Aspiring to provide
Brilliant care to
One + all

Royal Cornwall Hospitals
NHS Trust

Annual Report & Accounts 2020 - 2021

We're stronger together

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Safe, compassionate care
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Leadership, culture and celebrating achievement
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Chairwoman's Foreword

I am delighted to welcome you to our 2020/21 Annual Report. This is an important document for us to set out how we work, how we've performed and, where we are focussing to make improvements. We want to provide the best and safest possible acute care we can for our population.

It has been an incredibly challenging year due to the Covid-19 pandemic. We've all experienced the impact of the pandemic with feelings of loss, confusion and fear, and also experienced the amazing response of our county and our NHS to care for people in the most difficult of circumstances.

Our people have been astonishing in their resolve, resilience and compassion to care for the people of Cornwall and the Isles of Scilly. I am so proud of every single person, in every single role, at RCHT and 'thank you' doesn't quite seem enough.

We've also been supported by our brilliant volunteers who've helped patients to keep in touch with families, supported patients when they've been discharged from hospital, checking-in to see how they are, and providing much needed person-power to resource our Covid-19 vaccination sites. Their contribution is essential to our hospitals and our volunteers, including our Friends, are much valued partners in the work that we do.

I also want to thank the people of Cornwall and Isles of Scilly for their support for RCHT, the care they have given their own family and neighbours, and their understanding with regards the changes we had to make to keep people as safe as possible.

I hope you enjoy reading how we've done during 2020/21. I warmly invite you to our Annual Public Meeting in September to ask our Board questions on how we have done.

We look forward to 2021/22 with hope and courage.

Best wishes
Mairi

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Performance Report

01.

Chief Executive's Statement on Performance of the Organisation

By Kate Shields - Chief Executive

Few, if any of us, could have foreseen what the last 12 months would bring as the NHS faced the biggest public health crisis in its history. The Covid-19 pandemic has seen us dig deep on our resilience, resolve, flexibility, strength and courage – it has been the toughest of times.

It has meant many of our plans were put on hold whilst we prepared for, and responded to, the needs of our local community. For once, our more remote geography played to our advantage, giving us valuable extra time to prepare and learn from the experiences of others, as Covid-19 marched its way to our part of the country.

We saw the rapid introduction of new technologies to help us care for and keep in touch with patients and their families. For example, the vast increase in telephone and video outpatient clinics, use of online conferencing for meetings and discussion, and the shift to home working for those who are able, has been amazing.

Our clinical teams quickly adapted to make sure everyone had access to the level of care they needed; increasing our capacity for critical care, learning new skills, following infection prevention and social distancing requirements to keep people as safe as possible.

The pandemic didn't stop the development of our hospitals over the past year. We built and opened a major expansion of our Emergency Department, and new facilities for MRI and oncology, as well as a progressive recovery unit, are well underway. Many more projects are in the planning stages, including our eagerly anticipated Women's and Children's Unit.

We have been proud to play a part in vital research to develop the Covid-19 vaccines now protecting our population and have led an outstanding vaccination programme with our NHS partners in primary care. Our laboratories have processed hundreds of thousands of tests and Covid-19 has had a positive impact on our aim to be more sustainable. We were the first hospitals in the UK to start recycling the mountain of disposable masks that have become part of everyday life for us all.

As we begin our recovery and get our services back on track, our priority will be on those whose treatment has been delayed as a result of the pandemic, taking care to ensure people receive their treatment according to the severity of their condition. Our aspiration to provide brilliant care and be among the safest hospitals in the country remains firmly in our sights and will be working more closely than ever with our health and care partners to provide our population with the services they need and deserve.

This section of the Annual Report contains a description of our organisation and our strategy, and an assessment of the degree to which we have been able to deliver our strategic objectives this year, alongside responding to the Covid-19 pandemic.

It also provides an overview of how we are working to promote equality and reduce health inequalities, the key risks and issues that might affect our ability to deliver our strategic objectives, and how we have managed those risks this year.

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

Who we are

We have three main sites: Royal Cornwall Hospital, Truro; St Michael's Hospital, Hayle; and West Cornwall Hospital, Penzance.

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

5,887 full time equivalents (FTEs), which is 6,700 people, work together to provide acute hospital care and supporting services to a population of more than 430,000 residents; a figure which is boosted by an estimated 250,000 during the busy holiday periods.

Our team includes more than 400 volunteers, in addition to our wonderful Friends of Royal Cornwall Hospital, St Michaels Hospital and West Cornwall Hospital, and an in-house bank of 1,800 people (393 FTE's) working flexibly to help us respond to changes in demand.

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

The number of people living in Cornwall is rising faster than the national average and over the next 10 years, we are planning for a 6% increase in the number of people who live here.

Our population 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'.

The geography of our county, surrounded on three sides by the sea, and the remoteness of the Isles of Scilly, present unique challenges

Total Beds

609
Royal Cornwall Hospital

64
West Cornwall Hospital

69
St Michael's Hospital

Population Served

430,000

ONS 2019 Mid-year estimates, combined population for Cornwall and Isles of Scilly

Income

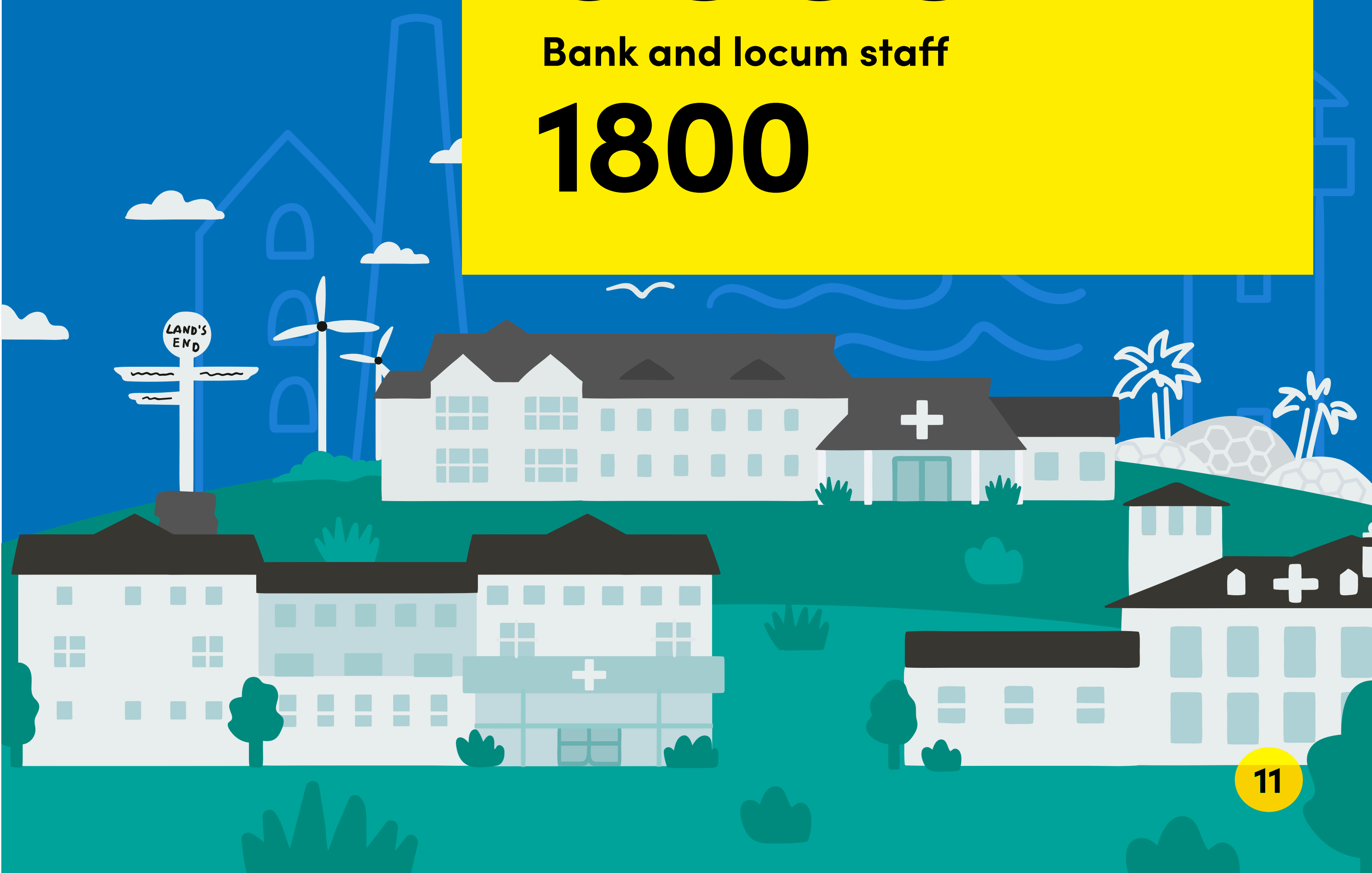
£537.2m

Full time equivalent employees

5800+

Bank and locum staff

1800



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**:

1	**Anaesthetics, Critical Care and Theatres**
2	**Clinical Support**
3	**General Surgery and Cancer**
4	**Specialist Medicine**
5	**Specialist Services and Surgery**
6	**Urgent, Emergency and Trauma**
7	**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 and a Corporate Care Group covering core supporting functions including finance, HR, estates and strategy.

Our team and governance

The RCHT Board is made up of Non-Executive and Executive Directors who together are responsible for leading our hospitals.

For 2020/21, our Board met in public 10 times. Our Chair is appointed by NHS Improvement and works with us to appoint other members of the Trust Board.

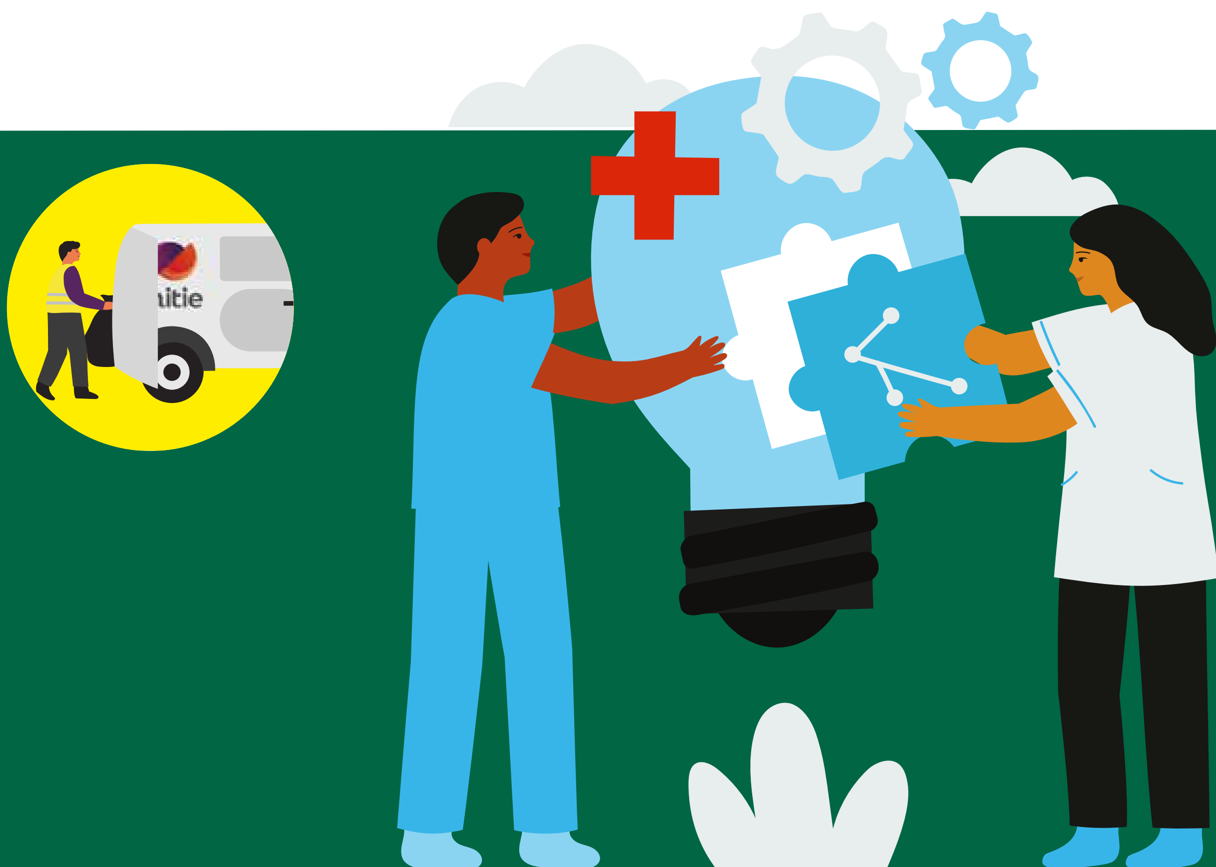
Our seven Clinical Care Groups are supported by corporate teams including finance, human resources and estates and facilities. Payroll and information technology services are hosted by Royal Cornwall Hospitals on behalf of the local NHS community, which includes the provision of IT services to GP surgeries.

Soft Facilities Management services - such as cleaning, portering and 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, operating as Sustenation, which is actively developing its business model as a provider to other NHS Trusts and commercial businesses.

We work together with our regulators and local commissioners to deliver care that meets NHS England standards and the expectations set out in the NHS Constitution.

Our main commissioner is NHS Kernow Clinical Commissioning Group. We are a base for medical and nurse training 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.



Our registration

RCHT is fully registered with the Care Quality Commission (CQC) to allow it to carry out a wide range of regulated activity. The principle location registration is for the Royal Cornwall Hospital at Treliske, with additional registrations in place for our other key sites and services.

Our services are currently rated as 'requires improvement' overall and rated 'good' for well-led, effective and caring. We were issued with a warning notice under Section 29a of the Health and Social Care Act 2008 as a result of an unannounced CQC inspection in December 2020 following a cluster of never events during the year.

We continue to work to address the findings and requirements of the warning notice and have a comprehensive integrated improvement plan that addresses the safety and governance concerns that were raised.

This is monitored monthly for assurance on behalf of the Board by the Quality Assurance Committee.

Overall Requires Improvement

Read overall summary

Safe	Requires Improvement
Effective	Good
Caring	Good
Responsive	Requires Improvement
Well-led	Good

How many people we cared for:

Our Emergency Department saw **68,077** patients.

We dealt with **35,569** emergency admissions.

We saw **428,206** outpatients and carried out over **48,944** day-case admissions.

3,930 babies were delivered at our hospital sites or at home with our midwifery team.

Strategic aims and priorities

Our Strategy describes our improvement journey, and is based on a recognition of our need to improve and aspiration to achieve greater things.

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

We are placing Quality Improvement at the heart of everything we do, so we become and remain a brilliant place to work and receive care.

We are continuing to change 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.

To do this, we focus on three key strategic goals: Brilliant Care; Brilliant People and Brilliant Improvement.

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

Care + Compassion, Inspiration + Innovation, Working Together, Pride + Achievment, Trust + Respect

Our Strategy is designed to take us through the next four years and we have set ourselves annual milestones.

It is aligned to our quality improvement programme and how we will meet our goals is given in more detail in our supporting strategies:

- **Brilliant Care**
- **Brilliant People**
- **Brilliant Improvement**
- **Clinical Strategy**
- **Digital Strategy**
- **Research & Development Strategy**
- **Equality, Diversity & Inclusion**

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 where possible and respond to situations professionally and calmly.

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Risks

Key risks that could affect the delivery of our objectives were set out within the Board Assurance Framework (BAF) 2020/21, developed in line with the Risk Management Strategy and Policy.

The BAF is the key document which records the principal risks to strategic objectives. The BAF also provides the Board with sources of assurance that controls are working effectively (see the Annual Governance Statement for more information). The 2020/21 BAF and the principal risks related to the strategic goals outlined in our 2019-22 Strategy and the impact of the pandemic.

The most significant (red) risks as highlighted by the BAF as at the end of March 2021 are as follows:

- Impact of the Covid-19 pandemic on our referral to treatment performance and elective waiting times caused by loss of both capacity and activity in response to the pandemic and resulting in patient harm and stress for our workforce
- Failure to deliver high quality, harm free, compassionate care to patients due to ongoing recruitment challenges and the use of temporary staff
- Failure to not be resilient at times of surge and extremis, which will adversely impact on the quality of care delivered, and our ability to deliver a range of constitutional standards

- Failure to align organisational strategies/priorities which will limit the scale and pace of our progress towards an integrated care system for the Cornwall and Isles of Scilly Health and Care Partnership
- Risk that our buildings, equipment and digital infrastructure are not fit for purpose, nor provide a safe and effective environment to deliver health care, due to insufficient capital resource
- Insufficient change management capacity and capability to quickly bring about cultural change to support the delivery of brilliant care
- Failure of systems and processes of health and safety due to insufficient specialist knowledge and resources to rectify identified gaps
- Failure to adequately manage and prioritise remedial works for existing unsafe conditions across the estate, leading to multiple statutory breaches, prosecutions, reputational damage, harm to staff and patients and damage to buildings and infrastructure

Our most significant risk at the end of March was the long term impact of Covid-19 on our services and the wellbeing of colleagues, and this risk was adjusted in year in response to the changing nature of the pandemic.

While the overarching risk relating to the immediate pandemic response reduced during the year, the impact of Covid-19 on our ability to meet referral to treatment times remains a significant concern.

Covid-19 planning and preparedness is managed through the Incident Control Centre (ICC), in close liaison with our partners, to achieve a Cornwall-wide response.

The Risk Manager reviews all risks held by the Incident Control Centre (ICC) cross referencing them with existing risks on our Datix incident recording system where required.

We also included new risks during the year in regards our estate in response to a fire on the Treliske site in October 2020 and improvements needed for compliance in key areas of our physical infrastructure.

The Corporate Risk Register (CRR) is reviewed regularly by the executive board.

Delivery of our strategic objectives in 2020-21

This has been a very unusual year – just as plans were being finalised in March 2020, we entered a global pandemic that has dominated our lives and significantly affected how we deliver health care over the past year.

Our care groups have had to manage ongoing uncertainty and change their plans dynamically to respond to the evolving situation.

However, while the delivery of some aspects of our strategy have become more difficult, our strategic goals remain our guiding principles and long-term objectives. As such, our Board of Directors has continued to monitor progress against our strategy, while also scrutinising and guiding our response to the Covid-19 pandemic.

Brilliant Care

In the context of the pandemic, the safety of our services has relied on us being able to ensure enough inpatient and critical care capacity to treat the people who need hospital care.

We have developed and implemented a four-phased plan to expand critical care capacity in response to the changing situation, and through the incredible efforts of our people we have been able throughout to care for those most in need of our services.

In common with other hospitals across the country, this response has meant a reduction in routine appointments and procedures.

This has been a significant factor in us not achieving all constitutional standards this year and has led to delays in providing people with the elective care they need.

Going forward, tackling waiting lists and getting our services back on track will be crucial to providing brilliant care to our population and we have plans to undertake this challenge.

One of the most important ways in which we can understand how well we are performing is to ask the people who use our services. We do this through the Friends and Family Test, our annual inpatient and outpatient surveys, and increasingly the online 'TripAdvisor-style' forum, Care Opinion.

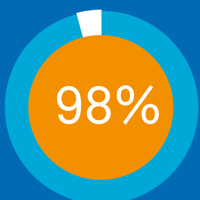
Detail on the results and actions we have taken can be found in our Quality Accounts 2020-21 (published from the end of June 2021).

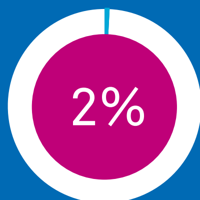
Friends and Family Test

Friends and Family Test (FFT) has looked a little different over the past financial year following a national pause in April 2020. FFT was relaunched in December 2020*, but due to the COVID-19 pandemic, twe have been unable to reimplement paper based surveys to collect data because of potential cross contamination; this is why response rates are low.

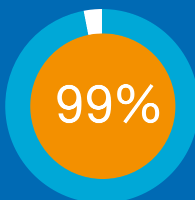
Following guidance from the Infection, Prevention and Control team, we have now ensured that all patient iPads have the survey app, 'My Meridian', installed in order to collect FFT data. We have also provided departments with QR code posters and hand out cards for patients to take away and complete the survey online at home.

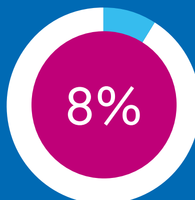
Inpatients and Day Case



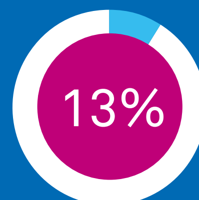


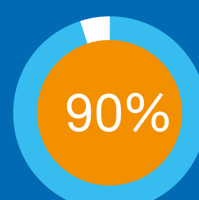
Maternity Birth



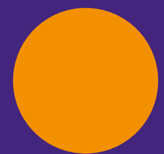


Emergency Department

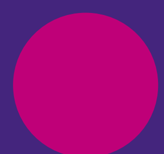




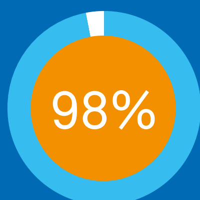
Overall Experience Rate



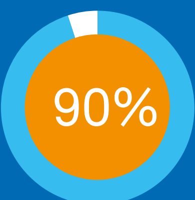
Response Rate



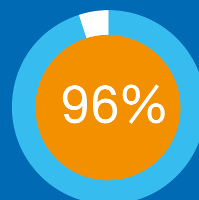
Postnatal Ward



Antenatal Care



Outpatients Department



Postnatal Community

* All figures reported are taken as an average between 01 December 2020 to 31 March 2021.

There are aspects of how we communicate with our patients that we need to improve. We have not achieved our aims this year of delivering 100% Duty of Candour compliance (we achieved 88%) or 95% of complaints responded to within 30 days (73%).

During the first quarter of 2020-21 it was apparent that the pandemic affected the amount of people contacting us to make complaints.

There are various factors which may have contributed to this which are all linked with COVID-19, such as the reduction in patient facing contact and community support of the NHS causing some people to refrain from making contact with the Patient Experience Team about their concerns.

During the period 1 April 2020 to 31 March 2021, we received 340 formal complaints and 1092 informal complaints.

This is a reduction in formal complaints of 166 less than the previous year, and increase of 171 in informal complaints from 921 the previous year.

There could be a number of reasons for these changes, including:

Formal Complaints reduction:

- Reduction in service provision and patient facing contact, meaning less interactions for patients to be dissatisfied with
- Reduction in patient intake meaning more staff available to tend to inpatients

Informal Complaints Increase:

- Influx of complaints which fall into the informal category regarding communication while visiting restrictions in place
- Informal complaints about unavoidable service provision changes during pandemic
- Families unable to raise concerns on the ward using Patient Experience to escalate concerns
- Property going missing whilst patients and families are unable to attend the site
- Better knowledge of the Patient Experience Team to share details with those who have concerns regarding their own care

We published our 2020-21 Annual Complaints Report for our May 2021 Board in Public meeting and the papers can be accessed here: https://doclibrary-rcht.cornwall.nhs.uk/RoyalCornwallHospitalsTrust/Internet/DocumentsLibrary/BoardMeetings/BoardMeetings2122.aspx

Another key factor in delivering brilliant care for our population is how we work with partner organisations in our health and care system.

This year has seen an evolution of government policy, with the publication of the white paper Integration and innovation: working together to improve health and social care for all, which sets out plans for integrated care systems (ICSs) and the forming of provider collaboratives.

In this context, and recognising the impact of Covid-19 on our workforce and priorities, plans to formally integrate RCHT with Cornwall Partnership Foundation Trust (CFT) by April 2022 have been placed on hold while we focus on recovering from Covid-19 and developing our ICS.

We continue to work closely with CFT, NHS Kernow Clinical Commissioning Group and our 14 primary care networks (PCNs) to improve pathways of care at a local level and deliver better care for the people we serve.

We have seen a four-fold increase in non-face-to-face appointments during Covid-19, which allow people to receive the support they need without coming into hospital.

Covid-19 has also presented some opportunities to transform and improve the care that we provide, and to bring in new models of care that are fit for the future.

We have seen a four-fold increase in telephone and virtual appointments during Covid-19, which allow people to receive the support they need without coming into hospital.

We have also established Community Assessment and Treatment Units (CATUs) that allow older people to receive care in a more appropriate community setting.

These changes have the potential to deliver better outcomes for our patients and allow us to do more within the resources we have. Our objective for the next year will be to embed these approaches and secure them for the future.

Never Events

We have been on a huge improvement journey over the last two and half years to lead, engage and support our staff on our journey to 'Brilliant'. This has led to a vastly improved culture of support, openness, candour and wellbeing, with a focus on safety and quality and culminated in the decision to remove us from Quality Special Measures in January 2020 and a Care Quality Commission rating of 'Requires Improvement'.

After coming out of special measures and then entering the most challenged period ever in the NHS, we reported eight Never Events:

Date of Incident	Description of incident
May 2020	Wrong site surgery
May 2020	Partial retained guide wire
June 2020	Wrong site surgery
June 2020	Incorrect intraocular lens (IOL) inserted
September 2020	Enteral medication given intravenously
September 2020	Wrong procedure performed (loop stoma instead of end stoma)
October 2020	Wrong site surgery
February 2021	Wrong site surgery

We have an improvement plan in response to these never events and are working closely with CQC to provide assurance on improving standards of care. Further information is available in our Quality Account for 2021-22.

Delivering brilliant care relies on being able to provide our people with the facilities they need to do so. Over the last year we have:

- **Opened a new resuscitation unit and rapid assessment and treatment unit as part of a major expansion of our Emergency Department**
- **Commenced work on a £30 million building to provide new accommodation for MRI and cancer services**
- **Begun the construction of a temporary modular ward unit that will create space for us to move other services to make way for other major developments on the Royal Cornwall Hospital site**
- **Received commitment to a new Women's and Children's Unit confirmed as part of the Government's New Hospitals Programme**
- **Completed a range of works to support the infection prevention and control and social distancing aspects of our response to Covid-19.**

A summary table outlining our performance against each of our strategic pledges for Brilliant Care is at Appendix I.

