Annual Public Meeting

Thu 18 September 2025, 09:45 - 11:30

G.09 Knowledge Spa

Royal Cornwall Hospitals NHS Trust

Members of the public can join the meeting via MS Teams Live at: https://bit.ly/RCHTAPM2025

Agenda

09:45 - 09:50
5 min

1. Welcome and apologies (25.01)

Information *Chair*

To receive apologies for absence.

09:50 - 09:50
0 min

2. Declarations of Interest (25.02)

Information *Chair*

To receive any declarations of interest in relation to agenda items.

09:50 - 09:55
5 min

3. Minutes of the previous Annual Public Meeting (25.03)

Decision *Chair*

- To approve the minutes of the previous Annual Public Meeting held 19 September 2024.

03.01_Draft Minutes of APM 19.9.24 (Chair approved).pdf (8 pages)

09:55 - 10:55
60 min

4. RCHT's Annual Report and Accounts 2024/25 including external auditors opinion (25.04)

Decision *Chief Executive and Chief Financial Officer*

- *To **receive and adopt** the Annual Report and Accounts for 2024/25 and note the auditors opinion.*

Royal Cornwall Hospitals NHS Trust Annual Report and Annual 2024 - 2025.docx.pdf (243 pages)

10:55 - 11:10
15 min

5. Questions from members of the public (25.05)

Discussion *Chair*

- To receive and respond to questions from members of the public in line with the protocol.

05_Protocol for Questions from Members of the Public.pdf (2 pages)

11:10 - 11:15
5 min

6. Summary and close (25.06)

Information *Chair*

Minutes of the **Annual Public Meeting** of the **Royal Cornwall Hospitals NHS Trust** held on **Thursday 19 September 2024** at 09.45 – 14.00 via Microsoft Teams and in room G09, Knowledge Spa, Royal Cornwall Hospital, Treliske, Truro

Voting Directors Present:

Mairi McLean (MM), Chairwoman (G09)

Steve Williamson (SW), Chief Executive (G09)

Adam Broome (AB), Non-Executive Director (G09)

Isobel Down (ID), Non-Executive Director (G09)

Kim O'Keeffe (KOK), Deputy Chief Executive and Chief Nursing Officer (G09)

Allister Grant (AG) Chief Medical Officer (G09)

Robin Jones (RJ), Chief Operating Officer (G09)

Ian Dean (IDe), Interim Chief Finance Officer (G09)

Adrian Davis (AD), Non-Executive Director (MS Teams)

In Attendance:

Kelvyn Hipperson (KH), Chief Information Officer (MS Teams)

Alison Thorne-Henderson, Dual Chief People Officer (MS Teams)

Ella Stracey (ES), Chief Performance, Partnerships and Transformation Officer (G09)

Uzma Bozai (UB), NExT Director (G09)

Lynsey Neave (LN), Company Secretary (G09)

Amanda Stratford (AS), Non-Executive, Cornwall Partnership NHS Foundation Trust

Councillor John Basin, Chairman of Health and Adult Social Care Overview and Scrutiny Committee at Cornwall Council

Minutes:

Susan McFadzean (SMcF), Deputy Company Secretary (G09)

APM 24.01 Welcome and Apologies for Absence

a. Apologies for absence from voting directors were recorded from Richard Kramer, Non-Executive Director and Richard Stephenson, Non-Executive Director.

b. Apologies for absence from those usually in attendance were recorded from Aled Jones, Associate Non-Executive Director.

Chairwoman

i) The Chairwoman welcomed the Board and members of the public to the Trust's Annual Public Meeting for the 2023/24 annual report and accounts advising that the purpose of the AGM was to share information on overall Trust performance and provide transparency.

ii) Thanks were extended to all colleagues for their unfailing efforts during a year of change, financial constraints and ongoing operational pressures. All staff continue to work hard to keep patients safe and provide the best care they can.

iii) Reference to the improved staff survey results compared to the previous year and how many staff had fed back how positive it was to work at the Trust, noting that ongoing improvement was still needed to make the Trust a better place to work.

iv) Working collaboratively with partners and voluntary sectors to ensure services are provided closer to patients' homes through a range of community based services. The Trust continues to learn from patients' experiences and feedback is a gift.

v) That as Chair of the Trust how good it is to be able to visit wards and departments, speak to staff and gain their feedback (which includes St Michael's and West Cornwall Hospitals).

vi) The importance of equality, diversity and inclusion and the intention of the Board to develop this further. Reference to recent solidarity events held and the provision of support to staff in order to prevent unkind behaviour. The distress experienced when attending meetings with staff who had been subject to racism, violence or alternative forms of abuse. Continuing to strive to increase diversity on the Board and welcoming anyone in applying for Non-Executive Director positions. The appointment of the Trusts first NExT Director which had added strength to the Board.

vii) The Trusts strategy for 2022-2032 which was approved in November 2022 along with the refreshed values of respect, honesty, teamwork and trust. The strategy sets out the ambition to provide 'Outstanding Care for One and All'.

viii) Major capital projects being undertaken as well as investment in people to develop services further. The Trust received 36,000 emergency admissions and 3513 babies were delivery in hospital, birth units or at home with support from the Trusts midwifery team.

ix) Thanks, extended to patients, relatives and carers as well as volunteers and the important work they undertake to support the Trust.

x) Thanks, given to the Trust's Chief Executive and the Board for their leadership, care, dedication and compassion. The importance of setting the tone, values and behaviours and ensuring these are integral within everything that is said or done.

xi) Having been Chairwoman of the Trust for the past 5 years Mairi expressed great sadness to be leaving in January 2024 due to completing tenure. She praised the openness, learning and pride in all of the work being done at RCHT.

xii) Positive feedback received from the Care Quality Commission (CQC) following recent visits and inspections regarding how engaging staff are and the brilliant care they endeavour to deliver under very challenging situations.

APM 24.02 Declaration of Interest

a. Directors declared no interests in relation to items on the agenda.

APM 24.03 Minutes of Previous Annual Public Meeting

a. The minutes of the meeting held on 21 September 2023 were approved as an accurate record without amendment.

APM 24.04 RCHT's Annual Report and Accounts 2023/24, including external auditors opinion

a. The Board and members of the public in attendance on MS Teams Live received a presentation from the Chief Executive and Deputy Chief Executive and Chief Nursing Officer on the performance of the Trust during 2023/24, followed by a briefing from the Chief Financial Officer on the Trust's financial position. The key points covered by each included:

Chief Executive

i) The extraordinary efforts of staff across the Trust and thanks for their care, safety and compassion in the delivery of healthcare to patients. The amazing achievements in very difficult circumstances.
ii) Thanks to colleagues across the health and care system as well as volunteers for their dedicated support. Having the privilege of spending time with volunteers.
iii) Challenges with being able to discharge patients from the Trust who had finished their acute episode of care. The importance of discharging patients quickly to enable their ongoing recovery and rapid access to services for new patients requiring admission. The ongoing work being undertaken to identify solutions and options to address delays in discharges through the provision of schemes such as the mobile x-ray car, as well as providing same day emergency care services in alternative locations (all of which impact on admissions to and discharges from the Trust).
iv) That the operational position continues to be challenging and all possible actions are being taken to address this. Staff have worked hard to deliver the best care.
v) Embarking on the 10 year strategic plan with the vision of providing excellent care to One and All.

vi) The creation of the Trust values of respect, honesty, compassion and teamwork.
vii) Recruitment of over 100+ international staff who bring diversity to the Trust.
viii) Improvements in the Trusts Staff Survey results and that the Trust was a leader in achieving this performance but noting the further work to be done.
ix) Improvements in areas where colleagues recommend the Trust as a place to work and to receive care.
x) Solidarity events undertaken. An opportunity for colleagues to share experiences. The Trust's zero tolerance for racism, bullying and harassment and steps that will be taken to address this to support the best culture within the Trust.
xi) Experience of industrial action across 2023/24 which resulted in the loss of 9,000 operations as well as high numbers of planned outpatient appointments creating additional pressures across the organisation. Despite this the Trust continues to do what it can to address and improve waiting times and access to services.
xii) Programmes which are designed to address issues within urgent and emergency care. These look at alternatives to Emergency Department treatment as well as providing the most rapid flow through the urgent and emergency system whilst also ensuring patients are discharged at the earliest opportunity.
xiii) Waiting lists reduced by 5k over the year and fewer people are now on waiting lists at the end of the year. For 52 week waits the Trust being ahead of national expectations. Improvement in orthopaedic care continue to be accelerated.
xiv) Fantastic examples of partnership working with the implementation of diagnostic centres within the community enabling patients to receive care closer to home and reduce admissions to the Trust.
xv) Feedback on maternity services and amazing teams who provide compassionate care each day. 90% of respondents surveyed advising they were directly involved in their care during labour and birth.
xvi) Fantastic innovation and empowering patients to help aid delivery of their own care with patient initiated follow ups being quoted as an example. Enabling direct control of when appointments are necessary. The Trust being the best in the Country for patient initiated follow up.

Improvement journey

i) As part of 10 year strategic plan improvements made in planned trajectories.
ii) Creation of Lowen MRI Cornwall Cancer Centre which provides state of the art facilities transforming the environment for staff and patients.
iii) Being half way through a new build at West Cornwall Hospital to create a state of the art outpatient department and environment for patients and staff.
iv) Enabling works being undertaken for the new Women and Children's Hospital. The Trust is awaiting a review of the New Hospital Programme by the Government and continuation of this project.
v) Opening of new day surgical centre (partnership with CFT) which will provide 2 new operating theatres as well as day surgery facilities. Patients in the North of the County will be able to receive care closer to home and the facility will also aid the reduction of waiting times.
vi) Electronic patient record transformation through the E-Care project. This will provide a single patient record enabling clinicians and other staff to see information in one place.
vii) Achievement of financial balance which included delivering £28m of financial savings throughout the year which should be commended given the ongoing operational challenges.

viii) Changes within the Trust Board throughout the year. Welcome to Ian Dean as the new Chief Finance Officer who brings a wealth of finance and expertise and was a welcome addition to the Executive Leadership Team.
ix) Thanks to Allister Grant, Chief Medical Officer who will be retiring after providing 5 years of service in post. Acknowledgement of Allister's leadership, particularly during the Covid-19 pandemic, as well as other extraordinary challenges faced during his tenure.
x) Thanks to Mairi McLean as Chairwoman for being an inspirational chair as well as dealing with the challenges of leading the Trust through the Covid-19 pandemic and subsequent recovery.
xi) That it might not always be clear of the roles and associated challenges the Chair and Board members face. Gratefulness extended to the Chairwoman for her kindness, compassion and wisdom as well as wishing her success for the future.
xii) Importance of partnership working to deliver healthcare for Cornwall and Isles of Scilly patients. The importance of further strengthening these partnerships as well as working with other acute Trusts across the peninsula.

Deputy Chief Executive and Chief Nursing Officer

i) How hard it is to summarise all quality outcomes achieved within 4 slides.
ii) During 2023/24 the top priorities of committing to listening to patients, carers and other voices. The Trust has recruited 8 lived experience patient leaders (hoping to recruit more) who are fully trained, are volunteers and work with staff to ensure the patient and carer voice remains central to any change. The Patient Leaders sit on various Task and Finish Groups and are also involved in the recruitment of new staff and not only ensuring they would work in accordance with Trust values but also have the right skills and competencies. The aim to enhance the programmes of work these Patient Leaders are involved in. Thanks, extended to the Patient Leaders for their work noting the various forums they presently are involved in.
iii) A 128% increase in patients recruited to research studies and thanks given to the research teams to enable further improvement of quality and safety outcomes.
iv) A 5% reduction in hospital onset healthcare associated cases of clostridioides difficile noting the overall rate was 15% higher than the national average. Work continues with core clinical staff regarding prevention.
v) The good rating by the CQC for maternity and neonatal services. The completion of all actions from the 2023 CQC inspection and that work undertaken by the Trust continued to exceed national expectations.
vi) Strong relationships formed with Kernow Neonatal Voices Partnership which had been instrumental in making cultural as well as the clinical changes required.
vii) Launch of a Volunteer Strategy which was coproduced with all voluntary organisations.
viii) A 6.3% decrease in patient falls and the opening of a Falls and Delirium Event which a high number of individuals joined. The buzz during the event which outlined the severe impact a fall can have on patients.
ix) A 41% increase in quality improvement ideas submitted by staff which supports staff engagement and wanting to improve the journey for staff as well as patients.
x) Work with partners to launch Carers Corner where people coming into main receptions and can meet with staff and have face to face discussions and receive support.

xi) The importance of supporting staff. The Trust had celebrated the graduation of the second cohort of Chief Nursing Officer Fellowes. Dedicated time had been provided to enable participants to undertake research projects and the Trust was commencing with cohort 3.
xii) An increase in the number of mental health first aiders and several other initiatives which support the mental health and wellbeing of staff (resilience, financial, health to name a few). A relaunch of these staff networks.
xiii) Continued work on the Flow Programme which includes 4 Care, 4 Patients, 4 Hours to ensure patients are treated in the safest place to obtain the best outcomes.
xiv) Commitment that all patients over 75 are assessed for delirium within 24 hours with the aim of reducing this to 65 years of age.
xv) Continue to improve quality and safety standards in maternity and perinatal care through the implementation of 10 national actions to reduce stillbirths, deaths and brain injury.
xvi) Continued work with partners, patients, carers and relatives to ensure that the patient voice is heard, acted upon and the Trust continues to sustain and demonstrate change.

Chief Finance Officer

i) That the financial framework in 2023/24 remained largely unchanged from the previous year. The Trust receives income via aligned payment and incentive contracts with commissioners (block value of assumed activity). Elective elements of care to target long waits (post Covid-19) are variable.
ii) Continuation of system based resource allocation to ensure monitoring of finances as one with and shared accountability.
iii) The Trusts annual accounts for 2023/24 were prepared and submitted on time.
iv) That 2023/24 had been a challenging year operationally and financially. The Trust delivered a £0.1m surplus on turnover of £672m so a significant achievement. This included delivery of over £28m of savings and the Chief Finance Officer gave thanks to all staff for enabling delivery of this overall position.
v) The Trust ended 2023/24 with a £18.7m cash balance compared to a plan of £10m. 96.7% of non-NHS invoices were paid on time which exceeds the national target of 95% which is important given the Trust is an anchor institute.
vi) Capital investment of £44m which takes expenditure to £190m over the last 4 years.
vii) Trust income continues to increase year on year primarily linked to inflation as well as variable income received from treating patients and long waits. This increased to £672m up 8% from the previous year which was £624m). It was £581m in 2021/22. £483m income is received from ICBs (mainly local ICB with some from other ICBs across the Country.
viii) Income received from NHSE including for specialist cancer drugs and screening services provided.
ix) £66.4m of income from education and training as well as research activity which forms a key part of the Trusts strategy. The largest area of expenditure relates to staffing which is 61% (£408.6m).
x) The largest expenditure for non-pay being supplies and consumables at £147m. £34.5m relates to services from other organisations with £29m related to depreciation and impairments relating to assets.

xi) 76% of expenditure relates to the provision of direct patient care with Acute and Emergency Medicine making up 17% of total expenditure.

Capital Expenditure

i) £44m of capital investment during 2023/24. The Trust lived within its statutory capital limit but maximised this where possible and had a marginal underspend of £36k at the year end. Capital expenditure supports several key projects within the Trust.
ii) Expenditure on major projects which were also supported by internal capital funding. Over £10m was spent on strategic estates projects.
iii) Continued work to develop the Women and Children's Hospital (including design and enabling schemes) of £5m.
iv) Expenditure during the year comprising £2.6m on the new outpatient department for West Cornwall Hospital with £0.6m on the West Cornwall Community Diagnostic Centre build.
v) Digital elements of care and how staff and patients use this to improve care and patient experience which was £15.1m in the financial year. The majority (£11.2m) was spent on E-Care which is the new electronic patient record.
vi) Estates and maintenance of the services which totalled £7.3m. £2.5m was spent on fire improvement works within the Tower Block of the main Royal Cornwall Hospital site.
vii) Medical equipment expenditure totalled £11.7m during the year and included £1.5m on a replacement gamma camera, £1.1m on a cardiac catheter laboratory and £4.5m to replace general medical equipment at the end of its life. All expenditure contributes to improving services.

Annual Accounts

i) The Trusts annual accounts are independently audited and each year a report is given by the auditors. This confirms the accounts were submitted on time, prepared in accordance with national guidance and to a high standard and give a true and fair view of the financial position of the organisation.
ii) No unadjusted misstatements were made within the Trusts annual accounts.
iii) A section 30 referral to the Secretary of State for Health regarding a historic cumulative deficit relating to previous financial years totalling £21m. The auditors are required to make this referral and it is consistent with all organisations with such a deficit.
iv) The auditors are required to provide a Value for Money (VFM) conclusion which identified one weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in the use of its resources.
v) Despite the challenges the Trust faced in 2023/24 it delivered its key financial targets which is a major achievement not only for the Trust but also the healthcare system in Cornwall.
vi) Thanks, extended to the Finance Team and wider organisations to enable delivery of the key targets.
vii) The Trusts accounts can be accessed by downloading on the website, using the QR code provided in the slides presented, or by emailing the Corporate Governance Team at rcht.corporategovernance@nhs.net.

b. The Chief Executive introduced a 10 minute video that provided a lookback and a look forward of the Trust activities and priorities. Link to the video: https://vimeo.com/1008215318/534bbaa24d

Thanks, extended to Peter Young, Audio Visual Communication Specialist, for compiling the lookback video outlining the outstanding work that occurred within the Trust for 2023/24.

c. The Board **resolved** to:
   i) Formally **receive** and **adopt** the Trust's annual report and accounts for 2023/24.
   ii) **Note** the external auditors annual report for 2023/24 which included the value for money assessment.

APM 24.05 Questions from Members of the Public

a. The Chair invited the Company Secretary to read the questions from members of the public. No questions were raised through the Q&A function.

b. The Board noted a comment received from Amanda Stratford, Non-Executive Director at CFT, extending thanks for the approach taken by the Trust towards partnership working.

APM 24.06 Summary and Closing Remarks

a. (MM) thanked staff for attending meetings throughout the year as well as their thoughtfulness adding that she hoped all staff had heard the thanks and value given to them for all that they do. The Trust will continue to strive to best the best it can be. (MM) added that the community depends on the Trust as well as CFT as the main providers of healthcare in Cornwall.

NHS
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Annual Report and Accounts

2024-2025

Outstanding Care for **One+All**

Royal Cornwall Hospitals
NHS Trust

Royal Cornwall Hospitals NHS Trust

Annual Report and Accounts

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Chair's Foreword

For much of the year under review the RCHT Board was chaired by my predecessor Dr Mairi McLean. I am glad of this opportunity to pay tribute to her work which, following my appointment on 7 January 2025, I hope to continue.

2024/25 was a challenging year for the NHS in general as well as RCHT. A new Government was elected and took office in July last year and soon announced an additional settlement for the NHS nationally in excess of £22 billion over two years. However, inflation, pharmaceutical costs and the cost of settling widespread industrial action has largely accounted for this increase. Nevertheless, for a remarkable sixth year running RCHT has broken even, including making savings of some £35 million.

Under the leadership of our Chief Executive Steve Williamson we have enjoyed considerable success, for example the award of the £350 million Women and Children's Hospital which should open in 2031, some of the best elective care performance in England, strong performance on cancer diagnosis and treatment times and highly regarded maternity services. However, we have to recognise that our urgent and emergency care requires improvement. We are only too well aware that patients wait too long for ambulances to arrive, spend too long in ambulances waiting to be assessed in the Emergency Department and that it can take too long to discharge patients even though they are medically fit to leave us.

However, although there is still much to do, we are now seeing improvements consistently and, when we are overwhelmed by demand, we are able to recover more quickly. We are dependent on partners, including the public, to help us and we are very grateful for the support we get from our Integrated Care Board, Cornwall Partnership NHS Foundation Trust, the South Western Ambulance NHS Foundation Trust and many others.

The detail of our reforms is set out elsewhere in this report but includes a new Clinical Vision of Flow through our hospitals, a new medical model aligning senior clinicians more with peak ambulance arrival times and numerous changes designed to enable patients to flow through the hospital more smoothly, and to be safely discharged sooner. Our focus on improving urgent and emergency care is relentless and is our top priority. We know that every minute counts so we will fight for every minute of improvement.

During 2024/25 a new surgical hub was opened on the St Austell hospital site capable of performing 5000 day case surgical procedures a year. The new Outpatients Centre at West Cornwall Hospital in Penzance continued to be constructed and welcomed its first patients in June 2025. At St Michael's Hospital in Hayle we carry out elective orthopaedic surgery and breast surgery, so all our three hospitals are busy serving the people of Cornwall and the Isles of Scilly.

I would like to place on record our gratitude to our many volunteers and Friends for providing all those little extras for patients and staff, which do so much to improve morale and aid recovery. We are also grateful to all our donors who provide the means to enable us to distribute millions of pounds in grants through our Charitable Funds Committee.

Finally, can I thank all our Board members, executive and non-executive for all their dedication and hard work, our amazing staff for their expertise, compassion and commitment and of course our patients and their families. We never forget you are who we are here for.

If 2024/25 was tough, 2025/26 will be even tougher with savings of some £50 million required alongside performance improvements. However, we have a plan and a determination to deliver. I look forward to reporting on our progress next year.

David Allen, OBE

Chair of the RCHT Board of Directors

Performance Overview

1. Purpose of this Section

To provide a short summary that provides sufficient information to understand the organisations, its purpose, the key risks to the achievement of its objectives and outline how the Royal Cornwall Hospitals NHS Trust (RCHT) has performed during the year 2024/25

2. Chief Executive's Summary

Each day I am humbled by the tireless work of teams and individuals across our hospitals as they strive to provide and support the delivery of safe and compassionate care for those who need our services. It is truly a privilege to be a part of 'team RCHT'.

Notwithstanding the complex operational pressures we face within our hospitals and across our wider health and care system, we have made strong progress in many areas. Waiting times for planned care and cancer diagnosis and treatment continue to reduce and in fact we have been among the best performers in these areas across the southwest region. We have improved care and safety through changes in the way we work, as well as finishing the year in financial balance, which reflects the passion and commitment of colleagues across Royal Cornwall Hospitals.

We are all too aware we still have more to do to consistently deliver the level of care we want for those needing urgent and emergency care, and to drive up productivity, but we are proud of the progress we are making. Through focussed work within our hospitals, we are bringing down delays and enhancing our own process to improve patient flow, not least with our drive on getting patients home for lunch and most recently with the clinically led development of our clinical vision for flow. Whilst we have made progress in reducing our longest ambulance handover waits and in our length of stay in ED, we have much more to do, and this area will be an overarching priority for our Trust over the next 12 months.

This programme of work to improve urgent and emergency care flow is setting the direction and pace of change. It is very much aligned to the principles which will inform the national NHS 10-year plan and support the shift from hospital to community wherever possible and sustainable.

Throughout the last 12 months we have worked closely with our wider health and care partners, particularly Cornwall Partnership NHS Foundation Trust (CFT), Cornwall and Isles of Scilly Integrated Care Board (CIOSICB), Cornwall Council, South Western Ambulance NHS Foundation Trust (SWAST), Council of the Isles of Scilly and other key partners. This strong partnership working has supported the development of frailty same day emergency care services, community assessment and treatment centres, x-ray car, significant development of virtual wards services and many other transformations to improve how patients can access services. Already we are seeing many more people receiving care in their own homes or in the community with the support of community and voluntary services. For many, it also means they avoid admission to our hospitals, freeing up space for those most in

need of specialist acute care.

We have seen developments too in new services and facilities including an upgraded cardiac catheter laboratory, a new gamma camera, and replacement of interventional radiology equipment, all supporting very specialist treatment for some of our more acutely unwell patients. Building works also continued on a long-awaited new outpatient department at West Cornwall Hospital and the start of a major upgrade of our sterile services department which provides decontamination services for theatres across our hospitals, as well as community hospital and GP surgery locations.

We have also celebrated the 80th anniversary of the Friends of Royal Cornwall Hospital. Our Friends and volunteers provide an amazing source of support, kindness and friendship to our patients, visitors and to our staff. We are incredibly privileged to have the gift of their time, and I know all our patients and our staff are so grateful for the support they give.

One of the highlights of our year has to be confirmation from the Department of Health and Social Care that our Women and Children's Hospital will go ahead in the first wave of the New Hospital Programme. We have waited a generation for this much needed project to come to fruition, and together with becoming one of 21 UK sites to host a Commercial Research Delivery Centre, and the go-live of eCare, our electronic patient record, in 2026, we are set to see some of the biggest ever transformations in healthcare in Cornwall and the Isles of Scilly. The benefits for our patients, our staff and our population are immense, and it is an exciting time for us all.

Alongside our Annual Report, we publish our Annual Quality Account setting out our performance against our patient safety objectives. Patient safety remains our absolute priority. While we have reported two Never Events during this year, I'm reassured that robust investigations and subsequent learning have led to change. Care Quality Commission assessments in May and July 2024 both highlighted the care and compassion of our people, and we welcomed and responded to the recommendations for improvement.

This year, our staff survey results have reinforced the need for us to do more to support the wellbeing of our people. We want to ensure every one of our employees feels they are respected and equally empowered to 'speak up' with confidence. Building a culture of kindness and openness is an essential part of our organisational development.

Looking ahead, we remain focused on addressing the challenges highlighted in our performance indicators, particularly in reducing potentially avoidable admissions, reducing length of stay, and in improving emergency care access. We will be refreshing the RCHT 10-year strategic plan to stay aligned to the forthcoming national plan, affirming our commitment to the three shifts; hospital to community, analogue to digital and sickness to prevention. With continued determination from our outstanding teams, I'm confident we will continue our journey of improvement and in delivering outstanding care for one and all.

Steve Williamson

Chief Executive Officer

3. Who we are

The Royal Cornwall Hospitals NHS Trust (RCHT) was founded in 1992 as part of the second wave of NHS Trusts to be established in England. We have three hospital sites: Royal Cornwall Hospital, Truro; St Michael's Hospital, Hayle; and West Cornwall Hospital, Penzance.

RCHT also provides imaging and outpatient services at 10 community hospitals and other locations across Cornwall and the Isles of Scilly, as well as birthing centres in St Austell, Helston and on the Isles of Scilly.

We serve around 480,000 residents across Cornwall and the Isles of Scilly (CIOS), with the remainder of Cornwall's population in the east and far north of the county looking to Plymouth and North Devon respectively, for their acute hospital services. As a year-round tourist destination, the number of people we care for is boosted by holidaymakers, which can more than double our population at the busiest times.

Over 7,000 people work together across our hospitals and services, including 400 volunteers and an in-house bank of over 1500 people working flexibly to help us respond to changes in demand.

The geography of our county, surrounded on three sides by sea, and the remoteness of the Isles of Scilly present unique challenges. Our population is growing and ageing. The number of people living in Cornwall is rising faster than the national average and we are planning for a six percent increase by 2035 in the number of people who live here.

According to the 2021 census 53.9% of households in Cornwall were deprived in at least one of the four dimensions of deprivation which include education, employment, health and housing and the number of people claiming Universal Credit rose by 35% between May 2022 and December 2024. Additionally, our population of people over 65 years grew by 25.1% between 2011 and 2021. Cornwall's wages remain below the national average, with current media wage around £3,500 below the average for UK full-time workers.

4. Our strategy and values

The RCHT Strategy 2022 to 2032 was approved in November 2022, along with a renewed set of RCHT Values. The Strategy sets out our ambition to provide 'Outstanding Care for One and All', and is underpinned by three strategic priorities to achieve this by 2032:

Supported and Valued People: We will become a great University Hospital, known for its excellence in supporting staff in wellbeing, training and development and career pathways.

Safe, High-Quality Care: We will provide safe, high-quality care, refining our model of care to be person-centred and as close to home as possible.

Journey of Improvement: We will embed a culture of learning, leadership, and improvement across RCHT, focussed on core business, and grow our reputation for research.

We have also identified four key enablers to help us deliver our objectives:

- Partnership working.
- Digital transformation.
- Person centred approach.
- Making best use of our estate.

Our Strategy describes our Values, which were developed through an inclusive engagement process with our staff, and define what we stand for at RCHT:

Respect: We promote diversity and equality, and we are respectful to others and to our environment.

Compassion: We treat everyone with the care and compassion we would want for our loved ones.

Honesty: We speak up and learn from our mistakes and do what we say we will do.

Teamwork: We help each other to deliver the best outcomes for 'One and All'.

The priorities for year 2 of our strategy, were as follows:

- Support the development of our staff and embed a safety culture that ensures people feel safe and supported to speak up.
- Deliver system-wide workforce transformation through the Workforce Efficiencies Programme, with a focus on collaboration, reducing agency, developing our workforce and enabling new models of care.
- Make it easier for our staff to do their jobs through the delivery of the Workforce Systems Transformation Programme, ensuring our Electronic Staff Record (ESR) system effectively supports staff.
- Improve quality and safety across the CIOS system by supporting the development and delivery of the system-wide Flow Programme and our internal Flow Programme, with a specific focus on frailty, end of life and falls.
- Improve waiting times for elective care and cancer care and provide more care closer to home through the Elective Recovery Programme.
- Through provider collaboratives with Cornwall Partnership NHS Foundation Trust, the Peninsula Acute Providers Provider Collaborative and Integrated Care Areas, work with system partners to improve clinical pathways of care.

- Ensure the Trust and system are financially sustainable through the delivery of the System Finance Recovery Programme and improvements to productivity.
- Build upon our relationships with local universities to support our application for University Hospital Status and to develop a Cornish Medical School.
- Work with our system partners to deliver our local green plan and achieve our ambitious commitment of net zero by 2030.
- Establish a significant operational estate improvement programme to ensure we deliver a safe and effective environment.
- Through the Patient Leader Programme, strengthen patient involvement in the development and delivery of our strategic priorities.
- This is further supported by the following key enablers:
    - Deliver the key enabling schemes in support of the Women and Children's new build, including relocation of the Cardiac Department and starting building work for the new Pathology building.
    - Through the eCare Programme, translate the plans of the new Electronic Patient Record into delivery of clinical transformation and optimise our digital capabilities throughout the organisation. Our role as an organisation extends beyond our provision of acute hospital care. As a major anchor institution, we are strongly rooted in our communities and have a responsibility to more broadly support our population's health and wellbeing.

5. Our services

Our hospitals provide acute emergency and planned care services to our local population, in addition to maternity services. We also provide specialised services (such as the treatment of endometriosis and interventional radiology), often working as part of a network with other acute hospital providers.

Following restructure in February 2024, our services are provided through seven Care Groups and leadership teams:

Care Group	Acute and Emergency Medicine	Specialist Services	Clinical Support	Women and Children	General Surgery and Cancer	Anaesthetic, Critical Care and Theatres	Peripheral Sites
Specialties	**UEE Services** • Acute Medicine • Emergency Department • Eldercare • Stroke **Spec Med Services** • Cardiology • Respiratory • Neurology • Sleep	**SSS Services** • ENT • Gastroenterology • Hepatology • Ophthalmology • Oral Surgery • Dermatology • Rheumatology **Spec Med Services** • Endocrine/ Diabetes/ Renal	**CS Services** • Imaging • Medical physics • Pathology • Patient services • Pharmacy • Therapies • Sterile services **Spec Med Services** • CFS/ME/Long Covid service	• Acute Paeds • Community Paeds • Contraception • HIV service • Neonatal • Obstetrics, Gynaecology & Maternity	**GSC Services** • Cancer services, including Oncology and Haematology General Surgery • Breast • Urology • Vascular	• Theatres • Pre-Assessment • Anaesthetics • Critical Care • Pain services	• Trauma and Orthopaedics • SMH • West Cornwall Hospital

The improved alignment of clinical pathways within the new 7 Care Group structure has helped us to improve our models of care and consequently the safety and experience of our patients. We will further review its effectiveness in the coming year to establish whether any further changes would bring additional benefit to patient care and their potential to contribute to our cost improvement plan.

6. Our team and governance

The RCHT Board is made up of Non-Executive and Executive Directors who together are responsible for leading our hospitals. The Board meets in public at least six times each year and anyone is welcome to attend in person or online. The hybrid production of our meetings has led to a significant increase in staff and stakeholder engagement.

Our Chair is appointed by NHS England (NHSE) and works with us to appoint other members of the RCHT Board. A new Chair was appointed on 7 January 2025.

Our Clinical Care Groups and two peripheral sites are supported by corporate teams including finance, human resources, patient safety, and estates and facilities. Payroll and information technology services are hosted by the Royal Cornwall Hospital NHS Trust on behalf of the local NHS community, which includes the provision of IT services to GP (General Practitioner) surgeries.

Car parking facilities for visitors and staff are managed by Saba. Our patient and retail catering are produced by our in-house team, operating under the name Sustenation.

Our work is founded on the National Health Service (NHS) Constitution and achieving the national standards set by NHSE and the United Kingdom Government, working in partnership with our regulators and local commissioners. Our main commissioner is the Cornwall and Isles of Scilly Integrated Care Board.

Our hospitals 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), as well as students from many other professions with whose training providers we work. We also have a growing and increasingly diverse Research, Development and

Innovation portfolio, Clinical School and Academy.

We have continued to build our strategic partnerships with our local universities in recent years, entering into a Memorandums of Understanding with the Falmouth University, the University of Plymouth and the University of Exeter which enables us to pursue joint strategic ambitions for the benefit of our staff, students and patients alike. As these relationships continue to mature, we will seek to strengthen our clinical academic links, for example through the use of joint appointments for senior clinicians to our partner universities, further supporting local research and development. In turn, we hope the strength of the relationships with our local academic institutions will enable us to apply for University Hospital Status – a key feature of our Trust Strategy.

7. Our registration

All health and adult social care providers must be registered and licensed with the Care Quality Commission (CQC). This is a legal requirement under the Health and Social Care Act 2008.

The CQC is the independent regulator of health and social care in England. Its purpose is to ensure health and social care services provide safe, effective, compassionate, high-quality care and it encourages care providers to improve.

RCHT is not fully compliant with the regulations underpinning its registration with the CQC. At the end of 2024/25, we continued to be rated as 'requires improvement' overall by the CQC (rating received in December 2019).

Throughout 2024/2025, engagement with the CQC continued through regular relationship meetings with our senior leadership team, ongoing responses to requests for information, and the provision of updates on actions agreed from previous inspections.

The Director-Led CQC Scrutiny Group continues to monitor our response to requirement notices and other key concerns arising from CQC inspection reports. The group is responsible for oversight and monitoring of action plans to demonstrate and sustain improvements.

7.1 CQC Inspections in 2024/2025

In May 2024, the CQC carried out an inspection of urgent and emergency care services at the Royal Cornwall Hospital site under its single assessment framework.

The final report, received in January 2025, highlighted:

- There was some improvement against the areas of concern found at the previous inspection in 2022. However, there were two breaches of regulation which are detailed in the table below;
- There were issues of crowding of the Emergency Department, a lack of care packages available in the local community, and that patients experienced waits in ambulances when the Emergency Department was at capacity.

- Most patients spoken to during the inspection felt they had been treated well and with kindness from caring staff. Patients waiting in ambulances felt safe and understood the pressures on the department;

- There was an inclusive and positive culture of continuous learning and improvement. Leaders were capable, compassionate and inclusive and supported their staff in challenging and stressful times;

- The Emergency Department had improved its staff numbers and retention, and that staff were doing their best to mitigate risk at times of very high occupancy.

The urgent and emergency care core service was re-rated at this inspection with one change to the rating for the Safe key question which improved from 'requires improvement' to 'good':

Urgent and Emergency Care Core Service	
Key Question	**Rating**
Overall	Requires improvement
Safe	Good
Effective	Requires improvement
Caring	Good
Responsive	Requires improvement
Well-led	Good

There were two regulation breaches identified by the CQC during the inspection:

Service	Regulation	Breach
Urgent and Emergency Care	12	Care and treatment were not always provided in a safe and timely way in line with clinical guidance and in an area of the department or correct specialty where it is safe to do. Patients were not always admitted from the Emergency Department to a ward bed in a timely manner. Patients experienced waits in ambulances when the Emergency Department was at capacity.
	18	Persons employed by the service did not receive regular appraisals.

A comprehensive action plan in response to the regulation breaches was submitted to the CQC in February 2025.

On 10 July 2024 the CQC carried out a responsive assessment of medical care on Zennor Ward at the Royal Cornwall Hospital site. The assessment was carried out under the single assessment framework, looking at 10 quality statements across the safe and well-led key questions. Immediately following the visit, the CQC wrote to confirm no serious breaches or areas of concern were highlighted during the assessment.

The final report was received in January 2025, highlighting:

- The service had a good safety culture where staff regularly discussed patient care.
- Staff escalated deteriorating patients appropriately and provided safe care and treatment using well-defined procedures.
- The environment was clean and tidy, but in need of modernisation and adjustments for which an investment case was in progress.
- The leadership team were experienced, capable and visible on the ward.
- Improved governance, training and information sharing had resulted in a reduction of patient falls.
- People's experience of the ward was good, and people felt they were receiving considerate support from competent staff.

Most people felt they were listened to and commented that the ward was clean and tidy with equipment available as needed.

As the CQC only assessed one ward as part of this inspection their ratings were not reviewed. The CQC did not identify any regulation breaches during the Zennor Ward inspection.

In November 2024, the CQC conducted an announced inspection of compliance with the Ionising Radiation (Medical Exposure) Regulations 2017 (IR(ME)R) of the diagnostic radiology, radiotherapy, and nuclear medicine services at the Royal Cornwall Hospital as part their proactive inspection programme.

The final report was received in December 2024, highlighting:

- The diagnostic radiology service provided evidence and assurance of compliance with IR(ME)R. The service showed several areas of good practice, most notably around the detailed training records and the use of an innovative questionnaire for carers and comforters. Staff they spoke to were engaged, open, and citied a positive culture within the hospital.

- The radiotherapy service staff were engaged and experienced. The department demonstrated good practice with regards to detailed and organised employer's procedures (EPs), quality assurance of documents, regulatory audit, incident management, clinical evaluation, Medical Physics Experts provision, and training records. The management and governance structure ensured a good oversight of the service.

- The nuclear medicine service demonstrated good practice with regards to comprehensive examination protocols, along with procedures and documents that were well-written and considered in their content. Exposures of carers and comforters were managed robustly and included centralised records of exposure information, clear guidelines for operators to follow, and easy to understand information for patients and carers.

