One + all | we care

NHS
Royal Cornwall Hospitals
NHS Trust

Annual Report 2018/19

Starting on our journey to become brilliant for care, brilliant for improvement and brilliant for our people.

Table of Contents

A renewed appetite for change and ever motivated by the desire to ensure patients and their families receive the brilliant care and support they deserve.

'Our diagnostic imaging services received an '**Outstanding**' rating from the Care Quality Commission.'

We care deeply about all our stated values and will continue to hold ourselves to account for doing all that we do it in ways which demonstrate these through our behaviours.

Introduction

Chairwoman's Foreword

This last year has been one of celebration for the NHS as it reached its 70th Anniversary and for us at Royal Cornwall Hospitals NHS Trust one where we have laid firm foundations to transform our hospitals and to continue on our journey to become brilliant for care, brilliant for improvement and brilliant for our people.

The placing of our hospitals into 'special measures', by the Care Quality Commission (CQC), was a low point for all of us, but has acted as a spur for real change. There is much for us to do, but we have made real progress in a short period of time.

Kate in her introduction sets out some of the detail, however I want to acknowledge the hard work put in by everyone at the Trust which resulted in December 2018 the CQC raised our rating from 'Inadequate' to 'Requires Improvement'. We remain in "special measures", but are working hard with our regulator NHS Improvement to have this lifted, which we aim to do in the coming year.

.

Our health and care system partners too, play an integral part in supporting and enabling the changes we need to make to the way we work.

We are reaping the rewards of closer working and forward planning through our local sustainability and transformation partnership – Shaping Our Future – to ensure we are all working well together to better meet the needs of our community, now and in the future.

That's not to say it has, or will be, an easy path to achieving the transformation we all want to see.

This is why we are also making sure that we focus on our people, their health and wellbeing, making sure they are involved every step of the way and have the support and tools they need to make change happen.

We care deeply about all our stated values and will continue to hold ourselves to account for doing all that we do it in ways which demonstrate these through our behaviours.

On behalf of the Board we would like to say a huge thank you to our staff, to our Mitie colleagues and to our volunteers for the amazing work they have been doing throughout the year.

Together we can, and should, aspire to the very best for our hospitals; for those we care for and for those who work here.

Dr Mairi Mclean
Chairwoman

Introduction from the Chief Executive

The last 12 months has been the start of a journey for RCHT, setting out our aspiration to become brilliant for care, brilliant for improvement and brilliant for our people.

Being placed in 'special measures', by the Care Quality Commission (CQC) was a significant turning point for us.

It is one that has driven to us to raise our game, to respond urgently to warning notices, and importantly to focus on how we value our people, so that every one of us is supported to deliver safe, compassionate care.

We are making progress and we know we have a great deal yet to do. Whilst having improved our Care Quality Commission rating, remaining in 'special measures' has provided the extra support to allow us to continue a steady programme of improvement.

It is of course our staff who will lead the way and only by changing our culture and involving everyone in the improvements we have to make, will we be successful.

That is why we are taking a fresh approach to staff engagement and investment in developing our leaders at every level.

Generating a renewed appetite for change and with the desire of us all to ensure patients and their families receive the brilliant care and support they deserve; examples of transformation are happening across our hospitals.

We can see this in the better and safer environment we now have for those needing urgent and emergency care, the cultural change and improvement in maternity services and the 'can do' approach to a host of projects that have been delivered through our Trust Improvement Programme.

I am proud to be a part of the RCHT team and want to thank colleagues for their inspiration, motivation and determination.

Together we can, and should, aspire to the very best for those we care for and for those who work here.

For our patients,
'We are it' and being
Brilliant is up to us,
One+All

Kate Shields
Chief Executive

It is of course our staff who will lead the way and only by changing our culture and involving everyone in the improvements we have to make, will we be successful. That is why we are taking a fresh approach to staff engagement and investment in developing our leaders at every level.

Kate Shields - Chief Executive

Our Values will underpin our transformation journey and our aspiration to be Brilliant for Care, Brilliant for Improvement and Brilliant for the People who work for us.

1.
Performance Report

Who we are

The Royal Cornwall Hospitals NHS Trust was created in 1992 as part of the second wave of NHS Trusts to be established in England.

We have three main sites:

Royal Cornwall Hospital, Truro

St Michael's Hospital, Hayle

West Cornwall Hospital, Penzance

We also provide imaging and outpatient services at a number of locations spread across the Cornwall and the Isles of Scilly, as well as birthing centres in St Austell, Helston and on the Isles of Scilly.

More than 5,700 people work together providing a comprehensive range of acute hospital and supporting services to a population of approximately 430,000 residents; a figure which is boosted significantly during the busy holiday periods.

We also have more an in-house bank of more than 1000 people and over 600 volunteers and who work flexibly and help us to reduce our use of external agency staff.

The geography of our county, surrounded on three sides by sea, and the remoteness of the Isles of Scilly present unique challenges. Our population is growing and changing.

The number of people living in Cornwall is rising faster than the national average and in 10 years, we anticipate there will be a 6% increase in the number of people who live here.

The number of people aged over 75 is also above the national average and increasing. More information on our demography can be found in our 'Trust Strategy 2019-2022 - Our Journey to Brilliant'.

Our services

Our hospitals provide acute emergency and planned care services to our local population, in addition to maternity services. We also provide a number of specialised services (such as the treatment of cystic fibrosis and head & neck cancer), often working as part of a network with other acute hospital providers.

Our services are split into seven Care Groups:

- ➔ Anaesthetics, Critical Care and Theatres
- ➔ Clinical Support
- ➔ General Surgery and Cancer
- ➔ Specialist Medicine
- ➔ Specialist Services and Surgery
- ➔ Urgent, Emergency and Trauma
- ➔ Women, Children and Sexual Health

We also have leadership teams in place at St Michael's Hospital and West Cornwall Hospital to provide dedicated management to these sites.

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.

Our seven Clinical Care Groups 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. Car parking facilities for visitors and staff are managed by Q-Park Limited.

Our patient and staff meals are produced by our in-house catering team, now operating under the name Sustenation, which is actively developing its business model as a provider to other NHS Trusts and commercial businesses.

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.

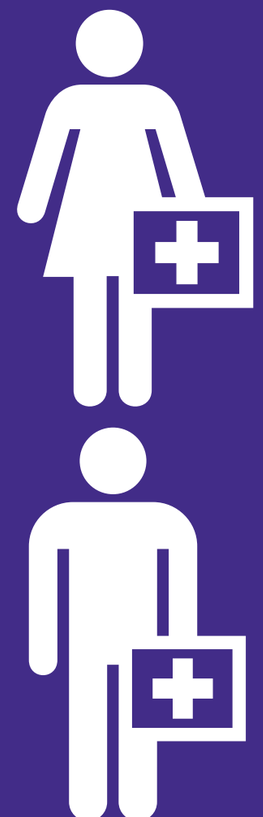
We are a teaching hospitals trust as part of the University of Exeter Medical School and the University of Plymouth (nursing and dental faculties). We also have an expanding Research, Development and Innovation portfolio.

5,700+
Staff members

430,000+
Population

600+
Volunteers

1,000+
Flexible workers



Strategic aims and priorities 2018-19 and beyond

In January 2019 we launched a wide-reaching programme to engage our people and our stakeholders in developing our future strategy. This work led to the launch of our new 2019-2021 strategy in May 2019.

Our Strategy describes our improvement journey, and is based on a recognition that the Trust has to improve and aspire to achieve greater things than has been the case over recent years.

We know that our patients and our local population expect and deserve more.

In order to achieve this, we want to reinvent our organisation, placing Quality Improvement at the heart of everything we do, so we become and remain a brilliant place to work and receive care.

We need to change, transform and modernise, refocussing our efforts on delivering the right services, in the right locations, with the right workforce, to a brilliant standard. Ultimately, we want to ensure we are one of the safest hospitals to receive care.

Our **ASPIRE** ward accreditation programme is driving consistently high standards in patient care and safety.

Our Vision

Aspiring to provide Brilliant Care to One + All

Goal 1
Brilliant Care

Always providing safe, effective and compassionate care, where we listen and learn to provide an excellent patient experience and reduce avoidable harm

Goal 2
Brilliant People

Working together in a supportive environment to attract, develop and retain brilliant people

Goal 3
Brilliant Improvement

Instilling a culture of quality improvement where everyone feels empowered to make changes for the benefit of our patients

Brilliant Care Pledges

1. We provide care that is consistently safe and avoids harm.
2. We are open and honest with people about their care.
3. We listen and learn from patients, their families and carers and treat them with compassion and respect.
4. We provide clinically effective care, which minimises delay and the amount of time people have to spend in our care.
5. We work with our health and care system to improve the health of our community.
6. We provide an environment that is clean, safe and welcoming.

Brilliant People Pledges

1. We provide great leadership and support to help colleagues be the best they can be.
2. We create a safe environment so colleagues feel supported to speak up.
3. We make sure colleagues receive feedback to know how they are doing.
4. We provide development to help colleagues learn and grow.
5. We provide an environment that supports colleague safety, health & wellbeing.
6. We are true to our values and create a brilliant place to work.

Brilliant Improvement Pledges

1. We ensure that everyone has the capability and capacity to pursue quality improvements for our patients.
2. We use innovation and digital technology to improve the quality, experience and cost of our care.
3. We are growing the Trust's national reputation for excellence in research and development.
4. We make good use of the resources that are available to us.
5. We celebrate achievement and will create a culture that enables continuous improvement.

To deliver this, we will focus upon three key strategic goals: **Brilliant People**, **Brilliant Care**, and **Brilliant Improvement**.

Journey to Brilliant: Our Year 1 Milestones

Brilliant Care

Always providing safe, effective and compassionate care, where we listen and learn to provide an excellent patient experience and reduce avoidable harm

1. Develop the foundations of a brilliant safety culture through a) Improving our patient safety information; b) Implementing an ambitious avoidable harm reduction programme; and c) Developing patient safety knowledge and capability across the trust.
2. Ensure 90% of our patients receive their planned care within 18 weeks of referral.
3. Implement Ward Accreditation across outpatient and interventional areas.
4. Begin the development of our Clinical Centres of Excellence within Cornwall, supporting our services to develop a reputation for excellence in clinical care and patient feedback.
5. With our partners, realign services within our Integrated Care System so we become the lead provider for Urgent and Emergency Care pathways.

Brilliant People

Working together in a supportive environment to attract, develop and retain brilliant people

1. Demonstrate our values through our behaviours, making it consistently clear what should be expected from our colleagues and from the organisation.
2. Implement our Being Brilliant Leadership programme.
3. Support our colleagues to speak up through increasing the number of Freedom to Speak Up Champions.
4. Roll-out an improved appraisal process which considers not just achievement against objectives, but also values and behaviours.
5. Support Care Groups to develop sustainable workforce plans through our new People & Organisational Development Transformation Board.
6. Expand our health and wellbeing offering.
7. Develop our flexible working and flexible rostering programme.

Brilliant Improvement

Instilling a culture of quality improvement where everyone feels empowered to make changes for the benefit of our patients

1. Embed the Quality Improvement Hub and new Brilliant Improvement Board governance across the trust.
2. Appoint to the Associate Medical Director for Quality Improvement, to strengthen our clinical leadership around QI.
3. Train and assign a QI ambassador for every team in the Trust.
4. Develop and roll out an in-house quality improvement training programme.
5. Develop our Digital Strategy.
6. Deliver our key year 1 milestones on the Brilliant Improvement programme.
7. Build a reputation as centre of excellence for QI in the NHS and share our successes and lessons from our QI activities at national and regional forums.

Recognising the requirement for significant improvements across a variety of services, as well as culture and leadership, the Trust established a Quality Improvement Delivery Board (QIDB) to review progress and receive assurance on the improvements being made.

There were three main quality workstreams resulting from the action plan:

- ➔ Tackling Delay
- ➔ Strong Governance
- ➔ Safety Culture.

There were also three enabling workstreams from the action plan:

- ➔ Culture and Leadership
- ➔ Communication and Engagement
- ➔ QI Capability

Following the organisation's most recent CQC inspection in September 2018, the Trust's rating improved from 'inadequate' to 'requires improvement'. A quality improvement plan was developed in response to the areas identified for improvement, including in the well-led domain.

Our Values

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.

How are we doing?

Summary of progress

Our performance has improved in a number of important areas in 2018-19, most evidently shown in the emergency care standard, which is a key indicator of safer care and patients getting a better experience from admission through to discharge and onward care, where needed.

We have been working hard to cut down delays to clinical procedures and to address the weak governance in areas such as maternity and operating theatres that led to a significant lack of confidence by our regulators in the safety and quality of our services. Our efforts were recognised in the movement of our Care Quality Commission rating to 'Requires Improvement' and whilst we remain in 'special measures', this does demonstrate we are making steady progress.

Mortality rates are now below what would be expected given our patient population and our early identification and rapid treatment for sepsis is much improved. Patient feedback remains positive overall but there is more we need to do to improve our timely response to complaints, learning from incidents and the evidence that we complete our duty of candour.

Initiatives such as our ward accreditation programme and SAFER care are playing an important part improving patient safety and raising standards of care across the board.

Allied to these has been a wide range of quality and efficiency improvement projects and our staff are being empowered to take these, and many more, forward with the support of our newly established Quality Improvement Hub.

Our staff survey results were disappointing and as part of our organisational development programme we have put a renewed focus on our people. We know that for them to provide brilliant care, they need to feel supported and valued; something that has not always happened in recent years.

Financially, we ended the year with a deficit of £4.1m for 2018/19. In addition to the £8.9m baseline Provider Sustainability Fund (PSF) funding earned through the year from meeting quarterly financial and operational standards, the Trust received £6.7m of additional PSF Incentive income at year end. Before any PSF incentive income was received the deficit was £10.9m; which was £1m better than the planned outturn position.

With our partners we have continued to work on the system transformation that is vital to the long term sustainability of health and care services. One of the biggest challenges for us all is recruiting people to our teams and reducing our reliance on temporary and agency staff. The launch together of a virtual academy to provide new routes into training, successful international recruitment and the expansion of our apprenticeship scheme are all innovative ways in which we are approaching the challenge.

In summary, 2018-19 has been a year where we have begun to make the change we need and given us firm foundations on which to build over the coming year.

Dr Mairi Mclean, Chairman
Kate Shields, Chief Executive

Quality: Providing compassionate, safe, effective care

Going into the year with a Care Quality Commission (CQC) rating of inadequate, two Section 29A warning notices requiring us to take urgent action in specific areas, and being in 'special measures', made clear the need for us to make rapid and sustained improvement.

This has been driven through our Trust Improvement Programme and the progress we have made was evidenced in moving our CQC rating to 'Requires Improvement' following a further assessment in September 2018.
As well as receiving a 'Good' overall rating for the Caring domain, there was an 'Outstanding' rating for our Clinical Imaging Diagnostic service which subsequently achieved further endorsement by attaining the respected quality mark of ISAS accreditation. The 'Inadequate' rating for the Well Led domain reflected there being a relatively new leadership team at board level and the upheaval associated with changes to our organisational structure.

Are services

Safe?	Requires improvement
Effective	Requires improvement
Caring?	Good
Responsive	Requires improvement
Well led?	Inadequate

Our need for improvement was acutely sharpened following the publication, in October 2018, of the report into the death of Coco Rose Bradford. We acknowledged in full the failings and findings of the Independent Investigation and made a commitment to respond to all of the recommendations that were made.

Progress has been reported monthly through our public Board meetings and we continue to work closely with Coco's family to ensure that her legacy is one that brings about real and long term change in clinical practice and behaviours.

The themes for our quality improvement programme in 2018-19, developed with our staff, were 'Safety Culture', 'Strong Governance' and 'Tackling Delay'. Allied to these were supporting work streams on culture and leadership, communication and the development of a quality improvement hub.

The following are examples of improvements to care and safety delivered in the last year and further work is continuing, to be led through our newly launched Quality Improvement Hub, focussing on both patient care and the wellbeing of our staff.

How our services are improving

Faster access to emergency care

Access to emergency and urgent care has long been a challenge of the health and care system in Cornwall and one where we are at last making progress. Changes within the emergency department and better working relationships with health and care providers across Cornwall & the Isles of Scilly has seen a dramatic transformation in our ability to provide safe and timely urgent care services.

Having seen our hospitals on their highest level of operational alert more days than not between January and March 2018, 2019 could not have been more different. This year OPEL4 (indicating the highest level of operational pressure) was declared for short periods on only 2 occasions.

The introduction of a rapid assessment area and redesign of the minor injuries area to create a new urgent treatment centre for Truro, has vastly improved patient flow in the emergency department.

Improvements to our same day emergency care model have resulted in an increase in the number of patients using this service and avoiding unnecessary admissions to hospital. Run in partnership with acute GPs, patients referred to hospital with medical conditions can be triaged in the unit and in many cases treatments commenced that can then be continued at home.

Early in 2018 West Cornwall Hospital became the first of the planned Urgent Treatment Centres for the county.

The already established model of care, involving local GPs to provide an enhanced service offering local access to specialists, is playing a key role in avoiding admissions, as well as patients being less likely to need to travel long distances to access urgent care.

SAFER critical care

An urgent need to respond to the Section 29a warning notice from the Care Quality Commission prompted a new approach to tackling the problem of delayed and overnight discharges from the critical care unit. These were compromising safety for patients and frequently making it difficult to admit new patients in urgent need of these specialist services.

The SAFER patient care bundle is as a collection of actions to cut out delays in a patient's care, ensuring that everything necessary is in place as soon a person is clinically fit to move on to the next step in their care pathway.

The SAFER bundle requires input from all members of the multi-disciplinary team. Its successful implementation in critical care has delivered huge benefits with delayed and overnight discharges down by 75% and bed occupancy rates considerable reduced.

Improving care for planned orthopaedic surgery

Building on the established reputation of St Michael's Hospital as a centre of excellence for breast and orthopaedic surgery, a £4million investment in facilities and recruitment of additional staff has enabled the transfer of all but the most complex patients to the hospital for their planned orthopaedic procedures. The move means patients are unlikely to be affected by last minute cancellations and has seen the numbers waiting more than 52 weeks fall from 233 to 3 by the end of March 2019.

New side rooms and bathroom facilities at St Michael's have made it possible to increase the number and type of patients suitable for surgery at our Hayle hospital.

Taking action against Sepsis

Sepsis has become one of the most high profile killers in our population and one that is equally high on the agenda across our hospitals.

Over the year we have made huge strides in ensuring patients with suspected sepsis receive antibiotics within one hour and have been progressing plans to bring in more safeguards, including the introduction of sepsis module on our electronic observation system.

We have benefited from the support of Sepsis campaigner Melissa Mead, working alongside us at staff training sessions, and in partnership at community events, to raise public awareness.

Quicker diagnosis for people at risk of stroke

In January a pilot scheme to co-locate the Transient Ischaemic Attack (TIA) service onto the Royal Cornwall Hospital site, with hospital and community staff working together has resulted in an increase in the number of people receiving an appointment within 24 hours of their referral; and everybody that requires a CT and Doppler scan now gets one on the day, instead of a secondary appointment. This is better for patients and removes duplication of appointments, in turn freeing up clinical capacity to see more people. The change has also enabled the clinic to go paperless speeding up correspondence with GPs.

We are also providing early supported discharge following a stroke co-located with the community-based stroke rehabilitation teams, and supporting more joined-up care. We expect to see the benefits of this during 2019-20.

Transforming trauma services

The introduction of a new hand assessment and treatment service has improved patient experience by reducing long waits in the emergency department and unnecessary inpatient admissions.

A new outpatient clinic allows patients to be treated the same day or the next day and be able to wait in the comfort of their own home, rather than in a busy emergency department or on a hospital ward.

The extension of scheduled working hours in the trauma theatres has reduced the number of patients needing an overnight stay by more than 60%. In January all patients had been

accommodated in the scheduled operating sessions, preventing the need for night time (after 8pm) theatre lists.

Partnership reduces cardiology waits

Working with the Duchy Hospital we have introduced a single waiting list for cardiology first outpatient appointments. This has reduced the waiting time at our hospitals from 24 weeks to eight weeks, and improved the time from referral by a GP to receiving treatment (where needed) from 75% in October 2018 to 88.9% in January 2019.

End of Life and Palliative Care

People reaching the end of their lives have the right to receive high quality care which meets their needs. We also need to ensure that we prepare and support people at the end of their lives and their families so they can have a good and dignified death.

We have been working with our health and care partners to further improve end of life care for people in Cornwall and the Isles of Scilly.

Key priorities include raising public awareness about the importance of talking about death and bereavement, providing end of life education training for health professionals, and ensuring we provide a timely and appropriate response wherever a person is being cared for.

Our Palliative and End of Life Care team introduced a number of schemes including Butterfly Cornwall - a discrete way to flag an end of life situation with everyone caring for that person; Rainbow Days - an RCHT Charity funded scheme to provide additional comforts and special requests; and pre-prepared Wedding Boxes equipped with the essentials to support ceremonies at short notice.

Raising standards and spreading best practice

Ward Accreditation aspires to brilliant care

During the year we introduced our ward accreditation scheme, ASPIRE. The scheme was among the first projects as part of our Trust Improvement Programme.

Ward accreditation schemes have been shown to promote safer patient care in organisations, by motivating staff and sharing best practice between ward areas.

They aim to promote better health outcomes, better patient experience and ensure the wards and departments are a better place to work, train and learn.

Ward accreditation assesses a number of clinical standards at ward level, providing a consistent, validated assurance at an individual ward level; essential when triangulating safe staffing, skill mix, quality and safety of care.

During the year five wards achieved coveted GOLD status with a further 18 attaining SILVER. There is a continuing programme of assessments.

ASPIRE continues to evolve and the measures against which wards are assessed are regularly reviewed and made more challenging to support an ethos of continuing improvement and consistency of standards right across our hospitals.

ASPIRE will be extended to the Emergency Department, maternity services and paediatrics during 2019.

Tackling infection to reduce antibiotic use

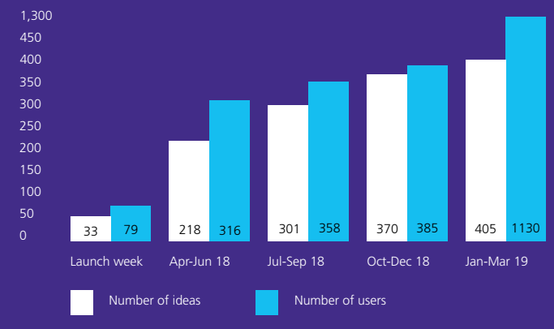
Our ‘Drug & Bug’ team nurse educators have been supporting a community care based project to reduce the need for antibiotic prescribing by preventing infections.

As part of the national ambition to reduce health care associated blood stream infections our priority has been to reduce urine infections which are a common cause.

A year in review

ImproveWell.

Staff love it because it is so easy to use. That positivity and momentum feeds positivity within the workplace - Kerry Eldridge - Director of Human Resources & Organisational Development



405 Ideas submitted

1130 Total users of **Improvewell** platform

1250 Surveys sent

92% Ideas responded to

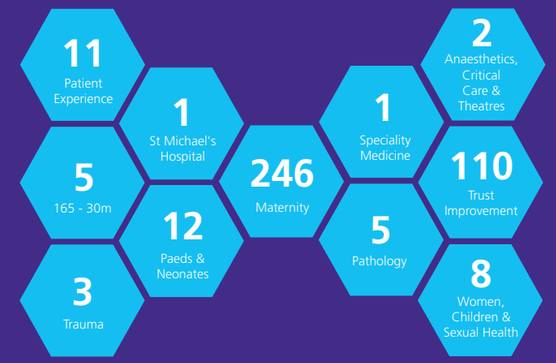
1486 Sentiment submissions

27 Project teams

36 Improvement themes

24 Hours a day usage

5 Improvement reports published



We really, passionately believe in bottom up change, in that our staff have all of the answers to many of the problems we face - Pete Gray, Service Improvement Lead

Building on the work of the previous year education sessions were taken to care home staff and community nurses to promote accurate diagnosis and correct treatment.