Brilliant People

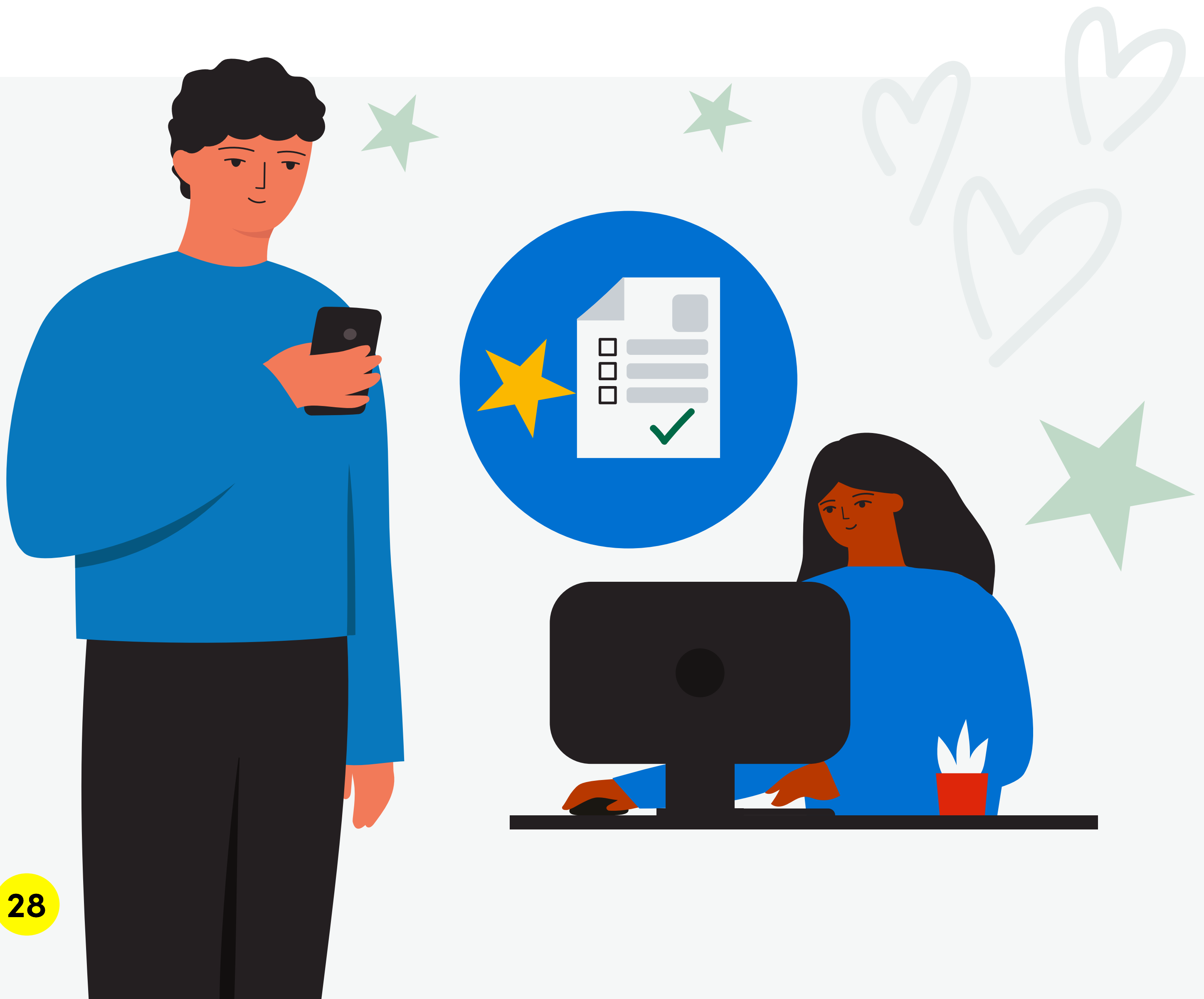
Our people are important to us and never has this been clearer than over the past year.

We have only been able to respond to the Covid-19 pandemic and deliver brilliant care in the most testing of circumstances thanks to the efforts of those who work for us, together with our colleagues from health and care partners across Cornwall and the Isles of Scilly.

The demands this has put on our people also make it more important than ever we do everything we can to support and care for them, so that we have a happy, productive and resilient workforce to tackle the challenges of the year ahead.

Supporting our people starts with great leadership, and despite the challenges of the pandemic, we have continued to roll out our Being Brilliant leadership programme during 2020-21 using a blended approach of classroom based and virtual learning, although we have fallen short of our pre-Covid target of reaching 1000 people.

With face-to-face meetings drastically reduced, senior managers have made extra efforts to remain visible; taking advantage of online meetings and discussion such as our monthly Team Talk sessions with colleagues which are hosted by our chief executive.



We fell just short of our ambition of 45% of staff reporting effective communication with senior management (our figure was 41%) and this continues to be an important area of development.

Last year saw our highest ever response rate to the national NHS staff survey. At 59%, this was an improvement on 2019 of 3%. More people's views mean we get a more accurate a representation of what it's like to work at RCHT.

Overall our results were similar to those in 2019. Whilst we may not have seen the intensity of Covid-19 activity as hospitals in some parts of the country, our people have been under many of the same pandemic pressures.

The table below summarises our results across the key themes of the staff survey:

Theme	2019 score	2019 respondents	2020 score	2020 respondents	Statistically significant change?
Equality, diversity & inclusion	9.2	3055	9.2	3679	Not significant
Health & wellbeing	5.8	3069	6.1	3691	↑
Immediate managers +	7.0	3077	6.9	3698	Not significant
Morale	6.3	3047	6.3	3691	Not significant
Quality of care	7.3	2688	7.3	3224	Not significant
Safe environment - Bullying & harassment	7.8	3056	8.0	3677	↑
Safe environment - Violence	9.4	3063	9.4	3682	Not significant
Safety culture	6.5	3069	6.7	3697	↑
Staff engagement	6.9	3096	6.9	3701	Not significant
Team working	6.8	3050	6.6	3656	↓

* Statistical significance is tested using a two-tailed t-test with a 95% level of confidence.

+ The calculation for the immediate managers theme has changed this year due to the omission of one of the questions which previously contributed to the theme. This change has been applied retrospectively so data for 2016-2020 shown in this table are comparable. However, these figures are not directly comparable to the results reported in previous years. For more details please see the technical document.

We are developing action plans to address the findings from the staff survey to ensure our staff are heard and improvements are made where needed.

A notable area for us this year; and across the last five years, is the 'staff friends and family test'. More colleagues report they would recommend our hospitals as a place to work, and more are reporting they would be happy with the standard of care if a friend or family member needed treatment, with rises of 6% and 9% respectively. Our scores remain, however, below the national average, and these questions will form a key part of our improvement plans we are discussing and developing with colleagues for the coming year.

The impact of Covid-19 and increased levels of home working have had an impact on our ambition to better support our people. While we have been able to deliver enhanced wellbeing support for colleagues, an increase in remote working and reduced face-to-face time has impacted on mandatory training and appraisals. As we recover our services from the impact of Covid-19, we also need to recover these important aspects of how we support our people.

Engaging colleagues at all levels in how we develop RCHT is a central part of how we support and empower

brilliant people. We ran a series of staff roadshows focusing on our planned integration with Cornwall Partnership NHS Foundation Trust. Although these plans are now on hold, the high level of engagement in these events and the enthusiasm for delivering better, more integrated care show what an asset our people will be as we continue to develop and mature as an ICS.

We also need our people to feel supported to speak up when they have concerns, and we have rolled out the WorkInConfidence app to make this easier.

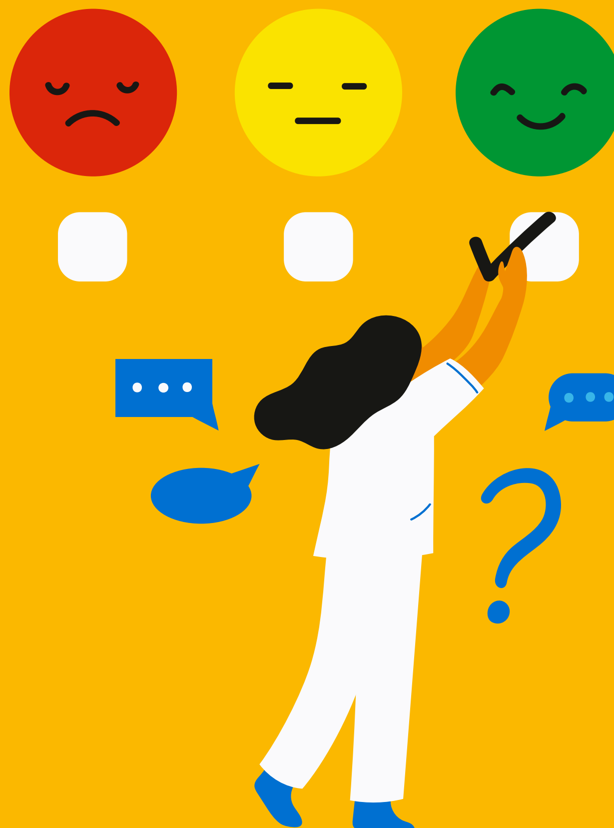
There are areas where we still need to improve. Only 54% of our people reported they can make improvements at work, which fell short of our target of 60%.

The pandemic has also presented real challenges for mandatory training and appraisal, which we have plans in place to recover.

The statutory and mandatory training compliance rate is 80.7% having reduced by 8.2% since Apr 2020. This is against a target of 90%. Social distancing has presented some challenges in terms of room capacity to Level 2 moving and handling training but we are finding ways to offer blended approaches to learning. E-learning is available for most mandatory subjects, including moving and handling level 1 training, and colleagues are being supported to access this blended learning approach by their managers and the People and Organisational Development Partner team.

Non-medical annual appraisal compliance was 74.3% at end of year, against a target of 90%. Appraisal compliance has reduced month on month from a high of 77.8% in Apr-20, down 6.9% in Dec-20 so the end of year figure has improved, and plans are in place to support increased compliance. Efforts continue to data cleanse electronic systems and work with managers to plan for appraisals in a timely way. A new appraisal template and user guide is in circulation.

A summary table outlining our performance against each of our strategic pledges for Brilliant People is at Appendix II.



Brilliant improvement

As part of the development of our Quality Improvement (QI) capability RCHT Board members have been trained in our approach to QI so they can be effective ambassadors for improvement. Our QI methodology has underpinned our response to Covid-19.

Digital technology will be central to how we deliver better services that are fit for the future. We continue to develop a comprehensive Electronic Health Record for Cornwall.

The outline business case was approved in May 2020 and we have been awarded a place on the NHSX Digital Aspirant programme, providing us with £250k funding for further business case development.

Our new Innovation Strategy sets out how we will support colleagues to develop and implement their ideas to improve the care they deliver, although, the impact of Covid-19 has delayed plans for a programme of innovation training.

Our reputation for research and innovation has continued to grow and this year has seen a significant focus on contributing to the urgent Public Health Covid Trials.

The research and development team reacted rapidly to open trials. This included being one of just 15 UK hospitals running the Novovax Covid-19 vaccine trial which was mobilised within one week and recruited over 250 participants locally.

The team also supported other Covid-19 related studies including the Recovery Study and the SIREN Study. The latter was a Public Health England study that recruited 538 RCHT staff, the second highest number in the south west; and which was essential to helping to understand Covid-19 immunity.

As we recover from the Covid-19 pandemic, making efficient use of resources will be more important than ever. Progress has been made this year in key areas and we have exceeded our target of reducing bank and agency spend by 20%. All variable pay, which includes bank, agency and overtime) reduced from £43.9m in 2019-20 to £29.1m in 2020-21, representing a 34% reduction. However, we are under no illusion about the challenges ahead, and how we make the best possible use of the resources we have will be a priority for the coming year.

Celebrating our people is an essential part of building a culture that delivers brilliant care and improvement. Our Brilliant You Festival, where our colleagues can get together enjoy live entertainment and celebrate the work they have done over the past year, wasn't possible in the same format in 2020.

The Covid-19 pandemic forced us to innovate and our communications and organisational development teams hosted an online festival in which colleagues and their families could participate at home.

The centre piece of the Festival is our Brilliant You awards, recognising the outstanding contributions of individuals and teams across our hospitals and for the first time this year, our partner organisations too. 'Oscar-style' virtual presentations were made to winners' in their place of work by those who had nominated them, recording each one on video for broadcast as part of the Festival.

As well as marking our achievements on a local level, our people have also been recognised on regional and national platforms.

These are some of the examples from the last year:

- **Rated by junior doctors as one of the top performing hospitals in the South West, which is the best performing region in the General Medical Council survey**
- **MySunrise support app for cancer patients receives a South West Digital Health Award**
- **National Waterloo Foundation award for our Learning Disability and Safeguarding teams 'Going to Hospital' book**
- **Our first 'A' ratings in the Sentinel Stroke National Audit Programme – April-September 2020**
- **Florence Nightingale Award for Excellence in Healthcare Data Analytics for our Business Intelligence Team**
- **Our Cardiac Rehabilitation Programmes gains a national British Medical Journal Award for helping heart failure patients achieve a better quality of life**
- **Two category wins in the Patient Experience Network National Awards for our Palliative and End of Life Care Team**

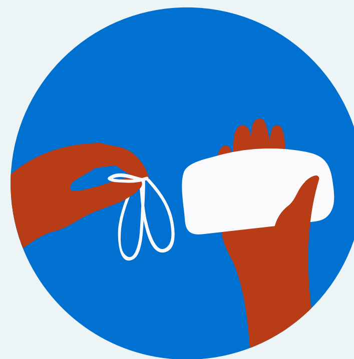
Continuing our commitment to reducing our carbon footprint, the pandemic has brought unexpected opportunities.

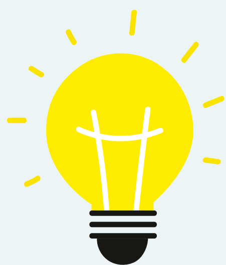
We were the first hospitals in the UK to introduce a recycling system to tackle the mountain of reusable masks; instead of being sent for incineration they are now being turned into useful plastic items such as litter pickers, car bumpers and water bottles.

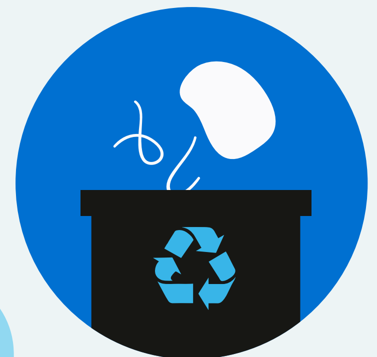
We also provided approved reusable face coverings for colleagues working in non-clinical areas and are piloting the use of reusable masks in clinical areas.

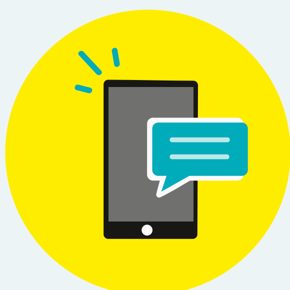
An electric cargo bicycle has replaced a diesel van that used to transport theatre instruments across our site and the home-working has greatly reduced the impact of emissions on our environment.

Many more initiatives are planned over the coming year; among them the development of wildlife-friendly green spaces.









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How we have performed

Details of the performance against constitutional and statutory obligations can be found in the monthly Integrated Performance Reports found at the Trust Board papers section of our website.

Performance against standards for quality of care is reported in our Quality Account which is published before the end of June each year.

Key indicators

A summary of performance against the key indicators and constitutional standards for the Trust **are set out below:**

Access Standards - 2020/21 (as at 31 March 2021)	Standard	Performance	Achieved
Emergency Department Attenders 4 hours to discharge, admission or transfer	95.0%	86.67%	✗
Cancer referral and seen within two weeks	93.0%	98.10%	✓
Cancer diagnosis to treatment within- 31 days	96.0%	98.90%	✓
Cancer referral to start treatment within 62 days	85.0%	92.70%	✓
Cancer 62 day screening	90.0%	84.00%	✗
Fractured Neck of Femur operated in 36 hours	80.0%	87.31%	✓
Referral to treatment incomplete pathways	92.0%	72.35%	✗
Referral to treatment 52 week waiters	0	1105	✗
Diagnostics within 6 weeks	99.0%	85.18%	✗
Average length of stay in days	3.30 (local)	3.38	✗
Same day cancellations of surgery	0.80% (local)	0.84%	✗
Stroke patients 90% time on unit	90.0%	74.67%	✗
Admission to stroke unit in 4 hours	70.0%	50.68%	✗
CT scan within 12 hours for stroke patients	95.0%	90.54%	✗
CT scan within 1 hour for stroke patients	50.00%	62.16%	✓

The overall rolling 12 months Hospitalised Standardised Mortality Ratio [2] (HSMR), which enables the comparison of mortality rates between hospitals, increased during the Covid-19 period and started to reduce in January to 96.83.

Overall, the HSMR remains below the latest national benchmark 100.45, and below the South West average of 102.36 (being below the national and regional average is positive).

The Standardised Mortality Ratio (SMR) is the ratio of the number of deaths in hospital within a given time period, to the number that might be expected if the hospital had the same death rates as some reference population.

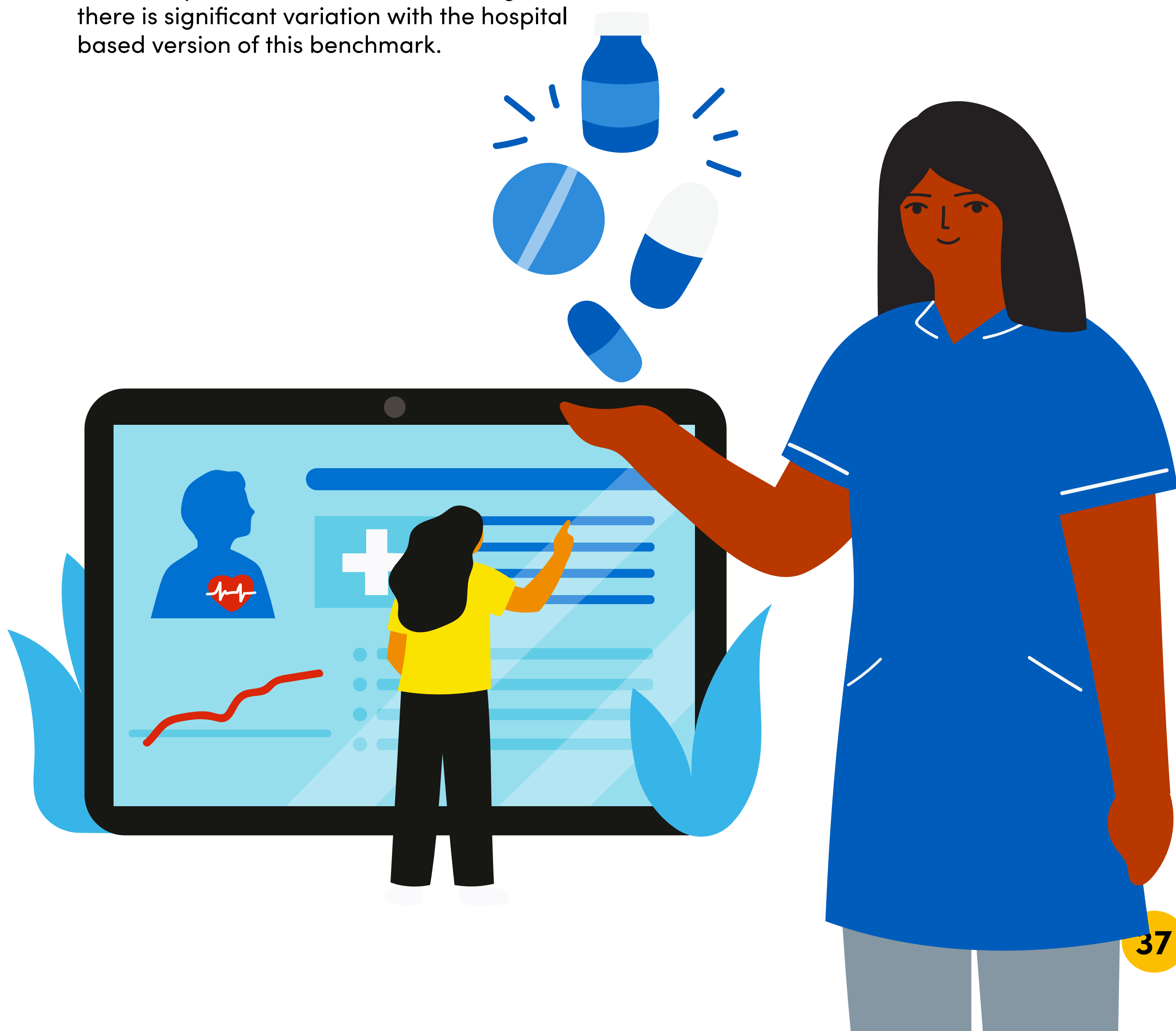
The SMR has continued to drop since April 2020 compared to the HSMR, indicating that there is significant variation with the hospital based version of this benchmark.

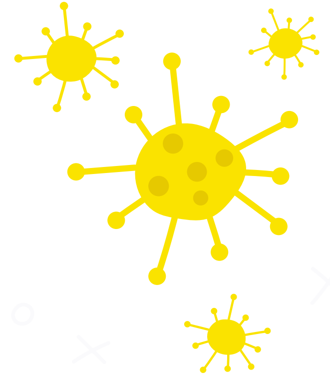
This is due to Cornwall seeing a lower rate of deaths compared to other areas during Covid-19 combined with the reduction in inpatient activity and elective surgery.

We have reported an SMR of 78.0 for January, whereas national benchmarking gives a rate of 100.34 and the South West average a rate of 100.62.

Further detail on how we have performed against our strategic objectives is provided in Appendices I, II and III.

[2] As at January 2021 (latest data at the time of writing)





The impact of Covid-19 on our performance

Although Cornwall has had the lowest rates of Covid-19 of any local authority area in the country, every aspect of our work has been materially affected by the pandemic.

We implemented a four-phase plan approach to responding to Covid-19 which was driven by the demand for intensive care beds. We prioritised referrals for cancer and urgent cases and implemented a harm review process to assess people on our waiting lists. We have recovery targets and trajectories and continue to implement actions to work towards those, while recognising and working within the constraints of a Covid-19 environment. This includes a reduced bed base (due to social distancing), additional cleaning, staff sickness and the principle of no 'corridor queues'.

Around 1,250 patients presented to the Emergency Department with a diagnosis of Covid-19 up to 31 March 2021. We had treated and discharged 696 Covid-positive patients since the start of the pandemic at the time of writing, and 221 patients sadly died in our hospitals.

The highest number of Covid-19 positive patients we had on any particular day was 105 on 2 February 2021; during the first wave, the peak number had been 40.

This included up to 43 patients at any one time on oxygen, and up to 13 on mechanical ventilation.

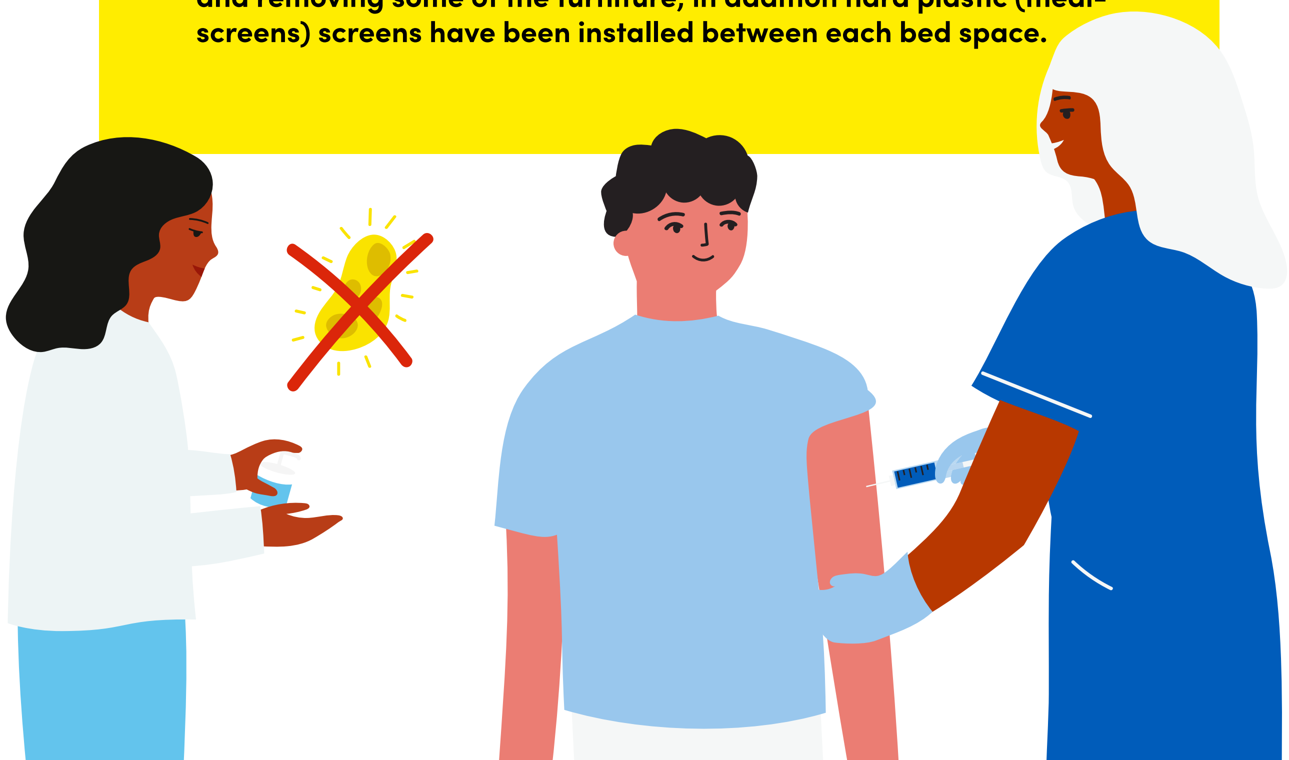
We conducted around 172,000 Covid-19 tests (including antibody and PCR tests) and completed 2-3,000 vaccinations every week since beginning our vaccination programme in December 2020.

Infection, prevention and control

The Covid-19 pandemic highlighted the critical importance of effective infection prevention and control for safe care. We assessed ourselves against the Covid-19 Infection Prevent and Control Board Assurance Framework to provide a source of internal assurance that quality standards were being maintained through the pandemic.

The Framework covers ten areas of Public Health England and related guidance and we were largely compliant with the key lines of enquiry. **The key actions we took were to:**

- **introduce a daily team brief as a reminder to meet personal protective equipment and social distancing requirements**
- **issue staff communications through different mediums including via dedicated Coronavirus Communications, Chief Executive Vlogs and Director of Nursing, Midwifery and Allied Health Professionals Blogs in a weekly newsletter**
- **put in place Covid-19 wardens to monitor compliance.**
- **adapt bed spaces to create as much space as possible by relocating and removing some of the furniture; in addition hard plastic (medi-screens) screens have been installed between each bed space.**



Equality, diversity and inclusion

We are committed to delivering inclusive health services for all in a dignified and respectful way, by a workforce which is equally respected.

We recognise all patients, colleagues and members of the public are individuals and we will strive to meet their needs.

We aim to ensure no one is discriminated against or treated unfairly due to age, disability, race, religion or belief, gender, sexual orientation, gender reassignment, marriage/civil partnership or pregnancy/maternity. Where necessary we make every effort to ensure adjustments are made to prevent less equitable experiences occurring.