Services are not rated under the IR(ME)R inspection process. The reports identified five areas for improvement where a breach had been found which did not justify regulatory action:

Service	Regulation	Action required
Diagnostic Radiology	6(1)	The service should review EPs as required by Schedule 2 of IR(ME)R17. The EPs should contain all appropriate information to support staff fully and the service should ensure that they are easily accessible to all required entitled user groups.
Nuclear Medicine	6(1)(a) Employer's procedures	The employer should ensure that procedures include all detail required by the Regulations.
	6(1)(a) Pregnancy and breastfeeding	The guidance given in EPs for making pregnancy and breastfeeding enquiries should be consistent, to support duty holders in performing these checks.
	11(1)(e) Non-medical imaging	The EPs should include arrangements for non-medical imaging exposures.
	11(5) Authorisation	The employer should ensure that authorisation guidelines for therapies are clearly issued by the practitioner.

A comprehensive action plan in response to the areas for improvement was submitted to the CQC in January 2025. The CQC have confirmed that they are assured the measures taken or planned will address the recommendations with a view to maintaining compliance with IR(ME)R in the future and they have closed the inspection.

8. Our year in numbers

Here are a few of the numbers that help to show how many people we cared for during 2024/25.

- Our Emergency Department and Urgent Treatment Centre saw 96,000 attendances.
- We cared for over 37,000 emergency admissions (excluding maternity).
- We carried out over 19,000 planned care operations.
- We saw over 646,000 outpatients, including 202,000 which were remote or virtual appointments, and cared for more than 68,000 day-case admissions.
- Over 3,100 babies were delivered at our hospital birth units or at home with support from our midwifery team.
- More than 408,000 diagnostic imaging examinations were carried out.
- Our pathology laboratories processed more than 4.5 million tests.

9. Principal risks

The principal risks to RCHT during 2024/25 primarily related to sustained operational pressures and its related impact on patient safety and staff wellbeing. Significant ambulance holds, related waiting times in the Emergency Department and challenges with flow through the hospital due to delayed discharges, presented our biggest operational and safety risks. The other key principal risks related to our ability to achieve financial recovery and achieve CIP schemes for 2024/25 and the required delivery of workforce efficiencies.

Further detail on risks and their impacts can be found in the Performance Analysis section and detail on RCHT's approach to managing risk is within the Annual Governance Statement.

Performance Analysis

1. Purpose of this section

The purpose of this section on Performance Analysis is to outline how our hospitals and services have performed during the year, in the context of our risk environment. We will focus on those areas that have been most challenging for us, and the impact this has had on our patients and staff.

We will also highlight our achievements in research, capital projects and sustainability projects, and our work with system partners to progress the priorities for the Cornwall and the Isles of Scilly. Finally, we will look forward into 2025/26 and highlight the areas we will be focussing on and their link back to our corporate strategy.

2. Our risk environment

The most significant risks to us during 2024/25 related to the sustained operational pressure particularly our acute urgent and emergency care pressures, including the continued impacts of ambulance handover delays and response times, the challenges with continued delayed discharges from our hospitals, staff sickness rates remaining high, and the ability to deliver the required workforce efficiencies whilst ensuring a workforce fit for the future whilst addressing the financial challenge. Whilst responding to and addressing the pressure on quality of care and the continued focus on improving urgent and emergency care metrics.

Recognising our staff – clinical and non-clinical – did all they could to support safe, high-quality care for our patients in the most challenging of contexts.

Urgent and emergency care risk

Numbers in the emergency department remained well above its capacity for most months of the year and patients experienced extended waits for admission to a ward. This in turn significantly impacted on ambulance handovers, ultimately resulting in longer waits for people making category 1 and category 2 999 calls (category 1 calls are for life-threatening injuries and illnesses such as a heart attack and category two calls are for emergency calls such as stroke patients). We recognised the escalation of the risk which was reflected in our ED Crowding Risk (corporate risk 9048) which was a consequence of continued longer category 2 ambulance response times, delayed ambulance handovers and poor patient flow in, through and out of our hospital. The Trust in considering this risk, and the risk to increased harm the Trust escalated the risk score from a 20 to a 25 which is the highest scoring risk in the Trust.

A key measurement of improvement is the reduction in aggregated patient delay which has seen a sustained change, but is being closely monitored through the Executive Risk Group.

Actions to deliver improvement are co-ordinated through the internal improvement programmes that link the Clinical Vision for Flow which aims to eliminate delays in every element of patients' care pathways at RCHT and the system reform programme which focuses on frailty, end of life care, discharge to assess and integrated neighbourhood teams. All of these actions are clinically led and link to the seven Urgent and Emergency Care actions being delivered across the system.

Financial and Transformation Risk

One of the significant risks in 2024/25 was the RCHT's ability to deliver a financial break-even position for 2024/25 in the environment when there was continued high number of patients with no criteria to reside in our hospitals and the number of escalation spaces that we have been required to maintain above our operational plan level and above our financial recovery plan level.

The Trust implemented a range of robust control measures and assurance mechanisms which included a monthly combined Cost Improvement Plan (CIP) and financial recovery assurance report to Finance and Performance Committee, Quality Assurance Committee and People and Culture Committee which ensured there was a clear understanding and triangulation of the actions for financial recovery and the potential impact on quality and workforce, as well as finance and performance.

These measures were successful in ensuring the Trust break even position being achieved for the sixth consecutive year in 2024/25.

During 2024/25 there was an emerging risk around management and delivery of eCare which include system, product and delivery risk which are overseen by the Senior Responsible and Officer (SRO) into the eCare Programme Board and Finance and Performance Committee and the associated work programme for 2025/26.

Changes to risk during the year

As of 31 March 2025 there were 29 extreme risks approved onto the RCHT Corporate Risk Register. These risks are reviewed regularly by the Care Group governance processes and the Executive Risk Group and monitored via the Audit and Risk Assurance Committee.

New risks added to the Corporate Risk Register included:

- 7163 Sterile Services Clean Room Validation.
- 8462 Use of ICE for blood tests in Rheumatology.
- 9534 Renewal of critical infrastructure.
- 9006 Neonatal experienced ITU and shift leader nurse staffing pressure.
- 9110 Paediatric Medical Staffing.
- 9336 Major Trauma rota gaps.
- 9346 Breast Oncology Staff Shortfall.
- 6603 Nurse Call System Age.

- 9368 Histopathology Scientific and Medical Workforce.

The Executive Risk Group also received new and emerging risks identified in relation to the eCare project.

Risks removed from the risk register include:

- 9110 Paediatric Medical Staffing.
- 8528 Diagnostic Imaging Performance and Backlogs (Capacity and Demand).
- 8519 Transitional Care Staffing Risk.
- 8729 Disruption to global supply chains causing short term shortages, delays or increased costs (EPRR).
- 8114 Cardiac Catheter Laboratory 1 Refurbishment.
- 6752 Buildings, equipment and digital infrastructure.
- 7861 Mass Cancellations.
- 8835 Risk of Industrial Action.
- 7261 Neurology Service Consultant shortage.
- 9273 National Discontinuation of E3 System.
- 8613 Trust-wide cancer waiting times performance.

Further detail on our capacity to handle risk and key risk challenges during the year can be found in the Annual Governance Statement.

3. How we measure performance

Our Performance Accountability Framework (PAF) describes the mechanisms, processes and lines of accountability which provides assurance we remain on track to achieve our corporate strategy.

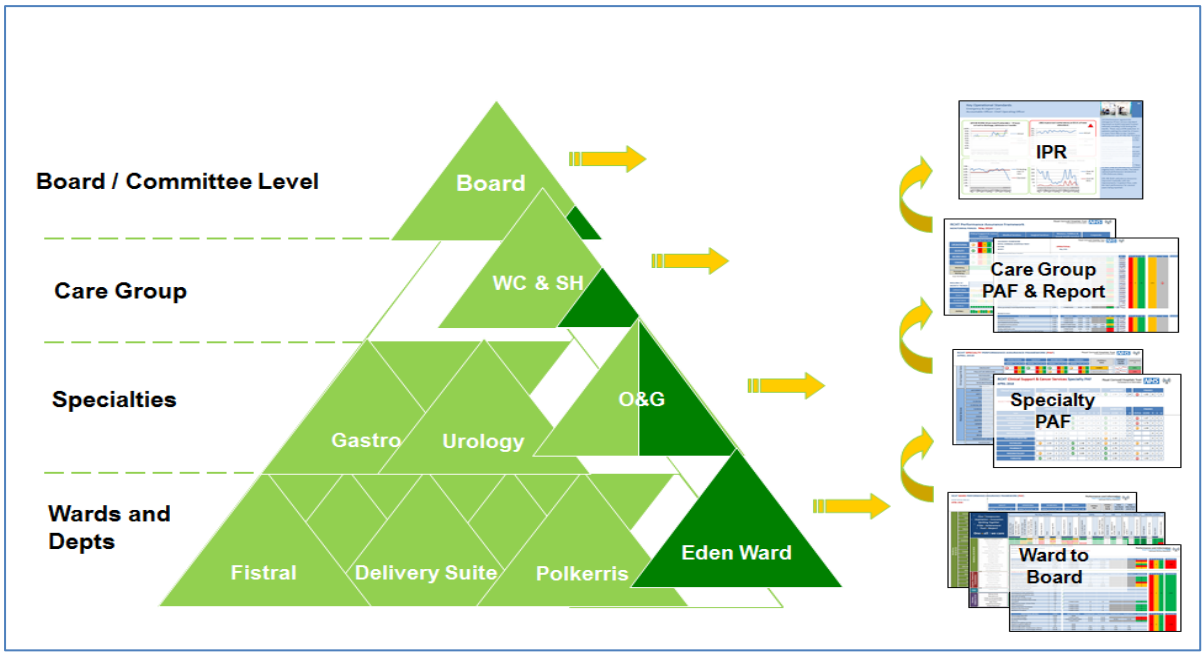
In this context, the objectives of the PAF are to:

- Provide assurance as to the delivery of the corporate strategy, at both a ‘macro’ (RCHT-wide) and ‘micro’ level (service strategies).
- Ensure performance is seen ‘in the round’ and owned at an individual, team and functional level by all.
- Ensure clear, simple and effective performance/operational management (driven by our objectives) from ‘Board to Ward’.
- Create clear and well understood accountabilities.

- Remove duplication and ‘pop up’ interventions and meetings.
- Enable appropriate oversight and assurance to govern how we are working and identify risks to performance.

The graphic below illustrates, at a high level, the ‘Ward to Board’ performance structures and the performance reporting arrangements which support the scrutiny of performance within each tier of the organisation:

Figure 1: Performance Information Escalation/Aggregation



The Integrated Performance Report (IPR) and the Care Group performance data packs are produced monthly by our Commissioning, Performance and Intelligence team.

The Chief Operating Officer is accountable to the Chief Executive for the delivery of all performance standards where responsibility for such standards sits within our clinical Care Groups. Performance meetings with our Care Groups, which consider Care Group Performance in line with our PAF, are chaired by the Chief Performance, Partnerships and Transformation Officer. Corporate Teams also participate in performance meetings, through the Corporate Performance Review Meeting.

Each year the PAF is reviewed and updated to reflect any change to reporting standards and KPIs. Amendments to the PAF for 2024/25 were:

- Alignment of the PAF to the 2024/25 priorities.
- Simplification of the PAF metrics to ensure these are focused on critical areas across people metrics, quality and safety, and financial performance.

Against the backdrop of a challenging operational environment and rising demand to meet the needs of our growing and ageing population, we have worked hard to improve our performance. We are committed to meeting the key national standards that are set to ensure patients receive the safe, timely and high-quality care they have a right to expect. The continued impact of delayed transfers of care and of industrial action have affected our ability to move as quickly as we would like to reduce delays in both emergency and planned care, but we have made progress.

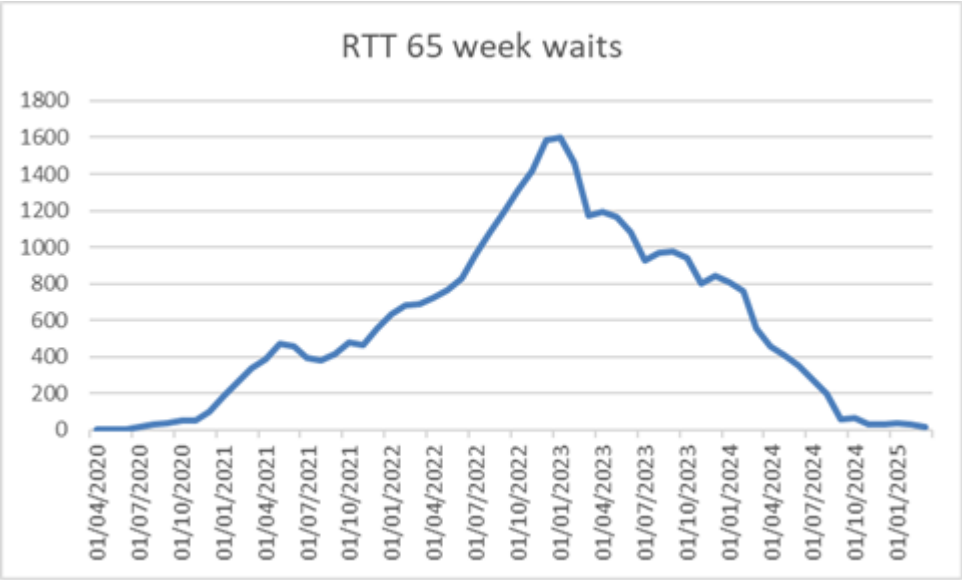
Safe, high-quality care

Reducing waiting times for people needing planned care

Over the last year our teams have continued to work hard to bring down waiting times for patients and waiting for planned operations and procedures.

We have carried out almost 81,000 procedures which is 7% percent more than we did in 2019. Almost 70% of patients go from referral to treatment within 18 weeks. In February 2025 we had the lowest average waiting times in the southwest region and the fourth lowest number of patients waiting more than 52 weeks for treatment.

The graph below demonstrates our success in reducing over 65 week waits since the peak they reached following the Covid-19 pandemic, with our focus now being eradicating over 52 week waits.



The largest number of over 52 week waiting times continues to be in trauma and orthopaedics. In the coming year we will look to create additional capacity through improved theatre utilisation and job planning. Diagnostic cardiology, where there are recruitment difficulties due to national skills shortages, has also been under significant pressure, and we continue to use insourced support to help us bring down waiting times.

Our waiting times for diagnostic tests continued to reduce, with 83% seen within 6 weeks in the first month of the year, rising to 91% by the end of the year, routinely showing the best performance across southwest acute providers.

We continue to perform strongly on our waiting time reduction, which placed us in the top 20 Trusts in the country and are already achieving the national standard for 2025/26 of less than 1% of the waiting list to be waiting over 52 weeks.

A key component of planned care recovery remains waiting list validation and a robust daily waiting list data quality process. We contact on average 7,000 patients each month who are on our waiting list for treatment and have waited more than 12 weeks (and every 12 weeks thereafter). This routinely achieves over 99.6% data quality confidence level on the referral to treatment waiting list – both of which benchmark the organisation within the top 10 providers in the country.

Elective recovery programme

Through successful bids to the national Elective Recovery Fund our patients have benefited for reductions in waiting times. These have included our collaborative projects with Cornwall Partnership NHS Foundation Trust, including the continued success of Bodmin Community Diagnostic Centre as well as West Cornwall Hospital Community Diagnostic Centre, which between them have seen over 88,772 patients since they opened and St Austell Surgical Hub which has treated over 1,200 patients since opening in November 2024.

A further independent sector operated Community Diagnostic Centre is due to opened at Camborne-Redruth Community Hospital in 2025 and we will seek to continue to bid for available elective recovery fund resource to deliver temporary and permanent electivity activity.

Outpatient transformation

We have continued the transformation of our outpatient services to improve patient experience, timely access to care, and the efficiency of virtual and face-to-face clinics.

Our patient engagement portal, Patient Hub, is now used across all specialties to notify and remind patients of their appointments. Its use has continued to grow, and we monitor its use through key demographics including age and deprivation, which both show use by 80% of patients. There is a reduction in use by people over 70 years old and those in the highest deprivation decile; any patient can continue to opt for letters by mail.

The Patient Hub portal allows us to carry out automated waiting list validation. Over 80% of patients typically respond with around 3% opting for discharge, helping us to keep waiting lists up to date. Again, we use traditional methods for patients who cannot or do not engage digitally.

In March 2025 we introduced electronic referral acknowledgement to reduce the need for posted letters and over the coming year we intend to introduce pre and post-appointment questionnaires and a ‘waiting well’ functionality to allow additions such as pre-screening questionnaires when patients are listed for a procedure, for example, to identify patients who may need pre-optimisation intervention prior to surgery. We will also be using it to help triage referrals by triggering a questionnaire when patients are listed, in the first instance for patients referred for tinnitus and hearing loss, to help individually tailor the next steps in each patient’s journey.

Over the year we have seen a continued reduction in missed appointments, at 5.6%, compared to 6.1% in 2023/24 – the equivalent of approximately 3,000 appointments. This has been achieved through improvements including electronic reminders, enabling patients to reschedule or cancel their own appointments, using artificial intelligence to identify and then better support patients at most risk of missing appointments, and flagging when a current inpatient has an outpatient appointment.

Over 65,000 patients were moved to patient-initiated follow-up or open appointments, where RCHT continues to be the top Trust in England. This empowers patients to choose when they need to be seen based on their condition and symptoms, avoiding unnecessary routine appointments and travel. We continue to exceed national standards for the percentage of outpatient appointments provided remotely, receiving high levels of patient satisfaction, with video consultation as a preference over all other consultation types.

Delivering timely urgent care

Providing safe and timely care for those in need of emergency care in our hospitals remains an absolute priority and we continue with our improvement programme to support improved patient flow and reduce delays in ambulance handovers and in the Emergency Department.

In February 2025 we implemented an updated approach to supporting patient flow by commencing the first phase of our Timely Ambulance Handover Protocol approach with a view to progressively reducing handover times to bring them back in line with the national standard of 15 minutes. We have also implemented a revised medical model of care to increase the presence of senior clinical decision makers at our times of highest demand and have engaged external support to help us take forward further changes to improve patient flow and support discharge. Both initiatives are part of our clinical vision for flow referred to later in this report.

As a health and care system we saw initial signs of improvement from these actions with ambulance handover times moving to some of the best in the southwest region during February 2025. Whilst significant further improvement is necessary to achieve the national standard, this represents a considerable improvement for patients across Cornwall. We still have some way to go before we can consistently provide the timely care we want for all our patients and recognise that some still experience unacceptable delays.

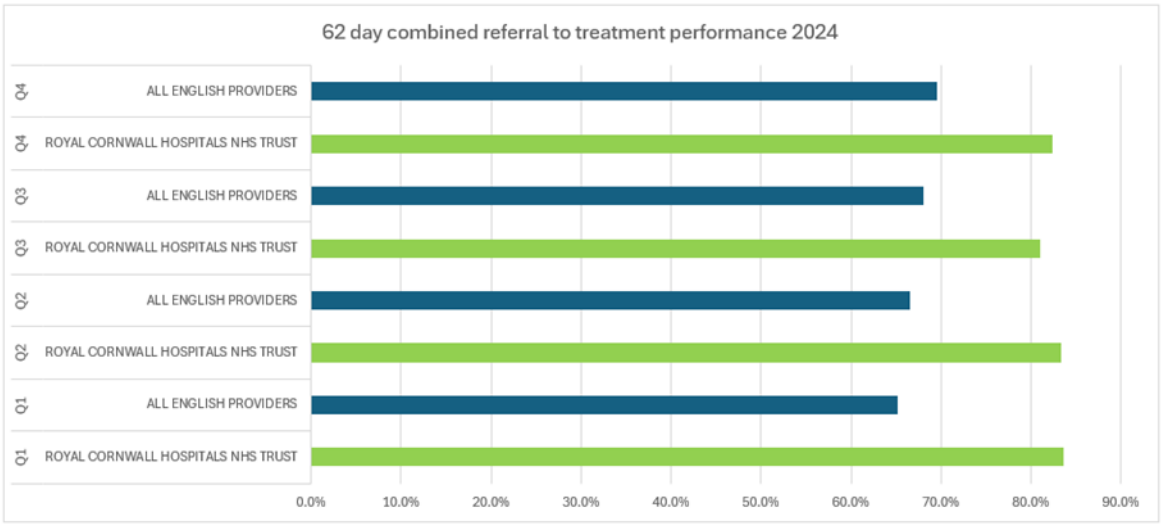
Recognising the harm a prolonged hospital stay can have on frail and elderly patients who are at risk of hospital acquired deconditioning – loss of mobility and independence - we have continued to work with health and care partners, including voluntary sector care enterprises such as Age UK, CHAOS and Cornwall HUMANS, to reduce delays in leaving hospitals for patients with onward care needs.

A focussed ‘home for lunch’ campaign launched in November 2024, seeking to minimise in-hospital delays and system ‘perfect weeks’ aimed at all partners working to increase the number of supported discharges has contributed to a lower number of patients with no criteria to remain in hospital, although not yet to the level of system agreed targets.

Continuing to improve our cancer care

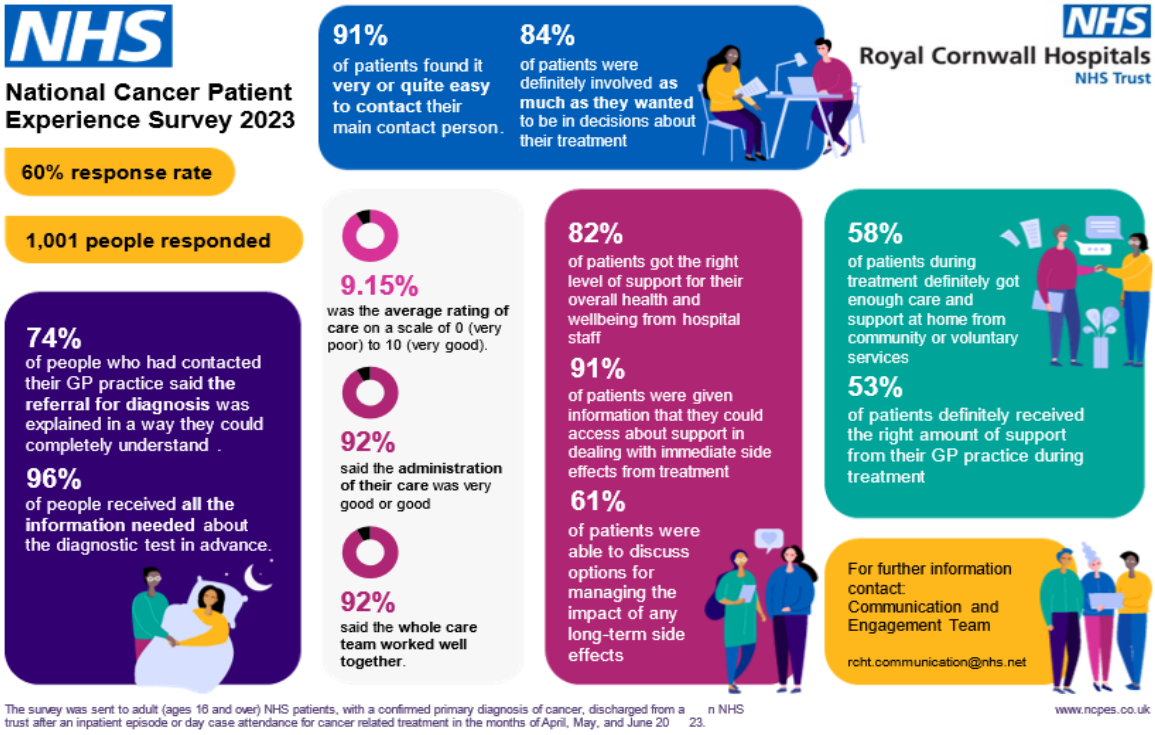
For cancer services 2024/25 was another year of improvement and innovation across a range of areas.

The most well-known targets are around national Cancer Waiting Times which are centred on time to diagnosis and time to treatment. We performed well against the England average and are regularly a top performer compared to similar sized providers.



We had another strong year in the National Cancer Patient Experience Survey. A total of 1,678 patients were invited to respond and 1,001 replied which resulted in a 60% response rate, above the national response rate. Questions can be above or below expected range and the organisation reported 30 questions out of 59 above the expected range and just one below the expected range.

There is a question specifically asking for the patient's average rating of care scored from very poor to very good. RCHT was joint seventh nationally, reporting a rating of 9.1 out of 10 against a national score of 8.9. Only thirteen Trusts had responses from 900+ patients and within this cohort, the Trust was the best scoring provider nationally for this question.



RCHT has invested in multiple cancer pathways in 2024 and this has included:

- Breast – upgrading and replacing equipment in the Mermaid Unit, which has provided an additional ultrasound room and imaging equipment to capture high quality images.
- Colorectal – are in the process of trialling a prehabilitation pathway for patients undergoing surgery to optimise their outcomes and fitness for treatment. This pilot includes a multi-disciplinary team including staff who offer physiotherapy, dietetics and occupational therapy input.
- Dermatology – the team have expanded teledermatology across the county and won an award for Health Tech Case Study of the Year in collaboration with Isla Health. This innovative service has taken care closer to home for patients and reduced time waiting to be seen for suspected skin cancer patients despite growing demand which saw the service receive over 10,000 referrals in 2024.
- Urology – towards the end of 2024, urology implemented fusion-biopsies for prostate patients. This allows a patient's MRI to be combined with real-time ultrasound to target areas of concern. This focuses biopsies on specific areas of the prostate and potentially reduces the number of biopsy samples needed.
- Lung – continuing rollout of the Targeted Lung Health Check programme which started in 2023.
- Oncology – the Late Effects Services Team which is aimed towards patients who have had radiotherapy and are struggling with pain/discomfort post treatment won two top prizes at the 2024 Radiography Awards. This included Radiography

Team of the Year for the southwest region.

The Cove Macmillan Support Centre – our cancer support centre - has gone from strength to strength since opening in 2016 with expansion to the team and the range of services offered to patients and their families. Outreach across the county has been successful including walking groups, wellbeing workshops, cold water swimming and support groups in many localities. The team uses its presence on social media to promote events and support which has generated year-on-year increased footfall into the centre and positive feedback in our patient survey.

Delivering care closer to home

A key part of our 10-year strategy is to provide more care to people closer to their own homes, something particularly pertinent in a rural and geographically dispersed population. Over the last year this has included both service and physical building developments.

Our dermatology team has continued to develop its virtual skin cancer service, offering triaging clinics in GP surgeries, reducing the need to travel whilst speeding up the diagnostic process. This is also freeing up consultants and specialist nurses to focus on those with confirmed cancers.

The opening of the St Austell Surgical Hub is not only helping us to reduce waiting times but also offers another community-based location in the east of Cornwall where patients can access low-risk surgical services. Situated on a community hospital site it benefits from easier parking arrangements and has purpose-built facilities that enable and streamline flow for patient care.

The continued development of same day emergency care and community assessment and treatment units are providing a valuable alternative to hospital admission, particularly for frail and elderly patients. These units, alongside the continued expansion of virtual wards, are providing highly successful in getting people back home, with support where needed. We know people recover more quickly and more fully in a familiar environment.

In 2025 we will see the opening of a new outpatient department at West Cornwall Hospital, transforming the environment for clinics where the outpatient team already sees around 35,000 patients every year. This £9.1m investment is a key element of our development plans for West Cornwall Hospital and the vital role it plays in provider care close to home for communities in the west of Cornwall.

We continue to work with our system partners to plan how we can deliver more care closer to home. The current areas of focus are improvements to end of life care pathways across CIOS, improvements to how we deliver care for people living with frailty and supporting our colleagues in primary care to develop Integrated Neighbourhood Teams.

Performance against national standards

The following tables show how we have performed against core national standards for people accessing our urgent and emergency care services or for those being

referred on planned treatment pathways. These compare our performance during 2024/25 with that in 2022/23 and 2023/24.

Access Standards – 2024/25	Standard	2024/25 Performance	Achieved
ED (Emergency Department) Attenders 4 hours to discharge, admission or transfer (average over 12 months)	78%	44%	x
ED (Emergency Department) 95th percentile time to initial assessment (average over 12 months)	15 minutes	33	x
ED median time from arrival to treatment (average over 12 months)	60 minutes	92	x
Cancer diagnosis to treatment - 31 days (average over 12 months)	96%	94%	x
Cancer referral to start treatment - 62 days (average over 12 months)	70%	83%	ü
Percentage of patients meeting the cancer faster diagnosis standard	77%	79%	ü
Fractured NOF operated in 36 hours (average over 12 months)	70%	36%	x
RTT (Referral to Treatment) incomplete pathways within 18 weeks (average over 12 months)	92%	68	x
RTT (Referral to Treatment) 65-week waits (March'25 end)	0	16	x
Diagnostics within 6 weeks (average over 12 months)	99%	85%	x
Average LOS (length of stay) in days (average over 12 months)	3.62	3.77	x
Same day cancellations (average over 12 months)	0.80%	1.44%	x

Access Standards – 2024/25	Standard	2024/25 Performance	Achieved
Stroke patients 90% time on unit (average over 12 months)	90%	77%	x
Admission to stroke unit in 4 hours (average over 12 months)	90%	42%	x
CT within 12 hours for stroke patients (average over 12 months)	90%	96%	ü
CT within 1 hour for stroke patients (average over 12 months)	50%	66%	ü
Non-face-to-face appointments attended (average over 12 months)	25%	31%	ü
Patient Initiated Follow-up (PIFU)	5%	10%	ü

Access Standards – 2023/24	Standard	2023/24 Performance	Achieved
ED (Emergency Department) Attenders 4 hours to discharge, admission or transfer (average over 12 months)	76.0%	44.19%	x
ED (Emergency Department) 95th percentile time to initial assessment (average over 12 months)	15 minutes	35	x
ED median time from arrival to treatment (average over 12 months)	60 minutes	98	x
ED attenders who left without being seen (average over 12 months)	5.0%	2.69%	ü
Cancer referral 2ww (average over 12 months)	93.0%	68.2%	x

Access Standards – 2023/24	Standard	2023/24 Performance	Achieved
Cancer diagnosis to treatment - 31 days (average over 12 months)	96.0%	95.5%	x
Cancer referral to start treatment - 62 days (average over 12 months)	85.0%	75.5%	x
Cancer 62-day screening (average over 12 months)	90.0%	67.7%	x
Cancer 2ww treated within 104 days of referral (average over 12 months)	100.0%	95.3%	x
Cancer referral to diagnosis within 28 days - 2ww (average over 12 months)	75.0%	69.7%	x
Cancer referral to diagnosis within 28 days - screening (average over 12 months)	75.0%	62%	x
Cancer referral to diagnosis within 28 days - breast symptomatic (average over 12 months)	75.0%	82.6%	ü
Fractured NOF operated in 36 hours (average over 12 months)	70.0%	43.6%	x
RTT (Referral to Treatment) incomplete pathways within 18 weeks (average over 12 months)	92.0%	61.9%	x
RTT (Referral to Treatment) 65-week waits (March'24 end)	0	601	x
Diagnostics within 6 weeks (average over 12 months)	99.0%	64.9%	x
Average LOS (length of stay) in days (average over 12 months)	3.62	3.99	x
Same day cancellations (average over 12 months)	0.80%	1.23%	x

Access Standards – 2023/24	Standard	2023/24 Performance	Achieved
Stroke patients 90% time on unit (average over 12 months)	90.0%	77.84%	x
Admission to stroke unit in 4 hours (average over 12 months)	90.0%	43.37%	x
CT within 12 hours for stroke patients (average over 12 months)	85.0%	95.53%	ü
CT within 1 hour for stroke patients (average over 12 months)	75.0%	63.0%	X
Non-face-to-face appointments attended (average over 12 months)	25.0%	31.32%	ü

Access Standards – 2022/23	Standard	2022/23 Performance	Achieved
ED (Emergency Department) Attenders 4 hours to discharge, admission or transfer (average over 12 months)	95.0%	43.48%	x
ED (Emergency Department) 95th percentile time to initial assessment (average over 12 months)	15 minutes	40.7	x
ED median time from arrival to treatment (average over 12 months)	60 minutes	91	x
ED attenders who left without being seen (average over 12 months)	5.0%	2.36%	ü
Cancer referral 2ww (average over 12 months)	93.0%	76.6%	x
Cancer diagnosis to treatment - 31 days (average over 12	96.0%	95.0%	x

Access Standards – 2022/23	Standard	2022/23 Performance	Achieved
months)			
Cancer referral to start treatment - 62 days (average over 12 months)	85.0%	76.4%	x
Cancer 62-day screening (average over 12 months)	90.0%	67.9%	x
Cancer 2ww treated within 104 days of referral (average over 12 months)	100.0%	93.1%	x
Cancer referral to diagnosis within 28 days - 2ww (average over 12 months)	75.0%	72.6%	x
Cancer referral to diagnosis within 28 days - screening (average over 12 months)	75.0%	69.5%	x
Cancer referral to diagnosis within 28 days - breast symptomatic (average over 12 months)	75.0%	37.5%	x
Fractured NOF operated in 36 hours (average over 12 months)	80.0%	44.29%	x
RTT (Referral to Treatment) incomplete pathways within 18 weeks (average over 12 months)	92.0%	60.9%	x
RTT (Referral to Treatment) 52-week waiters (March'23 end)	0	3144	x
Diagnostics within 6 weeks (average over 12 months)	99.0%	53.90%	x
Average LOS (length of stay) in days (average over 12 months)	3.33	4.17	x
Same day cancellations (average over 12 months)	0.80%	0.93%	x
Stroke patients 90% time on unit (average over 12 months)	90.0%	73.99%	x

Access Standards – 2022/23	Standard	2022/23 Performance	Achieved
Admission to stroke unit in 4 hours (average over 12 months)	90.0%	34.30%	x
CT within 12 hours for stroke patients (average over 12 months)	85.0%	96.26%	ü
CT within 1 hour for stroke patients (average over 12 months)	75.0%	60.32%	x
Non-face-to-face appointments attended (average over 12 months)	25.00%	31.20%	ü

5. Patient safety

Work continues to address our patient safety priorities which includes reducing ambulance handover times, improving neck of femur pathways, reviewing patient harm when referral to treatment is over 65 weeks, improving delirium assessment and management, improving the experience of discharge for patients and families, and improving support for staff following an adverse event.

We now have a designated Director for Patient Safety, who has oversight of both the delivery of the Patient Safety Incident Response Framework (PSIRF) and integration of the framework within our overall governance. Our Patient Safety Partner is now a well-established member of the Patient Safety Team, and we have plans to recruit a second Patient Safety Partner with a complimentary skill set to further broaden our independent scrutiny of patient safety, and to help us continue to improve. An external assurance report confirmed our on-going maturity in the application of our PSIRF.

We moved over to the new Learning from Patient Safety Events (LfPSE) system in April 2024. In reporting to LfPSE, we are contributing to the national picture of patient safety events in NHS England, which allows data modelling and safety alerts to be issued at scale and pace.

Never Events

We reported two Never Events between 1 April 2024 and 31 March 2025, both were investigated as a Patient Safety Incident Investigation. The incidents were different in nature but related to checking of items used during surgery. Although neither patient came to harm, there was learning regarding pre-peri and post procedural checking processes, and which has been implemented as part of safety actions following the

investigations.

More detail on our patient safety related incidents, responses and improvement plans can be found in our Quality Account 2024/25, as well as a summary of our performance against the National Quality Indicators.

6. What our patients' say

Our patients are our most important critics from whom we can learn where we are doing well and where we need to do better.

Responding to complaints, listening and making changes

Over the last year we have seen a progressive and consistent improvement in our response times to formal complaints, reaching 100% of complaints responded to on time for a full three quarters. The response rate overall for the year of 2024/25 was 90%, 5% below the target.

We received 332 formal complaints and 1464 informal complaints over the year, in comparison to 463 and 1524 respectively the previous year; a decrease in the number of formal and informal complaints received compared to the previous year. Complaints may have more than one theme, although communication remains the most common, as can be seen in the table below.

Complaint Theme	2021/22	2022/23	2023/24	2024/25
Communication with patient	124	145	191	**233**
Communication with relatives/carers	167	147	150	**190**
Attitude of Medical Staff	44	N/A	46	**58**
Attitude of Registered Nursing Staff/Midwives	50	35	51	**42**
Care needs not adequately met	64	45	44	**68**
Discharge Arrangements	55	60	52	**58**
Lack of Clinical Assessment	37	N/A	N/A	**34**
Inappropriate	34	30	N/A	**25**

Complaint Theme	2021/22	2022/23	2023/24	2024/25
treatment				
Conflicting Information	48	43	52	**63**
Discharged too early	64	N/A	N/A	**36**

During 2024/25, we received 1556 compliments or expressions of thanks.

More than 63,000 Friends and Family Tests were completed over the year. 92.98% of inpatients who completed a Friends and Family Test survey rated their care as very good or good, with 3.31% saying they had poor or very poor experience. In our outpatient services, 94.46% of those responding rated that their experience was very good or good and 2.46% rated their experience as poor or very poor.

Examples of changes that have been made in response to concerns and complaints over the last year include:

- Introduced or started work on improvements to support the deaf community. These include communication boxes with items that can be used by staff to aid communication barriers, the use of pagers or buzzers for deaf people waiting to be called into clinic appointments, a maintenance plan for hearing loop systems, and hearing loss awareness training for staff.

- A ‘You said, We Did’ patient story for the RCHT board in public to showcase actions taken in response to complaints.

- Using patient experience in ‘We walk in your shoes’ training scenarios for maternity staff.

Maternity care rates among the best in the southwest

Users of our maternity services are asked to rate their care during each part of their pregnancy. In 2024, 127 service users (43% of those sent surveys) responded to the national maternity survey. 99% said they were treated with respect and dignity and had confidence and trust in the staff caring for them. 98% said they felt sufficiently involved in decisions about their care during labour and birth.

For the overall themes of labour and birth and care from staff, our maternity services compared ‘somewhat better than expected’ to other Trusts, although the results showed us as being ‘somewhat worse than expected’ for care in hospital after the birth.

Working with the Kernow Neonatal and Maternity Voices Partnership we will develop and take forward our plans for improvement over the coming year, accepting some of the areas where we score lowest for care after birth relate to the constraints of our current buildings. The development of our new Women and Children’s Hospital will make a huge different to the experience for service users, their partners and families.

Improving our support for carers

Support for carers and changes needed to ensure our hospitals and services meet accessibility legislation were key areas of focus for our patient experience team.

During the last year a new quiet room has been created on St Mawes ward at the Royal Cornwall Hospital for carers to take some time out or to have a confidential space for more difficult conversations. We have also been working to refresh and heighten awareness among our staff of the many resources available for unpaid carers, including the Carer's Passport and access to car parking concessions.

