffing levels.

The daily staffing plans are further supported by a six-monthly skill mix review which is presented to the Trust Board. The skill mix reviews use the relevant tools as set out by the National Quality Board in 2016 and also detail clinical judgement, triangulated with safety metrics and patient outcomes to support safe and effective skill mix.

Where service changes are identified, such as a reduction of beds due to staffing shortfalls, for example in community hospital settings, they are always supported by a quality impact assessment.

The Patient Safety Operational Group also use metrics including staffing and safety measures to assess the effectiveness and safety of care with a deep dive being undertaken in to the staffing-related incidents reported in the last 12 months.

Recruitment and retention remain a priority for the Trust with a working group established to develop and monitor the implementation of a retention plan. Turnover has seen a significant improvement in year and there continues to be a focus across the organisation on recruiting to gaps and minimising agency usage.

The Trust has been supported by NHS Improvement with a review of its temporary staffing systems and processes with agency usage being managed and monitored robustly against establishment through an electronic system. This is also reported to the Board on a monthly basis through the Integrated Performance Report.

The Trust believes the above is in line with the 'Developing Workforce Safeguards' recommendations on using evidence based tools, professional judgement and outcomes to ensure safe staffing processes exist and are in line with the National Quality Board guidance.

Register of Interests

The Trust requires all staff to make an annual declaration of interests in line with the "Managing Conflicts of Interests in the NHS" guidance introduced in 2017. In addition, staff are asked to submit updates during the course of the year should there be a change or addition to their declaration. Work is in progress to publish an up-to-date register of interests for decision-making staff for 2018/19 which will be published on the Trust's public website and updated as declarations are received during the course of the year.

The Trust publishes on its public website a full Register of Interests declaration for all Trust Board members quarterly and regular 'live' updates when new interests are declared or there are changes to existing interests.

NHS Pension Scheme

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the scheme regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments into the scheme are in accordance with the scheme rules, and that member pension scheme records are accurately updated in accordance with the timescales detailed in the Regulations.

Equality, diversity and human rights

Control measures are in place to ensure that all the organisation's obligations under equality, diversity and human rights legislation are complied with.

All policies and procedural documents have an equality impact assessment which must be completed to assess impact against the protected characteristics.

The Trust has an Equality and Diversity Strategy and Equal Opportunities Policy which covers patients and staff.

Sustainable development management plan

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The Trust ensures that its obligations under the Climate Change Act and Adaption Reporting requirements are complied with. Full details of the management plan are included on page 41 of the annual report.

Review of economy, efficiency and effectiveness of the use of resources

The financial environment that Northern Devon Healthcare NHS Trust is operating in continues to be challenging. Whilst the Trust delivered a surplus position during the 2017/18 financial year, this was through non-sustainable measures, including a level of additional income from the Devon STP to cover additional costs incurred.

Moving into 2018/19, the underlying financial deficit was exposed as part of the planning round, recognising the significant financial pressures the organisation is facing in order to stabilise deteriorating operational performance. A plan for a £12m deficit was scrutinised by the Trust Board and accepted resulting in a rejection of the breakeven control total (before sustainability funding) set by NHS Improvement.

During the year patient demand has continued to grow and containing the financial pressure within planned resource became untenable without impacting on the delivery of safe services to our patients. The Board therefore made some key decisions to invest in areas of patient care to support the delivery of this activity whilst understanding the financial consequences. This led to a reforecasting of the financial position at the end of quarter one with a revised deficit of £17m. The Trust has delivered this revised deficit position.

As a consequence of the financial deficit the Trust has required financial support in the way of a working capital loan from the Department of Health to support the cash position.

A key driver of the financial position continues to be our workforce challenges with a number of substantive medical vacancies being filled through bank and agency appointments to ensure our services are operating at safe staffing levels. This is an invaluable staffing resource to the Trust, but the flexible ad hoc nature comes with a financial premium attached. A recent review of our agency processes through NHS Improvement has confirmed we have sound control of agency usage but work will continue to seek more sustainable workforce solutions.

The Board along with its supporting committee structure, particularly finance committee and audit and assurance committee, has played a vital role in assuring the overall financial position during this time of financial challenge. The Board has a clear responsibility to test the deficit position and any movement from plan to ensure that decisions made provide the best value and are linked to a need to safeguard against worsening clinical outcomes for our population. The Board need to manage the balance between the financial position, operational performance and quality of services delivered.

Detailed briefings have been provided directly to the Board and also to the finance committee on the emerging financial position, ensuring all risks identified were reported to the Board in a clear, concise and timely manner. The non-executive Board members have been key in testing the validity of assumptions and deliverability of mitigating actions to provide assurance on the accuracy of the financial reporting.

An element of assurance provided to the Board is the rigidity of the financial control processes. A review has been undertaken in year of key controls in place to manage cost growth within the organisation. This includes:

- Revisiting the role of the vacancy panel
- Budget setting and budget management processes
- Divisional performance meetings and accountability
- The use of the operational board for decision making
- The business case process
- Demand and capacity planning and planning process for 2019/20
- Monitoring of cost improvement plans

Assurance on the Trust's financial control environment is provided through the internal audit plan which includes sections on financial assurance and managing resources effectively; the findings of all audits are reported to the audit and assurance committee.

There is also scrutiny as to the economy, efficiency and effectiveness of the use of resources as part of the external audit plan.

A key priority for the Trust moving forward is on clinical and financial sustainability and the financial recovery plan needed to more the Trust towards a breakeven position whilst providing the level of service required for our population. The key drivers of the deficit are being understood so that the recovery plan focuses on those areas of cost that we are able to control whilst recognising the pressures facing a remote organisation such as Northern Devon Healthcare NHS Trust.

Single Oversight Framework

NHS Improvement's Single Oversight Framework provides the framework for overseeing providers and identifying potential support needs.

The framework looks at five themes:

- Quality of care
- Finance and use of resources
- Operational performance
- Strategic change
- Leadership and improvement capability (well-led)

Based on information from these themes, providers are segmented from 1 to 4, where 3 reflects providers receiving the most support, and 1 reflects providers with maximum autonomy.

Northern Devon Healthcare NHS Trust has been placed in segment 2 based on support needs identified in quality of care, finance and use of resources and operational performance. This support is being provided through the collaborative agreement with the Royal Devon and Exeter NHS Foundation Trust.

This segmentation information is the Trust's position in March 2019. Current segmentation information for NHS trusts is published on the NHS Improvement website.

Finance and use of resources

The finance and use of resources theme is based on the scoring of five measures from 1 to 4, where 1 reflects the strongest performance. These scores are then weighted to give an overall score.

Given that finance and use of resources is only one of the five themes feeding into the Single Oversight Framework, the segmentation of the Trust disclosed above might not be the same as the overall finance score here. The scores below are reflective of the deficit position the Trust is in for 2018/19 which is above planned deficit. In addition, the reliance on agency workforce is above the agency cap set by the regulator as a percentage of total staff pay. The cap is calculated based on the historic level of agency spend in the 2016/17 financial year.

Area	Metric	2018/19 score
Financial sustainability	Capital service capacity	4
	Liquidity	4
Financial efficiency	I&E margin	4
Financial controls	Distance from financial plan	4
	Agency spend	4
Overall scoring		**4**

Information governance

There were no serious incidents relating to information governance at Level 2 or which required reporting to the Information Commissioner's Office during 2018-19.

Annual quality account

The directors are required under the Health Act 2009 and the National Health Service (Quality Accounts) Regulations 2010 (as amended) to prepare Quality Accounts for each financial year.

The Trust prepares, submits and publishes quality accounts annually in line with the above regulation. The requirements of the quality account are submitted from the relevant services with current data. The projects for improvement for the forthcoming year are agreed through key data metrics with oversight from the safety and risk committee and approved at Trust Board. It is important to the Trust that the account is co-designed.

Review of effectiveness

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

The governance development programme undertaken in year has enabled me to ensure that the right governance structure is in place and working supported through a strong culture of governance. Whilst this is a period of change I am assured that the right mechanisms are being embedded to ensure governance flows through all levels of the organisation. The Board assurance framework has been suspended during this review period to enable the review of all Trust risks to be complete. During this suspension assurance is provided through the risk and safety committee through to the governance committee of which the board have sight.

In addition to this my view of the effectiveness of systems of control is informed by:

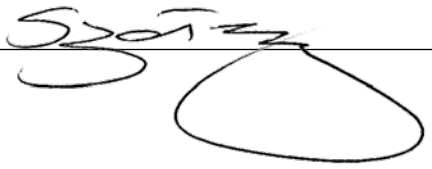
- A view of the overall position with regard to internal control by the Board of Directors through its routine reporting processes and its work on corporate risk
- Receipt of Internal and External Audit reports to the Audit Committee
- Personal input into the controls and risk management processes from all executive directors, senior managers and clinicians
- The annual head of internal audit opinion which states that satisfactory assurance can be given, that there is a sound system of internal control and that controls are generally being applied, recognising that the Board assurance framework will be re-launched following the completion of the governance development programme
- Safe Staffing reviews
- Assessments by external agencies.
- Care Quality Commission 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 activities of the Trust Board, its sub-committees and the Trust management.

Conclusion

I am satisfied that effective systems of internal control are in place and that the culture of risk management is a key focus at Northern Devon Healthcare NHS Trust. There are no significant internal control issues which have been identified during the course of the year or in relation to this annual governance statement.

Signed _____
Chief Executive



Date: 23 May 2019

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 2019

Roles and responsibilities of the organisation

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

The Annual Governance Statement is an annual statement by the accountable officer, on behalf of the Trust Board, setting out:

- How the individual responsibilities of the accountable officer are discharged with regards 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 committee structure, the structure and use of the board assurance framework (BAF), as assessment of the Trust Board's effectiveness and its compliance with the corporate governance code.
- How risk is assessed and managed including a description of the risk management and review processes.
- The conduct and results of the review of the effectiveness of the system of internal control including any disclosures of significant control deficiencies together with assurances that actions are or will be taken where appropriate to address issues arising.

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

Roles and responsibilities of internal audit

In conformance with the internal audit charter, public sector internal audit standards and the core principles for the professional practice of internal auditing, the head of internal audit 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).

The purpose of the head of internal audit opinion

The purpose of my annual opinion is to contribute to the assurances available to the accountable officer and the Trust Board which underpin the organisation's own assessment of the effectiveness of the organisation's system of internal control. This opinion will in turn assist the Trust Board in the completion of its annual governance statement. The opinion does not imply that internal audit has reviewed all risks and assurances relating to the organisation.

The opinion is substantially derived from our risk-based plan generated from an organisation-led assurance framework that takes into consideration the strategies, objectives and risks of the organisation, the expectations of senior management, the Trust Board and other stakeholders, that has been agreed by management and approved by the audit and assurance committee. The opinion also provides an appropriate context and oversight of the organisation. This approach provides a reasonable level of assurance, subject to the inherent limitations described in the opinion.

As such, it is one component that the Trust Board takes into account in making its annual governance statement.

The head of internal audit opinion for Northern Devon Healthcare NHS Trust set out below is based upon the assessment of our work carried out for 2018/19

Overall opinion

Context of opinion

This opinion is provided by internal audit, externally assessed as compliant with public sector internal audit standards.

The Trust was rated as "requires improvement" following the October 2017 CQC inspection with concerns raised around "safe", "effective", "responsive" and "well-led". The Trust has responded positively to make the required improvements and reported that the CQC has returned it to a "normal inspection regime".

The Trust has been working in partnership with the Royal Devon and Exeter NHS Foundation Trust (RD&E) as part of a collaborative agreement since June 2018 in order to sustain clinical services in northern Devon and to provide leadership and management support. As part of that agreement, the Trust has been reviewing and developing its governance arrangements. The Trust's risk management strategy and processes have been reviewed and modelled after the RD&Es own arrangements. Following further consideration of the Trust's strategic objectives and risks, the Trust is looking to agree a new BAF in June 2019. During 2019/20 the Trust will focus on embedding the new arrangements.

NHS Improvement have removed the Trust from "challenged provider" status.

The capacity at board and senior management level to provide robust sustainable governance arrangements so the Trust can appropriately respond to strategic, operational and emerging governance needs has been strengthened through the partnership with the RD&E and is looking to be strengthened further in 2019/20.

The Trust set an initial financial plan for a deficit of £11.9m. During the year, recognising that patient demand was continuing to grow and the impact on delivery of patient care, the Trust re-forecasted its financial position at the end of quarter one of 2018/19 to a revised deficit of £17m. The year-end deficit was £16.6m (£0.1m favourable) and the Trust delivered £6.5m of its £8m CIP savings target. The Trust has reviewed its CIP arrangements to ensure that they are strengthened for 2019/20.

A key priority for the Trust moving forward is clinical and financial sustainability.

The Trust has acknowledged the areas of weakness identified from internal audit reviews undertaken during the year and is looking to monitor improvements through its performance assurance framework.

The **basis** for forming my opinion, taking into consideration the context and oversight of the organisation set out above, 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 the internal audit risk-based plan that have been reported throughout the year. This assessment has taken account of the relative scope and materiality of these areas and management's progress in respect of addressing control weaknesses; and

3. Any reliance that is being placed upon third party assurances.

My **overall opinion based on our work** is that:

Satisfactory assurance can be given that there is a generally sound system of internal control, designed to meet the organisation's objectives, and controls are generally being applied consistently, **except for the presence of an agreed, regularly reviewed board assurance framework for the year**. Weaknesses in the design and/or inconsistent application of controls in some key areas put the achievement of particular objectives at risk.

The assurances provided from the work undertaken, which together support this opinion, are set out below.

Assurance framework – corporate governance and risk management

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

Audit	Assurance rating
CQC mock review (surgical inpatients – KGV Ward)	Significant
CQC action plan (2017/18)	Satisfactory
Care Quality Commission (CQC) actions	Satisfactory
Freedom to Speak Up	Satisfactory
Closed actions (internal audit recommendations/SIRI actions)	Limited
Duty of candour (follow-up review)	Limited

Risk management/Board assurance framework arrangements

In consideration of the Trust reviewing and developing its governance and risk management arrangements during 2018/19, we did not undertake a full assurance review of these arrangements. Our desk-top review has concluded that the Trust has made significant progress in improving its governance arrangements and is working in partnership with the RD&E, to an agreed plan of action. This will be strengthened when the new BAF is developed, agreed and becomes embedded within the Trust.

With guidance from the RD&E, the Trust has completely revised its governance structure, incident and risk policy and provided training to the governance support team and senior staff regarding the new arrangements. A formal timeline for undertaking the entire governance development review has been established, against which the Trust is on target to complete. All Trust risks are being reviewed, the Trust's risk appetite has been agreed and a new corporate risk register has been established.

The Trust has requested an early assurance review of the Trust's enhanced governance and risk management arrangements in 2019/20.

Closed actions – internal audit recommendations/ SIRI actions – October 2018

The Trust did not have sufficiently robust systems in place to ensure that actions put in place to address risks are completed and embedded in the Trust on a consistent basis.

The Trust's process for closing all actions (iInternal audit and SIRI) has since been revised as part of the wider review of governance. We understand that all risk are reviewed with specialties on a bi-monthly basis at risk surgeries and all closed actions are required to be evidenced within Datix. Closed actions are to be monitored by either the incident review group, or the relevant sub-committee.

Duty of candour (follow-up review) – November 2018

Overall, there was not sufficient improvement in regards to compliance with duty of candour (DoC) national standards and the Trust policy following our previous DoC review. The Trust could not demonstrate that DoC documentation is completed and consistently maintained and reporting on its compliance needed to be strengthened.

The Trust has responded positively to our findings, advising that all actions have been completed in line within our suggested improvement plan and that it plans to start the process of auditing patient records for compliance with DoC in April 2019.

Financial assurance

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

Audit	Assurance rating
High level financial controls	Significant (creditors, cash and bank, charitable funds)
Satisfactory (debtors)	Satisfactory
Budgetary control	Significant
Capital accounting	Significant
Payroll	Significant

Third party assurances

ISAE 3000 third party assurance report in respect of IT general controls in respect of the electronic staff record (ESR)

In common with all NHS bodies, the Trust utilises the electronic staff record (ESR) for its HR and payroll functions. An established routine is in place whereby third party assurance is provided annually within an Independent service auditor's ISAE 3000 third party assurance report, which helps to inform the Trust's annual governance statement on internal control. This covers the IT general controls operated by IBM UK in relation to the ESR. Additionally there are certain controls related to the NHS general ledger interface, which are the responsibility of the NHS Systems Integration Team.

