NHS
Royal Cornwall Hospitals
NHS Trust

Annual Report and Accounts

1 April 2017 - 31 March 2018

One + all | we care

Care + Compassion | Inspiration + Innovation | Working Together | Pride + Achievement | Trust + Respect


Getting ready to leave hospital
NORWEGIAN WOOD
CHOPPING, STACKING, DRYING WOOD THE SCANDINAVIAN WAY

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Chief Executive Foreword

This Annual Report, from 1st April 2017 to 31st March 2018, covers one of the most challenging periods in the Trust's recent history.
In July 2017, the Care Quality Commission (CQC) rated the Trust 'Inadequate' and the organisation was placed in 'special measures' for quality.

The Trust Board has understood the clear message from our regulators that progress in recent years has been insufficient and as an organisation we have been too slow to respond to concerns.

The focus throughout 2017/18 was to make urgent and sustained improvement. We established a Trust Improvement Programme to respond to the immediate CQC concerns and then to maintain progress on quality and safety in three critical areas: safety culture; tackling patient delay; and strong governance.

Towards the end of the reporting year, with the support of our partner organisations, we started to see improvement in several areas including the management of emergency and urgent patients which impacts significantly on other services. In the last days of March, we were able to achieve the national emergency care access standard and sustain that improvement into 2018/19. We also started to provide normal levels of planned care again in March 2018, following a winter of extreme demand for urgent care and during which we were only able to carry out minimal routine operations.

Overall, performance for 2017/18 was below the high standards expected and we owe it to the community we serve to make further improvements in 2018/19.

We remain grateful for the strong community support for our staff and hospitals, and despite the current challenges, patient feedback remains overwhelmingly positive and there is strong recognition for the caring staff and volunteers in all our hospitals. In July 2017, the CQC did also praise our caring staff and pinpointed areas of good practice. West Cornwall Hospital and St Michael's Hospital achieved 'Good' overall ratings and St Michael's Hospital and Critical Care services were rated 'Outstanding for Caring'.

Our staff can be proud of service improvements in important areas such as paediatric care, investment in diagnostic and treatment technology, leadership in research and innovation and new facilities such as the new neonatal unit and birth centre in Truro. In areas such as mortality, sepsis and pressure ulcers we have seen good progress and on cancer care we remain one of the few Trusts in the region to achieve the national standards each quarter.

The Trust Board would like to thank Roger Gazzard and Charlotte Russell, whose terms of office as Non-Executive Directors both came to the end in 2017/18, for their service to the organisation and local community and we wish them both well for the future.

The priority for the forthcoming year is to provide safe care every time and we will only do this through improved support for our staff and collaboration with our partners. We started to see progress in this area in 2017/18 with positive signs in the annual staff survey, the joint work to de-escalate from winter pressures and the set-up of an integrated NHS 111 and out of hours GP service to better manage demand for urgent care.

Our clinical and frontline staff have responded admirably to the service pressures and the concerns of regulators. We must now invest in our staff and clinical leaders if we are to achieve our ambition of 'outstanding care' for Cornwall and the Isles of Scilly.

Kathy Byrne
Chief Executive

1 Performance Report overview

About Royal Cornwall Hospitals NHS Trust

Royal Cornwall Hospitals NHS Trust (RCHT) is the main provider of acute hospital and specialist services for the majority of the population of Cornwall and the Isles of Scilly, approximately 450,000 people. The population we serve can more than double during busy holiday periods.

Our work is founded on the National Health Service (NHS) Constitution and achieving the national standards set by NHS England and the UK Government, working in partnership with our regulators and local commissioners. Our main commissioner is NHS Kernow Clinical Commissioning Group and the Trust is registered with the Care Quality Commission.

We deliver care from three main sites – Royal Cornwall Hospital, Truro; St Michael's Hospital, Hayle; and West Cornwall Hospital, Penzance – as well as providing outpatient, maternity and clinical imaging services at community hospitals and other locations across Cornwall & the Isles of Scilly.

Our vision and values

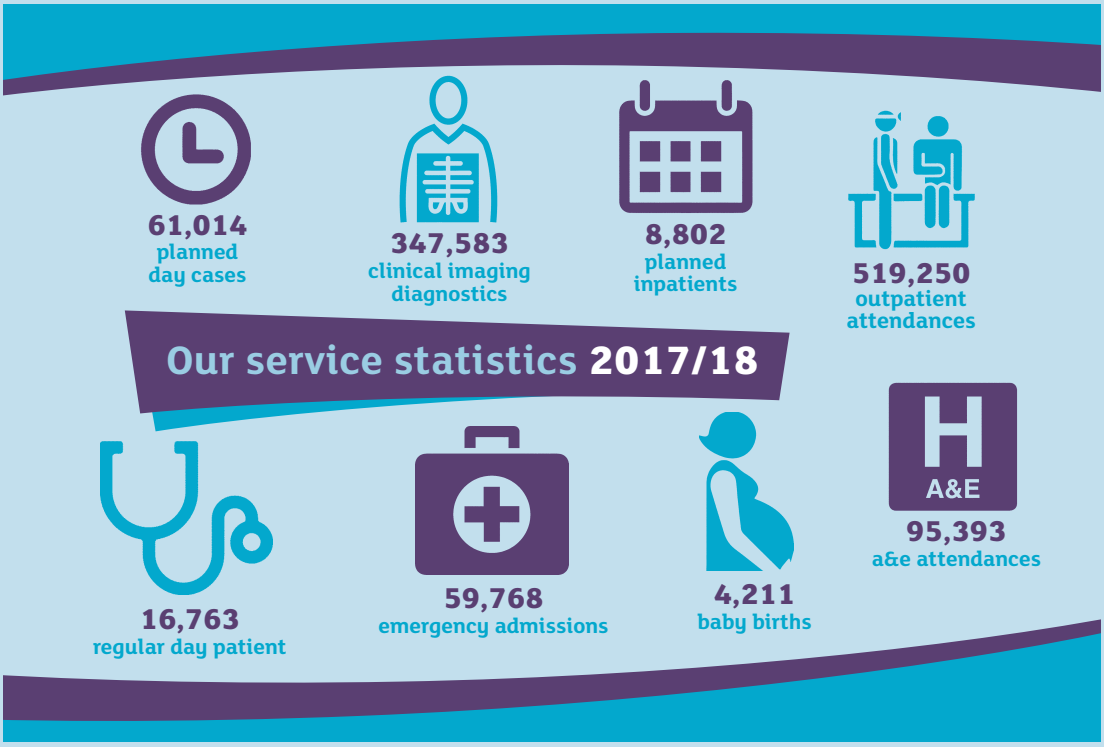
The Trust has set its vision as 'Working together to provide outstanding care' to reflect our ambition and principles with a set of core values developed through engagement with our staff. Our values are:

- **Care + Compassion**
  We see the person in every patient, communicating with honesty and compassion. We listen and act on feedback to ensure outstanding care.
- **Inspiration + Innovation**
  We welcome new ideas and use our initiative to solve problems together. We value learning and research to improve services.
- **Working Together**
  We work to create a positive team spirit, recognise achievements and celebrate success. We are open,inclusive and want to continually improve.
- **Pride + Achievement**
  We take pride in our work and always go the extra mile. We lead by example and ensure quality is at the heart of all we do.
- **Trust + Respect**
  We respect and consider other people's views and feelings. We seek consensus and respond to situations professionally and calmly.

Our team and governance

The Trust Board is made up of Non-Executive and Executive Directors who together are responsible for leading Royal Cornwall Hospitals NHS Trust. The Trust has four clinical divisions: Medicine; Surgery; Clinical Support and Cancer Services; Women, Children and Sexual Health.
Clinical services are supported by corporate teams including finance, human resources and estates and facilities. Payroll and information technology services are hosted by Royal Cornwall Hospitals on behalf of the local NHS community, which includes the provision of IT services to GP surgeries. Soft Facilities Management services - such as cleaning, portering, ward host/ housekeeping, mail room – are provided by MITIE Clean Environments. Car parking facilities for visitors and staff are managed by Q-Park.

The Royal Cornwall Hospitals NHS Trust is a teaching hospitals trust as part of the University of Exeter Medical School and the University of Plymouth (nursing and dental faculties). We also have an expanding Research, Development and Innovation portfolio.
With over 5,000 staff we are among the largest employers in Cornwall. During 2017-18 our staff provided care for more than 650,000 inpatient and outpatient attendances.



Strategic aims and priorities

To help achieve the Trust's vision and required national standards we have developed a set of strategic aims and priorities summarised below. These have been developed with our staff based on our ambitions and challenges as well as reflecting on the views of our regulators, partners and the population we serve.

Our Vision - 'Working together to provide outstanding care'

Our strategic aims:

Quality
Provide Compassionate, safe, effective care

People
Attract, develop and retain excellent staff

Partnership
Offer, integrated care, as close to home as possible

Resources
Make the best use of all of our resources

Our priorities 2017-2019:

- Improve patient experience and outcomes by reducing waits in ED and maximising our elective capacity
- Keep our patients safe, focus on a reduction in falls and pressure ulcers
- Deliver our CQC action plan to achieve national quality standards
- Listen and respond to our patients to inform how we improve our services.

- Ensure our staff have the right skills & experience to provide effective care.
- Make RCHT an employer of choice by listening and acting on staff feedback.
- Create a learning environment where staff reach their full potential every day.
- Improve patient outcomes by empowering our clinical leaders to design effective services.

Through 'Shaping our Future' we will form an accountable care system to;

- Eliminate organisational barriers
- Enable our citizens to live healthier lives and maximise independence
- Offer urgent, community and social care which meets the needs of our citizens

- Expand our Research and innovation opportunities in order to improve patient care.

- To be a financially stable organisation
- Increase funds available for patient care by reducing overhead costs across the Trust and health system
- Transform services to increase quality and reduce inefficiency and waste
- Invest to improve our equipment, IT systems and infrastructure.

In our 2017/19 Operational Plan we said that of particular importance were:

- Delivering core standards for emergency and elective care, in particular the availability of care and support to reduce delays.
- Improving the safety and responsiveness of our services – as reflected in the findings of the CQC inspection in 2016 and subsequent revisit in January 2017.
- Working with partners to develop and implement the Sustainability and Transformation Plan, 'Shaping our Future'.
- Adopting a transformation programme to achieve quality and financial goals, consistent with Shaping our Future.

In December 2017, following an inspection report by the Care Quality Commission and through engagement with our staff, we developed our priorities to focus resources on quality improvement. We established three Trust improvement priorities with specific projects within each area with progress tracked through a Quality Improvement Delivery Board. The three Trust improvement priorities are:

- Safety Culture: We will adopt best practice to keep patients safe from avoidable harm.
- Tackling Delay: We will eliminate patient delay at every stage of care in the pursuit of safety.
- Strong governance: We will be a well-led, learning organisation that places the patient at the centre of care.

We give full consideration to the risks we face and the mitigation to achieve our priorities. Our main risks include:

- The impact of rising demand for urgent care services and delayed transfers of care to domiciliary and residential care.
- The delivery of Cost Improvement Programmes without impacting on quality. Insufficient capital/revenue investment required for a sustainable future.
- Evidencing the delivery of the Care Quality Commission improvement plan.
- Recruitment, retention and motivation of our workforce to ensure services are delivered and that service transformation is prioritised.
- Delay in the delivery of the 'Shaping Our Future' plans and the transformation of services across health and social care.

Recruiting new staff and investing in training and development has been a priority this year.

Summary of progress

2017/18 has been one of the most challenging years in the Trust's recent history. The organisation is not alone in the NHS in facing rising demand for services, a squeeze on resources and difficulty recruiting the people required to provide outstanding services.

The Trust's performance deteriorated in a number of important areas in 2017/18, including the emergency care access standard and referral to treatment waiting times. Overcrowding in the Emergency Department, delays to clinical procedures and weak governance in areas such as maternity and operating theatres led to a significant lack of confidence by our regulators in the safety and quality of our services. The Trust ended the year in 'Special Measures', after being assessed as 'inadequate' overall by the Care Quality Commission (CQC). Further information on the Trust's CQC inspections is detailed in the quality section.

However, in areas such as mortality, sepsis and pressure ulcers we have seen good progress and on cancer care we remain one of the few Trusts in the region meeting the national standards each quarter. Patient feedback remains positive overall but we have work to do to improve our timely response to complaints, learning from incidents and the evidence that we complete our duty of candour.

We have invested this year in recruiting permanent staff, training and development programmes with a particularly strong apprentice scheme and started a leadership development course for our top leaders in all professions. We saw a significant increase in the number of staff taking part in the national staff survey with many scores remaining the same or improving.

The Trust's financial outturn was a deficit of £2.6m for 2017/18. During the year the Trust received £4.7m from the Sustainability and Transformation Fund (STF) through meeting quarterly financial and operational standards and an additional £2.6m of STF income at year end. Before any STF incentive income was received the deficit was £5.2m and whilst this was £0.8m better than the forecast outturn, it was £6.5m off the original planned surplus of £1.3m. Further detail on financial performance is in the section on resources.

System transformation will be a critical part of our strategy in 2018/19 and with our partners we made progress this year in establishing the approach for an Integrated Care System. We demonstrated through the integrated NHS 111 and out of hours GP service set up in December 2017 and the 'Gold Command' structure in March 2018, that system and clinical leaders working together delivers results for patients. Both practical and operational changes helped us to return to good performance on the emergency care access standard and tackle delay in our system so that we ended the reporting year with a strong foundation for 2018/19.

Performance against key national access standards 1 April 2017 to 31 March 2018 as reported to Trust Board through the Integrated Performance Report (IPR)

2017/18 Metric	From IPR Standard	From IPR Performance	Achieved
ED attenders 4 hours to discharge, admission or transfer	95% (90% local)	77.59%	✗
Cancer referral 2ww (average over 11 months)	93%	95.83%	✓
Cancer diagnosis to treatment (31 days) (average over 11 months)	96%	97.96%	✓
Cancer referral to start treatment (62 days) (average over 11 months)	85%	85.92%	✓
Fractured NOF operated in 36 hours (average over 12 months)	80%	79.48%	✗
RTT incomplete pathways (average over 12 months)	92%	86.09%	✗
Diagnostics within 6 weeks (average over12 months)	99%	96.50%	✗
Average LOS in days (average over 12 months)	3.31	3.34	✗
DTOCs (average over 12 months)	3.50%	8.73%	✗
Same day cancellations (average over 12 months)	0.80%	1.56%	✗
Stroke patients 90% time on unit (average over 12 months)	82%	83.35%	✓
Admission to stroke unit in 4 hours (average over 12 months)	57%	62.60%	✓
CT within 12 hours for stroke patients (average over 12 months)	88%	94.87%	✓
CT within 1 hour for stroke patients (average over 12 months)	44%	70.27%	✓

1 Performance Report

Quality: Providing compassionate, safe, effective care

Achieving safe, good quality care for every person we serve is our number one priority. In April 2017, we set our priorities for two years:

- Improve patient experience and outcomes by reducing waits in the Emergency Department and maximising our elective capacity.
- Keep our patients safe, focus on a reduction in falls and pressure ulcers.
- Deliver our Care Quality Commission action plan to achieve national quality standards.
- Listen and respond to our patients to inform how we improve our services.

Safe care is our number one priority.

The number of people attending the emergency department rose by 4.9% in 2017/18 compared to 2016/17 and the number of delayed transfers of care by 19.8% in 2017/18 compared to 2016/17.

The national Emergency Access Standard which requires over 95% of patients' care within the Emergency Department to be less than four hours was not met for each quarter in 2017/18. Although a range of factors contributed to this performance, the main reasons were the significant increase in delayed transfers of care as well as continued growth in attendances. The problems were particularly acute during the 2017/18 winter period when the Trust operated almost every day at the highest level of alert – Operational Pressures Escalation Level 4. In March 2018, the Trust established with our partners an Incident Control Command Centre (Gold Command with senior clinicians and executives) to maintain safe health and care services across Cornwall.

The Gold Command approach was a success and performance on emergency care improved significantly by the end of March 2018 with the Trust finishing the final 10 days of 2017/18 at the lowest level of alert Operational Pressures Escalation Level 1. This performance was sustained into the first month of 2018/19 when the Trust hit the national emergency care national standard for the first time in nearly five years. Sustaining this performance is critical with significant benefits for patient experience and outcomes.

The Trust's elective or planned work was significantly affected by the performance in emergency and urgent services. Planned surgery and procedures were too frequently cancelled and there was an increase in the number of outpatient clinics cancelled at short notice. We failed to meet the national standard to ensure that at least 92% of patients receive treatment within 18 weeks of referral, achieving only 81%, and we finished the reporting year with over 200 patients waiting more than 52 weeks for treatment. In respect of diagnostic services, we have also seen a lengthening of waiting times.

However, the significant operational improvement during March 2018 meant that elective work could resume to close to normal levels and we start the 2018/19 in a stronger position. The focus for 2018/19 will be on expanding the number of beds available for surgical procedures and investing in our sites at St Michael's and West Cornwall Hospitals to extend our elective capacity.

Case Study: Improving quality and meeting demand for Cardiology Services

Due to a combination of increasing demand on Cardiology services and challenges in relation to recruitment and staffing, a programme of improvements began during the year. The key improvements include:

- *Recruiting additional consultants and appointing a Cardiology Specialty Lead*
- *The Roskear Cardiology Ward nursing establishment was increased by 2.72 whole time equivalent (WTE) Registered Nurses and 2.72 WTE Health Care Assistants in June 2017 to meet the increased acuity and dependency of care using the recognised Safer Care workforce establishment review tool.*

A refurbished cardiac catheter laboratory was opened in July.

- *The cardiology team has introduced a new process to monitor patients waiting for follow up appointments. All patients past their follow up date have a review by their consultant which includes clinical prioritisation, diagnostic tests or continued monitoring. This change in practice resulted in more patients being seen sooner and documented according to the clinical indicators, in the full range of individual patients' records.*
- *A demand and capacity review identified a shortfall for the echocardiography service and this was addressed through the recruitment and development of a seven day in-patient service.*

I went into the Cardiac Investigation Unit and had an angiogram the next day. I can honestly say that I couldn't have received better care and attention if I had been a private patient…Special thanks to the members of staff whose sense of humour made my stay a pleasant experience! At times like this compassion and humour help get us through. We are so lucky to have our NHS - long may it last!!!

Keeping our patients safe, with a focus on a reduction in falls and pressure ulcers

In this section we set out our performance on the priority areas, the highlights and challenges.

Reducing avoidable harm

There are a number of commonly occurring conditions that can be acquired in hospital which through screening and careful management can usually be avoided, such as pressure ulcers, blood clots, urinary tract infections and falls. Audit data on avoiding harm is recorded using a nationally recognised 'safety thermometer' and our aim is to achieve harm free care for at least 95% of patients. The rate of "new" harms (acquired harm in our hospitals) during 2017/18 was better than the target at 98.8%.

Case Study: Pressure ulcers

The 'safety thermometer' focuses on prevalence of pressure ulcers and captures all patients in the Trust with pressure ulcers on one day each month. 'Old' pressure ulcers are reported as being pressure ulcers that were present on admission or within 72 hours of admission and 'New' pressure ulcers, being those that developed after 72 hours of admission. Pressure ulcers are reported if they are Grades 2-4 (4 being the worst).

The Trust reported data shows that there has been a decrease in the prevalence of 'old' and 'new' pressure ulcers over the year. Since September 2017, the Trust has been part of the National Pressure Ulcer Collaborative - learning and sharing best practice with acute Trusts from across England. The initiative to date has seen a 46% reduction in pressure ulcers across three higher risk clinical areas.

This quality improvement work will be implemented further during 2018/19, to reduce pressure ulcer incidence by a further 25%. The use of the SSKIN assessment tool will be promoted as a way of assessing skin integrity and ensuring accurate preventative action.

Whilst the rate of new harm free care remained above target throughout the year, there was variable performance on blood clots and falls. Overall, the performance data shows a small decrease in the number of slips, trips and falls at the Trust but we want to make further progress in 2018/19 with the appointment and leadership of a falls practitioner, as well as sharing learning across the health and care system.

The prevalence of catheter associated urinary tract infections reduced significantly during the second half of 2017/18, putting the number of incidents around 5% below the national rate for acute hospitals.

All instances of avoidable harm are reviewed in order to identify learning opportunities among the immediate team and we need to improve the way we share information more widely across the Trust.

Lead Nurse for Sepsis Helen Winn has been working closely with campaigner Melissa Mead to raise awareness of sepsis within our hospitals and the local community.

Sepsis

In February 2018, NHS England recognised the RCHT as one of the NHS trusts seeing greatest improvement in timely identification and treatment of sepsis.

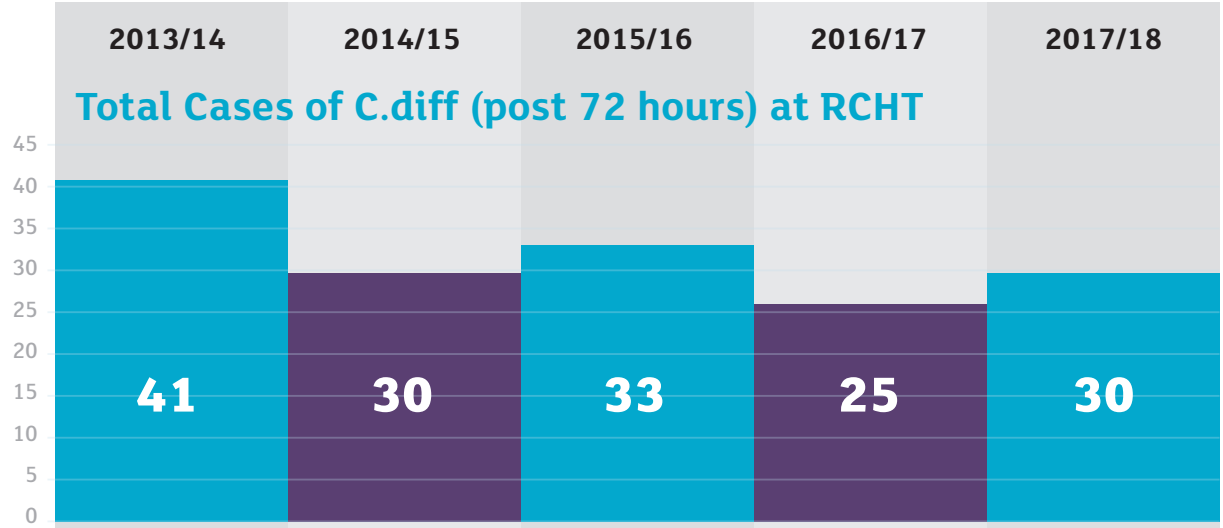
The improved performance reflects growing awareness among staff and the public. Our Lead Sepsis Nurse has been working closely with national campaigner Melissa Mead, who has delivered a series of educational workshops for staff.

Based on random audit of patient records, RCHT has seen a significant increase in the numbers of patients assessed for sepsis in the Emergency Department. In-patient assessment for sepsis increased from 8% in August 2016 to 70% in March 2018 and treatment commencing within the hour has increased from 60% in October 2016 (when data collection started) to 75% in March 2018.

During 2018-19, we will introduce a sepsis screening module for mobile devices to record vital observations and to prompt action when results show signs a patient's condition may be deteriorating. At the same time as the introduction of the screening tool, the Trust will change to NICE (National Institute for Health and Care Excellence) guidelines for the recognition and treatment of sepsis.

Infection Prevention and Control

The tolerance for hospital associated infection was reduced further during 2017/18. In 2017/18, 30 cases of Clostridium difficile were apportioned to the Trust which is above the year end tolerance of 23. All cases have been reviewed and 7 have been considered potentially avoidable. The rate of Clostridium difficile infection per 100,000 bed days for the Trust is 12.87 compared to the National rate of 13.84.


2013/14
2014/15
2015/16
2016/17
2017/18
Total Cases of C.diff (post 72 hours) at RCHT
45
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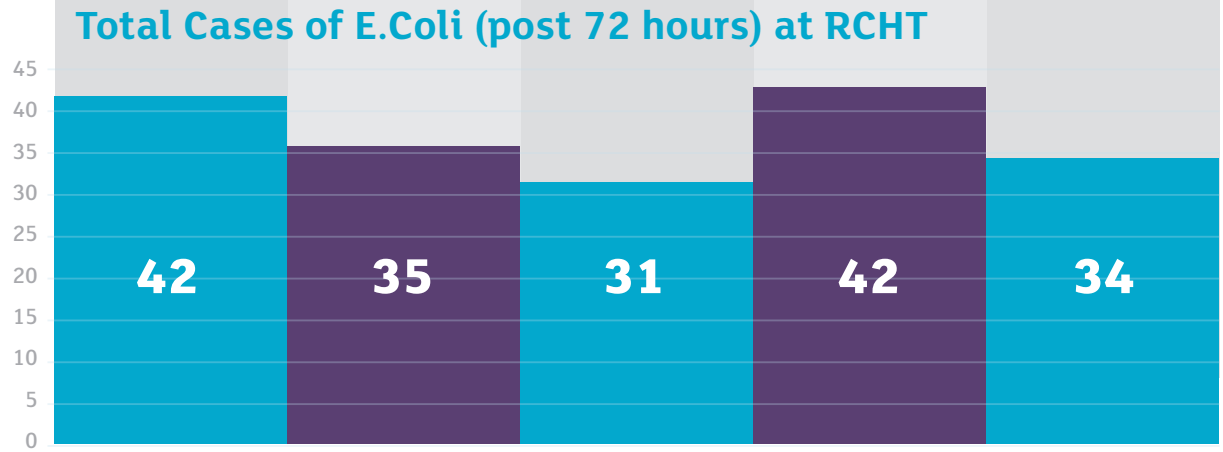
35
30
25
20
15
10
5
0
41
30
33
25
30


Total Cases of E.Coli (post 72 hours) at RCHT
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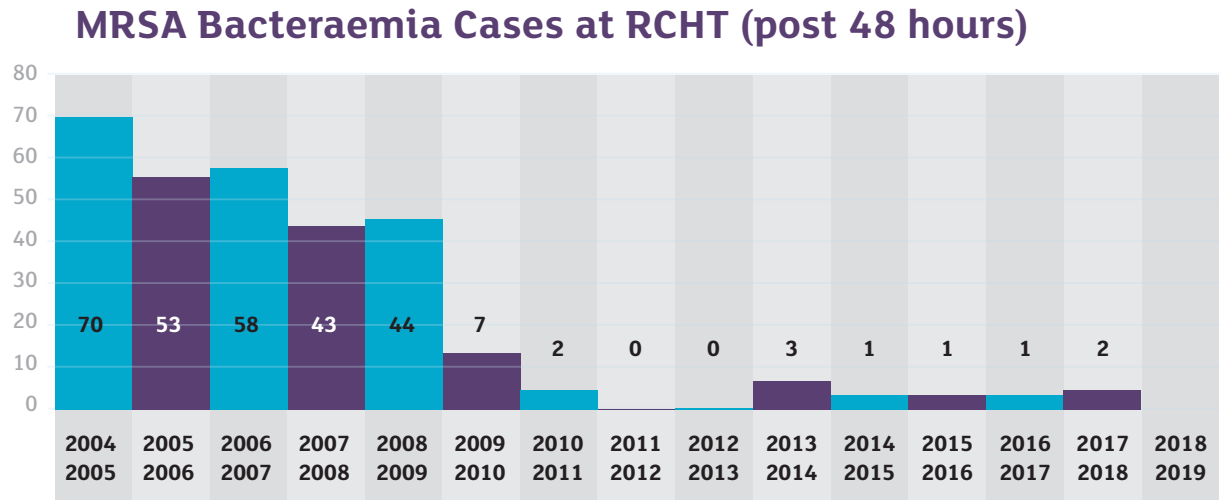
42
34


MRSA Bacteraemia Cases at RCHT (post 48 hours)
80
70
60
50
40
30
20
10
0
70
53
58
43
44
7
2
0
0
3
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2018 2019

Our hospitals were less affected by norovirus during the 2017/18 winter period compared to the previous year but there were significantly more cases of influenza, peaking at almost 210 during February 2018. Both viruses led to intermittent ward closures which contributed to pressures on bed capacity during the 2017/18 winter months.