Making our hospitals and services more accessible

During the year we have undertaken several projects to improve different aspects of accessibility, supported by our Accessibility Advisory Group.

We have opened 50 fully accessible car parking spaces in readiness for future construction work and as part of ongoing wayfinding improvements, we have increased the colour contrast on our signage and are in the process of refining our site maps to be easier to navigate.

As mentioned previously, our estates team has completed the relocation of a 'Changing Places' facility at the Royal Cornwall Hospital and is due to open a similar unit at West Cornwall Hospital in Spring 2025.

Our public facing website has remained the highest ranked NHS website for accessibility on the SilkTide Index and we have launched a new patient information leaflet template for improved readability in print and online. We are also increasing our range of 'easy read' literature.

Giving service users a greater voice

In early 2023 the patient experience team launched a Patient Leader Programme, offering patients a stronger voice in decision making and the development of services. There are currently 6 patient leaders with a plan to recruit more during 2025/26.

Key projects in which they have been involved in during the year and continuing into the coming year include the project to develop our Clinical Vision of Flow, aiming to eliminate delays in every element of patients' care pathways at RCHT, and on the hearing loss action plan taking this forward in partnership with Cornwall Deaf Centre.

We continue to work with patient representatives such as the Kernow Neonatal and Maternity Voices Partnership, our Accessibility Advisory Group and many patient support groups who bring their shared and lived experiences to informing our service developments and priorities.

7. Supported and valued people

Our people are our most valuable asset, and we are working with them to improve our culture, support their wellbeing and development, and to achieve our aim of RCHT becoming an outstanding place to work.

We have a significant challenge as we head into the new financial year with the need to stand out in a recruitment market where there are recognised national shortages, to seek greater productivity from our workforce, whilst at the same time being required to meet national targets for a reduction in our corporate support teams. Looking after our people, in every sense, will be more important than ever.

Looking after our people

What our colleagues say about working at RCHT

Over the last year we have been working with our people to respond to the feedback from the 2023 national NHS Staff Survey with our focus on four priority areas:

- Developing Compassionate Leadership.
- Improving confidence in Raising Concerns and Speaking Up.
- Reducing negative experiences in relation to Sexual Safety.
- Improving the Trust Appraisal process.

In response we formed a plan that focused on compassionate leadership, raising concerns, sexual safety and appraisals.

We launched the LEAD programme; a programme developing leaders in the culture of the organisation, with short, targeted sessions and we also focused on individual, and team approaches to communication. All programmes support the development and embedding of our RCHT values ensuring our commitment to these is understood and communicated across the organisation.

We focussed on improving the communication provision (newsletter, screen savers, regular champion bios and SharePoint page) relating to raising concerns awareness.

We are committed to the 'Sexual safety in healthcare – organisational charter' and are supporting its roll out through the recruitment of a Domestic Abuse and Sexual Violence lead and the establishment of a steering group

Responding to the need to further improve our appraisal process a new appraisal module has been included in our LEAD programme to better support managers and ensure a more consistent and meaningful outcome to objective setting and career planning.

The results of the 2024 national NHS Staff Survey were published in March 2025. Although in several areas our people reported slightly better experience than 2 years ago, our results have declined on those from the 2023 survey.

Our results show we are below the national average in all the People Promise

elements and in the broader themes of staff engagement and morale. This can be seen in the table below.

Results Summary

People Promise elements	RCHT 2024	National Av.
We are compassionate and inclusive	7.08	7.21
We are recognised and rewarded	5.84	5.92
We each have a voice that counts	6.52	6.67
We are safe and healthy	5.96	6.09
We are always learning	5.27	5.64
We work flexibly	6.07	6.24
We are a team	6.67	6.74
Themes		
Staff Engagement	6.56	6.84
Morale	5.79	5.93

We each have a voice that counts

All Scores are out of 10 (higher is better) and are calculated using subthemes made up of the questions from the survey.

People Promise

The Survey results provide valuable insight into the experience of those of working at RCHT. Given the challenging productivity and financial environment we face, we are more determined than ever to use this feedback to bring about change in partnership with our people.

In the coming year, our primary focus will be on two key areas: raising concerns and development. We want to ensure every member of our team feels safe and supported in speaking up, and that we foster an environment where people are developed to reach their full potential.

In addition to our two Trust-wide priorities, each Care Group will be tasked to identify and focus on one local priority specific to the needs and challenges of its teams. We have launched a series of events and Care Group discussions to engage teams to share thoughts and ideas on how we can improve these important areas.

Creating a safe culture in which to Speak Up

Throughout the year we have continued to increase awareness of the ways our people can raise concerns and importantly, feel safe to do so. Whilst we have made progress, we know there is still more to do, and this was reflected in our staff survey results.

Our network of Freedom to Speak Up champions has grown to 70 and towards the latter part of the year this reflects our move to integrated Freedom to Speak Up activities across RCHT and Cornwall Partnership Foundation NHS Trust (CFT).

During the year 81 Freedom to Speak Up cases were received either directly to our Guardian (47) or through the speak up App (34).

For Freedom to Speak up month in October 2024, we launched a new shared intranet site accessible to colleagues across RCHT and CFT. It offers a more engaging and easier to navigate platform, as well as easy links to Speak Up champion contacts, as well as a wide range of resources and signposts to the full range of ways in which concerns can be raised. Further awareness raising was done through walkabouts with a programme to continue throughout the year with the involvement of executive and non-executive board members.

Working towards the delivery of an outstanding health and wellbeing offer

The Health and Wellbeing of our colleagues has continued to be a priority for us.

During the last year we have continued the focus on supporting mental and emotional health for colleagues. We have seen a marked increase in requests for support in all aspects of wellbeing through our employee assistance programme and counselling support services. At the same time, we have continued to support managers in education and development around how best to engage with their teams to understand the challenges they may be facing and be in a better place to create a good working environment.

In partnership with our staff and networks we continue to explore options and ideas to create a package of health and wellbeing support which takes a holistic approach for colleagues, their managers and the organisation to support health and to sustain a good working environment for all our staff.

Financial support has been through the continued offer of salary sacrifice schemes for bicycles and cars. Changes in the national minimum wage have increased the number of staff who now qualify to take up these schemes.

We continue to support and train Mental Health First Aiders and are developing the TRiM Manager and Practitioner network. In addition, we are piloting a programme of support with the local Citizens Advice Bureau.

Interventions and support continue to exist alongside our comprehensive multidisciplinary Occupational Health department who, as well as undertaking activities such as health surveillance to identify work-related health issues at an early stage, manage a variety of referrals, both from managers and colleagues, via our

Occupational Health team.

There have been challenges for the occupational health service during the year. A national shortage of qualified occupational health specialists has made filling vacant roles and retaining staff difficult and will require decisions on future investment in the coming year. The Occupational Health and Wellbeing team continue to deliver well-being events to colleagues across all three hospital sites, as well as providing voluntary health checks throughout the year. We have linked events to national campaigns to raise awareness and continue to publish a monthly newsletter that outlines all the various health and wellbeing events locally.

Specialist occupational health nurses, physiotherapists, counsellors, and mental health nurses ensure we offer timely and responsive professional advice, support and care to our colleagues.

Developing our future workforce

In an increasingly competitive recruitment environment, training and educating our own workforce and providing opportunities to maximise the potential of our people is ever more important. Working alongside university and higher education partners we are establishing a growing number of routes into healthcare careers and continue to work toward our aim to become a university hospitals Trust.

‘Earn while you learn’ apprenticeships offer great opportunities

On average we have approximately 200 Apprentices on programmes at RCHT at any one time. In the academic year 2024/25, 35 Apprentices completed a programme and 114 commenced one.

Our first cohort of Operating Department Practitioners finished their programme with Truro and Penwith College (Greenwich University) in Summer 2024. This cohort commenced 3 years ago and are part of the principle of ‘growing our own workforce’ in theatres. Similar approaches continue to be undertaken in diagnostic Radiography where 6-degree Apprentices have graduated during this academic year.

We continue to slowly increase the number of Nursing Associates being trained. Attrition is low and pass rate is high – again with Truro and Penwith College - providing a solid foundation for future workforce provision.

T-levels opening doors for young people

We continue to provide placements for T-level Students. Our second cohort of second years completed their programme this Summer. Of the 11 Students, 5 have continued to work on Kernowflex, one is commencing Nursing Associate training and one Operating Department Practitioner (ODP) training in September. 10 students will progress to their second year this Autumn and we will continue to support them in placements. We expect the need for T level placements to grow at Cornwall College. In addition to Truro and Penwith College is aiming to commence T level programmes. We won the regional Gatsby award for our support to T level students.

An attractive prospect for student placements and preceptorships

Capacity for placements for students on pre-registration programmes has been maintained this year despite staffing challenges. This sets us up well for any increase in student numbers in the coming years as the NHS Long-Term Workforce plan is implemented.

We are proud to have been awarded the preceptorship Quality Mark and have introduced a ‘fast track’ Preceptorship Programme for nurses registering through our global nurse recruitment programme. The Preceptorship Programme recognised the previous experience held by this staff group alongside the need to be supported as they adapted to being a registered nurse in the UK. The programme focused on developing leadership skills and has resulted in conversations relating to career progression, including some interview and application preparation.

Recognising and growing the skills of our healthcare support workers

We have developed a core competency booklet for healthcare support workers moving from a band 2 to a band 3 to align with the national changes in Agenda for Change. The booklet was developed collaboratively by the Learning and Development team and Care Group-based Practice Educators, aiming to reflect practice needs in a simple easy to use format, and has so far been completed by many of our healthcare support workers across our hospitals.

Creating a safe and supportive learning environment

During the year we began the implementation of the NHS Safe Learning Environment Charter (SLEC) which was launched nationally in February 2024. The Charter ‘sets out the supportive learning environment required to allow learners to become well-rounded professionals with the right skills and knowledge to provide safe and compassionate care of the highest quality’. It is aligned to the NHS People Promise, recognising learners are a critical part of our workforce.

At RCHT, implementation of the Charter has been led by the Learning and Development team. We have completed the self-assessment matrix, developing action plans for areas where we did not score ourselves at the highest possible level, with a particular focus on ensuring student and learners know how, and feel empowered to, speak up if they have any concerns. We will use the Charter as we train and prepare new practice supervisor and A=assessors and will embed it within other quality improvement assessments and projects relating to practice placements and learners in practice.

Successfully rolling out mandatory Oliver McGowan training

On behalf of the Cornwall and Isles of Scilly Healthcare System, we have been leading the implementation of the Oliver McGowan Mandatory training. This training aims to enable healthcare workers to provide appropriately adjusted care for people with autism and those with a learning disability. A key component of the training is its co-facilitation by experts with lived experience who are either autistic or have a learning disability.

At RCHT, co-facilitators have been appointed to our in-house bank, Kernowflex, and work as part of the Learning and Development team. Consequently, not only is the training itself helping to raise awareness but working alongside experts with lived experience as colleagues and team members, has helped us to focus more on being inclusive and recognising the skills and talents that people living with autism and those with learning disabilities can bring to our team.

Embracing technology in our learning environment

We are excited to have started to use virtual reality (VR) technology in our Preceptorship Programme. This has primarily been used as an alternative to simulation training. The VR training package enables groups to participate in patient scenarios. One person undertakes the virtual scenario, and the rest of the group can watch on the big screen. They can interact and give advice and prompts making the session valuable for all, and not just the person using the headset. Similarly to simulation sessions, all scenarios have a debrief and opportunity to reflect on the experience and learning. Feedback has been positive with recognition of the benefits of this training modality.

Organisational and cultural development

Recognising cultural change takes time to embed and our 'We are RCHT' programme is a 3-year commitment, initially focused on embedding the basis of our culture, using sessions on values, leadership development, team development and tailored team sessions

Year one of the Programme included:

- LEAD (Leadership Empowerment and Accountability Development): a training package for leaders and potential leaders with support to develop their skills and knowledge.

- SAFE and Compassionate leadership programme: designed to provide skills to be compassionate leaders.

- Insights programme: a team development programme, included in SAFE and available as a standalone programme for teams. Focused on aiding retention and team working, the programme was designed to initially support RCHT, moving to a system wide programme.

- Tailored Team Development solutions: working with team leaders and managers, the OD team will design and deliver development solutions which use elements of our existing values programmes alongside our wider OD interventions.

Over the coming year our 'We are RCHT' programme will continue its year one work and expand to support the development of our equality, diversity and improvement, and health and wellbeing agenda.

Equality, diversity and inclusion

We stand firm in our intolerance to discrimination of any kind, and we are firmly committed to our equality, diversity and inclusion agenda.

National protests and a heightened level of racist incidents across the UK were a stark reminder of the discrimination faced by our black and ethnic minority colleagues. This led us to hold speak up sessions jointly with Cornwall Partnership Foundation NHS Trust to better understand the issues faced and to come together in solidarity to do our part to help create a more inclusive society. Through this we also reaffirmed our commitment to our Anti-discrimination Statement, which is referenced throughout the We Are RCHT programmes which focus on Culture, Civility and Respect.

We have 8 Employee Network Groups which are supported by the Equality, Diversity and Inclusion team and who lead on promotional and education events. These are:

- Allies Network.
- Armed Forces Network.
- Carers Network.
- Ethnic Minority Network.
- Gender Equality Network.
- LGBTQ+ Network.
- Long Term Conditions and Disability Network.
- Faith Network.

Each of our Employee Network Groups has a member taking on the responsibilities of the role of the Chair, and there is an Executive Sponsor for each network. Our Executive Directors all have an EDI objective aligning to either their operational area of responsibility, or the Employee Network Group they champion.

We have made a commitment to four objectives for 2024/28. These are agreed jointly across the Cornwall and the Isles of Scilly Integrated Care Board and Cornwall Partnership Foundation NHS Trust. The objectives will ensure we achieve the requirements of the Equality Act (2010) Public Sector Equality Duties. Our objectives include feedback from our solidarity events referred to above. They are:

- We are aware of and adaptable to meeting people's needs creatively to ensure that they have a sense of belonging and are empowered to contribute authentically within our organisation.
- We are all role models of positive behaviours, and we stand shoulder to shoulder to address bullying, harassment, and discrimination.

- We have a recruitment process that creates a diverse workforce and ensures opportunities are provided that are equitable and offers career growth for everyone.

- We will work with patient communities to make sure that they are involved in the design of services provided by us and our partners to make sure that they are accessible and well understood.

Progressing into 2025/26 we will develop our year 2 equality, diversity and inclusion focus of the 'We Are RCHT', programme to support our leaders, managers and staff with learning and development requirements. This will not only improve experiences of our staff within the workplace, but it will also impact positively upon patient care for those from marginalised groups.

The Board introduced its first Board Diversity Plan in March 2021 and since then the People and Culture Committee reviews progress on actions on behalf of the Board on a quarterly basis and the Board receives a bi-annual report.

The Board Diversity Plan is deliberately focussed on improving diversity across the Board of Director and senior staff body, recognising that diversity is a governance issue. The Trust's broader approach to Equality, Diversity and Inclusion (ED andI) is set out in the Trust Strategy and the Equality Annual Equality Report.

The requirement to have a Board Diversity Plan was set out within the NHS People Plan and it is recognised that diversity within Boards of Directors – in all its forms – enables better governance because individuals bring different perspectives, experiences and ways of thinking to help ensure well considered decisions are taken for the benefit of the population an organisation serves.

NHS England (NHSE) and the Care Quality Commission (CQC) have recognised the importance of equality, diversity and inclusion (EDI) within their forthcoming changes to the NHSE Oversight Framework and the new CQC well-led inspection framework.

An affordable and sustainable workforce

During 2024/25 we advertised 1,431 roles across our hospitals, successfully filling many vacancies, including a number in areas where there are national skills shortages. We recruited to 43 consultant posts and our Band 5 registered nursing vacancies dropped to their lowest for over 2 years, at just under 70 whole time equivalent posts.

We have seen a rise in applications for employability support and of the 21 people who successfully completed the programme with us at RCHT, 20 have gone on to secure substantive employment.

In January 2025 we held our first Discovery Day event open to anyone interested in pursuing a career in the NHS. It attracted over 300 people and was supported by more than 100 RCHT colleagues who served as ambassadors for their many different professions.

Whilst ensuring we recruit to essential posts; it is equally important we stay within our pay budget. Our workforce efficiencies and resourcing teams have been successfully reducing hourly rates of agency and locum staff for the occasions where we have been unable to fulfil shifts through our own bank and need to use them to maintain safe staffing. The average hourly rate for Band 5 registered nursing staff has been reduced by nearly £13 per hour at RCHT and nearly £18 per hour at CFT. Overall, we have been set a national target to ensure we spend no more than 3.2% of our overall pay bill on agency staffing.

Our 2-year workforce system transformation programme has been successfully completed with significant improvements to our electronic staff record, with greater access for managers and more efficient payroll transactions. We have also achieved benefits from the National Payroll Improvement Programme which has led to a reduction in payroll error rates and improved training and resources for those with team management responsibilities.

During the second half of the year, we introduced tighter vacancy and resourcing controls which continue into the new financial year. All requests to recruit are reviewed at Care Group level, with a hold on posts where there is no direct impact on patient safety and an in-house bank first approach to filling short-term, essential shifts.

In line with the Government directive, coupled with our biggest ever cost improvement programme, in 2025/26 we will need to reduce our workforce by almost 500 posts. This will include a 25% reduction in roles in corporate support services. It is expected this will be achieved through holding vacancies, redeployment and an anticipated national mutually agreed resignation or voluntary redundancy scheme. We will also be looking at options for integrating services with our NHS partner organisations, as well as potential for wholly owned subsidiaries.

Awards and achievements

Teams and individuals across RCHT have been recognised in regional and national awards over the last year. Among these were:

- NHSE Chief Midwifery Officer Silver Award and a Mariposa Lifetime Achievement Award for Bereavement Specialist Midwife, Karen Stoyles.
- NHSE Chief Midwifery Officer ‘Working together for patients’ award for Midwife Support Worker, Amanda Rosenfeld.
- Winners and finalists across 18 categories in the 2025 Cornwall Apprenticeship Awards.
- Dermatology team winners in the Health Tech Awards for their tele-triage pathway in collaboration with Isla Health.
- South West Radiography Team of the Year award for the Late Effects Services Team.

- Greener AHPs Award for Faith Toogood at the Chief Allied Health Professions Officer national awards.
- Gatsby T-Level Employer of the Year at the regional Department of Education regional apprenticeship and skills awards.
- Biomedical Scientist of the Year award for Leoni Wheeldon Dementia Nurse and Outreach Awards at the inaugural national Dementia Care Awards.
- CITS Cyber Security Lead, Martin Price, won the 2024 NHSE Cyber Contributor of the year. He was also a finalist in the National Cyber Awards NHS England Award 2024.
- RPA and Data Quality teams shortlisted for Quality Improvement of the Year at the Patient Safety Awards.
- Assistant Project Manager, Bethan Andrew was a finalist Rising Star category of the 2024 Inspiring Women in Construction and Engineering Awards.
- Roberta Fuller, shortlisted for Digital Innovator of the Year for Silent Hospital Project in the 2025 Health Service Journal Digital Awards.

During the year we piloted our new monthly Values awards where colleagues can nominate others who have been outstanding in demonstrating one or more of our Values. A full launch of the scheme will take place in during 2025/26.

Our annual in-house awards paused for a second year whilst we redesigned the scheme and seek sponsorship or charitable funding to support a new scheme to sit alongside our new Values and organisational development programme.

8. Working together with our partners and stakeholders

We have continued to develop strategic partnerships with each of our local universities over the last 3 years and these have been formalised using Memorandum of Understanding (MoU), setting out some key strategic principles for the partnerships, to ensure that the outcomes are positive for each party. These relationships have been maturing and are now starting to yield some clear and tangible outcomes alongside broader ambitions including University Hospital status.

Continuing to develop these strategic relationships holds benefits including:

- Continuing to support the education of future clinicians.
- Assisting in the recruitment and retention of senior clinicians, through joint academic appointments with research opportunities alongside clinical responsibilities.
- Supporting our strategic ambitions to pursue University Hospital Status.
- Enabling us to continue to grow our research portfolio and research income through a growing research-focused clinical workforce.

- Building our reputation within the region.
- Enabling our role as an anchor institution to better support our communities beyond the provision of healthcare.

The MoU between RCHT and University of Falmouth was agreed in May 2022 and was reviewed by both parties in 2024. The priorities set out within the MoU to explore further are:

- Arts in healthcare.
- Innovation in healthcare related design for patient benefit.
- Innovation in health and wellbeing.
- Business development and collaboration.
- Sustainability.

Current areas of work for this partnership, include:

- Exploring implementing a visiting lecturer to the University supporting architecture students in healthcare design.
- Securing agreement between RCHT, the University and our key building contractors that we can offer weeklong placements for architecture students at RCHT as part of broader social value programme. This is intended to start in September 2025.
- Continuing to develop our new digital Innovation Scout training module between the Trust and the University, to fill a market gap in the training provision for healthcare innovation.
- The University launched a new, full time Masters in Healthcare Innovation in September 2024. The priority this year will be to support students during their course through access to expertise as needed, and also to support future uptake of the course.

The MoU between RCHT and University of Plymouth was signed in November 2022 and is in the process of being reviewed in 2025. The University has seven proposed key priorities, and these are being further explored with the intention to refresh the MoU to better reflect the new strategic priorities with the University over the next 3-5 years. We continue to explore the opportunities for joint appointments with the University.

The MoU between RCHT and University of Exeter was reviewed in 2023 and formally signed by both parties. The priorities are:

- Research and teaching objectives to meet the University Hospitals Association criteria.

- Joint clinical appointments.
- Sustainability.

We are working in partnership with the university to develop a plan for a medical school for Cornwall, offering placement and a postgraduate and 4-year course based solely within Cornwall with supported routes to access for Cornish students from disadvantaged backgrounds. At this stage, we are continuing with joint engagement within the region. For RCHT, this is around securing support of the partners within the Integrated Care System. For the University, this is centred around securing the additional training allocations required within the region, and through negotiation with other medical schools around the training placement requirements.

The Trust is currently seeking to identify where there may be opportunities for joint appointments between the Trust and the University as a mutual strategic priority

A review of the University Hospital Status requirements has been undertaken in January 2025. We are confident that by the time we have reached the research funding threshold of £200k average over 2 consecutive years we will be able to meet all criteria as the partnerships progress.

Working together for a sustainable future for specialist services across the Peninsula

Through the Peninsula Acute Sustainability Programme, system partners across Cornwall and the Isles of Scilly and Devon are working together to develop service delivery models for the long-term delivery of high quality, safe, and affordable services as locally as possible.

Together our aim is to achieve this by stabilising some of our more fragile services, where we know we have skills shortages, working together to ensure we deliver the best outcomes for the population across our counties through a joined-up system of services, crossing organisational barriers.

The Peninsula Pathology Network is looking into innovative solutions that support the sustainability of pathology services, and through them can have a positive impact on other clinical services. So far, with representatives from each of the four acute Trusts in our area, we have been working to identify different options to transform pathology services across Devon, Cornwall, and the Isles of Scilly.

The aim is to make pathology services more resilient and to increase capacity by looking at what we can achieve as a group of Trusts rather than individually as four Trusts operating across five sites.

During the early part of 2025/26 an outline business case will be developed to inform our target operating model for pathology service delivery across the peninsula.

Volunteering

Our volunteers at RCHT provide a significant contribution to the quality of care received by our patients and their families, as well as supporting staff. We are proud of our volunteers over the three hospital sites and Marie Therese House, who give freely of their time and skills.

Over the last year almost 90 new volunteers have joined our volunteering teams, including 'third party' activities such as Community and Hospitals Broadcasting Network (formerly hospital radio), Kidney Care supporting the renal unit and Pets as Therapy. There are now more than 400 volunteers supporting our hospitals.

As well as approval of a strategy to support the development of our volunteering activities, we have refreshed our volunteer induction and essential training.

Volunteers have been involved in a wide range of activities including annual Patient-Led Assessment of the Care Environment surveys and representing volunteering at training and awareness events both internally and externally. More on their work can be found in our Quality Account 2024/25.

9. Financial review

Statement of Comprehensive Income

We have reported a surplus of £0.1m. For 2024/25, most of our income from NHS commissioners was in the form of aligned payment and incentive (API) contracts. These are a type of blended payment consisting of fixed and variable elements. Most of our income was from the fixed element.

The retained surplus has remained consistent with the £0.1m reported for 2023/24. A breakeven budget for 2025/26 has been approved by the Board.

Within the income and expenditure position, income from commissioners has increased by £45.0m year on year, whilst income received directly from NHSE has increased by £22.7m.

Operating expenses have increased by £63.2m year on year. £41.2m of this relates to pay changes linked to the 2024/25 pay awards, changes in pension costs and increases in workforce numbers. Additionally, drug costs have increased by £10.9m, purchase of healthcare from non-NHS and non-DHSDC bodies by £5.0m and depreciation and amortisation charges by £4.5m, year on year.

The Statement of Financial Position

The Statement of Financial Position (Balance Sheet) as of 31 March 2025 shows net assets of £253.7m. This is a £21.6m increase year on year.

We ended the year with a cash balance of £30.4m which is a £13.5m increase year on year. Cash balances can vary each year depending on the timing of receipts and payments.

We have delivered considerable improvements in estates infrastructure, medical equipment and IT systems and infrastructure through our Capital Programme in 2024/25. The total level of capital expenditure in 2024/25 was £49.2m (£43.0m in 2023/24).

During 2024/25, we made the final repayments of £0.8m against our last capital investment loan from the Department of Health and Social Care, and we did not draw further capital or revenue loans. Revenue support of £7.3m was received during the year in the form of Public Dividend Capital (PDC).

Cumulative breakeven duty

Whilst we have achieved a surplus for the last 6 years, we now hold a cumulative deficit of £21.2m at 31 March 2025. We expect to fail to achieve breakeven on a cumulative basis at 31 March 2026, but aim to recover our financial position as quickly as possible.

Other financial duties

During 2024/25, we again operated within our External Financing and Capital Resource Limits, as set by the Department of Health and Social Care.

Performance against the Better Payment Practice Code

The Better Payment Practice Code requires 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, 93.5% (96.7% in 2023/24) of non-NHS trade creditor invoices and 96.2% (91.8% in 2023/24) of NHS invoices by volume were paid on time. Note 25 to the accounts provides 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.

Cost improvement plan (CIP)

We delivered £32.5m (£28.1m in 2023/24) of cost improvement plans which was on target and 44.8% of projects were recurrent (41.4% in 2023/24).

10. Journey of Improvement

eCare - transforming how we work to help deliver safer care

During 2024/25 we have continued to progress one of our biggest transformation projects - introducing an electronic patient record across our health system. This will bring many of our digital and paper-based systems together, giving staff easier access to up-to-date patient data, reducing administrative tasks, supporting clinical workflows, and providing smoother and safer care journeys for our patients. Our electronic patient record is known as, eCare.

eCare will inform our future ways of working and will help us to provide a safer and more integrated healthcare service. For our patients, eCare will mean they will be able to access their own health record and appointment information via a patient portal, making it easier for them to manage their own health.

Over the last year we have been working with clinical and operational colleagues as well as external stakeholders to develop our system. We are now in the testing stage with staff training planned for late 2025, and an anticipated go-live date for the winter.

In preparation for eCare a comprehensive upgrade of our tech hardware is underway. Since April 2024 this has included 880 desktops, 1103 laptops, 275 monitors, 130 workstations on wheels, and 1025 mobile devices. We have also upgraded our Wifi network across our hospital sites and updated over 500,000 patient GP practices and contact details in readiness for data migration.

Staff engagement is crucial to the success of eCare, and this year has seen colleagues from our organisation as well as stakeholders from across our health system get involved in the programme. We have over 200 enlisted as Subject Area Experts to provide invaluable expertise during major programme activity and workshops, and over 650 signed up as an eCare Champion to help cascade key messages to their areas and support the change.

Our work will not end with go-live; we will continue to optimise the system once it is in place to refine and improve what we do as eCare helps us transform our services to support our vision for outstanding care for one and all.

Building for our future

The Major Capital Projects Department has continued to deliver a busy programme of planned infrastructure and estates improvement schemes over the last 12 months.

Social Value Contribution

In the last 12 months, the Major Capital Projects Department has reviewed and improved its approach to delivering Social Value for the wider community. All new major capital projects tendered by RCHT will include the requirement for a Social Value Action Plan to be developed and delivered, providing benefits that support jobs, skills and employability; the growth of responsible local businesses; working with voluntary organisations to improve the wellbeing of local people; and minimising the environmental impact of our major projects and the construction companies that help us build them.

Women and Children's Hospital Programme

The new Women and Children's Hospital, to be built on the Royal Cornwall Hospital site, is part of the national New Hospital Programme (NHP) originally announced in October 2020.

This one project represents the biggest ever single investment in the NHS in Cornwall. It will bring together most women and children's services provided by RCHT into one building to deliver the best possible experience for patients and carers.

In January 2025, it was confirmed the project would proceed as part of "Wave 1" of a refreshed and rescheduled NHP. The next step is development of a Full Business Case for approval before construction is expected between 2027 and 2030 and opening in 2031.

Some works to make way for the Women and Children's Hospital have started or completed in the last 12 months. These include:

- The Gravel Pit car park extension (required to re-provide the parking spaces to be lost due to construction work) was completed in July 2024.
- The provision of 50 fully accessible parking spaces in visitor car park 1C was completed in May 2024 to re-provide existing accessible spaces when construction work starts in the visitor car park 1A (outside the Trelawny Main Entrance).
- A two-storey modular building to the rear of The Royal restaurant, was completed in June 2024 to accommodate pharmacy staff due to be displaced by construction work.
- The relocation of the Cardiac Department, from the Link Corridor area to Trelawny Wing, began during 2024 with completion anticipated by November 2025. This scheme also involves the relocation of the Neurophysiology Department and the Fracture Clinic within the Trelawny wing to make way for the Cardiac Department.
- Early orders were placed during 2024 for an additional electrical power supply. This is required to support the new Women and Children's Hospital, and to ensure a resilient electrical supply for the whole Royal Cornwall Hospital site up until at least 2050. The programme of works to support this new supply will continue until late summer 2026.

Women and Children's Hospital digital innovation

Digital innovation and technology development is an essential part of the Women and Children's Hospital Programme, and for the delivery of all new hospital buildings.

As an introduction to “smart hospital” technologies, the Silent Hospital project ran from April to November 2024, trialling the silencing of patient call bells on the postnatal ward and delivering those alerts quietly and directly to staff-held mobile phones. The project was supported by commercial partners who provided the technology for free in exchange for a full evaluation report. The trial proved to be successful in substantially reducing noise levels, and in providing a calmer, more therapeutic environment for patients and staff. Data collected from the trial evidenced a reduction in the average length of stay of 0.5 days per patient.

Based on this initial success, the project has been successful in attracting development funding from the New Hospital Programme to extend the study for a further 12 months. The funding will also be used to explore further applications available within the system to support the digital co-ordination of facilities services such as catering and cleaning.

The project has attracted considerable interest from across the NHS and has been shortlisted for several awards including HSJ Partnership Awards and the Digital Health Tech Awards.

The Building Information Modelling (BIM) project has also continued to develop in the past 12 months. This project aims to support the consistent and effective collection of technical estates and facilities data on all new construction projects, and for the existing estate. By describing and digitally recording every aspect of the RCHT estate, and modelling the data reported, the Estates and Facilities team will develop modern digital skills to support more effective management of the physical environment.

West Cornwall Hospital Outpatient Department

Construction on a new outpatient department building at West Cornwall Hospital in Penzance is due to complete in April 2025, with the first patients using the new unit from the afternoon of Tuesday 3 June 2025.

The modern, accessible building replaces ageing and cramped facilities and will provide fit-for-purpose consultation and examination rooms, plus provision for online, virtual clinics for digitally enabled patients at home.

This is the first major building project at RCHT to have solar panels installed as part of the design to generate sustainable energy. Works of art have also been commissioned for the new building from illustration students at Falmouth University.

To support patients with disabilities and impairments, Makaton signage is being fitted within the new unit following its successful deployment in the Trelawny Scanning Suite in Truro in 2023.

A new Changing Places facility for West Cornwall Hospital will open within the existing hospital, close to the main entrance, in April 2025.

High value medical equipment replacement programme

A continuous programme of high-value medical equipment replacements and upgrades ran throughout the last year.

Cardiac Catheter Laboratory 1: This important diagnostic facility at the Royal Cornwall Hospital opened in February 2025 after an 11-month upgrade and refurbishment programme. As well as new replacement imaging and laboratory equipment, this complex project included the upgrade of the ventilation system, new staff changing rooms, and a new Changing Places facility (relocated to accommodate works in the Catheter Laboratory). This project had to be supported with the provision of a hired temporary mobile catheter laboratory whilst construction work was carried out to keep the full clinical service in operation.

Nuclear Medicine Department: The replacement of one of the Gamma cameras, and the refurbishment of the associated dispensary and scanning room, was completed in May 2024. This project has now moved to phase 2, which is to separate the “hot” (radioactive) drainage system from the general drainage system. Works are due to complete in October 2025.

Newlyn Theatre 14: The end-of-life interventional radiology equipment in Theatre 14 (Newlyn Unit) was replaced during summer 2024. The project included the full refurbishment of the theatre, the recovery unit, and the supporting storage area. Works finished in September 2024.

Linear Accelerator replacement programme: Fit out works to the radiation-protected bunker, to accommodate the delivery of a new Linear Accelerator (LINAC) in the Sunrise Centre, began in December 2024. This is part of a programme to replace both LINACs at RCHT by the summer of 2027. The new equipment is due to installed in April 2025 and, following a high-precision commissioning period, will support first patients from October 2025. A Linear accelerator uses electricity to deliver high doses of radiation to treat cancer. The machines have inbuilt diagnostic capabilities which help to target malignant cells with pinpoint accuracy.

Sterile Services Department: After a lengthy period of planning, vital work started in March 2025 to upgrade the Sterile Services Department at RCHT. As the only provider of sterile services in Cornwall, the unit is responsible for the decontamination of three million reusable medical devices a year across the county’s entire healthcare system. As well as providing decontamination services for theatres on all three RCHT sites, the service also covers Cornwall NHS Partnership Foundation Trust sites, GP surgeries, Probus Surgical Centre, and all hospital clinics and wards using re-usable sterile devices.

The upgrade and replacement works will take up to 7 months to complete, and will include a new ventilation system, improved lighting, flooring, and hygienic wall cladding, and upgraded wash and clean room facilities.

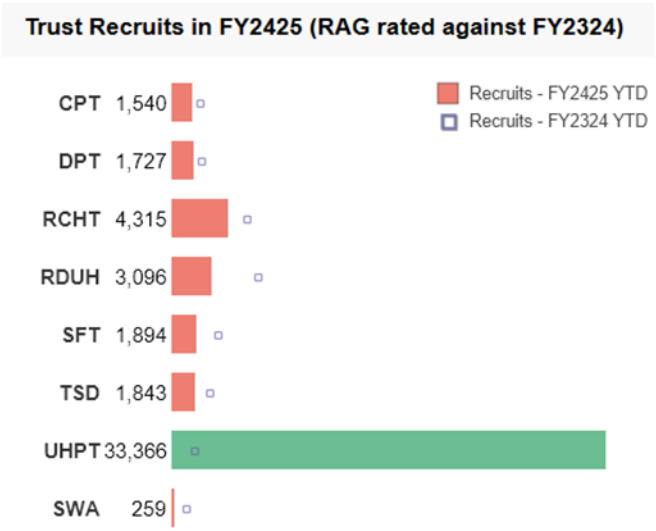
11. High quality care through innovation and research

Growing and building our reputation as a centre for research and development

Clinical research continues to be a key focus, firmly embedded within our ambition to become a university hospital and support our Research and Development (R andD) Strategy 2024/28, launched in July 2024. The strategy sets out how we intend to enhance research capabilities, integrate digital healthcare tools, and support workforce development.

Recruitment to studies

During 2024/25, we continued to demonstrate our strong performance within the southwest region.



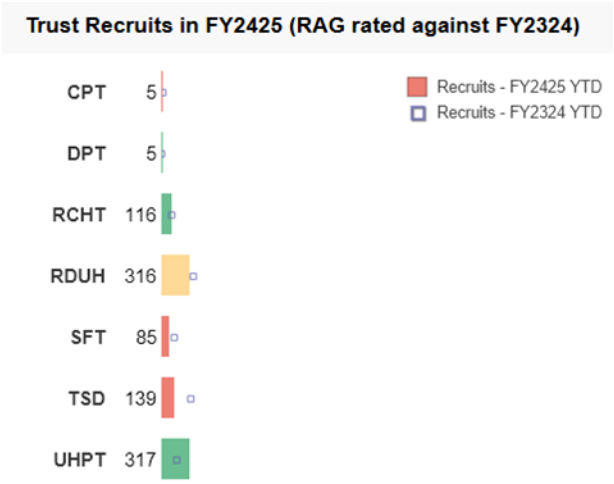
Source: Open Data Platform (ODP) NIHR SWP App Accessed 10/03/2025

RCHT fell to the second-highest recruiting site, surpassed by University Hospitals Plymouth due to its success with a non-consenting AI study in stroke prediction, which increased its recruitment by almost 31,000 participants.

Our high level of recruitment at RCHT was achieved despite considerable workforce challenges, including the unplanned retirement of the R andD Clinical Director, who was also a pivotal lead in research within the Oncology Specialty.

Commercial recruitment

Commercial recruitment remained consistent with the previous financial year, with a slight increase in the number of studies recruiting, thereby expanding opportunities for patients. As we move into 2025/26, we have a strong pipeline of commercial studies and, with the addition of several new staff members, are confident this will grow significantly.



Source: Open Data Platform (ODP) NIHR SWP App Accessed 10/03/2025

Phase One and High-Risk studies

As part of our strategy, we are committed to developing the skills and infrastructure required to conduct Phase One studies. These are studies where it is usually the first time a treatment is tested in humans and will usually investigate the safe dose range and potential side effects, how it is metabolised and whether it might work in patients.

To address the evolving landscape of research, RCHT has established a High-Risk Safety Committee to ensure effective oversight of high-risk clinical trials, including Phase I studies and Advanced Therapy Medicinal Products (ATMPs), both genetically modified and non-genetically modified.

Research funding success

The National Institute for Health and Care Research (NIHR) awarded £3.5 million for advanced research initiatives. This funding supports our ongoing research programs and will enable the expansion of several key projects in oncology, digital health, and workforce development. The investment further strengthens our commitment to delivering world-class research in collaboration with local, regional, and national partners.