Our Trust Board receives an Annual Equality Report, which was presented and approved in June 2020. This report highlighted our commitment to developing an organisational culture that encourages every colleague, whatever their role or background to succeed, and to celebrate our diversity through programmes of shared experiences and cultural events.

Alongside this, our Chief Executive has taken on the role of board-level lead for equalities and health inequalities, and in March 2021 our Trust Board approved a Board Diversity Plan, with a focus on increasing black and ethnic minority representation.

As we seek to restore elective care after the impact of the Covid-19 pandemic, doing so in a way that reduces health inequalities is a national and a local priority. We have updated the data that we use to monitor waiting lists, cancellations and attendances so that we can map it to levels of deprivation, which vary significantly between different communities in Cornwall and the Isles of Scilly.

We manage our waiting lists for risk, rather than waiting times, which means those with more risk factors (who are over-represented in deprived communities) are prioritised. However, there is more work to do and in the coming year we will be reviewing whether we can include protected characteristics and deprivation explicitly in our prioritisation criteria.

Digital transformation is a crucial part of how we will improve care over the coming years, but if it is not done right it can risk excluding some people, for example those who have lower digital literacy or limited access to the internet.

We are mitigating these risks by offering patients alternatives to video consultations if they are not digitally enabled and improving the documentation around our video appointments based on patient feedback. In the coming year we will go further by developing community inclusion hubs and digital support teams to help people access digital services.

Our maternity services are an example of where our colleagues are delivering fantastic support to disadvantaged groups.

The WREN Team (Women Requiring Extra Nurturing), established for the last year, is a team of dedicated midwives and maternity support workers for the following groups: perinatal mental health, the traveller community, Black and Minority Ethnic (BAME), bereavement (and previous baby loss), and other women requiring support with learning disability, domestic abuse, homelessness and family breakdown.

The team provide 100% continuity of care to the most vulnerable families. Over the past year, the Teyluva Midwives team provided care for pregnant women within a traveller community in West Cornwall, achieving fantastic outcomes: 100% continuity of care, a 100% increase in the uptake of flu vaccination and vitamin intake and 100% healthy mother and baby outcomes.

We continue to work on ensuring our car parking arrangements are compliant with required standards and have a car parking strategy to achieve that. We are also working to ensure we meet accessibility requirements with our website to meet the 2020 regulations.

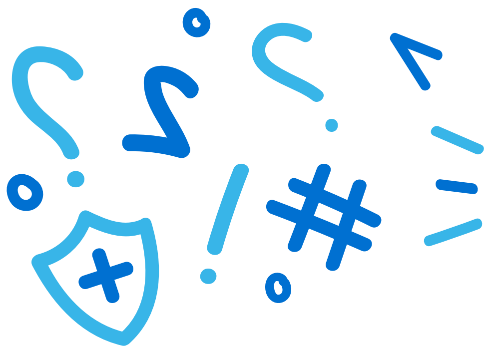
Freedom to Speak Up

An open and honest reporting culture is essential if we want to be brilliant for caring and for the people who work for us.

We have a dedicated Freedom to Speak Up Guardian and a network of champions who to protect patient and staff safety and quality of care.

We are committed to encouraging staff to speak up and our Guardian works to highlight barriers to speaking up and to ensure that they are addressed.

Freedom to Speak Up information features in our induction for new starters, mandatory training and in our Being Brilliant cultural and leadership development programme.



As a result of the increased profile of Freedom to Speak Up there has been an improvement, for the first time, of different staff groups who feel secure raising concerns about unsafe clinical/ operational practice to above the national average, with concerns followed up and appropriate actions taken.

Open cases are actively monitored, and the Guardian maintains regular contact with colleagues who have spoken up.

Some cases can remain open for a period of time, for example if an investigation needs to take place, or if the person speaking up requires guidance and support from the Guardian with working through issues and tackling situations which they are finding difficult.

The range of concerns are varied and often very individual, however patient safety, culture, behaviour, relationship and staff safety are the four most frequent category of concern reported against.

The Board discusses a quarterly report from the Freedom to Speak Up Guardian and complete the annual Board self-assessment to identify areas for further improvement.

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Key Financial Performance in 2020-21 and Adoption of Going Concern

Statement of Comprehensive Income

We reported a surplus of £2.8m. For 2020-21, the majority of our income from NHS commissioners was in the form of block contract arrangements as a result of the financial framework in place during the Covid pandemic. The related performance obligation was the delivery of healthcare and related services during the period, with our entitlement to consideration not varying based on the levels of activity.

The Statement of Financial Position

The Statement of Financial Position (Balance Sheet) as at 31 March 2021 shows net assets of £190.4m.

We ended the year with a cash balance of £42.1m.

We have delivered considerable improvements in our infrastructure through our Capital Programme in 2020-21, spending £55.3m.

At 31 March 2021 we had no Revenue Support Loans from the Department of Health and Social Care and Capital Loans from the Department of Health and Social Care of £4.8m, following the conversion of £59.1m of outstanding debt into Public Dividend Capital during 2020-21.

During 2020-21, we did not draw capital or revenue loans and made repayments of £7.1m against our capital investment loans and £53.3m against our revenue loans.

Cumulative breakeven duty

We now hold a cumulative deficit of £26.8m at 31 March 2021. We expect to fail to achieve breakeven on a cumulative basis at 31 March 2022, but aim to recover our financial position as quickly as possible. A plan to recover the current cumulative deficit over a 5 year period has not been agreed to date.

Other financial duties

During 2020-21 we operated within our External Financing and Capital Resource Limits, as set by the Department of Health and Social Care.

Performance against the Better Payments Practice Code

The Better Payment Practice Code requires us 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.

We have an on-going target to pay 95% of all invoices within a month of being received. Cumulatively to the end of the financial year, 95.5% of trade creditor invoices by volume were paid on time. Note 32 to our accounts provide details on payment performance.

Going concern basis

We have carried out an assessment to satisfy ourselves that we continue to operate as a going concern. There is no indication that the provision of services will materially change in the foreseeable future.

NHS England and NHS Improvement wrote to NHS organisations on 1 April 2021, advising that for the 2020-21 year end and onwards, while management would still need to document their going concern basis, this assessment should solely be based on the anticipated future provision of services in the public sector. The letter noted that this meant it highly unlikely that NHS organisations would have any material uncertainties over going concern to disclose.

Chief Executive
11 June 2021

Appendix I – Brilliant Care Pledges and Delivery Status

Pledge	2020-2021 Milestone	Status	Additional information
We provide care that is consistently safe and avoids harm	1 We will ensure we have sufficient inpatient and critical care capacity throughout 2020/21 to care for Covid-positive patients.	Delivered	
	2 We will develop a dynamic recovery programme to ensure wherever possible we are able to deliver all services throughout 2020/21 – this will be supported by all elective patients on a waiting list undergoing a harm review.	Delivered	
	3 Launch signed off patient safety programme.	Delivered	
We are open and honest with people about their care	4 Maintain 100% Duty of Candour compliance throughout 2020/21.	Not Delivered	Duty of Candour compliance is currently 99% for the year. The two remaining cases are being followed through to a conclusion. Our improvement over recent years continues with gaining significant assurance through our internal audit process in this financial year.
	5 Patient safety ambassadors in all Care Groups.	On hold	The national launch has been delayed. No new date has been set nationally. In the interim, patient safety training is being delivered to all staff across the three hospital sites.
We listen and learn from patients their families and carers and treat them with compassion and respect	6 Patient stories at all Care Group Boards.	Delivered	
	7 Establish 'public membership' for RCHT services as part of integration work stream; developing a patient consultative base.	On hold	This has been put on hold due to the pausing of formal integration with Cornwall Partnership NHS Foundation Trust.
	8 95% of complaints responded to within 30 days	Not Delivered	The overall response rate for the year was 73%. A full complaints response to pts and their families was maintained during Covid-19 and performance consistent throughout the whole pandemic.
We provide clinically effective care, which minimises delay and the amount of time people have to spend in our care	9 Establish a Progressive Recovery Unit on the Royal Cornwall Hospital site by October 2020 to support our response to Covid-19.	Not Delivered	Funding has now been secured and the unit is expected to be fully operational around August 2021.
	10 Working with our health and care partners, reduce Delayed Transfers of Care in 2020/21, based upon 2019/20 baseline.	Delivered	

Pledge	2020-2021 Milestone	Status	Additional information
We provide clinically effective care, which minimises delay and the amount of time people have to spend in our care	**11** 100% increase in non-face to face outpatient activity, and advice and guidance to be in place for all specialties.	Delivered	
	12 Full implementation of front door frailty model.	Delivered	
	13 Achieve all constitutional standards.	Not Delivered	While some standards have been harder to deliver during the Covid-19 pandemic, at year end RCHT is meeting all cancer standards with the exception of two-week waits. We have recovery plans in place for referral-to-treatment (RTT) standards. However, the 4-hour accident and emergency waiting time standard remains a challenge for the Trust.
We work with our health and care system to improve the health of our community	**14** Develop a system wide Incident Command Centre to ensure a dynamic, efficient and responsive system wide ICC to coordinate our response to Covid-19.	Delivered	
	15 Develop with CFT an approved Integration business Case.	On hold	Formal integration has been paused while our system focuses on developing our Integrated Care System.
	16 Develop regular engagement forums with all of our Primary Care Networks (PCNs) with the aim of improving pathways at PCN level.	Delivered	
	17 Engage in the development and delivery of the Peninsula Clinical Service Strategy work.	Delivered	
We provide an environment that is clean, safe and welcoming	**18** Delivery of the Health and Safety review action plan	Delivered	
	19 Develop a Building Brilliance Estate Strategy, supporting submission of a SOC for HIP 2 funding	Delivered	
	20 MRI and Cancer services enabling works to be delivered to programme.	Delivered	
	21 Submission of OBC for Women's and Children's unit.	Delivered	
	22 Submission of SOC and OBC for capital developments at WCH and SMH.	Delivered	
	23 ED resus redevelopment completed October 2020.	Delivered	

Appendix II - Brilliant People Pledges and Delivery Status

Pledge	2020-2021 Milestone	Status	Additional information
We provide great leadership and support to help colleagues be the best they can be	**1** Being Brilliant leadership programme rolled out to 1000 staff	Not Delivered	Roll-out has been affected by Covid-19 and the programme has had to move to a mix of virtual and face-to-face delivery. However, feedback from participants remains positive and 81% of participants would recommend the programme to a colleague.
	2 Over 90% of staff complete mandatory training	Not Delivered	Completion of mandatory training has fallen during the Covid-19 pandemic and is a 79.9% at year end.
	3 Over 45% of staff say communication between senior management and staff is effective as measured by National Staff Survey	Not Delivered	The latest data puts this at 41.1%. The Trust has sustained and embedded measures to improve communication, including online events and weekly video messages from CEO and the Executive Team, weekly staff news bulletins, and live Q&A's with senior leaders.
We create a safe environment so colleagues feel supported to speak up	**4** Building upon the roadshows held in 2019/20, hold further engagement events with our colleagues.	Delivered	
	5 Freedom to Speak Up enhanced through roll-out across the Trust of the 'WorkInConfidence' app.	Delivered	
We provide development to help colleagues learn and grow	**6** 95% of staff receive an appraisal	Not Delivered	At year-end, 74.3% of staff had received an appraisal. This has been affected by Covid-19 and increased home working, but People Partners are working with managers to improve compliance.
	7 60% of colleagues say they can make improvements at work, as measured by the NHS Staff Survey	Not Delivered	This was at 54% in the 2020 staff survey, slightly down from 56% in 2019. Empowering staff to make improvements remains a priority for RCHT. Our What Matters Most sessions were affected by Covid-19, so work is underway to develop a virtual option.
We provide an environment that supports colleague safety, health & wellbeing	**8** Mitie service to be brought back in house to ensure there is equity for Terms and Conditions for support staff and to deliver enhancements in these services.	Delivered	
	9 Health and wellbeing support is enhanced to support our response to Covid-19.	Delivered	
	10 Development of strategic outline case for Health and wellbeing hub.	On hold	This project has been stood down to be considered as part of a wider set of initiatives.

Pledge	2020-2021 Milestone	Status	Additional information
We are true to our values and create a great place to work	**11** Improve and expand food and catering offerings across all of our sites: Implement 'The Royal' restaurants on all 3 main sites, develop partnerships with local caterers.	Delivered	
	12 Be in the top quartile of Trusts for 'overall engagement' as measured by the NHS Staff Survey.	Not Delivered	After a significant improvement in 2019 the trust has maintained its engagement score in the 2020 staff survey at 6.9/10 – just below the national average of 7/10. Improving the measure further remains a priority for the Trust.

Appendix III - Brilliant Improvement Pledges and Delivery Status

Pledge	2020-2021 Milestone	Status	Additional information
We ensure that everyone has the capability and capacity to pursue quality improvements for our patients	1 QI principles underpin the trust Covid response and the development and rolling out of clinical and corporate service phasing plans.	Delivered	
	2 QI ambassador training delivered for all board members and senior leadership team	Delivered	
We use innovation and digital technology to improve the quality, experience and cost of our care	3 Approval of Electronic Health Record outline business case	Delivered	
	4 Develop and implement a programme of innovation training to support embedding of innovation across our Care Groups.	Not Delivered	The plans, set out in our Innovation Strategy, to train Innovation Scouts across the Trust were delayed due to Covid-19. We now expect to roll out this training in 2021/22.
We are growing our national reputation for excellence in research and development	5 Explore decision to applyfor University Hospital Status.	On hold	This ambition has been put on hold in light of the pause in plans to formally integrate with Cornwall Partnership NHS Foundation Trust. It will now be reviewed post-April 2022, once our Integrated Care System reaches maturity.
	6 Increase number of research partners and number of trials with commercial sponsors by 10%.	Not Delivered	Our research and development activity increased significantly in 2020/21 and for the first time it generated a net revenue for the Trust. However, the Covid-19 pandemic meant that the focus of R&D activities was very different to that envisaged at the start of the year, with a major focus on Urgent Public Health Covid-19 Studies. As a result, despite a very successful year for R&D, the specific measures set out at the start of the year were not achieved.
	7 Increase levels of research activity in all care groups by 10%.	Not Delivered	
We make good use of the resources that are available to us	8 Establish a system PMO.	Not Delivered	RCHT continues to work with partners to develop our system capability. Key system leadership posts have been filled and PMO systems aligned between partner organisations. Discussions continue on how a system wide PMO approach may operate.
	9 Reduce our bank and agency spend in 2020/21 by 20%.	Delivered	
We celebrate achievement and will create a culture that enables continuous improvement	10 Develop a virtual celebration of our colleagues that can be held in lieu of the Brilliant People festival	Delivered	

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62. Committee Meetings
64. Statement of the Chief Executive's responsibilities

Accountability Report

02.

Director's Report

The RCHT Board

The purpose of the RCHT Board of Directors is to govern effectively to ensure the Trust provides safe, high quality, patient-centred acute care. The Board is accountable to NHS Improvement as the provider regulator, to the Care Quality Commission for the quality of care, and to the people of Cornwall as a public body.

In particular, the RCHT Board is responsible for:

- → **Setting the vision, strategy and values of the organisation**
- → **Providing proactive leadership of RCHT towards achievement of corporate objectives, and constructively challenging performance in that regard**
- → **Ensuring a framework of sound internal controls, risk management and good governance that supports our strategic objectives and operational requirements**
- → **Promoting human rights and the principles of equality and diversity in our culture and decision-making**
- → **Ensuring appropriate use of public funds**
- → **Ensuring effective dialogue between the organisation and the local community on its plans and performance and that these are responsive to the community's needs**
- → **Undertaking all of its activities in line with the Nolan Principles of Public Life**

To achieve these objectives the RCHT Board receives regular detailed reports enabling appropriate decisions to be taken directly by the Board, in line with the our Standing Orders, or through delegation of authority to its Committees.

The RCHT Board acts as a unitary board and as such Directors have collectively responsibility for all decisions taken, regardless of their individual skills or status. This does not affect the particular responsibilities of the Chief Executive as RCHT's Accountable Officer.

The voting members of the RCHT Board comprise the Chairwoman, six non-executive directors and five executive directors, who are the Chief Executive, Director of Finance, Medical Director, Director of Nursing, Midwifery and Allied Health Professionals (AHPs) and Director of Strategy and Performance.

Standing Orders also provides that the Board may appoint additional Executive Directors, in crucial roles in RCHT, to be non-voting members of the RCHT Board. There were five such Directors during 2020/21. The Board may also appoint up to three Associate Non-Executive Directors, to be non-voting members of the RCHT Board. One of those Associate Non-Executive Directors will be a representative from a Higher Education Institution. The Associate Non-Executive Directors supplement skills and experience to the Board support succession planning.

The Non-Executive Directors (including the Associate Non-Executive Directors) bring a diverse skills set and expertise including clinical, financial and/or commercial, risk, human resources and broader public sector experience.

We have a Scheme of Reservation and Delegation which details the matters reserved to the Board and those matters that are delegated to committee. Our detailed Delegation Limits sets out the thresholds for delegated authority by body (e.g. Board, committee) or role holder.

During 2020/21, the Board met on a monthly basis in public, except for August and September. The RCHT Board also met in private on a monthly basis except for September. All meetings of the Board were quorate. The Board did not meet in September because the timing of the Board meetings was reset from meeting in the last week of each month to meeting in the first week of the month; this was to better facilitate business cycles.

Due to the Covid-19 pandemic, Board meetings were mostly or wholly in a virtual capacity to reduce footfall and minimise risk of infection to individuals. The Board also made more use of the provision in Standing Orders for e-governance decisions, where they were appropriate, and made 11 such decisions during the year. E-governance decisions are reported to formal board meetings for information.

We have sought to improve transparency and engagement in Board meetings by maximising the use of virtual meetings and communicating better with staff and the public about forthcoming meetings. The changes made included:

- ➔ **livestreaming the Board meetings from April 2020 with the functionality for members of the public to ask questions**
- ➔ **from November 2020, we recorded each Board meeting and made them available on our YouTube channel for a period of one month (replacing it each month with the next meeting's recording). In total, there have been 646 views of the recordings**
- ➔ **amending the approach to communications to include circulating a link to the papers to the two local Council's Overview and Scrutiny Committee membership; promotion via Twitter and facebook; and posted a diary appointment to staff diaries to enable them to attend if they wished**

When we had face-to-face meetings, without any recordings, approximately five to ten members of the public may have attended. Since the start of livestreaming, the Board meeting has averaged 67 viewers at any one time, with a total of 670 discreet views over the period; 617 of those from within the NHS and 53 external. Combined with the views of the meeting recordings this has significantly improved the reach of the Board and brought improved transparency and accountability to its business.

Trust Board members

The composition of the Trust Board of Directors as at 31 March 2021 was as follows:

Non-Executive Directors

Dr Mairi McLean – Chairwoman (voting)

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 – Vice-Chair of the Board (from January 2021) and Chair of Charitable Funds Committee (voting)

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

Sarah Pryce (Senior Independent Director) (voting)

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 during 2019/20 was Chairman of Cornwall Air Ambulance Trust and owns her own consultancy company specialising in leadership and organisational development.

Sarah Newton – Chair of Audit and Risk Assurance Committee (voting)

Sarah joined the Trust in March 2020 and has extensive experience in the public, business and voluntary sectors. She has held several leadership and change management roles, most recently as an elected Member of Parliament and Minister at the Department for Work and Pensions and the Home Office. Sarah has 30 years' experience of strategic planning, reputation management, innovation with a focus on sustainability and inclusion.

Richard Stephenson (Chair of Finance and Performance Committee and Acting Chair of Quality Assurance Committee) (voting)

Having started his career as a physiotherapist, Richard spent over 30 years in higher education holding executive leadership positions as Dean of Faculty (Health) in two institutions, pro vice-chancellor, and then as deputy vice-chancellor at both the universities of Plymouth and Salford. He has held a number of director and trustee roles, and served several national and regional bodies. He joined the Trust as Non-Executive director in February 2020 and is Emeritus Professor at the University of Salford.

Adam Broome (voting)

Adam Broome re-joined the Board in November 2020, having previously been a Non-Executive Director from 2014 to 2016. Adam has extensive experience at a strategic level across the public sector having been a Director for Plymouth City Council and for the Nursing and Midwifery Council, and an Associate Director for the Audit Commission. He is at present self-employed, currently providing coaching and training and is a member of the Chartered Institute of Public Finance and Accountancy (CIPFA), currently sitting on the CIPFA South West Council.

Ruth Allarton – Associate Non-Executive Director (non-voting)

Ruth joined the RCHT Board in October 2018. Having been a regular visitor to Cornwall all her life, Ruth 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. As an Associate Non-Executive Director, Ruth has used her allied health professions knowledge to bring an additional perspective to decision making and strategic planning.

Richard Smith – Associate Non-Executive Director (non-voting)

Rich joined the Board as an Associate Non-Executive Director 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.

Executive Directors

Kate Shields – Chief Executive (voting)

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 has also worked for NHS England as a Regional Director of Specialised Commissioning and as the National Head of Specialised Commissioning.

Dr Allister Grant - Medical Director (voting)

Allister joined the Trust in November 2019 and brings his experience in medical management, governance and quality, as well as extensive working with health and care partners and patient groups. Allister joined the Trust following an appointment at University Hospitals of Leicester where he spent 5 years as Head of the Liver and Gastro-intestinal Unit and was also the Clinical Director/Medical Director for the Leicester, Leicestershire and Rutland NHS Alliance – a partnership of providers and commissioners in Leicestershire with a remit to transform services and deliver care closer to home for Leicestershire patients.

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

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

Karl Simkins – Director of Finance (voting)

Karl Simkins, is an experienced Executive joining the Trust in July 2010, having previously undertaken senior finance and Director of Finance roles in Commissioning and Provider organisations across the West and East Midlands. Before joining the Trust Karl was Director of Finance at NHS Leicester County and Rutland – one of the largest Primary Care Trusts in the country at that time. Karl was seconded to the Cornwall & Isles of Scilly Health & Care Partnership System as Director of Finance before returning directly to the Trust in April 2020 as Strategic Financial Advisor, before resuming his substantive role as at December 2020.

Thomas Lafferty – Director of Strategy & Performance (voting)

Thom 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, Thom has held similar roles at other NHS Acute Trusts and has developed an expertise with regard to legal and governance matters within healthcare.

Kerry Eldridge – Director of People & Organisational Development (non-voting)

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.

Susan Bracefield – Chief Operating Officer (non-voting)

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 (non-voting)

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.

Kelvyn Hipperson – Joint Chief Information Officer (non-voting)

Kelvyn Hipperson joined the RCHT Board in Jan 2019 taking on a dual role as Chief Information Officer across RCHT and Cornwall Partnership Foundation NHS Trust. Kelvyn worked in senior technology delivery roles in both the private sector and civil service prior to joining the NHS and is a Chartered Engineer, Fellow of the Institution of Engineering & Technology and Member of the British Computer Society.

Karen Kay, Director of Urgent and Emergency Care (COIS Health System) (non-voting)

A substantive director of commissioning with NHS Kernow CCG, Karen has been operating as Director for Urgent & Emergency Care on behalf of the whole system since 2017. This post is hosted by RCHT and Karen is an associate member of the RCHT Board as part of our move towards an increasingly integrated care system. Prior to moving into NHS commissioning in Devon and Cornwall in 2009, Karen worked for 25 years in local government, including senior management roles in Neighbourhood Regeneration, local strategic partnership; customer care and business and service planning.

Three other senior staff were in attendance at Board meetings during 2020/21:

- **Deputy Director of Finance, Adam Wheeldon, who was in attendance at the Board meetings/for specific items to deputise for the then Director of Finance, supporting the Strategic Financial Advisor to the Chief Executive and the Board from April to December 2020.**
- **Acting Director of Operations, Robin Jones, who was acting for the Chief Operating Officer during a period of absence. The Acting Director of Operations was in attendance at the Board meetings from November 2020 to March 2021**
- **Interim Director of Estates, Ricky Daniel, who was in attendance at the Board meetings from July 2020 to March 2021**

The term 'in attendance' in this context means that the individuals were not members of the Board and had no voting rights. They participated as required when called upon by the Board.

RCHT Board Directors' Terms of Office and Changes during 2020/21

Members of the RCHT Board during 2020/21 and their terms of office are provided in the table below:

Board Member	Voting or non-voting	Position	Period	Change to board member ship
Non-Executive Directors				
Mairi Mclean	Voting	Chairwoman	January 2019 – to date	
Paul Hobson	Voting	Non-Executive Director	15 January 2016 - to date	
Margaret Schwarz	Voting	Non-Executive Director	1 November 2016 to 01 January 2021	Leaver
Sarah Pryce	Voting	Non-Executive Director	6 May 2016 – to date	
Gillian Vivian	Voting	Non-Executive Director	10 October 2018 – to 09 October 2020	Leaver
Richard Stephenson	Voting	Non-Executive Director	17 February 2020 - to date	
Sarah Newton	Voting	Non-Executive Director	16 March 2020 - to date	
Adam Broome	Voting	Non-Executive Director	16 November 2020 - to date	Joiner
Associate Non-Executive Director				
Rob Leighfield	Non-voting	Associate Non-Executive Director	15 October 2018– to 15 October 2020	
Ruth Allarton [1]	Non-voting	Associate Non-Executive Director	2 January 2019 – 31 March 2021	Leaver
Richard Smith	Non-voting	Associate Non-Executive Director	1 March 2019 – to date	Joiner

Board Member	Voting or non-voting	Position	Period	Change to board member ship
Executive Directors				
Kate Shields	Voting	Chief Executive	1 February 2019 to date	
Sally May	Voting	Director of Finance	May 2016 - 11 December 2020	Leaver
Karl Simkins	Voting	Director of Finance	11 December 2020 - to date	Joiner
Thomas Lafferty	Voting	Director of Strategy and Performance	10 September 2018 – to date	
Kim O'Keefe	Voting	Director of Nursing, Midwifery & Allied Health Professionals / Deputy Chief Executive	1 May 2017 – to date	
Allister Grant	Voting	Medical Director	1 November 2019 - to date	
Kerry Eldridge	Non-voting	Director of People & OD	30 August 2018 - 20 April 2021	
Bernadette George	Non-voting	Director of Integrated Governance	March 2019 - to date	
Susan Bracefield	Non-voting	Chief Operating Officer	March 2019 - to date	
Kelvyn Hipperson	Non-voting	Chief Information Officer	2 January 2019 – to date	
Karen Kay	Non-voting	System Director of Urgent and Emergency Care	10 December 2018 - to date	

[1] Please note that Ruth Allarton became a substantive Non-Executive Director following and NHSEI recruitment process from 1 April 2021

Appendix 1 – Attendance at Board and Committee Meetings 2020/2021

Board members' attendance at Board and committee meetings is summarised below

	Board Meetings	Remuneration Committee	Audit & Risk Assurance Committee	Quality Assurnce Committee	People and Organisational Development Committee	Charitable Funds Committee	Finance and Performance Committee
	10 meetings	12 meetings	09 meetings	11 meetings	06 meetings	06 meetings	11 meetings
Executive Directors							
Kate Shields	09/10						
Sally May	00/07		00/06				00/08
Karl Simkins	03/03		03/03				03/03
Kerry Eldridge	10/10			07/11	06/06	05/06	08/11
Thomas Lafferty	10/10						09/11
Kim O'Keefe	10/10		05/09	10/11	03/06		
Allister Grant	10/10		06/09	11/11	05/06	02/06	
Bernadette George	10/10		05/09	11/11	03/06		07/11
Susan Bracefield	05/10			05/11	02/06		05/11
Karen Kay	07/10						
Kelvyn Hipperson	10/10						10/11
Non-Executive Directors							
Mairi Mclean*	10/10	05/05		08/11	04/06**	05/06	07/11
Paul Hobson	09/10	10/12	05/06		03/03	06/06	11/11
Margaret Schwarz	06/07	05/07	04/06	05/08			01/02
Sarah Pryce	07/10	10/12	04/06	05/11	05/06	05/06	
Gillian Vivian	04/05	03/03	03/03	03/05	01/01	01/01	01/02
Richard Stephenson	10/10	12/12	05/06	10/11			08/08
Sarah Newton	10/10	03/05	06/06		03/04	03/05	
Adam Broome	04/04	06/08	03/04	04/05			04/05
Associate Non-Executive Directors							
Rob Leighfield	04/05	02/03	03/04			01/02	01/02
Ruth Allerton	10/10	03/05		08/08	06/06		03/03
Richard Smith	09/10	03/05			02/02		

* Other than Remuneration Committee where she was a member up to December 2020, the Chairwoman was in attendance at Committee meetings - attendance recorded for completeness and transparency. ** Attended to ensure quorum. Dec-20

It should be noted that not all Directors were eligible for attendance at all meetings due to effective date of employment and attendance of executive directors' at committees was sometimes affected by operational pressures due to the pandemic.