Mortality

The Hospital Standardised Mortality Ratio (HSMR) is calculated every month for each hospital in England. It includes deaths for the most common conditions which account for around 80% of deaths in hospital. HSMR is the ratio of observed to expected deaths, multiplied by 100, from 56 baskets of the 80% most common diagnoses. If the HSMR is above 100 then there are more observed deaths than expected deaths.

The Summary Hospital-level Mortality Indicator (SHMI) includes all deaths in hospital and within 30 days of discharge from hospital.

The Trust mortality ratio has been an area of sustained improvement with a 12 month rolling HMSR of 95.15 which is below the current national benchmark of 100. The data for the year also shows improvement in the HSMR for patients admitted at the weekends and this is below that for patients admitted during the week. We have also seen sustained improvement on the SHMI with the March 2018 position at 92.77.

RCHT is one of few NHS Trusts to have consistently met cancer diagnosis and treatment standards.

Our clinical teams aim to review all patients who die in our hospitals and where there is any potential cause for concern we undertake an in-depth case review so that any learning or necessary changes to practice can be identified and shared.

Cancer Care

We are one of few trusts in the south-west to have maintained our performance in meeting the standards for diagnosis within 31 days of referral, and to beginning treatment within 62 days of referral across all cancer types. These standards have been met consistently since September 2010. However, within some specific areas where there has been a rise in referral rates, such as breast, lung and colorectal cancer, a small number of patients have experienced longer waits. We are reviewing our capacity and resources to match this growing demand.

In January 2018, the Trust submitted a formal response to the NHS England Specialist Commissioning Public Consultation on Modernising Radiotherapy Services. The Trust Board and our clinicians are fully committed to the continued provision of a world class radiotherapy service for the population of Cornwall and to work collaboratively with partner organisations for the benefit of our patients. We are confident that we have outstanding equipment, facilities and clinicians to continue to provide the very best patient outcomes and experience for the local community.

In July 2017, we held an official celebration for the opening of The Cove Macmillan Support Centre, attended by His Royal Highness the Prince of Wales. The centre, which opened its doors in November 2016, provides advice and support for cancer patients and their families and continues to increase the range of services on offer including psychological and practical support in first class facilities.

Cancer nurses specialists meet HRH The Prince of Wales at a celebratory event following the open of The Cove Macmillan Support Centre at the Royal Cornwall Hospital.

The stroke team mark the opening of the hyper acute stroke ward.

Stroke care

The proportion of stroke patients spending at least 90% of their inpatient stay on the stroke unit was affected by the operational pressures throughout 2017/18 and less than half were admitted within 4-hours of admission to hospital. However, performance improved towards the end of the reporting year on fast access to a CT scan and the 7-day TIA (mini-stroke) clinics continue to see patients within 48 hours.

A review of stroke services in March 2018 recognised good progress being made and highlighted a number of areas for improvement, including work with community partners to reduce the time to get suspected stroke patients to a hospital.

Delivering our Care Quality Commission action plan to achieve national quality standards

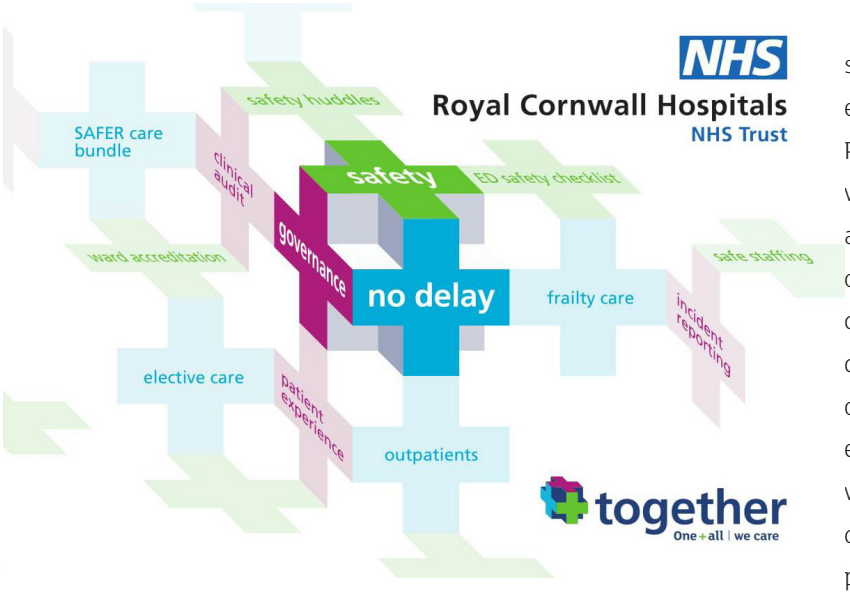
The Care Quality Commission (CQC) inspected the Trust twice during 2017/18, first in July 2017 and then in January 2018. Following the July 2017 inspection, the CQC rated Royal Cornwall Hospitals NHS Trust 'Inadequate' and the Trust was placed in 'special measures'. The Trust was issued with a 29A Warning Notice that required urgent action in specific areas. Those areas included:

- Surgery – risk assessments prior to surgery, consistent safety briefings, quicker treatment times.
- Maternity – effective use of observation charts and patient safety documentation, policies for high risk women, theatre processes including checklists and staffing, support and equipment for community midwives.
- Surgery – risk assessments prior to surgery, consistent safety briefings, quicker treatment times.
- Maternity – effective use of observation charts and patient safety documentation, policies for high risk women, theatre processes including checklists and staffing, support and equipment for community midwives.

- Critical Care – transfer delays and high bed occupancy.
- Fracture clinic – environment and infection control issues, suitable waiting area and booking process for children.
- Equipment – improving standards and consistency on repair, maintenance and testing.
- Governance – improving incident management and duty of candour.

The Trust made insufficient progress by January 2018 and was issued with a further 29A Warning Notice on those areas that still required improvement. The Trust submitted further evidence of its progress in April 2018 and expects a further CQC inspection in 2018/19. Further details on the CQC inspection and outcomes are provided in the Annual Governance Statement.

The Trust takes the CQC concerns extremely seriously and understands fully the consequences for patient safety, quality and confidence in services. The Trust Board is committed to full compliance with all national regulations. The Trust sought to respond to the CQC concerns quickly and effectively but acknowledges that improvement in safety culture and governance will take time to take root.

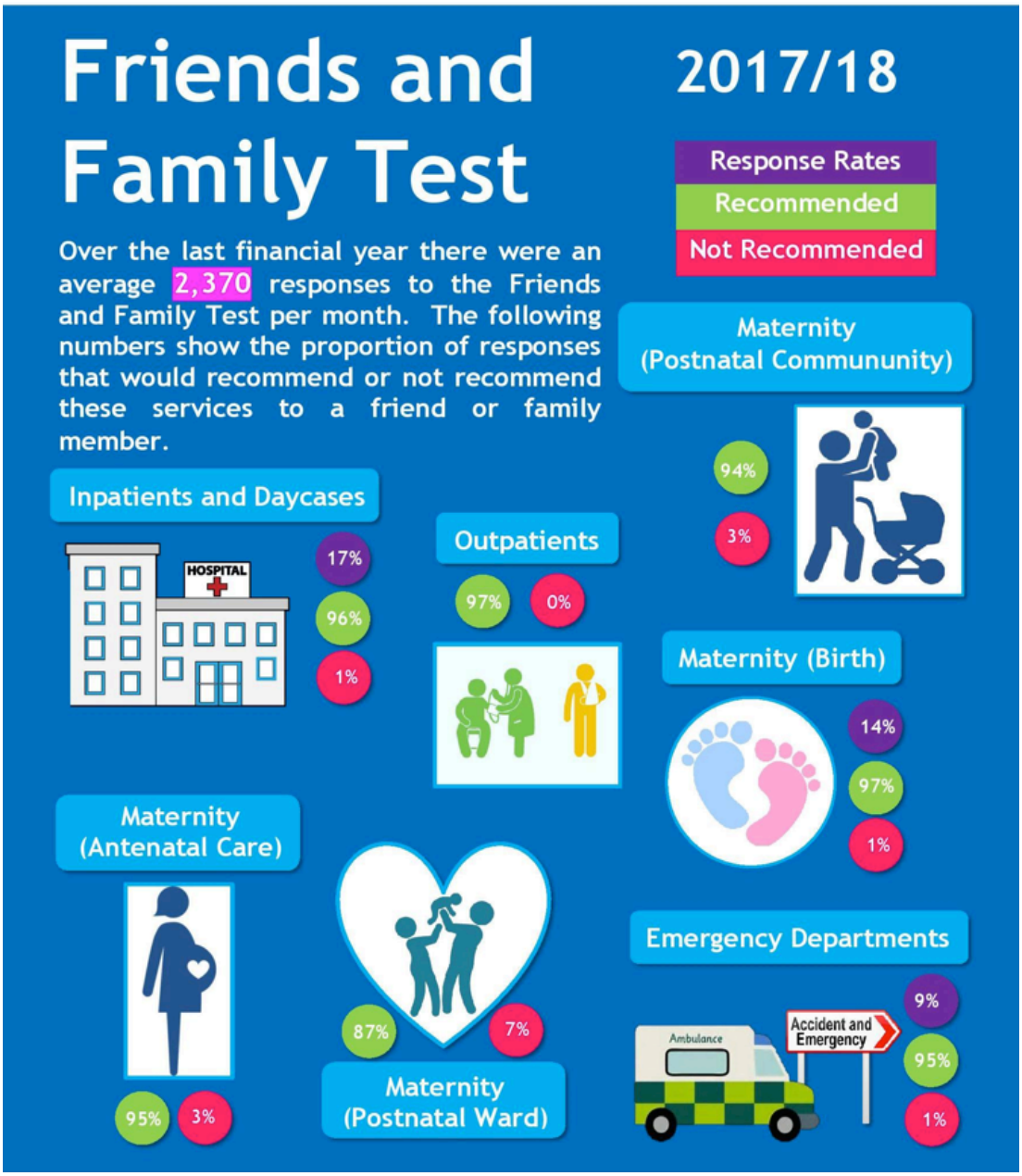


To establish and sustain a fundamental shift in our quality improvement approach we embarked on a long term Trust Improvement Programme in December 2017. The initial focus was delivering the actions required by the CQC and then developing a programme based on our quality priorities. We identified three broad quality priorities: Safety culture; Tackling patient delay; and Strong governance supported by work on culture and leadership; communication and engagement; and a Quality Hub to equip staff with the tools and skills to improve safety and quality. Within the programme are a range of projects for example on maternity, surgery and Emergency Department safety that will result in the Trust meeting our national quality standards and improved outcomes for patients. We will set out our success in the 2018/19 Annual Report.

We acknowledge the poor progress in the specific areas identified by the CQC and while we take this very seriously, we are pleased that the CQC recognised our caring staff and that performance in other areas was rated highly. West Cornwall Hospital and St Michael's Hospital achieved 'Good' overall ratings and St Michael's Hospital and Critical Care services were rated 'Outstanding for Caring'.

Listen and respond to our patients to inform how we improve our services

The Friends and Family Test and national patient surveys are just two of the ways in which patients are invited to tell us about their experience of our care. The Friends and Family test survey offers monthly feedback to individual wards and departments and the reports are shared with teams to aid learning and improvement. Results are visible on our 'How are we doing' noticeboards outside each ward.



Listening to patients is an essential part of our improvement programme.

Annual national patient survey results were published for inpatients and maternity services. In both surveys our hospitals and services are rated 'about the same' as similar hospitals in almost all areas.

Our hospitals continue to receive 4.5 star (Royal Cornwall Hospital) and 5 star (St Michael's and West Cornwall hospitals) on the NHS Choices website.

To help us boost the number of responses to the Friends and Family Test we have recruited a team of Patient Experience Volunteers (numbers doubled during 2017/18 to 35) who act as independent advocates to help encourage patients to provide feedback and complete surveys before leaving hospital. The Friends and Family Test questionnaire has been updated, and during 2018-19 we will be introducing new technology to allow online completion of surveys, with real-time data available at individual ward or department level.

We are also working with Care Opinion – a national online patient feedback portal which links to NHS Choices – to engage more widely with patients and relatives and to allow clinical leaders to respond directly to compliments and concerns. This will aid a more open approach and ideally a reduction in formal complaints.

The launch of Wonderwalls across our hospitals has been a great success, allowing patients, relatives and staff to publicly post their feedback on the experiences and care.

Case Study: Maternity and neo-natal services

Maternity services were highlighted as an area of concern by the Care Quality Commission in July 2017, with aspects of safety and governance identified as requiring urgent improvement in the CQC section 29A Warning Notices.

Maternity and neonatal unit staff and parents were delighted to meet Call The Midwife's Jenny Agutter who officially opened the extended and refurbished facilities.

In 2017/18, we continued to listen and work with families to improve the services we offer and it is important to say that feedback and outcomes for maternity and neonatal services remain good overall. At the start of 2017, we launched the Cornwall Birth and Baby Appeal to support the development of a new neonatal unit and birth centre which included four birth pools to improve family experience. Jenny Agutter, the 'Call the Midwife' television actress, joined staff and families to celebrate the opening of the new units in February 2018 and family feedback has been overwhelmingly positive. The fundraising appeal continues to help improve facilities across all maternity services.

The maternity team is also taking part in a leadership programme and national collaborative project to share, learn and to implement best practice and achieve the highest levels of safety for mothers and babies. The team has also recently developed with service users the 'Beanie Hat Project' which is a visual aid to identify babies who may be at higher risk of complications due to antenatal or intrapartum risk factors. Once the correct colour beanie hat has been identified, appropriate feeding and observation regimes are initiated. The project is showing early signs of success with the aim to reduce term admissions to neonatal unit by 5% by October 2018.

Compliments and complaints

The feedback we receive from patients, whether positive or negative, is an integral part of our learning and improvement journey to provide outstanding care.

A total of 384 formal complaints were received in 2017/18 compared to 377 in 2016/17.

01 April 2017 – 31 March 208 (inclusive)			
Formal Complaints		**Informal Complaints**	
Received	410	Received	410
Received	384		
Upheld	69		
Partly Upheld	133		
Not Upheld	94		
N/A or Still in Progress	88		

The Patient and Family Experience Team has changed the way it works in 2017/18 to reflect best practice in other NHS Trust so that we resolve complaints more quickly, reduce the number of formal complaints through improved communication and work alongside clinical teams to share feedback on recurring themes.

Environment, facilities and cleanliness

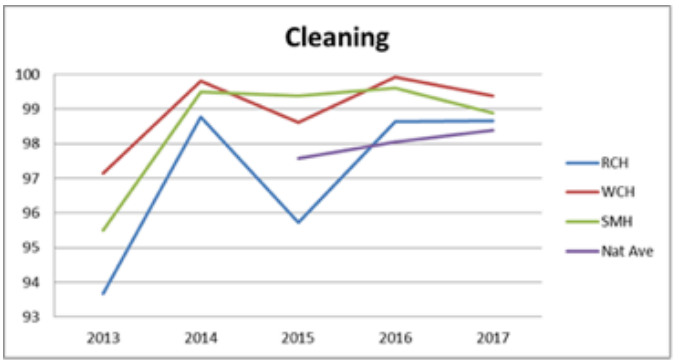
Our annual patient led assessments of the care environment (PLACE) are undertaken by teams of Trust staff working together with independent patient champions, looking at a number of criteria including, patient meals (food quality as well as service and mealtime assistance), cleanliness and the overall environment, privacy and dignity, dementia friendliness and disability.

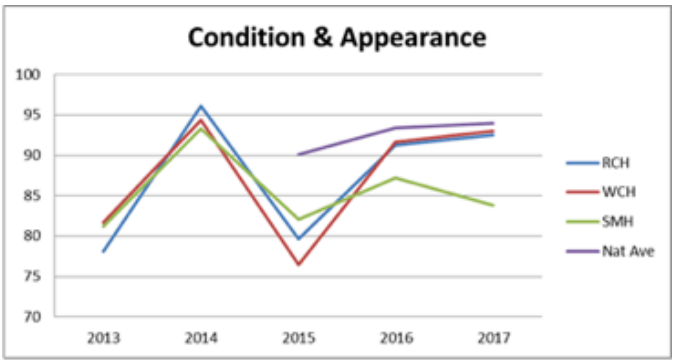
Small improvements were recorded in cleaning scores, with greater increases seen in the condition and appearance on two sites and in meal provision and service at the Royal Cornwall Hospital.

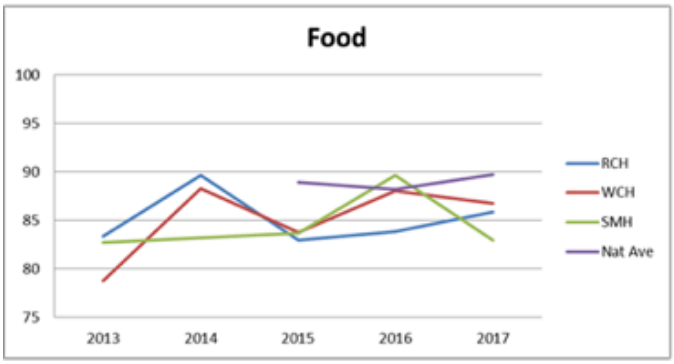
Scores for privacy and dignity saw a drop of around 3.5% across the three sites. Areas where the patient volunteers raised concerns related to limited space around beds and no lockable storage for personal items in inpatient areas. For outpatients there was felt to be a lack of private space for patients or relatives who may be upset and insufficient seating and single-sex toilets in some areas.

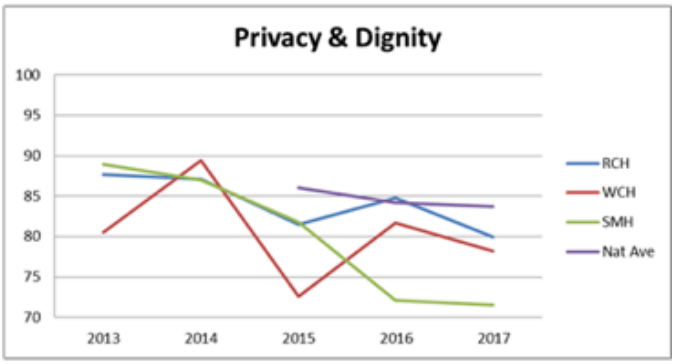
In the 2017/18 capital programme, around £1.5m was spent on painting and decoration, ward environment upgrades, ventilation, roof repairs, bike racks, signage, bedhead services, handwash basins and also specific schemes such as Lowen Ward improvements, Carnkie refresh, modular ward ventilation and cooling which will have a positive impact on the patient experience.

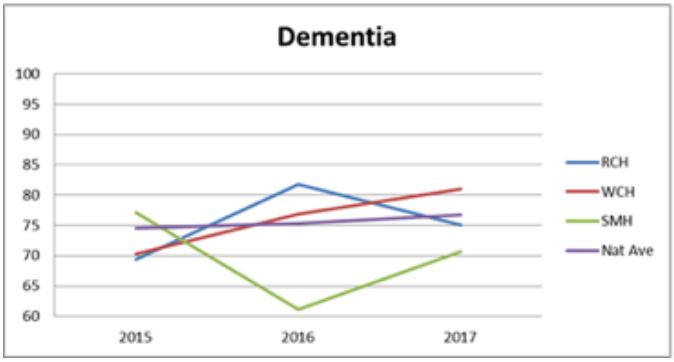
2017 scores for the key areas of assessment











Soft facilities services – cleaning, portering, ward house-keeping, mail room, catering (patient meal service and retail operations), and switchboard services – are provided by Mitie Clean Environments. In 2017 collaboration and performance has significantly improved on the contract. The Trust and Mitie are devising and implementing new systems to continually improve services and many of the changes have released savings for the Trust.

Environmental Sustainability

The NHS has an ambitious target to reduce carbon dioxide emissions from building energy use, travel and procurement of goods and services by 80% (against a 1990 baseline) by 2050. RCHT has a carbon management and reduction strategy which set outs to achieve a 34% reduction in carbon emissions by 2020.

In 2015 RCHT awarded a contract to Cofely (now ENGIE) to take forward a project through the NHS Carbon & Energy Fund to improve the energy infrastructure across our estate. The project will be completed at the end of June 2018. The project includes a combined heat and power plant, new generators, bio-mass boilers, LED lighting and solar PV. These combined will mean the Trust meeting its 2020 target to reduce carbon emissions two years early.

The Trust, in partnership with Mitie, is developing a Trust Waste Strategy to increase recycling, reduce the amount of plastic waste and single-use items, and increase the use of reusable products where appropriate.

Grants from Cornwall Council have provided the Trust with the opportunity to improve cycling facilities, including covered and secure cycle shelters and improved staff changing.
Sustainable design continues to be a key consideration in all new projects, with the Cove meeting BREEAM 'Very Good' standard.

Energy use

Resource		2014-15	2015-16	2016-17	2017-18*
Gas	Use (kWh)	24,411,742	24,455,258	25,045,387	26,398,315
	tCO2e	5,121.65678	4,501.479	4,599.460	4,852.27
Electricity	Use (kWh)	17,422,262	17,392,962	16,691,415	16,263,724
	tCO2e	10,790.1295	8,633.170	7,454.719	6,203.96
Green Electricity	Use (kWh) 1	9,761	16,423	11,996	19,111
Generated	tCO2e	- 9.687	- 7.529	- 4.913	-6.666
Total energy CO2e		5,911.7863	13,134.649	12,054.179	11,056.23
Total energy spend		**£2,885,524**	**£2,654,524**	**£2,417,061**	**£2,868,842**

* The replacement of the Trust main site Electricity Meter means that the Trust are still receiving amendments to the final energy figures for 2017-18 from our supplier and these figures may be subject to change.

Water use

		2014-15	2015-16	2016-17	2017-18
Mains	m3	147,955	152,609	154,840	151,383
Water and sewage spend		**£609,247.42**	**£589,545.29**	**£606,928.31**	**£587,923.28**

Waste

		2014-15	2015-16	2016-17	2017-18*
Recycling	(tonnes)	258.778	388.939	361.178	503.74
WEEE	(tonnes)	3.082	6.577	4.926	2.72
High temp disposal	(tonnes)	361.492	733.62	752.752	766.61
Non-burn disposal**	(tonnes)	512.808	1063.408	976.916	967.52
Total waste	(tonnes)	1136.16	2192.544	2095.772	2240.59
% of recycled or re-used		23	18	17	22

** The Trust sends all “Non-burn disposal” to the Energy from Waste Plant in Bodmin. There is zero waste to landfill.

1 Performance Report

People: Attracting, developing and retaining excellent staff

Like many NHS trusts across the UK, we face a challenging recruitment environment where competition for high calibre staff, particularly in specialist fields, is becoming increasingly difficult. We know that having permanent staff supports the delivery of high quality care and strong team working. In April 2017, we set our priorities for two years:

- Ensure our staff have the right skills & experience to provide effective care.
- Make RCHT an employer of choice by listening and acting on staff feedback.
- Create a learning environment where staff reach their full potential every day.
- Improve patient outcomes by empowering our clinical leaders to design effective services.

Ensure our staff have the right skills & experience to provide effective care

Regular reviews support safe staffing on our wards.

Safe staffing

A critical part of providing safe care is ensuring that we have the right staff with the right skills and experience on shift caring for patients. We have set targets to reduce our reliance on locum and agency staff, so that our vacancy rate for medical staff is no higher than 6% and for registered nursing staff, no higher than 5%.

For nursing, midwifery and health care support workers, staffing levels are published monthly, showing the planned number of staff against the actual number on each ward. This information is also displayed daily on each ward.