This reinforces RCHT's vision of a collaborative approach to research by fostering partnerships across primary, secondary, and community care services. A pivotal achievement this year has been the formation of new strategic alliances with academic institutions and industry leaders, providing access to cutting-edge research tools and expertise.

In collaboration with the NIHR Vaccine Innovative Pathways Team, Moderna, and other partners in early 2025 we began a pilot with Mobile Research Unit (MRU). This initiative is designed to bring clinical research directly to patients, particularly in remote or underserved areas.

Equipped with state-of-the-art research technology, the MRU supports a range of clinical trials, from early-phase studies to large-scale observational research. By removing geographical barriers, it enables broader patient participation in clinical studies, improving health outcomes and ensuring greater inclusivity.

The MRU has been recognised for its flexibility and impact, allowing research to be conducted in diverse locations and enhancing patient engagement in healthcare research.

Sponsored research and grant awards

Sponsored research continues to be a core growth area. In 2024/25, RCHT led or were co-applicants for the following awards:

- IBEX Study (AI and Bone Health) – £134,000 (NIHR Invention for Innovation (i4i) Connect, awarded Sept 2024) This study focuses on using artificial intelligence to improve bone health assessment and osteoporosis management.

- GLP-1 Study (Weight Loss and Pregnancy) – £200,000 (NIHR Research for Patient Benefit (RfPB), awarded in principle) This study investigates the use of GLP-1 agonists for weight management in pregnancy.

A total of nine grant submissions were made across various specialties in 2025, amounting to £5 million in potential funding. These applications cover diverse areas such as oncology, digital health, and rehabilitation, reflecting RCHT's broad research portfolio and commitment to improving patient care through innovative approaches.

Through these initiatives, RCHT continues to advance its mission of improving patient outcomes, supporting the development of cutting-edge therapies, and positioning itself as a leader in clinical and applied research.

First integrated southwest symposium

R andD hosted the inaugural Emerging Healthcare Technologies Symposium in August 2025 with almost 200 people attending the hybrid event in person and online. This landmark event attracted attendees from across the country, including healthcare providers, academic institutions, start-ups, and industry leaders.

Publications 2024/25

RCHT researchers have made significant contributions to the academic and clinical fields through a variety of publications in 2024/25. Among the highlighted studies:

- The HAWAII feasibility trial, published in April 2024, demonstrated the feasibility of a definitive trial on antimicrobial sutures in hand trauma.

- The MONITOR-UK study, published in June 2024, found that the occurrence of grade ≥3 treatment-related adverse events in first-line patients without residual disease was lower than in phase III clinical trials.

- The REACT-CEMI study, published in July 2024, supported the use of cemiplimab for treating CSCC in a real-world setting, with results similar to previous studies but involving a broader patient cohort, including immunocompromised individuals.

- The SAMueL 2 - Stroke Audit Machine Learning study, published in August 2024, found that real-world thrombolysis outcomes are consistent with clinical trials, while identifying significant between-hospital variation.

    - The SHED study, published in August and November 2024, showed that a negative CT-brain scan after headache onset effectively rules out subarachnoid haemorrhage, supporting its use as an initial screen in the Emergency Department.

    - The OPTIMAS study, published in November 2024, highlighted the safety and efficacy of early DOAC initiation in moderate-to-severe strokes, potentially influencing future NICE guidance on stroke treatment.

    - The SUPERNOVA study, published in Lancet Infectious Diseases, provided valuable insights into the management of infectious diseases in critical care settings. This article is freely accessible online.

Additionally, a study sponsored by RCHT, Ripal, published in June 2024, explored the complex factors influencing anaesthetists' use of perioperative penicillin prophylaxis in patients with a removed penicillin allergy label, offering insights for improving penicillin use in de-labelled patients.

12. Our hospital environments, sustainability and carbon reduction

Our patient care environment

Results of the latest Patient-Led Assessments of the Care Environment (PLACE) have shown improvement across several areas across our hospitals. PLACE is an annual survey to assess the healthcare environment from a patient’s perspective, involving independent patient representatives.

Patients, together with hospital staff, review six main areas related to the hospital environment:

- Cleanliness.
- Condition, appearance and maintenance.
- Dementia.
- Disability.
- Food.
- Privacy, dignity and wellbeing.

Our PLACE results saw improvements in most areas compared to 2023 with increases in the dementia, disability, food, and privacy, dignity and wellbeing domains.

Cleanliness was on a par with last year, with the condition, appearance and maintenance area 1% down. We expect these scores to improve as we deliver the building projects happening across the Royal Cornwall Hospital site as part of the New Hospital Programme.

The assessment results have been used to formulate a themed action plan, and we are now carrying out 'PLACE-lite' mini assessments across our wards to monitor standards on a more regular basis throughout the year, and which can feed into an ongoing improvement programme.

A summary of our Patient Led Assessment of the Care Environment results.

Domain	Site % (Percent change indicated)			Trust Ave %	2023 Ave
	RCH	WCH	SMH		
Cleanliness	98.08(ê0.39)	98.99(ê0.33)	99.41(é0.69)	98.24(ê0.31)	98.1
Condition, Appearance and Maintenance	92.87(ê1.50)	94.44(ê0.82)	93.38(é1.38)	93.28(ê0.98)	95.91
Food and Hydration (combined)	88.95(é6.36)	93.98(é1.90)	90.41(é11.95)	89.38(é6.41)	90.86
Privacy, dignity and wellbeing	82.67(é3.91)	84.19(é6.29)	77.78(é6.18)	82.42(é4.25)	87.49
Dementia	80.56(3.02)	82.86(é4.85)	82.55(é11.12)	80.87(é3.74)	82.54
Disability	75.99(ê0.36)	79.48(é4.70)	80.71(é12.57)	76.58(é0.96)	84.25

A more sustainable future

As a signatory to the Cornwall Climate Emergency declaration in 2019, we continue working toward our commitment to becoming carbon neutral no later than 2030.

In February 2025 we were awarded £1.4 million in funding from the NHS National Energy Efficiency Fund (NEEF). The money is for two energy efficiency schemes that will help reduce our carbon footprint at RCHT and deliver considerable financial savings on energy use.

£1.1 million has been allocated to provide more than 8,300 additional LED lights to the Royal Cornwall Hospital in Truro, St Michael's Hospital, and Marie Therese House. This includes wireless automated self-testing emergency lighting. A further £300,000 grant is for Solar PV (Photovoltaic) panels. These will enable us to install more than 900 roof panels to generate electricity across all three sites, at Royal Cornwall Hospital, West Cornwall Hospital, and St Michael's Hospital.

As more technology solutions, such as virtual appointments and our electronic patient record, play and ever bigger role in our day-to-day activity, these will contribute significantly to reducing our carbon footprint, reducing travel, paper use and storage.

Our hospitals are significant users of energy and water.

Energy use

Resource		2020/21	2021/22	2022/23	2023/24	2024/25
Gas	Use (kWh)	42,701,555	26,363,699	34,819,130	35,126,145	31,852,617
	tCO2e	7,821.22	4,828.77	6,267,443	6,322,706	5,876,489
Electricity	Use (kWh)	9,063,608	12,675,203	10,284,849	11,782,409	12,639,520
	tCO2e	1,924.48	0	0	0	0
Green Electricity	Use (kWh) 1	29893	27384	29,755	27,649	28,396
Generated	tCO2e	-840	-769	-833	-774	-795
CHP Produced Electricity	Use (kWh)	7,941,480	4,204,460	6,550,100	5,488,834	4,670,331
Total energy CO2e		9,745.70	4,828.77	6,267,443	6,322,706	5,876,489
Total energy spend		**£2,921,476**	**£2,732,574**	**£5,684,396**	**£8,767,188**	**£5,340,049**

From 2021-22 we moved to Clean Renewable Electricity from EDF meaning all our electricity supplied from the grid is carbon free. Electricity generated onsite using our

Combined Heat and Power plant uses gas for generation and any CO2 impact is recorded as part of our overall gas usage.

Water usage

		2022/23	2023/24	2024/25
Mains	M3	165,819	170,062	173,159
Water and sewerage spend		£629,158	£661,232	£691,510

13. Right care, Right place, Right time: taking forward our clinical vision for flow

During the coming year we will be taking forward our clinical vision for flow, a programme of improvements to the way we deliver services to ensure every patient receives the right care, in the right place, at the right time. Its aim is to improve patient outcomes and experience, and to realise the benefits for our staff or working in a more effective and less pressured working environment.

Using the strapline of 'Right care, Right place, Right time', our clinical vision for flow is focussed on 4 core workstreams – Emergency Department, Short Stay (same day care), inpatient specialty and general wards, inpatient frailty – each with their own objectives for improvement and outcome measures.

Our work started in early 2025 and saw the introduction a timely handover process in the Emergency Department and a new medical model which has brought together acute medicine and frailty admissions in a single unit. The Acute Medicine and Frailty Unit operates a medical staffing rota to enable more timely assessment and diagnosis, reducing length of stay and, where appropriate, referral to community based services, as well as achieving savings through the permanent closure of a ward.

An agreed set of internal professional standards has been devised by our clinical teams. These determine the timeliness of assessment and treatment interventions, alongside expectations of how individuals and teams work together to deliver our standards.

Through Right care, Right place, Right time, we expect to bring our hospitals back to a 90% bed occupancy level, whilst also further reducing the number of wards, supported by increasing the use of community services to avoid admissions, re-admissions and length of stay. By better aligning routine daily activity such as ward and board rounds with patient flow, reducing unnecessary diagnostics and medication, and enabling our patients to be more active during their hospital stay, we will reduce delays in every part of the patient pathway and improve outcomes.

14. Our contribution to the Integrated Care System

Our role within the Integrated Care System

We play a proactive and supportive role within the Cornwall and Isles of Scilly Integrated Care System (ICS).

- We were actively involved in the refresh of the ICB Joint Forward Plan
- Relevant Executive Directors are the SRO's (senior responsible officers) for some of the system-wide transformation programmes including frailty and urgent and emergency care
- Our detailed annual financial and operational plans are fully aligned to overall system objectives.
- The Dual Chief Information Officer has a system-wide remit in terms of delivery of digital infrastructure and transformation.
- Developed joint system committee arrangements.

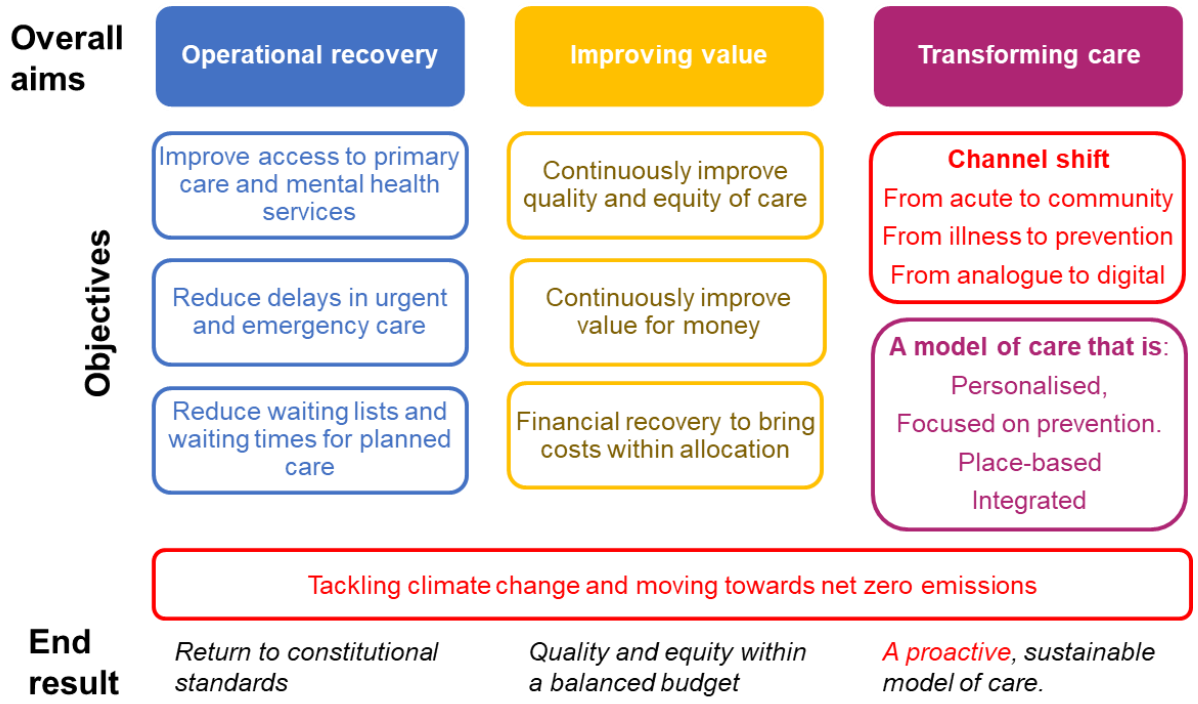
Contribution to system priorities and planning

Cornwall and Isles of Scilly (CIOS) Joint Forward Plan was agreed in March 2025. There is a statutory requirement under the Health and Care Act 2022 to review the Joint Forward Plan before the start of each financial year. It is the joint responsibility of the ICB, RCHT and Cornwall Partnership Foundation Trust (CFT) and the refresh was coordinated through the Integrated Care Board (ICB). The Joint Forward Plan is used by NHSE to inform annual assessments of the ICB. The RCHT Board approved the refresh in March 2025; this aligns with the Integrated Care Partnership's Integrated Care Strategy. It follows the strategy's vision and life course approach and describes the challenges we have to overcome as a system and how we will collaboratively recover, improve, and transform health services to meet the needs of our population over the next 5 years.

NHS England recognise that ICBs and Trusts would wish to undertake a limited refresh in March 2025 given the anticipated publication of the 10-Year Health Plan in the summer. NHS England will work with systems to develop a shared set of expectations and timetable for a subsequent more extensive revision of Joint Forward Plans, anticipated later in 2025/26.

It has been agreed to retain the current objectives of the Joint Forward Plan, but to add in two new objectives. These reflect the national ambition for channel shift (acute to community, analogue to digital, and treatment to prevention) and the national NHS commitment to sustainability and a greener NHS.

The following diagram summarises the current objectives of the Joint Forward Plan, including the two new strategic objectives (highlighted red) – channel shift and tackling climate change.



The three challenges are:

1. The consequence of the Covid-19 pandemic.
2. The changing needs of a growing population, a baby boomer effect, an increase in health problems that can be prevented, increasing health inequalities and climate change.
3. Challenges in providing care and support associated with workforce supply, resources to meet demand and our geography.

We have three areas of work to tackle the challenges.

1. Operational Improvement:

   This focuses on:

   a) Improving access to GP and dental services.

   b) Improving access to mental health services.

   c) Reducing delays in urgent care.

   d) Reducing waiting lists and times for planned care.

2. Improving Value:

   To overcome difficulties in providing care requires:

   a) A focus initially on financial recovery with a significant cost improvement programme to bring existing costs within allocation.

b) A programme of continuous improvement to ensure we get the most value from our finite resources. This will be a dedicated programme of change continuously looking for suggestions to improve value whilst transforming care as part of business as usual, utilising quality improvement and cost improvement methodology.

3. Transforming Care

Responding to our population's changing needs:

- Care reshaped around people at different stages of life.
- Integrated, focused on prevention and place based.
- Shifting where and how it is provided to meet local needs and take advantage of new technologies.
- Integrated Neighbourhood Teams joining up care across organisations and **bringing care closer to people's homes.**

Collaborative working

We continued to participate in the Peninsula Acute Provider Collaborative (PAPC). The purpose of the PAPC is to successfully work together to drive whole system acute services transformational change across the population in Devon and Cornwall – improving outcomes and performance, sharing skills and experience, making best use of scarce workforce resources, and realising tangible financial savings and sustainability.

The Board receives quarterly assurance reports on the PAPC which outline the activities and achievements of the workstreams underpinning the programme and the outputs from the phased programme (launched in 2022) which aims to ensure clinical, workforce and financial sustainability of services at the five acute hospitals in Devon, Cornwall and Isles of Scilly.

The Cornwall Hospitals and Community Health Group Provider Collaborative Committee in Common (CHCHGPC) agreed in July 2024 to recommend to both Boards that the Committee in Common transition to a Board to Board governance model to meet four times per year. It was recognised that the Board to Board meetings would provide an opportunity for the two NHS Providers to focus on strategic direction.

The Board reflected on areas of collaboration over the two years since the inaugural meeting and the benefits of the two NHS Provider Trusts working closely within the Cornwall and Isles of Scilly System and it was confirmed the organisations were much more closely aligned since the start of the Committee and that relationships had positively developed. There was recognition that during 2024/25 a formal statutory Joint Committee with the Integrated Care Board (ICB) had been established and noted the evolving ICB system governance structure as well as the changing system operating context. Both the Chief Executive and Chair of RCHT attend ICB Board meetings.

The Board recognised the value of the two Boards coming together and agreed the Committee in Common transitions to a Board-to-Board governance model to enable the two NHS Providers to jointly focus on strategic direction within the Cornwall and Isles of Scilly System and for the Boards to meet at least four times per year. There have been two meetings of the Board to Board informal during 2024/25 which have focussed on building neighbourhood teams, the development and oversight of the provider led rapid improvement actions, and the system financial challenge.

More detail on the governance structure of these collaboratives can be found in the Annual Governance Statement.

15. Reducing health inequalities

Our approach to addressing health inequalities

We are committed to reducing the health inequalities which exist across Cornwall and the Isles of Scilly. This is a core foundation within our RCHT strategy, and within the broader strategies we work towards as described by the Integrated Care Board (ICB).

We have started a programme of work to address health inequalities taking into consideration the relevant national guidance on reducing health inequalities, the 'triple aim' duty and our Public Sector Equality Duty. The Health Equalities Steering Group was launched in November 2022 and a review of the Term of Reference are being undertaken in 2025/26.

We agreed to adopt the NHS England priorities for health inequalities in January 2024. These are:

- Restoring NHS services inclusively.
- Mitigating against digital exclusion.
- Ensuring datasets are complete and timely.
- Accelerating preventative programmes.
- Strengthening leadership and accountability.

Responding to the recommendation of our local experts in Public Health, we have undertaken a self-assessment using an NHS Providers toolkit, designed to assess our maturity in tackling health inequalities and help us to identify areas which we could improve upon.

Broadly, our role within the acute considers:

- Our role as an anchor institution – how we can more broadly support our communities beyond the realm of solely providing healthcare.

- Our leadership role and clinical expertise within a complex system, in partnership supporting action to address wider determinants of health such as housing, education and employment.

- How we can best enable patients experiencing inequalities to access our services and ensure that we are meeting any particular needs experienced by those patient cohorts.

- How we can use our acute expertise to intervene earlier in pathways of care to support maintaining better health.

- How we can influence broader population health – for example through ensuring fitness for surgery, adopting Making Every Contact Count and signposting to the Voluntary, Community and Social Enterprise (VCSE) for support in the community to live healthier, active lives.

Despite the challenges around progressing our health inequalities agenda amid resourcing and operational pressures, and a sense that we need to clearer on our role as an acute provider, the toolkit has described the Trust as maturing-thriving against the following maturity matrix.

RCHT Self Assessment Score against NHS Providers Self Assessment Toolkit, completed November 2024.

Theme	Score	Percentage Complete	Maturity Level
Building public health capacity and capability	5	63%	Maturing
Data, insight, evidence and evaluation	11	79%	Thriving
Strategic leadership and accountability	14	78%	Thriving
System partnerships	10	100%	Thriving

The self-assessment recognises that we have made excellent progress in terms of our data in inequalities and how this is used, noting we have some limitations around self-reported datasets. We have good leadership and infrastructure to support taking our heath inequalities forward, and as an organisation we are well engaged in system working to continue to address health inequalities. Areas which we could look to in order to make further strides are around actively employing staff with specialist expertise in public health and inequalities (though note in Cornwall this is led by Cornwall Council); and taking action to ensure that we train all staff in health inequalities.

Key Health Inequalities Projects

Some examples of the work we have done to reduce health inequalities across Cornwall and the Isles of Scilly, include:

- Launching a mobile research van. This enables patients living in our more remote communities to participate in clinical trials without needing to travel as frequently to Truro, which was a barrier to people being willing to participate in clinical trials.

- Continued roll out of our Outpatient Transformation Programme has enabled digital access to outpatients.

- Roll out of Oliver McGowan training in learning disabilities and autism to our staff, raising greater awareness of the health and accessibility needs that some of our patients experience so that we are better able to provide care.

- Continued use of Making Every Contact Count approach – encouraging our clinicians to explore healthy lifestyle advice during routine appointments such as the importance of maintaining an active lifestyle where possible and encouraging people to stop smoking.

- We are working with our partners at the ICB and in Primary Care to review our clinical pathways. This includes developing Integrated Neighbourhood Teams, which address local health needs within their populations and understanding where there are opportunities to make impacts at a population health level using our more acute expertise.

16. Our plans for 2025/26

Our new Government means there are some changes ahead for the NHS.

We have a new government, and with that comes changing priorities for the NHS nationally and we are expecting a new 10 Year Plan for the NHS to be published in Spring 2025, which will guide how we deliver healthcare in the future. Some examples of what this means for RCHT are:

- Nationally, we are seeing a renewed focus on reducing the time that people wait for the care they receive, both for planned care, and for when people attend our Emergency Department. We need to continue to improve our local waiting times, building on the progress we have seen this year.

- There is an emphasis on moving towards digital solutions where we can, modernising our approach to healthcare. For RCHT, this is demonstrated through our plans to implement an electronic patient record which will transform our clinical note keeping and supporting our clinicians to deliver the best care.

- There is an ambition to develop more care at a neighbourhood level, meaning care is provided closer to where people live. With our partners, we need to consider how we can support delivering more acute care away from our traditional hospital settings and supporting our colleagues in primary and community care in different ways so that only people who really need to access our more specialist hospital do so.

- We have an obligation to improve how productive we are as an organisation - making the most out of the resources we have available to us, to deliver care in a cost-efficient way. This is to build on the recommendations described in the national report by Lord Darzi, published in September 2024.

As we look to 2025/26:

- We will take stock of our overarching RCHT Strategy in light of the new 10 Year Plan for the NHS, taking the opportunity to redefine our ambitions for our organisation.

- We will be developing new clinical strategies for both planned care and urgent/emergency care. These strategies will be developed by our clinical leaders, to shape the care we deliver in line with national priorities, emerging models of care and best practice, changes in technology, and addressing some of the challenges we continue to face locally.

- We will continue to work with our partners across Cornwall and the Isles of Scilly to transform our models of care, to ensure we are best meeting the needs of our population while also moving towards sustainable use of our resources.

- We will also support delivery of the Joint Forward Plan. As previously mentioned this is a Cornwall and Isles of Scilly wide document led by the CIOS Integrated Care Board which sets out how all providers of healthcare locally need to work together to address the needs of our population. The themes in this plan reflect the ongoing efforts for operational recovery (addressing the long standing impacts that the Covid-19 pandemic had on our services), improving value, transforming care, and tackling climate change.

- We will continue our ambitious transformation and improvement programmes. This includes enabling projects for our new Women and Children's Hospital, introduction of eCare, and working with our partners, for example, to improve how we deliver care for people living with frailty and patients at the end of their lives.

- We continue to operate in a financially challenged environment, we need to maintain a focus on reducing our costs in a safe and considered way and look at opportunities to become a more efficient and sustainable organisation.

In support of this, we have agreed our Annual Operating Plan for 2025/26.

The National Priorities and Success Measures for 2025/26 as per national planning guidance published 30.01.2025 are:

National priorities and success measures for 2025/26.

Priority	Success measure
Reduce the time people wait for elective care	Improve the percentage of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026, with every Trust expected to deliver a minimum 5% point improvement*
	Improve the percentage of patients waiting no longer than 18 weeks for a first appointment to 72% nationally by March 2026, with every Trust expected to deliver a minimum 5% point improvement*
	Reduce the proportion of people waiting over 52 weeks for treatment to less than 1% of the total waiting list by March 2026
	Improve performance against the headline 62-day cancer standard to 75% by March 2026
	Improve performance against the 28 day cancer Faster Diagnosis Standard to 80% by March 2026
Improve access to general practice and urgent dental care	Improve patient experience of access to general practice as measured by the ONS Health Insights Survey
	Increase the number of urgent dental appointments in line with the national ambition to provide 700,000 more
Improve mental health and learning disability care	Reduce average length of stay in adult acute mental health beds
	Increase the number of Children and Young People (CYP) accessing services to achieve the national ambition for 345,000 additional CYP aged 0-25 compared to 2019
	Reduce reliance on mental health inpatient care for people with a learning disability and autistic people, delivering a minimum 10% reduction

Priority	Success measure
Live within the budget allocated, reducing waste and improving productivity	Deliver a balanced net system financial position for 2025/26
	Reduce agency expenditure as far as possible, with a minimum 30% reduction on current spending across all systems
	Close the activity/ WTE gap against pre-Covid 19 levels (adjusted for case mix)
Maintain our collective focus on the overall quality and safety of our services	Improve safety in maternity and neonatal services, delivering the key actions of the 'Three year delivery plan'
Improve A and E waiting times and ambulance response times	Improve ED waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 2025/26 compared to 2024/25
	Improve Category 2 ambulance response times to an average of 30 minutes across 2025/26
Address inequalities and shift towards prevention	Reduce inequalities in line with the Core20PLUS5 approach for adults and children and young people
	Increase the % of patients with hypertension treated according to NICE guidance, and the % of patients with GP recorded cardiovascular disease (CVD), who have their cholesterol levels managed to National Institute for Health and Care Excellence (NICE) guidance

Board assurance statements

The Board is required to sign off the operational and financial plan and a series of assurance statements pertaining to the submissions. The current guidance requires that Boards must ensure that the planning process includes a robust Board led check and challenge process for their organisation and sign off the full plan, ahead of submission to NHS England. This must include a summary of the plan as shared with the Board as part of plan sign off, including key assumptions, trade-offs, an assessment of deliverability and a completed set of board assurance statements. The Board undertook a full assessment of the Operational Plan for 2025/26 in March 2025 as part of the approval process.

2025/26 will be a challenging year across the whole of the NHS. Within this challenging operational context, our 5 strategic and operational priorities for 2025/26 are:

- **Improving Urgent and Emergency care performance** - including making improvements to the 4 hour Emergency Department target, improvements to the 12 hour Decision to admit target, and working with our partners to reduce ambulance handover delays at our Emergency Department.
- **Improving access to elective services** - making improvements to the time patients wait for planned care).
- **Delivering ECare digital transformation**.
- Preparing for the £350m **Women and Children's Hospital.**
- **Delivering Financial balance.**

In addition to the above, RCHT will also continue to progress key existing transformations schemes such as our well-established Outpatient Transformation Programme.

We set out our Trust Strategy in November 2022. As an organisation, we have come a long way since then as we have continued to recover from the impact of the global Covid-19 pandemic. We have seen a change in Government, and with that a change in national priorities for the NHS. As previously mentioned we are expecting a new, national 10 Year Plan for the NHS to be published in the Summer of 2025. With this comes the opportunity for our Board to reconsider our strategic ambitions as a Trust. We will use this period of change as an opportunity to refresh our own Trust Strategy – building upon the progress we have made so far and redefining our ambitions for the future in line with national expectations.

Operational Plan Headlines

The NHS is facing an extremely challenging financial position in 2025/26. Whilst NHS investment is being protected by the Government over and above other public services, local budgets are still stretched because of the rising need for healthcare and increased costs.

All NHS Trusts have a statutory requirement to deliver a breakeven financial position. Alongside this, the Government has committed to improving performance for the NHS, with a particular focus upon reducing waiting times for planned care, improving flow across urgent and emergency care pathways and improving productivity.

In addition, there have been significant announcements nationally in relation to the abolition of NHS England, with the functions being absorbed into the Department of Health and Social Care, and 50% reductions in Integrated Care Board running costs. The underlying driver for these is to reduce duplication and ensure efficiency and value for money.

From an RCHT perspective, this means we are required to develop plans for 2025/26 which support delivery of improved operational performance, in the context of a constrained financial environment. Our 2025/26 Operational Plan is going to be a challenging plan to deliver, with us setting out significant improvements across both planned care and urgent care. The plan builds on the successes we saw in 2024/25, particularly for planned care.

The Trust has six key performance measures within the operational plan. We are submitting a compliant plan against all of these performance measures, as shown in the table below.

National Success Measure	2025/26 Target	Plan position
Improve the % of patients waiting no longer than 18 weeks for treatment to 65% nationally by March 2026 with every Trust expected to deliver a minimum 5% point improvement	74%	Compliant 74%
Improve the % of patients waiting no longer than 18 weeks for a first appointment nationally by March 2026, with every Trust expected to deliver a 5% improvement	82.4%	Compliant 82.4%
Reduce the proportion of patient waiting over 52 weeks for treatment to <1% of the total waiting list by March	<1%	Compliant 0.5%.
Improve performance against the headline 62 day cancer standard to 75% by March 2026	75%	Compliant 84.8% by March 2026
Improve performance against the 28 day cancer faster diagnosis standard to 80% by March 2026	80%	Compliant 83% by March 2026

National Success Measure	2025/26 Target	Plan position
Improve ED waiting times, with a minimum of 78% of patients admitted, discharged and transferred from ED within 4 hours in March 2026 and a higher proportion of patients admitted, discharged and transferred from ED within 12 hours across 25/26 compared to 24/25	78% - 4 hours 12 hour improvement	Compliant 85.8% by March 2026 Compliant – improvement in 12h performance, with 5.2% waiting over 12h by March 26

Financial headlines

The financial plan for 2025/26 is a breakeven plan at both system and Trust level. The financial and operational aspects of the plan will be highly challenging to deliver and financially high risk.

Key risks for 2025/26

There are a number of risks to delivery of our 2025/26 Operational and Financial Plan. The RCHT plan is built using well developed internal activity and finance modelling using the assumptions we have identified and agreed internally. An internal planning group comprising of colleagues across finance, workforce, performance, commissioning, and strategy have developed the plan. This has included identifying risks to the plan and mitigating actions where possible.

The plan is in the context of a continued challenging operational environment, and a continued financial challenge requiring significant transformation – as a result of this, there are a number of assumptions we have had to make about how we will deliver improvements which are not without risk. A summary of the key risks to our 2025/26 plan, as approved by our Board, are summarised below:

Financial risk

- The clear national and regional position is that organisations and systems must live within their means (within financial allocations).
- The Trust has a CIP target of £49.3m which includes 75% of recurrent schemes. This represents c7.6% of controllable budgets and will require significant transformational change including workforce reductions to achieve. An Improvement Director has recently been appointed to facilitate delivery; with schemes being subjected to a clinically led equality and quality impact assessment to mitigate the impact of our schemes on clinical service provision.
- The Trust has identified a number of investment requirements which remain unfunded business cases and we will not have any new resources in 2025/26 to resolve these. c£1.6m investment has been included in this year's plan for critical business cases.

- No new extreme risk business cases have been identified through planning, but there is a pipeline of high scoring risks which have also identified investment needs which are being managed through our risk management processes. No new investment will be possible to mitigate emerging new risks.

- There is a national review of Agenda for Change Terms and Conditions for nursing staff with the outcome of this currently unknown – any material change to bandings arising from this national review could have serious financial implications for the Trust.

- There is a risk in respect of financial income relating to elective activity as this continues to be variable and the Trust needs to deliver activity to deliver the Referral to Treatment (RTT) performance without incurring significant additional costs.

Operational and performance risk

- The Trust is submitting a compliant plan for planned care RTT, but it should be understood that this is a very ambitious plan to achieve that position, with a number of risks to mitigate. Enabling schemes to deliver this have been identified but require further planning.

- The CIP plans, which are in development assume some activity and performance reduction whilst change is implemented, which will be recovered when the productivity improvements are realised. In practice, this means the rate of improvement required through months 3-12 will be considerably higher than the rate delivered over the last 12 months.

- The Plan assumes we maximise the use of St Austell Surgical Hub.

- The Plan assumes all workforce risks to productivity, such as reducing overtime agency and bank, are mitigated.

- The ED plan assumes that any impact from planned bed closures are mitigated through reductions in Length of Stay or continued efforts to support admission avoidance.

Workforce

- There is no identified funding to support a headcount reduction through schemes such as redundancies. This means the Trust needs to focus on reducing bank and agency use and other means of reducing staffing costs to deliver the workforce savings required.

- There is a risk that the scale of the financial challenge to the organisation, amid broader ranging public sector cuts affecting NHS England and the ICB will have a negative impact upon the morale of the workforce, impacting upon staff wellbeing, turnover, and ultimately our organisational culture owing to the ongoing period of uncertainty. Mitigation is clear communications as the position becomes clearer, ensuring access to employee wellbeing services remains clear and ongoing monitoring of the culture indicators.

- There is a risk that the scale of organisational change and workforce reductions cause staff to leave increasing risk to business and service continuity as well as clinical productivity

- The ability to reduce reliance upon bank and agency is dependent upon our ability to substantively recruit to key vacancies; recruitment in CIOS has traditionally been challenging. The Resourcing Team are actively supporting Care Groups.

- Recruiting to the community workforce remains an ongoing issue across the system, which may impact on our partners' ability to support our plans, particularly access to social care impacting upon our discharges and hospital flow.

- There is a risk that a reduction in corporate services may increase workload for clinical staff thus potentially reducing clinical productivity.

Clinical and quality risks

- Our Cost Improvement Plans include closure of wards, reducing premium spend and overall workforce reductions. There is a risk that these schemes could detrimentally impact patient safety, clinical effectiveness, patient experience and safe staffing. For example:

    - Closure of wards could result in patients waiting longer in ED for a bed.

    - A significant reduction in premium spend could result in people waiting longer for their planned care.

    - Significant changes to patient pathways because of reconfiguration of services could result in patients not receiving the most clinically effective treatment (e.g. if delays to cancer pathways occur).

    - There is a risk that the cultural change required of the population to embrace the new community-based models of care may not keep pace with the speed of clinical change.

    - Individual CIP schemes will be subject to a full Equality and Quality Impact Assessment where the impact will be fully assessed. Clinical Directors are engaged in development of CIP plans with Care Groups and assist in the identification and mitigation of clinical risk.

Cross cutting risks

As previously referenced, significant national cuts have been announced to the ICB and NHSE – the impact of this on provider Trusts as yet is unclear but will lead to a significant period of instability at a system level. The scale of cost improvement needed for 2025/26 will require transformational change both within the Trust and across the system. This is in addition to the transformation described through the ICB's Reform Programme. There is a risk that we do not have the capacity to deliver the scale of transformational change needed among existing transformational programmes such as eCare, impacting upon our ability to deliver and transact the benefits described in line with our plans or trajectories.

Directors' Report 2024/25

1. Our Board of Directors

The purpose of the RCHT Board of Directors is to govern effectively to ensure we provide 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.

Our Board comprises Non-Executive and Executive Directors who together are responsible for leading the Royal Cornwall Hospitals NHS Trust. The Board brings together individuals from a variety of backgrounds and together they share corporate responsibility and accountability for all decisions that they collectively make.

The Board is responsible for the RCHT's overall performance and system of governance and control, which includes robust risk management, and therefore must seek and be provided with assurance on the effectiveness of the systems and processes in place for meeting the organisation's strategic objectives.

As determined by our Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved for the Board, the Board is comprised of the voting Directors and is therefore the most senior decision-making body of RCHT.

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 RCHT's 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 its activities in line with the Nolan Principles of Public Life.

To achieve the above objectives the Board has a range of Committees (statutory and non-statutory), chaired by Non-Executive Directors, that have key roles in relation to audit, risk, quality, safety, finance, performance, workforce and the RCHT Charity. Each of the Committees submits from the Chair of the Committee an assurance report to each public meeting of the Board (every other month), which outlines key

issues considered and highlights any risks and/or areas of development that the Board needs to be apprised of. There is cross membership between Committees to support the connection between the business of key Committees and also to seek to integrate assurance reporting where relevant. Decisions taken by the Board are in accordance with RCHT's Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved for Board, or through delegation of authority to its Committees.

The RCHT Board acts as a unitary board and as such Directors have collective 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 Chair, six Non-Executive Directors and five Executive Directors, who, as at 31 March 2025, are the Chief Executive, Deputy Chief Executive and Dual Chief Nursing Officer, Chief Financial Officer, Chief Medical Officer, and Chief Operating Officer.

As provided for in Standing Orders, 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 can be a representative from a Higher Education Institution. The Associate Non-Executive Directors supplement skills and experience to the Board to support succession planning.

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

During 2024 RCHT, in partnership with NHS England (NHSE), undertook active recruitment for a NExT Director to further enhance existing skills on the Board. The NExT Director Scheme (led by NHSE) provides support to senior people from groups who are currently under-represented on Trust Boards with the skills and expertise necessary to take that final step into the NHS board room. The focus of the scheme will be on supporting women, people from Black, Asian and minority ethnic (BAME) communities or with disabilities into NHS board roles. People with other protected characteristics that are underrepresented on boards may also be considered for inclusion in the scheme.

The NExT Director scheme gives participants a unique insight into the role and responsibilities of being an NHS Non-Executive Director by helping them to bridge gaps in their own experience such as operating at Board level, transition from Executive to Non-Executive roles, Board level exposure in organisations of huge size and complexity, as well as gain knowledge of NHS structures, accountability, how money flows, who the key partners are, where all the regulators fit and the Board's role in quality and safety. The NExT Director took up post in February 2024 for a twelve month placement and was successfully appointed, following a robust interview and assessment and commenced in post as a Non-Executive Director in February 2025. This demonstrates the success of the programme, and the Trust is launching a new campaign to recruit a NExT Director in May 2025.

The work of the Board is guided by our Standing Orders, which includes the Standing Financial Instructions and Scheme of Delegation and Matters Reserved for Board. The Board approved a number of changes to Standing Orders during 2024/25 to ensure they remain valid and responsive to changes in the external operating environment. The Scheme of Delegation details the matters reserved to the Board and those matters that are delegated to Committees or role holders.

During 2024/25, the Board met seven times in public (including the Annual Public Meeting). We publish the Integrated Performance Report in the intervening months for transparency of performance and timeliness of data for the public. The RCHT Board also met monthly in private and held three extraordinary meetings. All meetings of the Board were quorate.

The Board met either wholly virtually, during times of heightened infection rates, or in hybrid (both face-to-face and on MS Teams). The Board also made use of the provision in Standing Orders for e-governance decisions, where they were appropriate, and made two such decisions during the year. E-governance decisions are reported to formal board meetings for information.