A Cornwall Catheter Passport has been designed to underpin best practice and promote patient involvement, and a catheter champion role has been developed in the community to support the avoidance, safe use and removal of catheters. Prescribing initiatives in primary care have also looked at urine infections with the aim of reducing the use of broad spectrum antibiotics. The work has led to a national Antibiotic Guardian Award for our Lead Educator.

Quality Improvement Hub

Our Quality Improvement Hub was created in response to staff feedback and brings together support for our people to help them make changes and improvements in their area of work.

A core team, together with a network of over 80 quality improvement ambassadors across our hospitals, has been supported by the SW Academic Health and Science Network and is introducing colleagues to proven QI tools and techniques.

One of these tools is the ImproveWell App. This was first tested by our midwifery team where it was quickly used to capture more than 400 ideas many of which have already been put in place.

ImproveWell has now been rolled out across our hospitals and we are looking at further developments using the App that will support staff engagement, involvement and ownership of projects to improve care and safety.

Innovation Successes

Our Innovation Leaders have continued to promote innovation engagement activities across our hospitals. Most successful and well attended are the 'Innovation Breakfast Clubs'.

These enable colleagues to network as innovation and improvement information and learning is shared.

A number of staff generated innovation ideas have been identified and supported. Two technology developments are in early stages of becoming a reality as discussions with commercial partners progress.

Three products have reached prototype stages of development:

- a staff member's idea for an electrical safety system has been built and is being demonstrated to regional groups for feedback;
- a commercial partner has prototyped a staff member's idea for a new trolley to support nurses using our electronic prescribing and medicines administration system at the patient's bedside;
- finally, a further staff member has worked with a local college to design and implement a range of child-friendly environmental enhancement graphics for clinical imaging rooms. This package is now commercially available to other Trusts.

Technology playing a key role in safer care

Scan4Safety - We are one of six acute trusts in England to have completed Scan4Safety. The use of global data standards and scanning technology enables the capture of rapid and accurate digital data, so our staff can spend more time focussing on our patients.

The objective of the programme is to get the 4 P's right first time: Patient, Product, Place, Process.

Scan4Safety supports clinical productivity by:

- Making sure clinicians have What They Need, When They Need It and Where They Need It
- Faster, accurate data capture allowing more time to care for patients, spending less time looking for things or filling in forms
- Making Better Informed Clinical Decisions through more accurate and timely data

Improves patient safety by making sure:

- we have the Right Patient
- we (always) know What Product was used with Which Patient, When
- we have What We Need, When We Need It and Where We Need It

Our Scan4Safety programme was audited on-site by Department of Health and Social Care auditors and we were found to be compliant for 140 (94%) of the control points audited. Following approval for seven corrective actions we were officially certified as a Scan4Safety Trust.

Electronic observations flag early warning signs

We have continued to develop the NerveCentre e-observation application over the last year. Using hand-held devices our clinical teams can record patient observations and quickly escalate problems for more senior clinical input where it points to deterioration a person's condition.

We have most recently added the updated National Early Warning System (NEWS2) guidelines to the system and during 2018-19 will be adding a Sepsis module which will automatically prompt the critical actions, including the administration of antibiotics, within one hour.

Our People: Attracting, developing and retaining excellent staff

At the start of 2018 we have launched a new organisational development programme. We know that we can only deliver Brilliant Care if we have Brilliant People and we are committed to developing a positive culture where all colleagues feel valued and supported.

Under the banner of 'Aspiring to Brilliant' the programme commenced with an extensive round of conversations taking senior leaders into workplaces across the organisation to capture truly representative views on how we can work together to bring about change.

This feedback is being used to develop the commitments we make to our people and that they will make to our hospitals, and which will be launched in the early part of 2019-20.

Changing the culture in maternity services

Our maternity services colleagues have been leading the way in cultural change using a range of initiatives to improve communication, engagement and involvement. Changes to the leadership structure have provided better support and there is a strong focus on health and wellbeing through the relaunch of the team's 'Caring For You' staff support initiative.

The team has enthusiastically adopted projects such as ImproveWell, #joyinwork and the 30sec30mins challenge to take simple quick actions that save others much more time further down the line.

Together these projects have been transforming the sense of teamwork, leading to improvements in the care and safety of mums and babies and having a positive effect on recruitment, retention and career opportunities.

Being open and feeling free to speak out

During the year our hospitals were among the first to welcome a Freedom to Speak Up Review by the National Guardian's Office. Having a culture in which our people feel confident and able to speak up about any concern is vital in maintaining a safe environment for patients and staff.

The review made a number of recommendations and we have been working to further enhance our Freedom to Speak Up processes and support for our staff, including training a network of FTSU champions. Early in 2019-20 we will be extending our FTSU Guardian role to a full-time post to enable us to further develop this critical area of staff support.

What our people say about working here

The 2018 Annual NHS Staff Survey was completed by 1946 people at RCHT during October and November; a response rate of 36%. This coincided with the start of our organisational restructure and the disappointing results are likely to have been affected by the upheaval and challenge brought about by such major change.

During the year our hospitals were among the first to welcome a Freedom to Speak Up Review.

The survey results told us that the experience of working at RCHT is not made easy by the way colleagues are lead and managed. Since December 2018 we have been developing our leaders and managers, including the Trust Board, to lead in a very different way.

The results also show that stress is increasing and we could do more to support health and wellness at work.

We have a range of activity already in place and are making plans to do much more, including how we signpost people to services that will promote wellbeing – whether this is physical, mental or financial wellbeing.

Our staff did, however, say that they feel more confident about raising issues that concern them and that issues raised by patients are acted upon.

This is hugely encouraging as we continue to improve the safety and quality of the care that we provide.

The full survey results are published here: http://www.nhsstaffsurveyresults.com/

Developing our leaders as a key part of cultural change

In tune with the staff survey results, a key strand in our organisation development programme is the development of leaders as at all levels so that we live and lead by our values, caring for and supporting one and other as much as we do our patients.

Our Care Quality Commission assessment rated us as 'Inadequate' against the Well Led domain, which reflected the number of new and interim appointments on the Trust Board, as well as inadequacies more widely within our senior leadership structure.

Since the report permanent appointments have been made to all but one of the Trust Board posts.

A further major step has been to get our organisational structure fit for purpose, moving from four Divisions to seven Clinical Care Groups. Now in place, this will help us to improve communication from ward to board and make it easier for our people to be engaged and involved in the future direction of their services.

We have started a programme with 100 senior leaders from across the Trust that will better equip them with the skills to lead by example in demonstrating our Values and behaviours that will make us Brilliant for all of the people we employ.

These 100 leaders will go on to train 1,000 colleagues and the programme will continue to cascade to reach every one of us.

Vision for Nursing, Midwifery and Allied Health Professions is launched

Developed through consultation with staff, the Vision for Nursing, Midwifery and Allied Health Professions aims to empower these professional teams to lead change and to identify and reduce variations or delays in patient care and treatment, and to help us achieve better outcomes for patients, better patient and family experiences, and better use of our resources.

The creation of the vision together has allowed us the opportunity to collectively develop our plan for compassionate, multidisciplinary care at RCHT. The addition of the integrated healthy workforce as an important factor to flag that championing excellence, looking after each other and reducing unwarranted variation is an issue for all of us. The vision is a fabulous platform on which innovation in practice within the RCHT community can grow."

Claire Martin- Deputy Chief Nurse

Recognising and celebrating success

The past year has been rich in our people and teams being recognised for their outstanding work not only within our hospitals but on a regional and national stage.

The highlight of our RCHT calendar is the annual One+all I We Care awards where in November, 20 teams and individuals were recognised in the five categories reflecting our Values.

In addition there were special awards for nurses at St Michael's Hospital who, whilst on their way to work, bravely aided a family to escape a house fire and others recognising Lifetime Achievement to celebrate the 70th anniversary of the NHS.

Nationally these are among the awards our people have received:

The Cove Macmillan Support Centre wins a Macmillan Quality Environment Mark in recognition of the centre's excellent standards of care.

Lead Nurse Educator Louisa Forbes is recognised in the national Antibiotic Guardian Awards for her work helping to improve catheter care and reduce use of antibiotics for urinary tract infections in community settings.

Midwife Amy Dunstan is a finalist in The Sun newspaper Who Cares Wins awards following her support for one young couple facing pregnancy and birth after babyloss.

Dr Andrew King, registrar in Trauma & Orthopaedics wins an award from the Oxford Trauma Society as Trainee Principal Investigator of the Year for his work on the WHiTE8 research trial looking a treating infection in patients with hip fractures.

The RCH Choir wins the National NHS 70th anniversary song-writing and performance competition.

Macmillan Nurse Facilitator Judy Clapp is honoured for her inspirational work in cancer care at the National Cancer Excellence Awards.

Pharmacy – Finalists in two categories of the 2019 Health Service Journal Patient Safety Awards for their work on reducing dispensing errors and missed doses of medication, and for reducing antibiotic use.

Specialist Registrar Nicola Fine receives an award as the top trainee in trauma and orthopaedics in the country.

Cancer Services – Dr John McGrane, in partnership with The Sunrise Trust and Exeter University, win the App of the Year title from Health Tech News for their development of an app to support cancer patients through their care and beyond.

Uro-oncology Clinical Nurse Specialist, Debbie Victor, is winner of the British Journal of Nursing Urology Nurse of the Year award.

Paediatrics – Winners of two Patient Experience Network National Awards for the way they have involved young people in improving children's services.

Phoenix Ward is a finalist at the Student Nursing Times Awards after students rate the team highly for their support and holistic approach to mentoring through the Collaborative Learning in Partnership scheme.

Further opportunity to recognise the achievements of our people are taken through the Annual Cornwall Health Community Research and Innovation Awards and monthly though the Improving Working Lives team and individual awards.

Winners of our One+All I We Care Awards 2018

The highlight of our RCHT calendar is the annual One+all I We Care awards where in November, 20 teams and individuals were recognised in the five categories reflecting our Values.

Care + Compassion

Overall Winners – Laura Muir, Critical Care Staff Nurse and Dr Salem Murjaneh, Consultant & Ophthalmology Team. Winners – Rachel North, Midwife
Hannah Lyth, Acute Liaison Assistant Practitioner for Learning Disabilities & Autism

Inspiration + Innovation

Overall Winner – Susan Kennedy, Stuart Gerty & Amanda Davis, Specialist Renal Dietitians and Clinical Nurse Specialist in Diabetes. Winners – Sarah Bean & Karen Burt, Critical Care Staff Nurse & Research Nurse
Dr John McGrane, Oncology Consultant Electronic Prescribing Medicines Application Team

Working Together

Overall Winner – Sarah Budden, Clinical Matron, Speciality Medicine. Winners – Alison Wotton, Tintagel Ward Sister Procurement Team Kate Schroder-Hockey, Clinical Matron, Older People's Service

Pride + Achievement

Overall Winner – Caroline Goddard, Senior Research Nurse. Winner – Angela Moyle, Waiting List Co-ordinator Caroline Amukusana, Divisional Governance Lead Clinical Site Team

Trust + Respect

Overall Winner – Sarah Chaplin, Chaplain
Winners – Zoe Saunders, Serious Incident Administrator Tracey Larcombe, Healthcare Support Worker Kathryn Andrews, Pharmacy Administrator Lead and PA to Chief Pharmacist.

NHS 70 – Lifetime Achievement

Overall winner – Dr Ray Sinclair, Retired Consultant in Intensive Care. Winners – Dr John Barnes, Consultant Physician Dr Anne Prendiville, Consultant Paediatrician Elizabeth Farrington, Hepatology Consultant Nurse.

Health & Wellbeing

Looking after our staff has been given a high profile as we embark on our organisational development programme. As well as consolidating, improving awareness and access to the many supporting services offered through our Occupational Health service and the Improving Working Lives initiative funded by the Cornwall NHS staff lottery, we are working to expand these further.

Among the ideas put forward by colleagues is the development of health and wellbeing hubs on each of our sites to provide space away from the workplace where our people can access support services, have space to relax and reflect, or to take part in social activities.

An idea is also being taken forward to identify suitable spaces throughout our hospitals to provide facilities to better support nursing mothers returning to work.

Training our future people

Together with Cornwall Partnership NHS Foundation Trust, NHS Kernow and Cornwall Council we will be using the apprenticeship levy to provide training for students joining a new 'virtual academy' where they will study for professional roles.

Successful graduates will be expected to commit to remain working in the county for at least two years. Academic partners supporting the scheme include the University of Exeter, University of Plymouth, University College St Mark and St John, Callywith College and Truro and Penwith College.

It is hoped the Academy will also make for improved social mobility of people within Cornwall, which is at a very low level.

The first academy intake will be autumn this year and will include registered nurses (adults and mental health) and also clinical associate psychologists.

This custom made solution, creating an academy is hoped to put Cornwall at the cutting edge in developing new roles and apprenticeships for health and social care.

Conferences celebrate our support staff

Our first ever conferences aimed at health care support workers and administrative and clerical staff marked a new focus on the vital roles these people play in providing brilliant care. The events presented an opportunity to celebrate achievements, share best practice and to empower them to take forward ideas, not only to develop their roles for the future but to also use their knowledge and experience to improve the efficiency and effectiveness of our services.

Equality and diversity

In spring 2018 we achieved level 2 accreditation within the Department of Work & Pensions, Disability Confident Scheme. This scheme replaces the previous Two Tick system which supports the fair recruitment and retention of staff who have support needs, such as, disabilities or long term health issues. The new scheme is much more rigorous to evidence and over the coming year we will be working toward achieving the top, level 3 accreditation.

The Trust continues to support the facilitation of staff networks and currently supports a Minority Ethnic group, Disability Advisory Team, a Staff Carers Network and signposts staff to the public sector LGBTQ virtual group. There are aspirations to join an NHS initiative to improve the experiences of staff and patients who are non-heterosexual and to possibly facilitate a Women's' Network to support the career progression of females in predominantly male work areas.

The gender pay gap shows the differences in the average pay between men and women. We are 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 our part-time workers). All of these can impinge on female employees' career progression, especially into senior leadership roles. It is important to note though that over 80% of female workers thought that we offered fair career progression in the 2018 staff survey.

The gender split of the Trust Board is very positive, however, the disparity in female representation more generally in senior leadership roles is not as good which leads to a significant pay gap identified below.

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.

Further information can be found in our Annual Equality Report.

	Mean %	Median %
Gender Pay Gap	22.1%	9.8%
Gender Bonus Gap	89.7%	97.9%
Proportion of Males Receiving a Bonus	11.5%	
Bonus	16.2%	

How many people we treated

Outpatient Attendances	→ **536,723**
Planned Inpatient	→ **10,136**
Planned Day Cases	→ **64,538**
Regular Day Patient	→ **17,166**
Emergency Admissions	→ **62,239**
A&E Attendances	→ **99,034**
Baby Births	→ **4,076**
Clinical Imaging Diagnostics	→ **336,483**

(1April 2018 to 31 March 2019)

During the year our hospitals were among the first to welcome a Freedom to Speak Up Review by the National

Performance Report

Key performance indicators

2018/19 Metric	From IPR Standard	From IPR Performance	Achieved
ED Attenders 4 hours to discharge, admission or transfer	95% (90% local)	92.77%	✗ ✓ local
Cancer referral 2ww (average over 11 months)	93.00%	94.89%	✓
Cancer diagnosis to treatment - 31 days (average over 11 months)	96.00%	97.55%	✓
Cancer referral to start treatment - 62 days (average over 11 months)	85.00%	83.16%	✗
Cancer 62 day screening (average over 11 months)	90.00%	86.03%	✗
Fractured NOF operated in 36 hours (average over 12 months)	80.00%	76.00%	✗
RTT incomplete pathways (average over 12 months)	92% (79.3% local)	81.86%	✗ ✓ local
RTT 52 week waiters (March'19 end)	0 (102 local)	3	✗ ✓ local
Diagnostics within 6 weeks (average over 12 months)	99% (96.6% local)	93.74%	✗
Average LOS in days (average over 12 months)	3.49	3.22	✓
DTOCs (average over 12 months)	3.50%	6.24%	✗
Same day cancellations (average over 12 months)	0.80%	1.03%	✗
Stroke patients 90% time on unit (average over 12 months)	90% (83.8% local)	83.95%	✗ ✓ local
Admission to stroke unit in 4 hours (average over 12 months)	57.40%	66.14%	✓
CT within 12 hours for stroke patients (average over 12 months)	93.50%	94.46%	✓
CT within 1 hour for stroke patients (average over 12 months)	51.30%	66.09%	✓

With our partners we have continued to work on the system transformation that is vital to the long term sustainability of health and care services.

Key Financial Performance in 2018/19

1. **Statement of Comprehensive Income**

1.1. The Trust's outturn was a deficit of £4.1m for 2018/19. In addition to the £8.9m baseline Provider Sustainability Fund (PSF) funding earned through the year from meeting quarterly financial and operational standards, the Trust received £6.7m of additional PSF Incentive income at year end. Before any PSF incentive income was received the deficit was £10.9m; which was £1m better than the planned outturn position.

1.2. The Trust delivered £11.6m of savings in 2018/19 against a target of £12m. £8m (31%) of savings were delivered not-recurrently and the Trust is working to deliver a greater portion of savings recurrently in 2019/20.

2. **The Statement of Financial Position**

2.1. The Statement of Financial Position (Balance Sheet) as at 31 March 2019 shows net assets of £90.9m.

2.2. The Trust ended the year with a cash balance of £9.7m. This was £8.7m above the planned position of £1m.

2.3. Despite the financial challenges facing the Trust it has delivered considerable improvements in its infrastructure through its Capital Programme in 2018/19, spending £17.1m.

3. **Cumulative breakeven duty**

3.1. The Trust now holds a cumulative deficit of £30m at 31 March 2019. The Trust has set a breakeven plan for 2019/20. The planned breakeven will still result in the Trust continuing to breach its breakeven duty.

4. **Other financial duties**

4.1. During 2018/19 the Trust operated within its External Financing and Capital Resource Limits as set by the Department of Health and Social Care.

5. **Performance against the Better Payments Practice Code**

5.1. 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.

5.2. 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, 95.7% of all invoices by volume were cumulatively paid on time. Note 32 to the Trust's accounts provide details on payment performance.

6. **Going concern basis**

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

6.2. At 31 March 2019 the Trust had Revenue Support Loans from the Department of Health and Social Care of £55.2m and Capital Loans from the Department of Health and Social Care of £7.7m

6.3. During 2018/19 the Trust made repayments of £1.6m against its Capital Investment loans and £1.9m against its Revenue Loans

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 on our websites and nationally on nhs.uk, showing the planned number of staff against the actual number on each ward. This information is also displayed daily on each ward.

A comprehensive report on all professional staff groups is presented to our Trust Board on a bi-annual basis.

The twice-daily ward staffing review meetings are used to discuss and mitigate risks where shifts cannot be filled and staff are re-deployed in line with 'real time' patient acuity and dependency.

The night time handover meeting includes a further staffing review between the site team leader and the senior manager on call from where any issues are escalated as required.

We have set targets to reduce our reliance on locum and agency staff

Environment, facilities and cleanliness

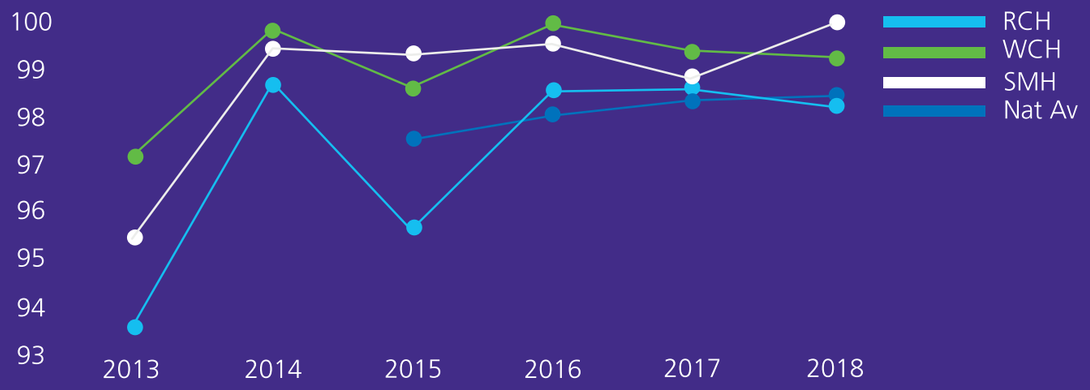
Our annual patient led assessments of the care environment (PLACE) are undertaken by teams of Trust staff working together with independent patient champions, looking at a number of criteria including, patient meals (food quality as well as service and mealtime assistance), cleanliness and the overall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

The majority of scores have shown little change since 2017. During the last year we have continued our programme of improvements including painting and decoration, ward environment upgrades, ventilation, roof repairs, signage, bedhead services, and handwash basins.

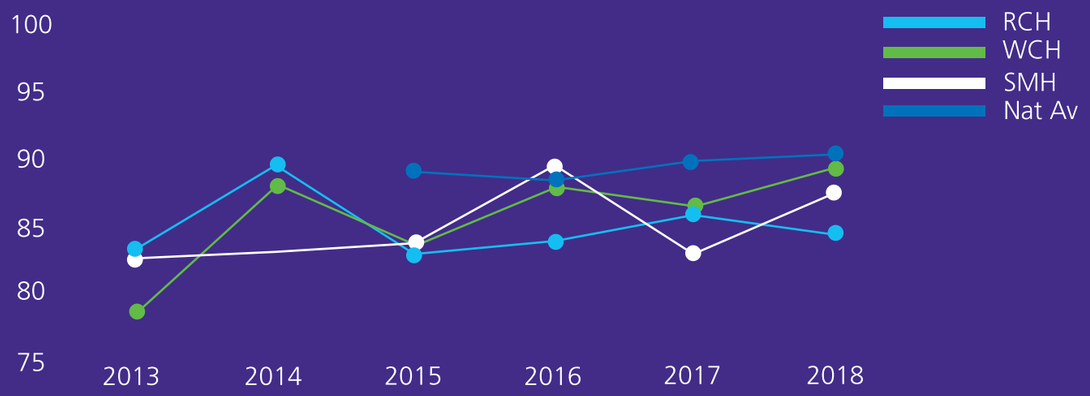
We expect these ongoing works and projects such as the refurbishments of therapy facilities at West Cornwall and pre-operative assessment clinic at St Michael's will help us achieve better results in 2019. Our in-house patient and restaurant food provider, now known as Sustenation, is also working closely with Mitie to introduce more healthy options on our menus and to improve food service on wards.