The 2018/19 independent service auditor's report provided by PricewaterhouseCoopers, dated 9 May 2019, provides reasonable assurance in respect of the IT general controls in relation to the national electronic staff record and the NHS general ledger interface.

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

- Change management;
- Logical security;
- Problem management and performance and capacity planning;
- Physical security and environmental controls;
- Computer operations; and
- Payslip distribution.

The key messages in the overall audit opinion of the report of the independent service auditor are as follows:

- The controls described in the report were suitably designed to provide reasonable assurance that the related control objectives would be achieved if the described controls operated effectively throughout the period from 1 April 2018 to 31 March 2019 and customers applied the complementary customer controls contemplated in the design of NHS ESR Programme;
- The controls tested, which were those necessary to provide reasonable assurance that the related control objectives were achieved, operated effectively throughout the period from 1 April 2018 to 31 March 2019.

No exceptions were noted during testing.

Corporate assurance

The table below details the work completed by internal audit on the Trust's corporate systems that have been considered as part of this opinion.

Although our work provided areas of limited assurance, the Trust has responded positively to our findings and is in the process of taking appropriate action to mitigate the risks we identified. Areas of limited assurance are planned to be re-visited as part of the strategic audit and assurance plan 2019/20 – 2021/22.

Audit	Assurance rating
Email and internet use (2017/18)	Limited (email)
Satisfactory (Internet)	Satisfactory
Smartcare programme governance (2017/18)	Satisfactory
Clinical audit	Satisfactory
Cyber security	Satisfactory
End of life	Limited
Clinical waste management	Limited

Email use and storage – October 2018

The Trust's policies and guidance relating to email use around retention and storage of emails/attachments, required strengthening.

Since our review we understand that the Trust has revised its Acceptable Internet and Email Use policy to take account of our suggested enhancements, data retention has become part of a Trust-wide driver, rather than being led by NHS Digital, and a records archive group has recently been set up, providing a taskforce supporting changing paper healthcare records to digital information asset. The Trust recognises that it will need to improve its information/ data retention strategy and supporting processes across all services.

Clinical waste management – November 2018

The Trust has a statutory duty to keep its clinical waste secure and appropriately segregated, but was not consistently applying these requirements. Considerable effort had been devoted to educating clinical staff regarding waste management and the importance of segregating waste, including the use of an external waste consultancy to carry out training and inspections, and a task and finish group has been set up to address Trust-wide issues. The Trust is reducing the number of waste types, to simplify the process and we understand it has taken a number of further actions with executive support in improving engagement from operational staff to enforce and comply with existing requirements.

End of life – May 2019

The Trust has responded to a recent CQC report by implementing new documentation to demonstrate that it meets the five priorities of care for the end of life processes. We were unable to provide good assurance that the new documentation was being consistently applied. If end of life training is made mandatory, clinicians should become more comfortable in recognising when a patient is nearing their end of life, recording this appropriately in the priorities of care record and in improving the last weeks/days of a patient's life.

Follow-up of recommendations

In respect of the reviews and other audits undertaken during the year, recommendations have been agreed with management to address gaps in control and assurance. The Trust monitors the status of the recommendations and implemented new reporting arrangements in year to strengthen the focus in this area. Internal audit reports to the audit and assurance committee on those recommendations which are outstanding on an ongoing basis. No significant matters have been brought to the organisation's attention in respect of these areas.

Jenny McCall
Director of Audit and Assurance Services
ASW Assurance


NHS
NHS

Remuneration report

As an NHS trust, we are required to follow the relevant national frameworks when remunerating staff, including NHS Agenda for Change for the majority of our workforce, and the Pay and Conditions Circular for medical and dental staff.

We have a remuneration and terms of service committee which determines the remuneration and conditions of service of the chief executive, executive directors, other directors who report to the chief executive and any staff not on the national terms and conditions of service. This committee is a sub-committee of the Trust Board and has delegated powers. Membership comprises the Trust Board chairman and non-executive directors, with the chief executive and interim director of people in attendance, except where their own pay award is being discussed.

The committee ensures the organisation complies with current statutory and NHS requirements, including any guidance issued by NHS Improvement on pay for very senior managers. The committee is vigilant to ensure that its decision-making is consistent when determining remuneration for NHS executive and director posts. Committee members ensure value for money and that they meet their statutory obligation to ensure decisions on remuneration match the economic climate.

Non-executive Board members are appointed by NHS Improvement in accordance with the Cabinet Office's Governance Code on Public Appointments. They receive remuneration in line with national rated set by the Secretary of State for Health and Social Care.

Introduction

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

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

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

Signed _____
Chief Executive

Date: 23 May 2019

A) Remuneration

2018/19

Name and title	(a) Salary (bands of £5,000) attributable to NDHT	Total Salary (bands of £5,000)	(b) Expense payments (taxable) total to nearest £100	(c) Performance pay and bonuses (bands of £5,000)	(d) Long term performance pay and bonuses (bands of £5,000)	(e) All pension-related benefits (bands of £2,500) attributable to NHDT	(f) TOTAL attributable to NDHT
A Hibbard – director of finance and performance	125-130	125-130	0			90-92.5	210-215
G Thomson – medical director (3)	295-300	295-300	0			32.5-35	330-335
D Allcorn – chief nurse	120-125	120-125	500			30-32.5	150-155
I Roy – director of facilities	90-95	90-95	300			7.5-10	100-105
A Ibbs – executive director of strategic development	125-130	125-130	200			65-67.5	195-200
J Nash – director of IM&T (6)	75-80	75-80	0			12.5-15	90-95
Roger French – chair (7)	15-20	15-20	200				15-20
Tim Douglas-Riley	5-10	5-10	400				5-10
Pauline Geen	5-10	5-10	300				5-10
Robert Down	5-10	5-10	100				5-10
Tony Neal	5-10	5-10	200				5-10
Judy Jones (9)	5-10	5-10	200				5-10
Mike Tucker (10)	5-10	5-10	100				5-10
Collaberative aAgreement – salary bands							
P Adey – chief operating officer (2)	50-55	135-140				32.5-35	85-90
J Cooper – director of people (5)	50-55	115-120				–	50-55
A Harris – interim medical director (4)	75-80	200-205				50-52.5	125-130
S Tracey – chief executive (1)	90-95	235-240				17.5-20	105-110
James Brent – chair (8)	15-20	45-50				–	15-20

(1) The chief executive commenced on 18 June 2018 as a joint appointment with the Royal Devon and Exeter NHS Foundation Trust.
(2) The chief operating officer commenced on 13 August 2018 as a joint appointment with the Royal Devon and Exeter NHS Foundation Trust.
(3a) The medical director left on 14 December 2018; the salary of the previous medical director includes a contractual payment in lieu of notice within the term of employment contract as included in tables shown on page 67.
(3b) The medical director's pay includes payments for services as a medical consultant as well as director duties.
(4) The interim medical director commenced on 2 July 2018 as a joint appointment with the Royal Devon and Exeter NHS Foundation Trustl.
(5) The interim director of people commenced on 27 August 2018 as a joint appointment with the Royal Devon and Exeter NHS Foundation Trust.
(6) The director of IM&T left on 3 August 2018.
(7) The chair left on 30 June 2018.
(8) The chair commenced on 2 July 2018 as a joint appointment with the Royal Devon and Exeter NHS Foundation Trust.
(9) The non-executive director left on 29 June 2018.
(10) The non-executive director commenced on 1 July 2018 and left 10 January 2019.
(11) The director acted up as chief executive until 18 June 2018.

B) Pension benefits

	2018-19								2017-18							
Name and title	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2019	Lump sum at age 60 related to accrued pension at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2019	Cash Equivalent Transfer Value at 31 March 2018	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension	Real increase in pension at age 60	Real increase in pension lump sum at age 60	Total accrued pension at age 60 at 31 March 2017	Lump sum at age 60 related to accrued pension at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2017	Cash Equivalent Transfer Value at 31 March 2016	Real Increase in Cash Equivalent Transfer Value	Employers Contribution to Stakeholder Pension
	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100	(bands of £2500) £000	(bands of £2500) £000	(bands of £5000) £000	(bands of £5000) £000	£000	£000	£000	To nearest £100
A Hibbard – director of finance	5-7.5	7.5-10	20-25	40-45	326	213	84									
Dr G Thomson – medical director	2.5-5	0.00	80-85	200-205	1,666	1,415	127	0	2.5-5	0-2.5	75-80	200-205	1,415	1,273	101	0
I Roy – director of facilities	0-2.5	2.5-5	45-50	135-40	1,080	937	98	0	0-2.5	2.5-5	40-45	125-130	937	855	57	0
D Allcorn – acting associate director of organisational development	0-2.5	0-2.5	35-40	90-95	638	514	90	0	5-7.5	12.5-15	35-40	85-90	514	391	104	0
A Ibbs – director of operations and strategy	2.5-5	2.5-5	45-50	115-120	964	780	142	0	7.5-10	7.5-20	40-45	110-115	780	590	168	0
J Nash – director of IM&T	5-7.5	0-2.5	5-10	15-20	259	182	21	0	0-2.5	0-2.5	5-10	10-15	182	154	15	0
P Adey – chief operating officer	5-7.5	5-7.5	55-60	140-145	1,136	914	194	0								
J Cooper – executive director of people	-	-	-	-	-	-	-	0								
A Harris – executive medical director	5-7.5	20-22.5	65-70	195-200	1,513	1,194	284	0								
S Tracey – chief executive	2.5-5	0-2.5	45-50	95-100	821	669	131	0								

Notes:

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

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

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

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

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

(6) The chief executive took retirement at the end of the year and therefore no CETV is available.

(7) The director of nursing left on 18 April 2017 and no pension data is available for the year.

C) Fair pay multiples

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

The banded remuneration of the highest paid director in Northern Devon Healthcare NHS Trust in the financial year 2018/19 was £125,000-130,000 (2017/18 was £170,000 – £175,000). This was 4.5 (2017/18 6.49) times the median remuneration of the workforce which was £28,900 (2017/18, £26,565).

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

In 2018/19 55 (2017/18 0) employees received remuneration in excess of the highest paid director. Remuneration ranged from £15,000 – £248,000 (2017/18 £15,000 – £246,000).

D) Non-executive directors

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

Name	Appointment start date	Appointment end date
James Brent (chair)	Under collaberative agreement	
Roger French (chair)	01.02.11	30.06.18
Pauline Geen^ (NED)	03.03.11	02.03.21
Tim Douglas-Riley (NED)	28.05.13	27.05.21
Robert Down (NED)	09.02.15	08.02.21
Tony Neal* (NED)	05.01.16	04.01.20
Judy Jones (NED)	06.09.17	29.06.18
Mike Tucker (NED)	01.07.18	10.01.19

^ Audit committee interim chair
* Audit committee member

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

E) Executive directors

Name	Position	Contract type	Start date	Employment status
Angela Hibbard	Director of finance	Permanent	19.03.18	
George Thomson	Medical director	Permanent	03.11.14	Left 14.12.18
Iain Roy	Director of facilities	Permanent	19.04.99	
Darryn Allcorn	Chief nurse	Permanent	11.02.15	
Andy Ibbs	Director of operations and strategy	Permanent	01.10.12	
Jenny Nash	Director of IM&T	Permanent	01.10.12	Left 03.08.18
Suzanne Tracey	Chief executive	Under collaborative agreement	18.06.18	
Peter Adey	Chief operating officer	Under collaborative agreement	13.08.18	
Prof Adrian Harris	Medical director	Under collaborative agreement	29.06.18	
Julie Cooper	Interim director of people	Under collaborative agreement	27.08.18	

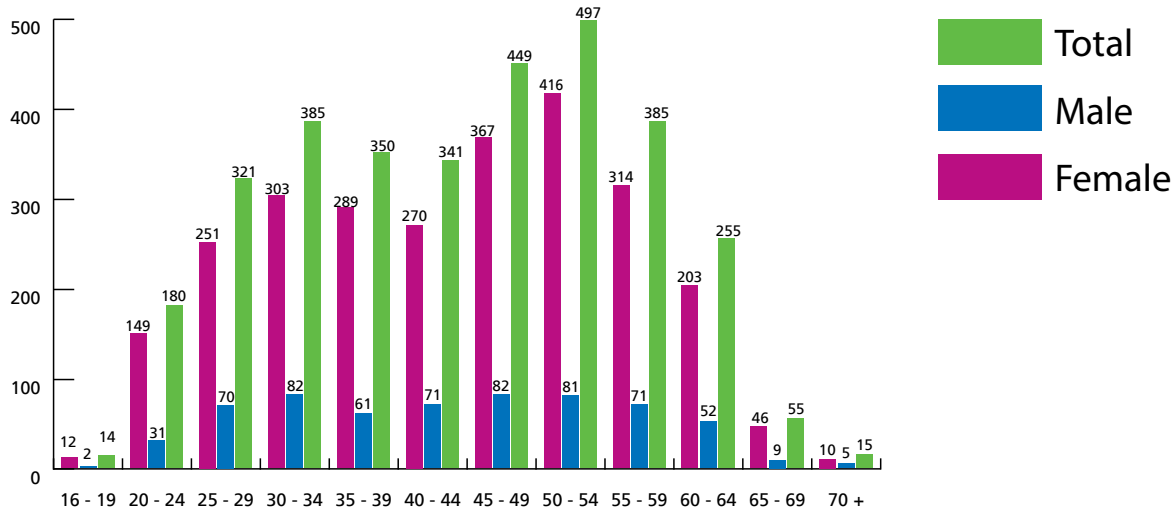
Staff report

Our workforce

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

At the end of 2018/19, Northern Devon Healthcare NHS Trust employed XX staff.

Workforce by gender and age



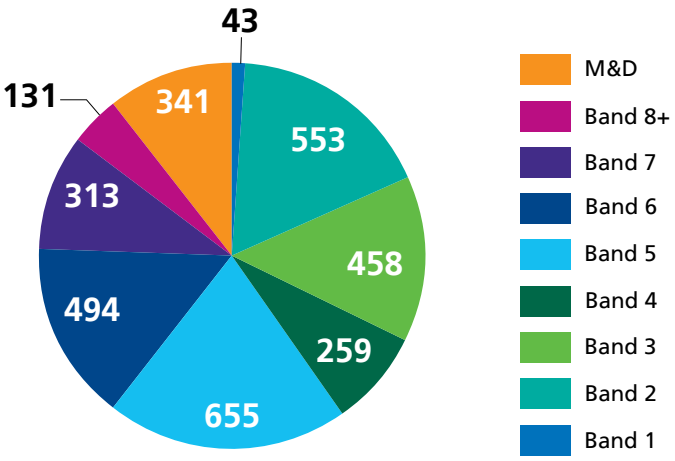
Similar to the NHS population as a whole, although significantly different to the general population (2001 census identified 48% of working age population as female) the gender split of our current workforce is 81% female and 19% male.

In comparison to the rest of the NHS workforce, NDHT employs lower numbers of staff within age bands 25-29, 30-34 and 35-39 and 40-44 and in contrast we employ higher numbers of staff within the 45-49, 50-54, 55-59, 60-64 and 65+ age bands. This distribution is reflective of the age profile of Devon as a region.

We continue to encourage younger people to join us employing a significant number of young apprentices accounting for a high proportion of our Agenda for Change band 2 post holders being under 20 years old.

Recognising the importance of the ability of staff to balance their work and home demands we offer a variety of flexible working options and the workforce directorate continues to work collaboratively to support all departments at the Trust, offering operational advice and training on deaf/deaf-blind communication awareness, disability equality, equality impact assessment, human rights and learning disability awareness.