Analysis of Safe Staffing Fill Rates 2017-18

	Skill Mix	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
Day	Registered Nursing	93.1%	92.8%	92.0%	92.1%	94.7%	92.2%	91.7%	91.7%	89.9%	91.5%	89.3%	89.5%
Day	Healthcare Support Workers	97.4%	96.7%	93.6%	96.6%	98.3%	93.5%	95.1%	90.0%	94.1%	97.3%	101.3%	97.5%
Night	Registered Nursing	92.7%	94.1%	92.7%	93.6%	94.6%	94.6%	94.4%	92.2%	94.2%	95.1%	94.0%	94.4%
Night	Healthcare Support Workers	107.6%	103.6%	101.2%	106.8%	107.8%	103.9%	105.6%	91.8%	103.7%	108.7%	114.1%	113.4%
Trust Fill Rate		**96.4%**	**95.7%**	**94.0%**	**96.0%**	**97.6%**	**94.9%**	**95.3%**	**91.4%**	**94.1%**	**96.5%**	**97.3%**	**96.4%**

Over the year we have recruited additional medical staff and registered nurses, prioritising critical areas such as cardiology and the Emergency Department. We have also been reviewing the skills needed in clinical areas to modernise and adapt our workforce to meet changing demands. Examples include developing nurse specialists to fully utilise their knowledge and skills, increasing nurse-led clinics and our cardiac physiologists have redesigned care pathways to reduce waiting times and unnecessary referrals to consultant colleagues.

Apprenticeships have been another significant part of our workforce development this year and a national incentive through the apprentice levy came into effect in April 2017. The Learning & Development Department at the Trust was successful in obtaining status as the main provider of apprenticeship programmes. Currently over 100 staff are completing apprenticeship programmes at the Trust. These include both clinical apprenticeships such as healthcare support worker and laboratory technician and non-clinical programmes including business administration and team leadership.

From Autumn 2018, we are expecting new recruits onto both nursing associate and nursing degree apprenticeships. In addition, the development of an advanced clinical practitioner apprentice will enable some of our registered clinical staff to further progress. The Trust continues to provide placements for a significant number of pre-registration students studying a range of different health professional qualifications. Eleven departments were nominated by students for an annual mentor award.

Collaboration with the learning and development teams in other local NHS organisations and care providers in Cornwall has improved this year. We streamlined our mandatory training so that staff who move between organisations are no longer required to repeat aspects of mandatory training unnecessarily. This enables new staff to get started in their new roles quicker.

The Trust has also worked in partnership to provide vital additional skills for our staff. For example in June 2017, as part of our work to improve quality, the Trust worked collaboratively with the Royal College of Nursing to host a conference for registered nurses on the provision of End of Life care. The conference was attended by 87 nurses from across Cornwall to learn about spiritual and pastoral care, communication at the end of life and facilitating patient choice. Evaluation of the day highlighted the growth in confidence and knowledge of those who attended.

Make RCHT an employer of choice by listening and acting on staff feedback

The 2017 Annual NHS Staff Survey was completed by 2860 staff in October and November. At this time, the Trust had just been placed in 'special measures' following a Care Quality Commission inspection.

On the 32 main areas of the survey, the Trust either improved or remained the same. This is contrary to the overall national position, which has generally declined. Historically, the Trust has featured in the bottom 20% of all Trusts for most questions. In 2016, 21 areas (68%) were in the bottom 20% while in 2017 10 areas (31%) feature in the bottom 20% with most improvement being seen in the job satisfaction key findings.

There is much to do to improve the reported experience of staff and the Trust Improvement Programme launched in December 2017 seeks to address the priorities with full involvement from staff. The data from the 2017 National Staff Survey has informed this work. Actions are already underway to address the elements set out in the report.

Deputy Chief Executive Kate Shields with members of the critical care team on one of her regular visits to meet and talk with staff across the organisation.

The key findings we are performing well in (our best scores) are as follows:

- % Staff experiencing discrimination at work in the last 12 months 9% (National 12%)
- % staff experiencing physical violence from staff in the last 12 months 2% (National 2%)
- % staff/colleagues reporting most recent experience of violence 70% (National 66%)
- % staff reporting error. Near misses or incidents witnessed in the last month 91% (National 90%)
- % staff attending work in the last 12 months despite feeling unwell because they felt
- pressure from their line manager, colleagues or themselves 51% (National 52%)

The key findings we are performing less well in (our worst scores) are as follows:

- Staff satisfaction with the quality of work and care they are able to give 3.72 (National 3.91)
- Fairness and effectiveness of procedures for reporting errors, near misses and incidents 3.49(National 3.73)
- % staff satisfied with the opportunities for flexible working patterns 44% (National 51%)
- Quality of appraisals 2.90 (National 3.11)
- Staff recommendation of the organisation as a place to work or receive treatment 3.46 (National 3.75)

The Trust has made the biggest improvement this year in the following metrics:

- Effective use of patient/service user feedback 3.60 (National 3.42)
- % Staff able to contribute towards improvement at work 68% (National 64%)
- Staff satisfaction with level of responsibility 3.86 (National 3.79)
- Effective team working 3.73 (National 3.66)
- Quality of non-mandatory training, learning and development 4.04 (National 3.99)

A summary of the main themes and actions include:

Appraisals & support for development	The results tell us that there are more appraisals happening with 87% staff reporting that they have had an appraisal (higher than the national average). Whilst the score for the quality of those appraisals has increased in year (from 2.79 to 2.90), the Trust is still considerably lower than the national average (3.11). The score relating to the quality of non-mandatory training, learning and development continues to improve and is in line with the national average.	**Action:** The Managers Passport training will be reviewed to improve the skills for managers to deliver a quality appraisal.
Errors and incidents	The number of incidents witnessed by staff has stayed the same as last year with 91% of staff saying they report any incident error or near miss (higher than the national average). We score well below national averages for fairness and effectiveness of procedures for reporting incidents errors and near misses, however, staff do feel more confident and secure in reporting unsafe clinical practice.	**Action:** We will continue to strengthen governance throughout the Trust, which includes the utilisation of systems and processes to help the organisation learn from incidents, errors and near misses.

Health and Wellbeing	Staff reporting work related stress has reduced by 1% to 37% (national 36%). Staff also report lower than national averages for pressure to attend work when feeling unwell. We have seen a positive increase in key findings associated with staff feeling that the Trust and management are interested in staff health and wellbeing.	**Action:** We will build on the work undertaken so far as set out in our Health and Wellbeing Strategy.
Job satisfaction	All metrics in this key finding improved, however we are still some way off the national averages on most findings. Only 54% of staff would recommend the Trust as a place to receive care or treatment and 48% would recommend the Trust as a place to work. (Nationally 71% and 61% respectively). Staff report feeling more motivated, more satisfied with their level of responsibility and feel better able to contribute to improvements. Team working satisfaction scores are equal to national averages.	**Action:** Team working and communication are key elements of the Culture and leadership improvement plans in the Trust. The implementation of Safety Huddles is rolling out with favourable evaluation so far.
Managers	We have seen a 3% increase in satisfaction of staff with communication between senior managers and staff, although this remains in the lowest 20% of Trusts. Staff feel more valued and also feel supported by their immediate Managers.	**Action:** Communication is a key enabler of the Trust Improvement programme. This includes a range of activity to improve the visibility and communication with senior managers. We will continue to strengthen the Improving Working Lives Thankyou Awards and our annual staff awards. We will continue to run LEAD, our internal Leadership Development Programme, with a further 3 cohorts this year.
Patient Care and experience	There was a significant improvement in staff reporting effective use of patient/service user feedback (up to 3.60 from 3.42) This is still, however, in the bottom 20% of acute Trusts. Staff report feeling that their role makes a difference to patients/service users (in line with national average) and whilst we saw improvement in this measure staff feel less satisfied with the quality of work they are able to deliver (bottom 20%).	**Action:** We will continue to share feedback from patients with staff and promote patient experience activity to improve services.

Case study: Equality and inclusion

Scores relating to discrimination and equity of opportunity at the Trust remain unchanged this year and we continue to perform in line with national averages. The views of our staff and the community are sought throughout the year and we engage with specific groups to assess our performance on equality and inclusion.

In 2017/18, the majority of our workforce has declared that they do not have a disability. There has been a slight increase in the number of people working in the Trust who have declared a disability, from 3.2% to 3.4%. Staff who identify with this group have a 91.4% retention rate compared to 90% of all other staff showing that staff with a disability are slightly more likely to remain working at the Trust.

The Trust has achieved level 2 accreditation of the Disability Confident Employer Scheme. This scheme has taken over from the previous Two Ticks system which enabled job applicants to declare a disability and request they were invited to interview if their application met the minimum requirements of the role. To achieve the level 2 award numerous improvements were made to the recruitment process to increase the possible number of applications from candidates who may have a disability. In addition, close partnership working with the local Job Centres continues to thrive as members of the recruitment team are regularly invited to attend job fairs to promote the jobs on offer and the Trust continues to host work placements for the long term unemployed, including for individuals who may have a disability or health condition.

The Trust continues to support a staff network for people with disabilities or long term health conditions. This network promotes staff wellbeing by providing an opportunity for peer support, to act in an advisory capacity for the Trust on issues which may affect disability and as a collective voice to be heard and responded to. Other staff networks the Trust supports are a Minority Ethnic Group and a carer's network to offer support, advice and guidance for staff who are also unpaid carers.

From 31st March 2018 all organisations with 250 or more employees are required to publish their gender pay gap information. The gender pay gap shows the differences in the average pay between men and women. The Trust is confident that men and women are paid equally for doing the same job; however, the greater proportion of men than women in senior roles creates a gender pay gap. There may be multiple factors responsible for this, such as, culture, family and work-life balance (women make up the vast majority of part-time workers in the Trust). All of these can impinge on female employees' career progression, especially into senior leadership roles. It is important to note though that 87% of female workers thought that the Trust offered fair career progression in the 2017 staff survey. Nevertheless, we will work hard to address this imbalance by continuing to offer flexible working, providing unconscious bias training for managers, and fostering an inclusive culture. Addressing the disparity in gender representation at senior levels will take time, but it will help close the current gender pay gap at the Trust.

Royal Cornwall Hospitals Trust recognises the importance of employing a diverse workforce which is reflective of the local community it serves, and in 2018/19 we will aim to develop a talent management framework with the Leadership Academy to improve in this important area.

Create a learning environment where staff reach their full potential every day

Alongside improving the training and education programme, we recognised from the staff survey results the need to improve the learning culture within the Trust and staff confidence in speaking openly and acting on concerns. This was also reflected in the Care Quality Commission's July 2017 report and therefore forms a core part of our Trust Improvement Programme on culture and leadership.

The independent 'Well-led' Review to be published in early 2018/19 identifies areas for Trust Board development and support for our senior leaders will be a high priority in the forthcoming year. Further information on this work is contained in the Annual Governance Statement.

The work on 'Strong governance', led by our Medical Director, is putting in place a comprehensive programme to support our staff at every level to manage risks, identify potential serious incidents and share learning across all professions to improve our care. This is supported by a training programme and enhancing the positive work we are already doing on simulation and human factors training at the point of care.

To ensure we provide the right support network for staff, we appointed a new Freedom to Speak Up Guardian, a team of Freedom to Speak Up Champions and an online reporting system in 2017. In May 2018, we are expecting a visit by the National Guardian Office to support further improvement in our work on speaking up and creating a learning environment.

Improve patient outcomes by empowering our clinical leaders to design effective services

Leadership development is a top priority for the Trust and specifically supporting clinically led services. Our LEAD programme has supported the top 60 leaders to develop their skills and undertake quality improvement projects to lead change. We are now broadening the scope of the programme to support a further 120 leaders across all professions.

Recently, places on LEAD have been offered to partners working across the whole health community. This has provided a rich opportunity for effective networking and has enabled individuals to gain a greater understanding of the challenges faced in different parts of the health and care system.

In 2017/18, the Trust worked alongside the Faculty of Medical Leadership and Management to specifically strengthen medical leadership. This included 360 degree feedback and the development of a nationally recognised programme that will specifically address leadership development needs for doctors.

For the wider workforce, culture and leadership workshops have been held as part of the Trust Improvement Programme to develop an organisational development plan and support staff to put forward ideas for service improvement. The resulting actions from these workshops will be a priority in 2018/19.

1 Performance Report

Partnership: Offering integrated care, as close to home as possible

Establishing an Integrated Care System and working more effectively with partner health and care organisations is a major goal for the Trust and integral to our strategy to provide outstanding care for the whole local community. It is recognised locally and nationally that improving the health and wellbeing of the population requires collaboration and putting the citizen at the centre of reform rather than organisations.

On this basis, our priorities on partnership are about creating an Integrated Care System that puts the individual need first. In 2017/18 we have worked to establish a system approach that brings organisations together to improve services. This programme is known locally as 'Shaping our Future' and our priorities are to:

- Eliminate organisational barriers
- Enable our citizens to live healthier lives and maximise independence
- Offer urgent, community and social care which meets the needs of our citizens

SHAPING OUR FUTURE

Cornwall and The Isles of Scilly Health and Social Care Partnership

During 2017/18, we took steps towards creating an Accountable Care System to jointly plan the use of health and care budgets, staff and resources to best meet people's needs. It doesn't mean creating a new organisation and each organisation will continue to work within its existing statutory framework. Steadily, throughout 2018/19 we want to integrate further the work of commissioning and provider organisations to simplify the health and care system and become more effective at achieving good outcomes for local people.

A good example of the potential for greater partnership working was evidenced by the set-up of the Gold Command structure in March 2018 to respond successfully to extreme pressure on health and care services. In 2018/19, further work is required to provide alternative services to hospitals and enable patients to be cared for in their community with the right support or information so that we prevent the need for hospital admission.

Expand our research and innovation opportunities in order to improve patient care

Greater partnership working with a wider cross section of health and care organisations, including the private sector and involving patient groups, is a part of our priority to 'expand our research and innovation opportunities in order to improve patient care'.

Innovation Leads Frazer Underwood and Judith Laity flying the flag for RCHT at the SW Area Health Science Network conferencing.

As a result of successful research expansion over the last 5 years, there are now live studies in just about every clinical specialty. This is hugely beneficial for patients who get early access to the latest treatments and for future patients who will benefit from the clinical evidence.

Royal Cornwall Hospitals Trust has a good track record on research, development and innovation. Close to 2500 people were recruited to trials which was 320 below plan for the year. However, the team saw commercial income grow by £169k which has delivered a breakeven position this year for the Research, Development and Innovation Department. This will help the financial position and support the workforce for 2018/19.

The neurovascular research team won an award for being the highest recruiters to stroke research in the country.

The Trust continues to work in close association with the South West Peninsula Clinical Research Network to develop a balanced portfolio of studies and maximise the benefits to patients in as many areas of medicine as possible.

1 Performance Report

Resources: Making the best use of all our resources

As a taxpayer funded organisation it is vital that we use the resources available effectively to provide outstanding care. Safe, high quality services will always be our top priority and we will achieve this through smart use of our financial and human resources. Our priorities set in 2017 for two years were:

- To be a financially stable organisation
- Increase funds available for patient care by reducing overhead costs across the Trust and health system
- Transform services to increase quality and reduce inefficiency and waste
- Invest to improve our equipment, IT systems and infrastructure

Becoming a financially stable organisation and increasing the funds available for patient care by reducing overhead costs across the Trust and health system

Over the past 10 years, the Trust has become a more financially stable organisation and continues to reduce historic debts. Like all NHS organisations though, Royal Cornwall Hospitals Trust faced significant financial challenges in 2017/18 and will continue to do so in forthcoming years, with a rise in demand for services and rising costs alongside required efficiency savings. Smarter working across the health and care system is at the forefront of our work to make the best use of all our resources.

Statement of Comprehensive Income

The Trust's outturn was a deficit of £2.6m for 2017/18. In addition to the £4.7m baseline Sustainability and Transformation Fund (STF) funding earned through the year from meeting quarterly financial and operational standards, the Trust received £2.6m of additional STF Incentive income at year end. Before any STF incentive income was received the deficit was £5.2m; whilst this was £0.8m better than the forecast outturn, it was £6.5m off the original planned surplus of £1.3m.

Income was £3.8m above plan for the year. Income from Kernow Clinical Commissioning Group (KCCG) was £1.0m over plan which reflects the year end agreement with KCCG. Within this, elective income from KCCG was £2.3m below plan for the year and non-elective income was £2.9m above plan. Non-Payment By Results income was £0.5m below plan for the year.

Pay totalled £20.8m in month 12 of 2017/18. This was £1.6m over plan and for the reporting year, pay costs were £5.2m above budget.

The Trust delivered £14.1m of savings in 2017/18 against a target of £17.3m. £8.5m (61%) of savings were delivered non-recurrently.

Statement of Financial Position

The Statement of Financial Position (Balance Sheet) as at 31 March 2018 showed net assets of £90m.

The Trust ended the year with a cash balance of £8.2m. This was £7.2m above the forecast position of £1m. A key factor in the cash balance being higher than plan was that revenue support funding was received based on the Trust's month 9 forecast deficit position of £9.3m rather than the actual deficit position of £2.6m. It is expected that excess funding received will be deducted from future funding requirements rather than be repaid.

Despite the financial challenges facing the Trust it has delivered considerable improvements in its infrastructure through its Capital Programme in 2017/18, spending £18.9m as planned.

Cumulative breakeven duty

The Trust reported a £2.6m deficit in 2017/18 and a £0.9m deficit in 2016/17 and now holds a cumulative deficit of £26m at 31 March 2018. The Trust has set a deficit plan of £11.9m in 2018/19. The planned deficit will result in the Trust continuing to breach its breakeven duty.

Other financial duties

During 2017/18 the Trust operated within its External Financing and Capital Resource Limits as set by the Department of Health and Social Care.

Performance against the Better Payment Practice Code

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

The Trust has an on-going target to pay 95% of all invoices within a month of being received. At the end of the year, 94.9% of all invoices by volume were cumulatively paid on time. Note 30 to the Trust's accounts provides details on payment performance.

Going concern basis

The Trust has carried out a detailed assessment to satisfy itself that it continues to operate as a going concern. There is no indication that the provision of services will materially change in the foreseeable future.

At 31 March 2018, the Trust had Revenue Support Loans from the Department of Health and Social Care of £43.2m and Capital Loans from the Department of Health and Social Care of £9.3m. During 2017/18, the Trust made repayments of £1.4m against its Capital Investment Loans and £1.9m against its Revenue Loans.

Transforming services to increase quality and reduce inefficiency and waste

The new Cornwall NHS 111 service played a part in reducing attendances to the Emergency Department in 2017/18. The 111 integrated service is managed by Royal Cornwall Hospitals NHS Trust and delivered in partnership with Kernow Health Community Interest Company and Vocare Limited to provide a combined GP Out of Hours and NHS 111 team.

Offering more streamlined access to expert clinicians, the service has been successful in directing more patients to alternative services and reducing referrals to emergency services. The integrated service offered simplification in the system during the pressured winter period and provided valuable clinical support when we set up the Gold Command structure in March 2018. Adapting and making the best use of the resources and facilities already in the health and care system will be critical to managing the increasing demand in 2018/19.

We know that system wide transformation projects are likely to result in most benefit to efficient and effective care, and so in 2018/19 we will continue to develop work started in 2017/18 in six priority areas:

(a) Implement best practice care for people who are frail;
(b) Accelerated implementation of re-enablement, recovery and rehabilitation functions that will further reduce delayed transfers of care and avoid acute admissions;
(c) Implement new Musculoskeletal pathways (initial focus on hips and knees, falls prevention and a fracture liaison service);
(d) Redesign Cardiovascular pathways (focussing on prevention, avoiding attendances at emergency departments and reducing unplanned admissions to hospital);
(e) Radical transformation of outpatient services, in particular through new care models and digital;
(f) Accelerate cost efficiency programme for Back Office services.

Investing to improve our equipment, IT systems and infrastructure

During 2017/18, we invested £18.9 million in capital projects, including IT, new and replacement equipment, new and refurbished buildings and general estate maintenance.

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During 2017/18, we invested £18.9 million in capital projects, including IT, new and replacement equipment, new and refurbished buildings and general estate maintenance.

Works to our buildings have included:

- The relocation and expansion of the Neonatal Unit
- Creation of a Midwife led Birthing Centre
- Replacement Gamma Camera
- Replacement CT scanner and X-Ray facilities at West Cornwall Hospital
- Alterations to the Emergency Department to provide facilities to support GP teams
- A number of minor ward upgrades and environmental improvements
- Progressing the design for the future Lowen Ward replacement and re-provision of MRI scanners

Investing in technology is playing an increasingly important role to keep patients safe and in improving the efficiency of the services we provide. Our eHealth Programme which encompasses a wide range of new technologies is being delivered by Cornwall IT Services (CITS). Clinicians play a lead role in the development of new IT systems and, increasingly, app-based solutions.

Examples of systems that have been implemented over the year are: NerveCentre; Scan4Safety; eReferrals, all of which improve efficiency and safety within the Trust. Over the next 12 months we will be continuing the development of projects that transform our health records service, moving more information online and enable easier sharing of information between clinicians. We will also be working toward the replacement of our core patient administration system.

Scanning technology is playing an increasing role in patient safety.

Making best use of all the resources and community support available

Volunteers play an essential role in everyday life at our hospitals.

Volunteers and Friends

Volunteers have continued to fulfil vital supporting roles to patients, visitors, and staff across all three hospital sites. There are currently around 600 individuals carrying out a wide range of tasks from reception hosts to pastoral visitors and refreshment cafes to memory cafes. Through a partnership with Truro & Penwith College, we also continue to see a rise in the number of young volunteers. Many of our volunteers are members of our respective hospitals' Leagues of Friends. They not only give time for their many volunteering duties, but also support patient care and staff through their fundraising activities.

Charitable Funds

Alongside the Friends fundraising activities, we have Trust Charitable Funds which enable the organisation to fundraise for gold standard care in Cornwall and the Isles of Scilly through state-of-the-art equipment, healing environments, specialised staff training, and innovative research.

The Cornwall Birth And Baby Appeal
Going above and beyond in maternity and new born care

In early 2017, we launched the Cornwall Birth and Baby Appeal to support the redevelopment of the Princess Alexandra Wing so that we could provide additional equipment and enhance the environments in our maternity and neonatal units. The appeal aim is give parents and babies in Cornwall the very best start in life and access the best possible care. A new neonatal unit and birthing centre opened in 2017/18 providing better choice and experience for the local community supported so far by £100,000 of charitable funds. In 2018/19 we will continue to fundraise for the appeal to support improvements across maternity and neonatal services.

Kathy Byrne
Chief Executive

24 May 2018

2 Accountability Report

Directors' Report & Governance Disclosures

Register of interests

A copy of the Board Register of Interests is available on our website (www.royalcornwall.nhs.uk) or can be obtained from the Chairman's Office, Bedruthan House, Royal Cornwall Hospital, Truro, TR1 3LJ. Board members declare any new interests at each Board meeting.

Compliance with cost allocation and charging guidance

The Trust has complied with the cost allocation and charging guidance issued by HM Treasury.

Political donations

The Trust did not make any political donations during 2017/18.

Better Payment Practice Code

The Better Payment Practice Code requires the Trust to pay all valid invoices by the due date or within 30 days or receipt of goods of a valid invoice, whichever is the later, unless other payment terms have been agreed with the supplier. The Trust's compliance with the code is set out in the notes to the accounts.

Disclosures relating to quality governance

Disclosures in relation to quality governance can be viewed within the Quality Accounts.

To the best of the directors' knowledge, there are no known material inconsistencies between:

- The annual governance statement
- The annual and quarterly statements required by the risk assessment framework, the corporate governance statement submitted with the annual plan, the quality report and the annual report
- Reports arising from the Care Quality Commission (CQC) inspections and the Trust's consequent action plans

Code of governance compliance statement

Royal Cornwall Hospitals NHS Trust is committed to effective, representative and comprehensive governance which secures organisational capacity and the ability to deliver high quality clinical services. The Trust's governance arrangements are reviewed yearly against national best practice (including the NHS Code of Governance) to ensure the suitability of its governance arrangements.

For the year ending 31 March 2017, Royal Cornwall Hospitals NHS Trust complied with all relevant provisions of the Code of Governance.

Board of Directors

During 2017-18 the Trust Board had eight non-executive directors (including the chairman) and nine executive directors (2 non-voting), including the chief executive. As at 31 March 2018 the Board comprised 7 male and 10 female directors. Each director's skills, expertise and experience (those on the Board at the end of March 2018) are detailed below.

Non-Executive Directors

Jim McKenna – Chairman

Jim McKenna took on the role of Chairman in January 2017. He is also a local Cornwall councillor as independent member for Penzance Promenade and was formerly Chief Executive of Penwith District Council. Jim has experience of working in health and social care and his links to the local community are valuable in the transformation of local services.

Dr Mairi McLean

Mairi has been a non-executive director since 2014. She has a background in social work, psychology and leadership and has held senior positions in local government and is a former Council Chief Executive Officer. Mairi currently runs her own consultancy business which provides leadership and executive coaching, strategic planning and team development. She also holds a number of other local and national advisory and visiting lecturer position.

Charlotte Russell

Charlotte joined the Trust in October 2013 and left at the end of March 2017/18. She was a Non-Executive Director at the South Western Ambulance Service for nine years and part of the team that achieved NHS Foundation Trust status in 2011. She is a company director of an organic farming business with her partner and has been involved in the strategic development of the food and farming industry in Cornwall for many years. She is currently Head of Learning for the Eden Project and has previously worked in both print and broadcast media with a particular interest in the environment.

Paul Hobson

Paul joined the Trust Board in February 2016. Paul is the Chief Executive of the CSW Group which is owned by the local authorities in Cornwall and Devon. CSW provide a range of services and products, supporting people and businesses across the South and West. Paul has held senior director posts for over 30 years in the public and private sector having started his clinical career as a radiographer in his native Cornwall.

Sarah Pryce

Sarah is a former Head of Human Resources and Organisational Development at the Royal National Lifeboat Institution (RNLI). She joined the Trust Board in February 2016 and is currently Chairman at Cornwall Air Ambulance Trust and owns her own consultancy company specialising in leadership and organisational development.

John Lander

John joined the Trust Board in June 2016 bringing extensive financial leadership experience including senior corporate banking appointments at HSBC and Board level appointments at two major motor companies. Having been Chairman of Coastline Housing Ltd. for eight years he is now a director of Cornwall Rural Housing Association Ltd. John is now Vice Chair of Cornwall Rural Housing Association Ltd. John is also a Board Member of Truro and Penwith College where he chairs the Finance and General Purposes Committee.