Environment Graphs

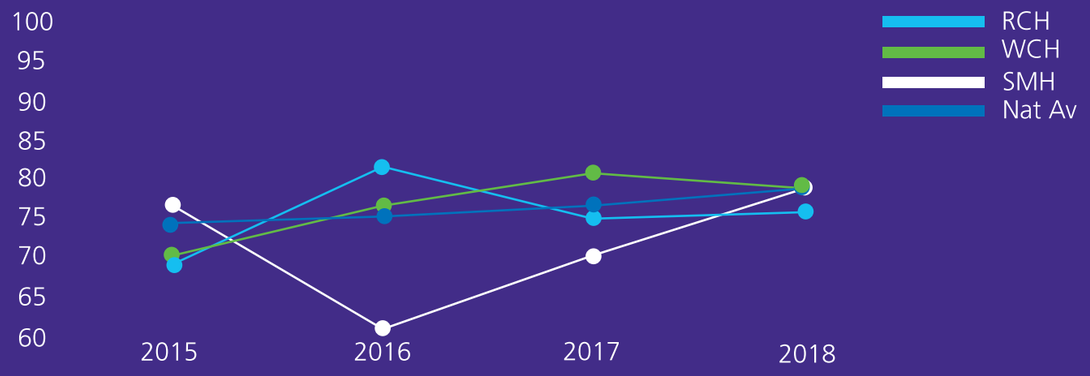
Cleaning



Food

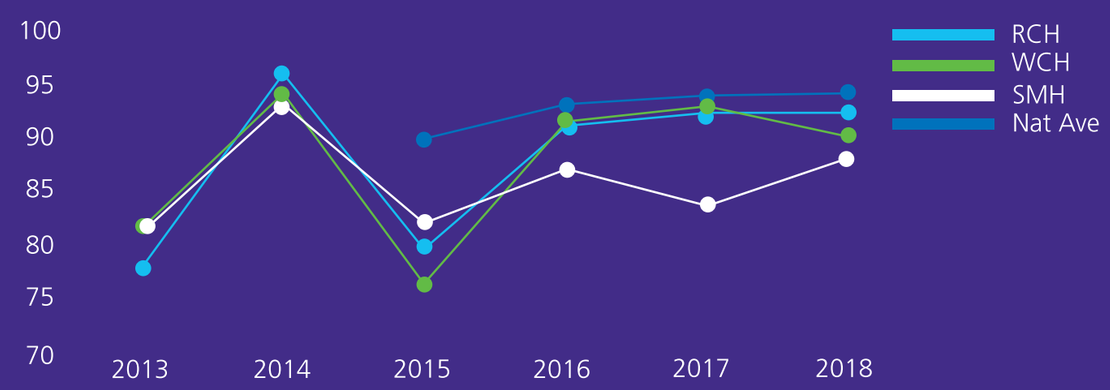


Dementia

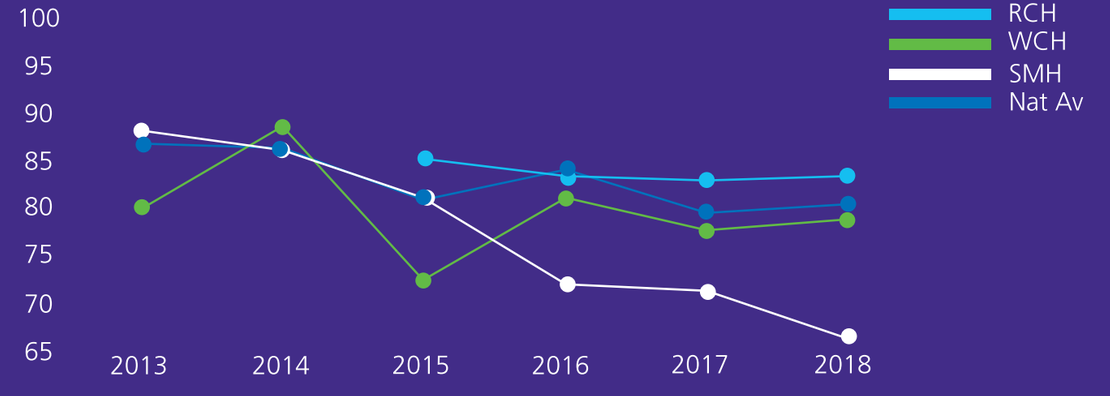


Environment Graphs

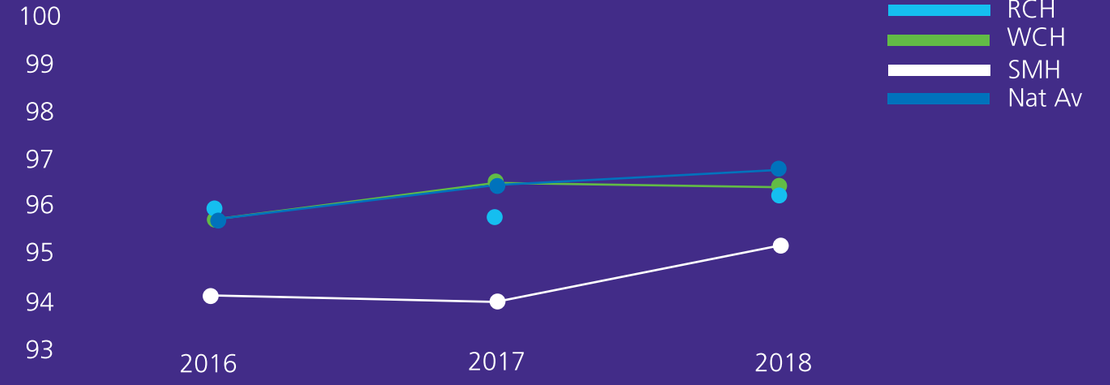
Condition & Appearance



Privacy & Dignity



Disability



Partnership: how we are working together to improve care and services

Through our local Sustainability and Transformation Plan, 'Shaping Our Future', we have been working with health and care system partners to redesign services to improve the way patients access care and to provide more services closer to home.

It is our aim to avoid admissions to hospital wherever possible and to get them home more quickly when then do. We want to play a part in maintaining people's independence, helping them to manage long term conditions and to prevent ill health wherever possible.

Working together with Addaction

Among the services we have developed over the past year are the partnership with Addaction and our Alcohol Liaison Team which is reducing the number of repeat admissions for people with alcohol addiction, and the Trusted Assessors for Care Homes who are working with local care providers to support residents through a hospital admission and get them back to their home more quickly.

We also looking to expand our virtual clinics and remote monitoring capabilities so that patients do have to make unnecessary trips to hospital and our specialists can concentrate their time on those who need it. In the coming year we will be looking to reduce the number of routine follow-up appointments, replacing these with other forms of support or open referrals, so that patients are empowered to take more control of their care.

LEAF programme

Our community dietetic team has been part of the LEAF programme (Lifestyle, Eating and Activity for Families 0-6 years) which is helping families to achieve healthier lifestyles and weight loss. Working in partnership with Cornwall Council through the Healthy Cornwall initiative the programme runs over 4 months and focusses on obesity in the 0-6 year old age group. It brings together the expertise of our dietitians, physical activity specialists and paediatricians to support families in changing habits, with longer term support provided by health visitors and school nurses.

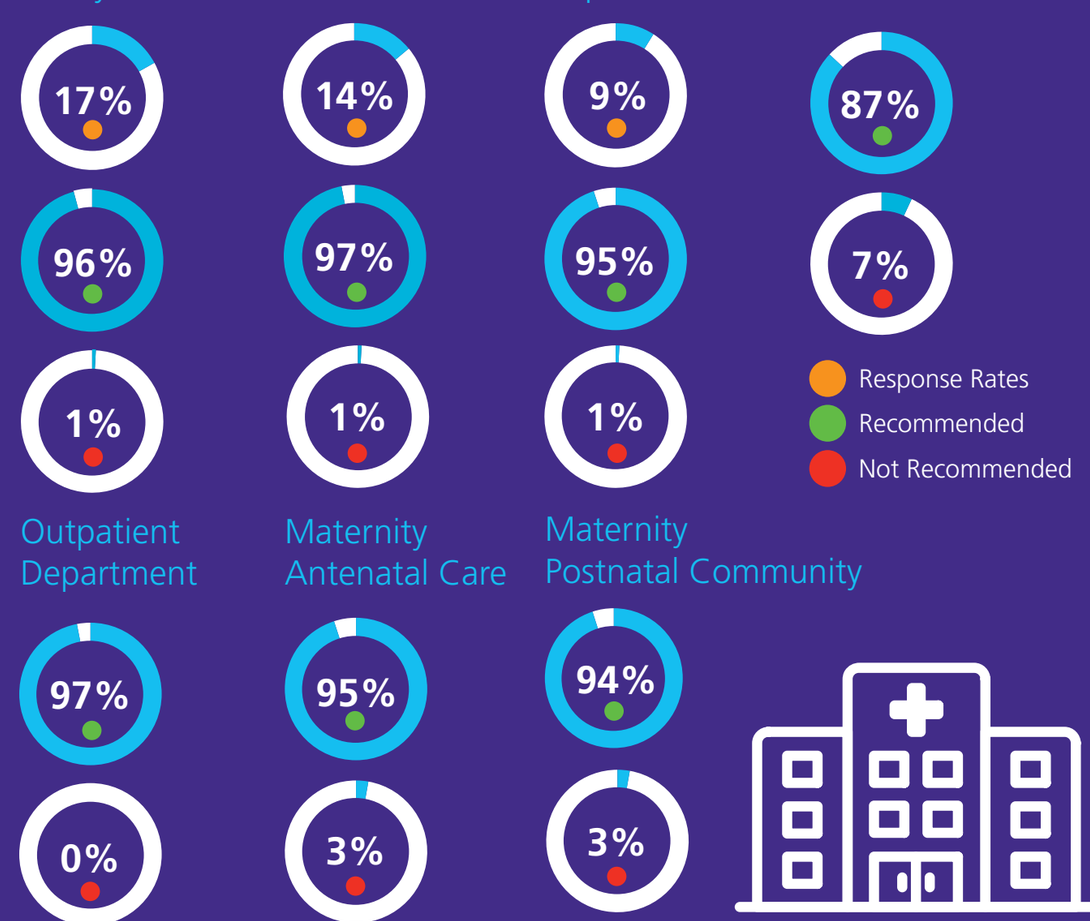
Maternity Voices

Our maternity team plays an active part in the local Maternity Voices Partnership (MVP), representing Cornwall and The Isles of Scilly. Part of the 'Better Birth's' national programme, the aim of the Kernow Maternity Voices Partnership is to ensure that all women and families have the opportunity to actively be involved in the evaluation of local maternity services and make them even safer, kinder, more personalised and family friendly.

The independent team of volunteers is working hard to put women, their partners and families at the heart of plans to transform maternity services before, during and after pregnancy by making sure the hard to reach voices are heard and communicated to health and care professionals.

Friends and Family Test

Over the last financial year there were an average **2,370** responses to the Friends and Family Test per month. The following numbers show the proportion of responses that would recommend or not recommend these services to a friend or family member.



Improving support for patients with mental health crises

Construction work has begun on a new modular hub that will see staff from our safeguarding service (adults, children and midwifery); psychiatric liaison; complex care and dementia; Addaction; Shelter; SEAP Advocacy; child and adolescent mental health in-reach and perinatal mental health teams based in a single location so they can provide prompt, joined up care for people who are vulnerable to, experiencing, or recovering from a mental health crisis.

Representatives from talking therapies, Outlook Southwest, police and CFT's home treatment teams will also be invited to use space within the hub. The £1.5 million investment has come from the Department of Health and Social Care Beyond Places of Safety initiative. The building is due to open in 2020.

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.

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-stars (Royal Cornwall Hospital) and 5-stars (St Michael's and West Cornwall hospitals) on the nhs.uk website.

Over the last year we have focussed our efforts on using 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 is aiding a more open approach and in many cases quickly resolving problems that might otherwise have become formal complaints. We are now one of the top users of Care Opinion in the country.

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 brilliant care. Over the last year we have received over 7,800 compliments.

We collect feedback in a variety of ways, increasingly through the national Care Opinion website, as well as the national Friends & Family Test, a summary of which is shown below.

Set against the context of more than 650,000 patient appointments and admissions, a total of 471 formal complaints were received in 2018/19, compared to 414 in 2017/18.

We aim to answer every issue raised in an open and honest manner and we will do everything that we can to try and achieve local resolution. However, if the complainant remains unhappy at the end of the local resolution process, they

Top 10 Sub-Subjects of Formal Complaints in 2018/19

Sub-subjects	2017/18	2018/19
Communication with patient	79 →	118 →
Communication with relatives/carers	73 →	100 →
Attitude of Medical Staff	59 →	53 →
Attitude of Registered Nursing Staff/Midwives	40 →	53 →
Care needs not adequately met	39 →	70 →
Discharge Arrangements (inc lack of or poor planning)	37 →	42 →
Inadequate pain management	33 →	54 →
Patient not listened to	29 →	24
Lack of clinical assessment	27 →	6 →
Delay or failure in treatment or procedure	24 →	39 →
Missed or incorrect diagnosis	15	44 →
Incorrect diagnosis	14	43 →

have the right to ask the Parliamentary and Health Service Ombudsman (PHSO) to conduct an independent review and the way the investigation has been handled.

The Trust's referrals to the PHSO have steadily decreased over the past 2 years, by a total of 75%. This demonstrates that, although more complainants appear to be requesting to re-open their complaint, the local resolution process as a whole is more successful.

In 2018/19, we received 5 final reports from the PHSO. Four were partly upheld, and one was not upheld. Details of the actions we have taken in response to complaints can be found in our Patient Experience Annual Report.

Equality and inclusion improvements for patients and the public

We have a duty to ensure all its processes, practices and outcomes are fair for both patients and staff. This is monitored by our lead for equality, diversity and inclusion, and through both local and statutory reporting.

We also recognise the importance of respecting and protecting the human rights of our patients, staff and members. This is a core element in staff training, when designing processes and within our communications and decision making.

Complaints Accepted by PHSO for Investigation

	2016/17	2017/18	2018/19
Complaints accepted by PHSO for investigation	16 →	6 →	4 →

We are committed to safeguarding all ourpatients, including the most vulnerable. We participate in our local, multiagency safeguarding boards and aim to safeguard vulnerable people through a partnership approach. Care and treatment is provided to all patients with their consent, and for patients who cannot consent to treatment, care is provided in their best interests in accordance with the Mental Capacity Act 2005.

A multi-faith spiritual care team is available to support patients and staff, and reflects the faiths and beliefs of our local population.

Work continues to improve accessibility and promote inclusion across our hospital sites with the introduction of a new fully accessible toilet and shower facility in the Tower Block building in Royal Cornwall Hospital, Truro. This facility also includes a new device called a Room Mate which supports people with sight loss to use the bathroom independently by giving an audio description of the layout of the room.

This device has also been installed in one of the public toilets within the Ophthalmology Department and one of the assisted toilets near the entrance to Trelawney, with a further device installed in one of the assisted toilets in St Michaels Hospital.

We have improved the collection of patients' equality data by explaining to staff the importance of knowing this information and how it can lead to service improvements. We have also provided information posters and literature for reception areas to explain to patients why providing this information will improve the service offered.

The Homeless Patient Advisor post has been jointly funded by Cornwall Housing, Cornwall Foundation Trust and RCHT for at least a further year. This post has greatly improved the health inequalities that exist for homeless people.

Working with our 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 benefit from the involvement number of young volunteers, a large proportion of whom use their experience to go on to study for careers in the health and care sector.

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.

There is no doubt that many of our projects to improve patient experience and staff working environments would not be possible without the input of our Leagues of Friends. Over the last year these have included the refurbishment of therapy facilities at West Cornwall Hospital and specialist equipment for the Emergency Department at the Royal Cornwall Hospital.

Our hospitals receive 4.5-star and 5 star ratings on nhs.nuk

Resources: Making the best use of our resources

It is our responsibility to deliver services within the resources available to us and our financial performance is covered in the annual accounts and governance statement sections of this report.

Building our facilities for the future
There are many demands on our capital programme and priorities.

Our Estates and Capital Projects team has worked hard throughout the year to deliver a wide range of projects to continue the maintenance and upgrade of our hospitals.

Within a limited budget they have brought more than x projects in on budget and on time, working closely with external contractors and at the same time enabling patient care and services to continue with minimal disruption.

Projects delivered during the year include:

- New side rooms and bathrooms at St Michael's Hospital
- Refurbished therapies unit at West Cornwall Hospital funded by the Friends of the West Cornwall Hospital
- Refurbishment of Pre-assessment Clinic facilities at St Michael's Hospital

Looking ahead, our hospitals are set to benefit from a £40 million investment from the Department of Health in key hospital and healthcare projects in Cornwall.

It signalled the go ahead for a new inpatient cancer ward to replace the existing Lowen Ward and MRI facilities at the Royal Cornwall Hospital, as well as improvements to the outpatients department at West Cornwall Hospital.

The investment will also make way for future plans to develop a much-needed new women's and children's unit at the Royal Cornwall Hospital.

Work has also started on the installation of a replacement CT scanner for our emergency department that will provide faster and better imaging.

Working together to transform care and services

Regionally, Shaping Our Future is the name of our Integrated Care System. Shaping Our Future brings together Cornwall's health and social care partners, to develop a shared vision and plan of how our system can be transformed to improve the outcomes for our patients.

Central to delivering this will be the development of 'out-of-hospital' care, which ensures care is delivered in a person's home wherever possible. The starting point for doing this is building a relationship with local people and communities.

To do this, we have developed seven Integrated Care Communities, where neighbouring GP practices work together to support their local population.

Raising the profile of the RCHT Charity

The RCHT Charity has an important role in boosting the resources available to us and has continued to build its profile over the last year.

As well as supporting community fundraising by individuals, groups and businesses, the charity team has coordinated a number of fundraising events involving our staff. The largest of these was the £70 Challenge which saw seven teams raise more than £40,000.

This year we have opened a new 'pod' unit for the charity in the main reception area at the Royal Cornwall Hospital which is helping to raise its profile with visitors and patients and is attracting a steady flow of impulse donations.

More information on the RCHT Charity can be found on our website and in the Charity's annual report.

Caring for our environment

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 we 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 was completed in 2018. It includes a combined heat and power plant, new generators, bio-mass boilers, LED lighting and solar PV. Together these have allowed us to meet our 2020 target to reduce carbon emissions two years early.

Working with Mitie we are developing a Waste Strategy to increase recycling, reduce the amount of plastic waste and single-use items, and increase the use of reusable products where appropriate.

Among the changes we have made this year are: a move to recyclable food containers in our restaurants; new recycling points across our hospitals; and in response to a staff idea, introducing a recycling scheme for crisp packets.

RCHT has a carbon management and reduction strategy which set outs to achieve a 34% reduction in carbon emissions by 2020.

In 2015 we 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 was completed in 2018.

Energy Use

Resource		2015-16	2016-17	2017-18	2018-19
Gas	Use (kWh)	24,455,258	25,045,387	26,398,315	31,211,806
	tCO2e	4,501.479	4,599.460	4,852.27	5,731.11
Electricity	Use (kWh)	17,392,962	16,691,415	16,263,724	12,118,418
	tCO2e	8,633.170	7,454.719	6,203.96	3,693.94
Green Electricity Generated	Use (kWh)	16,423	11,996	19,111	25,405
	tCO2e	- 7.529	- 4.913	-6.666	-7.135
Total energy CO2e		13,134.649	12,054.179	11,056.23	12,054.179
Total energy spend		£2,654,524	£2,417,061	£2,868,842	£2,417,061
Combined Heat & Power Unit (CHP) Produced Electricity					2,425,834

Water Use

		2015-16	2016-17	2017-18	2018-19
Mains	m3	152,609	154,840	151,383	164,811
Water and sewage spend		£589,545.29	£606,928.31	£587,923.28	676,081

Waste

		2015-16	2016-17	2017-18	2018-19
Recycling	(tonnes)	388.939	361.178	503.74	322
WEEE	(tonnes)	6.577	4.926	2.72	5
High temp disposal	(tonnes)	733.62	752.752	766.61	814
Non-burn disposal**	(tonnes)	1063.408	976.916	967.52	938
Total waste (tonnes)		2192.544	2095.772	2240.59	
% of recycled or re-used		18	17	22	16

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

2.

Accountability Report

Director's Report and Governance Statements

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 2018/19.

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 2019, Royal Cornwall Hospitals NHS Trust complied with all relevant provisions of the Code of Governance.

Trust Board members as at 31 March 2019

Kate Shields – Chief Executive

Kate joined the Trust as Deputy Chief Executive in 2017 and took on the role of Chief Executive in July 2018. Kate is an experienced NHS leader having worked as Director of Strategy and Partnerships at University Hospitals Leicester. She was a registered nurse and mental health nurse at the beginning of her NHS career. Kate also worked for NHS England as a Regional Director of Specialised Commissioning and as National Head of Specialised Commissioning.

Dr Rob Parry – Interim Medical Director

Rob re-joined the Trust Board as interim Medical Director in February 2019. Rob has worked at RCHT since 2000 and has played a key part in a host of developments within the renal service. Alongside that he has carried out a number of roles involving strategy development, implementation and working across multi-disciplinary teams. These include having been Renal Departmental Lead, over four years as Clinical Director for Acute Medicine, and five years as Renal Network Clinical Director for the Peninsula. Rob has also led Trust work on organ donation, clinical coding and appraisal.

Kim O'Keeffe – Director of Nursing, Midwifery & Allied Health Professions

Kim is a passionate, experienced and highly visible professional leader, with extensive strategic and operational experience at a senior management level, gained in health care systems in the United Kingdom and South Africa. She started general nurse training at Addington Hospital in Durban, South Africa in 1981 and went on to complete her mental health training at Townhill Hospital in Pietermarizberg, Natal. Kim returned to the UK in 1999 where she undertook various roles within the Dudley Group of Hospitals and went on to complete her MSc Professional Health Care Studies at Wolverhampton University in 2006.

Kerry Eldridge – Director of People & Organisational Development

Kerry joined RCHT in September 2018. Kerry is an experienced NHS leader and was previously the Director of Workforce for East and North Hertfordshire NHS Trust. Kerry has experience in organisational change, staff engagement, quality and financial transformation. She joined the NHS in 2001 and has worked in a variety of HR roles within different NHS providers including acute, health and social care partnership, community, commissioning and mental health trusts.

Thomas Lafferty – Director of Strategy & Performance

Thomas joined the Trust in January 2017 having most recently 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.

Sally May – Joint Director of Finance

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 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 Cornwall Partnership Foundation NHS Trust since 2011 and was previously Director of Finance at NHS Cornwall & Isles of Scilly.

Susan Bracefield – Director of Operations

Susan took on the role of interim Director of Operations in February 2019 and was appointed substantively in April 2019. She was formerly the Deputy Director of Operations, having joined RCHT in March 2018. A nurse by background, Susan has broad experience of leadership roles in primary and secondary care providers as well as with NHS England.

Bernadette George – Director of Integrated Governance

Bernadette joined RCHT in June 2018 having previously been Head of Safety Risk and Patient Experience at Royal Devon & Exeter NHS Foundation Trust. She was instrumental in the development of RCHT's ward accreditation programme – ASPIRE – and brings extensive experience of working in the hospital and health care industry, including change management, quality improvement, patient safety and performance management.

Brian Courtney – Interim Company Secretary

Brian joined RCHT in September 2018 bringing expertise in corporate governance and corporate affairs from many years of working in different healthcare sector across the country.

Non-Executive Directors

Dr Mairi McLean – Chairwoman

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.

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.

Ruth Allarton – Associate Non-Executive Director

Ruth joined the RCHT Board in October 2018. Having been a regular visitor to Cornwall all her life, Ruth Allerton has held roles as Head of Department of Allied Health Professions at Sheffield Hallam University since 2009 and Partner Governor at Doncaster and Bassetlaw Teaching Hospital Foundation Trust since 2012. More recently Ruth held an Associate Non-Executive role where she has used her allied health professions knowledge to bring an additional perspective to decision making and strategic planning.

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 a trustee at Cornwall Air Ambulance Trust and owns her own consultancy company specialising in leadership and organisational development.

Dr Gillian Vivian – Non-Executive Director

Gillian joined RCHT as a Non-Executive Director in October 2018. Dr Vivian is familiar with the Royal Cornwall Hospitals having previously worked in Cornwall as a consultant radiologist in nuclear medicine. mAn internationally recognised specialist in her field, Dr Vivian has lived in Cornwall since 1982 and has held clinical and leadership roles within the South West Peninsula and at Kings College Hospital, London. Dr Vivian has contributed to national training, research and innovation projects and has successfully delivered a range of service improvement programmes.

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 also Chair of the Methodist Ministers' Housing Society and is a governor of Truro and Penwith College where he chairs the Finance and General Purposes Committee.

Rob Leighfield – Associate Non-Executive Director

Rob joined RCHT in October 2018. He is a senior executive with 17 years' experience, including operating at board level in a variety of regulated roles within large, complex organisations in the UK and overseas. He has considerable experience of leading cultural change and effective engagement to improve ways of working and employee satisfaction, achieving Investors in People "Gold" accreditation.

Richard Smith – Associate Non-Executive Director

Richard joined the Board as an in March 2019. He is inaugural Deputy Pro-Vice Chancellor for the University of Exeter Medical School, and Professor of Health Economics. He was previously at the London School of Hygiene and Tropical Medicine, where he served as Head of the Department of Global Health & Development from 2008-2011, and as Dean of the Faculty of Public Health & Policy from 2011-2018.