Workforce by pay band



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

Staff costs and numbers

Staff costs

	Permanent £000	Other £000	2018/19 Total £000	2017/18 Total £000
Salaries and wages	93,398	2,541	**95,939**	98,847
Social security costs	9,636	0	**9,636**	9,228
Apprenticeship levy	468	0	**468**	413
Employer's contributions to NHS pensions	11,915	0	**11,915**	11,570
Pension cost – other	24	0	**24**	11
Other post employment benefits	49	0	**49**	36
Other employment benefits	0	0	**0**	0
Termination benefits	0	0	**0**	0
Temporary staff	0	15,565	**15,565**	6,054
Total gross staff costs	**115,490**	**18,106**	**133,596**	**126,159**
Recoveries in respect of seconded staff	0	0	**0**	(999)
Total staff costs	**115,490**	**18,106**	**133,596**	**125,160**
Of which				
Costs capitalised as part of assets	601	74	**675**	2,491

Average number of employees (WTE basis)

	Permanent Number	Other Number	2018/19 Total Number	2017/18 Total Number
Medical and dental	289	25	**314**	337
Ambulance staff	9	0	**9**	7
Administration and estates	411	29	**440**	501
Healthcare assistants and other support staff	844	77	**921**	828
Nursing, midwifery and health visiting staff	784	44	**828**	781
Nursing, midwifery and health visiting learners	0	0	**0**	0
Scientific, therapeutic and technical staff	326	10	**336**	332
Healthcare science staff	64	0	**64**	65
Social care staff	0	0	**0**	0
Other	0	0	**0**	0
Total average numbers	**2,727**	**185**	**2,912**	**2,851**
Of which				
Number of employees (WTE) engaged on capital projects	18	0	**18**	519

Reporting of compensation schemes – exit packages 2018/19

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	0	8	**8**
£10,000 – £25,000	0	2	**2**
£25,001 – 50,000	0	2	**2**
£50,001 – £100,000	0	0	**0**
£100,001 – £150,000	0	1	**1**
£150,001 – £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**0**	**13**	**13**
Total cost (£)	0	£265,000	**£265,000**

Reporting of compensation schemes – exit packages 2017/18

	Number of compulsory redundancies Number	Number of other departures agreed Number	Total number of exit packages Number
Exit package cost band (including any special payment element)			
<£10,000	2	0	**2**
£10,000 – £25,000	6	0	**6**
£25,001 – 50,000	0	0	**0**
£50,001 – £100,000	0	0	**0**
£100,001 – £150,000	0	0	**0**
£150,001 – £200,000	0	0	**0**
>£200,000	0	0	**0**
Total number of exit packages by type	**8**	**0**	**8**
Total cost (£)	£136,000	£0	**£136,000**

Exit packages: other (non-compulsory) departure payments

	2018/19		2017/18	
	Payments agreed Number	Total value of agreements £000	Payments agreed Number	Total value of agreements £000
Voluntary redundancies including early retirement contractual costs	0	0	0	0
Mutually agreed resignations (MARS) contractual costs	6	100	0	0
Early retirements in the efficiency of the service contractual costs	0	0	0	0
Contractual payments in lieu of notice	7	165	0	0
Exit payments following Employment Tribunals or court orders	0	0	0	0
Non-contractual payments requiring HMT approval	0	0	0	0
Total	13	265	0	0
Of which				
Non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary	0	0	0	0

All exit packages have been paid in accordance with contractual terms.

Gender pay gap

From 2017, any organisation with 250 or more employees must publish and report specific gender pay gap information under the Equality Act 2010 (specific duties and Public Authorities Regulations).

The gender pay gap is the difference between the average earnings of men and women expressed relative to means earnings and shows;

- The difference between the mean hourly rate of pay for male and female employees
- The difference between the median hourly rate of pay for male and female employees
- The difference between the mean bonus pay for male and female employees
- The difference between the median bonus pay for male and female employees
- The proportions of male and female employees who were paid a bonus
- The proportions of male and female employees on the quartile pay bands (lower, lower middle , upper middle and upper)

The analysis of the NDHT Gender Pay Gap report for 2018 has generally seen improvements in all areas in comparison with the previous year's data.

Gender	Mean hourly pay March 2017	Mean hourly pay March 2018	Median hourly pay March 2017	Median hourly pay March 2018
Male	21.37	21.96	16.81	17.33
Female	14.65	15.12	13.25	13.93
Difference	6.73	6.84	3.56	3.40
Pay gap %	**31.5%**	**31.1%**	**21.2%**	**19.6%**

Our workforce is predominantly female, with almost four times the number of women in our workforce as men, and this means we have by default a high number of women working in the lower paid roles positioning our median pay for women at a lower rate. We continue to work proactively to reduce our gender pay gap.

Proportions of male and female employees in the four quartile pay bands

Quantile	Gender	% 2017	% 2018
Upper	Male	32.7%	**34.4%**
	Female	67.3%	**65.6%**
Upper middle	Male	14.6%	**13.6%**
	Female	85.4%	**86.4%**
Lower middle	Male	14.0%	**12.8%**
	Female	86.0%	**87.2%**
Lower	Male	13.6%	**12.2%**
	Female	86.4%	**87.8%**

The Gender Pay Gap data relating to bonus pay relates to the distribution of Clinical Excellence Awards for consultants. Although female and male representation at consultant level has remained stable from the previous year the lower level of female consultants per se affect these figures.

Bonus paid (annual)

Gender	Mean March 2017	Mean March 2018	Median March 2017	Median March 2018
Male	1053	888	8958	7540
Female	708	618	5972	5026
Difference	3453	2703	2986	2513
Pay Gap %	**32.8%**	**30.4%**	**33.3%**	**33.3%**

No of employees paid bonus

Gender	% 2017	% 2018
Male	7.7%	6.8%
Female	0.7%	0.6%

Sickness absence

Target	Trust		South West 2018/19	NHS average 2018/19
	1053	888		
3%	3.6%	3.3%	4.25%	4.29%

Our sickness absence level has remained relatively static but slightly above our target. The Trust continues to proactively manage and support staff to attend work working jointly with staff side colleagues to promote a healthy working environment.

Disability

The Equality Act 2010 defines disability and makes it clear that a person is disabled if they have a physical or mental impairment that has a substantial and long-term negative effect on their ability to do normal daily activities. The Trust Board has reviewed our approach to inclusion and is taking a variety of actions to support both existing staff and applicants wishing to join the Trust.

The Trust has made a public commitment through the development of the equality and diversity strategy to plan to meet the needs and wishes of staff and local people. This strategy sets out how our Trust recognises the differences between people, and how we aim to make sure that (as far as possible) any gaps and inequalities are identified and addressed. Embedding equality and diversity in everything the Trust does will improve conditions for all staff and, ultimately, their patients.

The director of people is responsible for ensuring that the Trust complies with equality law and any relevant NHS standards for the promotion or and assessment of equality. This reflects the importance placed by the Trust on the proper and equitable treatment of all applicants, workers and service users regardless of disability.

All staff are required to undertake equality and diversity training and as at the end of March 2018/19, the Trust was at 96.5% compliance, raising awareness of personal and Trust responsibilities to those with protected characteristics including disability. Subject specific training is also provided on other relevant issues, for example, learning disability awareness.

NDHT is a signatory of the mindful employer charter. This means that the Trust has signed up to positively supporting employees with mental health problems. We have also signed the time to change employer pledge, a commitment to all staff to change how we think and act about mental health at every level of this organisation.

Recruitment

The recruitment and selection policy is designed to ensure that recruitment is carried out in accordance with the Equality Act 2010. Its aim is to ensure that applicants feel that they have been dealt with professionally, fairly and that they feel that the Trust values its staff.

The Trust is accredited by Jobcentre Plus to use the 'Disability Confident Employer' symbol. This means the Trust will:

- Interview all applicants with a disability who meet the minimum criteria for a position and consider them on their abilities
- Consult with employees with a disability about how the Trust can help develop their abilities

- Make every effort when employees acquire a disability to make sure they stay in employment
- Take action to ensure that all employees develop sufficient awareness of disability to make these commitments work
- Review these commitments and plan on ways to improve them.

All applicants for employment with the Trust complete a health questionnaire that is reviewed by the Occupational Health Service (OHS) as part of the recruitment process. If issues are identified, the individual will be invited to attend the OHS where an assessment is completed and recommendations made so that whenever possible the person may be employed safely. Experts from both the Occupational Health Services and Human Resources are available to provide reasonable to provide reasonable adjustment advice and guidance to managers during and after the recruitment process.

Staff who become disabled

Whenever possible we support staff to either prevent or minimise the impact of any disability on the ability to work. Early referrals to occupational health service are encouraged so that action can be taken to aid rehabilitation and return to work following illness or injury, making any reasonable adjustments that can assist.

The Trust will make reasonable adjustments to support existing staff who become disabled and will these adjustments will be reviewed in response to the changing needs of the individual. These adjustments may apply to a physical feature or working arrangements, which would cause a substantial disadvantage to a disabled person compared to a non-disabled person.

The management of work related stress policy is supported by a library of leaflets, assessment templates and external links to help managers have a positive impact on the health and wellbeing of employees.

Staff survey results

The National NHS Staff Survey 2018 questionnaires were sent to 3021 members of staff, with 1137 questionnaires returned, a response rate of 37.6%.

Our overall Staff Engagement score remains strong in 2018 at 7.29, a 0.05% increase on the 2017 score.

Our top 5 results were:

- Experienced physical violence at work from managers in the last 12 months (0% – the lower the score the better)
- Experienced physical violence at work from other colleagues in the last 12 months (1%)
- Experienced discrimination at work from patients / service users, their relatives or other members of the public in the last 12 months (4%)
- The last time you saw an error, near miss or incident that could have hurt staff or patients / service users did you or a colleague report it? (96% – the higher the score the better)
- If you were concerned about unsafe clinical practice, would you know how to report it? (96% – the higher the score the better)

Satisfaction with pay has increased in 2018 to 40% – a 6.71% improvement, however this still remains low. 58% of staff have said that feedback from patients/service users is used to make informed decisions within their directorate/ department – a 6.46% increase on last year and 65% of staff said they receive regular updates on patient/service user experience feedback in their directorate/department, a 6.63% increase on 2017.

Overall 91% of staff responded positively that the organisation takes positive action on health and wellbeing; however this has declined since last year by 2.53%.

Questions relating to the health and wellbeing of staff are areas that require focus, these include:

- A large increase in the amount of staff putting themselves under pressure to come to work – this has risen to 93% in 2018, compared with 75% in 2017 – an 18.3% rise
- A 5.99% increase in staff feeling pressure from colleagues to come to work
- A 5.38% increase in staff feeling pressure from managers to come to work in 2018
- 41% of staff report feeling unwell due to work related stress in the last 12 months, a 4.63% increase since 2017
- Just over half of staff said they had come to work in the last three months, despite not feeling well enough to perform their duties

86% of staff have been appraised in the last 12 months and 78% of staff said that their appraisal left them feeling like their work is valued by the organisation, a 2% decrease from 2017.

Results concerned with senior management communication remain low and will form of this years action plan:

- 41% of staff saying that communication between senior management and staff is effective (the same as 2017)
- 36% of staff saying senior managers try to involve staff in important decisions (a 2% decrease from 2017)

- 32% of staff saying senior managers act on staff feedback (a 2% decrease from 2017).

Feedback on immediate managers was more positive, with 73% of staff saying their immediate manager can be counted on to help them with a difficult task at work (however this is a 2% decrease on 2017) and 81% of staff saying their immediate manager is supportive in a personal crisis (however this is a 2% decrease on 2017).

Staff health and wellbeing

NDHT recognises that a healthy workforce leads to improved patient experiences, performance and a healthy workplace. This also attracts talent into the organisation and helps retain staff who already work at NDHT.

There are a number of support mechanisms for staff in place, including the occupational health team, physiotherapy service and human resources. These provide our staff with free access to consultant, nurse, counselling and physiotherapy services provided in house and in a timely manner.

Alongside these clinical services we also support staff health and wellbeing by providing a number of on-site classes such as yoga, pilates, dance and circuit training at a reduced cost. For those unable to attend classes we source local provider discounts. We regularly promote national health campaigns such as World Mental Health Day, Time to Talk and Diabetes week and provide staff with easy access to health information on our intranet.

We have trained over 40 mental health first aiders to support our staff and continue to do so to ensure we can listen, reassure and provide help on a first aid basis to those who need it. We are signatories of mindful employer and time to change and are committed to end mental health stigma. To help us do this we also have workplace health and wellbeing champions across the Trust who advocate a healthy lifestyle, provide information and support their colleagues.

We are able to provide a free health and wellbeing training course for staff in conjunction with Loughborough College – Step Into Health, which covers physical activity, nutrition and weight management and stress management.

We provide a one day resilience workshop for all staff and our staff counsellors provide de-brief training to our line managers to ensure we can effectively support staff following traumatic events.

To recognise our staff we run a monthly Staff Awards scheme. Staff can nominate colleagues for recognition of going above and beyond their day job. Successful nominations receive a letter and pin badge from Suzanne Tracey, chief executive.

As part of the NHS 70 birthday celebrations we recognised long service for staff who had completed 10, 15, 20, 25 and 30+ NHS employment.

NDHT offer the annual flu vaccination to 100% of staff from October until March. This is to protect our staff, our patients and those around us from flu. Last year our flu vaccination rate for front line staff was 63.4% and this year's is expected to be between 65-70%.

Organisational change and employee consultations

As detailed in the 2017/18 report the Trust won the contract to run adult and paediatric sexual assault referral centre (SARC) services for Devon and Cornwall, including the Isles of Scilly. This was a significant expansion over the existing contract running the adult SARC based in Exeter. 2018/19 saw the mobilisation of this contract which formally came in to effect from 1 October 2018.

The HR team were involved in supporting this including facilitating formal consultation with staff from First Light and G4S who transferred to the employ of the Trust in accordance with the Transfer of Undertakings (Protection of Employment) Regulations (TUPE) and their subsequent orientation in to the Trust. A paediatric consultant was successfully recruited to provide clinical leadership for the children's SARC. A number of forensic doctors have also been recruited along with additional crisis workers. The original SARC facility in Plymouth was closed just prior to the transfer of the service. A new building was sourced by the Trust and furbished to provide a new state of the art SARC. The new facility opened in December 2018.

The contract for running independent sexual violence adviser (ISVA) services was awarded to First Light. This also took effect from 1 October 2018. Again, the HR team were involved in facilitating formal consultation with affected staff in accordance with the TUPE regulations. We were able to offer some of the staff in scope to transfer to First Light alternative roles in the expanded SARC service allowing them to maintain their employment with the Trust. Likewise, First Light were able to offer some of their staff in scope to transfer to the Trust the opportunity to take up alternative posts in their revised structure. This collaborative approach by both organisations kept the impact on staff to a minimum.

The HR team have also supported a number of internal restructuring programmes and supported other service tender/bid considerations.

Employment advice and employee relations

The employee advice line continues to handle a significant volume of calls supporting staff and managers with a wide range of queries and providing them with advice and guidance. The most popular subject areas were queries relating to sickness absence, queries pertaining to annual leave or special leave, contractual queries and questions about maternity/family leave. Increasing use is also being made of the dedicated HR enquiry email address which provides staff with an alternative to the HR advice line.

The team has supported the management of over 200 formal employee relations cases. There were 135 sickness absence management cases, 15 performance management cases, 42 disciplinary investigations, 11 grievances and seven bullying and harassment investigations. The HR team have also been key in the development and application of 'compliance' processes. These are designed to assist in ensuring compliance with a number a number of processes including the DBS Subscription Service, completion of the Care Certificate, completion of mandatory training and compliance with the car parking policy. The number of these cases continues to increase. Other cases supported during this period included complex flexible working requests, contractual issues, complex individual redeployment work. The team also assist in a number of very individual cases. For example, the team played a significant role in supporting a registered health care professional with a disability to successfully take up a post with the Trust ensuring appropriate modifications were put in place and facilitating input from relevant professionals.

We have continued to build on and develop further strong partnership working with Staff Side and Trade Unions colleagues to ensure that staff are appropriately consulted, developed and supported in the workplace. We have a number of formal committees/forums in place to support this partnership working including the workforce governance committee, partnership forum, and pay and reward group. Both Staff Side and HR also provide representation and input in to the STP partnership forum on a six-weekly basis.

Arrangements for supporting cases involving medical and dental staff have been significantly strengthened. A medical director advisory group has been established. This meets regularly and always has HR input. A close and effective partnership between HR and the deputy medical directors has been developed.

Recruitment and retention

The national picture remains challenging in relation to recruitment to a number of clinical professional roles. In this context, the Trust has been relatively successful in attracting staff to many of these hard to fill posts through recruitment initiatives and marketing campaigns. An open day to recruit Band 5 nurses saw 18 posts being offered. The Trust has continued to have a strong presence at various recruitment events nationally including representation at the RCN Congress in Belfast, Nursing Times Careers Live events, in Bristol and Birmingham and representation at University Careers Fairs.

During 2018/19 The Trust has successfully recruited 26 nurses from the EU and has run a wider international recruitment campaign with appointees from this campaign due to commence with the Trust in the 2019/20 reporting period. The Trust has been proactive in supporting and reassuring our EU staff. We participated in and very actively promoted the EU Settlement Scheme pilot encouraging our EU staff to apply early for "settled status" in the UK.