Board Committees

The RCHT Board has the following Committees:

- **Quality Assurance Committee**
- **Audit and Risk Assurance Committee**
- **Remuneration and Appointments Committee**
- **Finance and Performance Committee**
- **People and OD Committee**

The Board acts as the Corporate Trustee for the Royal Cornwall Hospitals Charity, which has one committee:

- **Charitable Funds Committee**

The Board reviews the Terms of Reference and membership of its committees at least annually and each committee undertakes an annual self-assessment of its effectiveness.

Directors' Interests

- **The Register of Directors Interests is available to the public at:** https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/DeclarationsOfInterest/TrustBoardMembersDeclarationOfInterest/BoardMembersDOI20200601.pdf

Membership of the Audit and Risk Assurance Committee

The membership of the RCHT's Audit and Risk Assurance Committee was revised in July 2020 to include the Chairs of all of the Board's committees. In December 2020, the committee's membership was further updated to include one other Non-Executive Director with accountancy/financial expertise, where that was not present through the membership of the Chairs.

Only Non-Executive Directors are members of the committee. Per best practice, the Chairwoman of the Board is not a member of the Committee. Membership of the Committee as at 31 March 2021 was:

- **Sarah Newton (Chair)**
  Richard Stephenson
  Sarah Pryce
  Paul Hobson
  Adam Broome

Other members of the Committee during the year (up to the point of the membership change and/or director retirement) included:

- **Margaret Schwarz (Chair of Audit and Risk Assurance Committee until December 2020)**
- **Gill Vivian, Non-Executive Director (April 2020 to June 2020)**

A number of other colleagues were regularly in attendance at the Committee meetings including the Director of Finance, Financial Controller, Joint Director of Nursing, Midwifery and Allied Health Professionals, Director of Integrated Governance, external audit, internal audit and the Counter Fraud lead.

During 2020/21, the Committee reviewed the Board Assurance Framework (strategic risks) and Corporate Risk Register on a quarterly basis, and received monthly reports from the counter fraud lead and internal audit. Where there were limited assurance reports, these were referred to the relevant Board committee for oversight, with an assurance report on actions reported back to the Audit and Risk Assurance Committee.

Our external auditors provide progress reports to each Audit and Risk Assurance Committee meeting highlighting key issues such as value for money, going concern and availability of capital.

In line with the recommendations within NHS Improvement's published Audit Code, we have drafted an annual report on the activities undertaken by the Committee during the year. The report draws attention to the nature of the reports received from both Internal and External Auditors and was presented to the July 2021 Board in Public.

Personal data incidents

Information on any personal data related incidents, where these have been formally reported to the Information Commissioner's Office is included in the Annual Governance Statement.

Directors' Statement

Each Director confirms they know of no information that would be relevant to the auditors for the purposes of their audit report, and of which the auditors are not aware, and has taken all the steps that he or share ought to have taken to make themselves aware of any such information and to establish that the auditors are aware of it.

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, other items of comprehensive income and cash flows for the year.**

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

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.

Chief Executive
11 June 2021

NHS
NHS
NHS

67. Scope of responsibility
67. The purpose of the system of internal control
67. The Risk and Control Framework
70. Risk Appetite, Identification and Management
74. Impact of Covid-19 on the risk environment
75. Learning from Risks and Incidents
75. Compliance with the NHS provider license, condition 4
80. Workforce Strategies and Staffing Systems
83. Pensions
83. Declarations of Interest
83. Equality, Diversity and Human Rights
84. Sustainable Development Management Plan
84. Review of economy, efficiency and effectiveness of the use of resources
84. Information governance
85. Data quality and governance
86. Review of effectiveness of internal control
87. Conclusion

Annual governance statement

03.

The following Governance Statement sets out the particular circumstances in which RCHT operated during 2020-2021.

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 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 Hospitals 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 Hospitals NHS Trust for the year ended 31 March 2021 and up to the date of approval of the annual report and accounts.

RCHT is part of a local health economy and national health system. In recognition, the Trust's Corporate Strategy and supporting strategies reflect a strong focus on improved and expanded integrated and partnership working. This was demonstrated more so during the Covid-19 pandemic and demonstrates the benefits of a fully Integrated Care System.

The Risk and Control Framework

The Risk Management Strategy

Risk management is the systematic method of identifying, analysing, managing, monitoring and reviewing of risks in order to ensure achievement of the Trust's objectives. We are committed to having a risk management approach that underpins and supports our strategic and business objectives and demonstrates an ongoing commitment to improving the safety culture of the organisation.

The purpose of our 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 Strategy was last approved by the Board in November 2020.

The Role of the Board in risk management

Our Risk Management Strategy states that all members of the Trust Board have a collective responsibility to ensure that systems and processes for the identification of risks are robust and that risks are appropriately managed and monitored through regular assurance.

The Board last reviewed and updated the Risk Management Strategy, which incorporates Risk Appetite, in November 2020, having previously had a dedicated session on risk in July 2020. The latter was to specifically to review the Trusts risk appetite during Covid-19. A further review of risk appetite took place in January 2021. The Audit and Risk Assurance Committee scrutinises the Trust's systems for risk management and internal control and on that basis reviews the Board Assurance Framework (which details the Trust's strategic risks) and Corporate Risk Register quarterly, with referral on to the Board for approval (in public). Since June 2020, to ensure that risk management remains responsive to changes in the internal and external operating environment, at every meeting, the Trust Board also reviews any changes to risk highlighted from matters considered at the meetings.

The annual internal audit review of the Trust's risk management arrangements returned a satisfactory opinion.

The Board provides leadership on risk management and in particular:

- ➔ determine the risk appetite for the Trust;
- ➔ ensure the approach to risk management is consistently applied;
- ➔ seek assurances that risks have been identified, assessed and all reasonable steps taken to manage them effectively and at sufficient pace;
- ➔ endorse the Annual Governance Statement which assures the organisation has the necessary controls in place to manage its exposure to risk;
- ➔ approve annually the Risk Management Strategy;
- ➔ oversight on Principal Risks specific to their portfolio;
- ➔ leading specific Committees responsible for the assurance of risk.

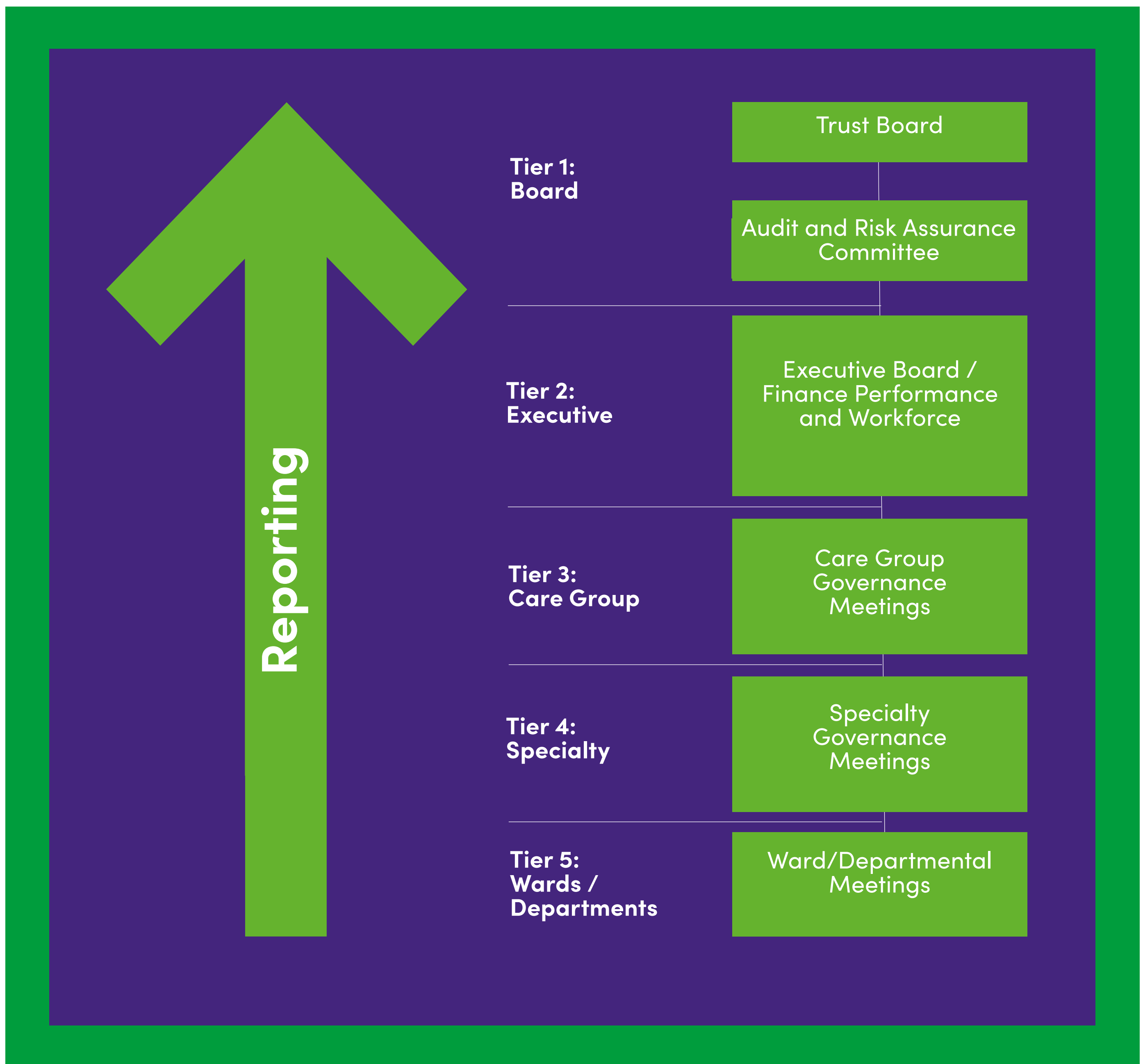
Tiers of Governing and Managing Risk

On behalf of the Trust Board, the Chief Executive is the accountable officer with overall responsibility for risk management and the Director of Integrated Governance has delegated responsibility for the Corporate Risk Register and overseeing the Board Assurance Framework process. Day to day responsibility for operational risk management is delegated to senior managers throughout the Trust. The Executive Board has reviewed the Board Assurance Framework and Corporate

Risk Register in 2020/21. More recently, in March 2021, an Executive Risk Group was established, as a subgroup of Executive Board, to provide more focus to risk identification and management across the Trust.

The work of the executive, care groups, board committees and the decisions of the Board itself 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.

These different 'tiers' of managing risk are shown by the below diagram:



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. General 'risk management' awareness training is provided by the risk manager through the Care Group structure. Risk management and assessment refresher training is available in the Trust's training programme. Board level training is delivered via the annual review of the Trust's risk appetite.

Risk Appetite

Risk appetite is 'the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives.' No organisation can achieve its objectives without taking and accepting some risk. The level of risk the Trust is prepared to accept or be exposed to will vary according to the nature of the risk, the context within which the Trust is operating and regulatory or legislative constraints for example the Trust will have a low tolerance for patient safety risks.

As a provider of healthcare services, we have minimal appetite for risks to patient safety, quality of care and the safety and wellbeing of its staff and visitors to any of our sites.

In practice this means that the Trust will always insist on the safest available option, with an aim of reducing any risks of physical or psychological harm to as low a level as is reasonable practicable.

The Trust's current statement of risk appetite by risk type, including a guide to the level of risk that may be considered as tolerable, is summarised on the **following table:**

Risk Type	Risk Appetite	Tolerable Risk
Harm (physical and psychological)	Minimal	Low
Risks to safety and continuity as a result of Covid -19	Minimal	Low
Services (internal)	Cautious	Medium
Services (systems)	Cautious	Medium
Reputation (with public)	Cautious	Medium
Reputation (with regulators)	Cautious	Medium
Finances	Cautious	Medium

The appetite of the Trust concerning risks to its finances, its reputation or the continuity of its services is described as cautious, which means that safe options are preferred but there is a recognition that prevailing risks of harm as part of the same proposal.

Identifying Risks

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.

This is shown by the diagram below:

	Reactive	Proactive
Internal	→ Complaints → Claims → Incidents / Near miss / Serious Incidents / Never Events → Trend analysis → Internal investigations → Performance dashboards → Patient & staff surveys → Audit - clinical, internal → Programme and project activities	→ Risk Assessments → Horizon scanning → Benchmarking
External	→ Care Quality Commission & other regulatory frameworks → External assessments / peer reviews → Safety alerts → Preventing Future Deaths → External audit reports and guidance	→ External horizon scanning → National body reports

Risk Evaluation

Once a potential risk has been identified, the risk is entered on the Trust's risk management system, Datix, where a risk assessment is carried out to assess the level of risk. Such assessment considers the activity within the context of the physical and emotional environment, the culture of the organisation and the staff who perform the activity. It also takes into account things that have gone wrong in the past and near-miss incidents.

A risk matrix aids staff in applying a consistent, objective approach to risk evaluation, with scores based on both the potential consequences of the risk developing along with the likelihood of the risk materialising. The National Patient Safety risk matrix – a 5 x 5 calculation involving an assessment of risk consequence and likelihood is used to score risks:

	Likelihood				
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 Trust's Risk Management Strategy:

The Trust's Risk Register is populated from risk assessments undertaken which are recorded on 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.

Risk Management

Following identification and assessment of a risk, a decision is made as to how to respond. The response options are listed below; the most appropriate response is selected according to the nature of the risk. Usually, the Trust will attempt to treat the risk and reduce it to an accepted level:

- **Treat:** Further management actions that ideally minimise the likelihood and/or impact of a threat or maximise the likelihood of opportunities. For each risk an action plan to eliminate, minimise, or maximise the risk is required.
- **Tolerate:** In cases where the ability to do anything may be limited, or the cost of taking any action may be disproportionate to the potential benefit gained.
- **Terminate:** Discontinuation of the activity which carries the risk (i.e. removing the source of the risk).
- **Transfer:** To insure against the risk; this includes sharing the risk.

If it is decided that the controls are not adequate and further management actions are required to reduce the risk (i.e. treat the risk), the risk owner would develop an action plan using Datix. These planned actions would address any gaps in control measures. Generally, as actions are completed these become controls measures. As control measures are put in place, the risk would reduce.

Actions are recorded in Datix individually and linked to the risk so that progress can be monitored by the risk owner. All actions to mitigate the risk should be SMART (Specific, Measurable, Achievable, Realistic, Time Specified), and include:

- Target implementation date
- Person responsible for implementing action
- How the action will be evidenced
- Progress on completion of action

The residual risk score is calculated by assuming all of the control measures and subsequent actions have been taken. It should be noted that specific risk assessment forms are used in some instances such as health and safety assessments and clinical assessments. Where this occurs, the process is outlined in the related policy; however risks arising as a result of these assessments are added to the Risk Register as appropriate.

Risks to Data Security

Risks to data security are managed through 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 will submit in June 2021 the Data Security & Protection Toolkit for 2020/21 and is currently predicting full compliance with all assertions at this stage.

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.

Impact of Covid-19 on the risk environment

Covid -19 has had a significant impact on existing risks to the Trust including:

- the effect of national changes to lockdown restrictions;
- the expected winter 2020/2021 surge in general demand for secondary health care;
- the delayed, or deferred, treatment of non-Covid -19 patients; with elective care recommencing and an increase in emergency cases;
- the potential for a third wave Covid-19 infection 'spike'; and
- overall capacity restrictions caused by remaining 'social distancing' proximity restrictions, imposed by national guidance.

The most significant risk to the Trust during 2020/21 was the impact of the Coronavirus pandemic on the Trust's ability to provide services and to safeguard patient and staff safety and well-being (see the Performance Report for further detail). Three Covid-19 related risks were added to the Corporate Risk Register since the onset of the pandemic. These were updated regularly during the year to reflect the changing nature of the pandemic, related national policies/ direction, and the impact of the virus within Cornwall and the Isles of Scilly.

In responding to the crisis the Trust quickly established an Incident Command Centre, led by the Chief Operating Officer and reporting to the Chief Executive and Trust Board, to coordinate information, decisions, actions and risks relating to Covid-19. The Trust employed a four-phase dynamic response plans to enable it to flex up and down in line with the need for intensive care beds. Reports and briefings on Covid-19 were taken straight to Trust Board and involved daily situation reports, weekly system-level briefings and weekly informal Board/Non-Executive Director briefings.

The Trust Board has continued to meet formally on a monthly basis since the start of the pandemic, as have its committee meetings. Agenda's and attendees at Board/Committees were streamlined to release capacity and focus on the most urgent issues, with patient safety at the forefront.

The Trust amended its corporate arrangements in March 2020 to enable it to respond swiftly and flexibly to the response. This included:

- use of e-governance for appropriate items, in line with the existing provision in the Trust's Standing Orders;
- revised financial delegations to Level A approvers (the Chief Executive, the Joint Director for Nursing, Midwifery and AHPs and the Director of Finance) for revenue and capital spend in relation to Covid-19 only, with associated controls (i.e. to report such decisions to Finance and Performance Committee)

Clinical governance was also adjusted during this time in terms of:

- temporary clinical governance arrangements introduced
- high level groups meeting virtually with streamlined and focused agendas
- serious incident reporting process and complaints process continued - ensuring timely review and organisational learning
- risk based approach to ensure progress against the Trust's Care Quality Commission action plan and External review process
- risk based approach with Care Groups to maintain and progress the Corporate Risk Register

We reviewed all external guidance issued in relation to the crisis and appropriate local responses were implemented as part of the overall response. We responded in a dynamic way to be able to 'turn on and turn off' again business as usual activity in line with data projections and actual presentations of the virus. Our business continuity plans were activated and aligned to the four-phase dynamic response approach.

Learning from Risks and Incidents

We are committed to delivering care in a safe environment to protect patients, visitors, staff and the organisation from harm. Understanding when things can go wrong is the first step to preventing them from recurring. Incident reporting presents an important opportunity to learn from past events and ensure steps are taken to minimise the likelihood of them happening again.

We promote an open learning culture where incidents, complaints and other learning events are investigated thoroughly to determine root causes and action where appropriate to improve services as a result. Staff are encouraged to report incidents and will not be blamed when things go wrong, as long as they are not wilfully aiming to cause harm and are not deliberately ignoring their professional standards, information, instruction and training.

Incident reporting and learning is overseen by the Director of Integrated Governance via the Trust's Incident Review and Learning Group (IRLG). The purpose of the group, chaired by the Director of Integrated Governance, is to ensure that the Trust abides by the national guidelines on Serious Incidents, to include reporting, investigating, learning and acting upon such untoward events.

The group provides clinical expertise and executive oversight of all reported patient safety incidents identified as a potential serious incident and/or never event. IRLG also provides operational oversight of the effectiveness of the Trust's processes for management and assurance of patient safety incidents, including serious incidents and/or never events, in line with national guidelines. This includes reporting, investigation, learning from and acting on such incidents or events. IRLG is accountable to the Trust Board via monthly updates to the Quality Assurance Committee.

Learning from incidents is shared via patient stories; Care Group shared learning events and a monthly Lessons Learnt Newsletter.

The standard corporate reporting template encourages report authors to consider and comment upon issues relating to equality and diversity and full Equality Impact Assessments are required for all Trust policies which are then considered by the Policy Review Group.

Compliance with the NHS provider license, condition 4

Undertakings

In March 2021, the Trust entered into a voluntary variation to its original Undertakings, which were approved in April 2019. The variation issued in March 2021 were in response to a cluster of never events during 2020, concerns about our estates compliance and weaknesses in some areas of corporate governance. We took seriously these amendments to undertakings and, working with external support advisors, put in place a mechanism of assurance to the Board and NHSI to deliver the actions required to strengthen governance. As at 31 March 2021, this process was just beginning, with the external support advisors expected to be with the Trust until 30 May 2021. At the time of writing a Governance Improvement Plan is being drafted, focusing on the three core components of good governance – systems, process and culture/behaviour – and will be presented to the July 2021 Board in Public Meeting.

Regard to best practice

The Audit and Risk Assurance Committee reviews the effectiveness of internal control and reviews the Trust's Standing Orders to ensure they are fit for purpose (last reviewed in July 2020). The Board conducted a gap analysis of its governance during a board development session in January 2021 which has informed further improvements to date. The Board appreciates that good corporate governance requires continuous focus and improvement and is committed to that premise. The Board has regard to key corporate governance publications and the NHS Code of Governance and seeks to inform its governance improvements by learning from best practice.

Board and committee structures

The Trust is compliant with its Establishment Order in terms of the maximum number of voting Directors on the Board (executive and non-executive). The Trust has taken steps to assure itself that all Executive Directors and Non-Executive Directors have been assessed according to the Trust's policy and standards, in line with regulations, to ensure compliance with Fit and Proper Persons (F&PP) Regulations. This has included a review of the F&PP policy during the year by the Remuneration and Appointments Committee to reflect the recommendations from the Kark Review.

The Board undertook a skills assessment in July 2020 which identified gaps in accountancy and clinical expertise which have subsequently been filled by substantive Non-Executive Director appointments in-year.

The effectiveness of the Board and each of its Committees is reviewed annually through member self-assessment, with the intention of an external review at least every three years (the next one to be scheduled for 2022). The completion of an Annual Report for each Board Committee incorporating a reflection on the achievement of objectives and business is also conducted each year, including a review of terms of reference. There are reporting lines for staff throughout the organisation and a network of executive-led groups/boards which report through to the Board/ its Committees – these reporting relationships and accountabilities will be further clarified as part of the Trust's governance improvements in 2021/22.

In 2020/21 the Board needed to adapt its governance processes in light of the national and local Covid-19 situation. The revised arrangements included weekly 'huddles' for non-executive directors and/or the wider Board to receive updates and specific briefings on the impact of the pandemic. These arrangements were kept under regular review to ensure the balance was maintained between good governance and agile decision-making. The Trust is taking steps in 2021/22 to further clarify the lines of accountability and responsibility through the governance structure, including a focus on the executive governance arrangements and a whole-scale review of Standing Orders, including delegated authorities. This is part of the Trust's continuous governance improvement agenda.

The Board met on a monthly basis during 2020/21 (other than August and September due to a change in the timing of meetings) to discharge its statutory responsibilities and has established the necessary statutory (Audit, Remuneration) and non-statutory (Quality Assurance, Finance and Performance, People & Organisational Development) Board Committees under Terms of Reference and delegated authorities contained within the Standing Orders. 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.

Core responsibilities relating to governance for each committee are set out below:

i. 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)

ii. 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, including through the Ward to Board Framework
- → 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.

iii. 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.

iv. 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:

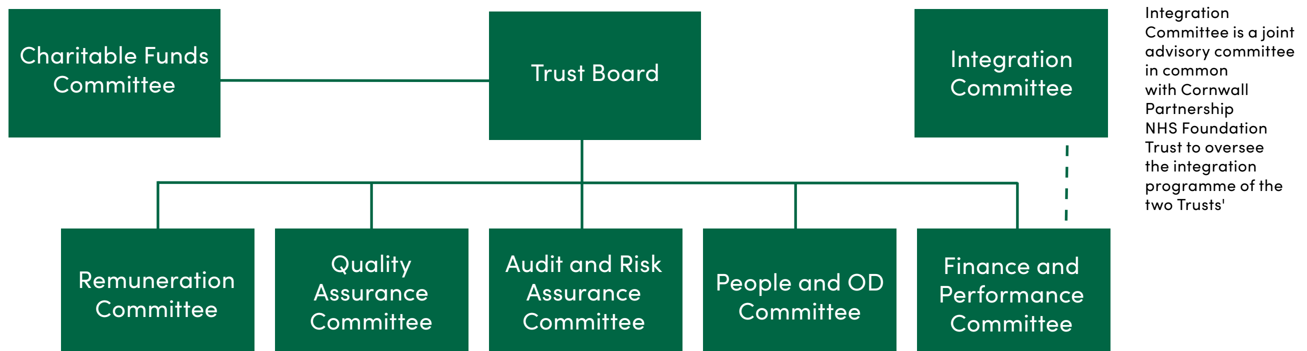
- → Strategic oversight and workforce planning
- → Organisational development and staff engagement
- → Compliance and risk management
- → Education and research
- → Inclusion

v. The Finance and Performance Committee maintains an objective overview of the Trust's financial and operational performance, business planning and associated risks. The committee meets monthly. 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

Reporting lines

Each committee reports to the Trust Board under a standing item for each monthly meeting. A visual of the reporting lines between the committees and the Board **is shown below:**



The Chairs of each committee summarise the business discussed and any issues for escalation to the Board. The Company Secretary ensures that the work programmes for the Board and its committees are aligned with clear decision/reporting routes for regulatory and statutory reports.