Margaret Schwarz

Margaret is an experienced non-executive director and joined the Trust on 1st November 2016 bringing expertise in finance and strategy. Margaret is the Governance Lead for Cornish Mutual Assurance and a non-executive director of Cornwall Foundation Trust.

Roger Gazzard ***(Associate Non-Executive Director)***

Roger is a born and bred Cornishman. A qualified accountant who spent thirteen years as a Director of a group of companies in the waste management and haulage industry sectors. He has also worked in local authority finance both locally and nationally. In recent years he ran a company providing business advice to small and medium businesses. Since the beginning of 2011 he has held the position of Town Clerk to Truro City Council. Roger was appointed in 2007 and left the organisation in March 2017.

Executive Directors

Kathy Byrne – *Chief Executive*

Kathy joined RCHT in April 2016. She has a long and distinguished career as a health service Chief Executive in Australia and was formerly head of Health Support Queensland and Deputy Director General at Queensland Department of Health.

She has considerable experience of leading major healthcare organisations and transforming health and social care systems.

Kate Shields – *Deputy Chief Executive*

Kate joined the Trust in October 2017 and is an experienced NHS leader. Kate has worked as Director of Strategy and Partnerships at University Hospitals Leicester and was a registered nurse and mental health nurse at the beginning of her NHS career. Kate has also worked for NHS England as a Regional Director of Specialised Commissioning and as the National Head of Specialised Commissioning.

Mark Daly – *Medical Director*

Mark joined the Trust in October 2017 first on an interim basis and then as the substantive Medical Director. Mark has been the Deputy Medical Director at Royal Devon and Exeter NHS Foundation Trust where he was also a consultant endocrinologist and Associate Medical Director for Surgical Services. He has held several clinical leadership roles in medicine.

Kim O'Keeffe – *Chief Nurse*

Kim was appointed as Chief Nurse in May 2017 having previously been Deputy Director of Nursing. With over 30 years clinical and managerial experience working in the NHS and private and state hospitals in South Africa, Kim began her career as a Registered Nurse in South Africa. She held a range of senior positions in the Dudley Group of Hospitals before joining the Royal Cornwall Hospitals in 2008 as Divisional Nurse Manager within Surgery, Anaesthetics and Trauma and Orthopaedics.

Sally May – *Joint Director of Finance (RCHT + CFT)*

Sally May, joined the RCHT Board in May 2017 taking on a dual role as Director of Finance across RCHT and Cornwall Partnership Foundation NHS Trust (CFT) whilst RCHT's Director of Finance is leading on financial strategy and planning for Cornwall & Isles of Scilly Shaping Our Future portfolio . Sally has been at CFT since 2011 and was previously Director of Finance at NHS Cornwall & Isles of Scilly.

Ethna McCarthy – *Director of Strategy and Business Development*

Ethna is an experienced Director having held a range of senior posts since 1995 across all sectors of the NHS. A chartered accountant by profession, Ethna has significant experience covering finance, business planning, strategic development, risk management, and research and development. Ethna joined the Board of RCHT in January 2012.

Catrin Asbrey – *Director of Human Resources & Organisational Development*

Catrin joined RCHT in December 2016. She has 10 years' experience of working at a senior level across different industries including within an international PLC successfully leading large scale, multi-site transformation programmes and developing multi discipline strategic workforce and people development plans.

Rab McEwan – *Chief Operating Officer*

Rab joined the Trust Board in August 2017. He is an experienced Chief Operating Officer in the NHS and has previously worked at Board level in Brighton, Worcestershire and Dorset. Rab has a background in Epidemiology and Public Health, with a PhD from Newcastle Medical School, and has an MBA from Durham University Business School.

Thomas Lafferty – *Director of Corporate Affairs*

Thomas joined the Trust in January 2017 having previously been Director of Corporate and Legal Affairs at Chelsea and Westminster Hospital NHS Foundation Trust where he played an instrumental role in the Trust's acquisition of West Middlesex University Hospitals NHS Trust. Prior to that, Thomas has held similar roles at other NHS Acute Trusts and has developed an expertise with regard to legal and governance matters within healthcare.

Annual Governance Statement 2017-18

Scope of responsibility

As Accountable Officer, I have responsibility for maintaining a sound system of internal control that supports the achievement of the 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 that the 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 the Trust's policies, aims and objectives. It therefore provides reasonable, but 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 the 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 the Trust for the year ended 31 March 2018 and up to the date of approval of the 2017/18 Annual Report and Accounts.

Capacity to Handle Risk

The Trust's Risk Management Strategy identifies the Chief Executive as ultimately responsible for effective risk management within the Trust, although the Director of Corporate Affairs is the responsible Board officer for ensuring the implementation of the Strategy which includes the production of Board Assurance Framework and Corporate Risk Register. The Strategy sets out how the responsibilities for managing division-specific and department-specific risks are delegated to all levels within the organisation.

The Audit & Risk Committee is responsible for ensuring that the Trust operates a sound and effective risk management process. In particular, the Committee oversees the processes in place for the development and monitoring of the Board Assurance Framework and Corporate Risk Register. Other Board Committees review risk data pertinent to their areas of focus to allow Board members to have appropriate oversight of the Trust's risk profile and of the mitigating actions being taken to address risk.

Staff receive risk management training as part of their induction process and are required to undertake ongoing mandatory risk management training. As part of this, staff are informed of the need to report incidents using the Trust's intranet reporting facility (incidents being a key

'identifier' of risk, as detailed below), to disseminate experience and to learn from incidents. Whilst there is good evidence of learning taking place in specific clinical areas within the Trust, in 2018/19, the Trust will be taking steps to ensure a more holistic approach to Trust-wide organisational learning, incorporating outcomes from incident investigations, clinical audit, complaints, legal claims and risk assessments.

The Risk and Control Framework

The Trust recognises that a key success factor for achieving good governance is the effective management of risk. The Trust's revised Risk Management Strategy will be approved by the Board in May 2018 and will be available to all staff through the Trust's document library. The revised Strategy will aim to provide a less complex and simpler approach to the escalation of risk throughout the organisation, enabling 'best practice' to be understood and followed. The Strategy will also:

- Define the Trust's attitude to risk;
- Describe all staff members' responsibilities in relation to risk;
- Define the process underpinning the escalation of risk;
- Recognise the legal basis for risk assessment and risk management;
- Describe the design of the Trust's risk scoring approach and the mechanisms for ensuring that the Board maintains its focus on mitigating the most critical risks;
- Describe the function of the Board Assurance Framework and risk registers; and
- Describe the structure of assurance, as delivered through the committees of the Board.

The Trust has developed a detailed process for monitoring the risks to achieving its objectives and strategic aims, based on the Board Assurance Framework. This framework:

- Identifies the principal risks to achievement of the Trust's strategic objectives;
- Identifies the components of the system of internal control in place to manage the risks;
- Identifies the assurance sources which the Board relies on, relating to the effectiveness of such systems; and
- Records the actions taken to address identified gaps in control and assurance on a regular basis.

Risk Identification

The identification of risks arising from work-related tasks or activities is undertaken by staff at all levels of the organisation. There are four methods of risk identification that the Trust uses:

1. Known ongoing inherent risks that the Trust is aware of which are controlled and managed;
2. Foreseeable local risks which are inherent and identified by competent persons proactively;
3. Strategic risks identified by the Board;
4. 'Retrospectively realised' risks from risk sources.

As per the fourth method of risk identification detailed above, risks can be identified from a number of sources, including but not restricted to:

- Risks/recommendations from incident investigations and themes/trends arising from cumulative analysis of incident data;
- Clinical risk assessments;
- Non-clinical risk assessments (security, health and safety, health and wellbeing etc.);
- Risks arising as a result of an external review or inspections;
- Recommendations from internal audit reports or other internal or external monitoring reviews/audits/assessments or reports;
- Patient surveys;
- Staff surveys;
- PALS and complaints key themes; and
- Risk shared by neighbours and/or other stakeholders/duty holders or authorities.

Furthermore, the Trust, wherever possible, identifies the risks associated with other processes and initiatives. For example, all Trust business cases, cost improvement plans and major strategic changes are each subject to a:

- Quality Impact Assessment;
- Equality Impact Assessment.

This helps to ensure that risk management practice is embedded in the activity of the organisation. Where quality/equality risks are identified, a decision is made as to whether the process/initiative can continue and, if so, what steps needs to be taken in order to mitigate any identified risk.

The Trust also works with a range of stakeholders to identify and manage risks, such as the Strategic Clinical Network and health system partner providers. It is a member of the Whole Systems Resilience Network (WSRN) of key public sector partners in the county, working together to manage operational risks and sustain safe clinical services. This ensures it keeps track of emerging risks across the healthcare system and wider public sector.

Risk Evaluation and Risk Control

The purpose of undertaking risk assessments is to effectively manage and control significant risks which are/have been identified/inherited or which are foreseeable in nature. Risks are evaluated in order to determine the level of exposure and provide input to decisions on where responses to reduce, accept or avoid risks are necessary/acceptable or likely to be worthwhile. The evaluation of the risk assessment will involve the analysis of the individual risk to identify the consequences/severity and likelihood of the risk being realised. The consequence and likelihood of the risk is given a numeric score (1-5) based on the following matrix:

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost Certain
5. Catastrophic					
4. Major					
3. Moderate			X		
2. Minor					
8. Negligible					

Further, the Risk Management Strategy includes descriptors of what constitutes each 'degree' of consequence and likelihood for financial, quality, strategic, operational and workforce risk.

Alongside the general risk assessment process the Trust employs, there are patient and staff specific risk assessment forms used at ward/department level in relation to particular risks, for example:

- Falls;
- Pressure ulcers;
- Moving and handling;
- Venous Thrombo-Embolism;
- Nutritional;
- Work station assessment.

The Risk Register template is structured in a way that requires the recording of an 'original risk rating', in addition to a 'current risk rating' and 'residual risk rating'. This allows the Trust to track changes in risk, from risk recognition through to an assessment of the risk post-mitigating actions. In each case, the Trust's risk 'appetite' is determined by the residual risk rating which effectively operates as a target rating, i.e. once the mitigating actions have been implemented successfully and the risk has reduced to the target, the Trust will tolerate the residual level of risk. However, each time a risk is reviewed and updated, the determination of the Trust's risk appetite is also reviewed; particularly after new mitigating actions have been identified.

The Risk Register template provides for any pre-existing 'controls' (mechanisms/safeguards in place to prevent the risk materialising) to be captured. Any future actions required to further mitigate the current level of risk are also captured, alongside any applicable timescale for implementation.

Quality Governance Arrangements

The Trust Board is clear that patient safety and the delivery of high quality clinical services is of paramount importance. To reflect this, quality matters are prioritised on the agenda at all formal Board meetings. Within its annual plan of business, the Board routinely receive reports on:

- Quality performance (via the Integrated Performance Report) across a wide range of KPIs pertinent to patient safety, clinical effectiveness and the patient experience;
- Incidents;

- Risk;
- Safe staffing;
- Quality Improvement (reports from the Quality Improvement Delivery Board).

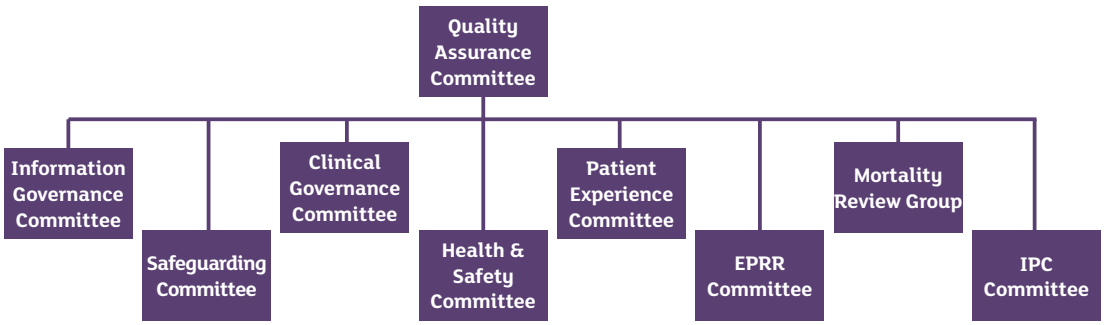
The Quality Assurance Committee is a formal Board Committee. Its primary role is to assist the Trust Board in ensuring that the Trust discharges its functions and meets its responsibilities with regard to the quality and safety of healthcare delivered. Its specific duties include:

- Providing assurance, both in relation to development and delivery, that the Board has an effective strategy for improving the quality and safety of care patients receive, and improving their overall experience;
- Providing the Board with assurance that effective and well supported operational governance arrangements for quality and safety are in place;
- Scrutinising assurances on compliance with Care Quality Commission (CQC) standards and the Information Governance Toolkit;
- Approving the annual Clinical Audit plan, ensuring alignment with Trust priorities and risk areas;
- Approving and monitor delivery of action plans arising from review/investigation reports and the work of external regulators;
- Seeking assurance on the handling of risks relating to quality and patient safety;
- Providing assurance to the Board that risks arising from major changes to services or pathways are managed by the Trust, including those arising from system wide developments;

Providing assurance to the Board in relation to its responsibilities for matters including:

- safeguarding vulnerable people, children and young people;
- safe staffing;
- infection prevention and control;
- serious incidents and duty of candour;
- emergency preparedness and business continuity;
- health and safety legislation;
- responding to incidents, concerns raised, claims and inquests;
- learning from complaints and experiences;
- information governance.

In turn, the Quality Assurance Committee has its own Committee sub-structure formed of groups chaired at Executive level, as illustrated within the diagram below:



As of December 2017, the Trust had established a Quality Improvement Delivery Board (QIDB), an Executive-led forum to oversee the implementation of the Trust Quality Improvement Programme. The QIDB also reports into the Board Quality Assurance Committee.

The Trust Quality Improvement Programme was launched in December 2017 and is supported by a dedicated quality improvement Project Management Office (PMO). The Programme is focused upon three core priorities:

- Safety culture – Adopting best practice to keep patients safe;
- Strong governance – Being a well-led, learning organisation that places the patient at the centre of care; and
- Tackling patient delay - Eliminating patient delay at every stage of care, in the pursuit of safety.

Three enabling work programmes underpin the core priorities:

- Culture and Leadership;
- Communication and Engagement; and
- Quality Improvement Hub.

Further details on the Trust's quality governance arrangements are set out within the Trust Quality Accounts

Quality of Performance Information

The Records, Information and Data Quality Strategy sets out the Trust's approach to managing information and data quality, however or wherever that data is collected (electronically or manually, by clinical or business support services). The Trust's aim is to maximise the accuracy, timeliness and quality of data collected. High standards in data quality aid the Trust in meeting its patient safety and governance obligations as well as maximising its planning and finance capabilities. Detailed guidance is in place for the construction and measurement of all key indicators generated from core Trust systems.

The Trust operates a Performance Assurance Framework that establishes the performance metrics needed for ongoing review of its level of compliance with CQC regulations and other mandated quality requirements. The Performance Assurance Framework is a balanced scorecard of quality, operational, finance and workforce indicators which is aggregated at a divisional, specialty and ward level. It includes a wide range of locally and nationally relevant indicators, benchmarked against best practice where applicable, or against previous trust performance. Each indicator is also weighted depending on their level of priority. These are used to support performance management processes, and the indicators are reviewed annually to ensure they are still relevant.

Care Quality Committee (CQC) Registration Requirements

Since October 2010, all health and adult social care providers have needed to be registered and licensed with the CQC to show that they are meeting essential standards of quality and safety.

The Trust is not fully compliant with the essential standards that underpin its registration with the CQC. As at the end of 2017/18, the Trust was rated as 'inadequate' overall by the CQC and had been subject to two Section 29(A) Warning Notices in year.

In June 2017, the Trust received the outcomes of an unannounced inspection undertaken in January 2017. The inspection focused on the Trust's Urgent and Emergency Care, Medical Services and End of Life Care services. Medical Care and End of Life Care were both assessed as being 'inadequate', whilst Urgent and Emergency Care was assessed as 'requires improvement'. However, due to the targeted focus of the inspection, the Trust's overall rating of 'requires improvement' was unaffected by these service specific ratings.

Following the publication of the January 2017 inspection report, a planned and more comprehensive inspection was carried out over 4-7 July 2017. The final outcome of the CQC inspection was published on 5 October 2017. Overall, the Trust was rated as 'inadequate', with Royal Cornwall Hospital rated as 'inadequate', West Cornwall Hospital as 'good', St Michael's Hospital as 'good' and Penrice Birthing Centre as 'requires improvement'. The CQC rated the Trust on being safe, responsive and well led as 'inadequate', on being effective as 'requires improvement', and on being caring as 'good' overall. Following the publication of the outcomes

of the report, the Trust launched its Quality Improvement Programme (referred to above) in order to address the longstanding concerns identified within the CQC report, focusing on the themes of Safety Culture, Strong Governance and Tackling Patient Delay.

As a result of the outcomes of the July 2017 inspection, the Trust was formally placed in 'special measures' by NHS Improvement.

On 29 August 2017, the CQC issued the Trust with a Section 29A Warning Notice under the Health and Social Care Act 2008, based upon aspects of the findings arising from the July inspection. The areas identified in the warning notice as requiring significant improvement included Outpatients (Ophthalmology and Cardiology), Surgical Services, World Health Organisation Checklist, Maternity Services, Flow within Critical Care, Fracture Clinic, Staffing Levels (generic and Paediatric Emergency Department), Equipment, Incident Management and Governance Systems. By 30 November 2017, the Trust had provided the CQC with written information confirming the improvements that had been made in response to the warning notice.

The CQC undertook an unannounced inspection on 16-18 January 2018 to inspect against the requirements in the warning notice. Whilst improvements within Outpatients (Ophthalmology and Cardiology) and in the Paediatric Emergency Department were explicitly acknowledged, concerns remained with regard to specific aspects of the original warning notice and a second Section 29(A) Warning Notice was issued on 1 March 2018, covering Surgical Services, WHO Checklist, Maternity Services, Flow within Critical Care, Fracture Clinic, Equipment, Incident Management and Governance Systems.

The Trust responded formally to the second warning notice on 13 April 2018. In making its submission, the Trust senior leadership team acknowledged that the process had enabled the team to gain a much deeper understanding of the issues and challenges faced in serving the Trust's patients. The Trust's response confirmed that the organisation had, in many cases, needed to initially 'rebase' its quality data, performance and expectations in order to embed a sustainable approach to Quality Improvement in the longer-term. The Trust Board is confident that this will place the organisation in a stronger position to move at the scale and pace required. The submission also confirmed that improvements had been made in each of the six areas associated with the Notice, although recognised the ongoing challenges that would continue to require attention.

The full inspection report associated with the January 2018 inspection was published on 6 April 2018.

Within the year, the Trust has established a weekly, Executive-led CQC Scrutiny Group which monitors the implementation of the Trust's response to the key concerns arising from each of the Trust's recent CQC inspection reports, including the requirements of both warning notices. The outcomes from these meetings are reported at the Quality Improvement Delivery Board.

Risks to Data Security

The Trust's overall arrangements for managing data security lie within the responsibilities of the Director of Strategy & Business Development. Where key data security risks arise, they are recorded in the relevant Trust risk register. Any significant data security incidents are comprehensively investigated and formally reviewed by the Information Governance Committee, chaired by the Trust Senior Information Risk Owner (SIRO).

Major Risks

The principal risks to achieving the Trust's objectives and strategic aims have been identified and scored, in line with the Trust's risk management matrix and are included in the Board Assurance Framework (BAF). The six principal risks as at the end of 2017/18 are as follows:

Risk ID 6212: Operational pressures and patient flow
Patient flow across the system in Cornwall is constricted due to increasing demand and inefficiencies in the discharge process. The resulting congestion leads to a sustained escalation state and delays in patient care delivery. It adversely affects the quality of care delivered and the overall patient experience, leads to cancelled/delayed treatment and impacts on the Trust's ability to deliver a range of performance standards, including the Emergency Department 4 hour standard. **Risk score: 20.**

Risk ID 6213: Delivery of quality objectives and the effectiveness of clinical governance arrangements

Without robust and effective clinical governance arrangements, there remains a risk that the Trust will not be able to meet (and evidence) compliance with regulatory standards and may not consistently deliver high quality, compassionate care to patients. **Risk score: 20.**

Risk ID 6214: Workforce capacity

There is a risk that the Trust does not have the 'right people in the right place at the right time for the right cost', posing a significant risk to its ability to meet its care obligations. **Risk score: 16.**

Risk ID 6215: Workforce engagement

The Trust's staff survey consistently highlights low levels of staff engagement within the Trust. This has the potential to adversely affect the delivery of transformational change and the day-to-day delivery of high quality and compassionate care. **Risk score: 12.**

Risk ID 6216: Partnership working (delivering "Shaping our Future")

Health and social care partners within Cornwall & the Isles of Scilly recognise that the current segregation of responsibilities for commissioning and providing primary, secondary, community and mental health services is uneconomical and ineffective. It provides local people with a disjointed service, rather than placing them at the centre of their care. Integrated working and new models of care need to be developed within the region in order to maximise available resources and provide a higher quality care pathway for patients. **Risk score: 16.**

Risk ID 6749: Non-delivery of financial plan 2018-2019-2020
The proposed Financial Plan has a £11.9m deficit, including a £12m savings target. The final plan will be approved by 30 April 2018. The deficit plan results in the Trust needing c.£13m of cash support and, without a plan to recover this deficit, the Trust's debt will increase rapidly. The key risks are that the Trust will not be able to operate without cash support and that the deficit plan is not sustainable. The Trust also needs to clearly evidence the level of expenditure needed in the year and put in place savings schemes that deliver the savings target. The Trust needs to reduce agency spend which is a risk as agency spend in 2017/18 totalled £12.6m. The proposed budget has no contingency to cover the costs of transition in models of care. The proposed budget is based on a block contract which secures the Trust's main income source and could bring a financial benefit if actual activity is below contracted levels, but exposes the Trust to financial risk should activity exceed contracted levels. **Risk score: 20.**

NHS Improvement's Well-led Framework
In March 2018, the Trust underwent a 'Well-Led Review' in line with NHS Improvement's well-led framework as part of its focus on being a well-led, learning organisation that places the patient at the centre of care. The overall purpose of the Review was to ensure that the Trust has the necessary leadership capacity and capability, supported by effective governance, to respond to the challenges it faces and to deliver sustainable improvements in patient services, now and in the future. The Review will provide an independent assessment of the Board and senior leadership team's current capacity and capability and identify the actions and improvements required to address the gaps identified. The Review will inform NHS Improvement's 'special measures oversight' and ensure the Trust makes the necessary improvements.

The outcomes from the Review are expected to be received by the Trust Board in June 2018.

Risks in Complying with the Provider Licence
NHS trusts are required to self-certify that they can meet the obligations set out in the NHS provider licence (which itself includes requirements to comply with the National Health Service Act 2006, the Health and Social Care Act 2008, the Health Act 2009 and the Health and Social Care Act 2012, and to have regard to the NHS Constitution) and that they have complied with governance requirements.

The Trust is at risk of non-compliance with the provider licence. Both of the S.29A Warning Notices identified that, overall, the Trust's

- systems to assess, monitor, and mitigate risks to patients receiving care and treatment are not operating effectively; and that its;
- governance systems and processes are not operating effectively.

The Trust's recognition of the ineffectiveness of aspects of its overall governance framework, particularly as it relates to clinical governance, is a key reason why 'strong governance' is an integral part of the Trust's Quality Improvement Programme. In terms of clinical governance, the Trust's processes for incident reporting and compliance with the Duty of Candour have

faced significant criticism in year and the Trust has particularly prioritised the 'turnaround' of performance in these essential areas. This has been supported by a £400,000 expenditure on the clinical governance leadership team, ensuring the capacity and capability to deliver in a sustainable way best practice in these areas.

Broader than this, the Trust commissioned a substantive review of its 'ward-to-board' governance processes in year which highlighted critical 'disconnects' within the overall reporting of performance/risk information to the Board, with particular concern expressed with regard to the effectiveness of divisional governance. The Trust Board recognises that the degree and rigour of oversight the Board has over the Trust's performance is fundamentally dependent upon this being resolved. In support of this, there were examples in year of key clinical risks which were not brought to the attention of the Board in a timely fashion. The externally facilitated 'Well-Led Review' commissioned by the Trust (detailed above) included consideration of how divisional governance could be improved, as well as whether the responsibilities of Directors and of the Trust's Board Committees were appropriate.

In view of the recognised risk that exists regarding the reliability of the Trust's ward-to-board/ divisional reporting framework, the Board and Quality Assurance Committee have started to receive 'direct assurance' as to the Trust's adherence to clinical quality standards via the 'ward-to-board' performance dashboard which is produced on a monthly basis. As at the end of the financial year, the Trust had commenced a pilot for the implementation of a 'ward accreditation' programme which will build upon the pre-existing ward-to-board dashboard and provide the Board with specific compliance/performance information with regard to each clinical area.

In terms of general licence Condition 4, concerning the Fit and Proper Persons' Test, whilst compliance risks in this area were identified following the January 2017 CQC inspection, the Trust took swift action to resolve this, with CQC concluding on re-inspection that there were no residual concerns associated with the Trust's compliance with this statutory requirement. In support of this, all Board Directors were subjected to performance appraisals in year, with key objectives and outcomes being clearly documented.

Compliance with NHS Pension Scheme regulations

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.

Compliance with equality, diversity and human rights legislation

Control measures are in place to ensure that all the Trust's obligations under equality, diversity and human rights legislation are complied with. The Trust ensures its compliance by utilising the Equality Delivery System tool (EDS2). This tool supports the Trust in proving it meets its Public Sector Equality Duty, by gathering evidence to meet the 18 outcomes within it.
In 2016, the Trust performed an updated assessment of its compliance using EDS2 and a refresh is planned for 2018, when the 18 criteria will be re-assessed.