The Staff Bank has continued to expand and develop. New appointees to substantive posts are also set up with a bank assignment so that they can opt to undertake bank shifts if they wish without having to separately apply for and be set up on the bank. Staff who are retiring can opt to remain on the bank with minimal bureaucracy. The bank team also run regular recruitment events for individuals who want the flexibility of working on an "as and when" basis. The number of workers on the bank with a "bank only" contract has continued to rise.

As well as maintaining strong recruitment programmes, we have increased our focus on improving retention. While our turnover rate (currently 11.25%) is much lower than that experienced by many Trusts, we want to reduce this further. The Trust is participating in a national nursing retention programme in partnership with NHSi. We are introducing a range of programmes to improve our retention and refining the data available to us in order to identify areas of high turnover and understand better the reasons for this so that we can target actions to address this.

Since the launch of our medical and dental (M&D)/allied health professional (AHP) bank in 2017 which is managed by the medical staffing team, we continue to offer all junior doctors and AHPs the opportunity to join the bank in order to enable them to pick up ad-hoc locum shifts at the Trust. Shifts are offered out to all suitable bank workers through an electronic booking system which ensures equity of access to bank shifts, weekly e-timesheets and improved visibility of both bank and agency work being undertaken by medical and dental and AHP staff within the Trust. Our bank contract includes the ability for our bank workers to work as part of the Devon STP M&D/AHP collaborative bank once this is established and we continue to work with our STP colleagues to ensure that bank workers who are recruited by one Trust are then able to seamlessly work at

other local Trusts to reduce the reliance on agency workers across the Devon STP area.

In early 2018, to support the on-going challenges we are facing with medical and dental recruitment, we engaged with Remedium to support us and the wider STP collaborative with permanent M&D recruitment of overseas doctors. Over the past 12 months we have successfully recruited into a number of vacant posts and through this model we continue to work with interested staff in a hope to see further people joining the Trust in the coming months.

Workforce development

We continue to identify new ways of developing our workforce to be confident and competent.

The first wave of nursing associate recruits completed their training in January 2019. We were one of 11 first-wave nursing associate pilot sites and Devon was the only Sustainability and Transformation Partnership (STP)-wide site selected and funded by Health Education England (HEE).

Our new model for the delivery of mandatory training has helped us with our compliance rates whilst removing some of the pressure on services through ensuring all essential subjects are delivered in one day. At the end of March 2019 Trust-wide statutory/mandatory training compliance stood at 92% with 1,421 staff attending a full mandatory training day.

We continue to work with our partners by signing up to a national streamlining project to avoid duplication of learning for new starters moving between trusts.

This financial year we have spent £295,543 supporting 1009 staff with personal development in addition to commissioning specific group development for safeguarding, a touring dementia bus, and spinal care, end of life care; communication skills, coaching and leadership programmes.

During the year we have developed a new format for appraisal conversations which aims to help employees have meaningful conversations about their performance and aspirations, identifying their potential for future roles. Our appraisal compliance for 2018/19 was 79.9% and is an area we will continue to work on during 2019/20 to meet our target of 85%.

Leadership and management development

We continue to promote and support a number of programmes to help develop the skills and expertise of our leaders and managers in the Trust and have delivered two cohorts of our manager's development programme in-house and supported three new ILM accredited leadership and coaching development programmes within the Trust.

We play a key role in developing and collaborating across the Devon STP, the South West and nationally to support leadership and workforce system development.

Apprenticeships

The apprenticeship levy continued to support new and existing staff gain national education standards from levels 2 to 7 thus enabling progression in various NHS careers including nursing and therapy. As a public sector employer we have an apprentice target of 2.3%.

At the end of the year 77 students were enrolled onto an apprenticeship programmes achieving 2.4%, including 16 apprentices who were new starters to the organisation.

In 2018/19 the trust committed £641,333 of the apprentice funding with an annual expenditure for the year of £340,293 equating to approximately 87% of this year's funds.

An integrated health and care, clinical apprenticeship rotational programme with Devon County Council was also successfully piloted involving placements in learning disabilities, a day care centre and the acute hospital. Two of the three individuals have since successfully gained employed within NDHT.

Various clinical apprenticeships were also undertaken including trainee assistant practitioners, nursing associates and MSc ACP with numerous non clinical apprenticeships being supported to meet service need from business administration and leadership to engineering.

Project SEARCH

Project SEARCH is a joint project between Petroc, Northern Devon Healthcare NHS Trust and Pluss, and is based at North Devon District Hospital (NDDH). The innovative project aims to support young people with a learning disability or autism into the world of work.

In 2018 11 students with learning disabilities joined our new cohort and have been making excellent progress, with one student gaining employment at the end of their first rotation.

Last year we gained 100% employment for the first time which is fantastic news.

Health and Care Academy/work experience

20 students took part in work placement programmes as part of our health and care, and medics academies.

28 school children from year 10 took part in our experiential work experience week supported by various departments across the trust. For people over the age of 16 we organised 50 work shadowing days to provide them with an insight into the NHS relating to their specific area of interest.

These projects are fundamental to our talent for care 'get in' work streams led by Health Education England and have continued to be successful across all areas.

Exit packages

Reporting of other compensation schemes - exit packages 2018/19

Exit package cost band (including any special payment element)	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages	Number of departures where special payments have been made	Cost of special payment element included in exit packages
	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19
	No.	£000	No.	£000	No.	£000	No.	£000
<£10,000			8	30	0	0		
£10,000 – £25,000			2	29	0	0		
£25,001 – £50,000			2	77	0	0		
£50,001 – £100,000					0	0		
£100,001 – £150,000			1	129	0	0		
£150,001 – £200,000					0	0		
>£200,000					0	0		
Total	**0**	**0**	**13**	**265**	**0**	**0**	**0**	**0**

Exit packages: other (non-compulsory) departure payment

	Payments agreed	Total value of agreements	Payments agreed	Total value of agreements
	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-19 2018/19	Accounts 31-Mar-18 2017/18	Accounts 31-Mar-18 2017/18
	No.	£000	No.	£000
Voluntary redundancies including early retirement contractual costs				
Mutually agreed resignations (MARS) contractual costs				
Early retirements in the efficiency of the service contractual costs				
Contractual payments in lieu of notice				
Exit payments following employment tribunals or court orders				
Non-contractual payments requiring HMT approval (special severence payments)*				
Total**	**0**	**0**	**0**	**0**
of which:				
non-contractual payments requiring HMT approval made to individuals where the payment value was more than 12 months' of their annual salary				

Other disclosures

Emergency preparedness, resilience and response

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

The Civil Contingencies Act

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

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

NHS core standards

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

The Trust undertook a self-assessment against the named core standards in October 2018 and of the 64 applicable standards, the Trust identified as being:

- Fully compliant with 59 of the standards (green)
- Partially compliant with five of the standards (amber)
- Non-compliant with zero of the standards (red).

Incident response plan

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

Fraud policies and procedures

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

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

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

The risk-based programme of anti-fraud work was delivered in 2018/19, addressing all strategic areas of the national counter-fraud strategy, as issued by the NHS Counter Fraud Authority. The LCFS has developed and maintains key relationships across the Trust and this, coupled with the work undertaken by the LCFS, has resulted in the development of an anti-fraud culture within the Trust.

Disclosure of personal data related incidents

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

For the 2018/19 financial year, the Trust reported:

Zero information governance SIRIs.

Zero cyber security SIRIs

Health and safety

To align with Royal Devon and Exeter NHS Foundation Trust governance structures, the last health and safety committee meeting was held 22 November 2018. From 2019, business will be conducted by the health and safety group and the first meeting was held 29 January 2019.

The terms of reference of the health and safety committee have been amended to reflect changes including reporting structures. Arrangements of the new group satisfy the health and safety executives statutory requirements for health and safety committees. Membership of the health and safety group includes union appointed safety representatives, management representatives and specialist advisors. The group's chair is the chief nurse, with the Trusts legal claims manager acting as deputy chair.

The Board oversees this work to ensure that health and safety matters are being appropriately identified and managed in accordance with statutory requirements. This is achieved by summary reports from each meeting presented to the safety and risk committee to highlight any key issues, proposals, implications and recommendation made.

The first summary report concerning business conducted at the 22 November 2018 meeting was presented at the 2 January 2019 safety and risk committee.

The Trust has duties under law including:

- Health and Safety at Work etc Act 1974
- Management of Health and Safety at Work Regulations 1999
- Regulatory Reform Fire Safety Order 2005
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

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

1. Receiving and responding to staff incident reporting:

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

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

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

During the financial year 2018/19 (1 April 2018 to 31 March 2019), the following incidents relating to health and safety were reported and presented in the quarterly incident reports to the health and safety committee (health and safety group from January 2019).

Patient fall accidents are reviewed on a monthly basis by the head of therapy services and trust falls lead. Patient falls escalated for further investigation and completion of 72 hour or significant event audit reports are also reviewed by the legal claims manager for identification of potential incidents that meet RIDDOR criteria.

See table below for the number of incidents reported per financial quarter.

Incident category	Quarter 1	Quarter 2	Quarter 3	Quarter 4
Patient accidents (including falls)	233	188	207	208
Staff accidents	52	71	48	61
Violence and aggression	57	77	86	83
Fire	10	29	18	9
Visitor / contractor accidents	8	5	6	8
Total	360	370	365	369

2. RIDDOR regulations:

Under the reporting of injuries, diseases and dangerous occurrences regulations (RIDDOR), certain categories of incident are reported externally to the health and safety executive (HSE). During the first three financial quarters of 2018/19, a total of 22 incidents were reported to the HSE under RIDDOR.

The number of RIDDOR's submitted have reduced in comparison to the same time period for the previous financial year when 26 reports were completed.

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

Under the memorandum of understanding that exists between the HSE and the Care Quality Commission (CQC), information contained within RIDDOR reports submitted to the HSE for patient accidents that meet the RIDDOR reporting criteria can be shared with the CQC (by the HSE).

The CQC may then choose to lead on any subsequent externally-led investigation that may be deemed appropriate by either organisation.

- Quarter 1 2018/19, eight incidents were reported under RIDDOR
- Quarter 2 2018/19, five incidents were reported under RIDDOR
- Quarter 3 2018/19, seven incidents were reported under RIDDOR
- Quarter 4 2018/19, two incidents were reported under RIDDOR

The incidents reported to the HSE fell under the RIDDOR categories indicated in the table below. It can be noted that six RIDDORs submitted during financial year 2018/19 were following patient accidents that met reportable criteria. The specified injuries suffered by patients include loss of consciousness following fall (head injury) and fractures following falls.

RIDDOR categories - reports submitted to HSE, during financial year 2018/19	Report of an injury	Report of a dangerous occurrence	Report of a case of disease	Total
Bone fracture excluding finger, thumb or toe	0	-	-	0
Loss of consciousness due to head injury or asphyxia	0	-	-	0
Off work for more than 7 days	12	-	-	12
Light duties for more than 7 days	3	-	-	3
Member of public taken directly to hospital	0	-	-	0
Occupational disease	-	-	1	1
Dangerous occurrence	-	0	-	0
Patient suffering specified injury	6	-	-	6
Total	19	0	1	22

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

Accounts

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

The chief executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the chief executive should be the accountable officer of the trust. The relevant responsibilities of accountable officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

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

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

Signed _____
Chief Executive

Date: 23 May 2019

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

The directors confirm that the annual report and accounts, taken as a whole, is fair, balanced and understandable and provides the information necessary for patients, regulators and stakeholders to assess the NHS trust's performance, business model and strategy.

By order of the board

23 May 2019 Date

Chief Executive

23 May 2019 Date

Finance Director

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

REPORT ON THE AUDIT OF THE FINANCIAL STATEMENTS

Opinion

We have audited the financial statements of Northern Devon Healthcare NHS Trust ("the Trust") for the year ended 31 March 2019 which comprise the Statement of Comprehensive Income, Statement of Financial Position, Statement of Changes in Taxpayers Equity and Statement of Cash Flows, and the related notes, including the accounting policies in note 1.

In our opinion the financial statements:

- give a true and fair view of the state of the Trust's affairs as at 31 March 2019 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 being relevant to NHS Trusts in England and included in the Department of Health Group Accounting Manual 2018/19.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) ("ISAs (UK)") and applicable law. Our responsibilities are described below. We have fulfilled our ethical responsibilities under, and are independent of the Trust in accordance with, UK ethical requirements including the FRC Ethical Standard. We believe that the audit evidence we have obtained is a sufficient and appropriate basis for our opinion.

Going concern

The Directors have prepared the financial statements on the going concern basis as they have not been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. They have also concluded that there are no material uncertainties that could have cast significant doubt over its ability to continue as a going concern for at least a year from the date of approval of the financial statements ("the going concern period").

We are required to report to you if we have concluded that the use of the going concern basis of accounting is inappropriate or there is an undisclosed material uncertainty that may cast significant doubt over the use of that basis for a period of at least a year from the date of approval of the financial statements. In our evaluation of the Director's conclusions we considered the inherent risks to the Trust's operations, including the impact of Brexit, and analysed how these risks might affect the Trust's financial resources, or ability to continue its operations over the going concern period. We have nothing to report in these respects.

However, as we cannot predict all future events or conditions and as subsequent events may result in outcomes that are inconsistent with judgements that were reasonable at the time they were made, the absence of reference to a material uncertainty in this auditor's report is not a guarantee that the Trust will continue in operation.

Other information in the Annual Report

The Accountable Officer is responsible for the other information presented in the Annual Report together with the financial statements. Our opinion on the financial statements does not cover the other information and, accordingly, we do not express an audit opinion or, except as explicitly stated below, any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether, based on our financial statements audit work, the information therein is materially misstated or inconsistent with the financial statements or our audit knowledge. Based solely on that work we have not identified material misstatements in the other information. In our opinion the other information included in the Annual Report for the financial year is consistent with the financial statements.

Annual Governance Statement

We are required to report to you if the Annual Governance Statement has not been prepared in accordance with the requirements of the Department of Health Group Accounting Manual 2018/19. We have nothing to report in this respect.

Remuneration and Staff Report

In our opinion the parts of the Remuneration and Staff Report subject to audit have been properly prepared in accordance with the Department of Health Group Accounting Manual 2018/19.

Directors' and Accountable Officer's responsibilities

As explained more fully in the statement set out on page 1 of the accounts, the directors are responsible for: the preparation of financial statements that give a true and fair view; such internal control as they determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error; assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern; and using the going concern basis of accounting unless they have been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity. As explained more fully in the statement of the Chief Executive's responsibilities, as the Accountable Officer of the Trust, on page 1 of the accounts the Accountable Officer is responsible for ensuring that annual statutory accounts are prepared in a format directed by the Secretary of State.

Auditor's responsibilities

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue our opinion in an auditor's report. Reasonable assurance is a high level of assurance, but does not guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists. Misstatements can arise from fraud or error and are considered material if, individually or in aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of the financial statements.

A fuller description of our responsibilities is provided on the FRC's website at

www.frc.org.uk/auditorsresponsibilities

REPORT ON OTHER LEGAL AND REGULATORY MATTERS

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

Under the Code of Audit Practice we are required to report to you if the Trust has not made proper arrangement for securing economy, efficiency and effectiveness in its use of resources.

Qualified conclusion

Subject to the matters outlined in the basis for qualified conclusion paragraph below we are satisfied that in all significant respects Northern Devon Healthcare NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in the use of resources for the year ended 31 March 2019.

Basis for qualified conclusion

The Trust did not achieve its control total for the year and reported a year end deficit before revaluation adjustments of £16.7 million compared to an original plan of a £11.9 million deficit. The main drivers were persistently high expenditure on agency staffing and shortfalls in the delivery of the Trust's cost savings plans of £1.5 million. This demonstrates weaknesses in the Trust's arrangements for planning its finances effectively to support the sustainable delivery of its strategic priorities and the maintenance of its statutory functions.

Respective responsibilities in respect of our review of arrangements for securing economy, efficiency and effectiveness in the use of resources

As explained in the statement set out on page 1 of the accounts, the Chief Executive, as the Accountable Officer, is responsible for ensuring that value for money is achieved from the resources available to the Trust. We are required under section 21(3)(c), as amended by schedule 13 paragraph 10(a), of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

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

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the specified criterion issued by the Comptroller and Auditor General (C&AG) in November 2017, as to whether the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. We planned our work in accordance with the Code of Audit Practice and related guidance. Based on our risk assessment, we undertook such work as we considered necessary.