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.

'We are committed to effective, representative and comprehensive governance'

Annual Governance Statement

The following Governance Statement sets out the particular circumstances in which the Trust operated during 2018/19.

Scope of responsibility

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

I am also responsible for ensuring that the NHS trust is administered prudently and economically and that resources are applied efficiently and effectively. I also acknowledge my responsibilities as set out in the NHS Trust Accountable Officer Memorandum.

The Trust is part of a local health economy and national health system. In recognition, the Trust's planning and key objectives reflect the strong focus that is now placed on improved and expanded integrated and partnership working through the Sustainability & Transformation Plan, locally named 'Shaping our Future'.

The Trust is accountable to NHS Improvement (NHSI) for performance and regulation control and oversight. Under the auspices of the Provider Accountability Framework, NHSI holds a range of meetings with the Chief Executive and Executive Directors, where generic and health system wide issues of performance and control are discussed, reviewed and actions agreed.

The Trust also has regular meetings with senior officers, patients and other interested parties across the local health community.

These include:

- Monthly System Oversight Meeting (SOM) reporting to NHSI on operational and financial performance and governance issues, with further meetings at regional and national level;
- Monthly performance meetings with NHS Kernow (also known as Kernow Clinical Commissioning Group, KCCG) and periodic meetings with NHS England in its role as a direct commissioner
- Joint meetings with other health service providers, including Cornwall Council and Cornwall Partnership NHS Foundation Trust
- Regular meetings with service users' representative groups, including Healthwatch, Citizens' Advisory Group and numerous patient groups throughout the Trust
- Regular attendance at health and social care scrutiny committee meetings

The Board of Directors and Committees

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.

The Trust is also the sole corporate trustee of Royal Cornwall Hospitals NHS Trust Charitable Fund and, through its Charitable Funds Committee, ensures that effective structures and systems are in place to manage those

charitable funds in accordance with statutory and other legal requirements and best practice as required by the Charity Commission. Critical responsibilities relating to governance are set out below:

Audit & Risk Assurance Committee has oversight responsibilities and, where appropriate, facilitates and supports the attainment of effective processes. It oversees the risk management system of the Trust. 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; 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
- 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 Quality Assurance Committee is responsible for assuring the Board about quality, safety, patient experience and the Trust's registration with the Care Quality Commission. The Committee's focus includes:

- Providing assurance that the Board has an effective strategy for improving the quality and safety of care patients receive and 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 the Care Quality Commission action plan
- Approving the annual Clinical Audit Plan, ensuring alignment with Trust priorities and risk areas
- Approving, and monitoring the delivery of action plans arising from review and investigation reports and the work of external regulators
- Seeking assurance for principal risks, and those above agreed tolerance levels, in relation to quality, patient safety and compliance risk domains, as well as risks managed by sub committees that have exceeded their tolerance for more than six months
- Providing assurance to the Board that risks arising from major changes to services or pathways managed by the Trust, including those arising from system wide developments, are managed in a way which ensures the on-going delivery of safe care to patients.

‘We are working to ensure our workforce is fit for purpose, flexible and affordable’

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 on-going 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
- Inclusion

The Finance and Performance 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
- Commercial and business development

During 2018/2019 Executive responsibility for integrated governance transferred from the Medical Director to the Director of Nursing, Midwifery and Allied Health Care Professionals with the post of Director of Integrated Governance developed to strengthen governance arrangements in the organisation. Also during 2018/19 the Trust reviewed and revised the structure of management committees.

Whilst not formal Board of Directors sub-committees, these management committees have 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 management committee structure is as follows:

The Executive Board (EB) has representation from Executive Directors and Clinical Directors from each of the seven care groups.

- ➔ Executive Meetings – weekly meetings of the executive team;
- ➔ Executive Board - meets fortnightly, alternatively dealing with quality & safety and finance, performance and people. The Executive Board membership includes the Chief Executive (chair), executive team and the eight clinical directors; and
- ➔ Operational Board – chaired by the Director of Operations (formerly the Chief Operations Officer) with the membership comprising the leadership team of the eight care groups – Clinical Director, Head of Nursing, and General Manager

The Board of Directors met a total of thirteen times in public in 2018/19, including the Annual General Meeting (AGM), in every calendar month.

All meetings of the Board of Directors were quorate.

Membership of the Board from 1 April 2018 to the date of approval of the Annual Report was as follows:

Board Member	Position	Period
Executive Directors		
Kate Shields	Chief Executive	1 February 2019 to date
	Interim Chief Executive	July 2018 to 1 February 2019
	Deputy Chief Executive	October 2017 to July 2018
Kathy Byrne	Chief Executive	April 2016 to July 2018
Sally May	Director of Finance	May 2016 - to date
Kerry Eldridge	Director of Human Resources and OD	30 August 2018 - to date
Catrin Asbrey	Director of Human Resources and OD	December 2016 to June 2018
Thomas Lafferty	Director of Strategy and Performance	10 September 2018 – to date
	Director of Corporate Affairs	January 2017 to 10 Sept2018
Ethna McCarthy	Director of Strategy and Performance	1 May 2013 – 1 July 2018
Kim O'Keefe	Director of Nursing, Midwifery & Allied Health Professionals	1 May 2017 – to date
Mark Daly	Medical Director	14 January 2018 – February 2019
	Interim Medical Director	October 2017 – January 2018
Rob Parry	Interim Medical Director	1/02/2019 – to date
Phil Orwin	Interim Chief Operating Officer	September 2018 – 31/01/2019
Rab McEwan	Interim Chief Operating Officer	August 2017 to September 2018
Bernadette George	Interim Director of Integrated Governance	1 October 2018 – to date
Susan Bracefield	Interim Director of Operations	01/02/2019 – to date
Kelvyn Hipperson	Chief Information Officer	02/01/2019 – to date

Accountability Report

Non-Executive Directors		
Mairi Mclean	Chairwoman	January 2019 – to date
	Interim Chairwoman	May 2018 to January 2019
	Non-Executive Director	January 2014 – May 2018
Jim McKenna	Chair	30 January 2017 – April 2018
Dr John Lander	Non-Executive Director	1 November 2016 - to date
Paul Hobson	Non-Executive Director	15 January 2016 - to date
Margaret Schwarz	Non-Executive Director	1 November 2016 to date
Sarah Pryce	Non-Executive Director	06 May 2016 – to date
Gillian Vivien	Non-Executive Director	1 October 2018 – to date
Charlotte Russell	Non-Executive Director	31 October 2013 – 20 April 2018
Non-Executive Directors		
Rob Leighfield	Associate Non-Executive Director	1 October 2018– to date
Ruth Allarton	Associate Non-Executive Director	2 January 2019 – to date
Richard Smith	Associate Non-Executive Director	1 March 2019 – to date

The Board's effectiveness is regularly assessed, by a self-assessment exercise or an independent external review, leading to the development of action plans where necessary.

A number of processes are in place to ensure the quality of waiting time data. These include weekly validation

Board members' attendance at Board and committee meetings is summarised in **Appendix 1**. It should be noted that not all Directors were eligible for attendance at all meetings due to effective date of employment.

Each Committee presents an annual report to the Board, so that it may review committee effectiveness and impact. Throughout the year, the Board also receives monthly assurance reports, highlighting the key items discussed by each committee. Directors are required to adhere to the highest standards of conduct in the performance of their duties. In respect of their interaction with others, the Board operates under an explicit Code of Conduct which is compliant with the NHS Code of Governance.

The Board is required to agree and adhere to the commitments set out in the Code of Conduct, which includes the principles set out by the Nolan Committee on Standards in Public Life. Once appointed, Board members are required to sign a declaration to confirm that they will comply with the Code in all respects.

The Board's effectiveness is regularly assessed, by a self-assessment exercise or an independent external review, leading to the development of action plans where necessary. All Board members receive an annual appraisal review. The Trust also appoints Associate Non-Executive Directors, where appropriate, to supplement skills and experience whilst the Board is maturing, and to support succession planning.

The purpose of the system of internal control

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

Capacity to handle risk

The Trust's Risk Management Strategy states that the Chief Executive is ultimately responsible for effective risk management within the Trust. At Director level, the Director Integrated Governance is responsible for the Corporate Risk Register and oversees the Board Assurance Framework process. However, day to day responsibility for operational risk management is delegated to senior managers throughout the Trust.

Delivery against these responsibilities is scrutinised by the Trust's Executive and Non-Executive Directors through meetings of the Board and its sub-committees; namely, the Audit & Risk Assurance Committee, Quality Assurance Committee, People and Organisational Development Committee and the Finance and Performance Committee.

Reports from these committees are reviewed in the public part of Board meetings. The work of the committees and the decisions of the Board provide evidence of on-going efforts to ensure the overall governance, risk management and clinical governance systems are working in the way they have been designed to operate.

The risk and control 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 (BAF), the Corporate Risk Register 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 Board.

The Trust was subject to a Care Quality Commission comprehensive inspection visit, "Well-Led" review and also an NHS Improvement "Use of Resources" assessment in September 2018.

The resulting report, published in December 2018, rated the Trust overall as "requiring improvement", however on the rating "are services Well-Led" the rating remained "inadequate".

This rating was based upon the following statement "We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services.

We rated other key questions by combining the service ratings and using our professional judgement."

The Trust is committed to having a risk management approach that underpins and supports the business of the Trust and demonstrates an ongoing commitment to improving the safety culture of the organisation.

Risk management is the systematic method of identifying, analysing, managing, monitoring and reviewing of risks in order to ensure achievement of the Trusts objectives.

The purpose of the Trust's Risk Management Strategy is to provide a framework which supports the incorporation of risk management as an integral part of improving care and supporting strategic/operational decision-making.

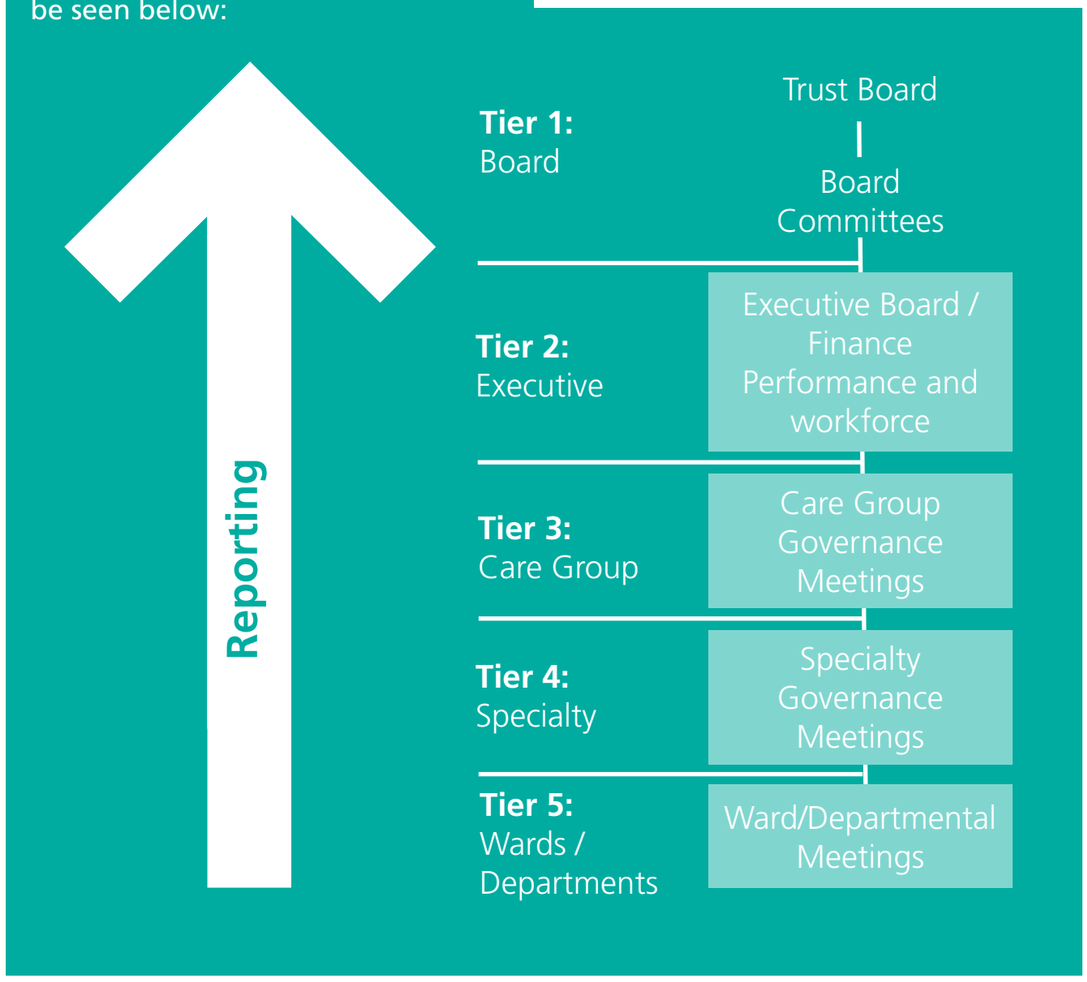
The identification of risks broadly falls into two categories: proactive and reactive identification.

Risks may be identified proactively through local risk assessment, compliance with national standards or regulatory frameworks (e.g.

Care Quality Commission Key Lines of Enquiry whereas the reactive process identifies risks from events that have already occurred such as incidents, complaints and claims.

Once a potential risk has been identified, this would be entered on the Trust's Datix system, a risk assessment will be carried out to assess the level of risk. It is vital that all risks are assessed in an objective and consistent manner.

There are different levels (or 'tiers') of governing risk within the Trust. Responsibilities within each tier can be seen below:



The NPSA risk matrix – a 5 x 5 calculation involving an assessment of risk consequence and likelihood- must be used to score risks:

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

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency - How often might it / does happen	This will probably never happen / recur	Do not expect it to happen / recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen / recur but it is not a persisting issue	Will undoubtedly happen / recur, possible frequency
Frequency - timeframe	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected	Expected to occur at least daily
Probability - Will it happen or not?	<0.1%	0.1 - 1.0%	1 - 10%	10 - 50%	>50%

Descriptors to guide staff on how to assess risk consequence (covering financial, quality, workforce, and operational risk descriptors) are also available as part of the Trusts Risk Management Strategy. The Trust's Risk Register is populated from risk assessments undertaken which are recorded on the trusts Risk Management System - Datix (assuming that the risk identified cannot be immediately resolved. Risks are reviewed on a basis proportionate to the current risk rating:

Risk Rating	Review Frequency
'Red' risks (risks that score 15 or above)	Monthly
'Amber' risks (risks that score between 8 and 12)	Quarterly
'Yellow' risks (risks that score between 4 and 6)	Six monthly
'Green' risks (risks that score between 1 and 3)	Annually

Risks are accepted onto the Trust's Risk Register when all reasonable mitigating actions have been carried out and the risk cannot be practically reduced any further. During 2018/19 the Board of Directors have received training on risk management, risk scoring and have agreed a risk appetite for the Trust. In relation to staff throughout the organisation on-going training is undertaken, and risk registers at Care Group level are reviewed on a monthly basis.

Board Assurance Framework

The Trust's Board Assurance Framework (BAF) identifies the principal risks to achievement of the Trust's strategic objectives, the components of the system of internal control in place to manage the risk and assurance about the effectiveness of those controls. In August 2018 work was undertaken with the Trust Board to fully revise the approach used to record and report the BAF, the Trust moved to a single page more detailed format for each of the principal risks.

As part of these development sessions the Trust's risk appetite was discussed at length and the Trust's Risk Appetite Statement was updated and approved by the Trust Board in October 2018.

The updated statement describes the appropriate exposure to risk the Trust would accept in order to deliver its strategy and the statement also reflected the Trust's new risk management strategy.

In summary The Trust has a measured approach to risk; but will support well managed risk taking whilst developing the skills ability and knowledge necessary to support innovation and maximise opportunities to further improve patient services and quality outcomes; The Trust will also take considered risks, where the long-term benefits outweigh any short-term concerns on a risk by risk basis; linked to organisational priorities

Major Risks

The Principal Risks to achieving the Trust's Objectives and Strategic aims have been identified and scored in line with the Trusts Risk Management Strategy and are included with the Board Assurance Framework. The key risks facing the Trust, as included in the BAF, are summarised in **Appendix 2**.

Quality Governance Arrangements

The Trust Board is clear that patient safety and the delivery of high quality clinical services are 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:

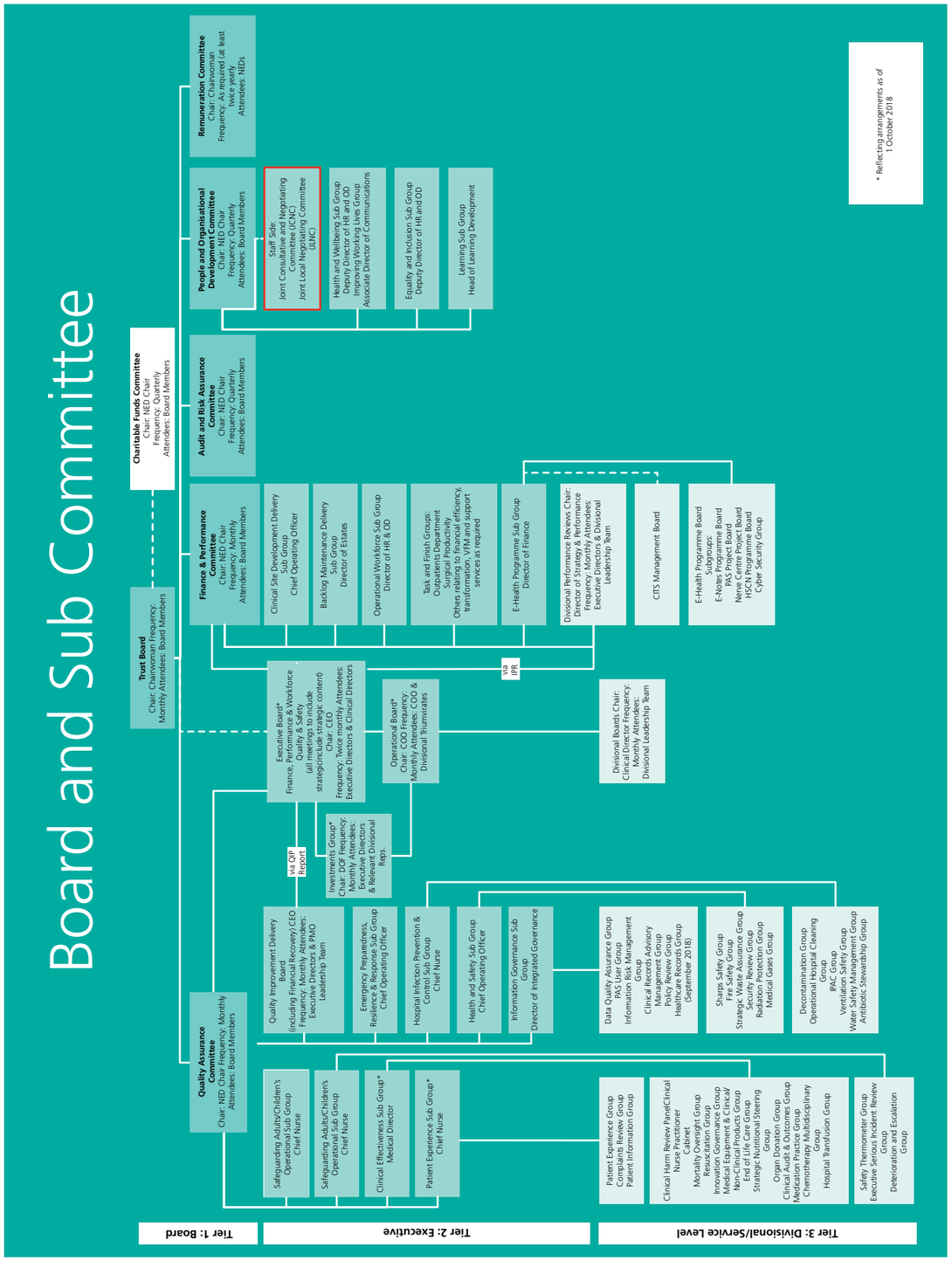
- Quality performance (via the Integrated Performance Report) across a wide range of KPIs pertinent to patient safety, clinical effectiveness and the patient experience;
- Incidents;
- Risk;
- Safe Staffing;
- Quality Improvement (reports from the Quality Improvement Delivery Board)
- Ward to Board Framework
- ASPIRE Ward Accreditation System

The Quality Assurance Committee as outlined earlier is a formal Board Committee which assists 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.

In addition to the duties specified earlier the Committee provides 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 of December 2017, the Trust 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.

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.

A number of processes are in place to ensure the quality of waiting time data. 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. Completed pathways in excess of 18 weeks are also validated both weekly and monthly.

An audit programme delivered by the Access Team enables detailed, objective scrutiny of waiting list management to provide assurance regarding the application of the Access Policy. The Access Policy has been externally reviewed with no identified actions required, and is in date.

Accountability Report

There are two inherent risks to the quality and accuracy of elective waiting times, which are common across many trusts. The first is the holding of waiting time information across a variety of clinical administrative systems, which could result in inaccurate waiting time data if not linked together robustly.

The second is the risk of human error in administering such systems. The outcome of each could be both under-recording and over-recording of pathway lengths. A number of provisions are in place to mitigate these risks, such as electronic processing of waiting time data, data quality reporting and the validation and audit processes described earlier. Any waiting list / time management errors are reported in accordance with the Trust's incident management procedure.

Previous the Trust has indicated an intention to move referral to treatment (RTT) processing to a more robust process of daily reporting underpinned within the Trust's data warehouse rather than a weekly report. This has now been completed leading to improvement in the timely availability of data. Further process improvements are anticipated when the Trust's Patient Administration System is replaced.

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. The Data Quality Policy was reviewed in 2016-17 and underpins the Records, Information and Data Quality Strategy.

CQC Compliance assurance – in order to ensure progress is made against the recommendations identified by the CQC in the September 2018 inspections, the Trusts has developed a detailed integrated CQC action plan, each action having both an operational and an executive lead, progress against the action plan is scrutinised fortnightly at an executive led group.

Risks to data security are managed through adhering to the Trust's risk management process. Risks to data security are logged on the Trust's incident and risk management tool Datix, this includes the current level of risk and residual risk once mitigating actions are taken.

The risks are reported to and managed through several groups (topic appropriate), these include:

- ➔ Information Risk Management Group
- ➔ Cyber Security Group
- ➔ Information Governance Group
- ➔ Quality and Risk Group

The Trust's approach to managing risks to data security form part of the Data Security & Protection Toolkit submission. The main elements cover:

- ➔ Managing default password settings
- ➔ Penetration testing for vulnerabilities
- ➔ Creation of a data security action plan
- ➔ Creating as strategy for security updates.

The Trust is predicting compliance against all assertions within the Data Security & Protection Toolkit.

The Trust receives weekly and urgent threat warnings from CareCERT, these are monitored by the Trust's IT Security Manager who provides a report to the Head of Information Governance who is the Cyber Security link to the Trust.

Visual checks of the how physical records are managed along with compliance with IT equipment is conducted monthly as part of a planned walkthrough for the three main hospital sites, this is reported to the Information Governance Group.

In relation to compliance with the NHS provider licence condition 4 the Trust has an action plan in place, as described above, to improve compliance with the Well-Led framework. This included:

- A thorough review of the Trust's governance structures was undertaken, which encompassed reporting lines and accountabilities between the board, its subcommittees, committees reporting into sub-committees and the executive team. This included a re-assessment of the responsibilities of individual directors and the Terms of reference of Board sub-committees;
- The changes were aimed at making the governance structures more robust and effective;
- the Board reviews the Board Assurance Framework on a monthly basis based on timely and accurate information to assess risks to compliance; and
- The Board has detailed oversight of the Trust's performance through its monthly review of the Integrated Performance report, which contains the detailed position on: quality and safety; operational performance; finance; our people (workforce) and partnership.