The Trust's Annual Equality Report contains information on the characteristics (e.g. age, gender) of its workforce and the people who use its services, in order to identify any possible inherent disadvantage or issue with individuals being excluded from opportunities or services. This remains a positive step towards ensuring equality is considered in all mainstream processes.

The NHS Workforce Race Equality Standard requires the Trust to publish a comparison of nine outcomes, as part of ensuring employees from black and minority ethnic (BME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. This is an annual requirement and is scheduled to be refreshed in July 2018. The data is used to identify and plan for any necessary improvements.

Climate Change and Sustainability

The Trust has Carbon Reduction Delivery Plans to ensure that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The Trust has adopted a Sustainable Management Development Plan aimed at ensuring all activities undertaken have considered the effect of climate change. All business cases are required to evidence how sustainable development has been considered, as part of proposals for the development of services, systems and estate. Specific activities have included working with the Transport and Travel Office to encourage active travel (making journeys by physically active means such as walking or cycling) and embedding 'sustainability' into the procurement of goods and services.

Reducing the use of single-use plastics on site was addressed and, to support this, three water bottle refill stations are planned to be installed. Other initiatives investigated included recycling single-use theatre instruments and reducing the use of plastic straws and disposable coffee cups.

Close links have been maintained with the wider community through co-operation on the Carbon-Wise intranet page, covering all Cornwall NHS healthcare organisations, and wider work with the Council and private sector on future plans for the county. Two successful grant applications to Cornwall Council have led to improved cycling facilities on site, including new covered cycle shelters and improvements to staff changing facilities in Trelawny Wing. Further work is planned to improve the Tower Block changing facilities.

The Trust continues to make significant progress with implementing a £6.4m Carbon and Energy Project which will result in the installation of some of the latest energy infrastructure (combined heat power plant, new boilers, bio-mass boilers, LED lighting programme, solar PV, low loss transformers and new building management system), to reduce its CO2 emissions by 32% and lead to considerable savings on its energy bills. This project is scheduled to reach practical completion in June 2018.

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

The Trust seeks to ensure value for money in a number of ways, including benchmarking performance and costs of services and setting challenging savings targets to test how services can be provided more efficiently and cost effectively. A key benchmarking tool is the Model Hospital ➤

which shows that the Trust has a lower productivity opportunity than the national average and has lower quartile pay costs based on the activity that is undertaken. The Trust is carrying out a series of reviews at specialty level to explore the opportunities set out in the Model Hospital and link these to outcomes at service level.

Delivery against the Trust's savings target is reported to the Finance Committee and Trust Board each month. Internal Audit carries out annual reviews of the governance arrangements in relation to the savings programme and, during 2017-18, the Trust also benefited from productivity reviews carried out by NHS Improvement. The Trust recognises the need to continue to explore all efficiency opportunities and to demonstrate that savings are planned for, and then delivered, in a robust way.

Information Governance

The Trust's overall arrangements for managing information governance issues lie within the responsibilities of the Director of Corporate Affairs, who also acts as the Trust's SIRO. During the year, one issue regarding a data breach was reported to the Information Commissioner. This was investigated and appropriate management action taken. The Information Commissioner, having reviewed the evidence and supporting statements provided, concluded that no regulatory action was required. As part of its response to the Information Commissioner, the Trust committed to undertake specified measures to migrate the centrally stored corporate files to a more secure and manageable solution.

The Trust's annual self-assessment declaration, using the information governance toolkit, provides assurance that good governance processes are in place to maintain the security and confidentiality of personal and sensitive information. The Trust assessed itself as compliant with the information governance toolkit v14.1 for 2017-18, with a recorded score of 71% which is considered satisfactory.

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. Quality Accounts are reports about the quality of services by NHS healthcare providers and are available to the public.

The framework for the 2017-18 Quality Accounts audit has been agreed with the external auditors.

A number of processes are in place to ensure the quality and accuracy of waiting time data contained within the Quality Accounts. These include weekly validation of any unknown clock starts, weekly review of incomplete pathways over 13 weeks' wait without an admission date, and validation of the pathway when patients with a decision to admit are added to the elective waiting list. In 2017/18 the Trust transitioned to SQL processing of referral to treatment (RTT) data, allowing daily refreshes of the waiting lists and supporting analysis. This was implemented after a significant pathway validation exercise.

Effective scrutiny of elective waiting times is in place via a fortnightly executive director-led meeting, supported by weekly meetings within the operational divisions in which performance against RTT standards is monitored. The performance management framework also reviews performance against other elective waiting time standards and key waiting time indicators, including oversight of booked patient waits. Training is provided routinely and as required, and is bespoke to support the management of access standards, whilst a demand and capacity training offer was also launched in 2017/18.

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 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 & Risk Assurance and the Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

Internal Control Framework: Assurance Framework

The Board actively reviews the Trust's internal control and risk management arrangements. This is achieved through maintenance and review of the Board Assurance Framework (described above) and consideration of matters referred to the Board and its committees. Significant internal control issues are immediately reported to the Chief Executive and, at the earliest opportunity, to the Executive Team, the Audit & Risk Assurance Committee and Trust Board.

In March 2017, the Board agreed to use a uniform template to capture both BAF and Corporate Risk Register requirements and this was reflected in the April and July 2017 risk papers received by the Board. However, during the year, the frequency of the reporting of the BAF to the Board did not meet the requirements of the Risk Management Strategy (bimonthly reporting) and, when reviewed by internal audit, there were concerns as to totality and adequacy of controls and assurances captured within the BAF. This poses a risk to the Trust being able to have an effective and comprehensive process in place to identify, understand, monitor and address current and future risks.

The Lead Executive has confirmed that, as part of the review and update of the Risk Management Strategy, the frequency and format of BAF reporting to the Board and its committees will be clarified. The new reporting arrangements will be supported by a newly appointed substantive Risk Management team which has received additional funding as a result of the recently concluded reconfiguration of the central governance team.

Internal Control Framework: The Board and Board Committees

The Board meets on a monthly basis to discharge its statutory responsibilities and has established the necessary statutory (Audit, Remuneration) and non-statutory (Quality Assurance, Finance) Committees under Terms of Reference which adopt national best practice. The Trust's committee structure and the coverage of each committee are included in each committee's Terms of Reference, as approved by the Board. Each Committee's critical responsibilities relating to governance are set out below:

The Audit & Risk Assurance Committee has oversight responsibilities and, where appropriate, facilitates and supports the attainment of effective processes. It has responsibility for risk management assurance, to enable proactive risk management to be embedded within its work. The Committee's focus includes:

- Independently and objectively monitoring, reviewing and reporting to Board on the processes of governance and internal control across the whole of the organisation's activities (both clinical and non-clinical);
- Considering the Risk Management Strategy and recommending its approval to the Board;
- Overseeing risk management and the development and monitoring of the Board Assurance Framework, and undertaking risk assurance on behalf of the Board;
- Reviewing and approving all risk and control related disclosure statements, including this Governance Statement and the Head of Internal Audit Opinion, prior to endorsement by the Board;
- Considering the integrity, completeness and clarity of the annual accounts and the risks and controls around the Trust's financial management;
- Reviewing the work of other committees, whose work can provide relevant assurance;
- Requesting and reviewing reports and positive assurances from directors and other managers on arrangements for internal controls;
- Ensuring there is an effective and appropriate Local Counter Fraud Specialist function in place at the Trust; and
- Acting as the Trust's Auditor Panel and advising the Board on the selection and appointment of an external auditor (under separate Terms of Reference).

The responsibilities of the Quality Assurance Committee are detailed above.

The Remuneration Committee determines appropriate remuneration and terms and conditions of service for the Chief Executive, executive directors, very senior managers and staff on local terms and conditions. The Committee also evaluates the individual performance of executive directors and oversees appropriate contractual arrangements for such staff. It assists the Board in ensuring the organisation recruits, retains and develops a strong executive leadership team that is capable of achieving Trust objectives. The Committee additionally takes responsibility for ensuring Trust compliance with the Fit & Proper Persons regulatory requirements.

The People and Organisational Development Committee maintains a strategic overview of the Trust's workforce, and associated educational and organisational development arrangements, to ensure it is fit for purpose, flexible and provides ongoing affordable, high quality care and good clinical outcomes for patients. The Committee's focus includes:

- Strategic oversight and workforce planning;
- Organisational development and staff engagement;
- Compliance and risk management;
- Education and research; and
- Inclusion.

The Finance Committee maintains an objective overview of the Trust's financial and operational performance, business planning and associated risks. It advises the Board on the financial stability of the Trust and ensures corrective actions, where necessary, are initiated and managed as appropriate. The Committee's focus includes:

- Strategic planning;
- Performance delivery; and
- Commercial and business development.

The Trust Management Group (TMG), whilst not a formal Board sub-committee, has executive responsibility for overseeing robust, effective and efficient operational management of the Trust, including the achievement of statutory duties, clinical standards and targets and the delivery of high quality, patient-centred care. It provides advice in setting and delivering the organisation's strategic direction and priorities and supports and enhances the Trust's ability to provide safe, effective, high quality patient care. The TMG has representation from executive directors and clinical directors.

Throughout the year, the Board receives monthly assurance reports from each of its Board Committee (with the exception of the Remuneration Committee), highlighting the key items discussed by each committee that has occurred. This allows the Board to form an assessment of the effectiveness of each Committee.

In addition, on an annual basis, a Committee self-assessment exercise takes place which analyses the balance of skills/competencies on each Committee and assesses the performance of the Committee in meeting the obligations set within its Terms of Reference, as well as complying with corporate governance best practice.

Internal Control Framework: Clinical Audit

Clinical Audit is recognised by the Trust as being one of the most important components of a successful Quality Improvement Strategy. As such, the Trust has a Clinical Audit Programme that is revised and signed off annually by the Audit & Risk Committee.

The Clinical Audit Programme is formed by the inclusion of all nationally required audit projects, augmented by other projects considered by the Trust to be a priority for review and improvement through the year. Consideration is then given, dependent on resources, for improvement areas identified in specific clinical areas of the organisation. The construction and delivery of this overall programme is regularly reviewed by Internal Audit, with findings used to further improve the efficacy of Clinical Audit within the context of the Quality Improvement Programme.

Internal Control Framework: Internal Audit

The overall opinion of the Trust's internal auditor, as set out within the 2017/18 Head of Internal Audit Opinion, was that only a 'Limited Assurance' assessment could be given as to the effectiveness of the Trust's systems of internal control. This was due to identified weaknesses in the design and inconsistent application of controls. The basis for the Opinion was as follows:

- An assessment of the design and operation of the underpinning Assurance Framework and supporting processes;
- An assessment of the range of individual opinions arising from risk-based audit assignments that have been reported throughout the year.
- Any reliance that is being placed upon third party assurances.

Internal Control Framework: Other Review Mechanisms

The narrative above details the circumstances under which the Trust was placed into 'special measures' during the year in the context of the outcomes of successive CQC inspections.
In addition, other material external assessments in year:

- NHS Improvement Review of Theatres: Following a number of reported Never Events in June-July 2017, a review of theatres was commissioned by NHS Improvement in agreement with the Medical Director in July 2017. The review included a review of the safety culture within the service and its teams. The review concluded that the Trust had not fully embraced the WHO surgical safety checklist and there were concerns regarding behaviours and culture within the teams. The report contained a series of recommendations which have been implemented by the Trust and monitored via the Quality Assurance Committee.

A follow-up review took place in March 2018 to review the progress made against the recommendations.

- NHS Improvement of Complaints Management: This review took place in July 2017 and was focused upon best practice when addressing both formal and informal complaints. The review generated 10 recommendations. At the end of March 2018, eight actions had been fully implemented. Two require longer-term implementation plans and have been incorporated into the review of clinical governance effectiveness (concerning the Trust's Datix system).

- Royal College of Physicians Stroke Peer Review: The Trust has received initial verbal feedback following the March 2018 review. Stroke mortality was a particular area of focus, in recognition that the Trust is an outlier in this respect (notwithstanding strong HSMR performance across clinical specialities). The Trust received praise for its strong nurse leadership within stroke services. The Trust is currently awaiting the full formal report arising from the review.
- 'Fresh Eyes' Review of Maternity Services: Following review by the CQC, the Chief Nurse commissioned an external Fresh Eyes review of maternity services in January 2018. In response to the issues raised, a comprehensive action plan has been developed. The action plan is reviewed weekly to update progress.

Following completion of all the actions, a comprehensive quality improvement plan will be developed by the Interim Head of Midwifery which will become an additional programme of the Trust's Quality Improvement Programme, monitored by the Quality & Delivery Improvement Board. Of the 16 actions, four are currently closed, 11 on track and one action is still being scoped.

- Neo-Natal Peer Review: The Quality Surveillance Team (QST) from BAPM undertook a comprehensive Neonatal Peer Review Visit in November 2017 of the Trust's Neo Natal Unit; the QST consisted of a multi-disciplinary team including parental representatives. Initial feedback from the review was positive, noting areas of good practice and recognising work to address known shortfalls, for example the lack of dedicated neonatal dietician and dedicated psychosocial member of staff for the unit, maintaining skills and competencies, admission reduction and engagement with the members of the Neonatal Network. A final formal report is awaited.
- End of Life 'Fresh Eyes' Review: As part of the End of Life national collaborative programme, a 'fresh eyes' review was carried out in March 2018, facilitated by NHS Improvement and Hospice UK. Overall, the Trust received positive feedback, although improvements were required with regard to the Mortuary environment and signage pertaining to all End of Life services (including PALS services). The work included a case note review which noted the need for improvement in documentation as regards communication with patients and families during periods of clinical uncertainty.

- Royal College of Physicians review of Cardiology Services: This work was commissioned following historical concerns with regard to culture and clinical processes within the Trust's Cardiology Department. It provided a follow-up mechanism to an earlier external review that had been conducted in 2013.

The Trust received the initial feedback arising from the review in March 2018, with the full report expected by end April 2018.

The Trust is due to undergo an assessment of its Freedom to Speak Up procedures in May 2018, led by the National Guardian's Office.

Conclusion

Whilst the Trust has a system of internal control that supports the achievement of its policies, aims and objectives, it is clear that there are specific gaps in control in respect of the governance processes and systems identified above. These control issues have been, or are being, addressed.

Kathy Byrne

Chief Executive, Royal Cornwall Hospitals NHS Trust

April 2018

Remuneration and Staff Report

Introduction

Section 234B and Schedule 7A of the Companies Act, as interpreted for the public sector, requires NHS bodies to prepare a Remuneration Report containing information about directors' remuneration. In the NHS the report will be in respect of the Senior Managers of the NHS body. 'Senior Managers' are defined as: 'those persons in senior positions having authority or responsibility for directing or controlling the major activities of the NHS body. This means those who influence the decisions of the entity as a whole, rather than the decisions of individual directorates or departments.' For the purposes of this report, this covers the Trust's Non-Executive and Executive Directors.

The Secretary of State for Health and Social Care determines the Remuneration of the Chairman and Non-Executive Directors nationally.

Remuneration for Executive Board members is determined by the Remuneration Committee

Certain detail included within the Remuneration Report is auditable and has been referred to in the Independent Auditors Opinion on the Financial Statements. Where information included within the Report is subject to audit, this has been highlighted.

The Remuneration Committee

The terms of reference for the Remuneration Committee were updated and approved by the Board in June 2016 as part of the review of governance arrangements. The membership of the Committee consists of the Trust Board Chairman and all Non-Executive Directors. In the absence of the Board Chairman a nominated Non-Executive Director will act as Chair.

Remuneration Policy – Executive Directors

Amendments to salary are determined annually by the Remuneration Committee. Salary is inclusive – other payments such as bonus, overtime, long hours, on-call, standby etc. do not feature in Executive Director remuneration. Executive Director performance is monitored through the formal appraisal process, based on organisational and individual objectives.

The Medical Director's salary is in accordance with the Terms and Conditions – Consultants (England) 2003. In addition, a responsibility allowance is payable for the duration of executive office.

Details of remuneration and pensions for Non-Executive and Executive Directors are detailed in the tables within this report.

Fair pay disclosure

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

The banded remuneration of the highest-paid director at the Trust in the financial year 2017-18 was £180,000-£185,000 (2016-17: £180,000-185,000). This was 6.87 times (2016-17: 6.94 times) the median remuneration of the workforce, which was £26,565 (2016-17: £26,302).

Based on the March 2018 payroll, the calculated annualised pay for 2017-18 of 3 employees would have exceeded that of the highest-paid director (2016-17: 5). The calculated remuneration of these individuals ranged from £187,110 to £206,334 (2016-17: £188,381 to £311,946).

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

The decrease in the pay multiple ratio arose from the slight increase in the median pay level compared to the unchanged salary of the highest-paid director.

Duration of contracts, notice periods and termination payments

Other than the Medical Director, whose executive role endures for the duration of office, Executive Directors are employed on contracts of service and are substantive employees of the Trust. Executive Directors' contracts can be terminated by either party with up to 6 months' notice. Following the departure of an Executive Director and in advance of a new appointee commencing, the Trust may engage a suitably qualified and experienced interim director to ensure continuity of leadership.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts. Early termination by reason of redundancy or, 'in the interests of the efficiency of the service' is subject to the provisions of the Agenda for Change NHS Terms and Conditions Handbook (Section 16).

Employees above the minimum retirement age who themselves request termination by reason of early retirement, are subject to the normal provisions of the NHS Pension Scheme. Termination packages for all staff, agreed by the Trust in the year, are detailed in tables within this report.

Non-Executive Directors

The dates of contracts and unexpired terms of office for the Non-Executive Directors are as follows:

Name	Appointment start date	Appointment end date	Reappointment start date	Reappointment end date
Jim McKenna (Chairman)	January 2017	May 2018		
Mairi McLean	January 2014	January 2018	January 2018	January 2020
Paul Hobson	February 2016	January 2018	January 2018	January 2020
John Lander	November 2016	October 2018		
Sarah Pryce	February 2016	May 2018		
Margaret Schwarz	November 2016	October 2018		

There is no period of notice required for Non-Executive Directors.

Salary and pension entitlements of Senior Managers

The following tables detail the salaries and allowances and pension benefits for those individuals deemed to be the 'Senior Managers' of the Trust. For these purposes, Senior Managers are regular attendees of the Trust Board, who are directing and controlling the organisation.

Salaries and allowances

	2017-18			2016-17		
Non-Executive Directors	**Salary (bands of £5,000)** £000	**Expense payments (taxable) total to nearest £100** £00	**TOTAL (bands of £5,000)** £000	**Salary (bands of £5,000)** £000	**Expense payments (taxable) total to nearest £100** £00	**TOTAL (bands of £5,000)** £000
Jim McKenna Charirman *(from January 2017 to May 2018)*	**35-40**	**0**	**35-40**	5-10	0	5-10
Mairi McLean Non-Executive Director Acting Chair *(from July 2016 to January 2017 & from June 2018)*	**5-10**	**0**	**5-10**	20-25	0	20-25
Paul Hobson Non-Executive Director	**5-10**	**0**	**5-10**	5-10	0	5-10
John Lander Non-Executive Director *(from November 2016)* Associate Non-Executive Director *(from June 2016 to November 2016)*	**5-10**	**0**	**5-10**	0-5	0	0-5
Sarah Pryce Non-Executive Director	**5-10**	**0**	**5-10**	5-10	0	5-10
Margaret Schwarz Non-Executive Director *(from November 2016)*	**5-10**	**0**	**5-10**	0-5	0	0-5
Charlotte Russell Non-Executive Director *(to April 2018)*	**5-10**	**0**	**5-10**	5-10	0	5-10
Roger Gazzard Associate Non-Executive Director *(November 2016 to March 2018)*	**5-10**	**0**	**5-10**	5-10	0	5-10
Jon Andrewes Chairman *(to July 2016)*				10-15	0	10-15
Adam Broome Non-Executive Director *(to May 2016)*				0-5	0	0-5

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

Salary and pension entitlements of Senior Managers (continued) - Salaries and allowances (continued)

	2017-18			
Senior Managers	**Salary whilst in post as Senior Manager (bands of £5,000)** £000	**Expense payments (taxable) total to nearest £100** £	**All pension-related benefits (bands of £2,500)** £000	**TOTAL (bands of £5,000)** £000
Kathy Byrne Chief Executive	**180-185**	**0**	**40.0-42.5**	**220-225**
Catrin Asbrey Director of Human Resources & Organisational Development	**110-115**	**0**	**25.0-27.5**	**135-140**
Richard Best Interim Chief Operating Officer *(from November 2016 to August 2017)*	**70-75**	**0**	**0**	**70-75**
Mark Daly Medical Director *(from January 2018)* Interim Medical Director *(from October 2017 to January 2018)*	**80-85**	**0**	**125.0-127.5**	**205-210**
Rab McEwan Chief Operating Officer *(from August 2017)*	**90-95**	**0**	**0**	**90-95**
Thomas Lafferty Director of Corporate Affairs	**110-115**	**0**	**27.5-30.0**	**135-140**
Sally May (1) Chief Finance Officer *(from May 2017)*	**80-85**	**0**	**0**	**80-85**
Ethna McCarthy Director of Strategy & Business Development	**120-125**	**0**	**67.5-70.0**	**190-195**
Kim O'Keeffe Chief Nurse *(from May 2017)*	**105-110**	**0**	**130.0-132.5**	**235-240**
Christine Perry Interim Nurse Director *(to April 2017)*	**10-15**	**0**	**0**	**10-15**
Karl Simkins (2) Director of Finance *(to April 2017)* Joint Director of Finance *(from May 2017)*	**10-15**	0	**5.0-7.5**	**15-20**
Malcolm Stewart Medical Director *(from October 2016 to January 2018)*	**115-120**	**0**	**0**	**115-120**
Mid-point of total **paid** remuneration band of the highest paid Director	**£182,500**			
Median total remuneration	**£26,565**			
Ratio	**6.87**			

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

(1) The salary costs disclosed here are those costs incurred by this Trust for the period May 2017 to March 2018. The full salary costs for the individual for that period would be in the band £130,000-135,000.

(2) Karl Simkins was on secondment from the Trust from May 2017, whilst retaining the post of Joint Director of Finance alongside Sally May. Salary figures included above relate to the post of Director of Finance for April 2017 only, whilst pension related benefits relate to the full financial year to 31 March 2018.

Salary and pension entitlements of Senior Managers (continued) - Salaries and allowances (continued)

	2016-17			
Senior Managers	**Salary whilst in post as Senior Manager (bands of £5,000)** £000	**Expense payments (taxable) total to nearest £100** £	**All pension-related benefits (bands of £2,500)** £000	**TOTAL (bands of £5,000)** £000
Kathy Byrne Chief Executive *(from April 2016)*	170-175	0	37.5-40	205-210
Catrin Asbrey Director of Human Resources & Organisational Development *(from December 2016)*	35-40	0	7.5-10	40-45
Richard Best Interim Chief Operating Officer *(from November 2016)*	60-65	0	0	60-65
Paul Bostock Chief Operating Officer *(to December 2016)*	100-105	0	0	100-105
Thomas Lafferty Director of Corporate Affairs *(from January 2017)*	20-25	0	37.5-40	60-65
Andrew MacCallum Deputy Chief Executive *(from April 2016 to March 2017)*	120-125	0	77.5-80.0	200-205
Ethna McCarthy Director of Strategy & Business Development	115-120	2,800	52.5-55	170-175
Rob Parry Medical Director (to September 2016)	140-145	2,600	0	145-150
Christine Perry Interim Nurse Director *(to April 2017)*	80-85	0	0	80-85
Karl Simkins Joint Director of Finance *(from May 2017)* Director of Finance *(to April 2017)*	140-145	3,400	20-22.5	160-165
Malcolm Stewart Medical Director *(from October 2016)*	75-80	0	0	75-80
Susan Young Interim Director of Human Resources & Organisational Development *(to April 2016)*	15-20	0	0	15-20
Sally May Chief Finance Officer *(from May 2017)*	0	0	0	0
Kim O'Keeffe Chief Nurse *(from May 2017)*	0	0	0	0
Mid-point of total **paid** remuneration band of the highest paid Director	£182,500			
Median total remuneration	£26,302			
Ratio	6.94			

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

No performance or bonus payments were made to senior managers in either 2017-18 or 2016-17. Clinical Excellence Awards are included within 'salary'.

'All pension related benefits' disclosed in the table above represent the increase in pension benefits in the financial year. Pension benefits are calculated as 20 times the annual pension entitlement at pension age plus the value of any lump sum pension entitlement. These figures are adjusted for inflation.

Taxable expense payments relate to lease vehicles. - Pension benefits

Senior Manager	Real increase in pension at pension age (bands of £2,500)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2018 (bands of £5,000)	Lump sum at pension age related to accrued pension at 31 March 2018 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2018 as provided by NHSPA	Cash Equivalent Transfer Value at 31 March 2017 as provided by NHSPA	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Kathy Byrne Chief Executive Officer	2.5 - 5.0	0	5 -10	0	103	48	55
Catrin Asbrey Director of Human Resources & Organisational Development	0 - 2.5	0	0 - 5	0	19	5	15
Richard Best Interim Chief Operating Officer *(to August 2017)*	0 - 2.5	2.5 - 5.0	20 - 25	65 - 70	498	439	54
Mark Daly Medical Director *(from January 2018)* Interim Medical Director *(from October 2017 to January 2018)*	5.0 - 7.5	12.5 - 15.0	45 - 50	120 - 125	821	692	122
Thomas Lafferty Director of Corporate Affairs	0 - 2.5	0	10 - 15	0	102	84	18
Ethna McCarthy Director of Strategy & Business Development	2.5 - 5.0	10.0 - 12.5	45 - 50	140 - 145	967	833	126
Kim O'Keeffe Chief Nurse *(from May 2017)*	5.0 - 7.5	15.0 -17.5	25 - 30	80 - 85	582	430	135
Sally May Chief Finance Officer *(from May 2017)*	10 - 12.5	(2.5) - 0	50 - 55	105 - 110	870	648	215
Karl Simkins Director of Finance (to April 2017) Joint Director of Finance *(from May 2017)*	0 - 2.5	2.5 - 5.0	55 - 60	170 - 175	1,165	1,068	87

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

The Trust made no employer contributions to stakeholder pensions. 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 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.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include 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. The prescribed rate of inflation used for 2017-18 was 1%.