Statutory reporting matters

We are required by Schedule 2 to the Code of Audit Practice issued by the Comptroller and Auditor General ('the Code of Audit Practice') to report to you if:

- we refer a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we issue a report in the public interest under section 24 of the Local Audit and Accountability Act 2014; or
- we make a written recommendation to the Trust under section 24 of the Local Audit and Accountability Act 2014.

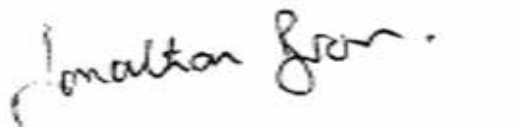
We have nothing to report in these respects.

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

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

CERTIFICATE OF COMPLETION OF THE AUDIT

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



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

24-May-19

Statement of Comprehensive Income

	Note	2018/19 £000	2017/18 £000
Operating income from patient care activities	3	188,541	188,416
Other operating income	4	12,684	21,783
Operating expenses	7, 9	(214,937)	(201,420)
Operating surplus/(deficit) from continuing operations		**(13,712)**	**8,779**
Finance income	12	75	21
Finance expenses	13	(191)	(1,191)
PDC dividends payable		(1,669)	(2,030)
Net finance costs		**(1,785)**	**(3,200)**
Other gains / (losses)	14	2	(3)
Gains / (losses) arising from transfers by absorption	44	0	(8,213)
Surplus / (deficit) for the year		**(15,495)**	**(2,637)**
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments	8	(2)	(105)
Revaluations	18	947	953
Total comprehensive income / (expense) for the period		**(14,550)**	**(1,789)**
Adjusted financial performance (control total basis):			
Surplus / (deficit) for the period		(15,495)	(2,637)
Remove net impairments not scoring to the Departmental expenditure limit		(1,228)	897
Remove (gains) / losses on transfers by absorption		0	8,213
Remove I&E impact of capital grants and donations		90	7
Adjusted financial performance surplus / (deficit)		**(16,633)**	**6,480**

Statement of Financial Position

	Note	31 March 2019 £000	31 March 2018 £000
Non-current assets			
Intangible assets	15	8,583	8,886
Property, plant and equipment	16	69,997	67,515
Receivables	23	838	1,036
Total non-current assets		**79,418**	**77,437**
Current assets			
Inventories	22	2,788	3,049
Receivables	23	9,794	13,800
Cash and cash equivalents	26	5,346	4,051
Total current assets		**17,928**	**20,900**
Current liabilities			
Trade and other payables	27	(17,846)	(14,437)
Borrowings	30	(6,075)	(711)
Other liabilities	29	(2,833)	(2,903)
Total current liabilities		**(26,754)**	**(18,051)**
Total assets less current liabilities		**70,592**	**80,286**
Non-current liabilities			
Borrowings	30	(12,526)	(8,247)
Provisions	32	(48)	(29)
Total non-current liabilities		**(12,574)**	**(8,276)**
Total assets employed		**58,018**	**72,010**
Financed by			
Public dividend capital		56,862	56,304
Revaluation reserve		8,507	7,562
Income and expenditure reserve		(7,351)	8,144
Total taxpayers' equity		**58,018**	**72,010**

The notes on pages 9 to 53 form part of these accounts.

Name Suzanne Tracey
Position Chief Executive
Date **23 May 2019**

Statement of Changes in Equity for the year ended 31 March 2019

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2018 - brought forward	**56,304**	**7,562**	**8,144**	**72,010**
Surplus/(deficit) for the year	0	0	(15,495)	**(15,495)**
Impairments	0	(2)	0	**(2)**
Revaluations	0	947	0	**947**
Public dividend capital received	558	0	0	**558**
Taxpayers' equity at 31 March 2019	**56,862**	**8,507**	**(7,351)**	**58,018**

* Following the implementation of IFRS 9 from 1 April 2018, the 'Available for sale investment reserve' is now renamed as the 'Financial assets reserve'

Statement of Changes in Equity for the year ended 31 March 2018

	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total
	£000	£000	£000	£000
Taxpayers' equity at 1 April 2017 - brought forward	**55,040**	**14,125**	**3,370**	**72,535**
Prior period adjustment	0	0	0	**0**
Taxpayers' equity at 1 April 2017 - restated	**55,040**	**14,125**	**3,370**	**72,535**
Surplus/(deficit) for the year	0	0	(2,637)	**(2,637)**
Transfers by absorption: transfers between reserves	0	(7,411)	7,411	**0**
Impairments	0	(105)	0	**(105)**
Revaluations	0	953	0	**953**
Public dividend capital received	1,264	0	0	**1,264**
Taxpayers' equity at 31 March 2018	**56,304**	**7,562**	**8,144**	**72,010**

Information on reserves

Public dividend capital
Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. Additional PDC may also be issued to trusts by the Department of Health and Social Care. A charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as the public dividend capital dividend.

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

Financial assets reserve / Available-for-sale investment reserve
This reserve comprises changes in the fair value of financial assets measured at fair value through other comprehensive income. When these instruments are derecognised, cumulative gains or losses previously recognised as other comprehensive income or expenditure are recycled to income or expenditure, unless the assets are equity instruments measured at fair value through other comprehensive income as a result of irrevivable election at recognition.

Other reserves
The Trust has no other reserves.

Merger reserve
This reserve reflects balances formed on merger of NHS bodies.

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

Statement of Cash Flows

	Note	2018/19 £000	2017/18 £000
Cash flows from operating activities			
Operating surplus / (deficit)		(13,712)	8,779
Non-cash income and expense:			
Depreciation and amortisation	7.1	5,328	6,214
Net impairments	8	(1,228)	897
Income recognised in respect of capital donations	4	(168)	(263)
(Increase) / decrease in receivables and other assets		4,379	(2,508)
(Increase) / decrease in inventories		261	45
Increase / (decrease) in payables and other liabilities		2,795	(1,540)
Increase / (decrease) in provisions		19	10
Net cash generated from / (used in) operating activities		**(2,326)**	**11,634**
Cash flows from investing activities			
Interest received		75	21
Purchase of intangible assets		(821)	(1,870)
Purchase of property, plant, equipment and investment property		(4,015)	(4,726)
Sales of property, plant, equipment and investment property		2	2
Receipt of cash donations to purchase capital assets		168	263
Net cash generated from / (used in) investing activities		**(4,591)**	**(6,310)**
Cash flows from financing activities			
Public dividend capital received		558	1,264
Movement on loans from the Department of Health and Social Care		10,274	412
Movement on other loans		(711)	(712)
Capital element of PFI, LIFT and other service concession payments		0	(341)
Interest on loans		(122)	(128)
Other interest		(15)	0
Interest paid on PFI, LIFT and other service concession obligations		0	(1,056)
PDC dividend (paid) / refunded		(1,772)	(2,314)
Net cash generated from / (used in) financing activities		**8,212**	**(2,875)**
Increase / (decrease) in cash and cash equivalents		**1,295**	**2,449**
Cash and cash equivalents at 1 April - brought forward		**4,051**	**1,602**
Cash and cash equivalents at 31 March	26.1	**5,346**	**4,051**

Notes to the Accounts

Note 1 Accounting policies and other information

Note 1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2018/19 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

Note 1.1.1 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.

Note 1.2 Going concern

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

The Directors, having made appropriate enquiries, have reasonable expectations that the Trust will have adequate resources to continue in operational existence for the foreseeable future and there are no material uncertainties that may cast significant doubt on this assessment. As directed by the 2018/19 Department of Health and Social Care Group Accounting Manual the Directors have prepared the financial statements on a going concern basis as they consider that the services currently provided by the Trust will continue to be provided in the foreseeable future.

Note 1.3 Interests in other entities

NHS Charitable Fund

Northern Devon Healthcare Trust is the corporate Trustee of Over and Above, Northern Devon Healthcare Trust Charitable Fund.

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

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

Other Subsidiaries

The Trust does not have any subsidiary undertakings.

Associates

The Trust does not have any assoiciate arrangements.

Joint Ventures

The Trust does not have any joint ventures.

Joint Operations

The Trust does not have any joint operations arrangements.

Note 1.4 Revenue

Note 1.4.1 Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under IFRS 15. The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS). As directed by the GAM, the transition to IFRS 15 in 2018/19 has been completed in accordance with paragraph C3 (b) of the Standard: applying the Standard retrospectively but recognising the cumulative effects at the date of initial application (1 April 2018).

Revenue in respect of goods/services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods/services to the customer and is measured at the amount of the transaction price allocated to those performance obligations. At the year end, the Trust accrues income relating to performance obligations satisfied in that year. Where the Trust's entitlement to consideration for those goods or services is unconditional a contract receivable will be recognised. Where entitlement to consideration is conditional on a further factor other than the passage of time, a contract asset will be recognised. Where consideration received or receivable relates to a performance obligation that is to be satisfied in a future period, the income is deferred and recognised as a contract liability.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for health care services. A performance obligation relating to delivery of a spell of health care is generally satisfied over time as healthcare is received and consumed simultaneously by the customer as the Trust performs it. The customer in such a contract is the commissioner, but the customer benefits as services are provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligns with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that are substantially the same and have a similar pattern of transfer. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

The effects of contract/invoice challenges are not considered significant in the determination of the transaction price for revenue recognition.

The effects of penalties are not considered significant in the determination of the transaction price for revenue recognition.

The effect of readmissions is reflected in the contract baseline.

The effects of CQUIN are not material.

Research income that falls under IFRS 15 is not material.

NHS injury cost recovery scheme

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, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9 requirements of measuring expected credit losses over the lifetime of the asset.

Note 1.4.2 Revenue grants and other contributions to expenditure

Government grants are grants from government bodies other than income from commissioners or trusts for the provision of services. Where a grant is used to fund revenue expenditure it is taken to the Statement of Comprehensive Income to match that expenditure.

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider, the corresponding notional expense is also recognised at the point of recognition for the benefit.

Note 1.4.3 Other income

Income from the sale of non-current assets is recognised only when all material conditions of sale have been met, and is measured as the sums due under the sale contract.

Note 1.5 Expenditure on employee benefits

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

Pension costs
NHS Pension Scheme
Past and present employees are covered by the provisions of the NHS Pension Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, general practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme.

Employer's pension cost contributions are charged to operating expenses as and when they become due.

Additional pension liabilities arising from early retirements are not funded by the scheme except where the retirement is due to ill-health. The full amount of the liability for the additional costs is charged to the operating expenses at the time the trust commits itself to the retirement, regardless of the method of payment.

Local Government Pension Scheme
The Trust has no employees that are members of the Local Government Pension Scheme.

Note 1.6 Expenditure on other goods and services

Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment.

Note 1.7 Property, plant and equipment

Note 1.7.1 Recognition

Property, plant and equipment is capitalised where:

• it is held for use in delivering services or for administrative purposes
• it is probable that future economic benefits will flow to, or service potential be provided to, the trust
• it is expected to be used for more than one financial year
• the cost of the item can be measured reliably
• 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 cost of more than £250, where the assets are functionally interdependent, had broadly simultaneous purchase dates, are anticipated to have similar disposal dates and are under single managerial control.

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

Note 1.7.2 Measurement

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

Revaluations of property, plant and equipment are performed with sufficient regularity to ensure that carrying values are not materially different from those that would be determined at the end of the reporting period. Current values in existing use are determined as follows:

- Land and non-specialised buildings – market value for existing use.
- Specialised buildings – depreciated replacement cost, modern equivalent asset basis.

The BCIS and Location Factor (LF) indices used in valuing specialised assets, by the Depreciated Replacement Cost method, are those published independently by the BCIS, the Building Cost Information Service of the Royal Institution of Chartered Surveyors. BCIS is the leading provider of cost and price information and its indices are widely used in the valuation of specialised operational assets across both the Public and Private Sector. Ultimately, the aim is to provide a reliable indication of cost in a given location at a given date in time. This is achieved by adoption of the BCIS All in TPI, coupled to a Location Factor.

The BCIS publications relevant to Quarter 1 2019, adopted for 31st March 2019 valuations, show some marked variations in BCIS Location Factors applicable to the South West region of England compared to those published by BCIS and adopted for the 31st March 2018 asset valuations. Typically the Qtr1 2019 Location Factors show an increase across the region in the order of 10% compared to Qtr1 2018.

In discussion with the District Valuer, the Trust has applied an average of the published Qtr1 Location Factor over a two year period (2017-19), reducing the LF increase between Qtr1 2018 and Qtr1 2019 from circa 10% to an average circa 4.5%.

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 and, where capitalised in accordance with IAS 23, borrowing costs. Assets are revalued and depreciation commences when they are brought into use.

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

Subsequent expenditure relating to an item of property, plant and equipment is recognised as an increase in the carrying amount of the asset when it is probable that additional future economic benefits or service potential deriving from the cost incurred to replace a component of such item will flow to the enterprise and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance, is charged to the Statement of Comprehensive Income in the period in which it is incurred.

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful lives in a manner consistent with the consumption of economic or service delivery benefits. Freehold land is considered to have an infinite life and is not depreciated.

Property, plant and equipment which has been reclassified as 'held for sale' cease to be depreciated upon the reclassification. Assets in the course of construction and residual interests in off-Statement of Financial Position PFI contract assets are not depreciated until the asset is brought into use or reverts to the trust, respectively.

Revaluation gains and losses
Revaluation gains are recognised in the revaluation reserve, except where, and to the extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating income.

Revaluation losses are charged to the revaluation reserve to the extent that there is an available balance for the asset concerned, and thereafter are charged to operating expenses.

Gains and losses recognised in the revaluation reserve are reported in the Statement of Comprehensive Income as an item of 'other comprehensive income'.

Impairments
In accordance with the GAM, impairments that arise from a clear consumption of economic benefits or of service potential in the asset are charged to operating expenses. A compensating transfer is made from the revaluation reserve to the income and expenditure reserve of an amount equal to the lower of (I) the impairment charged to operating expenses; and (ii) the balance in the revaluation reserve attributable to that asset before the impairment.

An impairment that arises from a clear consumption of economic benefit or of service potential is reversed when, and to the extent that, the circumstances that gave rise to the loss is reversed. Reversals are recognised in operating expenditure to the extent that the asset is restored to the carrying amount it would have had if the impairment had never been recognised. Any remaining reversal is recognised in the revaluation reserve. Where, at the time of the original impairment, a transfer was made from the revaluation reserve to the income and expenditure reserve, an amount is transferred back to the revaluation reserve when the impairment reversal is recognised.
Other impairments are treated as revaluation losses. Reversals of 'other impairments' are treated as revaluation gains.

Note 1.7.3 De-recognition
Assets intended for disposal are reclassified as 'held for sale' once all of the following criteria are met:

- the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;
- the sale must be highly probable ie:
  - management are committed to a plan to sell the asset
  - an active programme has begun to find a buyer and complete the sale
  - the asset is being actively marketed at a reasonable price
  - the sale is expected to be completed within 12 months of the date of classification as 'held for sale' and
  - the actions needed to complete the plan indicate it is unlikely that the plan will be abandoned or significant changes made to it.

Following reclassification, the assets are measured at the lower of their existing carrying amount and their 'fair value less costs to sell'. Depreciation ceases to be charged. Assets are de-recognised when all material sale contract conditions have been met.

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's useful life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Note 1.7.4 Donated and grant funded assets

Donated and grant funded property, plant and equipment assets are capitalised at their fair value on receipt. The donation/grant is credited to income at the same time, unless the donor has imposed a condition that the future economic benefits embodied in the grant are to be consumed in a manner specified by the donor, in which case, the donation/grant is deferred within liabilities and is carried forward to future financial years to the extent that the condition has not yet been met.

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

Note 1.7.5 Private Finance Initiative (PFI) and Local Improvement Finance Trust (LIFT) transactions

The Trust has no PFI or LIFT Transactions for the current financial year following the transfer of Tiverton Hospital to NHS Property Services on 31st March 2018.

Note 1.7.6 Useful lives of property, plant and equipment

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Land	0	99
Buildings, excluding dwellings	2	75
Dwellings	5	38
Plant & machinery	5	15
Transport equipment	7	7
Information technology	3	5
Furniture & fittings	10	10

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

Note 1.8 Intangible assets

Note 1.8.1 Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised.