Workforce

The Trust's workforce performance relates to standards set both nationally and locally, which are reviewed through a combination of:

- Regular monthly performance management meetings between members of the executive team and each care group
- Exception reporting via the Trust's executive board, which meets fortnightly
- Bi-monthly via the Board's People and Organisational Development Committee, as well as through the committee's bi-monthly report to the Trust Board
- Monthly via the Trust Board's Finance and Performance Committee, as well as through the committee's monthly report to the Trust Board
- Monthly via the Trust Board's via the integrated performance review (IPR) which is presented at all monthly Board committees and covers all of the Trust's current workforce key performance indicators
- Monthly via the Trust Board's Quality Assurance Committee
- Safe staffing processes:
  - evidence-based tools (where they exist)
  - professional judgement
  - outcomes.
- performance management processes, which complement quality outcomes, operational and finance performance measures.

The main workforce priorities for the Trust during the year were to:

- Strengthen the Trust's capacity and capability for strategic workforce planning;
- Ensure effective management of the workforce;
- Enable the health and well-being of the Trust's workforce;
- Ensure policies and procedures, developed in partnership with staff side, are in place to support the workforce and management of staff.

In order to deliver the workforce priorities, the following main themes were identified:

Workforce Planning

Robust workforce planning takes place to help support the future challenges facing the NHS and to also assist in completing the annual workforce plans for Health Education South West and NHS Improvement.

The focus for the year ahead of workforce (people) transformation, reviewing skills and competencies and looking at new roles to combat the national occupational shortages. This workforce redesign work will include new models of care and patient pathways which supports the system wide that has started in 2018/19.

Medical Resourcing

The main challenge for Medical Resourcing in the Trust is to attract good quality medical staff given national shortages. This was hampered by Immigration rules which saw the restriction of Certificates of Sponsorship for Core Trainee level doctors recruited from outside the European Union (EU).

Workforce Transformation

The focus was to ensure workforce implications of planned service expansions were appropriately implemented. There was continued support to address challenges of the current and future NHS which require new ways of working and innovative workforce strategies and practices to create a flexible workforce.

This included a number of projects to restructure departments, review skill mix, shift patterns and extend working hours/weeks to meet changing demands in the provision of patient care.

Workforce Operations

There was a continued focus on achieving Key Performance Indicators (KPI) and working with department managers and Staff Side to reduce the length of time taken to conclude disciplinary and grievance cases. Sickness absence rates increased in 2018/19, and work continued to drive this down, and further staff wellbeing developments.

Leadership passport training and was delivered to managers across the Trust to ensure that they have the necessary leadership skills to support the workforce.

Workforce Governance

Robust workforce governance systems continued to be utilised and embedded to ensure the Trust's compliance with legislative requirements and best practice.

Further progress was made in 2018/19 in developing an inclusive workforce and working environment with a continued focus going forward still required. The Trust published its diversity data and progress on equality initiatives in line with the Equality Delivery System and its duties under the Equality Act 2010 including the reporting of the Trust's Gender Pay Gap. The Staff Survey results were analysed, reported on and action plans developed.

There are some significant workforce issues that the Trust is facing currently in an uncertain and shifting political and economic climate. However, the Board can be assured that a number of work streams are ongoing in order to mitigate any risk to patients, staff or the Trust.

There are also many opportunities that can be maximised, with the strong foundation of a stable workforce that is highly committed, well-motivated and well managed with supportive, kind and compassionate leadership. For the coming year and beyond it is essential that standards are consistently applied across the entirety of the hospitals and work areas within the Trust.

The Trust has published an up-to-date register of interests for decision-making staff within the past twelve months, as required by the ‘Managing Conflicts of Interest in the NHS’ guidance. The register is reviewed annually with decision makers being asked to declare any interests.

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.

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

Head of Internal Audit Opinion – risks and gaps in control

Internal Audit is a key source of assurance on the sound operation of the Trust’s system of internal control. The independent Head of Internal Audit Opinion for 2017-18 provided ‘limited assurance’. During 2018/19, assurances were assessed by Internal Audit under the following three broad categories:

- Assurance Framework – Corporate Governance and Risk Management, which included:
  - Risk Management & Board Assurance Framework Desktop review;
  - Response to CQC Report 2018; and
  - Duty of Candour 2018
- Financial Assurance, which included:
  - Financial Savings Programme;
  - Local Financial Systems;
  - Payroll Function;
  - Payroll – Trust Management of Information;
  - Research and Development Income Review; and
  - Enhanced Financial Controls Review 2018
- Corporate Assurance, including:
  - eHealth – Use of Nervecentre (eObs) (Draft);
  - Patient Experience – End of Life Care;
  - Infection Control (Draft);
  - Review of Multi-Disciplinary Effectiveness and Governance;
  - Mitie Contract Follow Up Review;
  - Contract Management Review; and
  - Safeguarding Adults and Children

Risks identified through working with external stakeholders

The Trust works with a range of stakeholders to identify and manage risks. For its key clinical services contracts, the Trust is performance managed by NHS Kernow for clinical commissioning group services and by NHS England for specialised services. This includes regular contract review meetings covering quality and operational performance, such as patient ‘access’ times and contract

finance. Detailed monitoring and analysis of the contract is undertaken through the formal contract management arrangements agreed between the Trust and commissioners. These mechanisms are key to ensuring contract performance and related risks are effectively managed through the performance process.

The Trust, in its accountability to NHS Improvement (NHSI), is part of a wider system of external risk assessment and management with regard to all aspects of its operations. The Trust's Executive attend monthly meetings with senior officers from NHSI.

The Trust also engages more widely with other national and local stakeholders, 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.

Compliance with other regulators and regulations

The Trust has robust arrangements in place to discharge its statutory functions and ensure they are legally compliant. In particular: Compliance with the Care Quality Commission's essential standards of quality and safety

All health and adult social care providers have needed to be registered and licensed with the Care Quality Commission (CQC), the independent regulator of health and social care in England. On the 1 April 2015 the CQC replaced in its entirety CQC's Guidance about Compliance: Essential standards of quality and safety and its 28 outcomes with two groups of regulations:

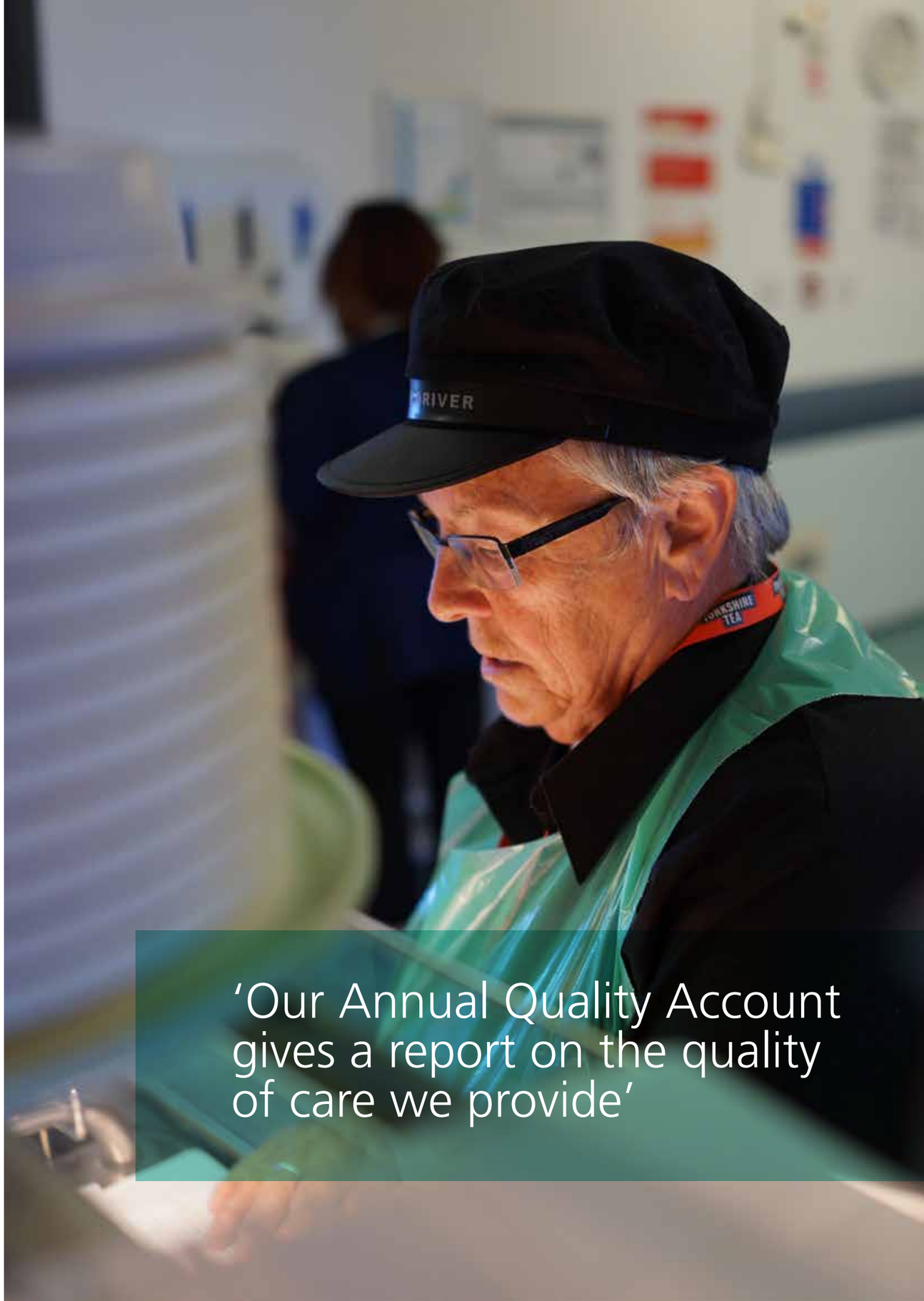
- ➔ Health and Social Care Act 2008 (Regulated Activities) Regulations 2014
- ➔ Care Quality Commission (Registration) Regulations 2009 (Part 4)

The regulations include fundamental standards to be met by registered providers. The CQC monitor, inspect and regulate services to make sure they meet fundamental standards of quality and safety.

The Trust is not fully compliant with the regulations that underpin its registration with the CQC. As at the end of 2018/19, the Trust was rated as 'requires improvement' overall by the CQC, and was not meeting all of the legal requirements as set out in the Regulations.

The CQC undertook an unannounced inspection on 26-27 June 2018 to inspect against the requirements in the Warning Notice issued under Section 29A of the Health and Social Care Act 2008 1 March 2018. The inspection focused solely on the issues identified in the warning notice where significant improvement was required in Surgery, Critical Care, Maternity, Outpatients and diagnostic imaging (Fracture clinic), and Governance (Trust-wide).

During this inspection the CQC found the Trust had made significant improvements against the requirements in the warning notice and had fully met the requirements in Surgery, Maternity and Outpatients. The CQC noted that further work was required in Critical Care and Trust-wide with Governance, but that where requirements had not been fully met, improvements had been made and comprehensive plans were in place to ensure ongoing and sustainable improvement.



'Our Annual Quality Account gives a report on the quality of care we provide'

The CQC carried out a comprehensive inspection was carried out between the 4-27 September 2018 which included a Well-led and Use of Resources assessment. The final outcome of the CQC inspection was published on 14 December 2018.

Overall, the Trust rating improved from 'inadequate' to 'requires improvement', with Royal Cornwall Hospital rated as 'requires improvement', West Cornwall Hospital as 'good', and St Michael's Hospital as 'good'. The CQC rated the Trust on being safe, effective and responsive as 'requires improvement' well-led as 'inadequate', and on being caring as 'good' overall.

The inspection report identified the legal requirements that the Trust was not meeting in relation to the regulations. This resulted in 166 identified areas for improvement - 50 must-do and 116 should-do actions. An action plan in response to these areas for improvement was developed and submitted to the CQC on 29 January 2019.

In 2017 the Trust established an 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 CQC inspection reports. The Group is responsible for oversight and monitoring of the latest CQC action plan to ensure that the Trust is able to demonstrate and sustain improvements.

The Quality Improvement Programme continues within the Trust, including a Strong Governance workstream which oversees the CQC compliance elements of the Strong Governance project plan. The key elements of the project plan include initiating a more proactive self-assessment approach against the CQC Key Lines of Enquiry, anticipated to commence in 2019.

National priorities from NHS Improvement's "Single Oversight Framework"

The Trust has taken account of the NHSI Single Oversight Framework in its internal management and Board reporting arrangements. Key metrics from the Single Oversight Framework are reported to the Board monthly through the Integrated Performance Report (IPR). The Trust is in segment 4 currently, as it remains in quality special measures.

In terms of the elements of the Single Oversight Framework which relate to operational performance and which could otherwise trigger a concern, performance on ED has improved this year but remains below the 95% standard overall, at 93.0% for the year (compared with 87.7% last year).

The Trust continues to work with partners across the system to mitigate and address the root causes adversely affecting its performance, including demand growth (of around 5.3% in emergency arrivals in 2018-19) and exit blocks with levels of delayed transfers of care that remain significantly above national averages and benchmarks. Progress in this area is overseen by a system-wide A&E Delivery Board chaired by the Trust Chief Executive.

The incomplete Referral to Treatment (RTT) standard has not been met during 2018-19 but performance has improved from 78% at the end of 2017-18 to 84.9% by 31 March 2019, with an improvement in 52 week waiters from 234 in April to three at year end.

Waiting list size will also have reduced in year. Diagnostic performance has not met national standards during the year, but 97.5% was achieved for March which was the best position of the year. A recovery trajectory is in place which is expected to mean that the

national standard will be recovered during Q2 2019-20.

There have also been significant improvements and developments in system working during 2018-19, with the urgent and planned care systems led by a System Director post which is helping to enhance the extent to which issues are owned generally across the system. Effective scrutiny of elective waiting times is in place via a weekly 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. The Trust has been successful this year in meeting national requirements around waiting list size, 52 week wait reduction, and improvement in RTT incomplete pathway waits. In addition, a rolling programme ensures that several quality indicators are also routinely scrutinised, including length of waits for non-monitored pathways. Training is provided routinely and as required, and is bespoke to support the management of access standards. Summary escalation papers go monthly to the Trust's Operational Board and the system's Planned Care Board.

A number of processes are in place to ensure the quality of waiting time data. 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. Completed pathways in excess of 18 weeks are also validated both weekly and monthly.

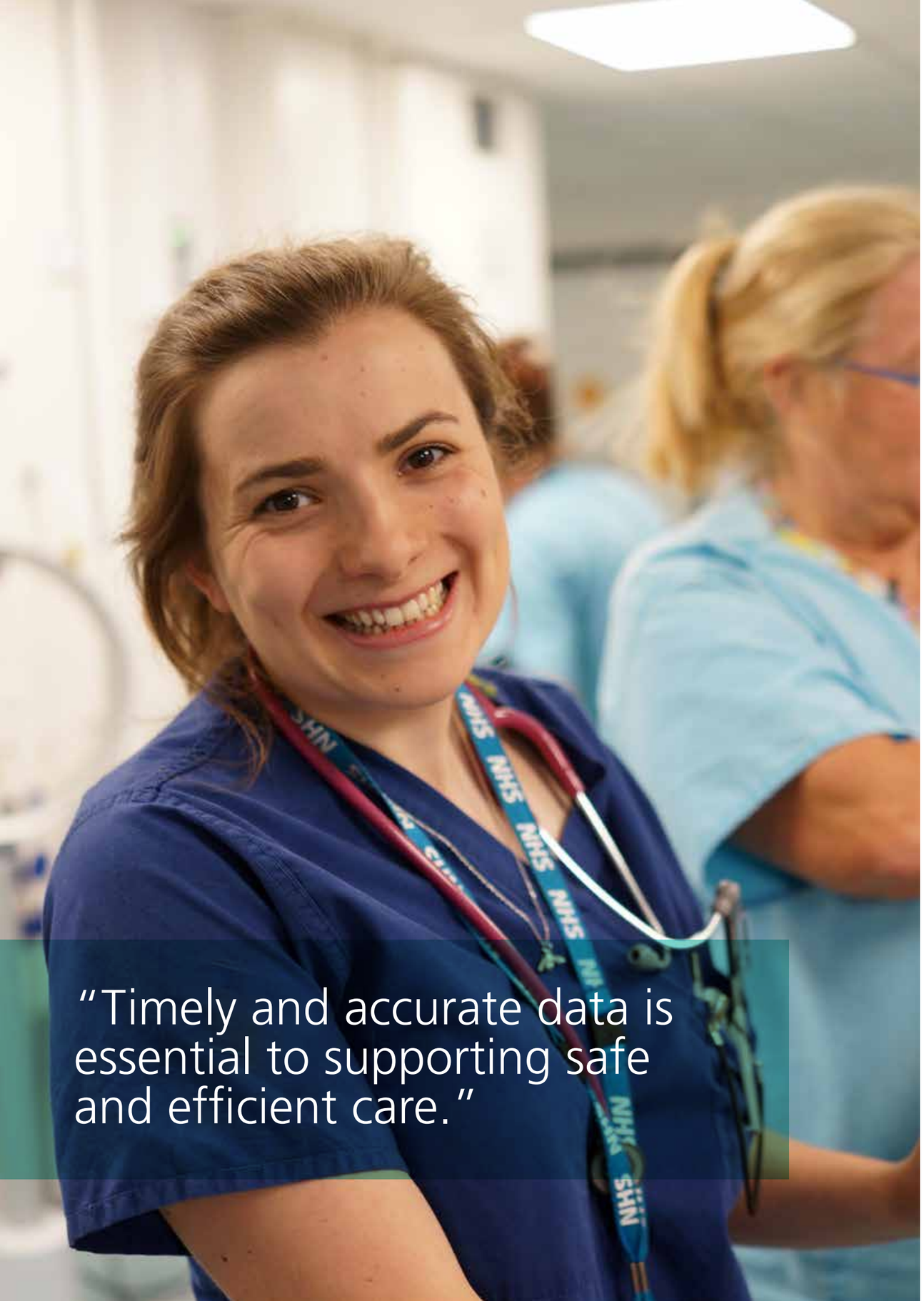
An audit programme delivered by the Access Team enables detailed, objective scrutiny of waiting list management to provide assurance regarding the application of the Access Policy. The Access Policy has been externally reviewed with no identified actions required, and is in date. There are two inherent risks to the quality and accuracy of elective waiting times, which are common across many trusts. The first is the holding of waiting time information across a variety of clinical administrative systems, which could result in inaccurate waiting time data if not linked together robustly.

The second is the risk of human error in administering such systems. The outcome of each could be both under-recording and over-recording of pathway lengths. A number of provisions are in place to mitigate these risks, such as electronic processing of waiting time data, data quality reporting and the validation and audit processes described earlier. Any waiting list / time management errors are reported in accordance with the Trust's incident management procedure.

RTT processing has been moved to a more robust process of daily reporting underpinned within the Trust's data warehouse rather than a weekly report leading to improvement in the timely availability of data. Further process improvements are anticipated when the Trust's Patient Administration System is replaced.

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. The Data Quality Policy was reviewed in 2016-17 and underpins the Records, Information and Data Quality Strategy.



Compliance with climate change adaptation reporting to meet the requirements under the Climate Change Act 2008

The Trust has adopted a Sustainable Management Development Plan and associated action plan aimed at ensuring all activities undertaken have considered the effect of climate change. 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.

Closer links have been forged 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. Successful grant applications have been made to Cornwall Council to improve cycling facilities on site, including new covered cycle shelters and improvements to staff changing facilities at the Royal Cornwall Hospital site.

The Trust has also completed a major £6.4m Carbon and Energy Project with its supply chain partner ENGIE resulting in the installation of some of the latest energy infrastructure (combined heat power, LED lighting, solar PV, biomass boilers, building management systems and generators) which will reduce its CO2 emissions by 32% and lead to considerable savings on its energy bills.

Counter Fraud

As part of the Trust's approach to preventing and deterring fraud, it uses the services of a Local Counter Fraud Specialist (LCFS). The LCFS produces a work plan each year which is agreed by the Trust's Audit & Risk Assurance Committee and allows for work on fraud detection, prevention and deterrence to be undertaken.

An annual report on counter fraud activity is provided to the Trust through the Audit & Risk Assurance Committee. Counter Fraud training is mandatory for all Trust staff.

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

The Trust utilises various processes and controls (such as its Standing Financial Instructions) to ensure economy, efficiency and effectiveness in its use of resources. Throughout the year, the Audit & Risk Assurance Committee oversees a comprehensive risk-based internal audit programme that reviews governance arrangements, efficiency and effectiveness across a range of services. Each financial year end, external auditors provide the Trust with a "Value for Money" conclusion regarding its arrangements for securing economy, efficiency and effectiveness in its use of resources.
The Trust also seeks to ensure value for money by benchmarking performance and costs of services and setting challenging savings targets to test how services can be provided more efficiently and cost effectively.

The Finance Department works closely with budget holders when planning savings, budget setting, developing business cases and monitoring delivery against plan throughout the financial year. Performance against

the Trust's financial plan and delivery of its savings target are reported to the Finance & Performance Committee and Trust Board each month.

Quality and efficiency go hand in hand and the Trust actively engages and encourages staff in identifying ways to become more efficient and deliver brilliant care and improvement.

A Quality Improvement Delivery Board is in place and a Quality Improvement Hub was launched to help progress staff suggestions that improve the efficiency and effectiveness of the Trust's services. The Trust also created a flatter hierarchy, moving to a Care Group structure that reduces the distance from ward to Board.

The Trust continues to explore all opportunities to maximise efficiency and effectiveness, including working with neighbouring health and social care partners across a range of clinical and non-clinical functions.

Information governance

The Trust's overall arrangements for managing information governance issues lie within the responsibilities of the Director of Integrated Governance. The Director of Strategy remains the SIRO until Spring 2019.

During the year, five issues regarding data breeches were reported to the Information Commissioner. Three are investigated and appropriate management action taken. The Information Commissioner, having reviewed the evidence and supporting statements provided, concluded that no regulatory action was required. Two incidents remain under investigation.

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 Standards Met in regard to the Data Security & Protection Toolkit for 2018-19, with a recorded score of 40 out of 40 assertions confirmed.

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 an NHS healthcare provider. The reports are published annually by each provider, including the independent sector, and are available to the public. The Quality Account is approved via the Executive Board, Quality Assurance Committee through to the Trust Board with a review via external stakeholders including Healthwatch and Kernow CCG.

An unqualified audit opinion on the Quality Accounts was received from the Trust's external auditors and the framework for the 2018-19 Quality Accounts audit has been agreed with the external auditors. The Quality Accounts can be found on our website: www.royalcornwall.nhs.uk or on the NHS Choices website.

Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust that have responsibility for the development and maintenance of the internal control framework.

I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports.

I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the board, the audit committee and the Quality Assurance Committee and a plan to address weaknesses and ensure continuous improvement of the system is in place.

The maintenance and review of the effectiveness of the system of internal control is a part of an on-going process, and in relation to this process I by:

The Board of Directors

The Board ensures that effective arrangements are in place to provide assurance on risk management, governance and internal control. The Board has determined in relation to internal control that it will:

- Operate as a unitary Board;
- Monitor the performance of the organisation against agreed plans.
- Be responsible for the overall system of control, ensure key risks are identified and appropriate mitigating actions are taken.
- Ensure compliance with relevant NHS and wider Government regulations and requirements, including the provision of excellent services and good value for money.
- Review, endorse and adopt, in support of the AO, the annual report, financial statements and statement to be given by the AO.

Audit and Risk Committee

Independently and objectively monitor, reviews and reports to the Board on the processes of governance and internal control across the whole of the organisation's activities (both clinical and non-clinical)

Quality Assurance Committee

Provides assurance to the Board about quality, safety, patient experience and the Trust's registration with the Care Quality Commission. This committee, in particular, provides the Board with assurance that effective and well supported operational governance arrangements for quality and safety are in place

Internal audit

Internal audit provides me with independent assurance that the Trust's risk management, governance and internal control processes are operating effectively. In 2018/19 the Independent Head of Internal Audit opinion was 'limited assurance'

Conclusion

Subject to the matters outlined in this statement, to the best of my knowledge the Trust has a generally sound system of internal control that supports the achievement of its policies, aims and objectives, and there are no significant internal control issues. The Head of Internal Audit gave an opinion of limited assurance.