Well-led framework

The Trust's last Care Quality Commission inspection report published in February 2020 noted that the Trust's overall rating was 'requires improvement', with safe and responsive rated as requires improvement (comprehensive action plan in place and monitored via Quality Assurance Committee). Well-led, effective and caring were rated good.

The Trust has actions in place to sustain and improve compliance with the Well-Led framework, driven by:

- Continuation of governance improvements from a 2019 Developmental Well-led Governance Review, and further informed by the Board's assessment of corporate governance strengths and gaps in January 2021. This has included actions to:
  - introduce corporate governance seminars for staff to help colleagues understand the key components of Standing Orders and improve report writing
  - re-introduce written briefings for Chairs of committees and enhance agenda setting meetings to keep better sight of committee/Board work programmes
  - improve the format of Board and Committee meetings to ensure challenge is more clearly recorded
  - update Standing Orders to ensure they reflect the most up-to-date legislation/guidance and clarify delegated authorities (reflected also in committee Terms of Reference)
- Actions to address the Trust's undertakings and section 29a warning notice. This work will continue into 2021/22 via a Governance Improvement Plan. Up to March 2021, this included actions to:
  - strengthen adherence to internal and national policies where relevant
  - run a board development session (held 25 March 2021, facilitated by external experts, to inform a broader board development plan
  - Draft a broader Governance Improvement Plan
  - Significantly strengthen governance of the Estates function, including:
  - establishment of an executive-led Estates Cabinet to focus on and draw

    - together key risks to operational and strategic estates
    - ensuring all Authorised Engineers were appointed and had undertaken an annual assessment of their area
    - developing a four phase plan to address estates' concerns which includes: phase 1: detailed assessment of all risks (including commissioning of relevant external assessments); phase 2: Completion of the Premises Assurance Model and prioritisation of remedial actions with reconciliation to the risk register; phase 3: development of a one year (short-term) plan; and phase 4: development of a longer-term three year plan
- Action to address the Trusts section 29a warning notice. This work will continue into 2021/22 via the CQC Action Plan, monitored via the Quality Assurance Committee, and up to March 2021 included actions to:
    - enhance compliance with the WHO safety checklist
    - improve shared learning of incidents across the Trust
    - promote 'human factors' training with regards patient safety
- An internal committee effectiveness review, undertaken by each committee, assessing the responsibilities of each committees, the way they are supported and the responsibilities of individual directors and the Terms of reference of Board sub-committees;
- Enhanced scrutiny of the Trust's performance through the Board's monthly review of the Integrated Performance Report, which contains the detailed position on: quality and safety; operational performance; finance; our people (workforce) and partnership. Extracts of the IPR are also discussed by each committee, relevant to their Terms of Reference; and
- Quarterly consideration of the Board Assurance Framework by Trust Board, including considerations with regards risk to the provider licence.

The Trust undertakes an annual review of committee effectiveness and for 2020/21 this was undertaken as a self-assessment. The Trust intends to follow a 2+1 model for committee self-assessment where every third year it will commission an external review of effectiveness of both the Board and its committees. The autumn 2019 external developmental review also was relevant in this regard. We therefore intend to commission an external review of governance and effectiveness of the Board and its committees towards the end of the 2021/22 year.

The Board and its committees assesse the effectiveness of each meeting at the end of the agendas so that live feedback is captured and can be acted upon. Common themes for development from the 2020/21 self-assessment of effectiveness included: timeliness of papers; quality of papers; and the need to focus on more strategic and less operational matters. All Board members participate in an annual appraisal review.

During the year the Board welcomed Adam Broome as a new Non-Executive Director. The induction process was impacted by Covid-19 so there were no opportunities for face-to-face meetings, however online briefings with senior staff were arranged, alongside being able to observe committee meetings and provision of background documentation. Mr Broome has attended the NHSI training course for Non-Executive Directors.

At each monthly meeting the Board review the Integrated Performance Report (IPR) which presents data on the previous month. This data is also scrutinised at committee-level prior to the Board meeting. The Trust Board is seeking to further enhance use of the IPR to ensure its focus on the key aspects of performance, ensuring sight on the key indicators required for national monitoring, and improving triangulation of data to better derive understanding of the organisation's internal performance and comparative positioning.

Each Committee presents an annual report to the Board, so that it may review committee effectiveness and impact. The June 2021 Board is scheduled to receive the annual reports for 2020/21. The Board also receives a monthly assurance report from the Committee Chair on the key items discussed by each committee. These reports were presented verbally during 2020/21.

Directors are required to adhere to the highest standards of conduct in the performance of their duties, including with regard to the Nolan Committee on Standards in Public Life.

Workforce Strategies and Staffing Systems

Developing Workforce Standards and Workforce Priorities

Building on existing National Quality Board guidance, the Developing Workforce Safeguards are to strengthen commitments to safe, high quality care across all staff groups. Ensuring that safe and effective staffing systems are in place, underpinned by a combination of evidence based workforce tools, professional judgement and outcomes to ensure the right staff with the right skills are in the right place at the right time.

The key requirements of the guidance are:

- Embedding National Quality Boards (NQBs) 2016 Guidance
- Governance arrangements for Workforce Planning and Redesign Extension of Safe Staffing across all the Clinical Workforce
- Trust Board Engagement
- Workforce Planning
- Safe Staffing Reports and Monitoring

There are a number of key processes in place at the Trust which provide the safeguards as outlined in the guidance in which workforce requirement are measured with quality and safety indicators to provide Board and/or Committee level assurance. They include:

- Monthly Care Group Performance reviews
- Monthly integrated performance (IPR) assurance report
- E-roster monthly performance reports
- Bi-annual safe staffing reviews
- Guardian safe working hours quarterly and annual Board reports
- Freedom to speak up quarterly and annual Board reports
- Monthly Professional Standards report
- Datix incident reporting
- Risk register aligned to the Board Assurance Framework and Performance Accountability Framework
- Annual staff survey report
- Pulse surveys
- Annual workforce planning return
- Friends and family tests
- Embedded Equality Impact Assessment process for all policies, service changes and QI projects
- Benchmarking supporting information and data – model hospital and 'get it right first time' (GIRFT)

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)
  - clinical professional judgement
  - patient acuity
  - outcomes
- Performance management processes, which complement quality outcomes, operational and finance performance measures.

During 2020/21 the Trust approved the Brilliant People (workforce) Strategy 2020-23, which is an enabler to the Trust's Corporate Strategy which was launched in 2019. The Brilliant People Strategy takes into account the impact of COVID-19 and the national "We are the NHS: People Plan for 2020/21 – action for us all" which was published in July 2020.

The main workforce priorities for the Trust in line with the Brilliant People Strategy focuses on 8 key areas for action, so that colleagues are supported and enabled to do their best every day. These include:

- Remaining true to our values and create a brilliant place to work
- Making sure colleagues receive feedback to know how they are doing
- Having an open, inclusive and partnership approach to working with our Brilliant People
- Providing development to help colleagues learn and grow
- Providing an environment that supports colleague safety, health & wellbeing
- Creating a safe environment, so colleagues feel supported to speak up
- Having great leadership and support to help colleagues be the best they can be
- Working with our partners across the health and care system to ensure a sustainable workforce for the future

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

Workforce Planning

One major point of agreement from the development of the Brilliant People strategy is that we must do more to put the people who provide care, and those who receive care, at the heart of our Trust. To do that, we must put workforce planning at the centre of our overall planning processes. We will only transform our services if we transform the way we work. Each Care Group and Corporate function will promote and lead the people agenda, supported by their People and Organisational Development (OD) Partner. Care Groups and Corporate functions will require managers to implement the Brilliant People strategy within their specialties and feed ideas and comments and individual Care Group performance through to People and OD Committee.

The focus for the year ahead is help Care Groups and Corporate functions to shape future services and the workforce required to deliver these effectively and efficiently, reviewing skills and competencies and looking at new roles, including maximising opportunities to recruit into apprenticeship roles for professional staff including non-medical consultant roles, further development of roles such as ACP' and anaesthetic practitioners and offer training opportunities to medical staff wishing to pursue a career as a consultant.

In late 2020, as follow up action to the implementation of the Brilliant People Strategy, the Trust approved a Recruitment Strategy setting out its plans to attract the right talent to the Trust, and develop streamlined recruitment processes focussed on the candidate journey which will positively impact on not only our ability to recruit, but also to retain colleagues.

Our recruitment plans will also maximise our now established partnership working with the Department of Work and Pensions (DWP). We will continue to offer opportunities for people seeking work to undertake programmes of learning and work placements at RCHT and will support them with their application processes. In order to particularly help young people access careers in health and care we are participating in the DWP Kickstart initiative and will be providing work placements for a number of people aged 16-24 who are in receipt of universal credit. We anticipate this approach will improve our local workforce supply whilst also helping with economic recovery in Cornwall and the Isles of Scilly.

Inclusive, just, safe and learning culture

We continue to work with all staff representative colleagues, leaders and colleagues to co-design, develop and implement policies, procedures and practices for an inclusive just and learning culture. This links with patient safety, staff engagement, diversity and inclusive, and health and wellbeing.

The focus for the Trust is to develop working practices that move people away from fear and blame, including tackling incivility and bullying, improve inclusive practices, and address the health and wellbeing needs for staff to help them work safely. Benefits of this approach include reducing the need for inappropriate disciplinary investigations, improve our learning about how day-to-day care is delivered, how it feels to work for frontline staff, and ways in which they need to adapt and adjust what they do to keep patients safe.

Health and wellbeing

As an employer, we have put the wellness of our colleagues at the forefront of our health and wellbeing activity.

To do this we have planned and delivered expansive activities and systems that support 5-pillars of wellbeing: Body; Family, Relationships and Home; Mind and Emotions; Community and Finance; and Work.

We are continuing to strengthen our links with our staff members to ensure that what we provide on health and wellbeing fits with what is important to our colleagues. We cannot underestimate that COVID-19 has affected all our lives and our livelihoods in profound ways over the last year. People's mental health has taken a harder, longer-lasting hit during the pandemic. We want to prevent people from becoming unwell and to support them to recover.

We have invested heavily in offering local and national wellbeing support including mental health services (for example, local wellbeing support line, trained mental health and psychological first aid trainers, access to virtual fitness classes and our employee assistance (EAP) programme providing psychological and counseling support) to improve wellbeing and reduce sickness absence. Leadership and management training continues to be delivered to managers across the Trust to ensure that they have the necessary leadership skills to support the workforce.

The Trust has learnt a lot about the changes we put in place as part of our COVID-19 planning and actions, including adopting different ways of working, for example, hybrid working; access to virtual wellbeing resources; reduction in carbon footprint through virtual meetings; digital transformation e.g. virtual interviews; focus on compassionate leadership and behaviours.

Workforce Systems and Operations

The Trust has recognised that its reporting data, specifically around workforce has been challenging and not always consistent. In line with Lord Carter recommendations, the Trust has, in April approved plans to progress with performing a 'System Reset' bringing together expertise from several departments with the aim of presenting 'one source of truth' with data. This in turn will aid us in our strategic workforce planning aims ongoing.

In relation to the reduction on bank and agency spend, the COVID-19 pandemic led to significant changes in how NHS services were delivered and used, this partly resulted in lower use of temporary staffing spend. At the same time our recruitment programme continues to be successful and we have also improved bank capacity both within RCHT and across Cornwall which has reduced our reliance on our temporary workforce solutions. Our aim is to remain within these new parameters, adhering to tight sign off procedures and by increasing our substantive headcount to fill our vacancies.

Workforce Governance

Robust workforce governance systems continued to be improved, utilised and embedded to ensure the Trust's compliance with legislative requirements and best practice. This ranges from further progressing our diversity and inclusion plans, ensuring responsive and effective reporting against the Equality Delivery System (EDS) and its duties under the Equality Act 2010 including the reporting of the Trust's Workforce Race Equality Standard (WRES), Workforce Disability Equality Standard (WDES) and Gender Pay Gap. Successful delivery of the Annual Staff Survey including the analysis of results, reporting and development of associated action plans.

The Trust has in place regular 'check-ins' with staff through mechanisms such as quarterly Pulse Check Surveys to periodically assess how the Trust is doing against e.g. culture, leadership, wellbeing and take appropriate actions. Integrated performance metrics related to care, people and improvement are incorporated into performance appraisal frameworks (PAFs) used to measure performance against our Trust Strategy.

Medical Rostering: the Trust is currently over 50% of the way through implementing digital medical rostering workforce solutions. This will aid the reporting functionality on our medical workforce in new ways never experienced before across RCHT and also puts us ahead of many Trusts across the breadth of the country. The aim is to have this fully implemented as business as usual by the end of June 2021.

Education and Training

We recognise that access to high quality education is key in the provision of patient care and in promoting higher levels of job satisfaction amongst our colleagues. During the pandemic, the use of virtual and electronic forms of learning were utilised and we will build upon this in 2021/22 by continuing to offer more varied approaches to training.

We will continue to increase the number of apprenticeships and aim to stay above the public sector target for numbers. We have established a local pre-registration programme for operating department practitioners at Truro and Penwith College/ Greenwich University and will see this commence in September 2021. We anticipate further opportunities with more programmes for nursing and nursing associates.

For our current colleagues, we aim to build on the skills obtained during Covid-19 and enable more portfolio and rotational posts that maintain skills in practice. Using our CPD investment funding we will be able to offer more bespoke education to enable personal career development.

Pensions

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.

Declarations of Interest

The Trust's Declarations of Interests policy is aligned to the NHS guidance on 'Managing Conflicts of Interests'. The policy was updated and approved by Audit and Risk Assurance Committee in January 2021 to change the method of reporting from paper based to electronic via the Employee Staff Record (ESR) module called 'Conflicts of Interest'. The update to the policy also included clarification on who was considered as decision-making staff, as follows:

- Executive and Non-Executive Directors (excluding Associate Non-Executive Directors) who have decision making roles which involve the spending of taxpayers' money
- Those at Agenda for Change band 8d and above (inc consultants)
- Staff in the Procurement Team that have a level of influence with suppliers and make procurement related decisions
- All staff listed as having delegated financial authorities per the Scheme of Reservation and Delegation

Guidance was issued to all staff in February 2021 by the Company Secretary on how to access the 'Conflicts of Interest' module and automatic reminders went to all decision-making staff, who have to make an annual declaration (even if it is only to declare that they have no interests). The trust has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by the trust with reference to the guidance) within the past twelve months, as required by the 'Managing Conflicts of Interest in the NHS' guidance: https://doclibrary-rcht.cornwall.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/ChiefExecutive/DeclarationsOfInterest/StaffMembersDeclarationOfInterest/

Equality, Diversity and Human Rights

Our Executive lead for Equality, Diversity and Inclusion is the Director of People and OD. We aim for our hospitals to be a place where our people work hard to make a difference for patients, where they access opportunities to learn, develop and grow and work in a positive environment, free from discrimination. Equality impact assessments are carried out when reviewing all Trust policies and procedures. The Company Secretary supports colleagues to understand the requirement for clear consideration of quality and diversity in reports written for the Board/its committees. The Board reviewed its annual Equality, Diversity and Inclusion Annual Report in June 2020, which provides insight in the experiences of both our colleagues and our patients with protected characteristics.

Sustainable Development Management Plan

In October 2020, the Royal Cornwall Hospitals Trust joined with Cornwall Partnership Foundation Trust and NHS Kernow CCG to make a climate emergency declaration, supported by the Boards and Governing Body.

Since then, detailed work has been undertaken to calculate a baseline carbon footprint and develop a system-wide Green Plan for healthcare in Cornwall. This Green Plan aligns the vision of the NHS in Cornwall with that of Cornwall Council, by targeting carbon net zero healthcare by 2030, a full decade ahead of the targets set by NHSE. Board approval has been given for the Green Plan, and work is ongoing to set up a system-wide programme to ensure the 2030 target is met efficiently and effectively.

The Trust's net carbon zero ambition extends across all facets of healthcare, including working to the latest national NHS England Estates guidance for all major construction schemes.

The Trust has undertaken risk assessments and has a sustainable development management plan in place which takes account of UK Climate Projections 2018 (UKCP18). The trust ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

Community partners are an active part of our Green Plan delivery groups, as well as staff forums across the participating organisations, ensuring that we work together to promote healthy communities and support our local population to stay well and reduce their own carbon impact as well as ours.

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 and 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" (VFM) conclusion regarding its arrangements for securing economy, efficiency and effectiveness in its use of resources. For the year just end this review is enhanced under the new national NAO code of audit practice VFM arrangements.

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. The last financial year has however seen significantly different national financial arrangements than in previous years due to the 'covid pandemic' which has meant a significantly lower level of savings in 20-21 compared to previous years.

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 Hub helps progress staff suggestions that improve the efficiency and effectiveness of the Trust's services. The Trust's Care Group structure ensures a flatter hierarchy 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.

The internal audit on Local Financial Systems for 2020/21 concluded that the design and operation of financial controls provided significant assurance. This provides assurance on the effectiveness to those charged with governance on the effectiveness and quality of the internal controls.

Information governance

The Trust reported the following serious incidents relating to information governance, which includes any incidents relating to data loss and/or confidentiality breach:

Date	Details	Reported to	Outcome/update
01/03/2021	Disclosure to another NHS Trust - .full disclosure would be prejudicial to an ongoing investigations or disciplinary or regulatory proceedings, so has been omitted.	ICO	No further action required as ICO considered the actions taken by the Trust to be proportionate
11/11/2020	Disks containing copies of Echo studies have been mislaid within the Anaesthetics department.	Not required to report	Although entered in to the incident tool, this was not considered to be reportable as much of the information is held electronically
16/10/2020	A staff member who was part of an interview panel accessed a failed applicants application and used the persons contact details, email and mobile phone number for purposes not approved by the Trust.	ICO	No further action required as ICO considered the actions taken by the Trust to be proportionate
02/07/2020	A member of staff (who has since resigned) was accessing her family's records and those of her daughter's ex-partner and his family's records.	ICO	No further action required as ICO considered the actions taken by the Trust proportionate

Data quality and governance

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 aims 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.

Each indicator in the Trust's Integrated Performance Report is rated depending on its 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, and mandated validation of the pathway when patients with a decision to admit are added to the elective waiting list. 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 was externally reviewed in 2019/20 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 administrating 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.

The Trust has moved 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 led to an 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 has been incorporated into the Management of Information, Records and Data Quality Policy and underpins the Records, Information and Data Quality Strategy.

Review of effectiveness of internal control

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within the NHS trust who have responsibility for the development and maintenance of the internal control framework. I have drawn on the information provided in this annual report and other performance information available to me. My review is also informed by comments made by the external auditors in their management letter and other reports. I have been advised on the implications of the result of my review of the effectiveness of the system of internal control by the Board, the Audit and Risk Assurance Committee and 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:

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; and
- review, endorse and adopt, in support of the Accountable Officer (AO), the annual report, financial statements and statement to be given by the AO

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. The committee also oversees clinical audits.

Audit and Risk Committee: Independently and objectively monitors, 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). The Committee receives key reports which comment on compliance with key statutory and regulatory duties, including reports from the internal auditor.

As part of the Trust's approach to clinical effectiveness is the role of clinical audit. The Clinical Effectiveness Group which is chaired by the Medical Director produces an annual clinical audit programme which is approved by the Audit and Risk Committee and includes local and national audit requirements.

Clinical audit: The RCHT Clinical Audit programme is made up of four 'tiers' with a hierarchy of importance, with priority 1 being the most important. This is modified from a model of prioritisation recommended in the Healthcare Quality Improvement Partnership (HQIP) publication, "Clinical Audit Programme Guidance Tools" and available on the HQIP website.

- Priority 1 — External 'must do' audits
- Priority 2 — Internal 'must do' audits
- Priority 3 — Care Group priorities
- Priority 4 — Clinician interest and prioritising local audits

As at March 2021, the Trust continues to fully participate in all qualifying national audits. National Audit Reports are published throughout the year, on the HQIP site as well as through the individual audit mailing lists and websites. Reports vary from audit to audit in format, amount of information provided and whether Trust level data is included.

When an audit report has been published the Clinical Effectiveness Team send this to the clinical lead for the audit (as registered on the audit database) with a request for commentary on any Trust level data and identification of actions resulting from the audit results. Responses vary and often do not include specific actions or completion dates.

National audit publications and responses from specialty leads are reported at each Clinical Effectiveness Group.

Internal audit: Provides the AO and the Board with independent assurance that the Trust's risk management, governance and internal control processes are operating effectively. In 2020/21 the Independent Head of Internal Audit opinion was 'limited assurance'.

While there had been an improvement in engagement with and accountability for internal audits and their recommendations by the Trust, there remained issues with regards rigour of some governance processes, particularly within estates and health and safety. The Trust acknowledges that it needs to improve upon the review and application of policies and procedures, ensuring adherence to regulatory and statutory duties, and ensuring clear responsibilities and accountabilities of leaders and managers of key functions. The Trust will focus on strengthening 'the basics' / good foundations for all of its corporate and clinical areas in 2021/22 as a means of addressing these issues. It is recognised that the Trust has received a limited assurance opinion from the Head of Internal Audit for since 2017/18 and the Trust's intention is to move to a 'satisfactory' opinion in 2021/22 by driving improvements in overall governance across the organisation.

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.

The Trust fully participates in the national Getting It Right First Time (GIRFT) programme. Getting It Right First Time is designed to improve the quality of care within the NHS by reducing unwarranted variations. Although GIRFT visits were stood down during the pandemic, we have still continued to implement the monitoring elements of the programme. When GIRFT visits operate, we:

- log and report outcomes to the Clinical Effectiveness Group
- monitor all recommendations and actions through our Care Quality Commission Scrutiny Group; and
- report quarterly to the Quality Assurance Committee.

Engagement with regulators: The Trust has lead liaison officers with key regulatory bodies and its integrated governance structure is mapped to ensuring key statutory and regulatory duties are adhered (e.g. through ensuring compliance with information governance law and regulation through regular reports through to Board)

Conclusion

Other than the issues specifically noted in the previous section of the Annual Governance statement in relation to the NHSI licence, there are no significant internal control issues which have been identified.

Chief Executive Kate Shields

11 June 2021

Statement of directors' responsibilities in respect of the accounts

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

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

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

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

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

By order of the Board

Chief Executive
11 June 2021

Director of Finance
11 June 2021

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Remuneration and Staff Report

04.

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 and regular attendees of Trust Board meetings.

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

Remuneration for Executive Board members is determined by the Remuneration Committee.

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

The Remuneration Committee

The terms of reference for the Remuneration Committee were updated and approved by the Board in July 2020 as part of the review of governance arrangements. The membership of the Committee was updated in December 2020 to include all Non-Executive Directors, apart from the Chairwoman and Chair of Audit and Risk Assurance Committee. The Senior Independent Director is the Chair of the Committee and in their absence 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 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.

In 2020-21, there were a small number of exceptional events that led to the Remuneration Policy not always being followed correctly. Consequently, this led to incorrect payments to Board members being processed. The individuals concerned were unaware of the errors and action has been taken to recover any payments made in error or made any payments that were omitted. The tables below include adjustments in respect of this.

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 of this report.

The Remuneration Committee determined in November 2020 to withdraw the Trust's Performance-Related-Pay Framework for Executive Directors.

Fair pay disclosure (subject to audit)

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 2020-21 was £230,000-£235,000 (2019-20: £210,000-215,000). This was 7.59 times (2019-20: 7.29 times) the median remuneration of the workforce, which was £30,642 (2019-20: £29,154).

Based on the March 2021 payroll, the calculated annualised pay for 2020-21 of 1 employee would have exceeded that of the highest-paid director (2019-20: 2).

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 compared to 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 external interim director to ensure continuity of leadership (with approval from NHS Improvement) or appoint a suitably qualified internal member of staff to act up for a period.

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

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

Non-Executive Directors

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

Name	Appointment start date	Appointment end date	Re-appointment start date	Re-appointment end date	Re-appointment start date	Re-appointment end date
Dr Mairi McLean (Chairwoman)	January 2019	January 2022				
Paul Hobson	January 2016	January 2020	January 2020	January 2021	January 2021	January 2022
Sarah Newton	March 2020	March 2022				
Sarah Pryce	May 2016	May 2018	May 2018	May 2020	May 2020	May 2022
Richard Stephenson	February 2020	February 2022				
Adam Broome	November 2020	November 2022				
Ruth Allarton, (Associate) (1)	January 2020	January 2021	January 2021	March 2021		
Richard Smith (Associate)	February 2020	February 2021	February 2021	March 2022		

(1) Appointed as substantive Non-Executive Director from 1 April 2021.

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

Salary and pension entitlements of Senior Managers

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

Salaries and allowances

Non-Executive Directors	2020-21			2019-2020		
	Salary (bands of £5000)	Expense payments (taxable) total to nearest £100	TOTAL (bands of £5000)	Salary (bands of £5000)	Expense payments (taxable) total to nearest £100	TOTAL (bands of £5000)
	£000	£00	£000	£000	£00	£000
Dr Mairi McLean Chairwoman	45-50	0	45-50	50-55	0	50.55
Adam Broome Non-Executive Director (from November 2020)	0.5	0	0.5			
Paul Hobson Non-Executive Director	10-15	0	10-15	5-10	0	5-10
Sarah Newton Non-Executive Director (from March 2020)	10-15	0	10-15	0.5	0	0.5
Sarah Pryce Non-Executive Director	10-15	0	10-15	5-10	0	5-10
Richard Stephenson Non-Executive Director (from February 2020)	10-15	0	10-15	0.5	0	0.5
Ruth Allarton Associate Non-Executive Director	10-15	0	10-15	5-10	0	5-10
Richard Smith Associate Non-Executive Director	10-15	0	10-15	5-10	0	5-10
Rob Leighfield Associate Non-Executive Director (to October 2020)	10-15	0	10-15	5-10	0	5-10
Margaret Schwarz Non-Executive Director (to January 2021)	5-10	0	5-10	5-10	0	5-10
Dr Gillian Vivian Non-Executive Director (to October 2020)	5-10	0	5-10	5-10	0	5-10
Scott Bennett Non-Executive Director (from July 2019 to August 2019)				0-5	0	0-5
Kevin Orford Non-Executive Director (October 2019 to November 2019)				0-5	0	0-5
Dr John Lander Non-Executive Director (to August 2019)				0-5	0	0-5

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

Senior Managers	2020-21				
	Salary whilst in post as Senior Manager (bands of £5,000)	Other salary (bands of £5,000)	Performance Pay and Bonuses (bands of £5,000)	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£000	£000	£000	£000
Kate Shields Chief Executive	200-225	0	5-10	0	230-235
Susan Bracefield Director of Operations	145-150	0	5-10	0	150-155
Kerry Eldridge Director of Human Resources & Organisational Development (to April 2021)	150-155	70-75*	5-10	0	225-230
Bernadette George Director of Integrated Governance	105-110	0	0-5	50.0-52.5	160-165
Dr Allister Grant Medical Director	180-185	0	0	242.5-245.0	425-430
Kelvyn Hipperson (3) Chief Information Officer	90-95	0	0-5	27.5-30.0	120-125
Karen Kay Director for Urgent & Emergency Care	115-120	0	0-5	37.5-40.0	160-165
Thomas Lafferty Director of Strategy & Performance	130-135	0	5-10	30.0-32.5	170-175
Karl Simkins Director of Finance (from December 2020) Strategic Financial Advisor (from April 2020 to December 2020)	150-155	0	0-5	0	150-155
Sally May (1) Director of Finance (to December 2020)	65-70	0	0	137.5-140	205-210
Kim O'Keeffe (2) Director of Nursing, Midwifery & Allied Health Professions	80-85	0	5-10	5.5-7.5	95-100
Ricky Daniel Interim Director of Estates (from July 2020)	95-100	0	0	20.0-22.5	115-120
Robin Jones Acting Director of Operations (from October 2020 to March 2021)	50-55	0	0	35.0-37.5	85-90
Adam Wheeldon Deputy Director of Finance	90-95	0	0	0	90-95
Mid-point of total paid remuneration bnd of the highest paid Director	£232,500				
Median total remuneration	£30,642				
Ratio	7.59				

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 was shared with Cornwall Partnership NHS Foundation Trust for the period to December 2020. Salary costs disclosed here are those costs incurred by this Trust for the period April 2020 to December 2020 (including arrears of £8,000 relating to 2019-20). The full salary costs for the individual for that period would be in the band £130,000-£135,000.
(2) The Director of Nursing, Midwifery & Allied Health Professions is shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those costs incurred by this Trust for the period April 2020 to March 2021. The full salary costs for the individual would be in the band £160,000-£165,000.
(3) The Chief Information Officer is shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those costs incurred by this Trust for the period April 2020-March 2021. The full salary costs for the individual would be in the band £120,000-£125,000.
*payment in lieu of notice, included within exit packages disclosed in the Staff Report below.
There were no taxable expense payments in respect of Senior Managers in 2020-21.