Expenditure on development is capitalised only where all of the following can be demonstrated:

• the project is technically feasible to the point of completion and will result in an intangible asset for sale or use
• the trust intends to complete the asset and sell or use it
• the trust has the ability to sell or use the asset
• how the intangible asset will generate probable future economic or service delivery benefits, eg, the presence of a market for it or its output, or where it is to be used for internal use, the usefulness of the asset;
• adequate financial, technical and other resources are available to the trust to complete the development and sell or use the asset and
• the trust can measure reliably the expenses attributable to the asset during development.

Software

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

Note 1.8.2 Measurement

Intangible assets are recognised initially at cost, comprising all directly attributable costs needed to create, produce and prepare the asset to the point that it is capable of operating in the manner intended by management.

Subsequently intangible assets are measured at current value in existing use. Where no active market exists, intangible assets are valued at the lower of depreciated replacement cost and the value in use where the asset is income generating. Revaluations gains and losses and impairments are treated in the same manner as for property, plant and equipment. An intangible asset which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13, if it does not meet the requirements of IAS 40 of IFRS 5.

Intangible assets held for sale are measured at the lower of their carrying amount or “fair value less costs to sell”.

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

Note 1.8.3 Useful economic life of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives are shown in the table below:

	Min life Years	Max life Years
Intangible Assets - internally generated		
Information technology	0	0
Development expenditure	5	10
Websites	0	0
Intangible Assets - purchased		
Software licences	5	5
Licences & trademarks	5	5
Patents	0	0
Other (purchased)	0	0
Goodwill	0	0

Note 1.9 Inventories

Inventories are valued at the lower of cost and net realisable value. The value of drug inventories is measured using the weighted average cost formula. All other items of stock are valued at cost.

Note 1.10 Investment properties
The Trust has no Investment properties.

Note 1.11 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. Cash, bank and overdraft balances are recorded at current values.

Note 1.12 Carbon Reduction Commitment scheme (CRC)
The Trust does not have any CRC or similar allowances.

Note 1.13 Financial assets and financial liabilities

Note 1.13.1 Recognition

Financial assets and financial liabilities arise where the Trust is party to the contractual provisions of a financial instrument, and as a result has a legal right to receive or a legal obligation to pay cash or another financial instrument. The GAM expands the definition of a contract to include legislation and regulations which give rise to arrangements that in all other respects would be a financial instrument and do not give rise to transactions classified as a tax by ONS.

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, ie, when receipt or delivery of the goods or services is made.

Note 1.13.2 Classification and measurement

Financial assets and financial liabilities are initially measured at fair value plus or minus directly attributable transaction costs except where the asset or liability is not measured at fair value through income and expenditure. Fair value is taken as the transaction price, or otherwise determined by reference to quoted market prices or valuation techniques.

Financial assets are classified as subsequently measured at amortised cost.

Financial liabilities classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost
Financial assets and financial liabilities at amortised cost are those held with the objective of collecting contractual cash flows and where cash flows are solely payments of principal and interest. This includes cash equivalents, contract and other receivables, trade and other payables, rights and obligations under lease arrangements and loans receivable and payable.

After initial recognition, these financial assets and financial liabilities are measured at amortised cost using the effective interest method less any impairment (for financial assets). The effective interest rate is the rate that exactly discounts estimated future cash payments or receipts through the expected life of the financial asset or financial liability to the gross carrying amount of a financial asset or to the amortised cost of a financial liability.

Interest revenue or expense is calculated by applying the effective interest rate to the gross carrying amount of a financial asset or amortised cost of a financial liability and recognised in the Statement of Comprehensive Income and a financing income or expense. In the case of loans held from the Department of Health and Social Care, the effective interest rate is the nominal rate of interest charged on the loan.

Impairment of financial assets
For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

Note 1.13.3 Derecognition
Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

Note 1.14 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.

Note 1.14.1 The trust as lessee

Finance leases
The Trust does not have any finance leases.

Operating leases
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.

Leases of land and buildings
Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Note 1.14.2 The trust as lessor

The Trust does not act as a lessor.

Note 1.15 Provisions

The Trust recognises a provision where it has a present legal or constructive obligation of uncertain timing or amount; for which it is probable that there will be a future outflow of cash or other resources; and a reliable estimate can be made of the amount. The amount recognised in the Statement of Financial Position is the best estimate of the resources required to settle the obligation. Where the effect of the time value of money is significant, the estimated risk-adjusted cash flows are discounted using the discount rates published and mandated by HM Treasury.

Clinical negligence costs
NHS Resolution operates a risk pooling scheme under which the trust pays an annual contribution to NHS Resolution, which, in return, settles all clinical negligence claims. Although NHS Resolution is administratively responsible for all clinical negligence cases, the legal liability remains with the Trust. The total value of clinical negligence provisions carried by NHS Resolution on behalf of the trust is disclosed at note 32 but is not recognised in the Trust's accounts.

Non-clinical risk pooling
The trust participates in the Property Expenses Scheme and the Liabilities to Third Parties Scheme. Both are risk pooling schemes under which the trust pays an annual contribution to NHS Resolution and in return receives assistance with the costs of claims arising. The annual membership contributions, and any "excesses" payable in respect of particular claims are charged to operating expenses when the liability arises.

Note 1.16 Contingencies
Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in note 33 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in note 33, unless the probability of a transfer of economic benefits is remote.

Contingent liabilities are defined as:
• possible obligations arising from past events whose existence will be confirmed only by the occurrence of one or more uncertain future events not wholly within the entity's control; or
• present obligations arising from past events but for which it is not probable that a transfer of economic benefits will arise or for which the amount of the obligation cannot be measured with sufficient reliability.

Note 1.17 Public dividend capital

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32.

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.

A charge, reflecting the cost of capital utilised by the trust, is payable as public dividend capital dividend. The charge is calculated at the rate set by HM Treasury (currently 3.5%) on the average relevant net assets of the trust during the financial year. Relevant net assets are calculated as the value of all assets less the value of all liabilities, except for
(I) donated assets (including lottery funded assets),
(ii) average daily cash balances held with the Government Banking Services (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility, and
(iii) any PDC dividend balance receivable or payable.

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

Note 1.18 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.

Note 1.19 Corporation tax
The Trust is not a separate legal entity and therefore not liable for Corporation tax.

Note 1.20 Foreign exchange
The functional and presentational currency of the Trust is sterling.

A transaction which is denominated in a foreign currency is translated into the functional currency at the spot exchange rate on the date of the transaction.

Where the Trust has assets or liabilities denominated in a foreign currency at the Statement of Financial Position date:
• monetary items are translated at the spot exchange rate on 31 March
• non-monetary assets and liabilities measured at historical cost are translated using the spot exchange rate at the date of the transaction and
• non-monetary assets and liabilities measured at fair value are translated using the spot exchange rate at the date the fair value was determined.

Exchange gains or losses on monetary items (arising on settlement of the transaction or on re-translation at the Statement of Financial Position date) are recognised in income or expense in the period in which they arise.

Exchange gains or losses on non-monetary assets and liabilities are recognised in the same manner as other gains and losses on these items.

Note 1.21 Third party assets
Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. However, they are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury’s *FReM*.

Note 1.22 Losses and special payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled. Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had the trust not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

However the losses and special payments note is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

Note 1.23 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers,such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

The Trust has no gifts to report in its accounts.

Note 1.24 Transfers of functions to / from other NHS bodies / local government bodies

For functions that have transferred to/from another NHS body/local government body, the assets and liabilities transferred are de-recognised from the accounts as at the date of transfer. The assets and liabilities re not adjusted to fair value prior to recognition.

There have been no assets or liabilities transferred to or from the Trust during the financial year.

Note 1.25 Critical judgements in applying accounting policies

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

The Trust has employed the services of the District Valuer to provide a valuation of its property and therefore used their assumptions in the revaluation of its property as set out in note 1.7.2. It is impracticable to disclose the extent of the possible effects of an assumption or another source of estimation uncertainty at the end of the reporting period. On the basis of existing knowledge, outcomes within the next financial year that are different from the assumption around the valuation of our land, property, plant and equipment could require a material adjustment to the carrying amount of the asset or liability recorded in note 16.

The Trust has made assumptions around the value of its accruals in the accounts based on historic data, or the subsequent receipt of a supplier invoice before the closure of the accounting period. A substantial proportion of accruals are agreed via the DH Agreement of Balances Exercise.

The Trust has made assumptions around the value of accrued income in the accounts based on historic data, the majority of which is agreed via the DH Agreement of Balances Exercise.

Note 1.25.1 Sources of estimation uncertainty

Due to the materiality around accruals the Trust does not consider it carries significant risk in its valuation of these items which could result in a material adjustment to the carrying amounts of assets and liabilities within the next financial year:

Note 1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2018/19.

Note 1.27 Standards, amendments and interpretations in issue but not yet effective or adopted

The HM Treasury FReM does not require the following Standard to be applied in 2018/19, as this item is still subject to HM Treasury FReM interpretation, and early adoption is not therefore permitted.

IFRS 16 Leases – Application required for accounting periods beginning on or after 1 January 2019.

Note 2 Operating Segments

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

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

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

	Healthcare		**Total**	
	2018-19	2017-18	**2018-19**	2017-18
	£000's	£000's	£000's	£000's
Income	**200,535**	210,199	**200,535**	210,199
Surplus/(Deficit)				
Common costs	**(214,247)**	(201,420)	**(214,247)**	(201,420)
Operating surplus/(deficit)	**(13,712)**	8,779	**(13,712)**	8,779
Net Assets:				
Segment net assets	**58,018**	72,010	**58,018**	72,010

Note 3 Operating income from patient care activities

All income from patient care activities relates to contract income recognised in line with accounting policy 1.4.1

Note 3.1 Income from patient care activities (by nature)	**2018/19**	**2017/18**
	£000	**£000**
Elective income	20,495	17,058
Non elective income	37,839	37,482
First outpatient income	15,117	10,736
Follow up outpatient income	8,514	11,459
A & E income	5,310	4,992
High cost drugs income from commissioners (excluding pass-through costs)	15,334	16,959
Other NHS clinical income	31,598	34,026
Community services		
Community services income from CCGs and NHS England	32,699	36,114
Income from other sources (e.g. local authorities)	19,239	18,355
All services		
Private patient income	560	634
Agenda for Change pay award central funding	1,739	0
Other clinical income	97	601
Total income from activities	**188,541**	**188,416**

Note 3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2018/19**	**2017/18**
	£000	**£000**
NHS England	17,885	19,517
Clinical commissioning groups	148,410	149,216
Department of Health and Social Care	1,759	20
Other NHS providers	295	174
NHS other	267	155
Local authorities	19,239	18,355
Non-NHS: private patients	560	634
Non-NHS: overseas patients (chargeable to patient)	31	30
Injury cost recovery scheme	17	276
Non NHS: other	78	39
Total income from activities	**188,541**	**188,416**

Note 3.3 Overseas visitors (relating to patients charged directly by the provider)

	2018/19	2017/18
	£000	£000
Income recognised this year	31	30
Cash payments received in-year	14	20
Amounts written off in-year	1	0

Note 4 Other operating income

	2018/19	2017/18
	£000	£000
Other operating income from contracts with customers:		
Research and development (contract)	408	399
Education and training (excluding notional apprenticeship levy income)	3,666	4,638
Non-patient care services to other bodies	2,181	3,580
Provider sustainability / sustainability and transformation fund income (PSF / STF)	0	6,066
Income in respect of employee benefits accounted on a gross basis	2,885	1,996
Other non-contract operating income		
Receipt of capital grants and donations	168	263
Charitable and other contributions to expenditure	153	223
Support from the Department of Health and Social Care for mergers	0	0
Rental revenue from finance leases	0	0
Rental revenue from operating leases	0	0
Amortisation of PFI deferred income / credits	0	0
Other non-contract income	3,223	4,618
Total other operating income	**12,684**	**21,783**

Other income includes property rental income, car parking income, sponsorship and various other items.

Note 5 Additional revenue information

Note 5.1 Additional information on revenue from contracts with customers recognised in the period

	2018/19
	£000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	2,903
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	0

Note 5.2 Transaction price allocated to remaining performance obligations

Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	31 March 2019 £000
within one year	0
after one year, not later than five years	0
after five years	0
Total revenue allocated to remaining performance obligations	**0**

The trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from (I) contracts with an expected duration of one year or less and (ii) contracts where the trust recognises revenue directly corresponding to work done to date is not disclosed.

The Trust does not have any comparators as IFRS15 had no impact on the prior year balances.

Note 6 Fees and charges

HM Treasury requires disclosure of fees and charges income. The following disclosure is of income from charges to service users where income from that service exceeds £1 million and is presented as the aggregate of such income. The cost associated with the service that generated the income is also disclosed.

	2018/19	2017/18
	£000	£000
Income	0	0
Full cost	0	0
Surplus / (deficit)	**0**	**0**

Note 7 Operating Expenses

Note 7.1 Detailed Operating expenses

	2018/19	2017/18
	£000	£000
Purchase of healthcare from NHS and DHSC bodies	3,187	2,867
Purchase of healthcare from non-NHS and non-DHSC bodies	1,769	770
Purchase of social care	11,605	11,810
Staff and executive directors costs	131,240	120,836
Remuneration of non-executive directors	41	51
Supplies and services - clinical (excluding drugs costs)	16,087	14,576
Supplies and services - general	7,092	6,578
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	16,046	15,719
Consultancy costs	27	30
Establishment	6,428	4,276
Premises	5,068	4,675
Transport (including patient travel)	1,331	1,363
Depreciation on property, plant and equipment	4,204	5,178
Amortisation on intangible assets	1,124	1,036
Net impairments	(1,228)	897
Movement in credit loss allowance: contract receivables / contract assets	(65)	0
Movement in credit loss allowance: all other receivables and investments	0	43
Increase/(decrease) in other provisions	19	0
Audit fees payable to the external auditor		
audit services- statutory audit	54	54
other auditor remuneration (external auditor only)	17	16
Internal audit costs	170	162
Clinical negligence	6,077	5,664
Legal fees	178	146
Insurance	150	129
Research and development	474	461
Education and training	2,343	2,130
Rentals under operating leases	374	347
Redundancy	0	136
Charges to operating expenditure for on-SoFP IFRIC 12 schemes (e.g. PFI / LIFT)	0	409
Car parking & security	35	22
Hospitality	53	53
Losses, ex gratia & special payments	0	5
Other services, eg external payroll	59	365
Other	978	616
Total	**214,937**	**201,420**

Note 7.2 Other auditor remuneration

	2018/19 £000	2017/18 £000
Other auditor remuneration paid to the external auditor:		
1. Audit of accounts of any associate of the trust	4	4
2. Audit-related assurance services	12	12
3. Taxation compliance services	0	0
4. All taxation advisory services not falling within item 3 above	0	0
5. Internal audit services	0	0
6. All assurance services not falling within items 1 to 5	0	0
7. Corporate finance transaction services not falling within items 1 to 6 above	0	0
8. Other non-audit services not falling within items 2 to 7 above	1	0
Total	**17**	**16**

Note 7.3 Limitation on auditor's liability

There is no limitation on auditor's liability for external audit work carried out for the financial years 2018/19 or 2017/18.

Note 8 Impairment of assets

	2018/19 £000	2017/18 £000
Net impairments charged to operating surplus / deficit resulting from:		
Changes in market price	(1,228)	897
Total net impairments charged to operating surplus / deficit	**(1,228)**	**897**
Impairments charged to the revaluation reserve	2	105
Total net impairments	**(1,226)**	**1,002**

Note 9 Employee benefits

	2018/19 Total £000	2017/18 Total £000
Salaries and wages	95,939	98,847
Social security costs	9,636	9,228
Apprenticeship levy	468	413
Employer's contributions to NHS pensions	11,915	11,570
Pension cost - other	24	11
Other post employment benefits	49	36
Temporary staff (including agency)	15,565	6,054
Total gross staff costs	**133,596**	**126,159**
Recoveries in respect of seconded staff	**0**	(999)
Total staff costs	**133,596**	**125,160**
Of which		
Costs capitalised as part of assets	675	2,491
Costs charged to Statement of Comprehensive Income	132,921	122,669
Analysed as:		
Staff and Executive Director Costs	131,240	120,836
Included in Research and Development Costs	474	461
Included in Education and Training Costs	1,207	1,236
Redundancy Costs	0	136
	132,921	**122,669**

Note 9.1 Retirements due to ill-health

During 2018/19 there were 2 early retirements from the trust agreed on the grounds of ill-health (1 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £193k (£66k in 2017/18).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

Note 10 Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019, is based on valuation data as 31 March 2018, updated to 31 March 2019 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care have recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018 Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

Note 11 Operating leases

Note 11.1 Northern Devon Healthcare NHS Trust as a lessor

The trust has no lessor agreements.