Signed
Kate Shields, Chief Executive
Date: 24 May 2019

Our annual self-assessment declaration, using the information governance toolkit, provides assurance

Appendix 1

	Board Meetings 13 Meetings	Remuneration Committee 5 Meetings	Audit & Risk Assurance Committee 6 Meetings	Quality Assurance Committee 11 Meetings	People and Organisational Development Committee 6 Meetings	Finance and Performance Committee 12 Meetings
Executive Directors						
Kate Shields	9/13			1/11		
Kathy Byrne	2/3					
Sally May	12/13					11/12
Kerry Eldridge	8/8			6/6	4/6	7/7
Catrin Asbrey	3/3			3/3	2/2	3/3
Thomas Lafferty	10/13			6/11		10/12
Ethna McCarthy	3/3				1/2	3/3
Kim O'Keefe	11/13			9/11	4/6	
Mark Daly	10/12			8/10		
Rob Parry	1/1			1/1	4/6	
Phil Orwin	5/5			4/10		
Rab McEwan	3/6			3/5	2/5	4/5
Bernadette George	7/7			5/5	1/3	5/5
Susan Bracefield	2/2				1/2	2/2
Kelvyn Hipperson	2/3				1/1	2/2

Non-Executive Directors						
Mairi Mclean	12/13	5/5	2/2	9/11	2/6	
Jim McKenna	2/4		0/0			
Dr John Lander	13/13	5/5	4/7		6/6	12/12
Paul Hobson	12/13	4/5	3/7	6/11	5/6	12/12
Margaret Schwarz	10/13	3/5	7/7	9/11		10/12
Sarah Pryce	11/13	4/5	0/7	7/11	6/6	
Gillian Vivian	4/6	2/2	1/3	1/5		
Charlotte Russell	1/1		1/1	1/1		
Associate Non-Executive Directors						
Rob Leighfield	5/7	1/2	1/3			
Ruth Allarton	3/3	2/2	0/1		1/1	3/3
Richard Smith	1/1					

Appendix 2: Principal risks in the Board Assurance Framework

Strategic Aim/ Sub Aim	Proposed Principal Risk	Proposed Risk Rating
Strategic Aim 1: Quality - "To provide compassionate safe effective care"		
1.1 - Safety Culture - Keep our patients safe in our care putting their needs above all else be assured about patient safety through; ➔ o ward accreditation ➔ o oversight of safe staffing ➔ o adoption of best practice at care handovers ➔ o daily safety briefings ➔ o compliance with WHO checklist	There is a risk that the Trust will not be able to meet (evidence) compliance with regulatory standards and may not consistently deliver high quality compassionate care to patients due to ongoing recruitment challenges. Risk that current resource plan (2.3) will not deliver the additional registered and non-registered workforce requirements.	12
1.2 - Strong Governance - Be fully open and transparent with our staff Ensure timely rapid learning when things go wrong Improve how we manage our risks and weaknesses to make us safer. Make sure we work consistently to provide safe care	The current governance structure is not optimally aligned to ensure the capacity and capability to adequately; escalate and cascade, patient safety, clinical effectiveness and patient experience concerns and to deliver the associated regulatory governance standards.	20
1.3 - Tackling Delays - Achieve the agreed standards for emergency and planned care Deliver cancer services in line with cancer standards Deliver an improved outpatient service Increase the proportion of patients who receive same day emergency care	There is risk that the Trust will not be resilient over the winter period, this will adversely impact on the quality of care delivered and the overall patient experience leading to cancelled or delayed treatment. Impacting the Trusts ability to deliver a range of regulatory performance standards including the A & E 4 hour standard, the cancer, diagnostics & RTT standards.	16
Strategic Aim 2: People - "Attract, develop and retain excellent staff"		
2.1 - Ensure we recruit and retain staff, which have the right skills and experience to provide safe, effective care.	There is a risk that the lack of a coherent aligned "People Strategy" for the Trust will result in the inability to provide the right people in the right place at the right time for the right cost'; posing a significant risk to the Trust's ability to meet its care, financial and performance obligations.	18
2.2 - Create an open, learning environment where all staff feel valued and able to contribute to our Quality Improvement Plan	There is a risk that staff do not know about or feel that they are able to contribute to the continued improvement of the organisation caused by insufficient communication and engagement of staff in decision making, linked to the pace of change required. This could adversely affect the improvements planned to safety, governance, unnecessary delays and the delivery of high quality and compassionate care.	12
2.3 - Enhance our leadership capability to drive optimal patient care	There is a risk that the Trust does not recruit to and develop the leadership capability at the pace required to drive & deliver the Quality Improvement Plan & deliver optimum patient care.	12

Strategic Aim 3: Partnership "Offer integrated care as close to home as possible"		
3.1 - Offer more acute services out of hospital and support locality teams to care for frail and vulnerable people at home	Risk that provision of acute, primary, community and social care outside of the Treliske environment is insufficient, meaning that patients do not always receive care and support in the most appropriate therapeutic environment.	16
3.2 - Implement "One Vision" for children's services	Risk that planning for county-wide children's services takes place without adequate Trust input, leading to the 'disconnection' of children's' services	12
3.3 - Adopt a "Digital First " approach to system wide transformation	Risk that the lack of a coherent organisation-wide Digital Strategy will mean that the Trust's IM&T infrastructure will be disconnected, sub-standard and be unable to support excellent clinical care.	15
3. 4 - Make services better by encouraging patient involvement in research	Lack of clinical buy-in/engagement with research will result in patients not having an opportunity to take part in trails that may enhance their quality of life / wellbeing now or in the future.	6
Strategic Aim 4: Resources "To make the best use of all our resources"		
4.1 - Be a financially stable organisation	Risk that the Trust does not achieve its financial target which will result in lost income, additional debt and a longer period of time to recover to a breakeven position.	12
4.2 - Increase funds available for front line care by reducing costs across the health system	Risk that the Trust does not identify and then deliver recurrent savings to enable it to achieve its financial plan and make best use of its resources.	12
4.3 - Transform services to increase quality and reduce inefficiency and waste	Risk that the Trust does not increase quality, reduce cost for the Trust and the system, and offer best value by delivering transformational schemes within the health economy.	12
4.4 - Ensure investments in technology and facilities improve experience for staff and outcomes patients	Risk that the Trust is not able to access or prioritise capital resources to enable it to ensure that service continuity is maintained, statutory regulations are adhered to and services are improved through the use of technology.	20

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.

There are no special contractual compensation provisions for the early termination of Executive Directors' contracts.

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 December 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 2018-19 was £195,000-£200,000 (2017-18: £180,000-185,000). This was 7.04 times (2017-18: 6.87 times) the median remuneration of the workforce, which was £28,052 (2017-18: £26,565).

Based on the March 2019 payroll, the calculated annualised pay for 2018-19 of no employees would have exceeded that of the highest-paid director (2017-18: 3).

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 increase in the pay multiple ratio arose due to the greater increase in the annualised pay for the highest paid director, than the increase in the median pay level.

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	Appointment end	Reappointment start	Reappointment end
Dr Mairi McLean (Chairwoman)	January 2019	January 2022		
Paul Hobson	February 2016	January 2018	January 2018	January 2020
Dr John Lander	November 2016	October 2018	November 2018	October 2020
Sarah Pryce	February 2016	May 2018	May 2018	May 2020
Margaret Schwarz	November 2016	October 2018	November 2018	October 2020
Dr Gillian Vivian	October 2018	October 2020		
Rob Leighfield (Associate)	October 2018	October 2019		
Ruth Allarton (Associate)	January 2019	January 2020		
Richard Smith (Associate)	March 2019	March 2020		

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. The Trust made no employer contributions to stakeholder pensions.

Salaries and allowances

	2018-19			2017-18		
Non-Executive Directors	**Salary (bands of £5000) £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**
Dr Mairi McLean Chairwoman (from January 2019) Acting Chairwoman (June 2018 to Jan 2019)	30-35	0	30-35	5-10	0	5-10
Jim McKenna Chairman (to May 2018)	5-10	0	5-10	35-40	0	35-40
Paul Hobson Non-Executive Director	5-10	0	5-10	5-10	0	5-10
Dr John Lander Non-Executive Director	5-10	0	5-10	5-10	0	5-10
Sarah Pryce Non-Executive Director	5-10	0	5-10	5-10	0	5-10
Margaret Schwarz Non-Executive Director	5-10	0	5-10	5-10	0	5-10
Dr Gillian Vivian Non-Executive Director (from October 2018)	0-5	0	0-5			
Ruth Allarton Associate Non-Executive Director (from October 2018)	0-5	0	0-5			
Rob Leighfield Associate Non-Executive Director (from January 2019)	0-5	0	0-5			
Richard Smith Associate Non-Executive Director (October 2018)	0-5	0	0-5			
Charlotte Russell Non-Executive Director (to April 2018)	0-5	0	0-5	5-10	0	5-10
Roger Gazzard Associate Non-Executive Director (to March 2018)				5-10	0	5-10

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

Accountability Report

	2018-19				
Senior Managers	**Salary whilst in post as Senior Manager (bands of £5000) £000**	**Other salary (bands of £5000) £000**	**Expense payments (taxable) total to nearest £100 £**	**All pension related benefits (bands of £2500) £000**	**Total (bands of £5000) £000**
Kate Shields Chief Executive (from February 2019) Interim Chief Executive (from July 2018 to February 2019)	165-170	45-50	0	0	215-220
Susan Bracefield Director of Operations (from March 2019) Interim Director of Operations (from February 2019)	15-20	85-90	0	0	105-110
Kerry Eldridge Director of Human Resources & Organisational Development (from August 2018)	75-80	0	0	110-112.5	185-190
Bernadette George Interim Director of Integrated Governance (from October 2018)	45-50	25-30	0	162.5-165	240-245
Kelvyn Hipperson Chief Information Officer (from January 2019)	20-25	0	0	5.0-7.5	30-35
Thomas Lafferty Interim Director of Strategy & Performance (from September 2018) Director of Corporate Affairs (to Sep 2018)	115-120	0	0	37.5-40.0	155-160
Sally May (1) Director of Finance	90-95	0	0	2.5-5.0	95-100
Kim O'Keeffe Director of Nursing, Midwifery & Allied Health Professions	130-135	0	0	102.5-105.0	235-240
Rob Parry Interim Medical Director (from February 2019)	25-30	125-130	2,900	0	150-155
Catrin Asbrey Director of Human Resources & Organisational Development (to July 2018)	30-35	0	0	0	30-35
Kathy Byrne Chief Executive (to July 2018)	105-110	90-95*	0	65-67.5	265-270
Mark Daly Medical Director (to February 2019)	140-145	10-15	0	252.5-255.0	405-410
Ethna McCarthy Director of Strategy & Business Development (to July 2018)	30-35	90-95	0	0	125-130
Rab McEwan Chief Operating Officer (to September 2018)	70-75	20-25	0	0	95-100
Phil Orwin Interim Chief Operating Officer (from September 2018 to January 2019)	185-190	65-70	0	0	250-255
Mid-point of total paid remuneration band of the highest paid director	£197,500				
Median total remuneration	£28,052				
Ratio	7.04				

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

(1) The Director of Finance is shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those costs incurred by this Trust for the period April 2018 to March 2019. The full salary costs for the individual for that period would be in the band £140,000 - 145,000.

* Payment in lieu of annual leave, included within exit packages disclosed in the Staff Report. Taxable expense payments relate to lease vehicles.

Senior Managers	2017-18 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 Director (to April 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.

No performance or bonus payments were made to senior managers in either 2018-19 or 2017-18. 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.

Pension benefits

Senior Manager	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2019 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2019 (bands of £5,000) £000	Cash equiv alent transfer value at 31 March 2019 as provided by NHSPA £000	Cash equiv alent transfer value at 31 March 2018 as provided by NHSPA £000	Real increase in cash equiv alent transfer value £000
Susan Bracefield Director of Operations	(2.5)-0	(2.5)-0	40-45	110-115	854	764	11
Kerry Eldridge Director of Human Resources & Organisational Development	2.5-5.0	5.0-7.5	15-20	50-55	298	181	66
Bernadette George Interim Director of Integrated Governance	2.5-5.0	7.5-10.0	30-35	90-95	646	434	99
Kelvyn Hipperson Chief Operating Officer	0-2.5	0	0-5	0	6	0	2
Thomas Lafferty Director of Corporate Affairs	2.5-5.0	0	15-20	0	151	102	46
Sally May Director of Finance	0-2.5	(5.0)-(2.5)	50-55	130-135	1,017	870	121
Kim O'Keeffe Chief Nurse	5.0-7.5	15.0-17.5	30-35	100-105	784	582	184
Catrin Asbrey Director of Human Resources & Organisational Dev (to July 2018)	(2.5)-0	0	5-10	0	76	83	-3
Kathy Bryne Chief Executive Officer (to July 2016)	0-2.5	0	10-15	0	190	105	50
Mark Daly Medical Director (from January 2018 to February 2019)	7.5-10.0	17.5-20.0	60-65	155-160	1,181	821	224
Ethna McCarthy Director of Strategy & Business Development (to July 2018)	0-2.5	0-2.5	50-55	150-155	1,119	967	31

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

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 2018-19 was 3%. The factors used to calculate the CETV increased on 29 October 2018 and will have affected the calculation of the real increase in CETV.

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

A single exit package was agreed by the Trust in 2018-19 in respect of a Senior Manager, as disclosed in the table of salaries and allowances above. The payment is also included within the exit packages 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 2018-19 these were as follows:

Staff type	Total staff number	Permanently employed staff Number	Bank and agency staff Number
Medical and dental staff	818	757	61
Administration and estates staff	1,325	1,262	63
Healthcare assistants and other support staff	712	572	140
Nursing, midwifery and health visiting staff	1,488	1,288	200
Nursing, midwifery and health visiting learners staff	50	50	0
Scientific, therapeutic and technical staff	804	768	36
Healthcare science staff	174	172	2
Other	6	6	0
Total	**5,377**	**4,875**	**502**

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	106
Band 8 - Range B	41
Band 8 - Range C	28
Band 8 - Range D	14
Band 9	8
Total	**197**

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)	67	159	226
Other staff	857	3,784	4,641
Total	**927**	**3,948**	**4,875**

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.

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.

Sickness absence data

The table below details the Trust's sickness absence data. The data is based on the 2018 calendar year, which the Department of Health & Social Care regards as a reasonable proxy for the 2018-19 financial year.

Sickness absence	Number
Total days lost	46065
Total staff years	4819
Average working days lost	10
Ill-health retirements	
Number of persons retired early on ill-health grounds	6
Total additional pensions liabilities accrued in the year	**£310,000**

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

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 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.

The Trust's Equality, Inclusion and Human Rights policy

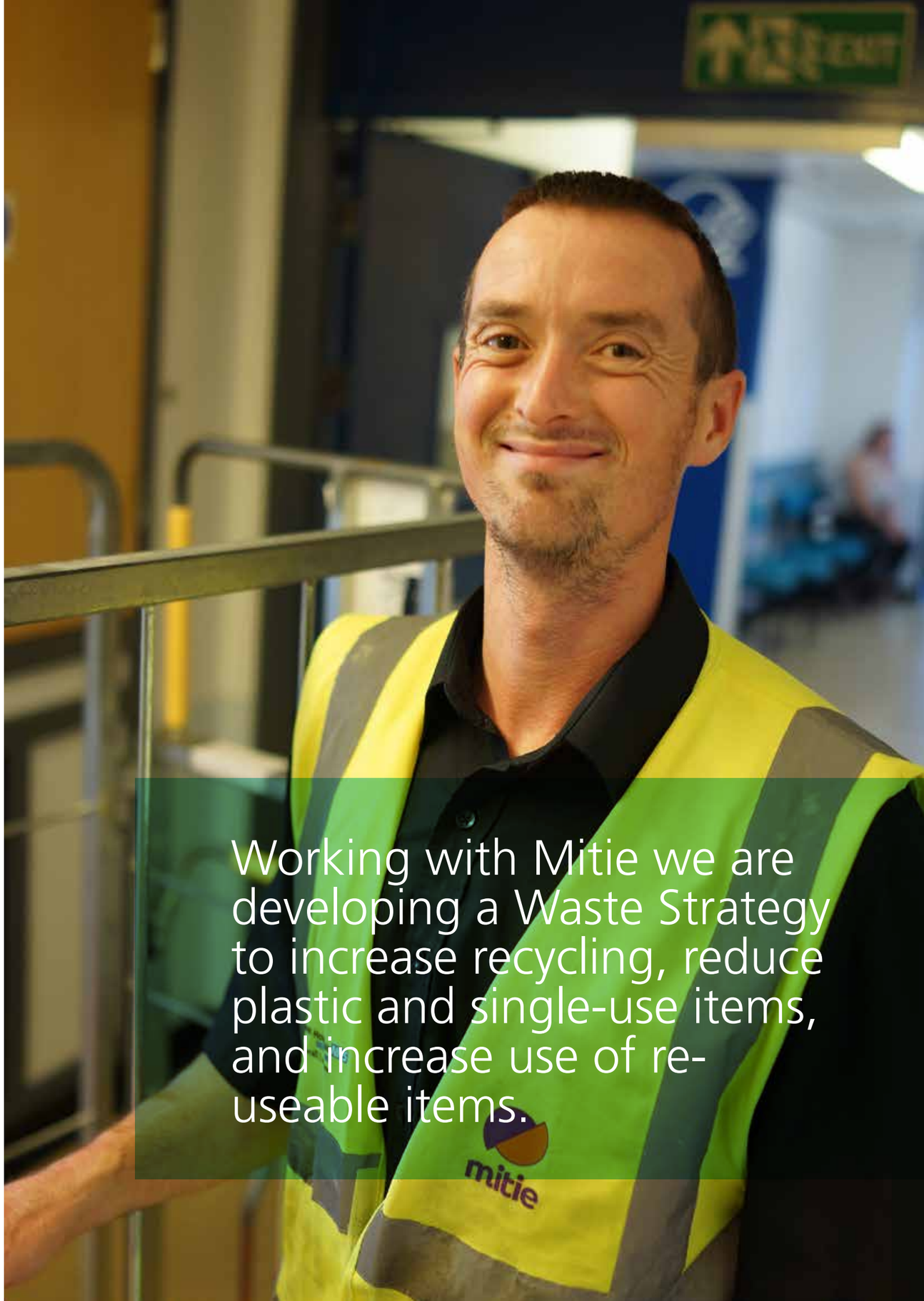
https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/HumanResources/EqualityDiversityAndHumanRightsPolicy.pdf

Consultancy expenditure

The Trust incurred the following consultancy expenditure in 2018-19:

Area	Expenditure £000
Organisational development and cultural review	87
Business analytics	42
Procurement support	8
Communications and management support	4
Service review	27
Strategic estates review	37
Promotional consultancy	4
Clinical record review	32
VAT recovered in respect of prior year consultancy expenditure	(32)
Total	**209**

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 2019, for more than £245 per day and that last for more than 6 months:

	Number
Number of existing engagements as of 31 March 2019	1

New off-payroll engagements, or those that reached six months in duration, between 1 April 2018 and 31 March 2019, 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 2018 and 31 March 2019	0

*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 2018 and 31 March 2019:

	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	1
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	26

Exit packages

The tables below detail the exit packages agreed in 2018-19 by the Trust:

Band	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed £000	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
Less than £10,000	0	0	5	15	5	15
£10,000-£25,000	0	0	3	48	3	48
£25,001-£50,000	0	0	2	73	2	73
£50,001-£100,000	0	0	1	92	1	92
Total	**0**	**0**	**11**	**228**	**11**	**228**

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.

Type (Excluding compulsory redundancies)	Total number of agreements	Total value of agreements
Voluntary redundancies including early retirement contractual costs	3	55
Contractual payments in lieu of notice	8	173
Total	**11**	**228**

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. Included in the tables above is a single payment in relation to an exit package for a senior manager, as a contractual payment in lieu of notice: £92,000.

Signed
Kate Shields, Chief Executive
24 May 2019

Statement of the Chief Executive's responsibilities as the Accountable Officer of the Trust

The Chief Executive of NHS Improvement, in exercise of powers conferred on the NHS Trust Development Authority, has designated that the Chief Executive should be the Accountable Officer of the Trust.

The relevant responsibilities of Accountable Officers are set out in the NHS Trust Accountable Officer Memorandum. These include ensuring that:

- there are effective management systems in place to safeguard public funds and assets and assist in the implementation of corporate governance;
- value for money is achieved from the resources available to the Trust;
- the expenditure and income of the Trust has been applied to the purposes intended by Parliament and conform to the authorities which govern them;
- effective and sound financial management systems are in place; 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.

Signed
Kate Shields, Chief Executive
24 May 2019

'We support a network for staff with disabilities or long term health conditions'

3.

Annual Accounts

Statement of Comprehensive Income for the year ended 31 March 2019

	NOTE	2018-19 £000	2017-18 £000
Operating income from patient care activities	3	**381,559**	356,862
Other operating income	4	**63,817**	48,158
Operating expenses	7	**(445,933)**	(408,248)
Operating surplus / (deficit)		**(557)**	(3,228)
Finance costs			
Finance income	12	**89**	35
Finance expenditure	13	**(1,312)**	(1,172)
Public dividend capital dividends payable		**(2,061)**	(2,297)
Net finance costs		**(3,284)**	(3,434)
Other gains and (losses)	14	**15**	53
Surplus / (deficit) for the financial year		**(3,826)**	(6,609)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments and reversals taken to the revaluation reserve	8	**(200)**	(3,383)
Revaluations		**3,368**	1,998
Total comprehensive income / (expense) for the year		**(658)**	(7,994)

Financial performance for the year			
Surplus / (deficit) for the year		**(3,826)**	(6,609)
Impairments (1)	8	**93**	4,051
Adjustments in respect of Donated Asset / Government Grant Reserve elimination (2)		**(403)**	(33)
Adjusted retained surplus / (deficit)		**(4,136)**	(2,591)

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

1. Impairment charges are not considered part of an NHS trust's operating financial position; and
2. 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 125 -166 form part of this account.

Statement of Financial Position as at 31 March 2019

	NOTE	31 March 2019	31 March 2018
		£000	£000
Non-current assets			
Intangible assets	**15**	**6,095**	7,342
Property, plant and equipment	**16**	**152,098**	144,702
Receivables	**18**	**909**	480
Total non-current assets		**159,102**	152,524
Current assets			
Inventories	**17**	**8,175**	8,133
Receivables	**18**	**25,223**	18,380
Cash and cash equivalents	**19**	**9,692**	8,156
Total current assets		**43,090**	34,669
Current liabilities			
Trade and other payables	**20**	**(37,327)**	(29,937)
Borrowings	**22**	**(17,956)**	(7,686)
Provisions	**24**	**(381)**	(412)
Other liabilities	**21**	**(3,948)**	(5,506)
Total current liabilities		**(59,612)**	(43,541)
Total assets less current liabilities		**142,580**	143,652
Non-current liabilities			
Borrowings	**22**	**(46,481)**	(47,476)
Provisions	**24**	**(4,110)**	(4,302)
Other liabilities	**21**	**(1,056)**	(1,584)
Total non-current liabilities		**(51,647)**	(53,362)
Total assets employed		**90,933**	90,290
Financed by:			
Public dividend capital		**170,426**	169,125
Revaluation reserve		**35,936**	32,768
Income and expenditure reserve		**(115,429)**	(111,603)
Total taxpayers' equity		**90,933**	90,290

The notes on pages 125 -166 form part of this account.