Senior Managers	2019-20				
	Salary whilst in post as Senior Manager (bands of £5,000)	Other salary (bands of £5,000)	Expense payments (taxable) total to nearest £100	All pension-related benefits (bands of £2,500)	TOTAL (bands of £5,000)
	£000	£000	£	£000	£000
Kate Shields Chief Executive	210-215	0	0	0	210-215
Susan Bracefield Director of Operations	130-135	0	0	192.5-195.0	320-325
Kerry Eldridge Director of Human Resources & Organisational Development (to April 2021)	135-140	0	0	0	135-140
Bernadette George Director of Integrated Governance	95-100	0	0	85.0-87.5	185-190
Dr Allister Grant Medical Director (from Nov 19)	75-80	0	0	242.5-245.0	315-320
Kelvyn Hipperson (3) Chief Information Officer	95-100	0	0	22.5-25.0	120-125
Karen Kay Director for Urgent & Emergency Care	115-120	0	0	47.5-50.0	160-165
Thomas Lafferty Director of Strategy & Performance	125-130	0	0	37.5-40.0	165-170
Sally May (1) Director of Finance (to December 2020)	90-95	0	0	10.0-12.5	100-105
Kim O'Keeffe (2) Director of Nursing, Midwifery & Allied Health Professions	125-130	0	0	62.5-65.0	185-190
Dr Rob Parry Interim Medical Director (to October 2019)	115-120	75-80	3,500	0	195-200
Mid-point of total paid remuneration bnd of the highest paid Director	£212,500				
Median total remuneration	£29,154				
Ratio	7.29				

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 2019 to March 2020. The full salary costs for the individual for that period would be in the band£140,000-145,000. However, a contract amendment for this Director has been actioned in 2020-21 which will be backdated to 1 April 2019. This contract amendment will be paid in 2020-21. Had the amendment been actioned in 2019-20, total remuneration for the post would have been in the band £155,000 to £160,000.

(2) The Director of Nursing, Midwifery & Allied Health Professions has been shared with Cornwall Partnership NHS Foundation Trust since December 2019. Salary costs disclosed here are those costs incurred by this Trust for the period April 2019 to March 2020. The full salary costs for the individual would be in the band £150,000-£155,000.

Clinical Excellence Awards are included within 'salary'. All 'pension-related benefits' disclosed in the tables 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)	Real increase in pension lump sum at pension age (bands of £2,500)	Total accrued pension at pension age at 31 March 2021 (bands of £5,500)	Lump sum at pension age related to accrued pension at 31 March 2021 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2021 as prvided by NHSPA	Cash Equivalent Transfer Value at 31 March 2020 as prvided by NHSPA	Real Increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Ricky Daniel Interim Director of Estates	0 - 2.5	0	0 - 5.0	0	41	19	1
Bernadette George Director of Integrated Governance	2.5 - 5.0	2.5 - 5.0	40 - 45	105 - 110	832	753	52
Dr Allister Grant Medical Director	10.0 - 12.5	25.0 - 27.5	65 - 70	160 - 165	1,354	1,077	231
Kelvyn Hipperson Chief Information Officer	0 - 2.5	0	0 - 5	0	66	33	16
Robin Jones Acting Director of Operations	0 - 2.5	0 - 2.5	20 - 25	40 - 45	302	265	20
Karen Kay Director for Urgent & Emergency Care	2.5 - 5.0	0	20 - 25	0	316	266	27
Thomas Lafferty Director of Strategy & Performance	2.5 - 5.0	0	20 - 25	0	215	185	8
Sally May Director of Finance (to December 2020)	5.0 - 7.5	7.5 - 10.0	60 - 65	145 - 150	1,256	1,079	95
Kim O'Keeffe Director of Nursing, Midwifery & Allied Health Professions	0 - 2.5	2.5 - 5.0	35 - 40	115 - 120	976	909	30
Karl Simkins Director of Finance (from December 2020) Strategic Financial Adviser (April 2020-December 2020)	0 - 2.5	(7.5) - (5.0)	65 - 70	185 - 190	1,542	1,497	(2)
Adam Wheeldon Deputy Director of Finance	(2.5) - 0	0	40 - 45	0	489	480	(12)

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

The Trust made no employer contributions to stakeholder pensions. A Cash Equivalent Transfer Value (CETV) is the actuarially assessed capital value of the pension scheme benefits accrued by a member at a particular point in time. The benefits valued are the member's accrued benefits and any contingent spouse's pension payable from the scheme.

A CETV is a payment made by a pension scheme, or arrangement to secure pension benefits in another pension scheme or arrangement when the member leaves a scheme and chooses to transfer the benefits accrued in their former scheme. The pension figures shown relate to the benefits that the individual has accrued as a consequence of their total membership of the pension scheme, not just their service in a senior capacity to which the disclosure applies.

The CETV figures and other pension details include the value of any pension benefits in another scheme or arrangement which the individual has transferred to the NHS Pension Scheme. They also include any additional pension benefit accrued to the member as a result of their purchasing additional years of pension service in the scheme at their own cost.

CETVs are calculated within the guidelines and framework prescribed by the Institute and Faculty of Actuaries.

Real increase in CETV

This reflects the increase in CETV effectively funded by the employer. It does not include the increase in accrued pension due to inflation, contributions paid by the employee (including the value of any benefits transferred from another pension scheme or arrangement) and uses common market valuation factors for the start and end of the period. The prescribed rate of inflation used for 2020-21 was 1.7%.

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 2020-21 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.

No exit packages were agreed in respect of senior managers in 2019-20.

Staff Report
Staff Costs

Staff costs for the year are shown below:

	2020-21			2019-20
	Permanent	Other	Total	Total
	£000	£000	£000	£000
Salaries and wages	228,554	12,531	241,085	212,480
Social security costs	21,331	1,281	22,612	20,852
Apprenticeship levy	1,093	56	1,149	1,059
Employer's contributions to NHS pension scheme	38,264	1,346	39,610	36,004
Pension cost - other	305	17	322	209
Termination benefits	160	0	160	23
Temporary staff	0	8,963	8,963	21,341
Total staff costs	289,707	24,194	313,901	291,968
Of which: Cost capitalised as part of assets	2,108	0	2,108	2,565

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

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 2020-21 these were as follows:

	2020-21			2019-20
Staff type	Permanently Employed Staff	Bank and Agency Staff	Total Staff	Total Staff
	Number	Number	Number	Number
Medical and dental staff	869	52	921	850
Administration and estates staff	1,466	63	1,529	1,388
Healthcare assistants and other support staff	710	99	809	758
Nursing, midwifery and health visiting staff	1,468	136	1,604	1,583
Nursing, midwifery and health visiting learners staff	50	0	50	50
Scientific, therapeutic and technical staff	893	28	921	856
Healthcare science staff	174	1	175	168
Other	8	0	8	7
Total	5,638	379	6,017	5,660
Number of employees (WTE) engaged on capital projects	67	0	67	86

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.

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	7	5	12
Senior Staff (Agenda for Change pay scales Band 8 and above)	85	197	282
Other staff	1,038	4,306	5,344
Total	1,130	4,508	5,638

Information relating to staff turnover rates at the Trust can be found through this link to NHS Digital's NHS Workforce statistics publications: https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics

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 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 was launched to offer support, advice and guidance for staff who are also unpaid carers. A local carer's charity offered to attend to provide their expertise on assessment and benefits available. The charity also provides a drop-in advice session for patient carers once a month which is hosted in the hospital.

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

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

http://www.rcht.nhs.uk/DocumentsLibrary/RoyalCornwallHospitalsTrust/HumanResources/EqualityDiversityAndHumanRightsPolicy.pdf

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

Sickness absence data

Information regarding staff sickness can be found using the link below:
https://digital.nhs.uk/data-and-information/publications/statistical/nhs-sickness-absence-rates
Ill-health retirement data is shown below:

Ill-health retirements	2020-21	2019-20
Number of persons retired early on ill-health grounds	4	3
Total additional pensions liabilities accrued in the year	£276,000	£114,000

Consultancy expenditure

The Trust incurred the following consultancy expenditure in 2020-21

Area	Expenditure £000
Operational consultancy	164
Health innovation support	8
Clinical record review	30
Governance support	4
Covid research consultancy	29
Total	235

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.

Length of off-payroll engagements

Off-payroll engagements as of 31 March 2021 for more than £245 per day:	Number
Number of existing engagements as of 31 March 2021	2
The number that have existed for less than 1 year at the time of reporting	1
The number that have existed for between 1 and 2 years at the time of reporting	1

Off-payroll engagements engaged at any point during the financial year

Off-payroll engagements between 1 April 2020 and 31 March 2021, for more than £245 per day	Number
Number of temporary off-payroll workers engaged between 1 April 2020 and 31 March 2021	3
Of which:	
Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	1
Number subject to off-payroll legislation and determined as out of scope of IR35	2
Number of engagements reassessed for compliance or assurance purposes during the year	0

A worker that provides their services through their own limited company or another type of intermediary to the client will be subject to off-payroll legislation and the department must undertake an assessment to determine whether that worker is in-scope of Intermediaries legislation (IR35) or out-of-scope for tax purposes.

Off-payroll engagements of Board members, and/or senior officials with significant financial responsibility, between 1 April 2020 and 31 March 2021:

	Number
Number of off-payroll engagements of Board members, and/or senior officers with significant financial responsibility, during the financial year	0
Number of individuals that have been deemed "Board members and/or senior officers with significant financial responsibility" during the financial year. This figure includes both off-payroll and on-payroll engagements	25

Exit packages

The tables below detail the exit packages agreed in 2020-21 and 2019-20 by the Trust:

Exit packages agreed in 2020-21

Band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£000
Less than £10,000	0	0	1	2	1	2
£10,000 - £25,000	0	0	3	35	3	35
£25,001 - £50,000	0	0	2	52	2	52
£50,001 - £100,000	0	0	1	71	1	71
Total	0	0	7	160	7	160

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.
Included in the table above is a single payment in relation to an exit package for a Senior Manager, as a contractual payment in lieu of notice: £71,000.

Exit packages agreed in 2019-20

Band	Number of compulsory redundancies	Cost of compulsory redundancies	Number of other departures agreed	Cost of other departures agreed	Total number of exit packages	Total cost of exit packages
	Number	£000	Number	£000	Number	£000
Less than £10,000	0	0	1	1	1	1
£10,000 - £25,000	0	0	1	22	1	22
£25,001 - £50,000	0	0	0	0	0	0
£50,001 - £100,000	0	0	0	0	0	0
Total	0	0	2	23	2	23

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

Exit costs in this table are accounted for in full in the year of departure. Where the Trust has agreed early retirements, the additional costs are met by the Trust and not by the NHS Pension Scheme. Ill-health retirement costs are met by the NHS Pension Scheme and are not included in the table.

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

None of the payments above include a special payment element.

Analysis of other departures

2020-2021

Type (Excluding compulsory redundancies)	Total number of agreements	Total value of agreements
		£000
Contractual payments in lieu of notice	6	149
Exit payments following employment tribunals or court orders	1	11
Total	7	160

The above table is subject to audit and has been referred to in the auditor's opinion on the financial statements.
Included in the table above is a single payment in relation to an exit package for a Senior Manager, as a contractual payment in lieu of notice: £71,000.

2019-2020

Type (Excluding compulsory redundancies)	Total number of agreements	Total value of agreements
		£000
Contractual payments in lieu of notice	2	23
Total	2	23

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

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

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

Chief Executive
11 June 2021

Kate Shields

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Annual Accounts

05.

Statement of Comprehensive Income for the year ended 31 March 2021

	NOTE	2020-21 £000	2019-20 £000
Operating income from patient care activities	3	**455,570**	422,712
Other operating income	4	**81,607**	58,911
Operating expenses	6, 8	**(529,262)**	(481,438)
Operating surplus / (deficit)		**7,915**	185
Finance costs			
Finance income	11	**2**	125
Finance expenditure	12	**(544)**	(1,405)
Public dividend capital dividends payable		**(3,516)**	(2,015)
Net finance costs		**(4,058)**	(3,295)
Other gains and (losses)	13	**(54)**	33
Surplus / (deficit) for the year		**3,803**	(3,077)
Other comprehensive income			
Will not be reclassified to income and expenditure:			
Impairments and reversals taken to the revaluation reserve	7	**(1,889)**	(1,067)
Revaluations		**585**	2,867
Total comprehensive income / (expense) for the year		**2,499**	(1,277)

The notes on pages 113 to 150 form part of this account.

The following information is not part of the Statement of Comprehensive Income and has been included to show the Trust's financial performance as it is assessed for NHS purposes.

NHS Financial performance for the year			
Surplus / (deficit) for the year (as above)		**3,803**	(3,077)
Remove impairments (1)	7	**(286)**	3,388
Remove impact of capital grants and donations (2)		**(575)**	146
Remove 2018-19 Provider Sustainability Funding (PSF) (3)			(407)
Remove net impact of inventories received from DHSC group bodies for COVID response (4)		**(186)**	
Adjusted retained surplus / (deficit) for NHS Purposes		**2,756**	50

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

(1) Impairment charges and reversals are not considered part of an NHS trust's operating financial position;
(2)This balance reflects the difference between capital charges incurred on donated and government grant funded assets and the donations credited to income during the year. The resultant impact on the Trust's operating surplus for the year is neutralised by this adjustment;
(3)The Trust received an additional distribution of PSF funding in 2019-20 which related to the 2018-19 financial year. This funding did not contribute to the Trust's NHS reported financial performance in 2019-20.
(4)This balance reflects the difference between amounts credited to income in 2020-21 and the amounts used and reflected in operational expenses during the same period.

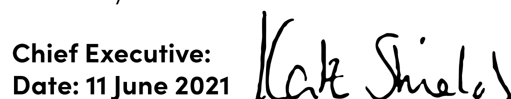
Statement of Financial Position as at 31 March 2021

	NOTE	31 March 2021	31 March 2020
		£000	£000
Non-current assets			
Intangible assets	14	**10,419**	8,662
Property, plant and equipment	15	**205,050**	164,569
Receivables	17	**1,123**	856
Total non-current assets		**216,592**	174,087
Current assets			
Inventories	16	**8,980**	9,006
Receivables	17	**11,265**	33,664
Cash and cash equivalents	18	**42,085**	6,576
Total current assets		**62,330**	49,246
Current liabilities			
Trade and other payables	19	**(72,373)**	(52,752)
Borrowings	21	**(1,655)**	(46,040)
Provisions	24	**(978)**	(407)
Other liabilities	20	**(3,835)**	(4,980)
Total current liabilities		**(78,841)**	(104,179)
Total assets less current liabilities		**200,081**	119,154
Non-current liabilities			
Borrowings	21	**(5,879)**	(22,377)
Provisions	24	**(3,826)**	(3,872)
Other liabilities	20	**0**	(678)
Total non-current liabilities		**(9,705)**	(26,927)
Total assets employed		**190,376**	92,227
Financed by:			
Public dividend capital		**268,647**	172,997
Revaluation reserve		**36,431**	37,735
Income and expenditure reserve		**(114,702)**	(118,505)
Total taxpayers' equity		**190,376**	92,227

The notes on pages 113 to 150 form part of this account.

The financial statements on pages 109 to 112 were approved by the Board on 11 June 2021 and signed on its behalf by

Chief Executive:
Date: 11 June 2021



Statement of Changes in Equity for the year ended 31 March 2021

Statement of changes in equity for the year ended 31 March 2021	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2020	**172,997**	**37,735**	**(118,505)**	**92,227**
Surplus / (deficit) for the year			3,803	3,803
Revaluations		585		585
Impairments		(1,889)		(1,889)
Public dividend capital received	95,650			95,650
Taxpayers' and others' equity at 31 March 2021	**268,647**	**36,431**	**(114,702)**	**190,376**

Statement of changes in equity for the year ended 31 March 2020	Public dividend capital £000	Revaluation reserve £000	Income and expenditure reserve £000	Total reserves £000
Taxpayers' and others' equity at 1 April 2019	**170,426**	**35,936**	**(115,429)**	**90,933**
Surplus / (deficit) for the year			(3,077)	(3,077)
Revaluations		2,867		2,867
Impairments		(1,067)		(1,067)
Transfer to income and expenditure reserve on disposal of assets		(1)	1	
Public dividend capital received	2,571			2,571
Taxpayers' and others' equity at 31 March 2020	**172,997**	**37,735**	**(118,505)**	**92,227**

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 2021

	NOTE	2020-21 £000	2019-20 £000
Cash flows from operating activities			
Operating (deficit) / surplus		**7,915**	185
Non-cash income and expense			
Depreciation and amortisation	6	**12,004**	10,812
Net impairments	7	**(286)**	3,388
Income recognised in respect of capital donations	4	**(1,389)**	(652)
(Increase) / decrease in receivables and other assets		**22,035**	(8,263)
(Increase) / decrease in inventories		**26**	(831)
Increase / (decrease) in trade and other payables		**10,669**	9,129
Increase / (decrease) in other liabilities		**(1,823)**	654
Increase / (decrease) in provisions		**543**	(225)
Net cash generated from operating activities		**49,694**	14,197
Cash flows from investing activities			
Interest received	11	**2**	125
Purchase of intangible assets		**(2,768)**	(3,302)
Purchase of property, plant and equipment		**(42,745)**	(15,800)
Sales of property, plant and equipment		**33**	38
Receipt of cash donations to purchase capital assets		**83**	357
Net cash generated / (used) in investing activities		**(45,395)**	(18,582)
Cash flows from financing activities			
Public dividend capital received		**95,650**	2,571
Movement on loans from the DHSC (1)		**(60,442)**	2,496
Capital element of finance lease payments		**(256)**	(245)
Capital element of LIFT payments (2)		**(27)**	(22)
Interest paid on DHSC loans		**(218)**	(955)
Other interest	12	**(1)**	0
Interest paid on finance lease liabilities		**(39)**	(46)
Interest paid on LIFT obligations		**(434)**	(427)
PDC dividend paid		**(3,000)**	(2,124)
Net cash generated from financing activities		**31,233**	1,248
Net increase / (decrease) in cash and cash equivalents		**35,532**	(3,137)
Cash and cash equivalents at 1 April		**6,553**	9,690
Cash and cash equivalents at 31 March	18	**42,085**	6,553

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

	2020-21 £000	2019-20 £000
Revenue support loans repaid	**(53,315)**	(1,788)
Capital investment loans repaid	**(7,127)**	(1,516)
New capital investment loans received	**0**	5,800
	(60,442)	2,496

(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 preparation

The Secretary of State for Health, in exercising the statutory functions conferred on NHS England has directed that the financial statements of NHS trusts 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 DHSC Group Accounting Manual 2020-21, 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 DHSC Group Accounting Manual permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the NHS 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.

Accounting Convention

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

1.2 Going concern

These accounts have been prepared on a going concern basis. The financial reporting framework applicable to NHS bodies, derived from the HM Treasury Financial Reporting Manual, defines that the anticipated continued provision of the Trust's services in the public sector is normally sufficient evidence of going concern. The directors have a reasonable expectation that this will continue to be the case.

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 from its involvement with the entity and has the ability to affect those returns through its power over the 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.

The Trust has considered the requirement to consolidate, with these financial statements, the financial statements of the Charity. 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 not been consolidated in either the current or preceding year. Details of the transactions between the Trust and the Charity are disclosed within Note 30 as related party transactions.

1.4 Critical judgements in applying accounting policies

The following are the judgements, apart from those involving estimations (see below) that management has made in the process of applying the Trust's accounting policies and that have the most significant effect on the amounts recognised in the financial statements.

In 2019-20 the Trust disclosed a material uncertainty in respect of the application of the going concern basis for preparation of the financial statements, due to the lack of clarity surrounding financial planning for 2020-21. Following the update of Practice Note 10 in respect of 2020-21, and the Trust's assessment confirmation that it's services will continue in 2021-22 and beyond, there is no longer a critical judgement with regard to going concern.

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. This approach was first adopted in 2014-15 and is in accordance with HM Treasury requirements. The valuation exercise was carried out in March 2021 with a valuation date of 31 March 2021. The decision to value the Trust's land and building based on the single off-site location represents a material judgement by the Trust.

1.5. Sources of estimation uncertainty

The Trust has not identified any assumptions about the future, or other major sources of estimation uncertainty, that would have a significant risk of resulting in a material adjustment to the carrying amounts of assets and liabilities within the next financial year.

1.6 Revenue

Revenue from contracts with customers

Where income is derived from contracts with customers, it is accounted for under International Financial Reporting Standard 15: Revenue from contracts with customers (IFRS 15). The GAM expands the definition of a contract to include legislation and regulations which enables an entity to receive cash or another financial asset that is not classified as a tax by the Office of National Statistics (ONS).

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.

Payment terms are standard reflecting cross government principles.

Comparative period (2019-20)

In the comparative period (2019-20), the Trust's contracts with NHS commissioners included those where the Trust's entitlement to income varied according to services delivered. A performance obligation relating to delivery of a spell of healthcare was generally satisfied over time as healthcare was received and consumed simultaneously by the customer as the Trust performed it. The customer in such a contract was the commissioner, but the customer benefited as services were provided to their patient. Even where a contract could be broken down into separate performance obligations, healthcare generally aligned with paragraph 22(b) of the Standard entailing a delivery of a series of goods or services that were substantially the same and had a similar pattern of transfer. At the year end, the Trust accrued income relating to activity delivered in that year, where a patient care spell was incomplete. This accrual was disclosed as a contract receivable as entitlement to payment for work completed was usually only dependent on the passage of time.

In 2019-20, the Provider Sustainability Fund and Financial Recovery Fund enabled providers to earn income linked to the achievement of financial controls and performance targets. Income earned from the funds is accounted for as variable consideration.

Contract income is typically invoiced on 30 day credit terms and is expected to be settled accordingly. All balances are regularly reviewed for potential credit losses and allowances provided for where necessary.

Revenue from NHS contracts

The accounting policies for revenue recognition and the application of IFRS 15 are consistently applied. The contracting arrangements in the NHS changed between 2019-20 and 2020-21 affecting the application of the accounting policy under IFRS 15. This difference in application is explained below:

2020-21

The main source of income for the Trust is contracts with commissioners for healthcare services. In 2020-21, the majority of the Trust's income from NHS commissioners was in the form of block contract arrangements. During the first half of the year the Trust received block funding from its commissioners. For the second half of the year, block contract arrangements were agreed at an Integrated Care System level. The related performance obligation is the delivery of healthcare and related services during the period, with the Trust's entitlement to consideration not varying based on the levels of activity performed.

The Trust has received additional income outside of the block and system envelopes to reimburse specific costs incurred and other income top-ups to support the delivery of services. Reimbursement and top-up income is accounted for as variable consideration.

For 2020-21 and 2019-20

In the application of IFRS 15, a number of practical expedients offered in the Standard have been employed. These are as follows:

- ➔ **the Trust does not disclose information regarding performance obligations as part of a contract that has an original expected duration of one year or less;**
- ➔ **the Trust is to similarly not disclose information where revenue is recognised in line with the practical expedient offered in the Standard, where the right to consideration corresponds directly with value of the performance completed to date; and**
- ➔ **the FReM has mandated the exercise of the practical expedient offered in the Standard that requires the Trust to reflect the aggregate effect of all contracts modified before the date of initial application.**

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. Some research income alternatively falls within the provisions of IAS 20: Accounting for Government Grants and Disclosure of Government Assistance.

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 performance obligations are satisfied. In practical terms this means that treatment has been given, 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.

1.7 Other forms of income

Grants and donations

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. Where the grant is used to fund capital expenditure, it is credited to the Statement of Comprehensive Income once conditions attached to the grant have been met. Donations are treated in the same way as government grants.

Apprenticeship service income

The value of the benefit received when accessing funds from the Government's apprenticeship service is recognised as income at the point of receipt of the training service. Where these funds are paid directly to an accredited training provider from the Trust's Digital Apprenticeship Service (DAS) account held by the Department for Education, the corresponding notional expense is also recognised at the point of recognition for the benefit.

1.8 Expenditure on employee benefits

Short-term employee benefits

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

Pension costs - NHS Pension Schemes

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Both schemes are unfunded, defined benefit schemes that cover NHS employer, general practices and other bodies, allowed under the direction of Secretary of State for Health and Social Care in England and Wales. The scheme is not designed in a way that would enable employers to identify their share of the underlying scheme assets and liabilities. Therefore, the scheme is accounted for as though it is a defined contribution scheme: the cost to the Trust is taken as equal to the employer's pension contributions payable to the scheme for the accounting period. The contributions are charged to operating expenses as 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.

1.9 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.

1.10 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 lives.

Subsequent expenditure

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

Measurement

Valuation

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

Assets are measured subsequently at valuation. Assets which are held for their service potential and are in use (ie 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.