Note 11.2 Northern Devon Healthcare NHS Trust as a lessee

This note discloses costs and commitments incurred in operating lease arrangements where Northern Devon Healthcare NHS Trust is the lessee.

	2018/19	2017/18
	£000	£000
Operating lease expense		
Minimum lease payments	374	347
Total	**374**	**347**

	31 March 2019	31 March 2018
	£000	£000
Future minimum lease payments due:		
- not later than one year;	388	298
- later than one year and not later than five years;	601	554
Total	**989**	**852**
Future minimum sublease payments to be received	0	0

Note 12 Finance income

Finance income represents interest received on assets and investments in the period.

	2018/19	2017/18
	£000	£000
Interest on bank accounts	75	21
Total finance income	**75**	**21**

Note 13 Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

Note 13.1 Interest expenditure

	2018/19	2017/18
	£000	£000
Interest expense:		
Loans from the Department of Health and Social Care	181	94
Interest on late payment of commercial debt	10	41
Main finance costs on PFI and LIFT schemes obligations	0	602
Contingent finance costs on PFI and LIFT scheme obligations	0	454
Total interest expense	**191**	**1,191**
Total finance costs	**191**	**1,191**

Note 13.2 The late payment of commercial debts (interest) Act 1998 / Public Contract Regulations 2015

	2018/19	2017/18
	£000	£000
Total liability accruing in year under this legislation as a result of late payments	0	0
Amounts included within interest payable arising from claims under this legislation	10	41
Compensation paid to cover debt recovery costs under this legislation	0	0

Note 14 Other gains / (losses)

	2018/19	2017/18
	£000	£000
Gains on disposal of assets	2	0
Losses on disposal of assets	0	(3)
Total gains / (losses) on disposal of assets	**2**	**(3)**
Gains / (losses) on foreign exchange	0	0
Fair value gains / (losses) on investment properties	0	0
Fair value gains / (losses) on financial assets / investments	0	0
Fair value gains / (losses) on financial liabilities	0	0
Recycling gains / (losses) on disposal of financial assets mandated as fair value through OCI	0	0
Total other gains / (losses)	**2**	**(3)**

Note 15 Intangibles - 2018/19

	Software licences	Licences & trademarks	Development expenditure	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018 - brought forward	**9,676**	**1,709**	**1,999**	**13,384**
Transfers by absorption	0	0	0	**0**
Additions	65	16	740	**821**
Reclassifications	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Valuation / gross cost at 31 March 2019	**9,741**	**1,725**	**2,739**	**14,205**
Amortisation at 1 April 2018 - brought forward	**3,184**	**1,255**	**59**	**4,498**
Transfers by absorption	0	0	0	**0**
Provided during the year	932	192	0	**1,124**
Reclassifications	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	**0**
Disposals / derecognition	0	0	0	**0**
Amortisation at 31 March 2019	**4,116**	**1,447**	**59**	**5,622**
Net book value at 31 March 2019	**5,625**	**278**	**2,680**	**8,583**
Net book value at 1 April 2018	**6,492**	**454**	**1,940**	**8,886**

Note 15.1 Intangibles - 2017/18

	Software licences	Licences & trademarks	Development expenditure	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**3,343**	**1,855**	**6,711**	**11,909**
Transfers by absorption	0	0	0	**0**
Additions	373	154	1,343	**1,870**
Reclassifications	6,055	0	(6,055)	**0**
Transfers to / from assets held for sale	0	0	0	**0**
Disposals / derecognition	(95)	(300)	0	**(395)**
Valuation / gross cost at 31 March 2018	**9,676**	**1,709**	**1,999**	**13,384**
Amortisation at 1 April 2017 - as previously stated	**2,452**	**1,346**	**59**	**3,857**
Transfers by absorption	0	0	0	**0**
Provided during the year	827	209	0	**1,036**
Reclassifications	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	**0**
Disposals / derecognition	(95)	(300)	0	**(395)**
Amortisation at 31 March 2018	**3,184**	**1,255**	**59**	**4,498**
Net book value at 31 March 2018	**6,492**	**454**	**1,940**	**8,886**
Net book value at 1 April 2017	**891**	**509**	**6,652**	**8,052**

Note 16 Property, plant and equipment - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation/gross cost at 1 April 2018 - brought forward	**6,330**	**54,848**	**524**	**1,059**	**17,419**	**12**	**4,558**	**768**	**85,518**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Additions	0	1,320	0	253	2,059	0	830	51	**4,513**
Impairments	0	(340)	0	0	0	0	0	0	**(340)**
Reversals of impairments	0	1,551	15	0	0	0	0	0	**1,566**
Revaluations	0	(1,435)	(15)	0	0	0	0	0	**(1,450)**
Reclassifications	0	1,210	0	(1,210)	0	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(380)	0	(705)	0	**(1,085)**
Valuation/gross cost at 31 March 2019	**6,330**	**57,154**	**524**	**102**	**19,098**	**12**	**4,683**	**819**	**88,722**
Accumulated depreciation at 1 April 2018 - brought forward	**0**	**0**	**0**	**0**	**14,820**	**12**	**2,884**	**287**	**18,003**
Transfers by absorption	0	0	0	0	0	0	0	0	**0**
Provided during the year	0	2,332	65	0	1,050	0	679	78	**4,204**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(2,332)	(65)	0	0	0	0	0	**(2,397)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(380)	0	(705)	0	**(1,085)**
Accumulated depreciation at 31 March 2019	**0**	**0**	**0**	**0**	**15,490**	**12**	**2,858**	**365**	**18,725**
Net book value at 31 March 2019	**6,330**	**57,154**	**524**	**102**	**3,608**	**0**	**1,825**	**454**	**69,997**
Net book value at 1 April 2018	**6,330**	**54,848**	**524**	**1,059**	**2,599**	**0**	**1,674**	**481**	**67,515**

Note 16.1 Property, plant and equipment - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017 - as previously stated	**7,530**	**67,097**	**524**	**3,228**	**18,427**	**12**	**5,205**	**610**	**102,633**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Valuation / gross cost at 1 April 2017 - restated	**7,530**	**67,097**	**524**	**3,228**	**18,427**	**12**	**5,205**	**610**	**102,633**
Transfers by absorption	(1,200)	(15,026)	0	0	0	0	0	0	**(16,226)**
Additions	0	1,902	0	1,266	538	0	737	201	**4,644**
Impairments	0	(1,410)	0	0	0	0	0	0	**(1,410)**
Reversals of impairments	0	394	14	0	0	0	0	0	**408**
Revaluations	0	(1,544)	(14)	0	0	0	0	0	**(1,558)**
Reclassifications	0	3,435	0	(3,435)	0	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,546)	0	(1,384)	(43)	**(2,973)**
Valuation/gross cost at 31 March 2018	**6,330**	**54,848**	**524**	**1,059**	**17,419**	**12**	**4,558**	**768**	**85,518**
Accumulated depreciation at 1 April 2017 - as previously stated	**0**	**0**	**0**	**0**	**14,925**	**12**	**3,468**	**273**	**18,678**
Prior period adjustments	0	0	0	0	0	0	0	0	**0**
Accumulated depreciation at 1 April 2017 - restated	**0**	**0**	**0**	**0**	**14,925**	**12**	**3,468**	**273**	**18,678**
Transfers by absorption	0	(374)	0	0	0	0	0	0	**(374)**
Provided during the year	0	2,821	64	0	1,436	0	800	57	**5,178**
Impairments	0	0	0	0	0	0	0	0	**0**
Reversals of impairments	0	0	0	0	0	0	0	0	**0**
Revaluations	0	(2,447)	(64)	0	0	0	0	0	**(2,511)**
Reclassifications	0	0	0	0	0	0	0	0	**0**
Transfers to / from assets held for sale	0	0	0	0	0	0	0	0	**0**
Disposals / derecognition	0	0	0	0	(1,541)	0	(1,384)	(43)	**(2,968)**
Accumulated depreciation at 31 March 2018	**0**	**0**	**0**	**0**	**14,820**	**12**	**2,884**	**287**	**18,003**
Net book value at 31 March 2018	**6,330**	**54,848**	**524**	**1,059**	**2,599**	**0**	**1,674**	**481**	**67,515**
Net book value at 1 April 2017	**7,530**	**67,097**	**524**	**3,228**	**3,502**	**0**	**1,737**	**337**	**83,955**

Note 16.2 Property, plant and equipment financing - 2018/19

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2019								
Owned - purchased	6,330	54,418	524	42	3,254	1,824	396	**66,788**
Finance leased	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts and other service concession arrangements	0	0	0	0	0	0	0	**0**
Off-SoFP PFI residual interests	0	0	0	0	0	0	0	**0**
Owned - government granted	0	0	0	0	0	0	0	**0**
Owned - donated	0	2,736	0	60	354	1	58	**3,209**
NBV total at 31 March 2019	**6,330**	**57,154**	**524**	**102**	**3,608**	**1,825**	**454**	**69,997**

Note 16.3 Property, plant and equipment financing - 2017/18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000
Net book value at 31 March 2018								
Owned - purchased	6,330	52,265	524	1,046	2,156	1,674	412	**64,407**
Finance leased	0	0	0	0	0	0	0	**0**
On-SoFP PFI contracts and other service concession arrangements	0	0	0	0	0	0	0	**0**
Off-SoFP PFI residual interests	0	0	0	0	0	0	0	**0**
Owned - government granted	0	0	0	0	0	0	0	**0**
Owned - donated	0	2,583	0	13	443	0	69	**3,108**
NBV total at 31 March 2018	**6,330**	**54,848**	**524**	**1,059**	**2,599**	**1,674**	**481**	**67,515**

Note 17 Donations of property, plant and equipment

Various donors have funded assets during the year, including Over and Above and League of Friends of all hospitals.

Note 18 Revaluations of property, plant and equipment

All land and buildings are restated to current modern equivalent asset value using professional valuations in accordance with IAS16 every five years and in the intervening years by annual desk top exercise undertaken by the District Valuer, an arm of the Valuation Office, which is an executive agency of HM Revenue and Customs. A professional valuation from D Corbett MRICS, District Valuer has been undertaken at the end of the year and the revaluation has been applied to all land and buildings. The District Valuer undertook a full revaluation on 31st March 2015 of all land and buildings and the next full valuation will be due on 31st March 2020. Asset valuations have increased this year as per the detail in note 1.7.2

	31 March 2019		31 March 2018	
	£000	£000	£000	£000
Impact of Revaluation:				
Impairments taken to SOCI	(328)		(1,272)	
Reversal of impairments previously taken to SOCI	1,556		375	
		1,228		(897)
Impairments taken to Revaluation Reserve	(12)		(138)	
Reversal of impairments previously taken to Revaluation Reserve	10		33	
		(2)		(105)
Revaluation taken to Revaluation Reserve		948		953
		2,174		**(49)**

Note 19 Investment Property

The Trust has no investment property.

Note 20 Investments in associates and joint ventures

The Trust has no investments.

Note 21 Disclosure of interests in other entities

The Trust does not hold any interests in other entities

Note 22 Inventories

	31 March 2019	31 March 2018
	£000	£000
Drugs	797	866
Consumables	1,902	2,082
Energy	89	101
Total inventories	**2,788**	**3,049**

Inventories recognised in expenses for the year were £32,405k (2017/18: £36,913k). Write-down of inventories recognised as expenses for the year were £0k (2017/18: £0k).

Note 23 Trade receivables and other receivables

Note 23.1 Trade receivables and other receivables

	31 March 2019 £000	31 March 2018 £000
Current		
Contract receivables*	7,671	0
Contract assets*	0	0
Trade receivables*	0	11,627
Capital receivables	72	0
Accrued income*	0	0
Allowance for impaired contract receivables / assets*	(14)	0
Allowance for other impaired receivables	0	(5)
Deposits and advances	0	0
Prepayments (non-PFI)	1,435	1,529
Interest receivable	0	0
Finance lease receivables	0	0
PDC dividend receivable	259	156
VAT receivable	371	437
Other receivables	0	56
Total current trade and other receivables	**9,794**	**13,800**
Non-current		
Contract receivables*	1,073	0
Contract assets*	0	0
Trade receivables*	0	1,345
Capital receivables	0	0
Accrued income*	0	0
Allowance for impaired contract receivables / assets*	(235)	0
Allowance for other impaired receivables	0	(309)
Deposits and advances	0	0
Interest receivable	0	0
Finance lease receivables	0	0
VAT receivable	0	0
Corporation and other taxes receivable	0	0
Other receivables	0	0
Total non-current trade and other receivables	**838**	**1,036**
Of which receivables from NHS and DHSC group bodies:		
Current	4,413	8,660
Non-current	0	0

*Following the application of IFRS 15 from 1 April 2018, the trust's entitlements to consideration for work performed under contracts with customers are shown separately as contract receivables and contract assets. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated under IFRS 15.

Note 23.2 Allowances for credit losses - 2018/19

	Contract receivables and contract assets	All other receivables
	£000	£000
Allowances as at 1 Apr 2018 - brought forward		**314**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	314	(314)
Transfers by absorption	0	0
New allowances arising	73	0
Changes in existing allowances	(85)	0
Reversals of allowances	(53)	0
Utilisation of allowances (write offs)	0	0
Changes arising following modification of contractual cash flows	0	0
Foreign exchange and other changes	0	0
Allowances as at 31 Mar 2019	**249**	**0**

Note 23.3 Allowances for credit losses - 2017/18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	All receivables
	£000
Allowances as at 1 Apr 2017 - as previously stated	**336**
Prior period adjustments	0
Allowances as at 1 Apr 2017 - restated	**336**
Transfers by absorption	
Increase in provision	81
Amounts utilised	(65)
Unused amounts reversed	(38)
Allowances as at 31 Mar 2018	**314**

Note 23.4 Exposure to credit risk

The Trust does not consider it has a material exposure to credit risk.

Note 24 Other assets

The Trust does not have any other assets to disclose.

Note 25 Non-current assets held for sale and assets in disposal groups

The Trust does not have any assets held for sale.

Note 25.1 Liabilities in disposal groups

The Trust does not have any liabilities in disposal groups.

Note 26 Cash and cash equivalents

Note 26.1 Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	2018/19	2017/18
	£000	£000
At 1 April	**4,051**	**1,602**
Prior period adjustments	0	0
At 1 April (restated)	**4,051**	**1,602**
Transfers by absorption	0	0
Net change in year	1,295	2,449
At 31 March	**5,346**	**4,051**
Broken down into:		
Cash at commercial banks and in hand	9	9
Cash with the Government Banking Service	5,337	4,042
Deposits with the National Loan Fund	0	0
Other current investments	0	0
Total cash and cash equivalents as in SoFP	**5,346**	**4,051**
Bank overdrafts (GBS and commercial banks)	0	0
Drawdown in committed facility	0	0
Total cash and cash equivalents as in SoCF	**5,346**	**4,051**

Note 26.2 Third party assets held by the trust

The trust may hold cash and cash equivalents which relate to monies held by the Trust on behalf of patients or other parties. This would be excluded from the cash and cash equivalents figure reported in the accounts, however the balance was zero at the end of the financial year (2017-18 - under £1,000).

Note 27 Trade and other payables

Note 27.1 Trade and other payables

	31 March 2019 £000	31 March 2018 £000
Current		
Trade payables	10,555	8,867
Capital payables	914	416
Accruals	3,795	2,740
Receipts in advance (including payments on account)	0	0
Social security costs	2,486	2,297
VAT payables	0	0
Other taxes payable	0	0
PDC dividend payable	0	0
Accrued interest on loans*	0	21
Other payables	96	96
Total current trade and other payables	**17,846**	**14,437**
Non-current		
Trade payables	0	0
Capital payables	0	0
Accruals	0	0
Receipts in advance (including payments on account)	0	0
VAT payables	0	0
Other taxes payable	0	0
Other payables	0	0
Total non-current trade and other payables	**0**	**0**
Of which payables from NHS and DHSC group bodies:		
Current	3,240	1,913
Non-current	0	0

*Following adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within note . IFRS 9 is applied without restatement therefore comparatives have not been restated.