The financial statements on pages 121 to 124 were approved by the Board on 24 May 2019 and signed on its behalf by

Acting Chief Executive: Kim O'Keeffe
{original copy signed}
Date: 24th May 2019

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

Statement of changes in equity for the year ended 31 March 2019	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total reserves
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2018	**169,125**	**32,768**	**(111,603)**	**90,290**
Surplus / (deficit) for the year			(3,826)	(3,826)
Revaluations		3,368		3,368
Impairments		(200)		(200)
Public dividend capital received	1,301			1,301
Taxpayers' and others' equity at 31 March 2019	**170,426**	**35,936**	**(115,429)**	**90,933**

Statement of changes in equity for the year ended 31 March 2018	Public dividend capital	Revaluation reserve	Income and expenditure reserve	Total reserves
	£000	£000	£000	£000
Taxpayers' and others' equity at 1 April 2017	**168,062**	**34,159**	**(105,000)**	**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**	**32,768**	**(111,603)**	**90,290**

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.

Statement of Cash Flows for the year ended 31 March 2019

	NOTE	2018-19 £000	2017-18 £000
Cash flows from operating activities			
Operating (deficit) / surplus		**(557)**	(3,228)
Non-cash income and expense			
Depreciation and amortisation	**7**	**13,007**	13,728
Net impairments	**8**	**93**	4,051
Income recognised in respect of capital donations	**4**	**(1,153)**	(734)
(Increase) / decrease in receivables and other assets		**(7,618)**	(938)
(Increase) / decrease in inventories		**(42)**	(238)
Increase / (decrease) in payables and other liabilities		**7,365**	1,037
Increase / (decrease) in provisions		**(226)**	(186)
Other movements in operating cash flows		**(42)**	0
Net cash generated from operating activities		**10,827**	13,492
Cash flows from investing activities			
Interest received	**12**	**89**	35
Purchase of intangible assets		**(2,216)**	(2,387)
Purchase of property, plant and equipment		**(16,518)**	(14,797)
Sales of property, plant and equipment		**18**	82
Receipt of cash donations to purchase capital assets		**854**	369
Net cash generated used in investing activities		**(17,773)**	(16,698)
Cash flows from financing activities			
Public dividend capital received		**1,301**	1,063
Movement on loans from the Department of Health and Social Care (1)		**10,253**	11,275
Capital element of finance lease payments		**0**	(223)
Capital element of LIFT payments (2)		**(18)**	(15)
Interest paid on loans		**(847)**	(670)
Interest paid on finance lease liabilities		**0**	(52)
Interest paid on LIFT obligations		**(420)**	(413)
PDC dividend paid		**(1,784)**	(2,698)
Net cash generated from financing activities		**8,485**	8,267
Net increase in cash and cash equivalents		**1,539**	5,061
Cash and cash equivalents at 1 April		**8,151**	3,090
Cash and cash equivalents at 31 March	**19**	**9,690**	8,151

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

	2018-19 £000	2017-18 £000
New revenue support loans received	**13,823**	8,486
Revenue support loans repaid	**(1,933)**	(1,933)
New capital investment loans received	**0**	6,161
Capital investment loans repaid	**(1,637)**	(1,439)
	10,253	11,275

(2) Local Improvement Finance Trust (LIFT) - see note 27 for additional information regarding the scheme.

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

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

The Trust's annual report and accounts have been prepared on a going concern basis. Non-trading entities in the public sector are assumed to be going concerns where the continued provision of a service in the future is anticipated, as evidenced by inclusion of financial provision for that service in published documents. 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 DHSC GAM, 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.

In undertaking the assessment of going concern, the Board has also considered the Trust's overall financial position and expectation of future financial support. The Trust has approved a breakeven budget for the year ended 31 March 2020. Achieving this plan requires, amongst other items, delivering an efficiency target of £14m and includes £17.3m of Provider Sustainability Fund (PSF), Financial Recovery Fund (FRF) and Marginal Rate Emergency Tariff (MRET) income. Of the £17.3m, the receipt of PSF and FRF elements totalling £12.8m are dependent on the achievement of financial targets.

In preparing the 2019-20 plan, the Trust has identified the need for additional cash support of £1.8m to support the financial position (excluding support required to repay £14.5m 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 DHSC, 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.

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 £4.5m). Those uncertainties are disclosed in Note 24.

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 and amortisation expenses totalling £13.0m are derived using estimated asset lives. An increase in asset lives of 1 year, for all non building and dwelling assets, would reduce the depreciation and amortisation charges by approximately £2.7m. A reduction in those asset lives of 1 year would increase depreciation and amortisation charges by approximately £2.4m in 2018-19.

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 £124.9m). This approach was first adopted in 2014-15 and is in accordance with HM Treasury requirements.

Accruals, totalling £25.2m (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's 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 37 as related party transactions.

1.4. Revenue from contracts with customers

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

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

Revenue from NHS contracts

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

Revenue is recognised to the extent that collection of consideration is probable. Where contract challenges from commissioners are expected to be upheld, the Trust reflects this through the recognition of credit loss allowances.

As per paragraph 121 of the Standard, the Trust does not disclose information regarding the performance obligations part of a contract that has an original expected duration of one year or less.

The GAM does not require the Trust to disclose information where revenue is recognised in line with the practical expedient offered in paragraph B16 of the Standard where the right to consideration corresponds directly with the value of the performance completed to date.

The GAM has mandated the exercise of the practical expedient offered in C7A of the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.

Payment terms are standard, reflecting cross government principles.

Revenue from research contracts

Where research contracts fall under IFRS 15, revenue is recognised as and when performance obligations are satisfied. For some contracts, it is assessed that the revenue project constitutes one performance obligation over the course of the multi-year contract. In these cases it is assessed that the Trust's interim performance does not create

an asset with alternative use for the Trust, and the Trust has an enforceable right to payment for the performance completed to date. It is therefore considered that the performance obligation is satisfied over time, and the Trust recognises revenue each year over the course of the contract.

NHS Injury Cost Recovery (ICR) Scheme

The Trust receives income under the NHS ICR scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid, for instance by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit, has completed the NHS2 form and confirmed there are no discrepancies with the treatment. The income is measured at the agreed tariff for the treatments provided to the injured individual, less an allowance for unsuccessful compensation claims and doubtful debts in line with IFRS 9: Financial Instruments requirements of measuring expected credit losses over the lifetime of the asset.

Government's apprenticeship service

The value of the benefit received when the Trust accesses funds from the Government's apprenticeship service are recognised as income in accordance with IAS 20: Accounting for Government Grants and Disclosure of Government Assistance . Where these funds are paid directly to an accredited training provider, non-cash income and a corresponding non-cash training expense are recognised, both equal to the cost of the training funded.

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 Schemes

Past and present employees are covered by the provisions of the NHS Pension Schemes. These schemes are unfunded, defined benefit schemes that cover NHS employers, General Practices and other bodies, allowed under the direction of Secretary of State, in England and Wales. The schemes are 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 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.

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 valuation. Assets which are held for their service potential and are in use (i.e. operational assets used to deliver either front line services or back office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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.

Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements of the services being provided.
Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees, where capitalised in accordance with IAS 23: Borrowings costs . Assets are revalued and depreciation commences when the assets 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 n the period in which it is incurred.

Depreciation

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

Property, plant and equipment which has been reclassified as 'held for sale' ceases to be depreciated upon 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 abandoned or significant changes made to it.

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

Property, plant and equipment which is to be scrapped or demolished does not qualify for recognition as 'held for sale' and instead is retained as an operational asset and the asset's 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, the charges for services and lifecycle replacement of components of the asset. The element of the annual unitary payment increase due to cumulative indexation is treated as contingent rent and is expensed as incurred.

The service charge is recognised in operating expenses and the finance cost is charged to finance costs in the Statement of Comprehensive Income.

Useful 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 2018 and applied throughout 2018-19. The lives determined by the 31 March 2019 valuation will be applied in 2019-20. 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.

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.

Revaluation 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 lives of intangible assets

Useful lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives 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.

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

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

Classification and measurement

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

Financial assets 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.

Financial assets and financial liabilities are classified as subsequently measured at amortised cost.

Financial assets and financial liabilities at amortised cost

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

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

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

Impairment of financial assets

For all financial assets measured at amortised cost including lease receivables, contract receivables and contract assets or assets measured at fair value through other comprehensive income, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, measuring expected losses at an amount equal to lifetime expected losses. Credit losses in respect of NHS bodies are not normally recognised.

Expected losses are charged to operating expenditure within the Statement of Comprehensive Income and reduce the net carrying value of the financial asset in the Statement of Financial Position.

De-recognition

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.

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.

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 24.2 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 Trust's control) are not recognised as assets, but are disclosed in Note 25 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 25, 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.

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 Financial Instruments: Presentation.

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 Provider Sustainability Fund (PSF) 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 of 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.

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 adopted early, in 2018-19.

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

The DHSC GAM does not require the following IFRS Standards and Interpretations to be applied in 2018-19. These Standards are still subject to HM Treasury FReM adoption:

- IFRS 16: Leases – Application required for public sector bodies from 2020-21; 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;
- FRIC 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 care group 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)

	2018-19 £000	2017-18 £000
Acute services		
Elective income	**63,499**	56,898
Non-elective income	**95,323**	93,879
First outpatient income	**26,744**	25,545
Follow up outpatient income	**30,714**	29,223
Accident and emergency income	**11,938**	11,311
High cost drugs income from commissioners (excluding pass-through costs)	**47,558**	45,673
Other NHS clinical income	**90,395**	88,695
Other services		
Private patient income	**361**	570
Agenda for change pay award central funding	**3,246**	0
Other clinical income	**11,781**	5,068
Total income from NHS bodies	**381,559**	356,862

3.2. Income from patient care activities (by source)

Income from patient care activities received from:	**2018-19 £000**	2017-18 £000
NHS England	**78,263**	75,855
Clinical commissioning groups	**295,617**	276,383
Other NHS providers	**58**	85
Department of Health and Social Care	**3,246**	0
NHS other (Public Health England)	**114**	114
Local authorities	**2,882**	2,880
Non-NHS: Private patients	**361**	570
Non-NHS: Overseas patients (chargeable to patient)	**184**	356
NHS Injury Cost Recovery (ICR) scheme	**545**	351
Other	**289**	268
Total income from patient care activities	**381,559**	356,862

All amounts above relate to continuing operations.

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

	2018-19 £000	2017-18 £000
Income recognised during the year	**184**	356
Cash payments received in-year	**137**	124
Amounts added to provision for impairment of receivables	**271**	269
Amounts written off in-year	**13**	8

4. Other operating income

	2018-19 £000	2017-18 £000
Operating income from contracts with customers:		
Research and development	**2,519**	3,082
Education and training	**12,038**	11,737
Non-patient care services to other bodies	**8,045**	8,085
Provider Sustainability Fund (PSF) and Sustainability & Transformation Fund (STF) income	**15,603**	7,320
Income in respect of staff costs where accounted on gross basis (1)	**4,989**	4,613
Other contract income (2)	**16,598**	10,500
Other non-contract operating income:		
Education and training - notional income from Apprenticeship Fund	**321**	86
Receipt of capital grants and donations	**1,153**	734
Charitable and other contributions to expenditure	**449**	284
Rental revenue from operating leases	**1,613**	1,717
Other non-contract income	**489**	0
Total other operating income	**63,817**	48,158

All amounts above relate to continuing operations.

(1) Included within 'Charitable and other contributions to expenditure' is £449,000 (2017-18: £284,000) in relation to 'income in respect of staff costs when accounted for on a gross basis'.

(2) 'Other contract 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 other categories in the note above.

5.1 Additional information on revenue from contracts with customers recognised in the period

	2018-19 £000
Revenue recognised in the reporting period that was included in within contract liabilities at the previous period end	**4,105**
Revenue recognised from performance obligations satisfied (or partially satisfied) in previous periods	**0**

5.2 Transaction price allocated to remaining performance obligations

	31 March 2019 £000
Revenue from existing contracts allocated to remaining performance obligations is expected to be recognised:	
- not later than one year	**3,420**
- later than one but not later than five years	**0**
- later than five years	**0**
Total revenue allocated to remaining performance obligations	**3,420**

The Trust has exercised the practical expedients permitted by IFRS 15 paragraph 121 in preparing this disclosure. Revenue from: (i) contracts with an expected duration of one year or less; and (ii) contracts where the Trust recognises revenue directly corresponding to work done to date is not disclosed.

6. Income generation activities

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

7.1. Operating expenses

	£000	£000
Purchase of healthcare from NHS and DHSC bodies	**10,918**	9,326
Purchase of healthcare from non-NHS and non-DHSC bodies	**13,710**	6,661
Staff and executive directors' costs	**253,639**	233,274
Remuneration of Chair and non-executive directors	**63**	82
Supplies and services - clinical (excluding drug costs)	**41,032**	37,028
Supplies and services - general	**23,226**	20,281
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**51,160**	48,043
Inventories written down	**350**	156
Consultancy costs	**209**	366
Establishment	**4,187**	3,897
Premises	**9,768**	9,232
Transport (including patient travel)	**2,906**	2,488
Depreciation on property, plant and equipment	**10,356**	10,451
Amortisation on intangible assets	**2,651**	3,277
Net impairments	**93**	4,051
Movement in credit loss allowance: contract receivables / contract assets	**499**	0
Movement in credit loss allowance: all other receivables and investments	**36**	738
Change in provisions discount rate(s)	**(54)**	47
Audit fees payable to the external auditor:		
- audit services - statutory audit	**63**	74
- other auditor remuneration (external auditor only)	**10**	10
Internal audit costs	**155**	140
Clinical negligence	**12,053**	9,981
Legal fees	**242**	343
Insurance	**73**	121
Research and development (including staff costs)	**3,261**	3,361
Education and training	**1,507**	1,008
Rentals under operating leases	**1,253**	1,051
Redundancy	**55**	0
Charges to operating expenditure for on-SOFP IFRIC 12 schemes (LIFT)	**324**	291
Car parking and security	**180**	78
Losses, ex gratia and special payments	**42**	103
Other	**1,966**	2,289
Total operating expenses	**445,933**	408,248

All amounts above relate to continuing operations.

7.2 Other auditor remuneration

Other auditor remuneration paid to the external auditor:	2018-19 £000	2017-18 £000
1. Audit of accounts of any associate of the Trust	**0**	0
2. Audit-related assurance services	**10**	10
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**	10

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

7.3. Limitation on auditor's liability

The limitation on auditor's liability for external audit work is £2m (2017-18: £2m).

8. Impairment of assets

Net impairments charged to operating surplus/deficit resulting from:	2018-19 £000	2017-18 £000
Changes in market price	**93**	4,051
Total net impairments charged to operating surplus/deficit	**93**	4,051
Impairments charged to the revaluation reserve	**200**	3,383
Total net impairments	**293**	7,434

Net impairments in 2018-19 and 2017-18 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.

9.1. Employee benefits

	2018-19 Total £000	2017-18 Total £000
Salaries and wages	**196,592**	184,277
Social security costs	**19,491**	18,050
Apprenticeship levy	**977**	914
Employer's contributions to NHS pensions	**23,498**	22,192
Other pension costs	**152**	111
Termination benefits	**228**	208
Temporary staff (agency)	**17,222**	12,695
Total gross staff costs	**258,160**	238,447
Included within:		
Costs capitalised as part of assets	**1,868**	2,688
Total staff costs excluding capitalised staff costs	**256,292**	235,759

9.2. Retirements due to ill-health

During 2018-19 there were 6 early retirements from the Trust agreed on the grounds of ill-health (8 in the year ended 31 March 2018). The estimated additional pension liabilities of these ill-health retirements is £310,000 (£499,000 in 2017-18).

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

10. Pension costs

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

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

a) Accounting valuation

A valuation of scheme liability is carried out annually by the scheme actuary (currently the Government Actuary's Department) as at the end of the reporting period. This utilises an actuarial assessment for the previous accounting period in conjunction with updated membership and financial data for the current reporting period, and is accepted as providing suitably robust figures for financial reporting purposes. The valuation of the scheme liability as at 31 March 2019 is based on valuation data as 31 March 2018, updated to 31 March 2019 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19: 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 report of the scheme actuary, which forms part of the annual NHS Pension Scheme Accounts. These accounts can be viewed on the NHS Pensions website and are published annually. Copies can also be obtained from The Stationery Office.

b) Full actuarial (funding) valuation

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

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2016. The results of this valuation set the employer contribution rate payable from April 2019. The Department of Health and Social Care has recently laid Scheme Regulations confirming that the employer contribution rate will increase to 20.6% of pensionable pay from this date.

The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap set following the 2012 valuation. Following a judgment from the Court of Appeal in December 2018, the Government announced a pause to that part of the valuation process pending conclusion of the continuing legal process.

11. Operating leases

11.1. 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.

	2018-19 £000	2017-18 £000
Operating lease expenses		
Minimum lease payments	**1,253**	1,051
Total	**1,253**	1,051
Future minimum lease payments due:		
- not later than one year	**1,061**	834
- later than one but not later than five years	**2,123**	1,941
- later than five years	**132**	120
Total	**3,316**	2,895

There are no future sub-lease payments expected to be received (2017-18: £nil).

11.2. The Trust as lessor

The Trust has three significant lessor arrangements: for the leasing of the main hospital site car park (3 years remaining); space within the Knowledge Spa (10 years remaining); and space within the Peninsula Dental School (16 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 92 and 1 years remaining respectively.

	2018-19 £000	2017-18 £000
Operating lease revenue		
Minimum lease receipts	**1,613**	1,717
Total	**1,613**	1,717
Future minimum lease receipts due:		
- not later than one year	**994**	1,022
- later than one but not later than five years	**2,879**	3,423
- later than five years	**3,224**	3,674
Total	**7,097**	8,119

12. Finance income

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

	2018-19 £000	2017-18 £000
Interest revenue:		
Interest on bank accounts	**89**	35
Total	**89**	35

13.1. Finance expenditure

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

	2018-19 £000	2017-18 £000
Interest expense:		
Loans from the Department of Health and Social Care	**889**	699
Finance leases	**0**	52
Main finance costs on LIFT scheme obligations	**318**	321
Contingent finance cost on LIFT scheme obligations	**102**	92
Total interest expense	**1,309**	1,164
Unwinding of discount on provisions	**3**	8
Total finance expenditure	**1,312**	1,172

13.2. 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 2018-19 or 2017-18.

14. Other gains and (losses)

	2018-19 £000	2017-18 £000
Gains on disposal of assets	**18**	82
(Losses) on disposal of assets	**(3)**	(29)
Total gains / (losses) on disposal of assets	**15**	53

15. Intangible assets

15.1. Intangible assets 2018-19

	Computer licences	Development expenditure - internally generated	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2018	**23,701**	**2,984**	**2,483**	**29,168**
Additions	**838**	**0**	**1,624**	**2,462**
Reclassifications	**461**	**0**	**(461)**	**0**
Disposals / de-recognition	**(1,152)**	**(32)**	**0**	**(1,184)**
Valuation / gross cost at 31 March 2019	**23,848**	**2,952**	**3,646**	**30,446**
Amortisation at 1 April 2018	**18,842**	**2,984**		**21,826**
Provided during the year	**2,651**	**0**		**2,651**
Disposals / de-recognition	**(94)**	**(32)**		**(126)**
Amortisation at 31 March 2019	**21,399**	**2,952**		**24,351**
Net book value at 31 March 2019	**2,449**	**0**	**3,646**	**6,095**
Net book value at 1 April 2018	**4,859**	**0**	**2,483**	**7,342**

15.2. 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 / de-recognition	(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 / de-recognition	(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**

15.3. 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 £16.6m (2017-18: £12.9m).

16. Property, plant and equipment

16.1 Property, plant and equipment 2018-19

	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 2018	**5,141**	**119,242**	**16**	**3,561**	**67,919**	**261**	**11,832**	**4,854**	**212,826**
Additions	0	8,419	0	3,359	1,642	0	1,218	42	**14,680**
Impairments	0	(200)	0	0	0	0	0	0	**(200)**
Revaluations	0	(4,879)	(2)	0	0	0	0	0	**(4,881)**
Reclassifications	0	1,624	0	(1,663)	0	0	39	0	**0**
Disposals / de-recognition	0	0	0	0	(2,679)	0	0	(23)	**(2,702)**
Valuation / gross cost at 31 March 2019	**5,141**	**124,206**	**14**	**5,257**	**66,882**	**261**	**13,089**	**4,873**	**219,723**
Accumulated depreciation at 1 April 2018	**0**	**8,247**	**2**		**50,067**	**251**	**5,367**	**4,190**	**68,124**
Provided during the year	0	4,389	1		3,979	4	1,759	224	**10,356**
Impairments	0	3,000	0		0	0	0	0	**3,000**
Reversals of impairments	0	(2,907)	0		0	0	0	0	**(2,907)**
Revaluations	0	(8,247)	(2)		0	0	0	0	**(8,249)**
Disposals / de-recognition	0	0	0		(2,676)	0	0	(23)	**(2,699)**
Accumulated depreciation at 31 March 2019	**0**	**4,482**	**1**		**51,370**	**255**	**7,126**	**4,391**	**67,625**
Net book value at 31 March 2019	**5,141**	**119,724**	**13**	**5,257**	**15,512**	**6**	**5,963**	**482**	**152,098**
Net book value at 1 April 2018	**5,141**	**110,995**	**14**	**3,561**	**17,852**	**10**	**6,465**	**664**	**144,702**

16.2 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**

16.3. Property, plant and equipment financing 2018-19

Net book value at 31 March 2019	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	105,342	13	4,738	13,649	6	5,932	417	**134,988**
On-SOFP LIFT contracts	250	950	0	0	0	0	0	0	**1,200**
Owned - government granted	0	5,392	0	0	0	0	0	0	**5,392**
Owned - donated	0	8,040	0	519	1,863	0	31	65	**10,518**
NBV total at 31 March 2019	**5,141**	**119,724**	**13**	**5,257**	**15,512**	**6**	**5,963**	**482**	**152,098**

16.4. 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**

16.5. 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 2019 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 2018-19.

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 £43.8m (2017-18: £37.4m).

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 37);
- Macmillan Cancer Support;
- Sunrise Appeal;
- The Peninsula Cancer Alliance;
- The Friends of St Michaels's Hospital Hayle;
- The Friends of The Royal Cornwall Hospital; and
- The League of Friends of the West Cornwall Hospital.

Other than the conditions imposed by Macmillan Cancer Support (referred to in Note 25), 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 2019 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	12,463	**13,303**
Accumulated impairment loss	(2,928)	(1,644)	**(4,572)**
Depreciation charge for the period	0	(309)	**(309)**
Impairment losses reversed for the period	0	32	**32**

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

17. Inventories

	31 March 2019	31 March 2018
Current	**£000**	£000
Drugs	**2,606**	2,315
Consumables	**5,446**	5,712
Energy	**123**	106
Total inventories	**8,175**	8,133

Inventories recognised in expenses for the year were £85.749m (2017-18: £81.256m). Write-down of inventories recognised as expenses for the year were £350,000 (2017-18: £156,000).

No inventory balances above are held at net realisable value (2017-18: £nil). No inventories have been pledged as securities for liabilities (2017-18: £nil).

18. Receivables

18.1. Trade and other receivables

	31 March 2019	31 March 2018
Current	**£000**	£000
Contract receivables*	**23,286**	
Trade receivables*		8,935
Capital receivables (including accrued capital related income)	**0**	86
Accrued income*		6,523
Allowance for impaired contract receivables / assets*	**(2,847)**	
Allowance for other impaired receivables	**(156)**	(2,501)
Prepayments	**3,407**	2,350
PDC dividend receivable	**0**	260
VAT receivable	**1,244**	888
Other receivables*	**289**	1,839
Total current trade and other receivables	**25,223**	18,380

	31 March 2019	31 March 2018
Non-current	**£000**	£000
Contract receivables*	**708**	
Prepayments	**201**	18
Other receivables*	**0**	462
Total non-current trade and other receivables	**909**	480

Of which receivables from NHS and DHSC group bodies:		
Current	**17,457**	11,888
Non-current	**0**	0
	17,457	11,888

*Following the application of IFRS 15 from 1 April 2018, the Trust's entitlements to consideration for work performed under contracts with customers are shown separately as 'contract receivables'. This replaces the previous analysis into trade receivables and accrued income. IFRS 15 is applied without restatement therefore the comparative analysis of receivables has not been restated. Furthermore, an amendment to the FReM in 2018-19 has resulted in Injury Cost Recovery Income being classified as arising under contract and as such, under IFRS 15, is accounted for within 'contract receivables' at 31 March 2019, rather than 'other receivables' as at 31 March 2018.