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

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

- **land and non-specialised buildings - market value for existing use; and**
- **specialised buildings - depreciated replacement cost, modern equivalent asset basis.**

For specialised assets, current value in existing use is interpreted as the present value of the asset's remaining service potential, which is assumed to be at least equal to the cost of replacing that service potential. Specialised assets are therefore valued at their depreciated replacement cost (DRC) on a modern equivalent asset (MEA) basis. An MEA basis assumes that the asset will be replaced with a modern asset of equivalent capacity and location requirements of the services being provided. Assets held at depreciated replacement cost have been valued on an alternative site basis where this would meet the location requirements.

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

IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost where these assets have short useful lives or low values or both, as this is not considered to be materially different from current value in existing use.

Depreciation

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

Property, plant and equipment which have been reclassified as 'held for sale' cease to be depreciated upon the re-classification. 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 expenditure.

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 criteria set out in IFRS 5: Non-current Assets Held for Sale and Discontinued Operations are met. The sale must be highly probable and the asset available for immediate sale in its present condition.

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

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

Donated and grant funded assets

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

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

In 2020-21 this includes assets donated to the Trust by the Department of Health and Social Care as part of the response to the coronavirus pandemic. As defined in the GAM, the Trust applies the principle of donated asset accounting to assets that the Trust controls and is obtaining economic benefits from at the year end.

Local Improvement Finance Trust (LIFT) transactions

LIFT transactions which meet the International Financial Reporting Interpretations Committee 12: Service Concessions Arrangements (IFRIC 12) definition of a service concession, as interpreted in HM Treasury's Government Financial Reporting Manual (FReM), are accounted for as 'on-Statement of Financial Position' by the Trust. In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent 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 lives reflect the total life of an asset and not the remaining life of an asset. The range of useful lives is shown in the table below:

	Min. Life Years	Max. Life Years
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	10

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

1.11 Intangible assets

Recognition

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

Internally generated intangible assets

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

Expenditure on research is not capitalised. Expenditure on development is capitalised when it meets the requirements set out in IAS 38: Intangible Assets (IAS 38).

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

Subsequently intangible assets are measured at depreciated historic cost, due to the absence of an active market on which to base a reliable estimation of current value in existing use.

An intangible asset which is surplus with no plan to bring it back into use is valued 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.

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

Amortisation

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

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 10 years.

1.12 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 inventories.

In 2020-21, the Trust received inventories including personal protective equipment from the Department of Health and Social Care at nil cost. In line with the GAM and applying the principles of the IFRS Conceptual Framework, the Trust has accounted for the receipt of these inventories at a deemed cost, reflecting the best available approximation of an imputed market value for the transaction based on the cost of acquisition by the Department.

1.13 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.

1.14 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 (ONS).

This includes the purchase or sale of non-financial items (such as goods or services), which are entered into in accordance with the Trust's normal purchase, sale or usage requirements and are recognised when, and to the extent which, performance occurs, i.e. 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, the Trust recognises an allowance for expected credit losses.

The Trust adopts the simplified approach to impairment for contract and other receivables, contract assets and lease receivables, measuring expected losses as at an amount equal to lifetime expected losses. For other financial assets, the loss allowance is initially measured at an amount equal to 12-month expected credit losses (stage 1) and subsequently at an amount equal to lifetime expected credit losses if the credit risk assessed for the financial asset significantly increases (stage 2).

Credit losses in respect of NHS bodies are not normally recognised.

For financial assets that have become credit impaired since initial recognition (stage 3), expected credit losses at the reporting date are measured as the difference between the asset's gross carrying amount and the present value of estimated future cash flows discounted at the financial asset's original effective interest rate.

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

De-recognition

Financial assets are de-recognised when the contractual rights to receive cash flows from the assets have expired or the Trust has transferred substantially all the risks and rewards of ownership.

Financial liabilities are de-recognised when the obligation is discharged, cancelled or expires.

1.15 Leases

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

The Trust as lessee

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 implicit interest rate is that which produces a constant periodic rate of interest on the outstanding liability.

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

The annual rental charge 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.

Operating leases

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially in other liabilities on the statement of financial position and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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

Leases of land and buildings

Where a lease is for land and buildings, the land component is separated from the building component and the classification for each is assessed separately.

Finance leases

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

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 on a straight-line basis over the lease term.

1.16 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 HM Treasury's discount rates effective for 31 March 2021, as follows:

		Nominal rate
Short-term	Up to 5 years	-0.02%
Medium-term	After 5 years, up to 10 years	0.18%
Long-term	Exceeding 10 years	1.99%

HM Treasury provides discount rates for general provisions on a nominal rate basis. Expected future cash flows are therefore adjusted for the impact of inflation before discounting using nominal rates. The following inflation rates are set by HM Treasury, effective 31 March 2021:

	Inflation rate
Year 1	1.20%
Year 2	1.60%
In to perpetuity	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of minus 0.95% in real terms.

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 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.

1.17 Contingencies

Contingent assets (that is, assets arising from past events whose existence will only be confirmed by one or more future events not wholly within the entity's control) are not recognised as assets, but are disclosed in Note 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.**

1.18 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital (PDC) is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS organisation. HM Treasury has determined that PDC is not a financial instrument within the meaning of IAS 32: Financial Instruments: Presentation (IAS 32).

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, with certain additions and deductions as defined in the PDC dividend policy issued by the Department of Health and Social Care. This policy is available at:

https://www.gov.uk/government/publications/guidance-on-financing-available-to-nhs-trusts-and-foundation-trusts

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

1.19 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.

1.20 Corporation tax

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

1.21 Climate change levy

Expenditure on the climate change levy is recognised in the Statement of Comprehensive Income as incurred, based on the prevailing chargeable rates for energy consumption.

1.22 Foreign currencies

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.

1.23 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.

1.24 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.

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.

1.25 Gifts

Gifts are items that are voluntarily donated, with no preconditions and without the expectation of any return. Gifts include all transactions economically equivalent to free and unremunerated transfers, such as the loan of an asset for its expected useful life, and the sale or lease of assets at below market value.

1.26 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early in 2020-21.

1.27 Prior year adjustment

Adjustments for misstatements detected subsequent to the year-end are made to the prior year financial statements only where the amount of the adjustment would distort the current year's values and prevent the financial statements from presenting a true and fair view of the Trust's results and financial position.

During the current year, the Trust has made a prior year adjustment in respect of the gross book value and accumulated depreciation balances for its building and dwelling assets at 31 March 2020, as shown in Note 15. This change has not impacted on the balances shown in the Trust's Statement of Financial Position at 31 March 2020.

1.28 International Financial Reporting Standards that have been issued but have not yet been adopted

IFRS 16: Leases (IFRS 16)

IFRS 16 will replace IAS 17: Leases , International Financial Reporting Interpretations Committee 4: Determining whether an arrangement contains a lease (IFRIC 4) and other interpretations and is applicable in the public sector for periods beginning 1 April 2022. The Standard provides a single accounting model for lessees, recognising a right of use asset and obligation in the Statement of Financial Position for most leases; some leases are exempt through application of practical expedients explained below.

For those recognised in the Statement of Financial Position the Standard also requires the remeasurement of lease liabilities in specific circumstances after the commencement of the lease term. For lessors, the distinction between operating and finance leases will remain and the accounting will be largely unchanged.

IFRS 16 changes the definition of a lease compared to IAS 17 and IFRIC 4. The Trust will apply this definition to new leases only and will grandfather its assessments made under the old standards of whether existing contracts contain a lease.

On transition to IFRS 16 on 1 April 2022, the Trust will apply the Standard retrospectively with the cumulative effect of initially applying the Standard recognised in the income and expenditure reserve at that date. For existing operating leases with a remaining lease term of more than 12 months and an underlying asset value of at least £5,000, a lease liability will be recognised equal to the value of remaining lease payments discounted on transition at the Trust's incremental borrowing rate. The Trust's incremental borrowing rate will be a rate defined by HM Treasury. Currently this rate is 0.91% but this may change between now and adoption of the Standard. The related right of use asset will be measured equal to the lease liability adjusted for any prepaid or accrued lease payments.

For existing peppercorn leases not classified as finance leases, a right of use asset will be measured at current value in existing use or fair value. The difference between the asset value and the calculated lease liability will be recognised in the income and expenditure reserve on transition. No adjustments will be made on 1 April 2022 for existing finance leases.

For leases commencing in 2022-23, the Trust will not recognise a right of use asset or lease liability for short term leases (less than or equal to 12 months) or for leases of low value assets (less than £5,000). Right of use assets will be subsequently measured on a basis consistent with owned assets and depreciated over the length of the lease term.

The implementation date for IFRS 16 in the NHS was revised to 1 April 2022 in November 2020. Due to the need to reassess lease calculations, together with uncertainty on expected leasing activity from April 2022 and beyond, a quantification of the expected impact of applying the Standard in 2022-23 is currently impracticable. However, the Trust does not expect this Standard to have a material impact on non-current assets, liabilities and depreciation.

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)

All income from patient care activities relates to contract income recognised in line with accounting policy 1.5.

	2020-21 £000	Restated 2019-20 £000
Acute services		
Block contract / system envelope income (1)	**379,876**	346,651
High cost drugs income from commissioners (excluding pass-through costs)	**47,413**	48,009
Other services		
Private patient income	**35**	401
Additional pension contribution central funding (2)	**12,038**	10,959
Other clinical income	**16,208**	16,692
Total income from NHS bodies	**455,570**	422,712

(1) As part of the Coronavirus pandemic response, transaction flows were simplified in the NHS and providers and their commissioners moved onto block contract payments at the start of 2020-21. In the second half of the year, a revised financial framework built on these arrangements but with a greater focus on system partnership and providers derived most of their income from these system envelopes. Comparatives in this note are presented to be comparable with the current year activity. This does not reflect the contracting and payment mechanisms in place during the prior year.

(2)The employer contribution rate for NHS pensions increased from 14.3% to 20.6% (excluding administration charge) from 1 April 2019. Since 2019-20, NHS providers have continued to pay over contributions at the former rate with the additional amount being paid over by NHS England on providers' behalf. The full cost and related funding have been recognised in these accounts.

3.2 Income from patient care activities (by source)

Income from patient care activities received from:	**2020-21 £000**	2019-20 £000
NHS England	**104,800**	96,383
Clinical commissioning groups	**350,111**	318,451
Other NHS providers	**0**	4,240
NHS other (Public Health England)	**114**	114
Local authorities	**0**	1,931
Non-NHS: Private patients	**35**	401
Non-NHS: Overseas patients (chargeable to patient)	**174**	295
NHS Injury Cost Recovery (ICR) scheme	**333**	736
Non-NHS: Other	**3**	161
Total income from patient care activities	**455,570**	422,712

All amounts above relate to continuing operations.

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

	2020-21 £000	2019-20 £000
Income recognised during the year	**174**	295
Cash payments received in-year	**61**	244
Amounts added to provision for impairment of receivables	**383**	124
Amounts written off in-year	**11**	10

4. Other operating income

	2020-21 £000	2019-20 £000
Operating income from contracts with customers:		
Research and development	**3,349**	2,509
Education and training	**13,640**	12,478
Non-patient care services to other bodies	**8,819**	8,811
Reimbursement and top up funding (2020-21 only)	**31,431**	
Provider Sustainability Fund (PSF), Sustainability & Transformation Fund (STF), and Marginal Rate Emergency Tariff (MRET) income (2019-20 only)		18,983
Income in respect of employee benefits accounted for on a gross basis (1)	**5,948**	5,685
Other contract income (2)	**8,574**	7,059
Other non-contract operating income:		
Research and development (non-contract)	**163**	191
Education and training - notional income from Apprenticeship Fund	**630**	497
Receipt of capital grants and donations	**1,389**	652
Charitable and other contributions to expenditure (3)	**6,460**	487
Rental revenue from operating leases	**1,204**	1,559
Total other operating income	**81,607**	58,911

All amounts above relate to continuing operations.

(1) Included within 'Charitable and other contributions to expenditure' is £214,000 (2019-20: £487,000) in relation to 'income in respect of employee benefits accounted for on a gross basis'.
(2)'Other contract income' includes outsourced facilities management, IT services provided, drug sales, food sales, transport and other miscellaneous income not falling into the other categories in the note above.
(3)'Charitable and other contributions to expenditure' includes centrally purchased inventories, provided by DHSC in response to the Coronavirus pandemic, totalling £5,823,000.

5. Income generation activities

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

6.1 Operating expenses

	2020-21 £000	2019-20 £000
Purchase of healthcare from NHS and DHSC bodies	**10,856**	11,130
Purchase of healthcare from non-NHS and non-DHSC bodies	**15,920**	14,208
Staff and executive directors' costs	**309,169**	286,773
Remuneration of Chair and non-executive directors	**147**	122
Supplies and services - clinical (excluding drug costs)	**43,193**	38,212
Supplies and services - general	**29,535**	23,943
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	**57,783**	54,948
Inventories written down	**338**	278
Consultancy costs	**235**	68
Establishment	**5,398**	4,849
Premises	**13,781**	9,961
Transport (including patient travel)	**3,162**	3,761
Depreciation on property, plant and equipment	**11,126**	10,108
Amortisation on intangible assets	**878**	704
Net impairments / (reversals)	**(286)**	3,388
Movement in credit loss allowance: contract receivables / contract assets	**2,747**	(1,560)
Movement in credit loss allowance: all other receivables and investments	**174**	(97)
Change in provisions discount rate(s)	**129**	230
Audit fees payable to the external auditor:		
- audit services - statutory audit	**102**	63
Internal audit costs	**155**	149
Clinical negligence	**11,991**	11,195
Legal fees	**254**	150
Insurance	**102**	105
Research and development (including staff costs)	**3,173**	2,979
Education and training	**1,756**	1,927
Rentals under operating leases	**1,754**	1,720
Charges to operating expenditure for on-SOFP IFRIC 12 schemes (LIFT)	**340**	334
Car parking and security	**2,153**	19
Losses, ex gratia and special payments	**22**	44
Other	**3,175**	1,727
Total operating expenses	**529,262**	481,438

All amounts above relate to continuing operations.

6.2 External audit fees: Additional Information

Audit fees shown above include VAT. The auditor received fees of £85,000 in relation to 2020-21 (2019-20:£53,000).

The Trust incurred no other auditor remuneration charges in either 2020-21 or 2019-20.

The limitation on auditor's liability for external audit work is £2m (2019-20: £2m).

7. Impairment of assets

	2020-21	2019-20
	£000	£000
Net impairments / (reversals) charged to operating surplus/deficit resulting from:		
Changes in market price	(286)	3,388
Total net impairments / (reversals) charged to operating surplus/deficit	(286)	3,388
Impairments charged to the revaluation reserve	1,889	1,067
Total net impairments	1,603	4,455

Net impairments and impairment reversals in 2020-21 and 2019-20 arose following the annual year end revaluations of the Trust's property assets on a modern equivalent asset basis.

All revaluations were undertaken by the Valuation Office Agency.

8. Employee benefits

	2020-21	2019-20
	£000	£000
Salaries and wages	241,085	212,480
Social security costs	22,612	20,852
Apprenticeship levy	1,149	1,059
Employer's contributions to NHS pensions	39,610	36,004
Other pension costs	322	209
Termination benefits	160	23
Temporary staff (agency)	8,963	21,341
Total gross staff costs	313,901	291,968
Included within:		
Costs capitalised as part of assets	2,108	2,565
Total staff costs excluding capitalised staff costs	311,793	289,403

8.1 Retirements due to ill-health

During 2020-21 there were 4 early retirements from the Trust agreed on the grounds of ill-health (3 in the year ended 31 March 2020). The estimated additional pension liabilities of these ill-health retirements is £276,000 (£114,000 in 2019-20).

These estimated costs are calculated on an average basis and will be borne by the NHS Business Services Authority - Pensions Division.

9. Pension costs

Past and present employees are covered by the provisions of the two NHS Pension Schemes. Details of the benefits payable and rules of the Schemes can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. Both are unfunded defined benefit schemes that cover NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State for Health and 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 2021 is based on valuation data as 31 March 2020, updated to 31 March 2021 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 to 20.6% of pensionable pay. The 2016 funding valuation was also expected to test the cost of the Scheme relative to the employer cost cap that was set following the 2012 valuation. In January 2019, the Government announced a pause to the cost control element of the 2016 valuations, due to the uncertainty around member benefits caused by the discrimination ruling relating to the McCloud case.

The Government subsequently announced in July 2020 that the pause had been lifted, and so the cost control element of the 2016 valuations could be completed. The Government has set out that the costs of remedy of the discrimination will be included in this process. HMT valuation directions will set out the technical detail of how the costs of remedy will be included in the valuation process. The Government has also confirmed that the Government Actuary is reviewing the cost control mechanism (as was originally announced in 2018). The review will assess whether the cost control mechanism is working in line with original government objectives and reported to Government in April 2021. The findings of this review will not impact the 2016 valuations, with the aim for any changes to the cost cap mechanism to be made in time for the completion of the 2020 actuarial valuations.

10. Operating leases

10.1 The Trust as lessee

The Trust leases equipment, vehicles and property under operating lease arrangements. There are no individually material leases. The leases are for periods of up to 10 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.

	2020-21 £000	2019-20 £000
Operating lease expenses		
Minimum lease payments	**1,754**	1,720
Total	**1,754**	1,720
Future minimum lease payments due:		
- not later than one year	**1,202**	1,191
- later than one but not later than five years	**2,192**	2,703
- later than five years	**589**	905
Total	**3,983**	4,799

There are no future sub-lease payments expected to be received (2019-20: £nil).

10.2 The Trust as lessor

The Trust has three significant lessor arrangements: for the leasing of the main hospital site car park (1 year remaining); space within the Knowledge Spa (8 years remaining); and space within the Peninsula Dental School (14 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 90 and 1 years remaining respectively.

	2020-21 £000	2019-20 £000
Operating lease revenue		
Minimum lease receipts	**1,204**	1,559
Total	**1,204**	1,559
Future minimum lease receipts due:		
- not later than one year	**986**	990
- later than one but not later than five years	**1,792**	2,335
- later than five years	**2,336**	2,778
Total	**5,114**	6,103

11. Finance income

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

	2020-21 £000	2019-20 £000
Interest revenue:		
Interest on bank accounts	**2**	125
Total	**2**	125

12.1 Finance expenditure

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

	2020-21 £000	2019-20 £000
Interest expense:		
Loans from the Department of Health and Social Care	**83**	952
Finance leases	**44**	13
Interest on late payment of commercial debt	**1**	0
Main finance costs on LIFT scheme obligations	**310**	314
Contingent finance cost on LIFT scheme obligations	**124**	113
Total interest expense	**562**	1,392
Unwinding of discount on provisions	**(18)**	13
Total finance expenditure	**544**	1,405

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

	2020-21 £000	2019-20 £000
Amounts included within interest payable arising from claims made under this legislation	**1**	0

13. Other gains and (losses)

	2020-21 £000	2019-20 £000
Gains on disposal of assets	**31**	33
(Losses) on disposal of assets	**(85)**	0
Total gains / (losses) on disposal of assets	**(54)**	33

14 Intangible assets

14.1 Intangible assets 2020-21

	Software licences	Development expenditure - internally generated	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020	**23,421**	**3,262**	**3,886**	**30,569**
Additions	**1,920**	**254**	**461**	**2,635**
Reclassifications	**33**	**0**	**(33)**	**0**
Disposals / de-recognition	**(2,726)**	**(787)**	**0**	**(3,513)**
Valuation / gross cost at 31 March 2021	**22,648**	**2,729**	**4,314**	**29,691**
Amortisation at 1 April 2020	**19,287**	**2,620**		**21,907**
Provided during the year	**750**	**128**		**878**
Disposals / de-recognition	**(2,726)**	**(787)**		**(3,513)**
Amortisation at 31 March 2021	**17,311**	**1,961**		**19,272**
Net book value at 31 March 2021	**5,337**	**768**	**4,314**	**10,419**
Net book value at 1 April 2020	**4,134**	**642**	**3,886**	**8,662**

14.2 Intangible assets 2019-20

	Software licences	Development expenditure - internally generated	Intangible assets under construction	Total
	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**23,848**	**2,952**	**3,646**	**30,446**
Additions	1,970	642	659	**3,271**
Reclassifications	419	0	(419)	**0**
Disposals / de-recognition	(2,816)	(332)	0	**(3,148)**
Valuation / gross cost at 31 March 2020	**23,421**	**3,262**	**3,886**	**30,569**
Amortisation at 1 April 2019	**21,399**	**2,952**		**24,351**
Provided during the year	704	0		**704**
Disposals / de-recognition	(2,816)	(332)		**(3,148)**
Amortisation at 31 March 2020	**19,287**	**2,620**		**21,907**
Net book value at 31 March 2020	**4,134**	**642**	**3,886**	**8,662**
Net book value at 1 April 2019	**2,449**	**0**	**3,646**	**6,095**

14.3 Intangible assets - additional information

Intangible assets comprise purchased computer software and licenses, which are carried at amortised historical cost, as a proxy for fair value.

Assets are capitalised and amortised over their useful lives on a straight-line basis. Useful lives are all finite and range from 1 to 10 years. The gross carrying amount of fully depreciated assets still in use is £14.9m (2019-20: £17.9m).

15 Property, plant and equipment

15.1 Property, plant and equipment 2020-21

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2020 *	**5,141**	**122,538**	**12**	**9,244**	**68,500**	**261**	**15,773**	**4,263**	**225,732**
Additions	15	5,474	0	29,628	13,783	24	3,480	308	**52,712**
Impairments	0	(1,889)	0	0	0	0	0	0	**(1,889)**
Revaluations	0	(3,930)	0	0	0	0	0	0	**(3,930)**
Reclassifications	0	1,956	0	(2,194)	238	0	0	0	**0**
Disposals / de-recognition	0	0	0	0	(7,658)	(18)	(704)	(887)	**(9,267)**
Valuation / gross cost at 31 March 2021	**5,156**	**124,149**	**12**	**36,678**	**74,863**	**267**	**18,549**	**3,684**	**263,358**
Accumulated depreciation at 1 April 2020 *	**0**	**0**	**0**		**48,251**	**258**	**8,854**	**3,800**	**61,163**
Provided during the year	0	4,816	0		3,582	4	2,614	110	**11,126**
Impairments	15	3,223	0		0	0	0	0	**3,238**
Reversals of impairments	0	(3,524)	0		0	0	0	0	**(3,524)**
Revaluations	0	(4,515)	0		0	0	0	0	**(4,515)**
Disposals / de-recognition	0	0	0		(7,571)	(18)	(704)	(887)	**(9,180)**
Accumulated depreciation at 31 March 2021	**15**	**0**	**0**		**44,262**	**244**	**10,764**	**3,023**	**58,308**
Net book value at 31 March 2021	**5,141**	**124,149**	**12**	**36,678**	**30,601**	**23**	**7,785**	**661**	**205,050**
Net book value at 1 April 2020	**5,141**	**122,538**	**12**	**9,244**	**20,249**	**3**	**6,919**	**463**	**164,569**

* Balances have been restated to correct an error in the disclosure in the prior year accounts. Net book values at 1 April 2020 are unchanged as a result of this restatement.

15.2 Property, plant and equipment 2019-20

	Land	Buildings excluding dwellings	Dwellings	Assets under construction	Plant & machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Valuation / gross cost at 1 April 2019	**5,141**	**124,206**	**14**	**5,257**	**66,882**	**261**	**13,089**	**4,873**	**219,723**
Additions	0	8,663	0	4,970	7,773	0	2,684	82	**24,172**
Impairments	0	(1,067)	0	0	0	0	0	0	**(1,067)**
Revaluations *	0	(9,842)	(2)	0	0	0	0	0	**(1,616)**
Reclassifications	0	578	0	(983)	405	0	0	0	**0**
Disposals / de-recognition	0	0	0	0	(6,560)	0	0	(692)	**(7,252)**
Valuation / gross cost at 31 March 2020	**5,141**	**122,538**	**12**	**9,244**	**68,500**	**261**	**15,773**	**4,263**	**233,960**
Accumulated depreciation at 1 April 2019	**0**	**4,482**	**1**		**51,370**	**255**	**7,126**	**4,391**	**67,625**
Provided during the year	0	4,839	1		3,436	3	1,728	101	**10,108**
Impairments	0	4,190	0		0	0	0	0	**4,190**
Reversals of impairments	0	(802)	0		0	0	0	0	**(802)**
Revaluations *	0	(12,709)	(2)		0	0	0	0	**(4,483)**
Disposals / de-recognition	0	0	0		(6,555)	0	0	(692)	**(7,247)**
Accumulated depreciation at 31 March 2020	**0**	**0**	**0**		**48,251**	**258**	**8,854**	**3,800**	**69,391**
Net book value at 31 March 2020	**5,141**	**122,538**	**12**	**9,244**	**20,249**	**3**	**6,919**	**463**	**164,569**
Net book value at 1 April 2019	**5,141**	**119,724**	**13**	**5,257**	**15,512**	**6**	**5,963**	**482**	**152,098**

* Revaluation adjustments have been restated to correct an error in the disclosure in the prior year accounts. When applying the 31 March 2020 valuation, the Trust should have zeroed the depreciation balance with an additional revaluation adjustment of £8,227,000. This adjustment was not applied and therefore the valuation / gross cost of Buildings and Dwellings at 31 March 2020 and the Accumulated Depreciation balance of Buildings and Dwellings at the same date were overstated by this value. Net book values at 31 March 2020 are unchanged as a result of this restatement.

15.3 Property, plant and equipment financing 2020-21

Net book value at 31 March 2021	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	4,876	110,251	12	36,678	24,683	23	5,960	570	**183,053**
Finance leased	0	0	0	0	0	0	1,232	0	**1,232**
On-SOFP LIFT contracts	250	950	0	0	0	0	0	0	**1,200**
Owned - government granted	15	12,948	0	0	5,478	0	11	91	**18,543**
Owned - donated	0	0	0	0	440	0	582	0	**1,022**
NBV total at 31 March 2021	**5,141**	**124,149**	**12**	**36,678**	**30,601**	**23**	**7,785**	**661**	**205,050**

15.4 Property, plant and equipment financing 2019-20

Net book value at 31 March 2020	Land £000	Buildings excluding dwellings £000	Dwellings £000	Assets under construction £000	Plant & machinery £000	Transport equipment £000	Information technology £000	Furniture & fittings £000	Total £000
Owned - purchased	4,891	108,105	12	9,244	18,335	3	5,457	395	**146,442**
Finance leased	0	0	0	0	0	0	1,446	0	**1,446**
On-SOFP LIFT contracts	250	950	0	0	0	0	0	0	**1,200**
Owned - government granted	0	5,367	0	0	0	0	0	0	**5,367**
Owned - donated	0	8,116	0	0	1,914	0	16	68	**10,114**
NBV total at 31 March 2020	**5,141**	**122,538**	**12**	**9,244**	**20,249**	**3**	**6,919**	**463**	**164,569**

15.5 Property, plant and equipment - additional information

Revaluations

Land and property assets are carried at valuation on the Statement of Financial Position. All of the Trust's land, building and dwelling assets have been revalued as at 31 March 2021 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 and 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 dte 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 2020-21.
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 £40.5m (2019-20: £40.7m).