Note 27.2 Early retirements in NHS payables above

Payables do not include any amounts relating to early retirements.

Note 28 Other financial liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Derivatives held at fair value through income and expenditure	0	0
Other financial liabilities	0	0
Total	**0**	**0**
Non-current		
Derivatives held at fair value through income and expenditure	0	0
Other financial liabilities	0	0
Total	**0**	**0**

Note 29 Other liabilities

	31 March 2019 £000	31 March 2018 £000
Current		
Deferred income: contract liabilities	0	2,903
Deferred grants	0	0
PFI deferred income / credits	0	0
Lease incentives	0	0
Other deferred income	2,833	
Total other current liabilities	**2,833**	**2,903**
Non-current		
Deferred income: contract liabilities	0	0
Deferred grants	0	0
PFI deferred income / credits	0	0
Lease incentives	0	0
Other deferred income	0	0
Net pension scheme liability	0	0
Total other non-current liabilities	**0**	**0**

Comparators are not restated for the change in impact of applying IFRS15 to the current year accounts.

Note 30 Borrowings

	31 March 2019 £000	31 March 2018 £000
Current		
Loans from the Department of Health and Scoial Care	5,364	0
Other loans	711	711
Total current borrowings	**6,075**	**711**
Non-current		
Loans from the Department of Health and Social Care	11,919	6,929
Other loans	607	1,318
Total non-current borrowings	**12,526**	**8,247**

Note 30.1 Reconciliation of liabilities arising from financing activities

	Loans from DHSC	Other loans	Total
	£000	£000	£000
Carrying value at 1 April 2018	**6,929**	**2,029**	**8,958**
Cash movements:			
Financing cash flows - payments and receipts of principal	10,274	(711)	**9,563**
Financing cash flows - payments of interest	(122)	0	**(122)**
Non-cash movements:			
Impact of implementing IFRS 9 on 1 April 2018	21	0	**21**
Transfers by absorption	0	0	**0**
Additions	0	0	**0**
Application of effective interest rate	181	0	**181**
Change in effective interest rate	0	0	**0**
Changes in fair value	0	0	**0**
Other changes	0	0	**0**
Carrying value at 31 March 2019	**17,283**	**1,318**	**18,601**

Note 31 Finance leases

Note 31.1 Northern Devon Healthcare NHS Trust as a lessor

The Trust has no current lease obligations as a lessor.

Note 31.2 Northern Devon Healthcare NHS Trust as a lessee

The Trust has no current lease obligations as a lessee.

Note 32.1 Provisions for liabilities and charges analysis

	31 March 2019 Legal claims £000	31 March 2019 Total £000	31 March 2018 Legal claims £000	31 March 2018 Total £000
At 1 April 2018	**29**	**29**	**19**	**19**
Transfers by absorption	0	**0**	0	**0**
Change in the discount rate	0	**0**	0	**0**
Arising during the year	32	**32**	21	**21**
Utilised during the year	0	**0**	(11)	**(11)**
Reclassified to liabilities held in disposal groups	0	**0**	0	**0**
Reversed unused	(13)	**(13)**	0	**0**
Unwinding of discount	0	**0**	0	**0**
At 31 March 2019	**48**	**48**	**29**	**29**
Expected timing of cash flows:				
- not later than one year;	0	**0**	0	**0**
- later than one year and not later than five years;	0	**0**	0	**0**
- later than five years.	48	**48**	0	**0**
Total	**48**	**48**	**0**	**0**

Provisions relate to Trust liabilities under the NHS Resolution LTPS and PES scheme for potential claims.

Note 32.2 Clinical negligence liabilities

At 31 March 2019, £128,203k was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Northern Devon Healthcare NHS Trust (31 March 2018: £123,066k).

Note 33 Contingent assets and liabilities

	31 March 2019 £000	31 March 2018 £000
Value of contingent liabilities		
NHS Resolution legal claims	(27)	(16)
Employment tribunal and other employee related litigation	0	0
Redundancy	0	0
Other	0	0
Gross value of contingent liabilities	**(27)**	**(16)**
Amounts recoverable against liabilities	0	0
Net value of contingent liabilities	**(27)**	**(16)**
Net value of contingent assets	**0**	**0**

Contingent liabilities relate to the associated provisions for claims under the NHS Resolution LTPS and PES schemes.

Note 34 Contractual capital commitments

	31 March 2019 £000	31 March 2018 £000
Property, plant and equipment	1,242	586
Intangible assets	0	0
Total	**1,242**	**586**

Note 35 Other financial commitments

The Trust has no other financial commitments

Note 36 Defined benefit pension schemes

There are no specific disclosures to make around the defined pension benefit scheme.

Note 36.1 Changes in the defined benefit obligation and fair value of plan assets during the year

There are no changes to report.

Note 36.2 Reconciliation of the present value of the defined benefit obligation and the present value of the plan assets to the assets and liabilities recognised in the balance sheet

There are no changes to reconcile.

Note 37 On-SoFP PFI, LIFT or other service concession arrangements

Tiverton Hospital transferred to NHS Property Services on 31st March 2018.

Note 37.1 Imputed finance lease obligations

Northern Devon Healthcare NHS Trust had no obligations in respect of finance lease elements of on-Statement of Financial Position PFI and LIFT schemes.

Note 37.2 Total on-SoFP PFI, LIFT and other service concession arrangement commitments

The Trust has no future obligations under on-SoFP schemes.

Note 37.3 Analysis of amounts payable to service concession operator

This note provides an analysis of the unitary payments made to the service concession operator:

	2018/19	2017/18
	£000	£000
Unitary payment payable to service concession operator	**0**	**1,806**
Consisting of:		
- Interest charge	0	602
- Repayment of finance lease liability	0	341
- Service element and other charges to operating expenditure	0	354
- Capital lifecycle maintenance	0	0
- Revenue lifecycle maintenance	0	55
- Contingent rent	0	454
- Addition to lifecycle prepayment	0	0
Other amounts paid to operator due to a commitment under the service concession contract but not part of the unitary payment	0	0
Total amount paid to service concession operator	**0**	**1,806**

Note 38 Off-SoFP PFI, LIFT and other service concession arrangements

Northern Devon Healthcare NHS Trust did not incur charges in respect of off-Statement of Financial Position PFI and LIFT obligations.

Note 39 Financial instruments

Note 39.1 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS Trust has with the CCG and the way those CCG'S are financed, the NHS Trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS Trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the board of directors. The Trust's treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust has borrowed from government for revenue financing, following approval by NHS Improvement. Interest rates are confirmed by the Department of Health (the lender) at the point borrowing is undertaken.

The Trust can borrow from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the trust's revenue comes from contracts with other public sector bodies, the trust's has low exposure to credit risk. The maximum exposures as at 31 March 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament . The trust funds its capital expenditure from funds agreed within its Capital Resource Limit. The Trust is not, therefore, exposed to significant liquidity risks.

Note 39.2 Carrying values of financial assets

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost	Held at fair value through I&E	Held at fair value through OCI	Total book value
	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	8,567	0	0	**8,567**
Other investments / financial assets	0	0	0	**0**
Cash and cash equivalents at bank and in hand	5,346	0	0	**5,346**
Total at 31 March 2019	**13,913**	**0**	**0**	**13,913**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables	Assets at fair value through the I&E	Held to maturity	Available-for-sale	Total book value
	£000	£000	£000	£000	£000
Trade and other receivables excluding non financial assets	9,574	0	0	0	**9,574**
Other investments / financial assets	0	0	0	0	**0**
Cash and cash equivalents at bank and in hand	4,051	0	0	0	**4,051**
Total at 31 March 2018	**13,625**	**0**	**0**	**0**	**13,625**

Note 39.3 Carrying value of financial liabilities

IFRS 9 Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

	Held at amortised cost	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2019 under IFRS 9			
Loans from the Department of Health and Social Care	17,283	0	**17,283**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	0	0	**0**
Other borrowings	1,318	0	**1,318**
Trade and other payables excluding non financial liabilities	11,873	0	**11,873**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2019	**30,474**	**0**	**30,474**

	Other financial liabilities	Held at fair value through the I&E	Total book value
	£000	£000	£000
Carrying values of financial liabilities as at 31 March 2018 under IAS 39			
Loans from the Department of Health and Social Care	6,929	0	**6,929**
Obligations under finance leases	0	0	**0**
Obligations under PFI, LIFT and other service concession contracts	0	0	**0**
Other borrowings	2,029	0	**2,029**
Trade and other payables excluding non financial liabilities	9,058	0	**9,058**
Other financial liabilities	0	0	**0**
Provisions under contract	0	0	**0**
Total at 31 March 2018	**18,016**	**0**	**18,016**

Note 39.4 Fair values of financial assets and liabilities

The Trust considers that book value (carrying value) is a reasonable approximation of fair value.

Note 39.5 Maturity of financial liabilities

	31 March 2019	31 March 2018
	£000	£000
In one year or less	17,948	9,770
In more than one year but not more than two years	2,252	2,357
In more than two years but not more than five years	4,774	605
In more than five years	5,500	5,284
Total	**30,474**	**18,016**

Note 40 Losses and special payments

	2018/19		2017/18	
	Total number of cases	Total value of cases	Total number of cases	Total value of cases
	Number	£000	Number	£000
Losses				
Cash losses	0	0	1	0
Fruitless payments	0	0	0	0
Bad debts and claims abandoned	124	10	39	2
Stores losses and damage to property	1	10	0	0
Total losses	**125**	**20**	**40**	**2**
Special payments				
Compensation under court order or legally binding arbitration award	0	0	0	0
Extra-contractual payments	0	0	0	0
Ex-gratia payments	16	47	12	12
Special severence payments	0	0	0	0
Extra-statutory and extra-regulatory payments	0	0	0	0
Total special payments	**16**	**47**	**12**	**12**
Total losses and special payments	**141**	**67**	**52**	**14**
Compensation payments received		0		0

Details of cases individually over £300k

There are none to report.

Note 41 Gifts

There are none to report.

Note 42 New standards

Note 42.1 Initial application of IFRS 9

IFRS 9 Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £21k, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model resulted in a £0k decrease in the carrying value of receivables.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classifiction of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £1,037k.

Note 42.2 Initial application of IFRS 15

IFRS 15 Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

Note 43 Related parties

During the year none of the Department of Health Ministers, Trust board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Northern Devon Healthcare NHS Trust.

The Department of Health is regarded as a related party. During the year Northern Devon Healthcare NHS Trust has had a significant number of material transactions with the Department, and with other entities for which the Department is regarded as the parent department. For example :

	2018-2019		2017-2018	
	Income £000's	Expenditure £000's	Income £000's	Expenditure £000's
NEW Devon CCG	138,251	349	139,784	120
NHS England and Local Area Teams	18,088	25	23,244	4
NHS Kernow CCG	7,172	0	6,241	0
NHS South Devon and Torbay CCG	1,306	0	1,343	0
Royal Devon & Exeter NHS Foundation Trust	1,235	5,481	2,810	5,306
Torbay and South Devon NHS Foundation Trust	14	1,321	4	283
North Bristol NHS Trust	0	111	40	106
Devon Partnership Trust	1,643	137	2,986	208
NHS Pensions Agency	0	11,915	0	11,570
Health Education England	4,441	6	4,353	13
NHS Litigation Authority	9	6,225	0	5,766
NHS Blood and Transplant	11	646	13	628

	2018-2019		2017-2018	
	Debtors £000's	Creditors £000's	Debtors £000's	Creditors £000's
NEW Devon CCG	1,988	449	1,149	17
NHS England and Local Area Teams	373	1,477	2,903	431
NHS Kernow CCG	239	0	29	0
NHS South Devon and Torbay CCG	0	0	0	58
Royal Devon & Exeter NHS Foundation Trust	554	812	769	1,035
Torbay and South Devon NHS Foundation Trust	42	209	28	11
North Bristol NHS Trust	0	26	16	31
Devon Partnership Trust	22	1	424	59
NHS Pensions Agency	0	1,702	0	1,598
Health Education England	288	0	201	0
NHS Litigation Authority	0	0	0	0
NHS Blood and Transplant	0	0	0	10

In addition, the trust has had a number of material transactions with other government departments, other central and local government bodies plus its linked charity.

	2018-2019		2017-2018	
	Income £000	Expenditure £000	Income £000	Expenditure £000
Most of these transactions have been with:				
Devon County Council in respect of Public Health Services and Domiciliary Care	18,853	330	18,412	84
Inland Revenue in respect of tax and national insurance; and	0	10,104	2,297	21,211
HMRC in respect of VAT payable and recoverable.	3,075	0	3,390	0
NHS Professionals	0	5,964	0	4,638
NHS Supplies Authority	0	3,685	0	3,226
Northern Devon Healthcare Trust Charitable Fund	204	0	140	0

Note 44 Transfers by absorption

Transfer by absorption costing relates to the transfer of Tiverton Hospital PFI to NHS Property Services on 31st March 2018. There were no transfers in 2018/19.

	31 March 2019 £000	31 March 2018 £000
Value of Property, plant and equipment transferred	0	(15,852)
Value of inventories transferred	0	0
Value of cash balances transferred	0	0
Less		
Amount of PFI liability transferred	0	7,639
	0	**(8,213)**

Note 45 Prior period adjustments

The Trust has not made any prior period adjustments.

Note 46 Events after the reporting date

There are no events to report

Note 47 Final period of operation as a trust providing NHS healthcare

The Trust is not completing accounts as a final period of operation.

Note 48 Better Payment Practice code

	2018/19 Number	2018/19 £000	2017/18 Number	2017/18 £000
Non-NHS Payables				
Total non-NHS trade invoices paid in the year	56,480	78,247	54,996	76,399
Total non-NHS trade invoices paid within target	54,284	74,933	41,770	65,367
Percentage of non-NHS trade invoices paid within target	96.1%	95.8%	76.0%	85.6%
NHS Payables				
Total NHS trade invoices paid in the year	1,811	74,862	2,051	70,230
Total NHS trade invoices paid within target	1,687	72,339	940	61,556
Percentage of NHS trade invoices paid within target	93.2%	96.6%	45.8%	87.6%

The Better Payment Practice code requires the NHS body to aim to pay all valid invoices by the due date or within 30 days of receipt of valid invoice, whichever is later.

Note 49 External financing

The trust is given an external financing limit against which it is permitted to underspend:

	2018/19	2017/18
	£000	£000
Cash flow financing	8,826	(1,826)
Finance leases taken out in year	0	0
Other capital receipts	0	0
External financing requirement	**8,826**	**(1,826)**
External financing limit (EFL)	12,963	(1,590)
Under / (over) spend against EFL	**4,137**	**236**

Note 50 Capital Resource Limit

	2018/19	2017/18
	£000	£000
Gross capital expenditure	5,334	6,514
Less: Disposals	0	(5)
Less: Donated and granted capital additions	(168)	(263)
Plus: Loss on disposal from capital grants in kind	0	0
Charge against Capital Resource Limit	**5,166**	**6,246**
Capital Resource Limit	5,428	6,265
Under / (over) spend against CRL	**262**	**19**

The Capital Resource Limit is set at the beginning of the year based on forecast depreciation, less any loan commitments. It is increased during the year on receipt of Public Dividend Capital to support the Trust's capital programme.

During the year depreciation underspent against plan by £254k,and this reduces the internal funding available to spend on the capital programme. At the year end the Trust had underspent against permitted funding levels by £8k.

Note 51 Breakeven duty financial performance

	2018/19
	£000
Adjusted financial performance surplus / (deficit) (control total basis)	(16,633)
Remove impairments scoring to Departmental Expenditure Limit	0
Add back non-cash element of On-SoFP pension scheme charges	0
IFRIC 12 breakeven adjustment	0
Breakeven duty financial performance surplus / (deficit)	**(16,633)**

Note 52 Breakeven duty rolling assessment

	1997/98 to 2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17	2017/18	2018/19
		£000	£000	£000	£000	£000	£000	£000	£000	£000	£000
Breakeven duty in-year financial performance		0	252	1,719	2,205	2,240	2,337	(4,647)	2,232	6,974	(16,633)
Breakeven duty cumulative position	251	251	503	2,222	4,427	6,667	9,004	4,357	6,589	13,563	(3,070)
Operating income		128,509	134,710	211,041	220,680	225,787	234,685	233,235	217,580	210,199	201,225
Cumulative breakeven position as a percentage of operating income		0.2%	0.4%	1.1%	2.0%	3.0%	3.8%	1.9%	3.0%	6.5%	(1.5%)