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.

There are no prepaid pension contributions included above in either 2018-19 or 2017-18.

18.2. Allowances for credit losses 2018-19

	Contract receivables and contract assets £000	All other receivables £000
Allowances at 1 April 2018		**2,501**
Impact of implementing IFRS 9 (and IFRS 15) on 1 April 2018	**2,371**	**(2,371)**
New allowances arising	**1,019**	**144**
Changes in existing allowances	**(327)**	**(102)**
Reversals of allowances	**(193)**	**(6)**
Utilisation of allowances (write-offs)	**(23)**	**(10)**
Allowances at 31 March 2019	**2,847**	**156**

Department of Health and Social Care guidelines require allowances for credit losses to be provided for injury cost recovery receivables at 21.89% (2017-18: 22.84%). However, the Trust has taken the decision to provide for older balances at a higher rate.

Credit losses for Non-NHS receivables are provided for on the basis of age and type, as follows:

	31 March 2019	31 March 2018
Balances older than 12 months	**75%**	75%
Balances between 6 and 12 months old	**75%**	75%
Balances less than 6 months old	**up to 75%**	up to 69%

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

18.3. Allowances for credit losses 2017-18

IFRS 9 and IFRS 15 are adopted without restatement therefore this analysis is prepared in line with the requirements of IFRS 7 prior to IFRS 9 adoption. As a result it differs in format to the current period disclosure.

	2017-18 £000
Allowances at 1 April 2017	**1,792**
Increase in provision	**822**
Amounts utilised	**(29)**
Unused amounts reversed	**(84)**
Allowances at 31 March 2018	**2,501**

19.1. Cash and cash equivalents movements

Cash and cash equivalents comprise cash at bank, cash in hand and cash equivalents. Cash equivalents are readily convertible investments of known value which are subject to an insignificant risk of change in value.

	31 March 2019 £000	31 March 2018 £000
Opening balance	**8,156**	3,099
Net change in year	**1,536**	5,057
Closing balance	**9,692**	8,156
Comprising:		
Cash with the Government Banking Service	**9,665**	8,128
Cash with commercial banks and in hand	**27**	28
Cash and cash equivalents as in the Statement of Financial Position	**9,692**	8,156
Bank overdraft - commercial banks and Government Banking Service	**(2)**	(5)
Cash and cash equivalents as in the Statement of Cash Flows	**9,690**	8,151

19.2. Third party assets

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

	31 March 2019 £000	31 March 2018 £000
Monies on deposit	**2**	2

20. Trade and other payables

Current trade and other payables	31 March 2019 £000	31 March 2018 £000
Trade payables	**6,626**	3,765
Capital payables	**3,789**	5,766
Accruals (revenue only)	**23,057**	18,786
Social security costs	**2,306**	811
PDC dividend payable	**17**	0
Accrued interest on loans*		101
Other payables	**1,532**	708
Total current trade and other payables	**37,327**	29,937
Of which payables to NHS and DHSC group bodies:	**3,385**	2,771

*Following the adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan within Borrowings (see Note 22). IFRS 9 is applied without restatement, therefore comparatives have not been restated.

Included in the amounts above are £709,000 (2017-18: £106,000) in respect of outstanding pension contributions. There are no amounts included to buy out early retirement liabilities in either 2018-19 or 2017- 18.

21. Other liabilities

Current	31 March 2019 £000	31 March 2018 £000
Deferred income: contract liabilities	**3,420**	5,506
Other deferred income	**528**	
Total other current liabilities	**3,948**	5,506

Non-current	31 March 2019 £000	31 March 2018 £000
Deferred income: contract liabilities	**0**	1,584
Other deferred income	**1,056**	
Total other non-current liabilities	**1,056**	1,584

Following the application of IFRS 15 from 1 April 2018, the presentation of this note has changed to disclose 'deferred income from contract liabilities' and 'other deferred income' separately. IFRS 15 is applied without restatement, therefore the comparative analysis has not been restated.

22. Borrowings

Current	31 March 2019 £000	31 March 2018 £000
Bank overdrafts	**2**	5
Loans from the Department of Health and Social Care	**17,932**	7,370
Obligations under LIFT contracts	**22**	18
Obligations under finance leases	**0**	293
Total	**17,956**	7,686

Non-current	31 March 2019 £000	31 March 2018 £000
Loans from the Department of Health and Social Care	**45,000**	45,166
Obligations under LIFT contracts	**1,481**	1,503
Obligations under finance leases	**0**	807
Total	**46,481**	47,476

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

Following the adoption of IFRS 9 on 1 April 2018, loans are measured at amortised cost. Any accrued interest is now included in the carrying value of the loan. IFRS 9 is applied without restatement therefore comparatives have not been restated.

Loan type	Value issued (£000)	Value outstanding (£000)		Interest rate (%)	Date issued	Term	Repayment start date	Date fully repaid
		31 March 2019	31 March 2018					
Revenue support loan	2,000	**141**	427	0.58	August 2012	7 years, 1 Month	March 2013	September 2019
Capital Investment loan	2,000	**141**	427	0.58	August 2012	7 years, 1 Month	March 2013	September 2019
Capital Investment loan	5,000	**2,778**	3,332	1.99	March 2014	10 years	September 2015	March 2024
Revenue support loan	24,733	**18,178**	19,791	1.65	February 2015	15 years	August 2015	August 2030
Revenue support loan	3,800	**3,806**	3,800	1.50	February 2016	2 years	February 2020*	February 2020*
Interim revenue support loan	10,709	**10,741**	10,709	1.50	January 2017	3 years	January 2020	January 2020
Capital Investment loan	6,161	**4,775**	5,564	1.07	February 2016	9 years	August 2017	February 2025
Revenue support loan	4,235	**4,248**	4,235	1.50	January 2018	3 years	January 2021	January 2021
Revenue support loan	1,790	**1,793**	1,790	1.50	February 2018	3 years	February 2021	February 2021
Revenue support loan	2,461	**2,462**	2,461	1.50	March 2018	3 years	March 2021	March 2021
Revenue support loan	4,396	**4,409**		1.50	July 2018	3 years	July 2021	July 2021
Revenue support loan	3,014	**3,019**		1.50	August 2018	3 years	August 2021	August 2021
Revenue support loan	3,082	**3,100**		1.50	November 2018	3 years	November 2021	November 2021
Revenue support loan	1,839	**1,847**		1.50	December 2018	3 years	December 2021	December 2021
Revenue support loan	1,005	**1,007**		1.50	February 2019	3 years	February 2022	February 2022
Revenue support loan	487	**487**		1.50	March 2019	3 years	March 2022	March 2022
TOTAL	**76,712**	**62,932**	**52,536**					

* The repayment date was originally February 2018, was extended in 2017-18 to February 2019 and was further extended in 2018-19 to February 2020.

23. Reconciliation of liabilities arising from financing activities

	DHSC loans £000	Finance leases £000	LIFT scheme £000	Total £000
Carrying value at 1 April 2018	52,536	1,100	1,521	**55,157**
Cash movements				
Financing cash flows - payments and receipts of principal	10,253	0	(18)	**10,235**
Financing cash flows - payments of interest	(847)	0	(318)	**(1,165)**
Non-cash movements				
Impact of applying IFRS 9 at 1 April 2018	101	0	0	**101**
Application of effective interest rate	889	0	318	**1,207**
Other changes	0	(1,100)	0	**(1,100)**
Carrying value at 31 March 2019	**62,932**	**0**	**1,503**	**64,435**

24.1. Provisions

	Pensions - early departure costs £000	Pensions - injury benefits £000	Legal claims £000	Other £000	Total £000
Balance at 1 April 2018*	**1,525**	**3,100**	**76**	**13**	**4,714**
Change in the discount rate	(7)	(47)	0	0	**(54)**
Arising during the year	106	91	37	0	**234**
Utilised during the year	(146)	(185)	(42)	0	**(373)**
Reversed unused	0	0	(20)	(13)	**(33)**
Unwinding of discount	1	3	(1)	0	**3**
Balance at 31 March 2019	**1,479**	**2,962**	**50**	**0**	**4,491**
Expected timing of cash flows:					
- no later than one year	146	185	50	0	**381**
- later than one year and no later than five years	582	735	0	0	**1,317**
- later than five years	751	2,042	0	0	**2,793**
Total	**1,479**	**2,962**	**50**	**0**	**4,491**

*Pension injury benefits and a portion of early departure pension costs were previously disclosed in other provisions at 31 March 2018.

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.

24.2. Clinical negligence liabilities

At 31 March 2019, £123.860m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Cornwall Hospitals NHS Trust (31 March 2018: £140.892m).

25. Contingencies

	31 March 2019	31 March 2018
Value of contingent liabilities	**£000**	£000
NHS Resolution legal claims (1)	**45**	56
Other (2)	**3,055**	3,040
Net value of contingent liabilities	**3,100**	3,096

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

(2) The Trust received funding between 2015-16 and 2018-19 totalling £3,055,000 from Macmillan Cancer Support, 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 2019, this percentage stands at 100% (31 March 2018: 100%).

The Trust has no contingent assets.

26. Contractual capital commitments

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

	31 March 2019	31 March 2018
	£000	£000
Property, plant and equipment	**844**	271
Intangible assets	**1,549**	0
Total	**2,393**	271

The Trust had no individually significant capital commitments at 31 March 2019.

27. 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.

	31 March 2019 £000	31 March 2018 £000
Gross LIFT liabilities	**4,678**	5,014
Of which liabilities are due:		
- not later than one year	**336**	336
- later than one but not later than five years	**1,345**	1,344
- later than five years	**2,997**	3,334
Finance charges allocated to future periods	**(3,175)**	(3,493)
Net LIFT liabilities	**1,503**	1,521
Of which payable:		
- not later than one year	**22**	18
- later than one but not later than five years	**148**	121
- later than five years	**1,333**	1,382
Total	**1,503**	1,521

27.2. Total on-SOFP arrangement commitments

The Trust's total future obligations under this on-SOFP scheme are as follows:

	31 March 2019 £000	31 March 2018 £000
Total future payments committed in respect of the LIFT arrangement	**12,040**	12,730
Of which liabilities are due:		
- not later than one year	**762**	719
- later than one but not later than five years	**3,116**	3,040
- later than five years	**8,162**	8,971
Total future payments	**12,040**	12,730

27.3. Analysis of amounts payable to LIFT provider

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

	31 March 2019 £000	31 March 2018 £000
Unitary payments payable to LIFT provider	**762**	719
Consisting of:		
- interest charge	**318**	321
- repayment of finance lease liability	**18**	15
- service element and other charges to operating expenditure	**324**	291
- contingent rent	**102**	92
Total amounts paid to LIFT provider	**762**	719

28. Financial instruments

28.1. 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 2019 are in receivables from customers, as disclosed in the trade and other receivables note.

Liquidity risk

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

28.2. Carrying values of financial assets

IFRS 9: Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial assets as at 31 March 2019 under IFRS 9	Held at amortised cost £000
Trade and other receivables excluding non-financial assets	**21,280**
Cash and cash equivalents at bank and in hand	**9,692**
Total at 31 March 2019	**30,972**

Carrying values of financial assets as at 31 March 2018 under IAS 39	Loans and receivables £000
Trade and other receivables excluding non-financial assets	**13,176**
Cash and cash equivalents at bank and in hand	**8,156**
Total at 31 March 2018	**21,332**

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

28.3. Carrying values of financial liabilities

IFRS 9: Financial Instruments is applied retrospectively from 1 April 2018 without restatement of comparatives. As such, comparative disclosures have been prepared under IAS 39 and the measurement categories differ to those in the current year analyses.

Carrying values of financial liabilities as at 31 March 2019 under IFRS 9	Held at amortised cost £000
Loans from the Department of Health and Social Care	**62,932**
Obligations under PFI, LIFT and other service concession contracts	**1,503**
Other borrowings	**2**
Trade and other payables excluding non financial liabilities	**35,002**
Total at 31 March 2019	**99,439**

Carrying values of financial liabilities as at 31 March 2018 under IAS 39	Other financial liabilities £000
Loans from the Department of Health and Social Care	**52,536**
Obligations under finance leases	**1,100**
Obligations under PFI, LIFT and other service concession contracts	**1,521**
Other borrowings	**5**
Trade and other payables excluding non financial liabilities	**29,126**
Total at 31 March 2018	**84,288**

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

28.4. Maturity of financial liabilities

Financial liabilities maturing in:	2018-19 £000	2017-18 £000
- one year or less	**52,957**	36,812
- more than one year but not more than two years	**11,511**	14,321
- more than two years but not more than five years	**22,935**	18,077
- more than five years	**12,036**	15,078
Total	**99,439**	84,288

29. Losses and special payments

	2018-19 Total number of cases	2018-19 Total value of cases £000	2017-18 Total number of cases	2017-18 Total value of cases £000
Losses:				
Cash losses	**9**	**10**	14	11
Bad debts and claims abandoned	**26**	**23**	37	18
Stores losses and damage to property	**7**	**350**	3	156
Total losses	**42**	**383**	54	185
Special payments:				
Compensation under court order or legally binding arbitration award	**1**	**1**	4	33
Ex-gratia payments	**70**	**73**	64	70
Total special payments	**71**	**74**	68	103
Total losses and special payments	**113**	**457**	122	288

There were no individual losses, special payments or gifts in excess of £300,000 in either 2018-19 or 2017- 18.

30.1 Initial application of IFRS 9

IFRS 9: Financial Instruments as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to reserves on 1 April 2018.

IFRS 9 replaces IAS 39 and introduces a revised approach to classification and measurement of financial assets and financial liabilities, a new forward-looking 'expected loss' impairment model and a revised approach to hedge accounting.

Under IFRS 9, borrowings from the Department of Health and Social Care, which were previously held at historic cost, are measured on an amortised cost basis. Consequently, on 1 April 2018 borrowings increased by £101,000, and trade payables correspondingly reduced.

Reassessment of allowances for credit losses under the expected loss model would have resulted in a £178,000 decrease in the carrying value of receivables however, on the grounds of immateriality, the Trust did not adjust its reserves at 1 April 2018.

The GAM expands the definition of a contract in the context of financial instruments to include legislation and regulations, except where this gives rise to a tax. Implementation of this adaptation on 1 April 2018 has led to the classification of receivables relating to Injury Cost Recovery as a financial asset measured at amortised cost. The carrying value of these receivables at 1 April 2018 was £2,169,000.

30.2 Initial application of IFRS 15

IFRS 15: Revenue from Contracts with Customers as interpreted and adapted by the GAM has been applied by the Trust from 1 April 2018. The standard is applied retrospectively with the cumulative effect of initial application recognised as an adjustment to the income and expenditure reserve on 1 April 2018.

IFRS 15 introduces a new model for the recognition of revenue from contracts with customers replacing the previous standards IAS 11, IAS 18 and related Interpretations. The core principle of IFRS 15 is that an entity recognises revenue when it satisfies performance obligations through the transfer of promised goods or services to customers at an amount that reflects the consideration to which the entity expects to be entitled to in exchange for those goods or services.

As directed by the GAM, the Trust has applied the practical expedient offered in C7A of the standard removing the need to retrospectively restate any contract modifications that occurred before the date of implementation (1 April 2018).

31. Events after the end of the reporting period

There are no known post balance sheet events requiring disclosure.

32. Better Payment Practice Code

	2018-19 Number	**2018-19 £000**	2017-18 Number	2017-18 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**96,376**	**173,114**	83,210	144,332
Total non-NHS trade invoices paid within target	**92,201**	**157,652**	78,932	137,011
Percentage of non-NHS trade invoices paid within target	**95.67%**	**91.07%**	94.86%	94.93%
NHS payables				
Total NHS trade invoices paid in the year	**2,419**	**57,773**	2,153	49,791
Total NHS trade invoices paid within target	**2,321**	**57,105**	2,074	48,749
Percentage of NHS trade invoices paid within target	**95.95%**	**98.84%**	96.33%	97.91%

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.

33. External financing

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

	2018-19 £000	2017-18 £000
Cash flow financing	**9,997**	7,039
External financing requirement	**9,997**	7,039
External Financing Limit	**20,292**	14,412
Underspend against the External Financing Limit	**10,295**	7,373

34. Capital Resource Limit

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

	2018-19 £000	2017-18 £000
Gross capital expenditure	**17,142**	18,893
Less: Disposals	**(1,061)**	(668)
Less: Donated and granted capital additions	**(1,153)**	(734)
Charge against the Capital Resource Limit	**14,928**	17,491
Capital Resource Limit	**16,004**	17,572
Underspend against the Capital Resource Limit	**1,076**	81

The reported underspend against the CRL for 2018-19 included a non-cash amount of £1,058,000. This underspend arises from the de-recognition of a finance lease and the consequent calculation of technical, non-cash proceeds on disposal credited against the CRL. The cash underspend against the CRL for 2018- 19 was £18,000.

35. Break-even duty financial performance

	2018-19 £000	2017-18 £000
Adjusted financial performance surplus / (deficit) (control total basis)	**(4,136)**	(2,591)
IFRIC 12 breakeven adjustment	**32**	34
Breakeven duty financial performance surplus / (deficit)	**(4,104)**	(2,557)

36. 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**	**2018-19 £000**
Break-even in-year financial performance		8,349	7,544	4,437	9,809	3,938	(6,908)	(6,906)	(929)	(2,557)	**(4,104)**
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)	**(30,095)**
Operating income		303,925	310,471	314,246	323,341	332,819	342,503	355,815	379,462	405,020	**445,376**
Cumulative break-even position as a percentage of turnover		-11.3%	-8.7%	-7.1%	-3.9%	-2.6%	-4.6%	-6.3%	-6.2%	-6.4%	**-6.8%**

The Trust reported a £4.1m deficit in 2018-19 and holds a cumulative deficit of £30.1m at 31 March 2019.

The Trust's approved plan is based on a breakeven budget for 2019-20 and therefore the Trust will continue to fail to achieve breakeven on a cumulative basis at 31 March 2020. 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.

37. 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 22.

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 2019

Entity	Revenue with related party £000	Expenditure with related party £000	Receivables with related party £000	Payables with related party £000
Kernow Clinical Commissioning Group	**297,447**	**192**	**2,972**	**1,788**
NHS England	**94,163**	**226**	**12,285**	**153**
Cornwall Partnership NHS FT(1)	**6,559**	**12,764**	**397**	**1,517**
University Hospitals Plymouth	**608**	**1,390**	**274**	**465**
Royal Devon and Exeter FT	**1,519**	**261**	**164**	**37**
NHS Resolution	**0**	**12,053**	**0**	**0**
Health Education England	**14,756**	**0**	**356**	**146**

Year to 31 March 2018

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

(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 Director of Finance.

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 former Chairman, who resigned in May 2018, is a Councillor with Cornwall Council. Transactions and balances with the Council are disclosed below:

Cornwall Council	Revenue with related party £000	Expenditure with related party £000	Receivables with related party £000	Payables with related party £000
Year to 31 March 2019	**5,061**	**72**	**495**	**0**
Year to 31 March 2018	3,790	57	263	1

The Trust contracted Orwin & Algeo Management Solutions to provide advisory services during the financial year. Subsequently the Trust contracted with Orwin & Algeo Management Solutions for an individual director to provided board director services, as Chief Operating Officer, to the Trust. The total cost for these services to the Trust was £252,000 (2017-18: £nil). No balances were outstanding at 31 March 2019 (£nil at 31 March 2018).

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

	2018-19 (Draft) £000	2017-18 *Restated £000
Total incoming resources	**543**	668
Total resources expended with bodies outside the NHS	**(58)**	(50)
Total resources expended with Royal Cornwall Hospitals NHS Trust	**(722)**	(717)
Total resources expended with other NHS providers	**(7)**	0
Total resources expended	**(787)**	(767)
Net (outgoing)/incoming resources	**(244)**	(99)
Investment gains/(losses)	**41**	6
Net movement in funds	**(203)**	(93)

Extracts from Charity's Balance Sheet

Extracts from Charity's Balance Sheet

	2018-19 (Draft) £000	2017-18 *Restated £000
Investments	**2,168**	2,094
Total fixed assets	**2,168**	2,094
Cash	**145**	298
Other current assets	**16**	105
Current liabilities	**(94)**	(59)
Net assets	**2,235**	2,438
Funds of the Charity		
Restricted funds	**862**	1,033
Non-restricted funds	**1,373**	1,405
Total funds	**2,235**	2,438

*Draft 2017-18 figures were previously presented in the 2017-18 Trust financial statements. The final 2017- 18 Charity figures are now presented, following the finalisation of the Charity's accounts.

Included within current liabilities at 31 March 2019 is £33,000 (2017-18: £14,000) 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 2019, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including a summary of significant accounting policies.

The financial reporting framework that has been applied in their preparation is applicable law and International Financial Reporting Standards (IFRSs) as adopted by the European Union, and as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2018-19.

In our opinion the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2019 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 2018-19; 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.

Material uncertainty relating to going concern

We draw attention to note 1.1.2 in the financial statements, which indicates that the Trust has identified the need for additional cash support of approximately £1.8 million to support the 2019-20 financial position and £14.5 million to repay loans falling due within one year. As stated in note 1.1.2, the required borrowing has not yet been formally approved by the Department of Health and Social Care. The Trust has approved a breakeven budget for the year ended 31 March 2020 which requires achievement of £14 million of efficiency

savings and receipt of £17.3 million of Provider Sustainability Funding (PSF), Financial Recovery Fund (FRF) and Marginal Rate Emergency Tariff income from the Department of Health and Social Care. Of the £17.3m the receipt of PSF and FRF elements totalling £12.8m are dependent on the achievement of financial targets.

These events or conditions, along with the other matters as set forth 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, other than 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 audit 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 the 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 Statement1 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 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 2018-19 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 issue a report 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 refer a matter to the Secretary of State under Section 30 of the Local Audit and Accountability Act 2014 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the body incurring unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency; or
- we make 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 that on 11 May 2018 we referred a matter to the Secretary of State under section 30(a) 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.

We further set out in this letter that as the Trust has not yet agreed a plan to recover its cumulative deficit over a five-year period it is expected that the Trust will remain in breach of its breakeven duty for the next five years.

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 they have been

Give a true and fair view of the financial position of the Trust as at 31 March 2019 and of its expenditure and income for the year then ended

informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

The Audit and Risk Committee is Those Charged with Governance. Those charged with governance are responsible for overseeing the Trust's financial reporting process.

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 2019.

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 is reliant on financial support from the Department of Health and Social Care in order to meet its commitments. At 31 March 2019 the Trust had a cumulative deficit of £30.1 million and borrowings from the Department of Health and Social Care totalling £62.9 million.
- The Trust has set a breakeven budget for 2019/20. However, delivery of this plan is dependent on receipt of £17.3 million of Provider Sustainability Funding, Financial Recovery Fund and Marginal Rate Emergency Tariff income and the Trust making £14 million of cost improvements. There is a risk that the Trust will not obtain all of this funding or make all of the planned cost improvements. This would have a significant impact on the Trust's ability to deliver a breakeven position.
- The Trust has been graded as 'requires improvement' in the Care Quality Commission's (CQC) December 2018 report. Whilst this shows improvement from the previous grading of'inadequate' the Trust remains in special measures. This is due to the 'Well-Led' element of the CQC's inspection being graded as 'inadequate'.

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 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(1)(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 2019, 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.

Use of our report

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.

Geraldine Daly, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor
2 Glass Wharf
Temple Quay
BS1 0EL
Bristol
29 May 2019

Royal Cornwall Hospitals NHS Trust
Annual Report 2018/19