As Non-Executive Directors do not receive pensionable remuneration there are no entries in respect of pensions for Non-Executive members.

Reporting of other compensation schemes for Senior Managers: exit packages

No exit packages were agreed by the Trust in 2017-18 for Senior Managers. Exit packages agreed for other staff are disclosed within the Staff Report.

Staff Report

Average whole time equivalent staff numbers

Reporting organisations are required to disclose details of their average whole time equivalent (WTE) staff numbers during the year. For the Trust in 2017-18 these were as follows:

Staff type	Total Staff Number	Permanently Employed Staff Number	Bank and Agency Staff Number
Medical and dental staff	**769**	719	50
Administration and estates staff	**1,256**	1,189	67
Healthcare assistants and other support staff	**719**	593	126
Nursing, midwifery and health visiting staff	**1,404**	1,256	148
Nursing, midwifery and health visiting learners staff	**48**	48	0
Scientific, therapeutic and technical staff	**738**	706	32
Healthcare science staff	**168**	167	1
Other	**5**	5	0
Total	**5,107**	**4,683**	**424**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

Senior staff numbers (average WTE)

Included within the permanent staff above, were the following number of senior staff. For the purposes of this disclosure, 'senior staff' are those staff employed at the Agenda for Change (AfC) Band 8 – Range A and above.

Pay Band	Number (WTE)
Band 8 - Range A	98
Band 8 - Range B	43
Band 8 - Range C	25
Band 8 - Range D	11
Band 9	7
Total	**184**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

Staff composition – permanent staff

The following table details the average WTE staff numbers of permanent staff by gender:

Staff Type	Male	Female	Total
Board members	3	5	**8**
Senior Staff (Agenda for Change pay scales Band 8 and above)	65	130	**195**
Other staff	821	3,659	**4,480**
Total	**889**	**3,794**	**4,683**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

Staff policies – equality and inclusion

The Trust supports a staff network for staff with disabilities or long term health conditions. This network promotes staff wellbeing by providing an opportunity for peer support, acting in an advisory capacity for the Trust on issues which may affect disability and as a collective voice to be heard and responded to.

Other staff networks the Trust supports are a Minority Ethnic Group which started as a focus group to examine the evidence for the Workforce Race Equality Standard, but decided to continue on a regular basis. Members of this group are offered support with career progression through access to mentors, coaches and career buddies.

With only a small number of staff coming forward to create an LGBT staff network, the Trust joined the local Public Sector LGBT network. A carer's network has just been launched to offer support, advice and guidance for staff who are also unpaid carers. A local carer's charity has offered to attend to provide their expertise on assessment and benefits available. The charity also provides a drop-in advice session for patient carer's once a month which is hosted in the hospital.

In 2016 the Trust introduced a Zero Tolerance to Discrimination Protocol to protect staff from being verbally abused by patients or treated in a derogatory way on the grounds of race, sexual orientation, transgender etc. This is designed to protect staff and ensure they feel valued and respected.

Further information on equality and inclusion can be found on the Trusts' website at www.royalcornwall.nhs.uk. The Trust's Equality, Inclusion and Human Rights policy can be found at:

https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/HumanResources/EqualityDiversityAndHumanRightsPolicy.pdf

The Occupational Health team provides a range of services for staff, supporting recruitment and on-going employment, from health screening to physiotherapy to confidential counselling services.

Sickness absence data

The table below details the Trust's sickness absence data. The data is based on the 2017 calendar year, which the Department of Health & Social Care regards as a reasonable proxy for the 2017-18 financial year.

Sickness absence	Number
Total days lost	**42,052**
Total staff years	**4,702**
Average working days lost	**9**
Ill-health retirements	
Number of persons retired early on ill-health grounds	**8**
Total additional pensions liabilities accrued in the year	**£499,000**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

Consultancy expenditure

The Trust incurred the following consultancy expenditure 2017-18:

Area	Expenditure £000
Governance support	60
CQC inspection project support	118
System analytics review	50
Medical leadership consultancy	47
Service review	22
Inventory management system review	3
Board development	2
Leadership capability review	50
Medical leadership programme	14
Total	**366**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

Off-payroll engagements

As part of the Review of Tax Arrangements of Public Sector Appointees, published by the Chief Secretary to the Treasury on 23 May 2012, NHS bodies are required to publish information in their Annual Report regarding off-payroll engagements, whereby individuals are paid through their own companies.

Off-payroll engagements as of 31 March 2018, for more than £245 per day and that last for more than 6 months:

	Number
Number of existing engagements as of 31 March 2018	0

New off-payroll engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018, for more than £245 per day and that last longer than 6 months:

	Number
Number of new engagements, or those that reached six months in duration, between 1 April 2017 and 31 March 2018	2
Of which:	
Number assessed as caught by IR35*	0
Number assessed as not caught by IR35*	2
Number engaged directly (via personal service company contracted to the Trust) and are on the payroll	0
Number of engagements re-assessed for consistency / assurance purposes during the year	2
Number of engagements that saw a change to IR35 status following the consistency review	2

*IR35 is tax legislation that is designed to combat tax avoidance by workers supplying their services to clients via an intermediary, such as a limited company, but who would be an employee if the intermediary was not used. Individuals caught by IR35 are required to have income tax and national insurance deducted by the Trust in the same way that they would if they were an employee.

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2017 and 31 March 2018:

	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	20

Exit packages

The tables below detail the exit packages agreed in 2017-18 by the Trust:

Band	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
Less than £10,000	0	0	7	29	7	29
£10,000-£25,000	0	0	1	11	1	11
£25,001-£50,000	0	0	3	109	3	109
£50,001-£100,000	0	0	1	58	1	58
Total	**0**	**0**	**12**	**207**	**12**	**207**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

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

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

None of the payments above include a special payment element.

Analysis of other departures

Type (Excluding compulsory redundancies)	Total number of agreements	Total value of agreements £000
Mutually agreed resignations (MARS) contractual costs	6	186
Contractual payments in lieu of notice	6	21
Total	**12**	**207**

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.

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

As single exit packages can be made up of several components, each of which will be counted separately in this disclosure, the total number above will not necessarily match the total numbers in the Exit Packages table, which details the number of individuals.

There are no payments in relation to the exit packages above for senior managers.

Kathy Byrne
Chief Executive

24 May 2018

Statement of 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; and
- 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.

Kathy Byrne
Chief Executive

24 May 2018

3 Finance

Annual Accounts 1 April 2017 to 31 March 2018

Royal Cornwall Hospitals NHS Trust - Annual Accounts 2017-18

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017-18 £000	2016-17 £000
Operating income from patient care activities	3	**356,862**	333,624
Other operating income	4	**48,158**	45,838
Operating expenses	6,8	**(408,248)**	(378,031)
Operating surplus/(deficit)		**(3,228)**	1,431
Finance costs			
Investment revenue	11	**35**	25
Finance costs	12	**(1,172)**	(1,305)
Public dividend capital dividends payable		**(2,297)**	(2,599)
Net finance costs		**(3,434)**	(3,879)
Other gains and (losses)	13	**53**	(4)
Surplus/(deficit) for the financial year		**(6,609)**	(2,452)
Other comprehensive income			
Not be reclassified to income and expenditure:			
Impairments and reversals taken to the revaluation reserve	7	**(3,383)**	(1,678)
Revaluations		**1,998**	1,836
Total comprehensive income for the year		**(7,994)**	(2,294)

Financial performance for the year			
Surplus/(deficit) for the year		**(6,609)**	(2,452)
IFRIC 12 adjustment (including IFRIC 12 impairments) (i)			48
Impairments (excluding IFRIC 12 impairments) (ii)	7	**4,051**	2,831
Adjustments in respect of Donated Asset/Government Grant Reserve elimination (iii)		**(33)**	(1,356)
Adjusted retained surplus/(deficit)		**(2,591)**	(929)

The Trust's reported NHS financial performance position is derived from its retained surplus/(deficit), as adjusted for the following:-

(i) The revenue cost of bringing Local Improvement Finance Trust (LIFT) scheme assets onto the Statement of Financial Position due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10. NHS trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to LIFT, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position. This adjustment has been withdrawn in 2017-18, for the purposes of calculating the Trust's financial performance.

(ii) Impairment charges are not considered part of an NHS trust's operating financial position; and

(iii) The revenue impact of the removal of the Donated Asset Reserve and Government Grant Funded Reserve. Donated and Government grant funded assets now incur capital charges, whilst the donations and grants are credited to income. The resultant impact on the Trust's operating surplus for the year is neutralised by this adjustment.

The notes on pages 5 to 41 form part of this account.

Royal Cornwall Hospitals NHS Trust - Annual Accounts 2017-18

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2018

	NOTE	31 March 2018	31 March 2017 *Restated
		£000	£000
Non-current assets			
Intangible assets	14	**7,342**	8,841
Property, plant and equipment	15	**144,702**	144,142
Trade and other receivables	17	**480**	732
Total non-current assets		**152,524**	153,715
Current assets			
Inventories	16	**8,133**	7,895
Trade and other receivables	17	**18,380**	16,844
Cash and cash equivalents	18	**8,156**	3,099
Total current assets		**34,669**	27,838
Current liabilities			
Trade and other payables	19	**(29,937)**	(27,347)
Borrowings	21	**(7,686)**	(6,995)
Provisions	23	**(412)**	(407)
Other liabilities	20	**(5,506)**	(5,214)
Total current liabilities		**(43,541)**	(39,963)
Total assets less current liabilities		**143,652**	141,590
Non-current liabilities			
Borrowings	21	**(47,476)**	(37,772)
Provisions	23	**(4,302)**	(4,485)
Other liabilities	20	**(1,584)**	(2,112)
Total non-current liabilities		**(53,362)**	(44,369)
Total assets employed		**90,290**	97,221
Financed by:			
Public dividend capital		**169,125**	168,062
Revaluation reserve		**32,768**	34,159
Income and expenditure reserve		**(111,603)**	(105,000)
Total taxpayers' equity		**90,290**	97,221

*Deferred income balances were previously disclosed within 'Trade and other payables' and are now disclosed within 'Other liabilities'

The notes on pages 5 to 41 form part of this account.

The financial statements on pages 1 to 4 were approved by the Board on 24 May 2018 and signed on its behalf by

Chief Executive: Kathy Byrne **Date: 24 May 2018**

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Royal Cornwall Hospitals NHS Trust - Annual Accounts 2017-18

STATEMENT OF CHANGES IN EQUITY FOR THE YEAR ENDED 31 MARCH 2018

Statement of changes in equity for the year ended 31 March 2018	Public dividend capital £000	Income and expenditure reserve £000	Revaluation reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2017	**168,062**	**(105,000)**	**34,159**	**97,221**
Surplus/(deficit) for the year		(6,609)		(6,609)
Revaluations			1,998	1,998
Impairments			(3,383)	(3,383)
Transfer to income and expenditure reserve on disposal of assets		6	(6)	
Public dividend capital received	1,063			1,063
Taxpayers' and others' equity at 31 March 2018	**169,125**	**(111,603)**	**32,768**	**90,290**

Statement of changes in equity for the year ended 31 March 2017	Public dividend capital £000	Income and expenditure reserve £000	Revaluation reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2016	**166,562**	**(102,770)**	**34,223**	**98,015**
Surplus/(deficit) for the year		(2,452)		(2,452)
Revaluations			1,836	1,836
Impairments			(1,678)	(1,678)
Transfer to income and expenditure reserve on disposal of assets		222	(222)	
Public dividend capital received	1,500			1,500
Taxpayers' and others' equity at 31 March 2017	**168,062**	**(105,000)**	**34,159**	**97,221**

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 and Social Care 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.

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

Royal Cornwall Hospitals NHS Trust - Annual Accounts 2017-18

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2018

	NOTE	2017-18 £000	2016-17 *Restated £000
Cash flows from operating activities			
Operating (deficit)/surplus		**(3,228)**	1,431
Non-cash income and expense			
Depreciation and amortisation	**6**	**13,728**	12,766
Net impairments	**7**	**4,051**	2,831
Income recognised in respect of capital donations		**(734)**	(2,012)
(Increase)/decrease in receivables and other assets		**(938)**	165
(Increase)/decrease in inventories		**(238)**	(1)
Increase/(decrease) in trade and other payables		**1,273**	(3,107)
Increase/(decrease) in other liabilities		**(236)**	1,043
Increase/(decrease) in provisions		**(186)**	161
Net cash generated from operating activities		**13,492**	13,277
Cash flows from investing activities			
Interest received	**11**	**35**	25
Purchase of intangible assets		**(2,387)**	(2,318)
Purchase of property, plant and equipment		**(14,797)**	(11,155)
Sales of property, plant and equipment		**82**	12
Receipt of cash donations to purchase capital assets		**369**	1,728
Net cash generated used in investing activities		**(16,698)**	(11,708)
Cash flows from financing activities			
Public dividend capital received		**1,063**	1,500
Movement on loans from the Department of Health and Social Care (2)		**11,275**	2,834
Capital element of finance lease payments		**(223)**	(190)
Capital element of LIFT payments (1)		**(15)**	(12)
Interest paid on loans		**(670)**	(785)
Interest paid on finance lease liabilities		**(52)**	(57)
Interest paid on LIFT obligations		**(413)**	(405)
PDC dividend paid		**(2,698)**	(2,521)
Net cash generated from financing activities		**8,267**	364
Net increase in cash and cash equivalents		**5,061**	1,933
Cash and cash equivalents at 1 April		**3,090**	1,157
Cash and cash equivalents at 31 March	**18**	**8,151**	3,090

*The 'Receipt of cash donations to purchase capital assets' balance was previously reported within 'Net cash generated from operating activities'. 'Increase/(decrease) in other liabilities' and 'Increase/(decrease) in trade and other payables' have been restated to reflect the change in classification of deferred liabilities within the Statement of Financial Position.

(1) Local Improvement Finance Trust (LIFT) - see note 26 for additional information regarding the scheme.

(2) Movement on loans from Department of Health and Social Care

	2017-18 £000	2016-17 £000
New revenue support loans received	**8,486**	5,609
Revenue support loans repaid	**(1,933)**	(1,933)
New capital investment loans received	**6,161**	0
Capital investment loans repaid	**(1,439)**	(842)
	11,275	2,834

NOTES TO THE ACCOUNTS

1. Accounting policies and other information

1.1 Basis of operation

The Department of Health and Social Care (DHSC) 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 2017-18 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 accounts.

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.

1.1.2 Going concern

IAS 1: Presentation of Financial Statements requires management to assess, as part of the accounts preparation process, the Trust's 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.

As directed by the 2017-18 Department of Health and Social Care Group Accounting Manual, the Board of Directors of the Trust has prepared the financial statements on a going concern basis as it considers that the services currently provided by the Trust will continue to be provided in the foreseeable future. On this basis, the Trust has adopted the going concern basis for preparing the financial statements and has not included the adjustments that would result if it was unable to continue as a going concern.

The Board has also considered the Trust's overall financial position and expectation of future financial support. The Trust has approved a deficit budget of £11.9m for the year ended 31 March 2019. Achieving this deficit requires amongst other items, delivering an efficiency target of £12.0m and includes £8.9m of Provider Sustainability Fund income, the receipt of which is dependent on the achievement financial and operational performance targets.

In preparing the 2018-19 plan, the Trust has identified the need for additional cash support of approximately £13m to support the financial position (excluding support required to repay £3.8m of current revenue loans falling due within the year) and will work with NHS Improvement to determine the most suitable form of borrowing available.

Whilst the required borrowing has not yet been formally approved by the Department of Health and Social Care, the Board of Directors is confident that this funding will be forthcoming through the monthly request and approval process. However this has not yet been confirmed formally for the whole year ahead and, therefore, the lack of formal confirmation of cash support represents a material uncertainty that may cast significant doubt about the Trust's ability to continue as a going concern. The material aspect relates to the need for cash support in the event of the Trust not achieving its financial plan, rather than in it achieving its financial plan. However, as stated above, the Board of Directors is certain that the services currently provided by the Trust will continue to be provided in the foreseeable future and as such is content with adopting the going concern status.

Notes to the Accounts - 1. Accounting policies (continued)

1.2 Critical judgements in applying accounting policies

The key judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust accounting policies and that have the most significant effect on the amounts recognised in the financial statements, are those in relation to the classification of leasing arrangements and the determination of asset lives for depreciation purposes.

In accordance with IAS 1: *Presentation of Financial Statements*, the Board of Directors of the Trust has assessed whether the Trust is a 'going concern'. In concluding that the Trust is a 'going concern' the Board of Directors has considered the Trust's overall financial position and expectation of future financial support. In the context of IAS 1 (which assumes the anticipated continuation of non-trading entities in the public sector) and expectation of continuing cash support, the Board of Directors has concluded that the Trust is a going concern. See disclosure at Note 1.1.2 above.

1.2.1 Sources of estimation uncertainty

Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year, are contained within the calculation of provisions (total value £4.7m). Those uncertainties are disclosed in Note 23.

Asset lives, other than those identified by professional valuation, have been estimated by management based on their expected useful lives and the Trust's own accounting policies. Asset lives are disclosed in Notes 1.7 and 1.8 below. Depreciation amnd amortisation expenses totalling £13.7m are derived using estimated asset lives.

The Trust has determined that an alternative off-site valuation approach, on a Modern Equivalent Asset basis, is the most appropriate estimation technique for valuing its land and building assets (total value £116.1m). This approach was first adopted in 2014-15 and is in accordance with HM Treasury requirements.

Accruals, totalling £21.1m (capital and revenue), have been included in the financial statements to the extent that the Trust recognises an obligation at the Statement of Financial Position date, for which it had not been invoiced. Estimates of accruals are undertaken by management based on the information available at 31 March, together with past experience.

1.3 Interests in other entities

Material entities over which the Trust has the power to exercise control are classified as subsidiaries and are consolidated. The Trust has control when it is exposed to, or has rights to, variable returns through its power over another entity. The income and expenses, gains and losses, assets, liabilities and reserves, and cash flows of the subsidiary are consolidated in full into the appropriate financial statement lines. Appropriate adjustments are made on consolidation where the subsidiary's accounting policies are not aligned with the Trust or where the subsidiary's accounting date is not co-terminus.

The Board of Royal Cornwall Hospitals NHS Trust acts as the Corporate Trustee of Royal Cornwall Hospitals NHS Trust Charitable Fund (Charity number 1049687). As Corporate Trustee, the Board of Royal Cornwall Hospitals NHS Trust is deemed to have the power to govern the financial and operational policies of the Charity so as to obtain benefits from its activities.

Following HM Treasury's instructions to apply IAS 27: *Consolidation and Separate Financial Statements* from 1 April 2013, the Trust considered the requirement to consolidate, with these financial statements, the financial statements of the Charity. However, the Trust has determined that as the transactions and balances of the Charity are immaterial in the context of the group, the financial statements of the Charity have therefore not been consolidated, in either the current or preceding year. Details of the transactions between the Trust and the Charity are disclosed within Note 35 as related party transactions.

Notes to the Accounts - 1. Accounting policies (continued)

1.4. Income

Income in respect of services provided is recognised when, and to the extent that, performance occurs and is measured at the fair value of the consideration receivable. The main source of income for the Trust is contracts with commissioners in respect of healthcare services. At the year end, the Trust accrues income relating to activity delivered in that year, where a patient care spell is incomplete.

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

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.

1.5. Expenditure on employee benefits

Short-term employee benefits

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

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 schemes are accounted for as though they are defined contribution schemes. 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.

The Trust also makes contributions to an occupational pension scheme set up in accordance with the *Automatic Enrolment (Miscellaneous Amendments) Regulations 2012*. The scheme is a defined contribution scheme, for which the Trust accounts for its employer contributions within 'other pension costs' in these financial statements.

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.

1.7. Property, plant and equipment

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 will be supplied to, the Trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has a cost of at least £5,000; or
- collectively, a number of items have a cost of at least £5,000 and individually have a cost of more than £250, where the assets are functionally interdependent, they had broadly simultaneous purchase dates, are anticipated to have simultaneous disposal dates and are under single managerial control.

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

Notes to the Accounts - 1. Accounting policies (continued)

1.7. Property, plant and equipment (continued)

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. All assets are measured subsequently at their current value in existing use.

Land and buildings used for the Trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the current value at the date of revaluation less any impairment.

Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. 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 basis; and
- plant and machinery and information technology assets - market value.

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

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23: *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 current value in existing use.

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.

An item of property, plant and equipment which is surplus with no plan to bring it back into use is valued at fair value under IFRS 13: *Fair value measurement*, if it does not meet the requirements of IAS 40: *Investment property* or IFRS 5: *Non-current assets held for sale and discontinued operations*.

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 Trust 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.

Notes to the Accounts - 1. Accounting policies (continued)

1.7. Property, plant and equipment (continued)

Depreciation
Items of property, plant and equipment are depreciated over their remaining useful economic 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' ceases to be depreciated upon the reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

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.

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

(i) the asset is available for immediate sale in its present condition subject only to terms which are usual and customary for such sales;

(ii) the sale must be highly probable i.e.:

• management is 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 dropped or significant changes made to it.

Notes to the Accounts - 1. Accounting policies (continued)

1.7. Property, plant and equipment (continued)

De-recognition (continued)
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 economic life is adjusted. The asset is de-recognised when scrapping or demolition occurs.

Donated, government grant and other 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.

Local Improvement Finance Trust (LIFT) transactions
LIFT transactions which meet the IFRIC 12 definition of a service concession, as interpreted in HM Treasury's Financial Reporting Manual (FReM), are accounted for as 'on-Statement of Financial Position' (on-SOFP) by the Trust. In accordance with *IAS 17: Leases*, the underlying assets are recognised as property, plant and equipment, together with an equivalent finance lease liability. Subsequently, the assets are accounted for as property, plant and equipment and/or intangible assets as appropriate.

The annual contract payments are apportioned between the repayment of the liability, a finance cost and the charges for services. The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

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

	Years	
	Minimum	**Maximum**
Buildings, excluding dwellings	**1**	**50**
Dwellings	**1**	**50**
Plant and machinery	**1**	**15**
Transport equipment	**1**	**10**
Information technology	**1**	**15**
Furniture and fittings	**1**	**7**

Building and dwelling asset lives were re-assessed by the District Valuer at 31 March 2017 and applied throughout 2017-18. The lives determined by the 31 March 2018 valuation will be applied in 2018-19. Asset lives have not been re-assessed for any other categories of asset.

Finance-leased assets (including land) are depreciated over the shorter of the useful economic 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.

Notes to the Accounts - 1. Accounting policies (continued)

1.8. Intangible assets

Recognition
Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the Trust's business or which arise from contractual or other legal rights. They are recognised only:

- when it is probable that future economic benefits will flow to, or service potential be provided to, the Trust;
- where the cost of the asset can be measured reliably; and
- where the cost is at least £5,000.

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;
- the intangible asset will generate probable future economic or service delivery benefits, e.g., 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, e.g. 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, e.g. application software, is capitalised as an intangible asset.

Measurement
Intangible assets comprise purchased computer software and licenses, which are carried at amortised historical cost, as a proxy for fair value, together with development expenditure which is carried at a nominal value.

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 or IFRS 5.

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

Useful economic life of intangible assets
Useful economic lives reflect the total life of an asset and not the remaining life of an asset. The range of useful economic lives applied by the Trust are from 1 to 5 years.

1.9. Revenue and other grants

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.

Notes to the Accounts - 1. Accounting policies (continued)

1.10. Inventories

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

1.11. 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.

1.12. Carbon Reduction Commitment (CRC) scheme

The CRC scheme is a mandatory cap and trade scheme for non-transport CO2 emissions. The Trust is registered with the CRC scheme, and is therefore required to surrender to the Government an allowance for every tonne of CO2 it emits during the financial year. A liability and related expense is recognised in respect of this obligation as CO2 emissions are made.

The carrying amount of the liability at the financial year end will therefore reflect the CO2 emissions that have been made during that financial year, less the allowances (if any) surrendered voluntarily during the financial year in respect of that financial year. The liability will be measured at the amount expected to be incurred in settling the obligation. This will be the cost of the number of allowances required to settle the obligation.

Allowances acquired under the scheme are recognised as intangible assets.

1.13. Financial assets and financial liabilities

Recognition
Financial assets and financial liabilities which arise from contracts for 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, are recognised when, and to the extent which, performance occurs, i.e., when receipt or delivery of the goods or services is made. Financial assets or financial liabilities in respect of assets acquired or disposed of through finance leases are recognised and measured in accordance with the accounting policy for leases described below. All other financial assets and financial liabilities are recognised when the Trust becomes a party to the contractual provisions of the instrument.

De-recognition
All financial assets are de-recognised when the rights to receive cash flows from the assets have expired or the Trust has transferred substantially all of the risks and rewards of ownership. Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

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

Notes to the Accounts - 1. Accounting policies (continued)

1.13. Financial assets and financial liabilities (continued)

Loans and receivables
Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market.

The Trust's loans and receivables comprise: cash and cash equivalents; NHS receivables; accrued income; and "other receivables". Loans and receivables are recognised initially at fair value, net of transactions costs, and are measured subsequently at amortised cost, using the effective interest method. The effective interest rate is the rate that discounts exactly estimated future cash receipts through the expected life of the financial asset or, when appropriate, a shorter period, to the net carrying amount of the financial asset.

Interest on loans and receivables is calculated using the effective interest method and credited to the Statement of Comprehensive Income.

Impairment of financial assets
At the Statement of Financial Position date, the Trust assesses whether any financial assets, other than those held at "fair value through income and expenditure", are impaired. Financial assets are impaired and impairment losses are recognised if, and only if, there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset's carrying amount and the present value of the revised future cash flows discounted at the asset's original effective interest rate. The loss is recognised in the Statement of Comprehensive Income and the carrying amount of the asset is reduced directly or through the use of a bad debt provision.

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.

1.14.1 The Trust as lessee

Finance leases
Where substantially all risks and rewards of ownership of a leased asset are borne by the Trust, the asset is recorded as property, plant and equipment and a corresponding liability is recorded. The value at which both are recognised is the lower of the fair value of the asset or the present value of the minimum lease payments, discounted using the interest rate implicit in the lease.