RCHT continues 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.

- During 2024/25 the Trust averaged 50-60 viewers of our livestream Board in Public meetings which offers functionality for members of the public to ask questions and includes live subtitles to support accessibility.

- 17 questions were posed/received from members of the public to the Board during 2024/25 (24 in 2023/24); questions included those relating to our operational pressures, service provision (points of clarification), staff wellbeing, recruitment and aspects of RCHT policy.

- Recordings of our Board in Public meetings are available on our YouTube channel for a period two months (and replaced each time with the next recording).

- We promote our Board in Public meetings via Twitter and Facebook and posted appointments to staff diaries to enable colleagues to attend if able.

2. Trust Board composition as at 31 March 2025

The composition of the RCHT Board of Directors as at 31 March 2025 was as follows:

Non-Executive Directors:

David Allen OBE – Chair (voting)

David joined as Chair of the Trust Board in January 2025. David is an experienced Chair and board member having worked in the areas of healthcare and education throughout his career. He is an expert in corporate governance

and has carried out numerous governance reviews on leading universities as a private consultant. In 2012, David was awarded an OBE for services to higher education. In 2013 he was awarded the honorary degree of Doctor of Laws (LLD) by the University of Exeter, and he was elected a Fellow of the Learned Society of Wales (the land of his birth) in 2021.

Isobel Down – Senior Independent Director, Vice-Chair, Chair of Remuneration and Appointments Committee and Chair of Quality Assurance Committee (voting)

Isobel has many years' experience working as a leadership consultant and executive coach to health and care organisations and systems within the UK. Following an early career as a systems analyst in the City of London, Isobel joined the NHS in the Southwest of England, working within a variety of primary and secondary care settings, before moving into the field of HR and OD as a Director. Since 2003 Isobel has worked independently as a consultant and coach, with an extensive client base from within the health and care sector. She has a strong track record of the design and delivery of medical, nursing and managerial leadership development programmes within the UK. Isobel, in addition to her role as Senior Independent Director and Vice Chair is also the NED responsible for Doctors Disciplinary and in her capacity as Chair of Quality Assurance Committee is the Patient Safety Non-Executive Director.

Adam Broome – Chair of Audit and Risk Assurance Committee (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. In his capacity as Chair of Audit and Risk Assurance Committee, Adam is the Security Management Non-Executive Director.

Richard Kramer – Chair of Charitable Funds Committee and Chair of People and Culture Committee (voting)

Richard Kramer joined the Trust Board in May 2024 from the disability charity, Sense and Sense International, where he served as Chief Executive between 2013 and 2025. Prior to joining Sense, Richard was Director at Turning Point and held a number of director-level positions, across policy, campaigns, business development. He led the department that developed the innovative Connected Care model, which involved members of local communities in the design and delivery of health and social care services. Richard was a Trustee of Respond for ten years, a Trustee of Whitefield Academy Trust for seven years and is a former board member of the Campaign to End Loneliness. Richard is the Freedom to Speak Up NED Champion and is the Non-Executive Director Wellbeing Guardian.

Adrian Davis - Chair of Finance and Performance Committee (voting)

An experienced Non-Executive Director, Adrian joined the Trust in June 2024. As a former firefighter, Adrian brings a wealth of major incident and emergency planning experience to our Board. He has previously been a multi-agency gold incident commander and a chemical, biological, radiological, and nuclear gold commander. Adrian holds a master's in business administration. He is a member of the Institution of Fire Engineers.

Matt Hill, Non-Executive Director (voting)

Matt graduated from the University of Nottingham Medical School and trained in the UK, South Africa, Australia and New Zealand before becoming a Consultant Anaesthetist at University Hospitals NHS Trust in 2008. He has a particular interest in patient safety, safety culture and quality improvement and has worked at a regional and national level. He was National Clinical Advisor on Safety Culture at NHSE and works with the team on the Perinatal Culture and Leadership Programme and is supporting this ongoing work with the Health Innovation Networks. Matt is a Health Foundation Generation Q Fellow and has postgraduate qualifications in Quality and Safety, Leadership (Quality Improvement). He is an Honorary Fellow at the University of Plymouth where he previously ran the Quality Improvement and Patient Safety module of the Masters in Healthcare improvement and Patient Safety. He was a founding member of the Health Foundation Q Initiative. Matt is the Maternity Board Safety Champion and Chairs the Organ Donation Committee.

Uzma Bozai (voting)

Uzma joined the RCHT Board as a NExT Director in February 2024 and became of Non-Executive Director in 2025. Uzma brings 20 years' experience of taking startups from seed to sale, growing multi-disciplinary teams and running operations of multiple small businesses. Uzma spent her early career in campaigning, communications and fundraising for a leading international non-governmental organisation (NGO) and in the public sector. She has spent the last 12 years building a sustainable fashion brand supporting local artisan communities and collaborating with charity partners to launch collections with social impact.

Aled Jones – Associate Non-Executive Director (In attendance)

Aled Jones is Professor of Patient Safety and Healthcare Quality and Head of School (Nursing and Midwifery) at the University of Plymouth.

He is an international expert on patient safety and healthcare quality, leading and participating in research, exploring the interface between workforce deployment, workplace culture, patient safety and staff wellbeing.

Current research focusses on evaluating the implementation of several initiatives aimed at improving patient safety in a range of different contexts, including mental health and midwifery settings.

He has advised a number of healthcare organisations in the UK and internationally, including contributing to the Welsh Government 'Speak Up Safely' advisory group and being an expert advisor and contributor to the United Nations (ODC) Guidance on Speaking Up in Healthcare.

Aled is the NHS People Promise Board Level Champion which is a role recommended to support and drive the delivery of the NHS People Promise.

Executive Directors:

Steve Williamson – Chief Executive (voting)

Steve has significant executive experience leading hospital and health services and has held senior roles in hospitals in Portsmouth, Southampton, South Tyneside and Australia. His most recent appointment was Chief Executive of Central Queensland Hospital and Health Service in Australia, a role he held for 5 years. In this role he was responsible for 12 hospitals and community health services across a region of 110,000 km2.

Kim O'Keeffe – Deputy Chief Executive and Dual Chief Nursing Officer (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.

Dr Meridith Kane – Chief Medical Officer (voting)

Merry joined RCHT in November 2024 from Somerset Foundation Trust where she held the role of Deputy Chief Medical Officer, Medical Director for Acute Hospitals (Somerset), Responsible Officer Yeovil District Hospital and Consultant Paediatrician. Merry provided paediatric outpatient care with a special interest in urology and nephrology. Merry is an experienced board member and offers executive, strategic, and operational leadership to the Trust, however it is her experience as a clinician that keeps patients and families at the heart of her decision making.

Robin Jones – Chief Operating Officer (voting)

Robin joined RCHT in March 2019 as a General Manager before becoming the Deputy Chief Operating Officer later that year. Robin is passionate about the need to make our operational delivery patient centred and works with clinical colleagues to deliver the principles of the right patient to the right place at the right time. Whilst working at RCHT, Robin has led the operational response to the Covid-19 pandemic and is now focused with teams on our recovery from the impacts of the pandemic. Prior to joining RCHT Robin worked in a number of NHS Trusts in operational roles between clinical support services and Urgent and Emergency Care, his NHS experience also includes Private Patient Services and Procurement.

Ian Dean – Chief Finance Officer (voting)

Ian joined Royal Cornwall Hospitals NHS Trust after relocating to Cornwall in 2017 and commenced in post as Interim Chief Finance Officer in January 2024 and also acts as Charity Treasurer for the Royal Cornwall Hospitals Charity.

Ian's NHS career began in 1999 as a trainee accountant in Lancashire. Over the last 24 years he was worked in NHS clinical commissioning groups and NHS Trusts and was Head of Management Accounts at the George Eliot Hospital and then Associate Director of Finance at South Warwickshire NHS Foundation Trust.

Ian is a CIMA qualified accountant and is currently part of the National NHS Finance Leaders Talent Pool programme.

For completeness, Executive Directors expected to be regularly in attendance at Board meetings as at 31 March 2025 were:

- Kelvyn Hipperson, Joint Chief Information Officer.
- Alison Thorne-Henderson, Dual Chief People Officer.
- Ella Stracey, Chief Performance, Partnerships and Transformation Officer.

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

3. RCHT Board Directors' Terms of Office and Changes during 2024/25

Members of the RCHT Board during 2024/25 and their terms of office are provided in the table below:

Board Member	Voting or non-voting	Position	Period	Change to member-ship (where applicable)
Non-Executive Directors				
Mairi Mclean	Voting	Chairwoman	7 January 2019 to 6 January 2025 (as Chair)*	Leaver
David Allen OBE	Voting	Chair	7 January 2025 – 6 January 2028	Joiner
Richard Stephenson	Voting	Non-Executive Director (Vice-Chair)	17 February 2020 to 16 February 2025	Leaver

Board Member	Voting or non-voting	Position	Period	Change to member-ship (where applicable)
Andy Whitfield	Voting	Non-Executive Director	1 June 2023 to 31 May 2025	Leaver
Adam Broome	Voting	Non-Executive Director	16 November 2020 to 15 November 2025	N/A
Isobel Down	Voting	Non-Executive Director (Senior Independent Director, Vice-Chair)	10 February 2022 to 9 February 2026	N/A
Richard Kramer	Voting	Non-Executive Director	01 May 2024 – 30 April 2026	Joiner
Adrian Davis	Voting	Non-Executive Director	01 June 2024 – 31 May 2026	Joiner
Matt Hill	Voting	Non-Executive Director	01 November 2024 – 31 October 2026	Joiner
Uzma Bozai	Voting	Non-Executive Director	17 February 2025 – 16 February 2027*	Joiner
Associate Non-Executive Director				
Aled Jones	Non-voting	Associate Non-Executive Director	1 May 2023 to 30 April 2025	N/A
Executive Directors				
Steve Williamson	Voting	Chief Executive	10 January 2022 to date	N/A
Kim O'Keeffe	Voting	Deputy Chief Executive and Dual Chief Nursing Officer	1 May 2017 to date	N/A
Ian Dean	Voting	Chief Finance Officer	15 January 2024	Joiner

Board Member	Voting or non-voting	Position	Period	Change to member-ship (where applicable)
Allister Grant	Voting	Chief Medical Officer	1 November 2019 to date 31 October 2024	Leaver
Meridith Kane	Voting	Chief Medical Officer	1 November 2024 to date	Joiner
Robin Jones	Voting	Chief Operating Officer	15 June 2022 to date	N/A

*For completeness:

- The Chair of the Board, Mairi McLean, was also a Non-Executive Director between 13 January 2014 to 12 January 2020. Between May 2018 and 7 January 2019 of this period, Dr McLean was Acting Chair of the Board.
- Ian Dean, Chief Finance Officer was Interim from January 2024 to August 2024 when he became substantive.
- Uzma Bozai joined the Board 20 February 2024 – 16 February 2025 as NExT Director.

For completeness, the following directors were in attendance at RCHT Board meetings for all or part of the year:

- Kelvyn Hipperson, Joint Chief Information Officer
- Ella Stracey, Chief Performance, Partnerships and Transformation Officer
- Alison Thorne-Henderson, Dual Chief People Officer

Board members' attendance at Board in Public and Board in Private is summarised below:

Non-Executive Directors	Board in Public (including APM) meetings attended	Board in Private meetings attended
Mairi McLean (Chairwoman)	5/5	11/11
David Allen (Chair)	2/2	5/5

Non-Executive Directors	Board in Public (including APM) meetings attended	Board in Private meetings attended
Adam Broome	7/7	14/16
Richard Stephenson	5/6	13/13
Richard Kramer	6/7	11/14
Adrian Davis	6/6	10/13
Isobel Down	7/7	16/16
Matt Hill	3/3	6/7
Uzma Bozai	1/1	3/3
Aled Jones (Associate)	3/7	7/16

Executive Directors	Board in Public meetings attended	Board in Private meetings attended
Steve Williamson (Chief Executive)	7/7	16/16
Kim O'Keeffe	6/7	14/16
Meridith Kane	3/3	6/7
Ian Dean	7/7	16/16
Robin Jones	7/7	16/16

It should be noted that not all Board members were eligible for all meetings due to their effective date of employment or leave date.

4. Board Committees

The RCHT Board has the following Committees and some information on the role of each of the Committees is provided:

- Audit and Risk Assurance Committee:

  This Committee has oversight responsibilities, and where appropriate, facilitates and supports the attainment of effective internal control processes. It oversees the risk management system of RCHT. The Committees Terms of Reference (ToR) map to the HFMA Audit Committee Handbook. Day to day responsibility for operational risk management is delegated to senior managers throughout RCHT and their responsibilities are set out in RCHTs Risk Management Strategy and Policy.

- Remuneration and Appointments Committee:

  This Committee seeks to identify and appoint candidates to fill all very senior manager (VSM) positions and to determine the remuneration and other conditions of service for VSMs. The Committee will on occasion review the circumstances of other staff outside VSMs in line with its Terms of Reference. The Committee is also responsible for ensuring there is a robust Fit and Proper Persons Policy for the Board of Directors and for reviewing the overall composition and skills mix of the Board.

- Quality Assurance Committee (which includes a 'Part 2' Committee with Cornwall Partnership NHS Foundation Trust; where both organisations' Quality Assurance Committee meets at the same time with the same agenda and is subject to their own quorum and decision-making arrangements):

  The Quality Assurance Committee is responsible for seeking assurance on behalf of the Board about quality, safety, patient experience and RCHT's registration with the Care Quality Commission.

- Finance and Performance Committee:

  This Committee seeks assurance on behalf of the Board on the RCHT's financial management and organisational performance, business planning, estates and facilities management and digital infrastructure.

- People and Culture Committee:

  The People and Culture Committee seeks assurance on behalf of the Board on all aspects of workforce and organisational development supporting the provision of safe, high quality, patient-centred care.

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

- Charitable Funds Committee:

  As RCHT is the sole Corporate Trustee of the Royal Cornwall Hospitals Charity, the 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.

  The Board also participates in one Provider Collaboratives through committees in common governance structures:

  - Peninsula Acute Provider Collaborative - The Cornwall Hospitals and Community Health Group Provider Collaborative met in July 2024 and recommended to the Board (September 2025) to stand down this meeting. This took immediate effect.

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. The 2024/25 annual reports from each Committee, including annual self-assessment analysis, were presented to the May 2025 Board in Public meeting.

5. Membership of the Audit and Risk Assurance Committee

The membership of RCHT's Audit and Risk Assurance Committee includes the Chairs of all the Board's Committees and requires that at least one Non-Executive Director, if not one of the Committee Chairs is a qualified accountant; this is as set out in the HMFA Audit Committee Handbook (which was updated in March 2024).

Only Non-Executive Directors are members of the Committee. Per best practice, the Chair of the Board is not a member of the Committee. Membership of the Committee as at 31 March 2025 was:

- Adam Broome (Committee Chair).
- Adrian Davis (Chair of Finance and Performance Committee).
- Isobel Down (Chair of Quality Assurance Committee).
- Richard Kramer (Chair of Charitable Funds Committee and People and Culture Committee).

Several other colleagues were regularly in attendance at the Committee meetings including the Chief Finance Officer, Deputy Chief Finance Officer, Financial Controller, Deputy Chief Executive and Chief Nursing Officer, Director of Nursing, Midwifery and Allied Health Professionals, Chief Medical Officer, external audit, internal audit and the Counter Fraud lead.

During 2024/25, the Committee reviewed at each meeting the Board Assurance Framework (strategic risks) and Corporate Risk Register and also receives reports from the counter fraud lead, internal and external audit.

Where there were limited assurance internal audit 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.

RCHT's external auditors provide progress reports to each Audit and Risk Assurance Committee meeting highlighting key issues such as value for money, going concern, sector updates, and availability of capital. The external auditors also share best practice information thus enabling us to continue to make improvements.

In line with the good governance and as set out in the HFMA NHS Audit Committee Handbook, we 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, counter fraud and finance and key outcomes were presented to the May 2025 Board in Public.

6. Directors' Interests

The Register of Directors Interests is available to the public at: Register of Board of Directors Declarations of Interest (cornwall.nhs.uk)

7. 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.

8. Modern Slavery

Our commercial income does not reach the £36million threshold at which we are required to prepare an annual slavery and human trafficking statement. However, we ensure through our procurement policy and practices that we support ethical business practice. The Trust has developed a Modern Slavery statement which will be issued in 2025/26.

The RCHT Procurement Policy reads: 'all staff involved with procurement have a responsibility to strive to achieve best value and comply with Standing Orders, Standing Financial Instructions, Procurement legislation, Code of Conduct for NHS Managers, Standards of Business Conduct, the Bribery Act, and be guided by the Chartered Institute of Purchasing and Supply (CIPS) Code of Ethics (copy available via the CIPS website).' This includes, with the Code of Ethics, a commitment to '*eradicating unethical business practices including bribery, fraud, corruption and human rights abuses, such as modern slavery and child labour".*

In support of RCHT's Procurement Policy, all purchase orders issued by RCHT are accompanied by the Standard NHS Terms and Conditions, which state the supplier shall:

- Comply with all relevant Law and Guidance and shall use Good Industry Practice to ensure that there is no slavery or human trafficking in its supply chains; and

- Notify RCHT immediately if it becomes aware of any actual or suspected incidents of slavery or human trafficking in its supply chains.

From a staff and patient perspective, our Safeguarding Adults Policy and Safeguarding Children Policy highlights modern slavery as one of the ten categories of abuse. RCHT's Adult Safeguarding Lead professionals are our leads for Modern Slavery. All concerns about adult Modern Slavery must be raised to our Safeguarding team who report concerns using the local reporting processes. If it is a life-threatening concern, the policy is clear that staff must use emergency services and dial 999. For children, in any case, where trafficking or modern slavery is suspected, staff also complete a safeguarding children referral and ensure the National Mechanism Referral (NRM) form is completed. The NRM referral is usually completed by either social care or the police, but RCHT and Cornwall Partnerships NHS Foundation Trust staff ensure this happens.

9. Directors' Statement

Each Director of RCHT confirms that 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 she ought to have taken* to make himself/herself aware of any such information and to establish that the auditors are aware of it.

Royal Cornwall Hospitals NHS Trust Annual Governance Statement for NHS Trusts 2024/25

1. 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*.

2. 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 the 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 2025 and up to the date of approval of the annual report and accounts.

3. Capacity to handle risk

Risk leadership

RCHT is committed to 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 Trust's commitment to good risk management extends to all levels of the organisation and all new staff are offered at induction an introduction to the key principles of risk assessment and risk management.

Our Risk Assessment and Management Strategy and Policy states that RCHT Board of Directors has 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 provides leadership on risk management and in particular:

- Determines the risk appetite for RCHT; (Board Assurance Framework and was approved by the Board in April 2023, and risk appetite was reviewed in June 2024).

- Ensures the approach to risk management is consistently applied.
- Seeks assurances that risks have been identified, assessed and all reasonable steps taken to manage them effectively and at sufficient pace.
- Via its assurance Committees, reviews the relevant principal risks within the Board Assurance Framework (BAF) and any gaps in assurance at each meeting.
- Approves the Annual Governance Statement, which assures the organisation has the necessary controls in place to manage its exposure to risk;.
- Approves the Risk Management Strategy and Policy, as a matter reserved to the Board (last approved June 2023).

The Audit and Risk Assurance Committee scrutinises the robustness of RCHT's systems for risk management and internal control and on that basis undertakes a review of the Board Assurance Framework (at every meeting and meetings of the Committee are held bi monthly), which details RCHT's principal risks to achievement of our strategy, and Corporate Risk Register (including deep dives), with referral on to the Board for approval (in public).

On behalf of RCHT Board, the Chief Executive is the accountable officer with overall responsibility for risk management. The Chief Nursing Officer / Deputy Chief Executive is responsible, via delegated authority from the Chief Executive, for RCHT's overall approach to risk management and, in turn, delegates day-to-day responsibility to the Director of Nursing, Midwifery and Allied Health Care Professionals

Day to day responsibility for operational risk management is delegated to senior managers throughout RCHT and their responsibilities are set out in the Risk Management Strategy and Policy. The Executive Risk Group reviews all new risks proposed for the Corporate Risk Register, on behalf of the Executive Leadership Team. Operational management of risk is through Care Group Boards/Governance meetings and through Care Group Risk Surgeries.

The Company Secretary is responsible for coordinating the development and updating of the Board Assurance Framework and risk appetite on behalf of the Board The nominated Executive Director lead is responsible for the content of the relevant BAF principal risk and for providing assurance to the Board on the controls and mitigations in place and on actions to address any gaps in assurance.

Risk training

We employ appropriately qualified staff who specialise in risk management to advise and support RCHT in implementation of the risk assessment and management strategy and policy and the processes that support it. In addition to training at induction, general 'risk management' awareness training is provided by the Risk Manager through the Care Groups and Corporate directorate structures. Risk management and assessment refresher training is available in RCHT's training programme via the Electronic Staff Record and through bespoke training sessions. Colleagues can also undertake more detailed training in health and safety and fire awareness using RCHT's package of e-learning. Board level training is delivered via the annual review of RCHT's risk appetite.

During 2024/25 the training offering included action planning training to enable staff to link incident to risks and generate more effective action plans; for both risk and incident management and to comply with the requirements of the Patient Safety Incident Review Framework (PSIRF).

4. The risk and control framework

4.1 Risk Management Strategy and Policy overview

We have a Risk Assessment and Management Strategy and Policy which was last approved by the Board in June 2023. The Board reviewed its risk appetite annually, however in 2024/25 did not make any changes to this risk appetite statements. The level of risk RCHT is prepared to accept or be exposed to will vary according to the nature of the risk, the context within which RCHT is operating and regulatory or legislative constraints. RCHT therefore identifies both its risk appetite and its risk tolerance as set out within the policy.

Following a comprehensive review in 2022/23, RCHT carefully considered and redeveloped its risk appetite statements to reflect the corporate strategy and refreshed Board Assurance Framework. The final risk appetite statements were approved by the Board in April 2023 and RCHT's risk appetite is mapped to the elements of its Board Assurance Framework, plus an additional, specific risk appetite statement on reputation. The current statement of risk appetite by risk type, including a guide to the level of risk that may be considered as tolerable, is summarised in the below table.

The Board reviewed its risk appetite in June 2024 and determined no changes and it is scheduled to review its risk appetite statements in June 2025 with a view to amending the amount and type of risk that the organisation is willing to take in order to meet its strategic objectives in light of the current financial and operational context. This includes both national context as well as locally i.e. in setting the Annual Plan for 2025/26 and the refresh of the Trust Strategy taking place in 2025/26 (commenced in 2024/25).

Risk Type	Risk Appetite
Safe and high-quality care RCHT has a low tolerance for risk which compromises patient safety and jeopardises compliance with our statutory duties for quality and safety. In order to achieve safe, high-quality care, RCHT accepts that there may be times when a higher level of tolerance for patient safety must be accepted, particularly when under prolonged, significant operational pressure or staffing challenges over the short term. A higher tolerance for risk may also be accepted when supporting patients through clinical trials. When such occasions arise, management will support staff to work and develop appropriate and safe care plans and/or dynamic risk assessments.	1 – Minimal

Risk Type	Risk Appetite
RCHT has a medium appetite for risk related to innovations in new models of care designed to improve quality of care, subject to appropriate and managed risk assessments to protect patient safety. RCHT is prepared to accept managed risks to our compliance with performance standards where they relate to patient safety and quality improvements as long as patient safety, quality of care and effective outcomes are prioritised. However, we recognise there may be unprecedented operational challenges which may result in lower performance levels and unsustainable service delivery for periods of time; these would need to be reported to the Board or the relevant Committee via the Integrated Performance Report or other appropriate mechanism.	3 - Open
Sustainable workforce RCHT is committed to ensuring our staff feel valued and supported to do their jobs well as reflected in one of our core strategic objectives. RCHT has a low tolerance for risks related to workforce decisions where they would negatively impact staff wellbeing or staff safety but, given recognised workforce shortages, may accept a higher tolerance at times of significant, short-term operational pressure, subject to appropriate risk assessments of staff wellbeing/safety. RCHT has a medium tolerance for risks associated with the implementation of innovative new models of working / changes transformation in patient pathways and in the working arrangements of staff where these are expected to enhance or improve patient safety, quality of care, staff experience and wellbeing, workforce sustainability or service delivery.	1 to 2 – Minimal to cautious 3 - Open
Integrated health services RCHT is open to developing and maintaining partnerships with organisations that have an aligned set of values, enable us to promote and support safe, high-quality care, enhance the reputation and effectiveness of the NHS in the county, and maintain the required level of compliance with our statutory duties. RCHT values its partnerships within the county, wider region and nationally and is committed to pursuing the objectives of the Integrated Care System to improve the quality of care for patients. RCHT has a high tolerance for risks associated with research and innovation and partnership with academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. RCHT will only take such risks where it has the capacity to manage	3 – Open (ICS partnerships) 4 – Seek (academic partnerships and

Risk Type	Risk Appetite
them and is confident there will be no adverse impact on the safety and quality of the services provided.	research)
Financial recovery RCHT has a medium tolerance to risks to financial sustainability, acknowledging however the balance required to meet statutory financial duties, including RCHT's financial duties as part of the Cornwall and Isles of Scilly health system, and to mitigate risks to patient and staff safety, where such related investments are required. RCHT strives to deliver its services within the revenue budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate significant risks to workforce, patient safety or quality of care. RCHT will ensure that all such financial responses deliver optimal value for money. RCHT will prioritise on the basis of risk assessments its finite capital resources and have a low tolerance to breaching its duties in relation to meeting its capital resource limit. On that basis, RCHT will prioritise capital investments, on a risk assessed basis, that are required to meet or address statutory compliance/safety requirements, with business cases for quality of care improvements as the second tier of priority. Where RCHT can apply for external funding to pump prime or drive improvement and innovation opportunities, the Board will accept a medium tolerance, subject to any resultant oncosts to RCHT being sustainable from resultant savings or resource reallocation. RCHT has no tolerance for accepting or pursuing risks that would leave the organisation open to fraud or breaches of Standing Financial Instructions/Scheme of Delegation.	2 – Cautious
Digital infrastructure RCHT has no tolerance to actions or decisions that may weaken RCHT's cyber security or that may threaten its critical digital infrastructure. RCHT has a medium tolerance for innovation risks relating to pursuing new technologies to enhance the quality of care and safety, accepting the possibility of failure in pursuing such innovations.	0 – Avoid (cyber security) 3 – Open (digital innovation)

Risk Type	Risk Appetite
Physical infrastructure and supply chain RCHT has a low tolerance for risks which may compromise health and safety of our staff, patients and visitors to our sites. RCHT is committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and regulator expectations and do not represent a health and safety risk	2 - Cautious
Reputation We aim to demonstrate our values by maintaining high standards of transparency, accountability and professionalism at all times; in doing so, we aim to protect the reputation of the organisation and the NHS. However, we have a medium tolerance for risks related to reputation as sometimes, particularly when under significant operational pressure, decisions may need to be taken which might have a negative impact, such as restricted visiting or cancellation of elective activity. In such instances, we will take a proactive approach to management of our reputation through clear communication and engagement with stakeholders/regulators.	3 - Open

4.2 Identifying risks

The identification of risks broadly falls into two categories throughout all levels of the organisation: proactive and reactive. 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. It is the role of all staff across RCHT to identify actual or potential hazards, issues or risks and escalating them.

Risk management is the systematic method of identifying, analysing, managing, monitoring, and reviewing of risks in order to ensure achievement of the Trusts objectives. It is also clear that managed risk taking is sometimes critical to taking developments forward and improving care for patients

4.3 Risk evaluation

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

RCHT uses the 5 x 5 National Patient Safety Agency Risk matrix (likelihood by consequence). This is a 5 x 5 calculation involving an assessment of risk

consequence and likelihood to score risks and aids staff in applying a consistent, objective approach to risk evaluation. In summary they are:

- Low: score of 1-3.
- Medium: score of 4-8.
- High: score of 8-15.
- Extreme: score of 15-25.

The articulated risk tolerance within the risk appetite statements are used to determine whether the actual risk scores are higher or lower than the tolerance; this informs any escalations to other governance bodies in RCHT as required.

Descriptors to guide staff on how to assess risk consequence (covering financial, quality, workforce, and operational risk descriptors) are also available as part of RCHT's Risk Assessment and Management Strategy and Policy.

RCHT'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. Risks are reviewed by the risk owner and discussed at the appropriate governance meetings; the review encompasses the risk descriptor, scoring, action plan progress and updates. Risks are also reviewed when there is a change but below is the risk review frequency guidance:

Risk Rating	Review Frequency
Risks that have been closed but have a recurring theme.	Annually
Risks that have been accepted and are not in the "Live risk" status. Green / low risks (risks that score below 4).	Six Monthly
Amber / high risks and Yellow / moderate risks (risks that score between 4 and 12).	Quarterly
Red/ extreme risks (risks that score 15 or above).	Monthly

Risks are accepted onto RCHT's Corporate Risk Register when all reasonable mitigating actions have been carried out and the risk cannot be practically reduced any further; these are reviewed and approved by Executive Risk Group before onward consideration by Audit and Risk Assurance Committee and Trust Board.

4.4 Risk management

All risks are curated by the Care Groups or specialist departments with the most influence or information to be able to update the risk record. As management of

significant RCHT wide issues and key risks to strategic objectives may require coordination at a senior level, these risks including action plans and performance are overseen by the Executive team.

Usually, we will attempt to treat a risk and reduce it to an accepted level. An accepted risk is identified as a risk which is below the residual (target) score where all reasonable actions have been carried out and the risk cannot be practically reduced any further or there are no further actions possible.

If it is determined 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 assessments 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

The annual internal audit review of RCHT's risk management arrangements for 2024/25 (February 2025) returned a significant assurance opinion.

Equality impacts assessments are integrated into core Trust business and are developed for all new or revied Trust policies, procedures, protocols, services, strategies and projects. The Trust will assess all its employment, patient and site policies, procedures, protocols, services, projects, strategies and business plans to minimise any undue or unintentional discrimination in relation to employment practice and how services are delivered and accessed by the community as per the Trust Equality Impact Assessment Policy.

Equality, quality impact assessments are undertaken for all cost improvement schemes, and it applies to all proposals to significantly change services at the Trust i.e. business cases. The assessment includes impact details for each of the quality domains (Patient Safety, Clinical Effectiveness and Patient Experience) including all mitigation that will be undertaken as part of the project and the assessed risk (based on the Trust standard methodology for risk assessment). Quality Assurance Committee has the responsibility of reviewing equality, quality impact assessments in relation to cost improvement programmes for assurance that a robust process is in place and that unintended consequences are identified, mitigated and monitored.

4.5 Embedding of risk management: learning from risks and incidents

4.5.1 Patient Safety Incident Response Framework (PSIRF)

The NHS England Patient Safety Incident Response Framework (PSIRF) was first introduced at RCHT in December 2021. The Trust has continued to embed PSIRF and deliver its second Patient Safety Incident Response Plan. The Executive oversight for PSIRF sits with the Director of Nursing, Midwifery and Allied Health Care Professionals.

A requirement of the PSIRF is that all Trusts have a designated Patient Safety Specialist (PSS). RCHT has one PSS and a Patient Safety Partner who support PSIRF as part of wider patient safety activity. This year the Trust has also introduced a Head of Patient Safety to further strengthen the delivery of PSIRF as the Trust looks to further mature its approach through data review, culture and improvement.

The National Reporting Learning System (NRLS) has been decommissioned and replaced with the Learn from Patient Safety Events (LfPSE) system by NHS England. This change required engagement across RCHT to ensure a smooth transition, reducing impact to all staff as incident report proformas were amended on our Risk and Incident Management System ‘DatixWeb’. This work was led by our Datix system administrator with support from the Patient Safety Specialist. The Trust implemented LfPSE in April 2024 with no issues. NHS England is planning to decommission the Strategic Executive Information System (StEIS) in 2025/26, and we await their further guidance on the actions needed.

Patient Safety Capability Build

We have a dedicated Trust-wide training programme to enable the delivery of PSIRF which includes the NHS England syllabus. Our in-house training is delivered by the Patient Safety Specialist and the Lead Patient Safety Incident Investigators who are highly trained in their fields, providing mentorship to investigating officers throughout learning responses.

We have 99 current colleagues trained in the Systems Engineering Initiative in Patient Safety (SEIPS) through our Patient Safety Review Training, and 33 who have undertaken the new patient safety module within the LEAD programme. This year the Trust has adopted the NHS England patient safety training level 1 and level 2 as part of growing understanding of safety science and safety culture; 79% of staff have completed level 1 training, and 31% have completed level 2. The PSS has completed level 3/4 of the syllabus and has also obtained an MSc in Patient Safety Science and Human Factors from the University of Edinburgh.

4.5.2 Patient Safety Incident Response Plan (PSIRP)

In September 2023, we approved our second Patient Safety Improvement Response Plan (PSIRP), and this had remained our PSIRP with a review date of March 2025. We have continued to work with colleagues in the Trust, commissioners in Cornwall and the Isles of Scilly, and our Patient Safety Partner. Our PSIRP is aligned to NHS England's Patient Safety Strategy and the incident response framework which supports the development and maintenance of an effective patient safety incident response system that integrates four key aims:

1. Compassionate engagement and involvement of those affected by patient safety incidents.

2. Application of a range of system-based approached to learning from patient safety incidents.

3. Considered and proportionate responses to patient safety incidents.

4. Supportive oversight focussed on strengthening response system functioning and improvement.

Our plan sets out how we will review, investigate, and learn from patient safety incidents to make improvements based on organisational priorities related to patient safety. It also explains how we will continue to involve and support those affected, including patients, families, carers, and staff, alongside building knowledge of patient safety science. Our plan is rooted in a safe and just culture, which encourages everyone to raise safety concerns that are then responded to in a compassionate and fair way.

4.5.3 Compassionate engagement and involvement of those affected by patient safety incidents.

To ensure a compassionate response to incidents, including restorative just learning culture we have further developed our skills and resources to support those affected by adverse events. We have worked closely with our People and Organisational Development (POD) colleagues to build a suite of psychological wellbeing resources to staff including mental health first aid and trauma informed management (TRiM) which two members of the Patient Safety Team are practitioners. We have developed a 'Supporting Staff' webpage with contributions from our People and Organisational Development team, Legal Services and the Patient Complaints team to bring all resources together in one place and easy access for colleagues.

We have also developed dedicated resources for patient and families, including a booklet with organisations at a county, regional and national level who can offer support. The Trust have encompassed the PSIRF Engagement Lead duties into the Lead Patient Safety Investigator role who provide expertise and oversight to each learning response. Our Patient Safety Partner (PSP) has been crucial to this work providing advice and guidance on our approach and associated resources.

4.5.4 Considered And Proportionate Responses to Patient Safety Incidents.

All incidents are reviewed, and any learning actions identified as a team, speciality, Care Group, or Trust wide level; we also link with our system partners as required.

From 01 April 2024 to 31 March 2025 17,510 patient incidents were reported, the vast majority (98.2%) involved no harm or minor harm (for example additional observations). 216 cases have received a further scrutiny, including two patient safety incident investigations relating to a Never Event.

4.5.5 Application of a range of system-based approached to learning from patient safety incidents.

We continue to apply systems-based methodologies to other learning responses including SEIPS, after action review, and multi-disciplinary (MDT) reviews. As we revise our PSIRP, we will be looking to increase our after-action review capability, recognising that facilitation of these forums is a skill and we need to develop this further across RCHT.

4.5.6 Supportive Oversight Focused on Strengthening Response System Functioning and Improvement

Oversight of PSIRF happens internally through our governance structures and externally via the Integrated Care Board (ICB). We have reviewed the Patient Safety Incident Response Policy to guide and strengthen the oversight responsibilities. The patient safety team works closely with the Chief Nursing Officer and Chief Medical Officer to understand risks to safety and respond to these. Each learning response or investigation is led by a Lead Patient Safety Incident Investigator who is specially trained in systems-based methodologies and supports investigating officers. Their duties include ensuring the requirements are met within the incident response. All reports are discussed and approved by the Incident Review Learning Group (IRLG)

which includes the PSS, PSP and representative from the ICB before final approval by the Executive for Patient Safety who assures all standards have been met. We report monthly to the Quality Assurance Committee and have updated our proforma to provide more assurance reporting to the Board. There are also links to the ICB, and we attend the Cornwall Safety Systems meeting to develop safety responses and learn from safety risks across the county. We also have good relationships with the provider partners in Devon and with NHS England on a regional and national level which provide support as we continue to mature our safety practices and culture. In 2024/25 we participated in a PSIRF external audit the results showed a maturity culture with the improvement plan now incorporated into the PSIRP for 2025/26.

4.6 Risks to data security

RCHT's Senior Information Risk Owner is the Dual Chief People Officer who chairs the Information Governance Group. RCHT's Caldicott Guardian role is held by the Associate Medical Director for Planned Care and is also a member of the Information Governance Group.

4.6.1 Cyber security

- A cyber security strategy was developed during 2024/25. This strategy outlines how the Cornwall and Isles of Scilly ICS (the C andIoS ICS) members will work together to collaboratively deliver long term cyber security direction and objectives.

- Implementation of the Cornwall Cyber Security Operations Centre (the Cornwall CSOC) has been highly successful and has enabled Cornwall IT Services (CITS) to provide greater value around cyber security operations as well as improvements around compliance, risk and governance.

- An NHS England simulated phishing campaign was run in October 2024 across the entire ICS. Across RCHT only 1.4% entered their NHS mail username and password on the fake login page.

- We have successfully responded to seventeen High Severity Alerts from NHSE in the twelve months ending 31 January 2025 and have successfully remediated sixteen of those (one being a notification of a pending change to tamper protection in MDE).

- We improved the percentage of supported Windows servers that we manage in MDE in the twelve months ending 31 January 2025 from 95.38% to 98.64%.

- Shared folders with the "Everyone" permission reduced by 73% between 1 September 2024 and 31 January 2024.

Risks to data security are managed through the CITS Quality Assurance and Risk Group (QARG). Cyber security risks are reported to the Cornwall Cyber Security Group and are overseen by the Information Governance Group, depending on the nature of the risk.

Risks to data security are managed in alignment with the Risk Assessment and Management Strategy and Policy. Risks to data security are logged on RCHT's incident and risk management tool Datix. This includes the initial, current and residual risk score once mitigating actions are taken.

Currently, as documented in the Risk Assessment and Management Strategy and Policy, the Trust has no tolerance to actions or decisions that may weaken the Trust's cyber security or that may threaten its critical digital infrastructure.