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 30);**
- **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.

16. Inventories

Current	31 March 2021 £000	* 31 March 2020 £000
Drugs	**3,073**	3,077
Consumables	**5,783**	5,786
Energy	**124**	143
Total inventories	**8,980**	9,006
Of which: held at fair value less costs to sell	**0**	0

Inventories recognised in expenses for the year were £94.417m (2019-20: £89.944m). Write-down of inventories recognised as expenses for the year were £338,000 (2019-20: £278,000).

In response to the Coronavirus pandemic, the Department of Health and Social Care centrally procured personal protective equipment and passed these to NHS providers free of charge. During 2020-21 the Trust received £5,823,000 of items purchased by DHSC.

These inventories were recognised as additions to inventory at deemed cost with the corresponding benefit recognised in income. The utilisation of these items is included in the expenses disclosed above.

* Restrictions on movement in the United Kingdom in March 2020 meant that the Trust's auditor was unable to attend the relevant year-end inventory counts. The auditor was been unable to gain sufficient audit evidence from alternative procedures, therefore limiting the scope of the auditor's work. Under auditing standards the auditor was required to issue a qualified opinion in respect of the inventory balances at 31 March 2020.

17.1 Receivables

	31 March 2021	31 March 2020
Current	**£000**	£000
Contract receivables	**10,433**	29,404
Allowance for impaired contract receivables / assets	**(4,010)**	(1,277)
Allowance for other impaired receivables	**(224)**	(54)
Prepayments	**3,379**	3,663
PDC dividend receivable	**0**	92
VAT receivable	**1,349**	1,473
Other receivables	**338**	363
Total current trade and other receivables	**11,265**	33,664
Non-current		
Contract receivables	**449**	714
Prepayments	**651**	115
Other receivables	**23**	27
Total non-current trade and other receivables	**1,123**	856
Of which receivables from NHS and DHSC group bodies:		
Current	**4,750**	22,690
Non-current	**23**	27
	4,773	22,717

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 2020-21 or 2019-20.

17.2 Allowances for credit losses

	2020-21		2019-20	
	Contract receivables and contract assets £000	All other receivables £000	Contract receivables and contract assets £000	All other receivables £000
Allowances at 1 April	**1,277**	**54**	2,847	156
New allowances arising	**1,856**	**102**	560	21
Changes in existing allowances	**891**	**72**	(1,652)	(118)
Reversals of allowances	**0**	**0**	(468)	0
Utilisation of allowances (write-offs)	**(14)**	**(4)**	(10)	(5)
Allowances at 31 March	**4,010**	**224**	1,277	54

Department of Health and Social Care guidelines require allowances for credit losses to be provided for injury cost recovery receivables at 22.43% (2019-20: 21.79%).

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

	31 March 2021		31 March 2020	
	Debts in query	Other	Debts in query	Other
Balances older than 12 months	100%	80%	30%	30%
Balances between 6 and 12 months old	100%	80%	30%	30%
Balances less than 6 months old	up to 100%	up to 80%	up to 25%	up to 25%

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

18.1 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 2021 £000	31 March 2020 £000
Opening balance	**6,576**	9,692
Net change in year	**35,509**	(3,116)
Closing balance	**42,085**	6,576
Comprising:		
Cash with commercial banks and in hand	**55**	57
Cash with the Government Banking Service	**42,030**	6,519
Cash and cash equivalents as in the Statement of Financial Position	**42,085**	6,576
Bank overdraft - commercial banks and Government Banking Service	**0**	(23)
Cash and cash equivalents as in the Statement of Cash Flows	**42,085**	6,553

18.2 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 2021 £000	31 March 2020 £000
Monies on deposit	**3**	3

19. Trade and other payables

Current trade and other payables	31 March 2021 £000	31 March 2020 £000
Trade payables	**5,111**	11,483
Capital payables (including capital accruals)	**18,633**	10,105
Accruals (revenue only)	**37,049**	20,769
Social security costs	**6,189**	5,708
PDC dividend payable	**424**	0
Other payables	**4,967**	4,687
Total current trade and other payables	**72,373**	52,752
Of which payables to NHS and DHSC group bodies:	**2,468**	3,468

There are no amounts included above to buy out early retirement liabilities in either 2020-21 or 2019-20.

20. Other liabilities

Current	31 March 2021 £000	31 March 2020 £000
Deferred income: contract liabilities	**3,252**	4,408
Deferred grants	**55**	44
Other deferred income	**528**	528
Total other current liabilities	**3,835**	4,980

Non-current	31 March 2021 £000	31 March 2020 £000
Deferred income: contract liabilities	**0**	150
Other deferred income	**0**	528
Total other non-current liabilities	**0**	678

21. Borrowings

Current	31 March 2021 £000	31 March 2020 £000
Bank overdrafts	**0**	23
Loans from the Department of Health and Social Care	**1,356**	45,732
Obligations under finance leases	**266**	258
Obligations under LIFT contracts	**33**	27
Total	**1,655**	46,040

Non-current	31 March 2021 £000	31 March 2020 £000
Loans from the Department of Health and Social Care	**3,492**	19,693
Obligations under finance leases	**965**	1,229
Obligations under LIFT contracts	**1,422**	1,455
Total	**5,879**	22,377

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

Loan type	Value issued (£000)	Value outstanding (£000)		Interest rate (%)	Date issued	Term	Repayment start date	Date fully repaid
		31 March 2021	31 March 2020					
Capital Investment loan	5,000	**1,665**	2,220	1.99	March 2014	10 years	September 2015	March 2024
Capital Investment loan	6,161	**3,183**	3,979	1.07	February 2016	9 years	August 2017	February 2025
Interim capital investment loan	4,800	**0**	4,781	1.19	March 2020	25 years	November 2019	*See below
Interim capital investment loan	1,000	**0**	1,000	0.43	March 2020	5 years	February 2025	*See below
Revenue support loan	24,733	**0**	16,528	1.65	February 2015	15 years	August 2015	*See below
Interim revenue support loan	3,800	**0**	3,807	1.50	February 2016	2 years	August 2020	*See below
Interim revenue support loan	10,709	**0**	10,740	1.50	January 2017	3 years	July 2020	*See below
Interim revenue support loan	4,235	**0**	4,247	1.50	January 2018	3 years	January 2021	*See below
Interim revenue support loan	1,790	**0**	1,793	1.50	February 2018	3 years	February 2021	*See below
Interim revenue support loan	2,461	**0**	2,462	1.50	March 2018	3 years	March 2021	*See below
Interim revenue support loan	4,396	**0**	4,409	1.50	July 2018	3 years	July 2021	*See below
Interim revenue support loan	3,014	**0**	3,019	1.50	August 2018	3 years	August 2021	*See below
Interim revenue support loan	3,082	**0**	3,099	1.50	November 2018	3 years	November 2021	*See below
Interim revenue support loan	1,839	**0**	1,847	1.50	December 2018	3 years	December 2021	*See below
Interim revenue support loan	1,005	**0**	1,007	1.50	February 2019	3 years	February 2022	*See below
Interim revenue support loan	487	**0**	487	1.50	March 2019	3 years	March 2022	*See below
TOTAL	**78,512**	**4,848**	65,425					

*Following the 2 April 2020 announcement of reforms to the NHS cash regime for 2020-21, a number of loans were extinguished during 2020-21 via the issue of Public Dividend Capital (PDC) by DHSC. Loan balances at 31 March 2020 were repaid with effect from 1 April 2020.

22.1 Reconciliation of liabilities arising from financing activities 2020-2021

	DHSC loans £000	Finance leases £000	LIFT scheme £000	Total £000
Carrying value at 1 April 2020	65,425	1,487	1,482	**68,394**
Cash movements				
Financing cash flows - payments and receipts of principal	(60,442)	(256)	(27)	**(60,725)**
Financing cash flows - payments of interest	(218)	(39)	(310)	**(567)**
Non-cash movements				
Application of effective interest rate	83	44	310	**437**
Other changes	0	(5)	0	**(5)**
Carrying value at 31 March 2021	**4,848**	**1,231**	**1,455**	**7,534**

22.2 Reconciliation of liabilities arising from financing activities 2019-20

	DHSC loans £000	Finance leases £000	LIFT scheme £000	Total £000
Carrying value at 1 April 2019	62,932	0	1,503	**64,435**
Cash movements				
Financing cash flows - payments and receipts of principal	2,496	(245)	(22)	**2,229**
Financing cash flows - payments of interest	(955)	(46)	(313)	**(1,314)**
Non-cash movements				
Additions	0	1,732	0	**1,732**
Application of effective interest rate	952	13	314	**1,279**
Other changes	0	33	0	**33**
Carrying value at 31 March 2020	**65,425**	**1,487**	**1,482**	**68,394**

23. Finance leases

Obligations under finance leases where the Trust is the lessee:

	2020-21 £000	2019-20 £000
Gross lease liabilities	**1,309**	1,605
of which liabilities are due:		
- not later than one year	**297**	296
- later than one but not later than five years	**1,012**	1,072
- later than five years	**0**	237
Finance charges allocated to future periods	**(78)**	(118)
Net lease liabilities	**1,231**	1,487
of which payable		
- not later than one year	**266**	258
- later than one but not later than five years	**965**	992
- later than five years	**0**	237
Total	**1,231**	1,487

The Trust leases software and telecoms hardware under finance lease arrangements. There are no individually material leases. The lease terms range from 3 to 6 years.

There are no future sub-lease payments expected to be received (2019-20: £nil).
No contingent rent has been recognised in the period (2019-20: £nil).

24.1 Provisions

	Pensions - early departure costs £000	Pensions - injury benefits £000	Legal claims £000	Other £000	Total £000
Balance at 1 April 2020	**1,448**	**2,718**	**86**	**27**	**4,279**
Change in the discount rate	32	97	0	0	**129**
Arising during the year	107	102	57	557	**823**
Utilised during the year	(146)	(171)	(26)	0	**(343)**
Reversed unused	(46)	(3)	(10)	(7)	**(66)**
Unwinding of discount	(6)	(13)	1	0	**(18)**
Balance at 31 March 2021	**1,389**	**2,730**	**108**	**577**	**4,804**
Expected timing of cash flows:					
- no later than one year	146	170	108	554	**978**
- later than one year and no later than five years	598	697	0	12	**1,307**
- later than five years	645	1,863	0	11	**2,519**
Total	**1,389**	**2,730**	**108**	**577**	**4,804**

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 2021, £208.487m was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Cornwall Hospitals NHS Trust (31 March 2020: £141.544m).

25. Contingencies

Value of contingent liabilities	**31 March 2021 £000**	31 March 2020 £000
NHS Resolution legal claims (1)	**41**	47
Other (2)	**3,055**	3,055
Net value of contingent liabilities	**3,096**	3,102

(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 2021, this percentage stands at 100% (31 March 2020: 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 2021 £000	31 March 2020 £000
Property, plant and equipment	**5,687**	938
Intangible assets	**0**	1,369
Total	**5,687**	2,307

Individually significant capital commitments

Progressive Recovery Unit

The Progressive Recovery Unit (PRU), currently being constructed on the Treliske site, will provide additional capacity for medical beds to facilitate and support both the response to the Coronavirus pandemic and the ambitious building programme planned at the Trust over the next 10 years.

The total cost of this project is expected to be £17,622,000 and construction is expected to be completed in August 2021. As at 31 March 2021 the Trust has incurred £9,980,000 of expenditure and is committed to a further £3,827,000, with the main contractor.

27. On-SOFP LIFT arrangements

The Trust's LIFT scheme relates to the property used by Sustenation (formerly known as 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.

27.1 Imputed finance lease obligations

	31 March 2021 £000	31 March 2020 £000
Gross LIFT liabilities	**4,006**	4,343
Of which liabilities are due:		
- not later than one year	**336**	336
- later than one but not later than five years	**1,345**	1,345
- later than five years	**2,325**	2,662
Finance charges allocated to future periods	**(2,551)**	(2,861)
Net LIFT liabilities	**1,455**	1,482
Of which payable:		
- not later than one year	**33**	27
- later than one but not later than five years	**220**	180
- later than five years	**1,202**	1,275
Total	**1,455**	1,482

27.2 Total on-SOFP arrangement commitments

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

	31 March 2021 £000	31 March 2020 £000
Total future payments committed in respect of the LIFT arrangement	**10,560**	11,311
Of which liabilities are due:		
- not later than one year	**801**	783
- later than one but not later than five years	**3,274**	3,194
- later than five years	**6,485**	7,334
Total future payments	**10,560**	11,311

27.3 Analysis of amounts payable to LIFT provider

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

	31 March 2021 £000	31 March 2020 £000
Unitary payments payable to LIFT provider	**801**	783
Consisting of:		
- interest charge	**310**	314
- repayment of finance lease liability	**27**	22
- service element and other charges to operating expenditure	**340**	334
- contingent rent	**124**	113
Total amounts paid to LIFT provider	**801**	783

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 2021 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 risk.

There have been no changes to the Trust's exposure to the risks above since the previous period. There have also been no changes in the methods used to measure the risks, or the policies and processes in place for managing the risks.

28.2 Carrying values of financial assets

Carrying values of financial assets	**31 March 2021 Held at amortised cost £000**	31 March 2020 Held at amortised cost £000
Trade and other receivables excluding non-financial assets	**7,009**	29,177
Cash and cash equivalents at bank and in hand	**42,085**	6,576
Total	**49,094**	35,753

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

28.3 Carrying values of financial liabilities

Carrying values of financial liabilities	**31 March 2021 Held at amortised cost £000**	31 March 2020 Held at amortised cost £000
Loans from the Department of Health and Social Care	**4,848**	65,425
Other borrowings	**0**	23
Obligations under finance leases	**1,231**	1,487
Obligations under LIFT contracts	**1,455**	1,482
Trade and other payables excluding non financial liabilities	**65,760**	47,044
Total	**73,294**	115,461

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

28.4 Maturity of financial liabilities

The following maturity profile of financial liabilities is based on the contractual undiscounted cash flows. This differs to the amounts recognised in the Statement of Financial Position which are discounted to present value.

Financial liabilities maturing in:	2020-21 £000	*Restated 2019-20 £000
- one year or less	**67,806**	93,509
- more than one year but not more than five years	**5,921**	13,983
- more than five years	**2,325**	11,160
Total	**76,052**	118,652

*This disclosure has previously been prepared using discounted cash flows. The comparatives have therefore been restated on an undiscounted basis.

29. Losses and special payments

	2020-21		2019-20	
	Total number of cases	**Total value of cases £000**	Total number of cases	Total value of cases £000
Losses:				
Cash losses	**4**	**4**	15	5
Bad debts and claims abandoned	**30**	**14**	19	11
Stores losses and damage to property	**14**	**236**	11	278
Total losses	**48**	**254**	45	294
Special payments:				
Compensation under court order or legally binding arbitration award	**0**	**0**	2	16
Ex-gratia payments	**47**	**50**	88	48
Total special payments	**47**	**50**	90	64
Total losses and special payments	**95**	**304**	135	358

There were no individual losses, special payments or gifts in excess of £300,000 in either 2020-21 or 2019-20. No compensation payments were received in respect of the above losses and special payments in either 2020-21 or 2019-20.

30. Related party transactions

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

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

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

Year to 31 March 2021

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 (2)	**350,796**	**21**	**19**	**441**
NHS England	**124,728**	**585**	**1,811**	**1,599**
Cornwall Partnership NHS FT(1)	**6,710**	**10,251**	**1,461**	**1,340**
University Hospitals Plymouth	**764**	**1,409**	**192**	**761**
Royal Devon and Exeter FT	**1,666**	**203**	**208**	**34**
NHS Resolution	**0**	**11,991**	**0**	**0**
Health Education England	**16,779**	**4**	**355**	**168**

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	311,846	341	2,708	2,311
NHS England	105,693	10	13,332	727
Cornwall Partnership NHS FT	10,697	11,419	4,643	2,108
University Hospitals Plymouth	620	1,553	130	430
Royal Devon and Exeter FT	1,573	250	212	33
NHS Resolution	0	11,200	0	0
Health Education England	15,271	0	216	186

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.

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.

Included within current liabilities at 31 March 2021 is £22,000 (31 March 2020: £121,000) owed to Royal Cornwall Hospitals NHS Trust. During 2020-21 the Trust received income of £697,000 (2019-20:£771,000) from the Charity.

31. Events after the reporting date

There are no known post balance sheet events requiring disclosure.

32. Better Payment Practice Code

	2020-21 Number	2020-21 £000	2019-20 Number	2019-20 £000
Non-NHS payables				
Total non-NHS trade invoices paid in the year	**96,125**	**227,383**	100,910	189,868
Total non-NHS trade invoices paid within target	**91,797**	**211,014**	94,528	166,253
Percentage of non-NHS trade invoices paid within target	**95.5%**	**92.8%**	93.7%	87.6%
NHS payables				
Total NHS trade invoices paid in the year	**2,358**	**79,544**	2,717	70,949
Total NHS trade invoices paid within target	**2,228**	**77,762**	2,468	65,348
Percentage of NHS trade invoices paid within target	**94.5%**	**97.8%**	90.8%	92.1%

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.

	2020-21 £000	2019-20 £000
Cash flow financing	**(607)**	7,937
External financing requirement	**(607)**	7,937
External Financing Limit	**39,739**	13,735
Underspend against the External Financing Limit	**40,346**	5,798

34. Capital Resource Limit

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

	2020-21 £000	2019-20 £000
Gross capital expenditure	**55,347**	27,443
Less: Disposals	**(87)**	(5)
Less: Donated and granted capital additions	**(1,389)**	(652)
Charge against the Capital Resource Limit	**53,871**	26,786
Capital Resource Limit	**59,383**	26,786
Underspend against the Capital Resource Limit	**5,512**	0

NHSE/I have notified the Trust of a technical adjustment to its CRL to show the level of funding originally approved rather than the amount finally agreed. As a result, the Trust's CRL shows a technical underspend of £5.512m, even though the Trust spent to within £50,000 of the funding it received.

35. Break-even duty financial performance

	2020-21 £000	2019-20 £000
Adjusted financial performance surplus / (deficit) (control total basis)	**2,756**	50
Add back income for impact of 2018-19 post accounts allocation of Provider Sustainability Funding (PSF)		407
IFRIC 12 breakeven adjustment	**28**	30
Breakeven duty financial performance surplus / (deficit)	**2,784**	487

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**
Break-even in-year financial performance		8,349	7,544	4,437	9,809	3,938	(6,908)
Break-even duty cumulative position	(42,768)	(34,419)	(26,875)	(22,438)	(12,629)	(8,691)	(15,599)
Operating income		303,925	310,471	314,246	323,341	332,819	342,503
Cumulative break-even position as a percentage of turnover		-11.3%	-8.7%	-7.1%	-3.9%	-2.6%	-4.6%

	2015-16 £000	**2016-17 £000**	**2017-18 £000**	**2018-19 £000**	**2019-20 £000**	**2020-21 £000**
Break-even in-year financial performance	(6,906)	(929)	(2,557)	(4,104)	487	2,784
Break-even duty cumulative position	(22,505)	(23,434)	(25,991)	(30,095)	(29,608)	(26,824)
Operating income	355,815	379,462	405,020	445,376	481,623	537,177
Cumulative break-even position as a percentage of turnover	-6.3%	-6.2%	-6.4%	-6.8%	-6.1%	-5.0%

The Trust reported a £2.8m surplus in 2020-21 and holds a cumulative deficit of £26.8m at 31 March 2021. The Trust expects to fail to achieve breakeven on a cumulative basis at 31 March 2022, however it aims to recover its financial position as quickly as possible. A plan to recover the current cumulative deficit over a 5 year period has not been agreed to date.

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

Report on the Audit of the Financial Statements

Qualified opinion on financial statements

We have audited the financial statements of Royal Cornwall Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2021, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Equity, the Statement of Cash Flows and notes to the 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 accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021.

In our opinion, except for the possible effects of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- **give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;**
- **have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and**
- **have been prepared in accordance with the requirements of the National Health Service Act 2006.**

Basis for qualified opinion

Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £9.006 million.

Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021.

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2020) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. 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 qualified opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Directors' use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Directors' conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2020 to 2021 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2020) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

In auditing the financial statements, we have concluded that the Directors' use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

The responsibilities of the Directors with respect to going concern are described in the 'Responsibilities of the Directors and Those Charged with Governance for the financial statements' section of this report.

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.

As described in the basis for qualified opinion section of our report, we were unable to satisfy ourselves concerning the inventory quantities of £9.006 million held as at 31 March 2020, and related balances. Accordingly, we are unable to conclude whether or not the other information is materially misstated with respect to this matter.

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 in April 2020 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the guidance issued by NHS Improvement, or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion, based on the work undertaken in the course of the audit:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 15 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- based on the work undertaken in the course of the audit of the financial statements and our knowledge of the Trust, 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 on 9 June 2020 we referred a matter to the Secretary of State under section 30 of the Local Audit and Accountability Act 2014 in relation to Royal Cornwall Hospitals NHS Trust's projected breach of its break-even duty for the five year period ending 31 March 2021.

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

As explained in the Statement of directors' responsibilities in respect of the accounts, 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 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 Assurance 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.

Explanation as to what extent the audit was considered capable of detecting irregularities, including fraud

Irregularities, including fraud, are instances of non-compliance with laws and regulations. We design procedures in line with our responsibilities, outlined above, to detect material misstatements in respect of irregularities, including fraud. Owing to the inherent limitations of an audit, there is an unavoidable risk that material misstatements in the financial statements may not be detected, even though the audit is properly planned and performed in accordance with the ISAs (UK).

The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021).
- We enquired of management and the Audit and Risk Assurance Committee concerning the Trust's policies and procedures relating to:
    - the identification, evaluation and compliance with laws and regulations;
    - the detection and response to the risks of fraud; and
    - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management and the Audit and Risk Assurance Committee whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, by evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls and revenue and expenditure recognition. We determined that the principal risks were in relation to:
    - journal entries posted by senior officers; and
    - the significant accounting estimates in the financial statements, including those related to the valuation of property, plant and equipment and the year-end accruals.

Our audit procedures involved:

- evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
- journal entry testing, with a focus on large and unusual journals;
- challenging assumptions and judgements made by management in its significant accounting estimates in respect of property, plant and equipment valuations and significant accruals;
- assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. However, detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as those irregularities that result from fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- The team communications in respect of potential non-compliance with relevant laws and regulations, including the potential for fraud in revenue recognition, and the significant accounting estimates related to property, plant and equipment valuations and accruals.
- Assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
    - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
    - knowledge of the health sector and economy in which the Trust operates

- understanding of the legal and regulatory requirements specific to the Trust including:
  - the provisions of the applicable legislation
  - NHS Improvement's rules and related guidance
  - the applicable statutory provisions.

- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - the Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - the Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

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

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

Our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources is not yet complete. The outcome of our work will be reported in our commentary on the Trust's arrangements in our Auditor's Annual Report. If we identify any significant weaknesses in these arrangements, these will be reported by exception in our Audit Completion Certificate. We are satisfied that this work does not have a material effect on our opinion on the financial statements for the year ended 31 March 2021.

Responsibilities of the Accountable Officer

As explained in the Statement of the chief executive's responsibilities as the accountable officer of the Trust set out on page 54, the Chief Executive, as Accountable Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 undertake our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We document our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we consider whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for Royal Cornwall Hospitals NHS Trust for the year ended 31 March 2021 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources.

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.

Peter Barber,
Key Audit Partner for and on behalf of;

Grant Thornton UK LLP,
Local Auditor
Bristol

17 June 2021

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

In our auditor's report issued on 17 June 2021, we explained that we could not formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2021, in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice, until we had:

- Completed our work on the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have now completed this work, and the results of our work are set out below.

Opinion on the financial statements

In our auditor's report for the year ended 31 March 2021 issued on 17 June 2021 we reported that, in our opinion, except for the possible effects of the matter described in the Basis for qualified opinion section of our report, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2021 and of its expenditure and income for the year then ended;
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2020 to 2021; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

The Basis for qualified opinion section of our opinion was as follows:

- Due to the national lockdown arising from the Covid-19 pandemic in March 2020, we were not able to observe the counting of the physical inventories at 31 March 2020 or satisfy ourselves by alternative means concerning the inventory quantities held at that date, which had a carrying amount in the Statement of Financial Position of £9.006 million.
- Consequently, we were unable to determine whether any adjustment to this amount at 31 March 2020 was necessary or whether there was any consequential effect on the drug costs and supplies and services for the year ended 31 March 2021.

No matters have come to our attention since that date that would have a material impact on the financial statements on which we gave this opinion.

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

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2021.

We have nothing to report in respect of the above matter except during September 2021 we identified the following significant weaknesses:

- Weakness in the Trust's arrangements around payments to senior managers. We recommended that management urgently review its application of pay policies and identify the system weaknesses to prevent further issues with payments to senior officers.
- Weakness in the Trust's governance arrangements, specifically around the estates team's engagement with processes. We recommended that the Trust ensure the estates team engages with governance processes and ensures actions to overcome the identified governance weaknesses are appropriately and regularly monitored by senior leadership and oversight committees.
- Weakness in the Trust's governance of seconded staff, especially those on senior positions. We recommended that the Trust immediately develop policies and procedures to ensure it can appropriately manage seconded staff.
- Weaknesses in the Trust's performance that lead to Care Quality Commission reviews raising performance concerns at the Trust. We recommended that the Trust urgently address the concerns raised by the Care Quality Commission and continue to regularly monitor its progress against outcomes of the reviews.

As a result of the above weaknesses in the Trust's internal controls we recommended that the Trust immediately addresses the identified failings and continue to work with NHS England Improvement to implement the agreed action plan.

Responsibilities of the Accountable Officer

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

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

We are required under Section 21(3)(c) and Schedule 13 paragraph 10(a) of the Local Audit and Accountability Act 2014 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. 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 issued by the Comptroller and Auditor General in April 2021. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and
- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Audit certificate

We certify that we have completed the audit of Royal Cornwall Hospitals NHS Trust for the year ended 31 March 2021 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.

Peter Barber,
Key Audit Partner for and on behalf of;

Grant Thornton UK LLP,
Local Auditor
Bristol

17 September 2021

Royal Cornwall Hospitals NHS Trust Annual Report 2020-2021

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Annual Report & Accounts - 2020-2021