The asset and liability are recognised at the commencement of the lease. Thereafter the asset is accounted for as an item of property plant and equipment.

The annual rental is split between the repayment of the liability and a finance cost so as to achieve a constant rate of finance over the life of the lease. The annual finance cost is charged to Finance costs in the Statement of Comprehensive Income. The lease liability is de-recognised when the liability is discharged, cancelled or expires.

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.

Notes to the Accounts - 1. Accounting policies (continued)

1.14.2 The Trust as lessor

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.

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

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

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 23.2 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.

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 24 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 24, 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.

Notes to the Accounts - 1. Accounting policies (continued)

1.17. Public Dividend Capital (PDC)

Public Dividend Capital 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 Service (GBS) and National Loans Fund (NLF) deposits, excluding cash balances held in GBS accounts that relate to a short-term working capital facility;
(iii) any PDC dividend balance receivable or payable; and
(iv) any Sustainability Transformation Fund (STF) incentive scheme and bonus receivables .

In accordance with the requirements laid down by the Department of Health & 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.

1.18. Value Added Tax (VAT)

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

1.19. Corporation tax

The Trust has no corporation tax liability as its activities are not subject to corporation tax.

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. 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.

1.21. Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the Statement of Financial Position, since the Trust has no beneficial interest in them. They are disclosed in a separate note to the accounts in accordance with the requirements of HM Treasury's FReM.

Notes to the Accounts - 1. Accounting policies (continued)

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).

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.

1.23. Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been early adopted in 2017-18.

1.24. Standards, amendments and interpretations in issue but not yet effective or adopted

The DHSC GAM does not require the following Standards and Interpretations to be applied in 2017-18. These standards are still subject to HM Treasury FReM adoption, with IFRS 9 and IFRS 15 being for implementation in 2018-19, and the government implementation date for IFRS 16 and IFRS 17 still subject to HM Treasury consideration.

- IFRS 9: *Financial Instruments* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted;
- IFRS 15: *Revenue from Contracts with Customers* – Application required for accounting periods beginning on or after 1 January 2018, but not yet adopted by the FReM: early adoption is not therefore permitted;
- IFRS 16: *Leases* – Application required for accounting periods beginning on or after 1 January 2019, but not yet adopted by the FReM: early adoption is not therefore permitted;
- IFRS: *17 Insurance Contracts* – Application required for accounting periods beginning on or after 1 January 2021, but not yet adopted by the FReM: early adoption is not therefore permitted;
- IFRIC 22: *Foreign Currency Transactions and Advance Consideration* – Application required for accounting periods beginning on or after 1 January 2018; and
- IFRIC 23 Uncertainty over Income Tax Treatments – Application required for accounting periods beginning on or after 1 January 2019.

The Trust has considered the potential impact of these standards for future accounting periods and does not anticipate that there will be any material impact on the financial statements.

2. Operating segments

The Trust has considered IFRS 8: *Operating Segments* and has taken the view that its activities should be reported as a single entity rather than in a segmental manner. Although financial performance is reported to the Executive Board members at a divisional level, the key financial information for decision making purposes is based on the entity as a whole. Furthermore, the Trust's business is the delivery of acute healthcare across a single economic environment. No separate reportable segments have therefore been identified.

3.1. Income from patient care activities (by nature)

	2017-18 £000	2016-17 £000
Acute services		
Elective income	**56,898**	60,853
Non-elective income	**93,879**	81,250
First outpatient income	**25,545**	23,629
Follow up outpatient income	**29,223**	31,952
Accident and emergency income	**11,311**	9,938
High cost drugs income from commissioners (excluding pass-through costs)	**45,673**	44,291
Other NHS clinical income	**88,695**	79,843
Other services		
Private patient income	**570**	628
Other clinical income	**5,068**	1,240
Total income from NHS bodies	**356,862**	333,624

3.2. Income from patient care activities (by source)

	2017-18 £000	2016-17 £000
NHS England	**75,855**	72,529
Clinical commissioning groups	**276,383**	256,513
Other NHS providers	**85**	58
NHS other (Public Health England)	**114**	119
Local authorities	**2,880**	2,950
Non-NHS: Private patients	**570**	628
Non-NHS: Overseas patients (non-reciprocal)	**356**	154
NHS injury scheme	**351**	473
Other	**268**	200
Total income from patient care activities	**356,862**	333,624

All amounts above relate to continuing operations.

3.3. Overseas visitors (relating to patients charged directly by the Trust)

	2017-18 £000	2016-17 £000
Income recognised during the year	**356**	154
Cash payments received in-year	**124**	153
Amounts added to provision for impairment of receivables	**269**	49
Amounts written off in-year	**8**	7

4. Other operating income

	2017-18	2016-17 *Restated
	£000	£000
Research and development	**3,082**	2,614
Education and training	**11,823**	12,678
Receipt of capital grants and donations	**734**	2,012
Charitable and other contributions to expenditure	**284**	651
Non-patient care services to other bodies	**8,085**	7,988
Sustainability & Transformation Fund (STF) income	**7,320**	11,352
Rental revenue from operating leases	**1,717**	1,334
Income in respect of staff costs where accounted on gross basis (1)	**4,613**	773
Other income (2)	**10,500**	6,436
Total other operating income	**48,158**	45,838

All amounts above relate to continuing operations.

* 2016-17 balances have been restated due to changes in the classifications used within this disclosure note. Research and development income was previously reported as a single balance within education and training income.

(1) Included within 'Charitable and other contributions to expenditure' is £284,000 (2016-17: £111,000) in relation to 'income in respect of staff costs when accounted for on a gross basis'.

(2) 'Other income' includes food and drug sales, grant income, winter resilience funding, special measures support funding, car parking income and other income not falling into the categories in the note above.

5. Income generation activities

The Trust has undertaken no material income generating activities in the current or preceding year.

6.1. Operating expenses

	2017-18 £000	2016-17 *Restated £000
Purchase of healthcare from NHS and DHSC bodies	**9,326**	4,749
Purchase of healthcare from non-NHS and non-DHSC bodies	**6,661**	3,372
Staff and executive directors' costs	**233,274**	223,628
Remuneration of Chair and non-executive directors	**82**	75
Supplies and services - clinical (excluding drugs costs)	**37,028**	35,630
Supplies and services - general	**20,281**	17,120
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**48,043**	46,805
Inventories written down	**156**	156
Consultancy costs	**366**	58
Establishment	**3,897**	2,802
Premises	**9,232**	7,544
Transport (including patient travel)	**2,488**	2,368
Depreciation on property, plant and equipment	**10,451**	10,092
Amortisation on intangible assets	**3,277**	2,674
Net impairments	**4,051**	2,831
Increase/(decrease) in provision for impairment of receivables	**738**	(899)
Change in provisions discount rate(s)	**47**	417
Audit fees payable to the external auditor		
- audit services - statutory audit	**74**	87
- other auditor remuneration (external auditor only)	**10**	12
Internal audit costs	**140**	141
Clinical negligence	**9,981**	7,228
Legal fees	**343**	58
Insurance	**121**	110
Research and development (including staff costs)	**3,361**	3,187
Education and training	**1,008**	597
Rentals under operating leases	**1,051**	1,147
Charges to operating expenditure for on-SOFP IFRIC 12 schemes (LIFT) on IFRS basis	**291**	295
Car parking and security	**78**	71
Losses, ex gratia and special payments	**103**	49
Other	**2,289**	5,627
Total operating expenses	**408,248**	378,031

All amounts above relate to continuing operations.

*2016-17 balances have been restated due to changes in the classifications used within this disclosure note. Total costs are unchanged. The new headings included in this note are 'Drug costs', 'Rentals under operating leases', Car parking and security', & 'Losses, ex gratia & special payments'. Drug costs were previously included in 'Supplies and services - clinical' and balances disclosed under the other new headings were included under various operating expenditure headings.

A further restatement has been included to better present 'purchases of healthcare from non-NHS and non-DHSC bodies', totalling £2.306m, which were previously disclosed within 'Supplies and Services - clinical'. Research staff costs (2016-17: £2.502m), previously reported within 'Staff and executive directors' costs', are now included within 'Research and development' costs.

6.2 Other auditor remuneration

Other auditor remuneration paid to the external auditor:	2017-18 £000	2016-17 £000
1. Audit of accounts of any associate of the Trust	**0**	0
2. Audit-related assurance services	**10**	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	**0**	0
Total	**10**	12

The audit fees above relate to the audit of the Quality Account.

6.3. Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2016-17: £0m).

7. Impairment of assets

Net impairments charged to operating surplus/deficit resulting from:	2017-18 £000	2016-17 £000
Changes in market price	**4,051**	2,831
Total net impairments charged to operating surplus/deficit	**4,051**	2,831
Impairments charged to the revaluation reserve	**3,383**	1,678
Total net impairments	**7,434**	4,509

Net impairments in 2017-18 and 2016-17 arose following the annual year end revaluations of the Trust's property assets on a modern equivalent asset basis.

All revaluations were undertaken by the Valuation Office Agency.

8.1. Employee benefits

	2017-18 Total £000	2016-17 *Restated Total £000
Salaries and wages	**184,277**	176,263
Social security costs	**18,050**	16,672
Apprenticeship levy	**914**	
Employer's contributions to NHS pensions	**22,192**	20,989
Other pension costs	**111**	117
Termination benefits	**208**	308
Temporary staff (agency)	**12,695**	14,192
Total gross staff costs	**238,447**	228,541
Included within:		
Costs capitalised as part of assets	**2,688**	2,411
Total staff costs excluding capitalised staff costs	**235,759**	226,130

*2016-17 balances have been restated as temporary staff costs are now required to be shown separately.

8.2. Retirements due to ill-health

During 2017-18 there were 8 early retirements from the Trust agreed on the grounds of ill-health (11 in the year ended 31 March 2017). The estimated additional pension liabilities of these ill-health retirements is £499,000 (£804,000 in 2016-17).

The cost of these ill-health retirements will be borne by the NHS Business Services Authority - Pensions Division.

9. Pension costs

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

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

a) Accounting valuation
A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2018, is based on valuation data as 31 March 2017, updated to 31 March 2018 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in *IAS 19: Employee Benefits*, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

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

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

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

The next actuarial valuation is to be carried out as at 31 March 2016 and is currently being prepared. The direction assumptions are published by HM Treasury which are used to complete the valuation calculations, from which the final valuation report can be signed off by the scheme actuary. This will set the employer contribution rate payable from April 2019 and will consider the cost of the Scheme relative to the employer cost cap. There are provisions in the Public Service Pension Act 2013 to adjust member benefits or contribution rates if the cost of the Scheme changes by more than 2% of pay. Subject to this 'employer cost cap' assessment, any required revisions to member benefits or contribution rates will be determined by the Secretary of State for Health and Social Care after consultation with the relevant stakeholders.

10. Operating leases

10.1. The Trust as lessee

The Trust leases equipment, vehicles and property under operating lease arrangements. There are no individually material leases. The lease terms range from 1 to 7 years and are arranged under standard NHS terms and conditions. Some of the leasing arrangements contain provisions for the option to renew or purchase at the end of the arrangement.

	2017-18 £000	2016-17 *Restated £000
Operating lease expenses		
Minimum lease payments	**1,051**	1,147
Total	**1,051**	1,147
Future minimum lease payments due:		
- not later than one year	**834**	953
- later than one but not later than five years	**1,941**	2,468
- later than five years	**120**	45
Total	**2,895**	3,466

Total future sub-lease payments expected to be received:	**0**	0

*Lease obligations in respect of employee salary sacrifice cars (£567,000) were previously disclosed within minimum lease payments, together with sub-lease payments (£967,000) expected to be received from employees.

10.2. The Trust as lessor

The Trust has three significant lessor arrangements: for the leasing of the main hospital site car park (4 years remaining); space within the Knowledge Spa (11 years remaining); and space within the Peninsula Dental School (17 years remaining).

The Trust also leases some land and some retail space on the main hospital site on a nominal rental basis. These leases have 93 and 1 years remaining respectively.

	2017-18 £000	2016-17 £000
Operating lease revenue		
Minimum lease receipts	**1,717**	1,334
Total	**1,717**	1,334
Future minimum lease receipts due:		
- not later than one year	**1,022**	1,026
- later than one but not later than five years	**3,423**	3,966
- later than five years	**3,674**	4,128
Total	**8,119**	9,120

11. Finance income

Finance income represents interest received on assets and investments in the period.

	2017-18 £000	2016-17 £000
Interest revenue:		
Interest on bank accounts	**35**	25
Total	**35**	25

12.1. Finance expenditure

Finance expenditure represents interest and other charges involved in the borrowing of money.

	2017-18 £000	2016-17 £000
Interest expense:		
Loans from the Department of Health and Social Care	**699**	785
Finance leases	**52**	57
Main finance costs on LIFT scheme obligations	**321**	324
Contingent finance cost on LIFT scheme obligations	**92**	81
Total interest expense	**1,164**	1,247
Unwinding of discount on provisions	**8**	58
Total finance expenditure	**1,172**	1,305

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

The Trust has not incurred any finance costs, or paid any compensation to cover debt recovery costs under this legislation, in either 2017-18 or 2016-17.

13. Other gains/(losses)

	2017-18 £000	2016-17 £000
Gains on disposal of assets	**82**	1
(Losses) on disposal of assets	**(29)**	(5)
Total gains/(losses) on disposal of assets	**53**	(4)

14. Intangible assets

14.1. Intangible assets 2017-18

	Computer licences	Development expenditure - internally generated	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017	**23,354**	**3,008**	**1,088**	**27,450**
Additions	**750**	**0**	**1,667**	**2,417**
Reclassifications	**272**	**0**	**(272)**	**0**
Disposals / derecognition	**(675)**	**(24)**	**0**	**(699)**
Valuation / gross cost at 31 March 2018	**23,701**	**2,984**	**2,483**	**29,168**
Amortisation at 1 April 2017	**15,601**	**3,008**		**18,609**
Provided during the year	**3,277**	**0**		**3,277**
Disposals	**(36)**	**(24)**		**(60)**
Amortisation at 31 March 2018	**18,842**	**2,984**		**21,826**
Net book value at 31 March 2018	**4,859**	**0**	**2,483**	**7,342**
Net book value at 1 April 2017	**7,753**	**0**	**1,088**	**8,841**

14.2. Intangible assets 2016-17

	Computer licences	Development expenditure - internally generated	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016	**19,054**	**3,008**	**0**	**22,062**
Additions	3,957	0	1,088	**5,045**
Reclassifications	355	0	0	**355**
Disposals	(12)	0	0	**(12)**
Valuation / gross cost at 31 March 2017	**23,354**	**3,008**	**1,088**	**27,450**
Amortisation at 1 April 2016	**12,941**	**3,008**		**15,949**
Provided during the year	2,674	0		**2,674**
Disposals	(14)	0		**(14)**
Amortisation at 31 March 2017	**15,601**	**3,008**		**18,609**
Net book value at 31 March 2017	**7,753**	**0**	**1,088**	**8,841**
Net book value at 1 April 2016	**6,113**	**0**	**0**	**6,113**

14.3. Intangible assets - additional information

Intangible assets comprise purchased computer software and licenses, which are carried at amortised historical cost, as a proxy for fair value, together with development expenditure which is carried at a nominal value.

Assets are capitalised and amortised over their useful lives on a straight-line basis. Useful lives are all finite and range from 0 to 5 years. The gross carrying amount of fully depreciated assets still in use is £12.9m (2016-17: £8.6m).

15. Property, plant and equipment

15.1. Property, plant and equipment 2017-18

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2017	**5,141**	**115,259**	**17**	**4,277**	**71,978**	**275**	**10,849**	**5,769**	**213,565**
Additions	0	8,483	0	2,793	3,984	0	985	231	**16,476**
Impairments	0	(3,383)	0	0	0	0	0	0	**(3,383)**
Revaluations	0	(4,626)	(1)	0	0	0	0	0	**(4,627)**
Reclassifications	0	3,509	0	(3,509)	0	0	0	0	**0**
Disposals / de-recognition	0	0	0	0	(8,043)	(14)	(2)	(1,146)	**(9,205)**
Valuation / gross cost at 31 March 2018	**5,141**	**119,242**	**16**	**3,561**	**67,919**	**261**	**11,832**	**4,854**	**212,826**
Accumulated depreciation at 1 April 2017	**0**	**6,624**	**1**		**53,785**	**262**	**3,693**	**5,058**	**69,423**
Provided during the year	0	4,194	4		4,296	3	1,676	278	**10,451**
Impairments	0	4,058	0		0	0	0	0	**4,058**
Reversals of impairments	0	(5)	(2)		0	0	0	0	**(7)**
Revaluations	0	(6,624)	(1)		0	0	0	0	**(6,625)**
Disposals / de-recognition	0	0	0		(8,014)	(14)	(2)	(1,146)	**(9,176)**
Accumulated depreciation at 31 March 2018	**0**	**8,247**	**2**		**50,067**	**251**	**5,367**	**4,190**	**68,124**
Net book value at 31 March 2018	**5,141**	**110,995**	**14**	**3,561**	**17,852**	**10**	**6,465**	**664**	**144,702**
Net book value at 1 April 2017	**5,141**	**108,635**	**16**	**4,277**	**18,193**	**13**	**7,156**	**711**	**144,142**

15. Property, plant and equipment (cont'd)

15.2 Property, plant and equipment 2016-17

	Land	Buildings excluding dwellings	Dwellings	Assets under construction & payments on account	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2016	**5,141**	**117,209**	**17**	**826**	**72,402**	**386**	**8,884**	**5,876**	**210,741**
Additions	0	5,020	0	3,816	2,712	0	1,970	120	**13,638**
Impairments	0	(1,678)	0	0	0	0	0	0	**(1,678)**
Revaluations	0	(5,003)	0	0	0	0	0	0	**(5,003)**
Reclassifications	0	10	0	(365)	0	0	0	0	**(355)**
Disposals / de-recognition	0	(299)	0	0	(3,136)	(111)	(5)	(227)	**(3,778)**
Valuation / gross cost at 31 March 2017	**5,141**	**115,259**	**17**	**4,277**	**71,978**	**275**	**10,849**	**5,769**	**213,565**
Accumulated depreciation at 1 April 2016	**0**	**6,838**	**1**		**52,501**	**366**	**2,396**	**4,997**	**67,099**
Provided during the year	0	4,092	1		4,404	7	1,302	286	**10,092**
Impairments	0	3,012	0		0	0	0	0	**3,012**
Reversals of impairments	0	(181)	0		0	0	0	0	**(181)**
Revaluations	0	(6,838)	(1)		0	0	0	0	**(6,839)**
Disposals / de-recognition	0	(299)	0		(3,120)	(111)	(5)	(225)	**(3,760)**
Accumulated depreciation at 31 March 2017	**0**	**6,624**	**1**		**53,785**	**262**	**3,693**	**5,058**	**69,423**
Net book value at 31 March 2017	**5,141**	**108,635**	**16**	**4,277**	**18,193**	**13**	**7,156**	**711**	**144,142**
Net book value at 1 April 2016	**5,141**	**110,371**	**16**	**826**	**19,901**	**20**	**6,488**	**879**	**143,642**

15. Property, plant and equipment (continued)

15.3. Property, plant and equipment financing 2017-18

Net book value at 31 March 2018	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	4,891	97,474	0	3,561	16,093	10	6,416	607	**129,052**
On-SOFP LIFT contracts	250	950	0	0	0	0	0	0	**1,200**
Owned - government granted	0	5,109	0	0	0	0	0	0	**5,109**
Owned - donated	0	7,462	14	0	1,759	0	49	57	**9,341**
NBV total at 31 March 2018	**5,141**	**110,995**	**14**	**3,561**	**17,852**	**10**	**6,465**	**664**	**144,702**

15.4. Property, plant and equipment financing 2016-17

Net book value at 31 March 2017	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction & payments on account £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	4,891	95,418	16	4,277	16,599	13	7,103	652	**128,969**
On-SOFP LIFT contracts	250	950	0	0	0	0	0	0	**1,200**
Owned - government granted	0	5,023	0	0	0	0	0	0	**5,023**
Owned - donated	0	7,244	0	0	1,594	0	53	59	**8,950**
NBV total at 31 March 2017	**5,141**	**108,635**	**16**	**4,277**	**18,193**	**13**	**7,156**	**711**	**144,142**

15. Property, plant and equipment (continued)

15.5. Property, plant and equipment - additional information

Revaluations

Land and property assets are carried at valuation on the Statement of Financial Position. All of the Trust's land, building and dwelling assets have been revalued as at 31 March 2018 by the District Valuers of the Valuation Office Agency. The valuations have been carried out in accordance with the Royal Institute of Chartered Surveyors' (RICS) Appraisal and Valuation Manual insofar as these terms are consistent with the agreed requirements of the Department of Health & Social Care and HM Treasury.

Since 30 June 2014, the valuation of the Trust's land and building assets has been undertaken on a Modern Equivalent Asset (MEA) basis with the assumption that the assets are situated on an alternative site to their current location.

The Trust's plant and machinery assets (with individual values in excess of £15,000) were last revalued at 1 April 2009, by the Valuation Office Agency. Since that date these assets have been carried on the Statement of Financial Position at those valuations less subsequent depreciation. Plant and machinery assets not valued as part of this revaluation continue to be carried at depreciated historical cost as a proxy for current value.

The Trust's tangible information technology assets were revalued by the Valuation Office Agency as at 31 December 2013. Prior to 31 December 2013, these assets were carried on the Statement of Financial Position on a depreciated historic cost basis. Since that date these assets have been carried on the Statement of Financial Position at those valuations less subsequent depreciation. Purchases since the valuation date are carried on a depreciated historic cost basis, as a proxy for current value.

There have been no changes to the valuation methods used by the Trust in 2017-18.
No compensation from third parties has been received for assets impaired, lost or given up.
The Trust has no temporarily idle assets.
The gross carrying amount of fully depreciated assets still in use is £37.4m (2016-17: £45.3m).

Donations

Donations towards property, plant and equipment expenditure in the year have been provided by the following organisations:

- Royal Cornwall Hospitals NHS Trust Charitable Fund (see related party transactions - Note 35);
- Macmillan Cancer Support;
- Sunrise Appeal;
- The Friends of St Michaels's Hospital Hayle;
- The Friends of The Royal Cornwall Hospital; and
- Cornwall Council.

Other than the conditions imposed by Macmillan Cancer Support (referred to in Note 24), no restrictions or conditions have been imposed by the donors.

Property, plant and equipment leased to other organisations

The following amounts have been recorded in these accounts within property, plant and equipment at 31 March 2018 in respect of assets leased to other organisations by the Trust, under operating lease arrangements:

	Land	Buildings (excluding dwellings)	Total
	£000	£000	£000
Gross carrying amount	840	11,827	**12,667**
Accumulated impairment loss	(2,042)	(215)	**(2,257)**
Depreciation charge for the period	0	(298)	**(298)**

There were no impairment losses recognised or reversed in the period.

16. Inventories

Current	31 March 2018 £000	31 March 2017 £000
Drugs	**2,315**	1,965
Consumables	**5,712**	5,838
Energy	**106**	92
Total inventories	**8,133**	7,895

Inventories recognised in expenses for the year were £81.256m (2016-17: £78.784m). Write-down of inventories recognised as expenses for the year were £156,000 (2016-17: £156,000).

No inventory balances above are held at net realisable value (2016-17: £nil). No inventories have been pledged as securities for liabilities (2016-17: £nil).

17. Receivables

17.1. Trade and other receivables

Current	31 March 2018 £000	31 March 2017 £000
Trade receivables	**8,935**	4,710
Capital receivables (including accrued capital related income)	**86**	0
Accrued income	**6,523**	9,200
Provision for impaired receivables	**(2,501)**	(1,792)
Prepayments	**2,350**	1,593
PDC dividend receivable	**260**	0
VAT receivable	**888**	1,155
Other receivables	**1,839**	1,978
Total current trade and other receivables	**18,380**	16,844

Non-current	31 March 2018 £000	31 March 2017 £000
Prepayments	**18**	138
Other receivables	**462**	594
Total non-current trade and other receivables	**480**	732

Of which receivables from NHS and DHSC group bodies:		
Current	**11,888**	9,976
Non-current	**0**	0
	11,888	9,976

There are no prepaid pension contributions included above in either 2017-18 or 2016-17.

The great majority of trade is with clinical commissioning groups. As clinical commissioning groups are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

17.2. Provision for impairment of receivables

	2017-18 £000	2016-17 £000
Balance at 1 April	**1,792**	2,714
Increase in provision	**822**	84
Amounts utilised	**(29)**	(23)
Unused amounts reversed	**(84)**	(983)
Balance at 31 March	**2,501**	1,792

Department of Health and Social Care guidelines require injury cost recovery receivables to be impaired at 22.84% (2016-17: 22.94%). However the Trust has taken the decision to provide for older balances at a higher rate.

Non-NHS receivables are impaired on the basis of their age and type, as follows:

	31 March 2018	31 March 2017
Balances older than 12 months	**75%**	75%
Balances between 6 and 12 months old	**75%**	75%
Balances less than 6 months old	**up to 69%**	up to 50%

Specific debts which are known to be doubtful have been provided for.

17.3. Analysis of financial assets

	31 March 2018	31 March 2017
Ageing of impaired financial assets	**Trade and other receivables £000**	Trade and other receivables £000
0-30 days	**391**	84
30-60 days	**307**	142
60-90 days	**198**	39
90-180 days	**224**	180
Over 180 days	**587**	274
Total	**1,707**	719

	31 March 2018	31 March 2017
Ageing of non impaired financial assets past their due date	**Trade and other receivables £000**	Trade and other receivables £000
0-30 days	**12**	15
30-60 days	**500**	38
60-90 days	**51**	175
90-180 days	**1,235**	48
Over 180 days	**254**	105
Total	**2,052**	381

The remainder of the Trust's financial assets not past due or impaired have been reviewed and are not considered to represent a significant credit risk.