RCHT's approach to managing risks to data security form part of the Data Security and Protection Toolkit submission. The top five cyber security risks are:

- Data Lost or Shared Inappropriately.
- Unauthorised Access.
- Cyber-Attack.
- IT Supply Chain Attack.
- Phishing Attack.

RCHT will submit before 30 June 2025 the Data Security and Protection Toolkit for 2024/25 and is currently working towards a compliant submission, but with some known areas that need additional attention before the submission date.

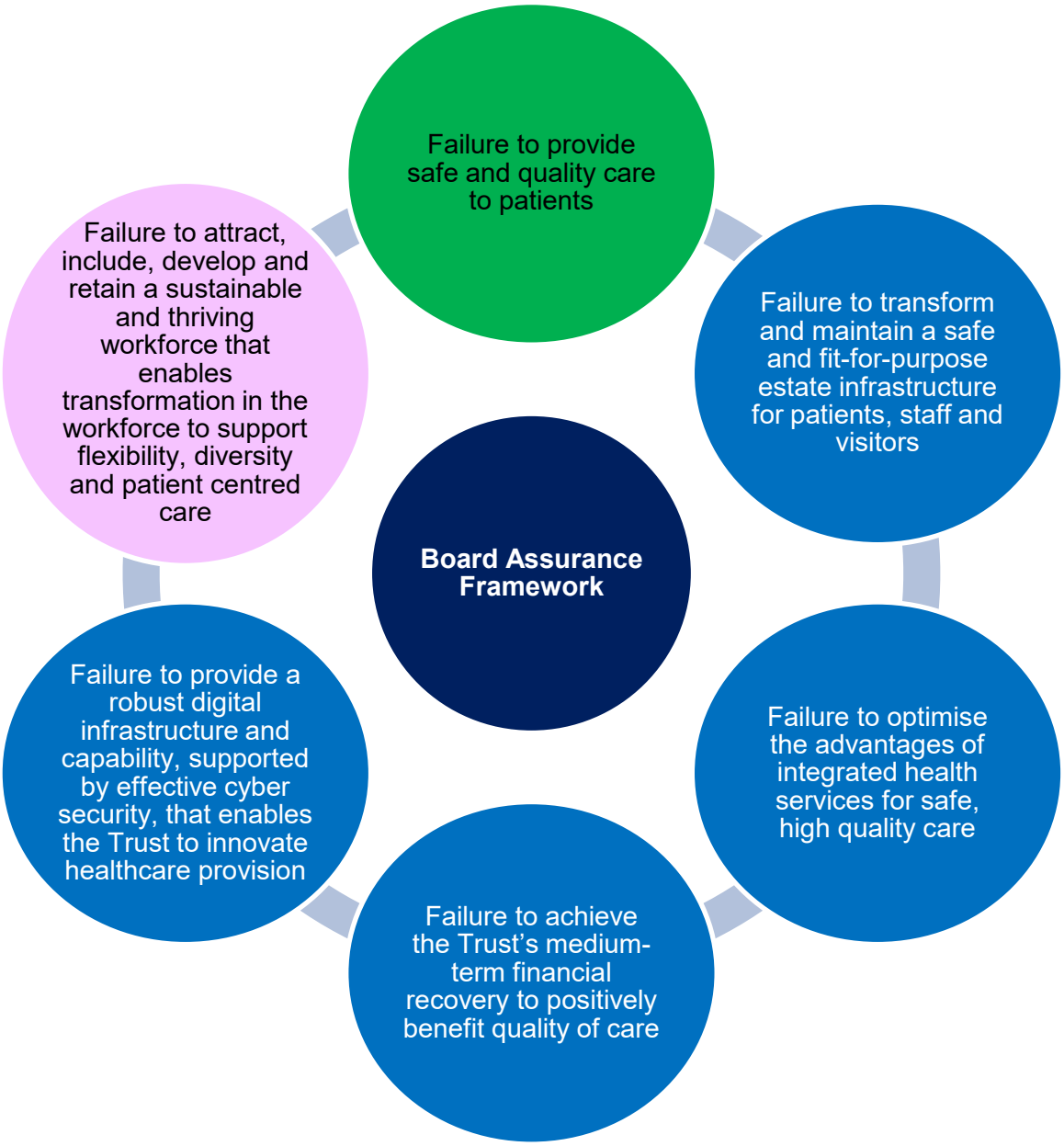
RCHT receives regular threat intelligence reports from the NHS England Cyber Security Operations Centre (CSOC), the national CSOC. These are monitored by the Cornwall CSOC, who ensure that the cyber security key stakeholders (including the heads of information governance, the SIROs and the Emergency Preparedness Resilience and Response (EPRR) leads) are briefed on the threat, any potential impact, any controls in place and actions to be completed via dedicated Microsoft Teams channels.

In the event of a High Severity Alert being issued by NHS England, a specific incident response team is formed to ensure that the incident is responded to within 48 hours and remediated within fourteen days. Where remediation is not technically feasible within the mandated timeframe the risk is documented and assessed and accepted by the Senior Information Risk Owner (SIRO) with an action plan detailing the key milestones and target dates for remediation of the alert. Specific teams are set up to remediate any high severity alerts within national deadlines. If this deadline cannot be met a report is sent to the SIRO with the current level of risk and action plan.

Visual checks of the how physical records are managed along with compliance with IT equipment is conducted monthly as part of a planned ad hoc walkthrough for the three main hospital sites, the results will be reported to the Information Governance Group in June 2025.

4.7 Board Assurance Framework

The Board Assurance Framework (BAF) was refreshed and mapped to the new strategic objectives of RCHT Strategy 2022/23. The six BAF principal risks are shown by the visual below:



Key	
	Safe, high-quality care
	Supported and valued people
	Journey of improvement

The BAF is reported every quarter to the Audit and Risk Assurance Committee for onward consideration by the Board. Each assurance Committee receives the BAF elements relevant to their remit to help ensure that the matters considered by the Committees reflect the assurance requirements articulated in the BAF. In 2023/24 it was agreed the Committee would receive a detailed assurance report, outlining any changes thus enabling the Committee to track progress against actions to address gaps in assurance. This has been well received and continued into 2024/25.

4.8 Significant risks during 2024/25

The most significant challenge and risk to the Trust during the year was the continued impact on exceptional, sustained operational pressures, culminating in continued significant poor performance in ambulance handover delays at our Emergency Department and impact on patient flow in and out of the hospital.

In January 2025 this saw the Cornwall and Isles of Scilly escalate to a system Critical Incident given the sustained and significant pressure on our Urgent and Emergency (UEC) system and the extended ambulance handover and category 1 and category 2 ambulance response times.

The Trust simultaneously reviewed the risk scoring of the ED Crowding Corporate Risk (risk ID 9048) and it was escalated from a risk of 20 to 25, the highest risk score on the matrix. The Executive Risk Group monitor the performance metrics around aggregated patient delay via the IPR and the Board were briefed regularly on the monitoring of this risk.

The operational pressures were, and continue to be, multi-faceted with risks to patient safety and quality of care and negative impact on staff wellbeing.

Management of actions to mitigate the risk were managed via the flow programme which was refined to the Trust Clinical Vision for Flow Programme which is clinically led and has fortnightly steering group meeting chaired by the Chief Executive. Actions focused on discharge with the aim to see the Emergency Department less crowded and able to see and treat patients sooner as well as updates to our acute medical model and how we use some of our clinical spaces.

Dedicated actions to support improvements on our mortality outliers which included the fractured neck of femur pathway and stroke pathway are in place with Quality Assurance Committee seeking regular assurance in these regards as well as our harm review process.

Key Schemes included:

- Home for Lunch early discharge programme.
- The Trust implemented the Timely Handover Protocol (THP) which aims to set a maximum ambulance handover duration.

- Acute Medical Model of care programme to increase the presence of senior clinical decision makers at times of highest demand for our urgent and emergency care services. This supports more rapid clinical assessment and support ongoing improvements in patient flow, admission avoidance, and more rapid discharge decision making.

- Winter Recovery actions delivered across Royal Cornwall Hospitals NHS Trust and Cornwall Partnership NHS Foundation Trust focussed on hospital at home for respiratory and cardiology, outpatient interface for GP practices, end of life services, as well as admission avoidance through Community Assessment and Triage Units (CATU) and community Same Day Emergency Care (SDEC) and development of a Single Point of Access (SPOA) to assist in the utilisation of alternatives to the Emergency Department.

The RCHT Board received briefings at every meeting, via the Chief Executive's report or dedicated papers, on the operational position relating to the urgent and emergency care and patient flow pathway, including ambulance handover delays, and the elective recovery plan. The Quality Assurance Committee also sought assurance in regard to mitigating impacts on mortality outliers. These key areas outlined above are also subject to regular discussion at Integrated Care Board meetings and through the Senior Executive Group.

4.9 Risks into 2025/26

We consider our most significant risks into 2025/26 are:

- Patient safety and quality of care in the context of the ongoing system challenges and focus on improving urgent and emergency care and reducing ambulance handover delays.

- Financial sustainability in the context of delivery of the high risk 2025/26 operational and financial plan and the CIP target.

- Delivery of a robust Organisational and Development plan and understanding, and improving, organisation engagement and culture.

- Delivery of the required workforce efficiencies, particularly delivery of headcount reduction to achieve the efficiency savings and ensure a workforce fit for the future. Supporting staff health and wellbeing in the context of these continued workforce challenges and supporting sickness absence remains a key priority and area of significant risk.

The Board will continue to monitor and scrutinise assurance on mitigations for these actions via the Board Assurance Framework and extreme corporate risks per the established process. The Board and/or the relevant Committee will also continue to commission more detailed 'deep dives' into key risk areas where they determine the internal controls need to be tested and/or improved.

4.10 Clinical Governance Arrangements

RCHT maintained its full clinical governance arrangements during the year.

4.11 Engagement in the development of the system's risk profile

RCHT continues to actively engage with system colleagues regarding risk and discusses risks across the system through the System Executive Group (SEG). The development of a System Assurance Framework and System Corporate Risk Register that looks at the information regarding principal and corporate level risks is something that we aspire to develop and an area that remained a key priority but was not strengthened in 2024/25. It was recognised that through the development of a Joint Service Improvement and Quality Committee arrangement this would have greater focus and consideration, but there has not been the level of discussion and development on the key system risks relating to patient safety and quality of care.

4.12 Well-led Framework – effectiveness of governance and CQC

4.12.1 CQC registration and inspections / CQC / Quality of Performance and compliance with CQC Regulation

All health and adult social care providers need to be registered and licensed with the Care Quality Commission (CQC). This is a legal requirement under the Health and Social Care Act 2008.

The CQC are the independent regulator of health and social care in England. Their purpose is to make sure health and social care services provide people with safe, effective, compassionate, high-quality care and they encourage care services to improve.

The Trust is not fully compliant with the registration requirements of the Care Quality Commission.

In May 2024, the CQC carried out an inspection of urgent and emergency care services at the Royal Cornwall Hospital site under their new single assessment framework.

In January 2025 the CQC published the final inspection report following their inspection of urgent and emergency care services in May 2024. The publication was delayed due to internal technical issues at the CQC.

There were two regulation breaches identified during the inspection:

- **MD1 (Regulation 12):** Care and treatment was not always provided in a safe and timely way in line with clinical guidance and in an area of the department or correct specialty where it is safe to do. Patients were not always admitted from the Emergency Department to a ward bed in a timely manner. Patients experienced waits in ambulances when the Emergency Department was at capacity.
- **MD2 (Regulation 18):** Persons employed by the service did not receive regular appraisals.

A comprehensive action plan in response to the regulation breaches was submitted to the CQC in February 2025. The response to MD1 reflected the actions being taken in relation to the new acute medical model, the clinical vision for flow, the Timely Handover Protocol, and commissioning intentions for 2025/2026.

The response to MD2 set out the detailed plan to improve appraisal compliance for all staff working in the urgent and emergency care service, with the aim to achieve the Trust target of 90% compliance by July 2025. The action plan was submitted to the CQC on the 13 February 2025 following approval and is being monitored by Quality Assurance Committee.

In July 2024, the CQC carried out a responsive assessment of medical care on Zennor Ward at the RCH site under their single assessment framework. There were no regulation breaches identified during the Zennor Ward inspection.

In November 2024 the Trust had an inspection of Ionising Radiation (Medical Exposure) Regulations (IR(ME)R).

For all inspections, the Quality Assurance Committee and Trust Board in Public are briefed on the outcomes and the Committee approves the action plans in response to the inspections' recommendations.

Engagement with the CQC continued through regular relationship meetings with RCHT's senior leadership team, ongoing responses to requests for information, and the provision of updates on actions agreed from previous inspections.

RCHT has a robust CQC Improvement Plan and the actions are monitored monthly by the Quality Assurance Committee.

At the end of 2024/25, RCHT continued to be rated as 'requires improvement' overall by the CQC (rating received in December 2019) and had not been assessed as meeting all the legal requirements as set out in the regulations.

None of the three targeted inspections affected the overall as summarised by the table below:

Category	Information
Safe	Requires improvement
Effective	Good
Caring	Good
Responsive	Requires improvement
Well-led	Good

Category	Information
Use of resources	Good
Combined rating	**Requires improvement**

4.12.2 Governance effectiveness and improvement plan

The last external well-led governance review was in March 2022 and identified no significant gaps in governance. It is best practice to complete a review every three years; this is scheduled for 2025/26 and will include the effectiveness of both the Board and its Committees. The outcomes from the external well-led governance review will inform the development of the 2025/26 Governance Improvement Plan. The review was delayed to Q1 of 2025/26 due to the change in leadership of the Trust Board and a new Chair commencing in post in January 2025.

The Board has had a Governance Improvement Plan since 2021/22 and determined to have one every year to build on and sustain enhancements to corporate governance efficiency and effectiveness – in terms of both governance processes and culture.

The 2024/25 governance improvement was developed using a number of related inputs including the outcomes from the Trust Board Evaluation outcomes from 2023/24, Committee Annual Reports and evaluation outcomes and improvements 2023/24, the review of the Code of Governance for NHS Providers Trusts and the review of the Trust Provider License in 2023/24. It also reflects actions that the Board agreed to carry over from the 2023/24 Governance Improvement Plan.

It is of note the Board agreed the Audit and Risk Assurance Committee should receive a year-end assurance report on how the Governance Improvement Plan was implemented during the year; this was actioned in year.

The key areas identified for the 2024/25 plan are:

- Embedding the executive governance structures – impact: carry over of the action relating to embedding the outcomes of the Executive Governance Review and taking learning/actions from the outcomes of the Internal Audit on the Corporate Governance Framework (Satisfactory) i.e. improving and embedding templates, strengthening documentation etc.

- Partnership working – impact: better sight of developments within the integrated care system; more joined up working arrangements and avoiding duplication through the establishment of the Joint Committee; understanding and utilising the provider collaboratives i.e. efficiencies as well as implementing a system assurance framework.

- Corporate governance – impact: improve the quality, length and content of Board and Committee reports i.e. review templates, workplans and fully implement internal report writing training.

- Governance mechanisms to support delivery of the 2024/25 financial and operational plan – impact: consideration and evolution of the role and function of Transformation Oversight Group (TOG) and existing governance structures to support and enable the scale of transformation i.e. e-Care and Women's and Children's Programme Board.

- Performance assurance – impact: utilising benchmarking and productivity data as well as model hospital data.

- Well led – Impact: preparation for a well-led inspection with the aim to support and prepare new Board members for an inspection; noting the Trust is due to commission an external well led review in 2024/25 (this is completed every 3 years as best practice).

Updates on the plan are provided to each Board Public (every two months). This is the Board's Plan and as such any requests for extensions to target dates require Board approval.

The Governance Improvement Plan 2024/25 comprises 14 actions grouped in seven areas, with various target dates for completion. There were two actions that were transferred across from the 2023/24 Governance Improvement Plan.

Key governance improvements made during 2024/25 included:

- Mechanisms to embed good governance practices through shared learning and training; using a Secretariat Community of Practice approach. This year particularly focussing on recording progress, actions and implementing effective workplans.

- Improved methods of communicating outcomes from the Trust Board to support greater organisational understanding of decisions and priorities.

- Developed, tested and implemented report writing sessions open for all staff.

- Review of Board and Committee work programmes to ensure alignment to statutory and regulatory duties.

- Embedded benchmarking and productivity as a key theme in reporting and into assurance reporting to operational, Executive and Committee level meetings.

- Reviewed the Cornwall Hospitals and Community Health Group Provider Collaborative Committees in Common and transitioned to a Board to Board governance model.

- Reviewed and made changes to the Trust key transformation programmes and oversight arrangements.

It is best practice to annually review Committee effectiveness; this was undertaken during quarter 4 of 2024/25 and reported to the Board in May 2025. The Board and its Committees also assess the effectiveness of each meeting at the end of the agendas so that live feedback is captured and can be acted upon. Common themes across the Committees for development from the 2024/25 self-assessment of effectiveness included the size and scale of the agendas, the quality and length of papers and having greater sight on national and local developments that impact the Committee.

4.13 Induction of RCHT Board members

RCHT has provision within Standing Orders for a number of Associate Non-Executive Directors to both boost skills on the Board and to provide a pipeline for new Non-Executive Directors.

The induction process for new Board directors was continued in 2024/25 and was well-received, positive feedback has also been received by new Board members. All new NEDs have the opportunity to complete the NHSE new Non-Executive Director Induction.

RCHT Board believes it is important to reflect the diverse community its serves and are committed to promoting diversity and to equality of opportunity for all. The NExT Director programme, managed by NHS England, offers opportunity to talented individuals who wish to become an NHS Non-Executive and to learn first-hand about the challenges and opportunities associated with being a Non-Executive Director in the NHS today. A NExT Director joined RCHT in February 2024 and following a successful recruitment campaign, was appointed a Non-Executive Director in 2025. A future recruitment campaign is planned for another NExT Director during May 2025.

4.14 Fit and Proper Persons

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.

The Fit and Proper Persons Policy was approved by the Remuneration and Appointments Committee in September 2023 following a comprehensive review of the NHS England Fit and Proper Persons Test Framework for Board Members (August 2023). An updated version of the policy was presented and approved in March 2024 which considered further changes to the Fit and Proper Person's Policy following a 6-month review of learning achieved. The latest version was approved in October 2024, this update reflected a full year of use of the policy and reflected the outcomes of a satisfactory internal audit on the Trust assessment process and application of the policy aligns to the national framework. Further learning and sharing of best practice have been incorporated into the policy.

An annual report on application for the Fit and Proper Persons Policy was considered by the Remuneration and Appointments Committee in October 2024. The Chairwoman at the time discharged her responsibility placed on the Trust in line with the new framework to ensure that all directors satisfy the Fit and Proper Person's Requirement in 2024.

NHSE published the NHS leadership competency framework for Board members in February 2024; the framework is for Chair's, Chief Executive's and all Board members in the NHS and supports the appointment of diverse, skilled and proficient leaders as well as the delivery of high-quality, equitable care.

On 1 April 2025 NHSE issued Board Member Appraisal Guidance, the guidance outlines NHS England's expectations and recommendations in the completion of board member appraisals. The Trust has determined to incorporate the framework which establishes clear expectations and enhances consistency in standards for board-level appraisals.

Annually, as part of RCHT's fit and proper person's self-attestation and annual appraisal process; Board members will be required to self-assess against the six competency domains and identify any development needs.

4.15 Compliance with NHS Provider license, condition 4

4.15.1 Provider license self-declaration

RCHT is required to make an annual self-assessment against the provider licence. The NHS provider licence forms part of the oversight arrangements for the NHS. It sets out conditions that providers of NHS-funded healthcare services in England must meet to help ensure that the health sector works for the benefit of patients, now and in the future.

As a result of the Health and Care Act 2022, NHS Trusts were no longer exempt from holding a licence. RCHT was issued its Provider Licence in April 2023.

It is up to providers how they undertake their self-certification, but any process should ensure that the provider's Board understands clearly whether or not the provider can confirm compliance. NHSE previously provided templates which RCHT used as the basis of documenting its evidence (G6 and FT4), however this approach is no longer in place.

In April 2025 RCHT self-assessed against the following conditions of the licence based on a number of factors:

- Section 4 – Trust Conditions – NHS2 Governance Arrangements and;
- Section 6 – Continuity of Services – CoS7: Availability of Resources.

The conditions require us to have processes and systems that identify risks to compliance within the licence and the self-assessment identified no significant risks to its compliance for 2024/25.

In making this self-declaration, the following key elements have been considered:

- Draft Head of Internal Audit Opinion for 2024/25 of 'satisfactory'.
- Any breaches of law or regulation by the Trust and mitigations put in place (e.g. HSE improvement notice or CQC breach of standards).
- Governance improvement work undertaken via the Governance Improvement Plan throughout 2024/25.
- Annual assessment of the Code of Governance for NHS Provider Trusts.

4.15.2 Evaluation against the NHS Providers Code of Governance

The Board has regard to key corporate governance publications and, in March 2024, reviewed its compliance with the new NHS England Code of Governance for Provider Trusts. The Code is issued on a 'comply or explain' basis.

The assessment identified we were fully compliant in all areas. This was an improvement on the previous year where we were not compliant with the tenure of the Chair as it exceeded the new standard of no more than nine years in post (including any previous Non-Executive Director role with the same NHS organisation). NHS England appointed a new Chair, David Allen, OBE, who commenced in post on 7 January 2025 as such at the time of reporting, the Trust is compliant with all areas.

The Board receives and considers updates from the broader policy and regulatory environment via the Chief Executive's reports to the Board to ensure members stay apprised of developments in governance requirements and key quality and safety matters.

4.16 RCHT Board Composition and Committee Structure

We are compliant with its Establishment Order in terms of the maximum number of voting Directors on the Board (Executive and Non-executive) of 12.

The Board undertook a skills assessment in July 2024 which identified gaps in public health/local government experience; estates management; digitisation and information technology; commercial and entrepreneurial skills and law. The Chair of the Board considered these gaps when initiating recruitment processes for three Non-Executive Directors:

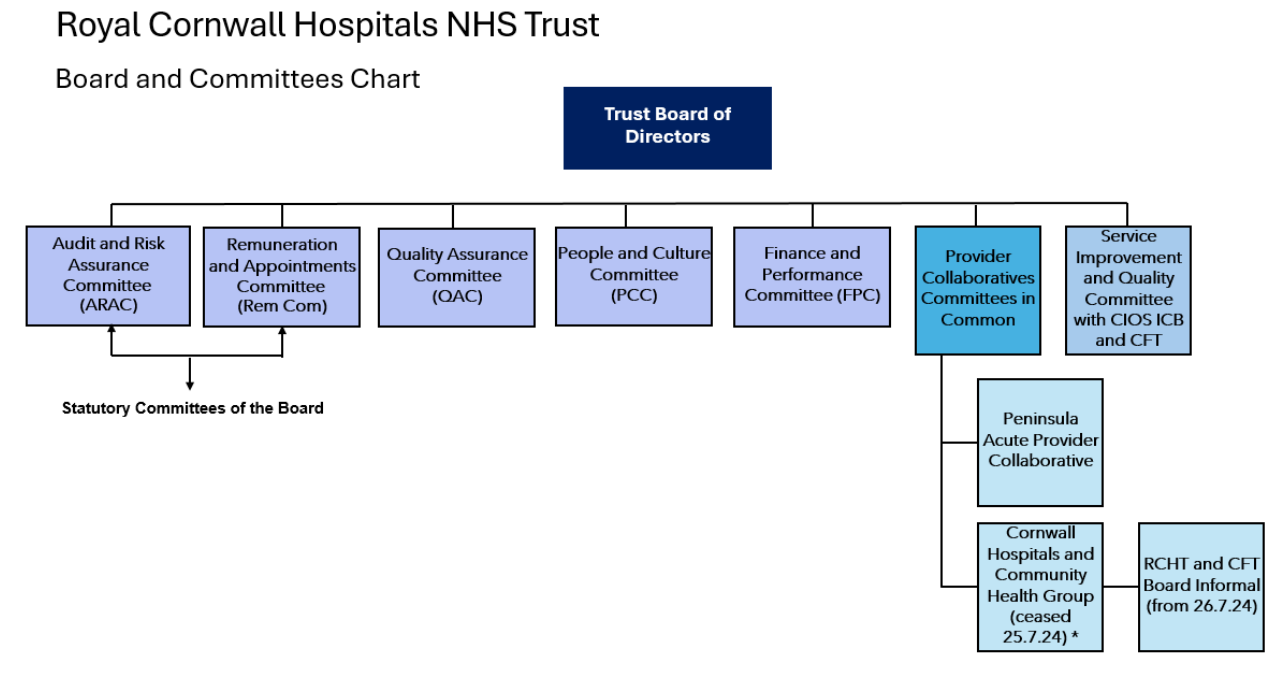
- Following interview in May 2024 the Trust appointed a NED with public health/local government experience;
- Following interview in August 2024 an appointment was made for a Clinician (a vacancy that arose is 2024).
- Following interview in December 2024 an appointment was made to a NED with commercial and entrepreneurial skills.

The Remuneration and Appointments Committee considers the composition and skills mix of the Board, including the reports from the annual skills assessment.

The Board meets in public on a bi-monthly basis to discharge its statutory responsibilities and has established the necessary statutory (Audit, Remuneration) and non-statutory (Quality Assurance, Finance and Performance, People and Culture) Board Committees under Terms of Reference and delegated authorities referenced within RCHT's Standing Orders. Committee Terms of Reference are reviewed at least annually or as required and are available on RCHT's website.

RCHT 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. The Board acts in its capacity of Corporate Trustee when significant matters are brought forward by the Committee outside of its remit, or to receive the Committee assurance report on matters it has considered.

The Board's Committee structure is shown in the chart below:



* Cornwall Hospitals and Community Health Group ceased on 25.7.24 and became RCHT and CFT Board informal

The core purpose of each Committee is as follows:

- **Audit and Risk Assurance Committee** review the establishment and maintenance of an effective system of governance, risk management and financial and non-financial internal controls that supports the achievement of RCHT's strategic objectives. The Committee's Terms of Reference map to the HMFA Audit Committee Handbook (which was updated in March 2024).

- **Quality Assurance Committee** rigorously keep under review all aspects of RCHT's quality and clinical governance. The Committee is responsible for assuring the Board about quality, safety, patient experience and RCHT's registration with the Care Quality Commission.

- **Remuneration and Appointments Committee** identify and appoint candidates to fill all very senior manager (VSM) positions and to determine the remuneration and other conditions of service for VSMs. The Committee will on occasion review the circumstances of other staff outside of VSM's in line with its Terms of Reference. The Committee is also responsible for ensuring there is a robust fit and proper persons policy for the Board of Directors and for reviewing the overall composition and skills mix of the Board. Per governance best practice, the Remuneration and Appointments Committee is chaired by the Senior Independent Director.

- **People and Culture Committee** provide assurance to the Board on all aspects of workforce and organisational development supporting the provision of safe, high quality, patient-centred care.

- **Finance and Performance Committee** provides assurance to the Board of RCHT's financial management and organisational performance, business planning, estate and facilities management and digital infrastructure. The Committee also makes decisions on behalf of the Board per the Scheme of Delegation and/or specific delegated authority made by the Board.

- **Peninsula Acute Provider Collaborative Committee** is an assurance committee in common with a number of acute providers in Devon. Its purpose is to successfully work together to drive whole system acute services transformational change across the population in Devon and Cornwall – improving outcomes and performance, sharing skills and experience, making best use of scarce workforce resources, and realising tangible financial savings and sustainability.

- **Cornwall Hospitals and Community Health Group Provider Collaborative Committee** was an assurance committee in common with Cornwall Partnership NHS Foundation Trust. Its purpose was to oversee the leadership, culture, vision, ambition and purpose of the provider collaborative and ensure that there is robust governance in place to deliver benefits and manage risk of each agreed collaborative programme of work. Committee members recognised the value of the two Boards coming together as part of the Committee but equally the evolving system operational landscape therefore in 2024 it was agreed to transition to a Board-to-Board governance model to enable the two NHS Providers to jointly focus on strategic direction within the Cornwall and Isles of Scilly System and for the Boards to meet at least four times per year. This change was reported to the Trust Board via the Chief Executive's report at the meeting in Public in September 2024.

The Chairs of each Committee provide an assurance report to each Board in Public meeting, summarising the business considered and any issues or significant risks 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; this includes consideration of system reporting.

Following the annual review of its Committees, the Board considers its governance structure to be effective; Committees have maintained strong performance against a number of key criteria that support effective governance. Areas of focus in 2025/26 will include how Committees can be appropriately sighted on developments within the Integrated Care System and in relation to system working and how they impact on the Trust. It is of note all Committees undertake a vast amount of business on behalf of the Trust Board; agendas are full and often overrun due to the volume of business to consider therefore greater consideration of workplans are needed to ensure less weighty/lengthy agendas and shorter Committee packs.

The quality and length of papers remains an area for improvement; there has been good engagement by management and improvements have been made but this should further be improved and embedded. Further work will also take place to improve how Committees have that greater regard to the 'triple aim' when making decisions within its authority, as required in the Health and Care Act 2022.

The Executive Leadership Team (ELT) is the most senior executive body of the organisation, comprising the Chief Executive, Executive Directors and Clinical Directors of RCHT. ELT has delegated authority from RCHT Board on particular matters as set out in the scheme of delegation and is responsible for implementing RCHT strategy and policies as set by the Board.

4.16.1 Oversight of performance

At each monthly meeting the Board reviews 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. RCHT Board has and continues 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.

Care Groups and Corporate areas meet monthly to review performance with members of the Executive team through a dedicated Performance Review meeting. The Finance and Performance Committee receives, on a monthly basis, a report providing key outcomes and themes from discussions.

Each Committee presents an annual report to the Board, so that it may review committee effectiveness and impact. The May 2025 Board in Public received the annual reports for 2024/25.

Following the publication of the Insightful Provider Board in November 2024, a guide to help boards to consider their approach to handling and acting on the information, they receive the RCHT Board considered an assessment though a comply or explain approach to the questions posed within the document which supports Boards to make use of data effectively in the context of increasing complexity and to use data intelligently to gain useful insight.

4.17 Developing Workforce Safeguards

There are a number of workforce safeguards as outlined in the Developing Workforce Safeguards guidance. There are four elements to this:

- Robust policies and guidelines for recruitment and development of staff to ensure our services to patients are delivered by competent and qualified individuals with the correct skills

- Mandatory and essential training for new and existing staff, this is closely monitored by the Board to ensure compliance and completion.

- All appraisal rates are monitored closely by the Board and via the People and Culture Committee to ensure all required interventions are managed or risks are highlighted and mitigated.

- Results of the annual staff survey, which RCHT undertakes active action planning against to identify and deliver improvements, with corporate actions and local care group plans.

Annual workforce planning is an integral part of RCHT's annual business planning process with which Care Groups (clinical and corporate) are involved from a bottom-up basis.

The People and Culture Committee approves RCHT's Strategic Workforce Plan and monitors delivery. RCHT has identified a need to strengthen its approach to long-term workforce planning and acknowledges the importance of wider system engagement on those matters. RCHT works collaboratively with system partners on a range of joint workforce issues, including via a collaborative bank, and on plans for the implementation locally of the long-term NHS plan. A System Workforce Plan is in development.

The development of the 2024/25 workforce plans was delayed due to the late publication of national guidance, however 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 through integrated performance reviews.

- Exception reporting via RCHT's Executive Leadership Team, which meets fortnightly.

- Bi-monthly via the Board's People and Culture Committee, as well as through the Committee's bi-monthly assurance report to RCHT Board.

RCHT's Board Assurance Framework (BAF) and Corporate Risk Register capture the key workforce risks, internal controls and levels of assurance to the organisation.

In November 2023 the Board signed up to the Sexual Safety Charter which outlines how RCHT will always take concerns seriously and ensure they are properly investigated. Following full support from the Quality Assurance Committee, the Board adopted the charter as a key part of our approach to keeping our staff safe from sexual harassment and abuse. Signatories of the sexual safety charter will commit to a zero-tolerance approach to unwanted, inappropriate and/or harmful sexual behaviours towards the workforce. The Trust is developing, through a working group the Sexual Misconduct Policy.

Regular reports from the staff survey, quarterly pulse survey, external reviews, RCHT's People Partners, Freedom to Speak Up Guardian and Guardian of Safe Working Hours also provide insights into issues that may be causing concern among staff. The key priority areas following the 2023 national staff survey results, which were released in March 2024, were identified as:

- Compassionate Leadership.
- Raising concerns.
- Negative experiences – Sexual Safety.
- Appraisals.

These areas had a clear action plan which reported into the People and Culture Committee on progress with the actions.

The 2024 staff survey results have recently been released and the key priority areas identified for next year include:

- Raising concerns.
- Organisational Development (OD).
- Compassionate Leadership.

Care Groups and directorates will be discussing the Trust key priority areas as part of their localised action plans which are currently being developed.

The We are RCHT OD programme was designed as a cultural change programme encompassing a number of key areas to support our staff, patients and wide strategic objectives.

The key programmes include:

- LEAD (Leadership Empowerment and Accountability Development) which is for first line management level, there are 20 modules delivered over teams.

- SAFE and Compassionate leadership programme, which is for leaders with skills to develop compassionate leadership. This is a 3 day in person session.

- Insights programme, which is a team development programme focused on aiding retention and team working, the programme was designed to initially support RCHT, moving to a system wide programme.

The OD and EDI team also currently lead on coaching, stay conversations and retention interventions. The focus on underperforming teams, as well as the offer of reverse mentoring programme which has been adopted systemwide.

Years two and three of the We Are RCHT OD programme were designed to bring in EDI and Health and Wellbeing as additional strands of the programme, however, have been delayed due to capacity. It is clear from the initial staff survey results and other engagement mechanisms that our staff from marginalised groups need to feel safe, that they belong and have a voice that counts.

Additional programmes that will be focused on in 2025 to expand the We Are RCHT programme to focus on EDI and Wellbeing include:

- Active Bystander – based on 1.5 hours proposal to move to specific training under the “Choose to Challenge.”

- Reset Programme – support for AMU and ED staff with burnout.

- Tensense Cultural Assessment Tool.

- Scope for Growth – career development.

- Trans and Gender awareness training - pilot in maternity.

We have extended our collaboration with Cornwall Partnership NHS Foundation Trust and are now actively working to develop policies and procedures that are suitable to work across both organisations and will continue to develop systems and process in these areas over the next few years.

We are developing closer working relationships with staff representative colleagues, leaders, and colleagues to co-design, develop and implement policies, procedures, and practices for an inclusive just and learning culture. Staff side colleagues are actively encouraged to work with the People Experience team to share knowledge so that we can create a better understanding of the issues that are affecting staff. This links with increased patient safety, staff engagement, diversity and inclusive, and health and wellbeing. The continued benefits of this approach include increased patient safety, reducing the need for inappropriate disciplinary investigations, and improving our learning about how day-to-day care is delivered to keep our patients safe.

4.18 Register of Interests

RCHT has published on its website an up-to-date register of interests, including gifts and hospitality, for decision-making staff (as defined by RCHT with reference to the guidance) within the past twelve months, as required by the '*Managing Conflicts of Interest in the NHS*' guidance.

RCHT defines decision-making staff as:

- Executive and Non-Executive Directors who have decision making roles which involve the spending of taxpayers' money.
- Those at Agenda for Change band 8d and above.
- 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.

RCHT's Declarations of Interests policy is aligned to the NHS guidance on *'Managing Conflicts of Interests'*. Members of staff record interests via the Electronic Staff Record and implementation of the policy is monitored annually by the Audit and Risk Assurance Committee.

Communication and guidance were issued to colleagues throughout the year on how to declare interests, including a specific reminder in December 2024 with regards declaring any gifts or hospitality during the festive period. ESR automatically reminds colleagues at 8d and above to make their declarations, including to confirm if they have no interests to declare and all-staff communications were issued to remind colleagues about the policy and how to declare any interest.

The Company Secretary provides ad hoc advice to colleagues as required to assist them in declaring and managing interests, noting however that each individual has responsibility for making their own judgements in this regard and for managing any interests appropriately, within the policy. The Company Secretary also liaises closely with the Counter Fraud Specialist and/or HR colleagues to support on investigations where a conflict of interest may be of concern and meets with procurement colleagues on a quarterly basis. In 2024/25 the Trust received a satisfactory internal audit on Declarations of Interest and took some learning around greater staff engagement and awareness around compliance and continuous improvement actions are underway into 2025/26.

Information on the policy, recording information, as well as sharing examples of compliance and good practice are made through the quarterly Standing Orders, Standing Financial Instructions and Scheme of Delegation training.

The registers for the RCHT Board of Directors, including those in attendance, and other decision-making staff are available from the following links:

- Register of Interests for Directors of RCHT.
- Register of Interests for other Decision-making staff.

4.19 NHS 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.

RCHT has implemented a Pension Restructuring Payment Scheme. The Remuneration and Appointments Committee receive an annual assurance report on its implementation and review the application and uptake of the Pension Contribution Recycling Scheme Policy. The Policy was reviewed in 2024.

4.20 Equality and Human Rights Legislation

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

At RCHT, we are committed to promoting Equality, Diversity, and Inclusion (EDI) in all that we do.

We want our NHS services at RCHT to be accessible and compassionate for our patients, their carers, and visitors, and we wish to demonstrate the strides we are making to embed equality within our world class refreshed values. These values are Respect, Compassion, Honesty and Teamwork.

We are a prominent service provider in Cornwall, drawing our staff from diverse ethnic backgrounds and life experiences. The growing diversity of our workforce and people who access our services bring a richness of cultures and lifestyles, driving the development of our annual equality work plans.

Our workforce and people using our services know that these services and how they are delivered need to be responsive to change. Therefore, to be successful, we are working in partnership with our staff, people using our services and key stakeholders to reduce health inequalities.

We are keen to ensure we comply with all elements of the Public Sector Equality Duty under the Equality Act (2010) and in doing so have worked in partnership with Cornwall Partnership NHS Foundation Trust (CFT) and Cornwall and Isles of Scilly Integrated Care Board (ICB) to develop four Equality Objective statements, these are cognisant of the NHS England EDI Improvement Plan and staff have been consulted with as these were developed.

The four jointly agreed Equality Objectives (EO) are:

- We are aware of and adaptable to meeting people's needs creatively to ensure

that they have a sense of belonging and are empowered to contribute authentically within our organisation.

- We are all role models of positive behaviours, and we stand shoulder to shoulder to address bullying, harassment, and discrimination.

- We have a recruitment process that creates a diverse workforce and ensures opportunities are provided that are equitable and offers career growth for everyone.

- We will work with patient communities to make sure that they are involved in design of services provided by us and our partners to make sure that they are accessible and well understood.

There is a four-year delivery plan that is reported on a quarterly basis to the People and Culture Committee. The delivery plan includes all actions from EDI mandated and statutory reports, so the Committee can be assured that all National and Regional actions as well as Trust Strategic ambitions are included within the delivery plan. In year 1 of the delivery plan (2024/25) there were 37 actions to be progressed before end of March 2025.

Focusing on progress against year 1 of the Equality Objectives delivery plan, of the 37 actions in total:

- 14 are completed actions.

- 16 are in progress – these will be required to be carried forward into the year 2 delivery plan.

- 7 are stalled – these will be required to be carried forward into the year 2 delivery plan.

The rationale for actions remaining at status of ‘in progress’ or ‘stalled’ relates to pilots in CFT that RCHT are keen to learn from before implementing the action, or the capacity to deliver the action based on current NHS financial and political climate meaning the work has had to stall as it is not the right time to be progressing with certain actions. In addition to this 2024 saw the increase of racial riots within the UK which resulted in solidarity listening events and new actions being developed throughout the year to support our staff from an Ethnic Minority background. These actions took priority and resulted in slower than expected progress with some of the other year 1 actions from the Equality Objectives.

We are continually reviewing our culture to ensure that the voices of those at most risk of being treated unfairly are heard, we are working closely with Cornwall Partnership NHS Foundation Trust (CFT) and Cornwall and Isles of Scilly Integrated Care Board (ICB) for the continued development of joint Employee Network Groups. There are now eight employee network groups and a new one relating to Faith was developed towards the end of 2024.

Employee Network Groups have an Executive sponsor and will now be run as joint groups with CFT and ICB. There is a quarterly Intersectionality meeting which brings together the Chairs for the employee networks, Chair persons, Chief Executives and EDI leads from each of the organisations to ensure smooth progression and continued support to Employee Network Chairs and their respective groups. The benefit to this is larger and hopefully more proactive groups to drive meaningful change within RCHT and improve the staff lived experience in the workplace and outside the place of work.

Terms of References for the network groups and role descriptions have been standardised to ensure parity, and OD training has taken place for the joint Chairs of the network groups. There is a half day release from substantive role which has been agreed weekly for the Chair of the networks, plus a small budget agreed for the network groups so they can promote and develop themselves.

The Trust has promoted many different diversity and inclusion initiatives throughout the year, these include:

- Filipino colleagues developed a cultural appreciation month, celebrating the many traditions within the Filipino culture throughout June 2024.
- Supporting of local PRIDE events across Cornwall throughout the summer months.
- A programme of events across Black History month and beyond from October 2024.
- The promotion of Disability History month and beyond from October 2024.
- Re-signing of the Armed Forces Covenant at a ceremony in October 2024, a copy of the signed covenant can be seen at Trelawny main entrance.
- A programme of events for Remembrance Week in November 2024 included; poppies for Paddington, Remembrance service onsite at the Chapel, which was live streamed, and laying of a wreath as part of Truro Cathedral serviced on remembrance Sunday.
- Talks in LGBTQ+ in February 2025 to improve understanding and the history for our LGBTQ+ community.
- Presentation in February 2025 of the Defence Employer Recognition Scheme (ERS) Gold Award, which is the highest honour available.
- Promotion of Ramadan and support information for those fasting, building improved connections between the Trust and the local Cornwall Islamic Centre.

Our Equality, Diversity and Inclusion team continue to work closely with the Employee Network Chairs. There is a calendar of events being developed jointly with the Communications team for 2025/26, which will allow the networks to lead and promote events that are important to our staff.

The Board introduced its first Board Diversity Plan in March 2021 and since then the People and Culture Committee reviews progress on actions on behalf of the Board on a quarterly basis and the Board receives a bi-annual report.

The Board Diversity Plan is deliberately focussed on improving diversity across the Board of Director and senior staff body, recognising that diversity is a governance issue. The Trust's broader approach to Equality, Diversity and Inclusion (ED andI) is set out in the Trust Strategy and the Equality Annual Equality Report.

The requirement to have a Board Diversity Plan was set out within the NHS People Plan and it is recognised that diversity within Boards of Directors – in all its forms – enables better governance because individuals bring different perspectives, experiences and ways of thinking to help ensure well considered decisions are taken for the benefit of the population an organisation serves.

NHS England (NHSE) and the Care Quality Commission (CQC) have recognised the importance of equality, diversity and inclusion (EDI) within their forthcoming changes to the NHSE Oversight Framework and the new CQC well-led inspection framework.

Areas of focus for 2024/25 have included embedding the arrangements for the Equality, Diversity and Inclusion Networks and the successful appointment of a NExT Director placement in February 2024 which resulted in a later appointment to the Trust Board in February 2025. The Trust is just about to start its next NExT Director campaign in Q1 of 2025/26.

4.21 Delivering a Net Zero Health Service

RCHT has undertaken risk assessments and has plans in place which take account of the 'Delivering a Net Zero Health Service' report under the Greener NHS programme. RCHT ensures that its obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with.

The RCHT Green Plan was approved by the Board in March 2021 and links to the local health system's Green Plan for Cornwall (2020 – 2030) which sets out the sustainability goals for the county and how they may be achieved.

As leading employers and healthcare providers in Cornwall, RCHT has committed to a goal of net zero carbon by 2030. The Green Plan sets out the pathway to achieving net zero carbon, addressing the role we play in tackling the climate health emergency, and build upon the key learnings from the global pandemic, which highlighted our ability to adapt and come together when faced with challenges.

Our 2022-2032 Strategy states *"We will become an environmentally sustainable organisation by focusing on planning for climate resilience and delivering our Green Plan"*. This has set sustainability as a priority within the organisation and should support the delivery of Green Plan projects, and ensure sustainability is a core part of all service developments, business cases and capital projects.

Our Green Plan drives a focused approach to sustainability in which delivering net zero carbon healthcare in Cornwall and the Isles of Scilly is owned by senior leadership as well as each and every member of the healthcare community. It sets out our contributions to meet the NHS Long Term Plan and the 'Delivering a Net Zero National Health Service' report. It also supports RCHT in meeting the new Care Quality Commission "Well Led" question relating to environmental sustainability.

RCHT's own Net Zero target is even more ambitious than the overall NHS ambition. NHS England have stated that "for the emissions we control directly (our NHS Carbon Footprint), we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2028 to 2032" in the publication "Delivering a net zero NHS." RCHT target for this scope of emissions was set at Net Zero by 2030 to align with the Cornwall Council target reflecting the partnership approach to sustainability in Cornwall. The Green Plan sets out a trajectory for meeting Net Zero; RCHT assesses progress through an annual calculation of our carbon footprint

The Trust is undertaking a review of the Green Plan, in particular the alignment of the local net zero target against the national NHS target owing to the level of investment required to decarbonise our estates. A review was undertaken in 2024 that considered progress against the Green Plan action plan and the investment required which will inform the refresh.

The Board receives assurance on a bi-annual basis on progress against the Green Plan (including an annual report and an annual calculation of the Trust's carbon footprint as a key indicator of our progress). Finance and Performance Committee also have remit to monitor the performance of the System Green Plan, the approach to sustainability and delivery against the commitment to be a net zero carbon organisation by 2030 (as set out in 'Delivering at Net Zero National Health Service'). In addition, the Trust undertakes a quarterly data return to NHS England for Greener NHS Data. As part of the Green Plan refresh, in 2025 the Trust has formed a Task and Finish Group to oversee development of the refreshed plan, with an intention that once the plan is approved this will become a quarterly steering group to oversee delivery and progress against the plan

Several successful projects have been undertaken across our hospitals to support our sustainability ambitions, and the Trust actively pursues nationally funding opportunities to support making improvements to our estate; this has included securing funding in 2024 to upgrade lighting to LED and to introduce solar panels to support green energy generation.

The Green Plan describes high level climate risks that the Trust needs to respond to through its action plan. The climate risks to health are further detailed in the Trust's Climate Change Adaptation Plan, developed through the Emergency Preparedness Resilience and Response Committee, with reporting against the plan through this meeting. All risks at the Trust are managed in line with the Trust's Risk Management Policy, however we recognise that we could be better at articulating climate and sustainability related risks within our existing risk register where there is a climate element to the risks we have identified.

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

We use various processes and controls (such as its Standing Financial Instructions) to ensure economy, efficiency, and effectiveness in its use of resources.

We have a Finance and Performance Committee whose remit is to monitor the use of resources as well as performance. The Finance and Performance Committee receives on a monthly basis revenue and capital reports as well as a quarterly deep dive in relation to cash. RCHT's overall capital programme is set annually and refreshed as required in year. All of this information is then reported to the RCHT Board in line with our governance processes.

We have an annual Cost Improvement Plan (CIP) and work in conjunction with Care Groups and Corporate Departments, as well as with system partners, to ensure appropriate oversight and delivery of savings to maintain and achieve financial balance. CIP performance is monitored by Care Groups and Corporate Performance Review meetings and is reported monthly to the Finance and Performance Committee. In 2024/25 the Board had significant interest in the delivery of the CIP plan therefore monthly assurance reports were presented on progress and delivery to each of the Committee meetings, with particular focus on matters relating to financial delivery and impacts on quality and safety and the workforce. There are several cross-system schemes in place to ensure the best use or transformation of services, whilst maintaining a focus on quality and patient safety.

Each 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 RCHT with a "Value for Money" conclusion regarding its arrangements for securing economy, efficiency, and effectiveness in its use of resources. During 2024/25 internal audit (as part of its audit plan) conducted a number financial control, productivity, efficiency, and value for money audits as follows:

- Financial Management (RCHT).
- RCHT and CFT Financial Management.
- High Level Financial Controls.
- Contract Management.
- Capital Prioritisation/Strategy.

We also seek 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. This includes using Model Hospital data and Patient Level Costing Information (PLICS) and national and regional published productivity metrics.

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. As indicated above performance against RCHT's financial plan and delivery of its savings target are reported to the Finance and Performance Committee and Trust Board each month. Although the cost saving target for 2024/25 was met, RCHT is improving but continues to struggle to identify adequate recurrent savings but achieved significantly more in 2024/25 versus 2023/24; this was and will continue to be a significant focus of improvement in the 2025/26 programme and efforts have already commenced to provide support and ensure progress in this area. It has however been made clear to Care Groups and Corporate areas of the level of recurrent savings required to be achieved for 2025/26 and the need to increase productivity and efficiency.

Quality and efficiency go hand in hand and RCHT actively engages and encourages staff in identifying ways to become more efficient and deliver improved care. RCHT has a Quality Improvement Hub which helps progress quality improvement initiatives from simple changes to major schemes of transformation. RCHT has its own dedicated idea platform called QIdeas where staff can submit their ideas and gain support from QI colleagues with getting these operational. Additionally, the Quality Improvement Hub are supporting a number of dedicated programmes across RCHT.

RCHT 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. Operational planning guidance places an emphasis on productivity in the NHS and this will be a key theme of our activity in 2025/26.

The internal audit on the high-level financial controls concluded with significant assurance on RCHT having the appropriate designed and effectively operating financial systems controls to support the accurate recording of RCHT's financial position and reporting of this to the Board.

RCHT has an agreed system Annual Financial and Operational Plan, with mechanisms in place through "triple lock" process to approve anything outside of plan. RCHT has underpinning, robust accounting policies which are reviewed by the Audit and Risk Assurance Committee.

6 Information governance

RCHT reported eight incidents directly to the Information Commissioners Officer as a result of a breach of data protection.

Date	What was reported	Reported to:
17.03.2025	A male member of staff accessed the contact details of a colleague held in our payroll system in order to make personal contact with her.	ICO

Date	What was reported	Reported to:
27.01.2025	A midwife has disclosed that a patient is pregnant following a ten week scan to colleagues of the patient who she know outside of work without consent. The patient had not told colleagues or anyone else she was pregnant as she had two previous miscarriages and did not want to share this information till later in the pregnancy.	ICB
14.01.2025	A midwife disclosed to a pregnant mother a message she had received to her work mobile from the father of the child that referred to domestic abuse he was subjected to. He was clear that this was not to be made known to the mother of his child. The midwife chose to ignore his wish and disclosed the information.	DHSC/NHS England and ICO
29.08.2024	A member of staff has used information obtained whilst working on a ward to contact a patient via social media in order to establish a relationship. The patient blocked the unwanted contact when it became clear it was of an unnerving nature. The staff member shared the name of the patient with a 3rd party and got them to contact the patient to tell them that the staff member was single. This implied that a hospital attendance occurred.	ICO
16.08.2024	A member of staff has been accessing a large number of records relating to patients without a legitimate relationship	ICO
29.07.2024	A staff member accessed the records of an ex-partner and his daughter's record. They were in a relationship 8 months ago which the complainant broke off. There have been allegations that the staff member has been stalking the complainant.	ICO
26.06.2024	Member of staff disclosed confidential health information on two separate occasions regarding another member of staff. At the time the information was given over the individual was a patient and the information was passed over confidentially during a health review. The data breach has caused considerable stress, anxiety and embarrassment to the individual concerned.	ICO

Date	What was reported	Reported to:
02.05.2024	A staff member working for Cornwall Partnership NHS Foundation Trust accessed the electronic clinical records of a colleague who was admitted to the Royal Cornwall Hospital Trust and shared the information with other colleagues within their department.	DHSC/NHS England and ICO

7 Data quality and governance

The Records, Information and Data Quality Strategy sets out RCHT's approach to managing information and data quality, however or wherever that data is collected (electronically or manually, by clinical or business support services). This is supported by the Policy on the Management of Information, Records and Data Quality. RCHT aims to maximise the accuracy, timeliness and quality of data collected. High standards in data quality aid RCHT 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 RCHT'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.

Several 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. The Patient Access Team carry out over 11 hours per day of waiting list data quality checks and the Trust benchmarks very favourably nationally for data quality confidence levels for the RTT patient tracking list, routinely achieving well above the 95% standard, in excess of 99.6%.

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 RCHT's incident management procedure. The Patient Access and Business Intelligence teams are working closely throughout 2025/26 to ensure that the transition to the new EPR, eCare, brings minimal risk in terms of waiting list data quality and waiting time reporting.

In October 2024 the internal audit report on data quality framework resulted in a satisfactory assurance opinion. The audit focussed on a review of RCHT's data quality framework in relation to four key performance indicators (KPI's) from the Integrated Performance Report (IPR) that is presented to RCHT Board and its committees.

1. RTT Waits for incomplete pathways; Unvalidated 65 week waits

2. Infection control: C-Difficile cases.

3. 28 day re-booking compliance.

4. Duty of Candour compliance.

It is of note RCHT has a significant number of key performance measures within the Integrated Performance Report an annual exercise is undertaken to risk assess the data quality standards of each metric reported in the IPR in terms of data quality. RCHT Board received the Integrated Performance Report Annual Review in May 2024, and it is scheduled again for May 2025. The data quality check is routinely carried out as part of the IPR review process and is included as assurance for the Board to regularly monitor the data quality of the metrics reported.

8 Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review of the effectiveness of the system of internal control is informed by the work of the internal auditors, clinical audit and the executive managers and clinical leads within RCHT 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 a plan to address weaknesses and ensure continuous improvement of the system is in place.

Maintaining and reviewing the effectiveness of the system of internal control

The Audit and Risk Assurance Committee has provided the Board of Directors with an independent and objective review of the financial controls in place at RCHT, via internal audit. The internal audit on the high level financial controls identified significant assurance. No significant gaps were identified during 2024/25, and assurance has regularly been provided to Audit and Risk Assurance Committee during 2024/25 that Trust financial internal controls continued to operate effectively.

As part of RCHT'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 RCHT's Audit and 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 RCHT through the Audit and Risk Assurance Committee. Counter Fraud training is considered as essential training for all Trust staff.

RCHT has lead liaison officers with key regulatory bodies and its 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 the Board).

The annual Clinical Audit Plan is agreed by the Quality Assurance Committee, and considered by Audit and Risk Assurance Committee, and reflects the priorities of RCHT and national best practice. Our Clinical Audit programme is made up of four 'tiers' with a hierarchy of importance, with priority one 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 One — External 'must do' audits.
- Priority Two — Internal 'must do' audits.
- Priority Three — Care Group priorities.
- Priority Four — Clinician interest and prioritising local audits.

As at March 2025, RCHT continues to fully participate in all qualifying national audits.

A quarterly review of progress against the plan is considered by Quality Assurance Committee and noted by the Board of Directors via the Committee Assurance Report to Board. Any significant issues that emerge are reported to the Board of Directors and a service improvement plan put in place.

Internal audit has reviewed and reported on control, governance and risk management processes, based on a plan approved by Audit and Risk Assurance Committee. The annual internal audit plan is informed by and mapped to RCHT's Board Assurance Framework and key corporate risks and is developed with engagement of Executive Directors. The internal audit plan included required audits in accordance with NHS Internal Audit Standards, as well as identifying and evaluating controls and testing their effectiveness.

Where scope for improvement has been found from internal audits, recommendations were made and action plans put in place by management; progress against recommendations is reported to each meeting of Audit and Risk Assurance Committee via a recommendations tracker. The tracker is also reviewed on a monthly basis by Executive Directors. Limited assurance internal audits are received by the Executive Leadership Team for consideration and by the relevant assurance Committee of the Board to ensure colleagues are aware of any issues and can monitor action plans for improvements as appropriate.

There has been significant focus on timely audits and RCHT works closely with its internal auditors regarding the management engagement and response. Audit and Risk Assurance Committee play close attention to compliance and seek assurances on internal controls.

RCHT has sustained the improvements it made during 2024/25 to its internal controls which is reflected in the maintenance of the Head of Internal Audit Opinion of 'satisfactory'. We continue to work to 'close the loop' on internal audit recommendations and fully embed and sustain learning from reviews.

9 Conclusion

Based on the above report, no significant internal control issues have been identified.

Steve Williamson.

Chief Executive.

26 June 2025.

Statement of the Chief Executive's responsibilities as the accountable officer of the Trust

The Chief Executive of NHS England 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.

Signed.....Chief Executive

Date.....

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

.....Date.....Chief Executive

.....Date.....Finance Director

Remuneration and Staff Report

1. 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, rather than the decisions of individual directorates or departments.' For the purposes of this report, this covers RCHT'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 Chair and Non-Executive Directors nationally.

Remuneration for Very Senior Managers, which includes Executive Directors and voting executives of the Board, is determined by the Remuneration and Appointments Committee.

Certain detail included within the Remuneration and Staff 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.

2. The Remuneration and Appointments Committee

The terms of reference for the Remuneration and Appointments Committee were last updated and approved by the Board in May 2025. The membership comprises all Non-Executive Directors, including the Chair of the Board but excluding the Chair of the Audit and Risk Assurance Committee. The Senior Independent Director is the Chair of the Committee and in their absence a nominated Non-Executive Director (other than the Chair of the Board) will act as Chair.

Remuneration Policy – Executive Directors

Any amendments to salary are determined annually by the Remuneration and Appointments Committee, subject to any relevant Treasury approvals required for salaries over £150,000, per national guidance. Salary is inclusive – other payments such as overtime, long hours, on-call, standby etc. do not feature in Executive Director remuneration. The Committee determines salaries within the context of RCHT's Very Senior Manager Remuneration Framework (last reviewed and approved March 2025) and relevant national policies. Executive Director performance is monitored by the Committee through the formal appraisal process, based on organisational and individual objectives.

The Chief Medical Officer's salary is in accordance with the *Terms and Conditions – Consultants (England) 2003*.

Details of remuneration and pensions for Non-Executive and Executive Directors are detailed in the tables within this report. RCHT does not operate a performance-related pay scheme for Executive Directors.

RCHT operates a Pension Contribution Recycling Scheme. The scheme is open to all employees of RCHT who meet the qualifying criteria. The Chief Executive Officer, who is the highest paid director of RCHT, opted to join the scheme from April 2022.

3. Fair pay disclosures (subject to audit)

The table below shows the year-on-year percentage change in salary, performance and bonus payments of the highest-paid director and employees of RCHT respectively. The changes in remuneration reflect the national pay award application which applies for most Trust staff.

Description	2024/25 Percentage change in salary to previous year	2024/25 Percentage change in performance-related pay and bonuses to previous year	2023/24 Percentage change in salary to previous year	2023/24 Percentage change in performance-related pay and bonuses to previous year
Highest Paid Director	5.20%	0.00%	0.95%	0%
Employees of the Trust as a whole	6.12%	0.00%	3.18%	0%

Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation against the 25th percentile, median and 75th percentile of remuneration of the organisation's workforce. Total remuneration is further broken down to show the relationship between the highest paid director's salary component of their total remuneration against the 25th percentile, median and 75th percentile of salary components of the organisation's workforce.

The banded remuneration of the highest-paid director in RCHT in the financial year 2024/25 was £230,000-£235,000 (2023/24: £220,000-£225,000). The relationship to the remuneration of the organisation's workforce is disclosed in the table below.

Year	25th Percentile Total Remuneration Ratio	25th Percentile Salary Ratio	Median Total Remuneration Ratio	Median Salary Ratio	75th Percentile Total Remuneration Ratio	75th Percentile Salary Ratio
2024/25	8.60:1	8.60:1	6.22:1	6.22:1	4.48:1	4.48:1
2023/24	8.39:1	8.39:1	6.16:1	6.16:1	4.54:1	4.54:1

The mid-point of the total banded remuneration of the highest-paid director was 6.22 times (2023/24: 6.16 times) the median remuneration of the workforce, which was £37,358 (2023/24: £36,105). The 25th percentile was £27,038 (2023/24: £26,520) and the 75th percentile was £51,892 (2023/24: £49,024). There are no significant changes in the ratios above.

Based on the March 2025 payroll, the calculated annualised pay for 2024/25 of 11 employees, who are medical staff, would have exceeded that of the highest-paid director (2023/24: 18 employees). Remuneration of these employees ranged from £235,000 to £297,000 (2023/24: £221,000 to £298,000). The annualised remuneration of all staff, ranged from £1,000 to £297,000 (2023/24: £1,000 to £298,000).

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

4. Duration of contracts, notice periods and termination payments

Other than the Chief Medical Officer, whose executive role endures for the duration of office, Executive Directors are employed on contracts of service and are substantive employees of RCHT. 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, RCHT may engage a suitably qualified and experienced external interim director to ensure continuity of leadership (with approval from NHS England) 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 RCHT in the year, are detailed in tables within this report.

5. Non-Executive Directors Terms of Office

The dates of tenure 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
David Allen (Chairman)	January 2025	January 2028				
Uzma Bozai	February 2025	February 2027				
Adam Broome	November 2020	November 2022	November 2022	November 2024	November 2024	November 2025
Adrian Davis	June 2024	May 2026				
Isobel Down	February 2022	February 2024	February 2024	February 2026		
Matt Hill	November 2024	October 2026				
Richard Kramer	May 2024	April 2026				
Aled Jones (Associate)	May 2023	April 2024	May 2024	April 2025	May 2025	April 2026

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

6. 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 RCHT. For these purposes, Senior Managers are regular attendees of RCHT Board, who are directing and controlling the organisation.

Salary and pension entitlements of Non-Executive Directors

	2024/25			2023/24		
Non-Executive Directors	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) total to nearest £100** **£**	**TOTAL (bands of £5,000)** **£000**	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) total to nearest £100** **£**	**TOTAL (bands of £5,000)** **£000**
David Allen OBE Chairman *(from January 2025)*	10 - 15	0	10 - 15	0	0	0
Uzma Bozai Non-Executive Director *(from February 2025)*	0 - 5	0	0 - 5	0	0	0
Adam Broome Non-Executive Director	10 - 15	0	10 - 15	10 - 15	0	10 - 15

	2024/25			2023/24		
Non-Executive Directors	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) total to nearest £100** **£**	**TOTAL (bands of £5,000)** **£000**	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) total to nearest £100** **£**	**TOTAL (bands of £5,000)** **£000**
Adrian Davis Non-Executive Director *(from June 2024)*	10 - 15	0	10 - 15	0	0	0
Isobel Down Non-Executive Director	10 - 15	800	10 - 15	10 - 15	0	10 - 15
Matt Hill Non-Executive Director *(from November 2024)*	5 - 10	300	5 - 10	0	0	0
Professor Aled Jones Associate Non-Executive Director (*from May 2023)*	5 - 10	0	5 - 10	5 - 10	0	5 - 10
Richard Kramer Non-Executive Director *(from May 2024)*	10 - 15	0	10 - 15	0	0	0
Professor Richard Stephenson Non-Executive Director *(to February 2025)*	10 - 15	1,100	10 - 15	10 - 15	0	10 - 15

	2024/25			2023/24		
Non-Executive Directors	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) total to nearest £100** **£**	**TOTAL (bands of £5,000)** **£000**	**Salary (bands of £5,000)** **£000**	**Expense payments (taxable) total to nearest £100** **£**	**TOTAL (bands of £5,000)** **£000**
Dr Mairi McLean Chairwoman *(to January 2025)*	40 - 45	1,100	40 - 45	55 - 60	200	55 - 60
Dr Andrew Whitfield Non-Executive Director (*from June 2023 to May 2024)*	0 - 5	100	0 - 5	10 - 15	0	10 - 15
Sarah Newton Non-Executive Director *(to March 2024)*	0	0	0	10 - 15	0	10 - 15
Dr Nina Khaira Non-Executive Director *(to January 2024)*	0	0	0	10 - 15	0	10 - 15
Ruth Allarton Non-Executive Director *(to May 2023)*	0	0	0	0 - 5	0	0 - 5

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

Salary and pension entitlements of Senior Managers 2024-25

Senior Managers: 2024/25	Note	Salary whilst in post as Senior Manager (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Steve Williamson Chief Executive	1	230 - 235	1,400	30.0 - 32.5	260 - 265
Kim O'Keeffe Deputy Chief Executive and Chief Nursing Officer	2	90 - 95	0	30.0 - 32.5	125 - 130
Ian Dean Chief Finance Officer *(from August 2024)* Interim Chief Finance Officer *(from January 2024 to August 2024)*		145 - 150	700	222.5 - 225.0	370 - 375
Dr Meridith Kane Chief Medical Officer *(from November 2024)*	3	125 - 130	0	25.0 -27.5	150 - 155
Kelvyn Hipperson Chief Information Officer	4	80 - 85	0	20.0 - 22.5	100 - 105

Senior Managers: 2024/25	Note	Salary whilst in post as Senior Manager (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Robin Jones Chief Operating Officer	1	165 - 170	0	0	165 - 170
Ella Stracey Chief Performance, Partnerships and Transformation Officer		140 - 145	600	47.5 - 50.0	190 - 195
Alison Thorne-Henderson Chief People Officer	5	80 - 85	0	20.0 - 22.5	100 - 105
Dr Allister Grant Chief Medical Officer *(to October 2024)*	1	120 - 125	100	15.0 - 17.5	135 - 140

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

Notes for 2024-25

1. Steve Williamson, Robin Jones and Dr Allister Grant were opted out of the NHS Pension Scheme throughout 2024/25. Pension benefits shown for Steve Williamson and Dr Allister Grant relate in full to payments under RCHT's pension contribution recycling scheme.

2. The Chief Nursing Officer post is a dual role shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those costs incurred by this Trust for the period April 2024 to March 2025. The full salary costs for the individual would be in the band £185,000-£190,000.

3. The Chief Medical Officer is an employee of Somerset Foundation Trust and has been seconded to the Royal Cornwall Hospitals Trust since November 2024. The salary costs disclosed above are the costs invoiced by Somerset Foundation Trust to Royal Cornwall Hospitals NHS Trust for the period from November 2024 to March 2025.

4. The Chief Information Officer post is a shared role with Cornwall Partnership NHS Foundation Trust and Cornwall and Isles of Scilly Integrated Care Board. Salary costs disclosed here are those costs incurred by this Trust for the period April 2024 to March 2025. The full salary costs for the individual would be in the band £160,000-£165,000.

5. The Chief People Officer post is a dual role shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those incurred by this Trust for the period April 2024 to March 2025. The full salary costs for the year to March 2025 would be in the band £160,000 to £165,000.

No performance pay or bonuses were received by the senior managers above in 2024/25.

Salary and pension entitlements of Senior Managers 2023/24

Senior Managers: 2023/24	Note	Salary whilst in post as Senior Manager (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Steve Williamson Chief Executive	1	220 - 225	1,100	27.5 - 30.0	245 - 250
Kim O'Keeffe Deputy Chief Executive and Chief Nursing Officer	2	90 - 95	0	0	90 - 95
Ian Dean Chief Finance Officer *(from August 2024)* Interim Chief Finance Officer *(from January 2024 to August 2024)*	3	0 - 30	100	5.0 - 7.5	35 - 40
Dr Allister Grant Chief Medical Officer	1	195 - 200	600	7.5 - 10.0	205 - 210
Kelvyn Hipperson Chief Information Officer	4	85 - 90	0	22.5 - 25.0	110 - 115
Robin Jones Chief Operating Officer	1	150 - 155	0	0	150 - 155

Senior Managers: 2023/24	Note	Salary whilst in post as Senior Manager (bands of £5,000) £000	Expense payments (taxable) total to nearest £100 £	All pension-related benefits (bands of £2,500) £000	TOTAL (bands of £5,000) £000
Karl Simkins Chief Finance Officer *(to January 2024)*		125 - 130	200	0	125 - 130
Ella Stracey Chief Performance, Partnerships and Transformation Officer *(from November 2023)* Interim Chief Strategy and Performance Officer *(to November 2023)*		120 - 125	1,100	2.5 - 5.0	125 - 130
Alison Thorne-Henderson Chief People Officer	5	75 - 80	0	20 - 25	100 - 105

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

Notes for 2023/24

1. Steve Williamson and Robin Jones have opted out of the NHS Pension Scheme. Pension benefits shown for Steve Williamson relate in full to payments under RCHT's pension contribution recycling scheme. Dr Allister Grant left the pension scheme during the year and pension costs disclosed include both pension scheme movements and pension recycling scheme payments.

2. The Chief Nursing Officer post is a dual role shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those costs incurred by this Trust for the period April 2023 to March 2024. The full salary costs for the individual would be in the band £185,000-£190,000.

3. Ian Dean held the position of Deputy Director of Finance to January 2024. Remuneration included here is for the period 15 January 2024 to 31 March 2024, in the post of Interim Chief Finance Officer.

4. The Chief Information Officer post is a dual role shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those costs incurred by this Trust for the period April 2023 to March 2024. The full salary costs for the individual would be in the band £140,000-£145,000.

5. The Chief People Officer post is a dual role shared with Cornwall Partnership NHS Foundation Trust. Salary costs disclosed here are those incurred by this Trust for the period April 2023 to March 2024. The full salary costs for the year to March 2024 would be in the band £155,000 to £160,000.

   No performance pay or bonuses were received by the senior managers above in 2023/24.

7. Pension benefits

Senior Manager	Real increase in pension at pension age (bands of £2,500) £000	Real increase in pension lump sum at pension age (bands of £2,500) £000	Total accrued pension at pension age at 31 March 2025 (bands of £5,000) £000	Lump sum at pension age related to accrued pension at 31 March 2025 (bands of £5,000) £000	Cash Equivalent Transfer Value at 31 March 2025 as provided by NHSPA £000	Cash Equivalent Transfer Value at 31 March 2024 as provided by NHSPA £000	Real increase in Cash Equivalent Transfer Value £000
Ian Dean	10.0 - 12.5	22.5 - 25.0	45 - 50	120 - 125	930	674	192
Kelvyn Hipperson	2.5 - 5.0	0	15 - 20	0	300	225	38
Dr Meridith Kane	2.5 - 5.0	0 - 2.5	75 - 80	195 - 200	1,748	1,550	69
Kim O'Keeffe	2.5 - 5.0	2.5 - 5.0	55 - 60	145 - 150	*165	*102	*22
Ella Stracey	2.5 - 5.0	0 - 2.5	30 - 35	70 - 75	561	478	34
Alison Thorne-Henderson	2.5 - 5.0	0	20 - 25	0	410	331	36

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

I Dean, K O'Keeffe, and E Stracey are affected by the Public Service Pensions Remedy and their membership between 1 April 2015 and 31 March 2022 was moved back into the 1995/2008 Scheme on 1 October 2023.

*National retirement age reached; therefore 2015 scheme figures only are provided.

Negative values are not disclosed in this table but are substituted with a zero.

RCHT 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. CETV figures are calculated using the guidance on discount rates for calculating unfunded public service pension contribution rates that was extant at 31 March 2025.

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 2024/25 was 6.7% (2023-24: 10.1%).

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

8. Reporting of other compensation schemes for Senior Managers: exit packages

There were no exit packages agreed in respect of Senior Managers in either 2024/25 or 2023/24.

9. Staff Report

Staff costs

Staff costs for the year are shown below:

Staff Cost	2024/25 Permanent £000	2024/25 Other £000	2024/25 Total £000	2023/24 Total £000
Salaries and wages	323,298	18,177	**341,475**	**305,517**
Social security costs	37,115	2,272	**39,387**	**36,486**
Apprenticeship levy	1,629	86	**1,715**	**1,592**
Employer's contributions to NHS pension scheme	62,692	2,404	**65,096**	**50,635**
Pension cost - other	178	134	**312**	**305**
Termination benefits	132	0	**132**	**127**

Staff Cost	2024/25 Permanent £000	2024/25 Other £000	2024/25 Total £000	2023/24 Total £000
Temporary staff	0	14,750	**14,750**	**22,583**
Total staff costs	**425,044**	**37,823**	**462,867**	**417,245**
Of which: Costs capitalised as part of assets	9,679	0	**9,679**	**5,281**

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 RCHT in 2024/25 these were as follows:

Staff type	2024/25 Permanently Employed Staff (Number)	2024/25 Bank and Agency Staff (Number)	2024/25 Total Staff (Number)	2023/24 Total Staff (Number)
Medical and dental staff	978	62	**1,040**	**1,012**
Administration and estates staff	2,116	97	**2,213**	**2,221**
Healthcare assistants and other support staff	790	137	**927**	**937**
Nursing, midwifery and health visiting staff	1,672	161	**1,833**	**1,765**
Nursing, midwifery and health visiting learners staff	29	0	**29**	**22**
Scientific, therapeutic and technical staff	1,115	44	**1,159**	**1,092**
Healthcare science staff	184	3	**187**	**173**
Other	3	0	**3**	**1**
Total	**6,887**	**504**	**7,391**	**7,223**
Number of employees (WTE) engaged on capital projects	177	0	177	**92**

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) and Staff composition – permanent staff

The following table details the average whole time equivalent staff numbers, included within the permanent staff figures above, by gender. 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 Type	Male	Female	Total
Board members	5	3	**8**
Senior Staff (Agenda for Change pay scales Band 8 and above)	122	240	**362**
Other staff	1,555	4,962	**6,516**
Total	1,682	5,205	**6,887**

Information relating to staff turnover rates at RCHT can be found through NHS Digital's NHS Workforce statistics publications on the NHS digital website (https://digital.nhs.uk)

10. Staff policies – equality and inclusion

RCHT 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 RCHT on issues which may affect disability and as a collective voice to be heard and responded to.

Other staff networks RCHT supports are an Ethnic Minority Group which started as a focus group to examine the evidence for the Workforce Race Equality Standard and 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 LGBTQ+ staff network, RCHT joined the local Public Sector 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.

The Trust has a Zero Tolerance to Discrimination and this is supported by the RCHT Anti-Discrimination Statement , 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, including RCHT's 'Equality, Diversity and Inclusion Policy', can be found on RCHTs' website, www.royalcornwallhospitals.nhs.uk

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

11. Sickness absence data

The table below details RCHT's sickness absence data. The data is based on the 2024 calendar year, which the Department of Health and Social Care regards as a reasonable proxy for the 2024/25 financial year.

Staff sickness absence	2024/25
Total days lost	78,160
Total staff years	6,873
Average working days lost (per WTE)	11

Ill-health retirement data is shown below:

Ill-health retirements	2024/25	2023/24
Number of persons retired early on ill-health grounds	9	13
Total additional pensions liabilities accrued in the year	£1,106,000	£1,889,000

12. Consultancy expenditure

RCHT incurred the following consultancy expenditure in 2024/25:

Area	Expenditure £000
Health innovation support	7
Estates consultancy	2
Management support	2
VAT credits in relation to previous years	(1)
Total	**10**

13. 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 2025 for more than £245 per day:	Number
Number of existing engagements as of 31 March 2025	0
The number that have existed for less than 1 year at the time of reporting	0
The number that have existed for between 1 and 2 years at the time of reporting	0

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

Off-payroll engagements between 1 April 2024 and 31 March 2025, for more than £245 per day	Number
Number of temporary off-payroll workers engaged between 1 April 2023 and 31 March 2025	0
Of which: Number not subject to off-payroll legislation	0
Number subject to off-payroll legislation and determined as in-scope of IR35	0
Number subject to off-payroll legislation and determined as out of scope of IR35	0
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 2024 and 31 March 2025:

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

14. Exit packages

The tables below detail the exit packages agreed in 2024/25 and 2023/24:

Exit packages agreed in 2024/25

Band	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
Less than £10,000	0	0	8	24	8	24
£10,000-£25,000	0	0	1	14	1	14
£25,001-£50,000	0	0	1	30	1	30
£50,001-£100,000	0	0	1	64	1	64
Total	**0**	**0**	**11**	**132**	**11**	**132**

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

Exit packages agreed in 2023/24

Band	Number of compulsory redundancies Number	Cost of compulsory redundancies £000	Number of other departures agreed Number	Cost of other departures agreed £000	Total number of exit packages Number	Total cost of exit packages £000
Less than £10,000	0	0	5	13	5	13
£10,000-£25,000	0	0	2	30	2	30
£25,001-£50,000	0	0	2	66	2	66
Total	**0**	**0**	**9**	**109**	**9**	**109**

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

No exit packages were agreed in 2024/25 or 2023/24 in respect of Senior Managers.

Exit costs in the tables above are accounted for in full in the year of departure. Where RCHT has agreed early retirements, the additional costs are met by RCHT 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.

Analysis of other departures

2024/25

Type (Excluding compulsory redundancies)	Total number of agreements	Total value of agreements £000
Contractual payments in lieu of notice	10	127
Special severance payments	1	5
Total	**11**	**132**

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

2023/24

Type (Excluding compulsory redundancies)	Total number of agreements	Total value of agreements £000
Contractual payments in lieu of notice	9	101
Exit payments following employment tribunals or court orders	1	8
Total	**10**	**109**

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.