18.1. Cash and cash equivalents movements

	31 March 2018 £000	31 March 2017 £000
Opening balance	**3,099**	1,171
Net change in year	**5,057**	1,928
Closing balance	**8,156**	3,099
Comprising:		
Cash with the Government Banking Service	**8,128**	2,886
Cash with commercial banks and in hand	**28**	213
Cash and cash equivalents as in the Statement of Financial Position	**8,156**	3,099
Bank overdraft - commercial banks	**(5)**	(9)
Cash and cash equivalents as in the Statement of Cash Flows	**8,151**	3,090

18.2. Third party assets

The Trust held cash and cash equivalents which relate to monies held by Trust on behalf of patients or other parties.

	31 March 2018 £000	31 March 2017 £000
Monies on deposit	**2**	2

19. Trade and other payables

	31 March 2018 £000	31 March 2017 *Restated £000
Current trade and other payables		
Trade payables	**3,765**	3,285
Capital payables	**5,766**	4,336
Accruals (revenue only)	**18,786**	16,281
Social security costs	**811**	0
PDC dividend payable	**0**	141
Accrued interest on loans	**101**	73
Other payables	**708**	3,231
Total current trade and other payables	**29,937**	27,347
Of which receivables from NHS and DHSC group bodies:	**2,771**	1,917

*Capital and revenue accruals were previously required to be reported within this note as one figure. Capital accruals are now reported in 'Capital payables'. Deferred income was previously included within this note and is now reported within 'Other liabilities' - see Note 20 below.

Included in the amounts above are £106,000 (2016-17: £2,935,000) in respect of outstanding pension contributions. There are no amounts included to buy out early retirement liabilities in either 2017-18 or 2016-17.

20. Other liabilities

	31 March 2018 £000	31 March 2017 *Restated £000
Current		
Deferred income	**5,506**	5,214
Total other current liabilities	**5,506**	5,214
Non-current	**£000**	£000
Deferred income	**1,584**	2,112
Total other non-current liabilities	**1,584**	2,112

*Deferred income balances were previously required to be reported within 'Accruals and deferred income' balances under the 'Trade and other payables' note above.

21. Borrowings

Current	31 March 2018 £000	31 March 2017 £000
Bank overdraft - commercial banks	**5**	9
Loans from the Department of Health and Social Care	**7,370**	6,575
Obligations under LIFT contracts	**18**	15
Obligations under finance leases	**293**	396
Total	**7,686**	6,995

Non-current	31 March 2018 £000	31 March 2017 £000
Loans from the Department of Health and Social Care	**45,166**	34,686
Obligations under LIFT contracts	**1,503**	1,521
Obligations under finance leases	**807**	1,565
Total	**47,476**	37,772

Loans: additional disclosure for loans with the Department of Health and Social Care

	31 March 2018		31 March 2017	
	Interest rate %	Value outstanding £000	Interest rate %	Value outstanding £000
Revenue support loan (1)	**0.58**	**427**	0.58	713
Capital investment loan (2)	**0.58**	**427**	0.58	713
Capital investment loan (3)	**1.99**	**3,332**	1.99	3,888
Revenue support loan (4)	**1.65**	**19,791**	1.65	21,438
Revenue support loan (5)	**1.50**	**3,800**	1.50	3,800
Interim revenue support loan (6)	**1.50**	**10,709**	1.50	10,709
Capital investment loan (7)	**1.07**	**5,564**		
Revenue support loan (8)	**1.50**	**4,235**		
Revenue support loan (9)	**1.50**	**1,790**		
Revenue support loan (10)	**1.50**	**2,461**		
Total loans with DHSC		**52,536**		41,261

(1) & (2) The Trust was issued with a revenue support loan of £2,000,000 and a capital investment loan of £2,000,000 in August 2012. Both loans have a term of 7 years and 1 month and repayments commenced in March 2013.

(3) A capital investment loan of £5,000,000, repayable within 10 years, was issued to the Trust in March 2014. An initial £1,500,000 of this loan was drawn down in March 2014 with the remainder drawn down in 2014-15. Repayment of the loan commenced in September 2015.

(4) A revenue support loan of £24,733,000 was issued to the Trust in February 2015. The loan term is 15 years and repayments commenced in August 2015.

(5) A revenue support loan of £3,800,000 was issued to the Trust in February 2016. The term of the loan was originally 2 years. Repayment of the loan has now been extended to February 2019.

(6) This revenue support loan was issued in January 2017. The term of the loan is 3 years and the loan is repayable in full in January 2020.

(7) In February 2016, the Trust secured a further capital investment loan of £6,161,000. The loan was drawn down in 2017-18 and has a 9 year term from the date of issue. Repayments commenced in August 2017.

(8), (9) & (10) Further revenue support loans were issued in January (£4,235,000), February (£1,790,000) and March 2018 (£2,461,000). Each has a 3 year term and is repayable in full in January, February and March 2021 respectively.

22. Finance lease obligations as lessee

In September 2016, the Trust entered into a 5 year contract with Servelec HSC for the provision of a Patient Administration System. The Trust has the option to extend the arrangement for a further 2 years.

	31 March 2018	31 March 2017
	£000	£000
Gross lease liabilities	**1,215**	2,222
Of which liabilities are due:		
- no later than one year	**347**	494
- later than one but not later than five years	**868**	1,728
Finance charges allocated to future periods	**(115)**	(261)
Net lease liabilities	**1,100**	1,961
Of which payable:		
- no later than one year	**293**	396
- later than one but not later than five years	**807**	1,565
Total	**1,100**	1,961

23.1. Provisions

	Pensions - early departure costs	**Legal claims**	**Other**	**Total**
	£000	**£000**	**£000**	**£000**
Balance at 1 April 2017	**889**	**83**	**3,920**	**4,892**
Change in the discount rate	8	0	39	**47**
Arising during the year	39	63	99	**201**
Utilised during the year	(75)	(58)	(249)	**(382)**
Reversed unused	0	(10)	(42)	**(52)**
Unwinding of discount	2	(2)	8	**8**
Balance at 31 March 2018	**863**	**76**	**3,775**	**4,714**
Expected timing of cash flows:				
- no later than one year	75	76	261	**412**
- later than one year and no later than five years	298	0	995	**1,293**
- later than five years	490	0	2,519	**3,009**
Total	**863**	**76**	**3,775**	**4,714**

Other provisions include £662,000 (2016-17: £686,000) in respect of pre-1995 pensions, £3,101,000 (2016-17: £3,234,000) in respect of permanent injury benefit provisions and £12,000 (2016-17: £nil) is in respect of NHS Resolution Property Expenses Scheme (PES) claims.

Pension provisions and pensions are calculated based on figures supplied by the NHS Business Services Authority - Pensions Division, using actuarial tables. As these tables cover significant time periods it is not possible to be precise about future amounts and timings of payment.

It is not possible to be precise regarding dates of settlement for industrial injury and other legal claims and therefore there is uncertainty over the calculation and timings of amounts due.

No reimbursements are expected in relation to the provisions disclosed above.

23.2. Clinical negligence liabilities

At 31 March 2018, £140.892m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Cornwall Hospitals NHS Trust (31 March 2017: £141.553m).

24. Contingencies

Value of contingent liabilities	31 March 2018 £000	31 March 2017 £000
NHS resolution legal claims (1)	**56**	60
Other (2)	**3,040**	2,954
Net value of contingent liabilities	**3,096**	3,014

(1) The balance relates to employer liability and public liability claims made against the Trust.

(2) The Trust received funding between 2015-16 and 2017-18 totalling £3,040,000 from Macmillan, to fund the building of the Cove Cancer Information Centre on the main hospital site in Truro. Under the terms of the agreement with Macmillan, the Trust is obliged to use the building for its intended purpose for a period of 15 years. Should the Trust not do so, the Trust will be obliged to repay a percentage of the funding to Macmillan. As at 31 March 2018, this percentage stands at 100% (31 March 2017: 100%)

The Trust has no contingent assets.

25. Contractual capital commitments

Contracted capital commitments at 31 March not otherwise included in these financial statements:

	31 March 2018 £000	31 March 2017 £000
Property, plant and equipment	**271**	3,749
Intangible assets	**0**	302
Total	**271**	4,051

The Trust had no significant capital commitments at 31 March 2018.

26. On-SOFP LIFT arrangements

The Trust's LIFT scheme relates to the property used by the Cornwall Food Production Unit. Lease payments are made each month and updated for inflation on an annual basis. Under the terms of the lease, the Trust enjoys rights and obligations to the property until February 2033. The lease agreement includes the need for the landlord to insure and maintain the property. The Trust is required to meet the costs of utilities and these are payable to the landlord.

The Trust has the option to purchase the premises, during and at the end of the term, and details are set out in the lease agreement. There are no other significant terms of the lease that may impact on the timing or certainty of cash flows. There have been no changes in the arrangement during the year.

26.1. Imputed finance lease obligations

	31 March 2018 £000	31 March 2017 £000
Gross liabilities	**5,014**	5,351
Of which liabilities are due:		
- not later than one year	**336**	336
- later than one but not later than five years	**1,344**	1,345
- later than five years	**3,334**	3,670
Finance charges allocated to future periods	**(3,493)**	(3,815)
Net lease liabilities	**1,521**	1,536
Of which payable:		
- not later than one year	**18**	15
- later than one but not later than five years	**121**	99
- later than five years	**1,382**	1,422
Total	**1,521**	1,536

26.2. Total on-SOFP arrangement commitments

The Trust's total future obligations under these on-SOFP schemes are as follows:

	31 March 2018 £000	31 March 2017 £000
Total future payments committed in respect of the LIFT arrangement	**12,730**	13,437
Of which liabilities are due:		
- not later than one year	**719**	712
- later than one but not later than five years	**3,040**	2,966
- later than five years	**8,971**	9,759
Total future payments	**12,730**	13,437

26.3. Analysis of amounts payable to LIFT provider

This note provides an analysis of the Trust's payments.

	31 March 2018 £000	31 March 2017 £000
Unitary payments payable to LIFT provider	**719**	712
Consisting of:		
- interest charge	**321**	324
- repayment of finance lease liability	**15**	12
- service element and other charges to operating expenditure	**291**	295
- contingent rent	**92**	81
Total amounts paid to LIFT provider	**719**	712

27. Financial instruments

27.1. Financial risk management

Financial reporting standard IFRS 7: *Financial Instruments: Disclosures* 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 Trust has with Clinical Commissioning Groups (CCGs) and the way those CCGs are financed, the 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 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 Trust in undertaking its activities.

The Trust's treasury management operations are carried out by the finance department, within parameters defined formally within the Trust's standing financial instructions and policies agreed by the Board of Directors. Trust treasury activity is subject to review by the Trust's internal auditors.

Currency risk

The Trust is principally a domestic organisation with the great majority of transactions, assets and liabilities being in the UK and sterling based. The Trust has no overseas operations. The Trust therefore has low exposure to currency rate fluctuations.

Interest rate risk

The Trust borrows from government for capital expenditure, subject to affordability as confirmed by NHS Improvement. The borrowings are for 1 - 10 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 may also borrow from government for revenue financing subject to approval by NHS Improvement. Interest rates are confirmed by the Department of Health and Social Care (the lender) at the point borrowing is undertaken.

The Trust therefore has low exposure to interest rate fluctuations.

Credit risk

Because the majority of the Trust's revenue comes from contracts with other public sector bodies, the Trust has low exposure to credit risk. The maximum exposures as at 31 March 2018 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with CCGs, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds obtained within its prudential borrowing limit. The Trust is not, therefore, exposed to significant liquidity risks.

27.2. Carrying values of financial assets

	2017-18 Loans and receivables	2016-17 Loans and receivables *Restated
Assets as per Statement of Financial Position	**£000**	£000
Trade and other receivables excluding non-financial assets	**13,176**	12,238
Cash at bank and in hand	**8,156**	3,099
Total at 31 March	**21,332**	15,337

The Trust has no 'available for sale' financial assets or financial assets carried 'at fair value through profit and loss'. The carrying value of these assets is considered to be a reasonable approximation of fair value.

*2016-17 figures have been restated to exclude balances totalling £3.6m that did not represent 'financial assets' for the purposes of this disclosure.

27. Financial instruments (continued)

27.3. Carrying values of financial liabilities

	2017-18 Other financial liabilities	2016-17 Other financial liabilities *Restated
Liabilities as per Statement of Financial Position	**£000**	£000
Borrowings excluding finance lease and LIFT liabilities	**52,541**	41,270
Obligations under finance leases	**1,100**	1,961
Obligations under LIFT arrangements	**1,521**	1,536
Trade and other payables excluding non-financial liabilities	**29,126**	27,206
Total at 31 March	**84,288**	71,973

The carrying value of the above liabilities is considered to be a reasonable approximation of fair value.

*Deferred income balances were previously disclosed within 'Other financial liabilities'. They are now disclosed within 'Other liabilities' on the Statement of Financial Position and are not included as a financial liability in the above disclosure.

27.4. Maturity of financial liabilities

	2017-18	2016-17
Financial liabilities maturing in:	**£000**	£000
- one year or less	**36,812**	34,201
- more than one year but not more than two years	**14,321**	3,211
- more than two years but not more than five years	**18,077**	18,829
- more than five years	**15,078**	15,732
Total	**84,288**	71,973

28. Losses and special payments

	2017-18		2016-17	
	Total number of cases	**Total value of cases £000**	Total number of cases	Total value of cases £000
Losses:				
Cash losses	**14**	**11**	18	13
Bad debts and claims abandoned	**37**	**18**	34	10
Stores losses and damage to property	**3**	**156**	6	156
Total losses	**54**	**185**	58	179
Special payments:				
Compensation under court order or legally binding arbitration award	**4**	**33**	0	0
Ex-gratia payments	**64**	**70**	41	49
Total special payments	**68**	**103**	41	49
Total losses and special payments	**122**	**288**	99	228

There were no individual losses, special payments or gifts in excess of £300,000 in either 2017-18 or 2016-17.

29. Events after the end of the reporting period

There are no known post balance sheet events requiring disclosure.

30. Better Payment Practice Code

	2017-18 Number	2017-18 £000	2016-17 Number	2016-17 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**83,210**	**144,332**	85,642	149,429
Total non-NHS trade invoices paid within target	**78,932**	**137,011**	78,739	136,089
Percentage of non-NHS trade invoices paid within target	**94.86%**	**94.93%**	91.94%	91.07%
NHS payables				
Total NHS trade invoices paid in the year	**2,153**	**49,791**	2,105	49,197
Total NHS trade invoices paid within target	**2,074**	**48,749**	1,995	48,701
Percentage of NHS trade invoices paid within target	**96.33%**	**97.91%**	94.77%	98.99%

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

31. External financing

The Trust is given an External Financing Limit (EFL) which it is permitted to under spend.

	2017-18 £000	2016-17 £000
Cash flow financing	**7,039**	2,199
Finance leases taken out in the year		190
External financing requirement	**7,039**	2,389
External Financing Limit	**14,412**	5,755
Underspend against the External Financing Limit	**7,373**	3,366

32. Capital Resource Limit

The Trust is given a Capital Resource Limit (CRL) which it is not permitted to exceed.

	2017-18 £000	2016-17 £000
Gross capital expenditure	**18,893**	18,684
Less: Disposals	**(668)**	(17)
Less: Donated and granted capital additions	**(734)**	(2,012)
Charge against the Capital Resource Limit	**17,491**	16,655
Capital Resource Limit	**17,572**	16,845
Underspend against the Capital Resource Limit	**81**	190

33. Break-even duty financial performance

	2017-18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	**(2,591)**
IFRIC 12 breakeven adjustment	**34**
Breakeven duty financial performance surplus / (deficit)	**(2,557)**

34. Break-even rolling duty assessment

	1997-98 to 2008-09 Total £000	2009-10 £000	2010-11 £000	2011-12 £000	2012-13 £000	2013-14 £000	2014-15 £000	2015-16 £000	2016-17 £000	2017-18 £000
Break-even in-year financial performance		8,349	7,544	4,437	9,809	3,938	(6,908)	(6,906)	(929)	**(2,557)**
Break-even duty cumulative position	(42,768)	(34,419)	(26,875)	(22,438)	(12,629)	(8,691)	(15,599)	(22,505)	(23,434)	**(25,991)**
Operating income		303,925	310,471	314,246	323,341	332,819	342,503	355,815	379,462	**405,020**
Cumulative break-even position as a percentage of turnover		-11.32%	-8.66%	-7.14%	-3.91%	-2.61%	-4.55%	-6.32%	-6.18%	**-6.42%**

The Trust reported a £2.6m deficit in 2017-18 and holds a cumulative deficit of £26m at 31 March 2018.

The Trust's approved budget is based on a £11.9m deficit in 2018-19 and therefore the Trust will continue to fail to achieve breakeven on a cumulative basis, with the cumulative deficit expected to be £37.9m at 31 March 2019. The Trust aims to recover its financial position as quickly as possible, although it has not yet agreed a plan to recover the current cumulative deficit over a 5 year period.

35. Related party transactions

During the year none of the Department of Health and Social Care Ministers, Trust Board members or members of the key management staff, or parties related to any of them, has undertaken any material transactions with Royal Cornwall Hospitals NHS Trust, other than those transactions disclosed in this note.

The Department of Health and Social Care is regarded as a related party. During the year, Royal Cornwall Hospitals NHS Trust has had material transactions with the Department in respect of the loans disclosed in Note 21.

The Trust has also had material transactions with other entities for which the Department is regarded as the parent department. These entities and their associated transactions with the Trust are listed below:

Year to 31 March 2018

Entity	Expenditure with related party £000	Revenue with related party £000	Payables with related party £000	Receivables with related party £000
Kernow Clinical Commissioning Group	**206**	**272,840**	**1,739**	**2,731**
NHS England	**86**	**84,908**	**88**	**6,145**
Cornwall Partnership NHS FT(1)	**9,409**	**6,988**	**978**	**555**
Plymouth Hospitals NHS Trust	**1,274**	**471**	**633**	**148**
Royal Devon and Exeter FT	**280**	**1,484**	**14**	**281**
NHS Resolution(2)	**9,981**	**3**	**0**	**0**
Health Education England	**0**	**14,604**	**48**	**116**

Year to 31 March 2017

Entity	Expenditure with related party £000	Revenue with related party £000	Payables with related party £000	Receivables with related party £000
Kernow Clinical Commissioning Group	348	252,752	2,103	2,147
NHS England	4	84,086	17	6,353
Cornwall Partnership NHS FT(1)	3,807	6,177	406	460
Plymouth Hospitals NHS Trust	1,252	590	393	95
Royal Devon and Exeter FT	161	1,439	32	1
NHS Litigation Authority	7,230	0	15	0
Health Education England	1	12,285	1	33

(1) One of the Trust's Non-Executive Directors is also a Non-Executive Director of Cornwall Partnership Foundation Trust and the two organisations share a Chief Finance Officer.
(2) Formerly NHS Litigation Authority.

In addition, the Trust has had a number of material transactions with other government departments and other central and local government bodies. Most of these transactions have been with the NHS Pension Scheme, National Insurance Fund, NHS Blood and Transplant and HM Revenue and Customs.

The Trust's Chairman is a Councillor with Cornwall Council. Transactions and balances with the Council are disclosed below:

Cornwall Council	Expenditure with related party £000	Revenue with related party £000	Payables with related party £000	Receivables with related party £000
Year to 31 March 2018	**57**	**3,790**	**1**	**263**
Year to 31 March 2017	1,785	2,986	8	535

35. Related party transactions (continued)

Royal Cornwall Hospitals NHS Trust Charitable Fund

The Royal Cornwall Hospitals NHS Trust is the Corporate Trustee for the Royal Cornwall Hospitals NHS Trust Charitable Fund. The Trust has not consolidated the accounts of the Charitable Fund within these financial statements on the grounds that the transactions with the Charity and the Charity's balances are not material to the Trust. However, summary financial data is disclosed below:

Extracts from Charity's Statement of Financial Activities

	2017-18 (Draft) £000	2016-17 *Restated £000
Total incoming resources	**580**	541
Total resources expended with bodies outside the NHS	**(36)**	(38)
Total resources expended with Royal Cornwall Hospitals NHS Trust	**(717)**	(575)
Total resources expended	**(753)**	(613)
Net (outgoing)/incoming resources	**(173)**	(72)
Investment gains/(losses)	**5**	254
Net movement in funds	**(168)**	182

Extracts from Charity's Balance Sheet

	2017-18 (Draft) £000	2016-17 *Restated £000
Investments	**2,093**	2,360
Total fixed assets	**2,093**	2,360
Cash	**298**	199
Other current assets	**16**	34
Current liabilities	**(44)**	(62)
Net assets	**2,363**	2,531
Funds of the Charity		
Restricted funds	**1,040**	1,328
Non-restricted funds	**1,323**	1,203
Total funds	**2,363**	2,531

*Draft 2016-17 figures were previously presented in the 2016-17 Trust financial statements. The final 2016-17 figures are now presented, following the finalisation of the Charity's accounts.

Included within current liabilities at 31 March 2018 is £14,000 (2016-17: £17,000) owed to Royal Cornwall Hospitals NHS Trust.

Independent auditor's report to the Directors of Royal Cornwall Hospitals NHS Trust

Report on the Audit of the Financial Statements

Opinion

We have audited the financial statements of Royal Cornwall Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2018, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the accounts, including Accounting policies and other information. The financial reporting framework that has been applied in their preparation is applicable law and the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2018 and of its expenditure and income for the year then ended; and
- have been properly prepared in accordance with International Financial Reporting Standards (IFRSs) as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law. Our responsibilities under those standards are further described in the Auditor's responsibilities for the audit of the financial statements section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Who we are reporting to

This report is made solely to the Directors of the 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 Trust's Directors 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 Trust and the Trust's Directors, as a body, for our audit work, for this report, or for the opinions we have formed.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust has approved a deficit budget of £11.9 million for the year, ended 31 March2019 and has identified the need for additional cash support of approximately £13 million to support the 2018-19 financial position. As stated in note 1.1.2, the required borrowing has not yet been formally approved by the Department of Health and Social Care.

These events or conditions, along with the other matters explained in note 1.1.2, indicate that a material uncertainty exists that may cast significant doubt about the Trust's ability to continue as a going concern. Our opinion is not modified in respect of this matter.

Other information

The Directors are responsible for the other information. The other information comprises the information included in the Annual Report excluding the financial statements and our auditor's report thereon. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

In connection with our audit of the financial statements, our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the course of our work including that gained through work in relation to the Trust's arrangements for securing value for money through economy, efficiency and effectiveness in the use of its resource or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements or a material misstatement of the other information. If, based on the work we have performed, we conclude that there is a material misstatement of this other information; we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and Staff Report to be audited have been properly prepared in accordance with IFRSs as adopted by the European Union, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2017-18 and the requirements of the National Health Service Act 2006; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust gained through our work in relation to the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice we are required to report to you if:

- we have reported a matter in the public interest under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit; or
- we have referred a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we had reason to believe that the Trust, or an officer of the Trust, was about to make, or had made, a decision which involved or would involve the body incurring unlawful expenditure, or was about to take, or had 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 have made a written recommendation to the Trust under Section 24 of the Local Audit and Accountability Act 2014 in the course of, or at the conclusion of the audit.

We have nothing to report in respect of the above matters except on 11 May 2018 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to Royal Cornwall Hospitals NHS Trust's breach of its break-even duty for the five year period ending 31 March 2018.

Responsibilities of the Directors and Those Charged with Governance for the financial statements

As explained more fully in the Statement of Director's Responsibilities, the Directors are responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions, for being satisfied that they give a true and fair view, and for such internal control as the Directors determine is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Directors are responsible for 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 the Trust lacks funding for its continued existence or when policy decisions have been made that affect the services provided by the Trust.

The Audit and Risk Committee is Those Charged with Governance.

Auditor's responsibilities for the audit of the financial statements

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 an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a 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 the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – Conclusion on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Qualified conclusion

On the basis of our work, having regard to the guidance issued by the Comptroller & Auditor General in November 2017, except for the effects of the matters reported in the basis for qualified conclusion section of our report, we are satisfied that, in all significant respects, Royal Cornwall Hospitals NHS Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018.

Basis for qualified conclusion

Our review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources identified the following matters:

- The Trust reported a deficit of £6.906 million in 2017/18, compared to a planned surplus of £1.3 million, following significant deficits in previous years.
- The Trust's 2018/19 draft financial plan shows a forecast deficit of £11.9 million for the 2018/19 financial year after receipt of £8.9 million of sustainability and transformation funding and delivery of a £12 million cost improvement programme.
- The Trust remains in special measures and continues to be graded as "Inadequate" by the Care Quality Commission (CQC).

These matters identify weaknesses in the Trust's arrangements for:

- setting a sustainable budget with sufficient capacity to absorb emerging cost pressures due to the current configuration of services; and
- responding to service delivery issues including deployment of workforce and governance arrangements raised by regulators, as required improvements to services have not been achieved.

These matters are evidence of weaknesses in proper arrangements for:

- sustainable resource deployment in planning finances effectively to support the sustainable delivery of strategic priorities and maintain statutory functions; and
- acting in the public interest through demonstrating and applying the principles of good governance to support informed decision-making.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's Responsibilities, as the Accountable Officer of the Trust, the Accountable Officer is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under Section 21(3)(c) and 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 and to report where we have not been able to satisfy ourselves that it has done so. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance on the specified criterion issued by the Comptroller and Auditor General in November 2017, as to whether in

all significant respects, the Trust had proper arrangements to ensure it took properly informed decisions and deployed resources to achieve planned and sustainable outcomes for taxpayers and local people. The Comptroller and Auditor General determined this criterion as that necessary for us to consider under the Code of Audit Practice in satisfying ourselves whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2018, and to report by exception where we are not satisfied.

We planned our work in accordance with the Code of Audit Practice. Based on our risk assessment, we undertook such work as we considered necessary to be satisfied that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources.

Report on other legal and regulatory requirements – Certificate

We certify that we have completed the audit of the financial statements of Royal Cornwall Hospitals NHS Trust in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice.

Geraldine.N.Daly

Geraldine Daly
Associate Director
for and on behalf of Grant Thornton UK LLP

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Date: 25 May 2018