15. Trade union facility time

As part of the trade union (facilities time publication requirements) regulations 2017, the Trust is required to report facility time, which is paid time-off during working hours for trade union representatives to carry out trade union activities.

The 2024 report provided to the Cabinet Office (gov.uk/government/stistical-data-sets / public-sector-trade-union-facility-time-data) is reflective of the period 1 April 2023 to 31 March 2024 and is shown below:

Number of trade union representatives

Number of employees who were relevant union officials during the relevant period	Full-time equivalent employee number
65	51

Percentage of time spent of facility time

Percentage of time	Number of employees
0%	41
1 - 50%	24
51 - 99%	0
100%	0

Percentage of pay bill spent of facility time

Description	Figures
Total cost of facility time	£26,382
Trust's total pay bill	£355,515,708
Percentage of the total pay bill spent on facility time	0.01%
Time spent of paid trade union activities as a percentage of total paid facility time hours	0.00%

Steve Williamson, Chief Executive.

26 June 2025.

Certificate on summarisation schedules

Trust Accounts Consolidation (TAC) Summarisation Schedules for Royal Cornwall Hospitals NHS Trust

Summarisation schedules numbers TAC01 to TAC34 and accompanying WGA sheets for 2024/25 have been completed and this certificate accompanies them.

Finance Director Certificate

1. I certify that the attached TAC schedules have been compiled and are in accordance with:

    - The financial records maintained by the NHS Trust.
    - Accounting standards and policies which comply with the *Department of Health and Social Care's Group Accounting Manual* and
    - The template NHS provider accounting policies issued by NHS England, or any deviation from these policies has been fully explained in the Confirmation questions in the TAC schedules.

2. I certify that the TAC schedules are internally consistent and that there are no validation errors*.

3. I certify that the information in the TAC schedules is consistent with the financial statements of the NHS Trust.

[Signature]

Ian Dean, Chief Finance Officer.

26 June 2025.

Chief Executive Certificate

1. I acknowledge the accompanying TAC schedules, which have been prepared and certified by the Finance Director, as the TAC schedules which the Trust is required to submit to NHS England.

2. I have reviewed the schedules and agree the statements made by the Director of Finance above.

[Signature]

Steve Williamson, Chief Executive.

26 June 2025.

Financial Statements for the year ended 31 March 2025

Statement of comprehensive income for the year ended 31 March 2025

Comprehensive income	Note	2024 to 2025 £'000	2023 to 2024 £'000
Operating income from patient care activities	**3**	675,054	606,404
Other operating income	**4**	58,487	65,476
Operating expenses	**5**	(738,891)	(675,677)
Operating deficit		**(5,350)**	**(3,797)**
Finance costs: Finance income		1,830	1,406
Finance costs: Finance expenditure		(1,039)	(864)
Finance costs: Public dividend capital dividends payable		(6,337)	(6,466)
Net finance costs		**(5,546)**	**(5,924)**
Other losses		(84)	(134)
Deficit for the year		**(10,980)**	**(9,855)**

Other comprehensive income that will not be reclassified to income and expenditure:	Note	2024 to 2025 £'000	2023 to 2024 £'000
Impairments and reversals taken to the revaluation reserve	**6**	(3,257)	(15,618)
Revaluations		1,388	2,169
Total comprehensive expense for the year		**(12,849)**	**(23,304)**

The notes on pages 175 to 232 form part of this account.

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

NHS Financial performance for the year	Note	2024 to 2025 £'000	2023 to 2024 £'000
Deficit for the year (as above)		**(10,980)**	(9,855)
Remove impairments (1)	**6**	**10,269**	9,604
Remove impact of capital grants and donations (2)		**784**	380
Remove net impact of inventories received from DHSC group bodies for COVID response (3)		**13**	6
Remove impact of IFRS16 on IFRIC12 schemes (4)		**6**	(36)
Adjusted retained surplus for NHS purposes		**92**	99

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

(1) Impairment charges and reversals arising from changes in market prices 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 deficit for the year is neutralised by this adjustment;

(3) This balance reflects the difference between amounts credited to income and the amounts used and reflected in operational expenses during the same period;

(4) This is the impact on the deficit of the application of IFRS16 to the Trust's on-Statement of Financial Position (on-SOFP) Local Improvement Finance Trust (LIFT) scheme.

Statement of financial position as at 31 March 2025

Asset	Note	As at 31 March 2025 £'000	As at 31 March 2024 £'000
Non-current: Intangible assets	**9**	34,084	27,227
Non-current: Property, plant and equipment	**10**	243,438	236,533
Non-current: Right of use assets	**11**	12,671	6,792
Non-current: Receivables	**13**	1,385	1,456
Total non-current assets		**291,578**	**272,008**
Current: Inventories	**12**	13,220	12,067
Current: Receivables	**13**	15,979	22,363
Current: Cash and cash equivalents	**14**	30,378	16,868
Total current assets		**59,577**	**51,298**
Total assets		**351,155**	**323,306**

Liability	Note	As at 31 March 2025 £'000	As at 31 March 2024 £'000
Current: Trade and other payables	**15**	(69,691)	(72,631)
Current: Borrowings	**16**	(1,458)	(2,164)
Current: Provisions	**17**	(3,340)	(2,210)
Current: Other liabilities		(5,659)	(1,889)
Total current liabilities		**(80,148)**	**(78,894)**
Total assets less current liabilities		**271,007**	**244,412**
Non-current: Borrowings	**16**	(13,842)	(8,027)
Non-current: Provisions	**17**	(3,450)	(3,421)
Non-current: Other liabilities		0	(877)
Total non-current liabilities		**(17,292)**	**(12,325)**

Description	As at 31 March 2025 £'000	As at 31 March 2024 £'000
Total assets employed	**253,715**	**232,087**
Financed by: Public dividend capital	375,678	341,201
Financed by: Revaluation reserve	25,606	27,475
Financed by: Income and expenditure reserve	(147,569)	(136,589)
Total taxpayers' equity	**253,715**	**232,087**

The notes on pages 175 to 232 form part of this account.

The financial statements on pages 166 to 174 were approved by the Board on 26 June 2025 and signed on its behalf by:

Steve Williamson, Chief Executive.

Statement of changes in equity for the year ended 31 March 2025

Statement of changes in equity for the year ended 31 March 2025	Public dividend capital £'000	Revaluation reserve £'000	Income and expenditure reserve £'000	Total reserves £'000
Taxpayers' and others' equity at 1 April 2024	**341,201**	**27,475**	**(136,589)**	**232,087**
Deficit for the year	0	0	(10,980)	(10,980)
Revaluations	0	1,388	0	1,388
Impairments	0	(3,257)	0	(3,257)
Public dividend capital received	34,477	0	0	34,477
Taxpayers' and others' equity at 31 March 2025	**375,678**	**25,606**	**(147,569)**	**253,715**

Statement of changes in equity for the year ended 31 March 2024	Public dividend capital £'000	Revaluation reserve £'000	Income and expenditure reserve £'000	Total reserves £'000
Taxpayers' and others' equity at 1 April 2023	**319,780**	**40,924**	**(125,358)**	**235,346**
Application of IFRS 16 measurement principles to LIFT liability on 1 April 2023	0	0	(1,376)	(1,376)
Deficit for the year	0	0	(9,855)	(9,855)
Revaluations	0	2,169	0	2,169

Statement of changes in equity for the year ended 31 March 2024	Public dividend capital £'000	Revaluation reserve £'000	Income and expenditure reserve £'000	Total reserves £'000
Impairments	0	(15,618)	0	(15,618)
Public dividend capital received	21,821	0	0	21,821
Public dividend capital repaid	(400)	0	0	(400)
Taxpayers' and others' equity at 31 March 2024	**341,201**	**27,475**	**(136,589)**	**232,087**

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 of 3.5%, 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 2025

Cash flows	Note	2024 to 2025 £'000	2023 to 2024 £'000
Operating deficit		(5,350)	(3,797)
Depreciation and amortisation	**5**	24,749	20,229
Net impairments	**6**	10,276	9,654
Income recognised in respect of capital donations	**4**	(411)	(796)
Decrease in receivables and other assets		6,662	3,762
Increase in inventories		(1,153)	(534)
Decrease in trade and other payables		(7,637)	(10,964)
Increase/(decrease) in other liabilities		2,893	(1,635)
Increase/(decrease) in provisions		1,044	(523)
Net cash generated from operating activities		**31,073**	**15,396**
Investing activity: Interest received		1,830	1,406
Investing activity: Purchase of intangible assets		(8,259)	(10,020)
Investing activity: Purchase of property, plant and equipment		(36,103)	(26,498)
Investing activity: Sales of property, plant and equipment		53	182
Investing activity: Receipt of cash donations to purchase capital assets		297	513
Net cash used in investing activities		**(42,182)**	**(34,417)**
Net cash outflow before financing		**(11,109)**	**(19,021)**
Cash flow from financing activity: Public dividend capital received		34,477	21,821
Cash flow from financing activity: Public dividend capital repaid		0	(400)
Cash flow from financing activity: DHSC Capital loans repaid		(794)	(1,347)
Cash flow from financing activity: Capital element of lease liability payments		(1,539)	(1,442)

Cash flows	Note	2024 to 2025 £'000	2023 to 2024 £'000
Cash flow from financing activity: Capital element of LIFT payments		(125)	(105)
Cash flow from financing activity: Interest paid on DHSC loans		(6)	(23)
Cash flow from financing activity: Interest paid on lease liabilities		(253)	(135)
Cash flow from financing activity: Interest paid on LIFT obligations		(599)	(583)
Cash flow from financing activity: PDC dividend paid		(6,544)	(6,519)
Net cash generated from financing activities		**24,617**	**11,267**
Net increase/(decrease) in cash and cash equivalents		**13,508**	**(7,754)**
Cash and cash equivalents at 1 April		**16,863**	**24,617**
Cash and cash equivalents at 31 March	**14**	**30,371**	**16,863**

Notes to the accounts

1. Accounting policies and other information

1.1 Basis of preparation

The Department of Health and Social Care has directed that the financial statements of the Trust shall meet the accounting requirements of the Department of Health and Social Care Group Accounting Manual (GAM), which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the GAM 2024-25 issued by the Department of Health and Social Care. The accounting policies contained in the GAM follow International Financial Reporting Standards to the extent that they are meaningful and appropriate to the NHS, as determined by HM Treasury, which is advised by the Financial Reporting Advisory Board. Where the GAM permits a choice of accounting policy, the accounting policy that is judged to be most appropriate to the particular circumstances of the Trust for the purpose of giving a true and fair view has been selected. The particular policies adopted are described below. These have been applied consistently in dealing with items considered material in relation to the accounts.

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 (FReM), 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 23 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:

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 2025 with a valuation date of 31 March 2025. The decision to value the Trust's land and buildings based on the single off-site location represents a material judgement by the Trust. It is estimated that land values are £11.4m lower and building values £84.6m lower, as a consequence of applying the off-site valuation approach.

1.5. Sources of estimation uncertainty

Other than the decision to value the land and building assets on an alternative site basis (see 1.4 above), 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 IFRS 15: Revenue from Contracts with Customers. 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 or services provided is recognised when (or as) performance obligations are satisfied by transferring promised goods or 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.

Revenue from NHS contracts

The main source of income for the Trust is contracts with commissioners for healthcare services. Funding envelopes are set at an Integrated Care System (ICS) level. The majority of the Trust's NHS income is earned from NHS commissioners under the NHS Payment Scheme (NHSPS). The NHSPS sets out rules to establish the amount payable to trusts for NHS-funded secondary healthcare.

Aligned payment and incentive (API) contracts form the main payment mechanism under the NHSPS. API contracts contain both a fixed and variable element. Under the variable element, providers earn income for elective activity (both ordinary and day case), out-patient procedures, out-patient first attendances, diagnostic imaging and nuclear medicine, and chemotherapy delivery activity. The precise definition of these activities is given in the NHSPS. Income is earned at NHSPS prices based on actual activity. The fixed element includes income for all other services covered by the NHSPS assuming an agreed level of activity with 'fixed' in this context meaning not varying based on units of activity. Elements within this are accounted for as variable consideration under IFRS 15 as explained below.

High costs drugs and devices excluded from the calculation of national prices are reimbursed by NHS England based on actual usage or at a fixed baseline in addition to the price of the related service.

The Trust also receives income from commissioners under Commissioning for Quality Innovation (CQUIN) and Best Practice Tariff (BPT) schemes. Delivery under these schemes is part of how care is provided to patients. As such CQUIN and BPT payments are not considered distinct performance obligations in their own right; instead, they form part of the transaction price for performance obligations under the overall contract with the commissioner and are accounted for as variable consideration under IFRS 15. Payment for CQUIN and BTP on non-elective services is included in the fixed element of API contracts with adjustments for actual achievement being made at the end of the year. BPT earned on elective activity is included in the variable element of API contracts and paid in line with actual activity performed.

Where the relationship with a particular integrated care board is expected to be a low volume of activity (annual value below £0.5m), an annual fixed payment is received by the provider as determined in the NHSPS documentation. Such income is classified as 'other clinical income' in these accounts.

Elective recovery funding provides additional funding to integrated care boards to fund the commissioning of elective services within their systems. Trusts do not directly earn elective recovery funding, instead earning income for actual activity performed under API contract arrangements as explained above. The level of activity delivered by the Trust contributes to system performance and therefore the availability of funding to the Trust's commissioners.

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 apprenticeship 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.
- 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 Trust and the cost of the item can be determined reliably. Where a component of an asset is replaced, the cost of the replacement is capitalised if it meets the criteria for recognition above. The carrying amount of the part replaced is de-recognised. Other expenditure that does not generate additional future economic benefits or service potential, such as repairs and maintenance is charged to the Statement of Comprehensive Income in the period in which it is incurred.

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 (i.e. operational assets used to deliver either front line services or back-office functions) are measured at their current value in existing use. Assets that were most recently held for their service potential but are surplus with no plan to bring them back into use are measured at fair value where there are no restrictions on sale at

the reporting date and where they do not meet the definitions of investment properties or assets held for sale.

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 and where they do not meet the definitions of investment properties or assets held for sale.

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

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

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. Assets are revalued and depreciation commences when the assets are brought into use.

With the exception of those assets subject to a revaluation exercise (see note 10.7), IT equipment, transport equipment, furniture and fittings, and plant and machinery that are held for operational use are valued at depreciated historic cost, 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 reclassification. Assets in the course of construction are not depreciated until the asset is brought into use.

Revaluation gains and losses

Revaluation gains are recognised in the revaluation reserve, except where, and to the

extent that, they reverse a revaluation decrease that has previously been recognised in operating expenses, in which case they are recognised in operating 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.

Local Improvement Finance Trust (LIFT) transactions

LIFT transactions which meet the International Financial Reporting Interpretations Committee 12: Service Concession 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. Annual contract payments to the operator (the unitary charge) are apportioned between the repayment of the liability including the finance cost, the charges for services and lifecycle replacement of components of the asset.

Initial recognition

In accordance with HM Treasury's FReM, the underlying assets are recognised as property, plant and equipment, together with an equivalent liability. Initial measurement of the asset and liability are in accordance with the initial measurement principles of IFRS 16: Leases (see leases accounting policy).

Subsequent measurement

Assets are subsequently accounted for as property, plant and equipment and/or intangible assets as appropriate.

The liability is subsequently reduced by the portion of the unitary charge allocated as payment for the asset and increased by the annual finance cost. The finance cost is calculated by applying the implicit interest rate to the opening liability and is charged to finance costs in the Statement of Comprehensive Income. The element of the unitary charge allocated as payment for the asset is split between payment of the finance cost and repayment of the net liability.

Where there are changes in future payments for the asset resulting from indexation of the unitary charge, the Trust remeasures the LIFT liability by determining the revised payments for the remainder of the contract once the change in cash flows takes effect. The remeasurement adjustment is charged to finance costs in the Statement of Comprehensive Income.

The service charge is recognised in operating expenses in the Statement of Comprehensive Income.

Initial application of IFRS 16 liability measurement principles to LIFT liabilities in 2023-24

IFRS 16 liability measurement principles were applied to LIFT liabilities in these financial statements from 1 April 2023. The change in measurement basis was applied using a modified retrospective approach with the cumulative impact of remeasuring the liability on 1 April 2023 recognised in the income and expenditure reserve.

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 (residual) useful lives is shown in the table below:

Asset	Min. Life Years	Max. Life Years
Buildings, excluding dwellings	1	60
Dwellings	1	15
Plant and machinery	1	15
Transport equipment	1	8
Information technology	1	5
Furniture and fittings	1	10

1.11 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance controlled by the Trust. They are capable of being sold separately from the rest of the Trust's business or arise from contractual or other legal rights. Intangible assets 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 where it meets the recognition criteria.

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.

The intangible assets held by the Trust are either software licenses or internal development costs, for which there are no external markets. Therefore, as there is no basis on which to establish a valuation, intangible assets are subsequently measured at depreciated historic cost as a proxy for fair value, as the best available option. This is a departure from the GAM.

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 15 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.

Between 2020-21 and 2023-24 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. Distribution of inventories by the Department ceased in March 2024.

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

A lease is a contract or part of a contract that conveys the right to use an asset for a period of time in exchange for consideration. An adaptation of the relevant accounting standard by HM Treasury for the public sector means that for NHS bodies, this includes lease-like arrangements with other public sector entities that do not take the legal form of a contract. It also includes peppercorn leases where consideration paid is nil or nominal (significantly below market value) but in all other respects meet the definition of a lease. The Trust does not apply lease accounting to new contracts for the use of intangible assets.

The Trust determines the term of the lease term with reference to the non-cancellable period and any options to extend or terminate the lease which the Trust is reasonably certain to exercise.

The Trust as a lessee

Initial recognition and measurement

At the commencement date of the lease, being when the asset is made available for use, the Trust recognises a right of use asset and a lease liability.

The right of use asset is recognised at cost comprising the lease liability, any lease payments made before or at commencement, any direct costs incurred by the lessee, less any cash lease incentives received. It also includes any estimate of costs to be incurred restoring the site or underlying asset on completion of the lease term.

The lease liability is initially measured at the present value of future lease payments discounted at the interest rate implicit in the lease. Lease payments includes fixed lease payments, variable lease payments dependent on an index or rate and amounts payable under residual value guarantees. It also includes amounts payable for purchase options and termination penalties where these options are reasonably certain to be exercised.

Where an implicit rate cannot be readily determined, the Trust's incremental borrowing rate is applied. This rate is determined by HM Treasury annually for each calendar year. A nominal rate of 4.72% applied to new leases commencing in 2024 and 4.81% to new leases commencing in 2025.

The Trust does not apply the above recognition requirements to leases with a term of 12 months or less or to leases where the value of the underlying asset is below £5,000, excluding any irrecoverable VAT. Lease payments associated with these leases are expensed on a straight-line basis over the lease term. Irrecoverable VAT on lease payments is expensed as it falls due.

Subsequent measurement

As required by a HM Treasury interpretation of the accounting standard for the public sector, the Trust employs a revaluation model for subsequent measurement of right of use assets, unless the cost model is considered to be an appropriate proxy for current value in existing use or fair value, in line with the accounting policy for owned assets. Where consideration exchanged is identified as significantly below market value, the cost model is not considered to be an appropriate proxy for the value of the right of use asset. The Trust relies on regular rent reviews, and the remeasurement of the assets arising from those reviews, as a proxy for not formally revaluing assets given the nature of the assets and the duration of the agreements.

The Trust subsequently measures the lease liability by increasing the carrying amount for interest arising which is also charged to expenditure as a finance cost and reducing the carrying amount for lease payments made. The liability is also remeasured for changes in assessments impacting the lease term, lease modifications or to reflect actual changes in lease payments. Such remeasurements are also reflected in the cost of the right of use asset. Where there is a change in the lease term or option to purchase the underlying asset, an updated discount rate is applied to the remaining lease payments.

The Trust as a lessor

The Trust assesses each of its leases and classifies them as either a finance lease or an operating lease. 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.

Where the Trust is an intermediate lessor, classification of the sublease is determined with reference to the right of use asset arising from the headlease.

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 to reflect a constant periodic rate of return on the Trust's net investment outstanding in respect of the leases.

Operating leases

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

1.16 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 from 31 March 2025, as follows:

Description	Period	Nominal rate	Prior year rate
Short-term	Up to 5 years	4.03%	4.26%
Medium-term	After 5 years, up to 10 years	4.07%	4.03%
Long-term	After 10 years up to 40 years	4.81%	4.72%
Very long-term	Exceeding 40 years	4.55%	4.40%

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 from 31 March 2025:

Year	Inflation rate	Prior year rate
Year 1	2.60%	3.60%
Year 2	2.30%	1.80%
In to perpetuity	2.00%	2.00%

Early retirement provisions and injury benefit provisions both use the HM Treasury's pension discount rate of 2.40% in real terms (prior year: 2.45%).

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 17.2 but is not recognised in the Trust's accounts.

Non-clinical risk pooling

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

1.17 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 18 where an inflow of economic benefits is probable.

Contingent liabilities are not recognised, but are disclosed in Note 18, 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 via the gov.uk website (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 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 (Note 22) is compiled directly from the losses and compensations register which reports on an accrual basis with the exception of provisions for future losses.

1.22 Early adoption of standards, amendments and interpretations

No new accounting standards or revisions to existing standards have been adopted early in 2024-25.

1.23 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.

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

The DHSC GAM does not require the following IFRS Standards to be applied in 2024-25:

IFRS 17: Insurance Contracts

The Standard is effective for accounting periods beginning on or after 1 January 2023. IFRS 17 has been adopted by the FReM from 1 April 2025. Adoption of the Standard for NHS bodies will therefore be in 2025-26. The Standard revises the accounting for insurance contracts for the issuers of insurance. Application of this standard from 2025-26 is not expected to have a material impact on the financial statements.

IFRS 18: Presentation and Disclosure in Financial Statements

The Standard is effective for accounting periods beginning on or after 1 January 2027. The Standard is not yet UK endorsed and not yet adopted by the FReM. Early adoption is not permitted. The expected impact of applying the Standard in future periods has not yet been assessed.

Changes to non-investment asset valuation

Following a thematic review of non-current asset valuations for financial reporting in the public sector, HM Treasury has made a number of changes to valuation frequency, valuation methodology and classification which are effective in the public sector from 1 April 2025 with a 5 year transition period. NHS bodies are adopting these changes to an alternative timeline.

Changes to subsequent measurement of intangible assets and PPE classification / terminology to be implemented for NHS bodies from 1 April 2025:

- withdrawal of the revaluation model for intangible assets. Carrying values of existing intangible assets measured under a previous revaluation will be taken forward as deemed historic cost.

- removal of the distinction between specialised and non-specialised assets held for their service potential. Assets will be classified according to whether they are held for their operational capacity.

These changes are not expected to have a material impact on these financial statements.

Changes to valuation cycles and methodology to be implemented for NHS bodies in later periods:

- a mandated 5-yearly revaluation frequency (or rolling programme) supplemented by annual indexation in the intervening years.
- removal of the alternative site assumption for buildings valued at depreciated replacement cost on a modern equivalent asset basis. The approach for land has not yet been finalised by HM Treasury.

As disclosed in note 1.4, it is estimated that the value of the Trust's buildings and dwellings, currently determined using an alternative site approach, would increase by £84.6m at 31 March 2025 if the alternative site valuation approach was not used. Therefore, the revised valuation assumption is expected to have a material impact on property, plant and equipment measurement in future periods.

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. Financial performance is not reported to the Chief Operating Decision Maker and Executive Board members in a segmental manner, and 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 1.6.

Description	2024 to 2025 £'000	2023 to 2024 £'000
Acute services: Income from commissioners under API contracts - fixed element (1)	539,716	499,937
Acute services: Income from commissioners under API contracts - variable element (1)	16,662	10,739
Acute services: High cost drugs income from commissioners (excluding pass-through costs)	73,345	64,079
Other services: Private patient income	1,011	188
Other services: Agenda for change pay award central funding (2)	1,464	283
Other services: Additional pension contribution central funding (3)	25,722	15,384

Description	2024 to 2025 £'000	2023 to 2024 £'000
Other services: Other clinical income	17,134	15,794
Total income from NHS bodies	**675,054**	**606,404**

(1) Aligned payment and incentive contracts are the main form of contracting between NHS providers and their commissioners. More information can be found in the '2023/25 NHS Payment Scheme' documentation on the NHS England website (england.nhs.uk/pay-syst/nhs-payment-scheme).

(2) Additional funding was made available directly to providers by NHS England in 2024-25 and 2023-24 for implementing the backdated element of pay awards where government offers were finalised after the end of the financial year. NHS Payment Scheme prices and API contracts are updated for the weighted uplift in in-year pay costs when awards are finalised.

(3) Increases to the employer contribution rate for NHS pensions since 1 April 2019 have been funded by NHS England. NHS providers continue to pay at the former rate of 14.3% with the additional amount being paid over by NHS England on providers' behalf. The full cost of employer contributions (23.7%, 2023-24: 20.6%) and related NHS England funding (9.4%, 2023-24: 6.3%) have been recognised in these accounts.

3.2 Income from patient care activities (by source)

Income from patient care activities received from:	2024 to 2025 £'000	2023 to 2024 £'000
NHS England	144,398	121,710
Integrated care boards	528,770	483,800
Non-NHS: Private patients	1,011	188
Non-NHS: Overseas patients (chargeable to patient)	225	222
NHS Injury Cost Recovery (ICR) scheme	650	484
Total income from patient care activities	**675,054**	**606,404**

All amounts above relate to continuing operations.

4. Other operating income

Operating income from contracts with customers	2024 to 2025 £'000	2023 to 2024 £'000
Research and development	3,213	3,771
Education and training	27,454	22,750
Non-patient care services to other bodies	9,936	12,012
Income in respect of employee benefits accounted for on a gross basis (1)	4,433	5,806
Other contract income (2)	10,660	17,729

Other non-contract operating income	2024 to 2025 £'000	2023 to 2024 £'000
Research and development (non-contract)	115	109
Education and training - notional income from Apprenticeship Fund	960	762
Receipt of capital grants and donations	411	796
Charitable and other contributions to expenditure	647	843
Operating leases - minimum lease receipts	658	898

Total	2024 to 2025 £'000	2023 to 2024 £'000
Total other operating income	**58,487**	**65,476**

All amounts above relate to continuing operations.

(1) Included within 'Charitable and other contributions to expenditure' is £289,000 (2023-24: £242,000) in relation to 'income in respect of employee benefits accounted for on a gross basis'.

(2) 'Other contract income' includes car park income, IT services provided, drug sales, food sales, staff accommodation, transport and other miscellaneous income not falling into the other categories in the note above.

5.1 Operating expenses

Operating expense	2024 to 2025 £'000	2023 to 2024 £'000
Purchase of healthcare from NHS and DHSC bodies	11,836	11,442
Purchase of healthcare from non-NHS and non-DHSC bodies	28,122	23,085
Staff and executive directors' costs	449,833	408,586
Remuneration of Chair and non-executive directors	146	146
Supplies and services - clinical (excluding drug costs)	53,023	51,192
Supplies and services - general	17,859	19,254
Drug costs (drugs inventory consumed and purchase of non-inventory drugs)	88,192	77,254
Inventories written down	479	449
Consultancy costs	10	36
Establishment	4,907	4,819
Premises	18,594	18,971
Transport (including patient travel)	2,990	4,678
Depreciation on property, plant and equipment and right of use assets	20,264	17,026
Amortisation on intangible assets	4,485	3,203
Net impairments	10,276	9,654
Movement in credit loss allowance: contract receivables/contract assets	700	(618)
Movement in credit loss allowance: all other receivables and investments	281	210
Change in provisions discount rate(s)	(118)	(122)
Audit fees payable to the external auditor: audit services - statutory audit	297	288
Internal audit costs	159	164
Clinical negligence	14,747	14,615
Legal fees	540	331

Operating expense	2024 to 2025 £'000	2023 to 2024 £'000
Insurance	129	118
Research and development (including staff costs)	4,231	4,022
Education and training	2,543	2,625
Expenditure on short term leases	65	65
Expenditure on low value leases	4	3
Redundancy	4	18
Charges to operating expenditure for on-SOFP IFRIC 12 schemes (LIFT)	320	312
Car parking and security	930	1,040
Losses, ex gratia and special payments	21	16
Other	3,022	2,795
Total operating expenses	**738,891**	**675,677**

All amounts above relate to continuing operations.

5.2 External audit fees: Additional Information

Audit fees shown above include VAT. The auditor received fees of £248,000 in 2024-25 (2023-24: £240,000).

The Trust incurred no other auditor remuneration charges in either 2024-25 or 2023-24.

The limitation on auditor's liability for external audit work is £1,000,000 (2023-24: £1,000,000).

6. Impairment of assets

Impairments	2024 to 2025 £'000	2023 to 2024 £'000
Net impairments/(reversals) charged to operating surplus/deficit resulting from: Changes in market price	10,269	9,604
Net impairments/(reversals) charged to operating surplus/deficit resulting from: Loss or damage from normal operations	7	0
Net impairments/(reversals) charged to operating surplus/deficit resulting from: Abandonment of assets in course of construction	0	50

Impairments	2024 to 2025 £'000	2023 to 2024 £'000
Total net impairments/(reversals) charged to operating surplus/deficit	**10,276**	**9,654**
Impairments charged to the revaluation reserve	3,257	15,618
Total net impairments	**13,533**	**25,272**

Market price impairments/(reversals) and impairments charged to the revaluation reserve in both 2024-25 and 2023-24 arose following the annual year end revaluations of the Trust's property assets on a modern equivalent asset basis. All revaluations were undertaken by Montagu Evans LLP.

7. Employee benefits

Employee benefits	2024 to 2025 £'000	2023 to 2024 £'000
Salaries and wages	341,475	305,517
Social security costs	39,387	36,486
Apprenticeship levy	1,715	1,592
Employer's contributions to NHS pensions	65,096	50,635
Other pension costs	312	305
Termination benefits	132	127
Temporary staff (agency)	14,750	22,583
Total gross staff costs	**462,867**	**417,245**
Included within: Costs capitalised as part of assets	9,679	5,281
Total staff costs excluding capitalised staff costs	**453,188**	**411,964**

.1 Retirements due to ill-health

During 2024-25 there were 9 early retirements from the Trust agreed on the grounds of ill-health (13 in the year ended 31 March 2024). The estimated additional pension liabilities of these ill-health retirements is £1,106,000 (2023-24: £1,889,000).

8. Pension costs

Past and present employees are covered by the provisions of the NHS Pension Schemes. Details of the benefits payable and rules of the schemes can be found on the NHS Pensions website (nhsbsa.nhs.uk/nhs-pensions). Both the 1995/2008 and 2015

schemes are accounted for, and the scheme liability valued, as a single combined scheme. 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”.

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 2025, is based on valuation data as at 31 March 2023, updated to 31 March 2025 with summary global member and accounting data. In undertaking this actuarial assessment, the methodology prescribed in IAS 19, relevant FReM interpretations, and the discount rate prescribed by HM Treasury have also been used.

The latest assessment of the liabilities of the scheme is contained in the Statement by the Actuary, which forms part of the annual NHS Pension Scheme Annual Report and 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 (considering recent demographic experience), and to recommend the contribution rate payable by employers.

The latest actuarial valuation undertaken for the NHS Pension Scheme was completed as at 31 March 2020. The results of this valuation set the employer contribution rate payable from 1 April 2024 to 23.7% of pensionable pay. The core cost cap cost of the scheme was calculated to be outside of the 3% cost cap corridor as at 31 March 2020. However, when the wider economic situation was taken into account through the economic cost cap cost of the scheme, the cost cap corridor was not similarly breached. As a result, there was no impact on the member benefit structure or contribution rates.

The 2024 actuarial valuation is currently being prepared and will be published before new contribution rates are implemented from April 2027.

9. Intangible assets

9.1 Intangible assets 2024-25

Description	Software licences £'000	Development expenditure - internally generated £'000	Intangible assets under construction £'000	Total £'000
Valuation / gross cost at 1 April 2024	**35,698**	**9,053**	**6,444**	**51,195**
Additions	1,553	0	9,789	11,342
Reclassifications	(6,055)	0	6,055	0
Disposals / de-recognition	(5,129)	(923)	0	(6,052)
Valuation / gross cost at 31 March 2025	**26,067**	**8,130**	**22,288**	**56,485**
Amortisation at 1 April 2024	**21,513**	**2,455**	**0**	**23,968**
Provided during the year	2,948	1,537	0	4,485
Disposals / de-recognition	(5,129)	(923)	0	(6,052)
Amortisation at 31 March 2025	**19,332**	**3,069**	**0**	**22,401**
Net book value at 31 March 2025	**6,735**	**5,061**	**22,288**	**34,084**
Net book value at 1 April 2024	**14,185**	**6,598**	**6,444**	**27,227**

9.2 Intangible assets 2023-24

Description	Software licences £'000	Development expenditure - internally generated £'000	Intangible assets under construction £'000	Total £'000
Valuation / gross cost at 1 April 2023	**28,331**	**9,284**	**691**	**38,306**
Additions	7,504	632	5,753	13,889
Disposals / de-recognition	(137)	(863)	0	(1,000)
Valuation / gross cost at 31 March 2024	**35,698**	**9,053**	**6,444**	**51,195**
Amortisation at 1 April 2023	**19,357**	**2,408**	**0**	**21,765**
Provided during the year	2,293	910	0	3,203
Disposals / de-recognition	(137)	(863)	0	(1,000)
Amortisation at 31 March 2024	**21,513**	**2,455**	**0**	**23,968**
Net book value at 31 March 2024	**14,185**	**6,598**	**6,444**	**27,227**
Net book value at 1 April 2023	**8,974**	**6,876**	**691**	**16,541**

9.3 Intangible assets - additional information

Intangible assets comprise purchased computer software and licenses, as well as internally generated development expenditure, which are all 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 15 years. The gross carrying amount of fully amortised assets still in use is £15.6m (2023-24: £16.9m).

10. Property, plant and equipment

10.1 Property, plant and equipment 2024-25

Valuation / Gross Cost	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Valuation / gross cost at 1 April 2024	**9,172**	**154,336**	**11**	**20,402**	**77,854**	**542**	**25,049**	**2,788**	**290,154**
Additions	0	10,252	0	20,427	6,260	0	160	732	**37,831**
Impairments	0	(19,812)	0	0	(11)	0	0	0	**(19,823)**
Reversals of impairments	0	2,723	0	0	0	0	0	0	**2,723**
Revaluations	0	(3,750)	0	0	0	0	0	0	**(3,750)**
Reclassifications	0	5,812	0	(1,391)	2,516	0	(6,997)	60	**0**
Disposals / de-recognition	0	0	0	0	(8,923)	0	(5,908)	(1,016)	**(15,847)**
Valuation / gross cost at 31 March 2025	**9,172**	**149,561**	**11**	**39,438**	**77,696**	**542**	**12,304**	**2,564**	**291,288**

Depreciation	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Accumulated depreciation at 1 April 2024	**0**	**0**	**0**	**0**	**38,729**	**137**	**12,985**	**1,770**	**53,621**
Provided during the year	0	8,651	2	0	8,526	58	1,125	234	**18,596**
Impairments	0	(5,080)	0	0	(4)	0	0	0	**(5,084)**
Reversal of impairments	0	1,517	0	0	0	0	0	0	**1,517**
Revaluations	0	(5,088)	(2)	0	0	0	0	0	**(5,090)**
Disposals / de-recognition	0	0	0	0	(8,786)	0	(5,908)	(1,016)	**(15,710)**
Accumulated depreciation at 31 March 2025	**0**	**0**	**0**	**0**	**38,465**	**195**	**8,202**	**988**	**47,850**

Net Book Value	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Net book value at 31 March 2025	**9,172**	**149,561**	**11**	**39,438**	**39,231**	**347**	**4,102**	**1,576**	**243,438**
Net book value at 1 April 2024	**9,172**	**154,336**	**11**	**20,402**	**39,125**	**405**	**12,064**	**1,018**	**236,533**

10.2 Property, plant and equipment 2023-24

Valuation / Gross Cost	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Valuation / gross cost at 1 April 2023	**5,270**	**150,112**	**12**	**45,722**	**69,600**	**572**	**25,544**	**2,757**	**299,589**
Additions	405	2,910	0	12,480	10,032	0	3,197	101	**29,125**
Impairments	(103)	(38,046)	0	0	(50)	0	0	0	**(38,199)**
Reversals of impairments	0	8,413	0	0	0	0	0	0	**8,413**
Revaluations	2,861	(2,624)	(1)	0	0	0	0	0	**236**
Reclassifications	739	33,571	0	(37,800)	3,303	0	126	61	**0**

Valuation / Gross Cost	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Disposals / de-recognition	0	0	0	0	(5,031)	(30)	(3,818)	(131)	**(9,010)**
Valuation / gross cost at 31 March 2024	**9,172**	**154,336**	**11**	**20,402**	**77,854**	**542**	**25,049**	**2,788**	**290,154**

Depreciation	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Accumulated depreciation at 1 April 2023	**0**	**0**	**0**	**0**	**36,463**	**109**	**15,022**	**1,657**	**53,251**
Provided during the year	0	6,438	1	0	6,994	58	1,781	231	**15,503**
Impairments	0	(5,339)	0	0	0	0	0	0	**(5,339)**
Reversal of impairments	0	825	0	0	0	0	0	0	**825**
Revaluations	0	(1,924)	(1)	0	0	0	0	0	**(1,925)**
Disposals / de-	0	0	0	0	(4,728)	(30)	(3,818)	(118)	**(8,694)**

Depreciation	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
recognition									
Accumulated depreciation at 31 March 2024	**0**	**0**	**0**	**0**	**38,729**	**137**	**12,985**	**1,770**	**53,621**

Net Book Value	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Net book value at 31 March 2024	**9,172**	**154,336**	**11**	**20,402**	**39,125**	**405**	**12,064**	**1,018**	**236,533**
Net book value at 1 April 2023	**5,270**	**150,112**	**12**	**45,722**	**33,137**	**463**	**10,522**	**1,100**	**246,338**

10.3 Property, plant and equipment financing 2024-25

Net book value at 31 March 2025	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Owned - purchased	8,710	137,445	11	39,438	37,207	334	4,100	1,528	**228,773**
On-SOFP LIFT contracts	435	908	0	0	0	0	0	0	**1,343**
Owned - donated / government granted	27	11,208	0	0	2,024	13	2	48	**13,322**
Total	**9,172**	**149,561**	**11**	**39,438**	**39,231**	**347**	**4,102**	**1,576**	**243,438**

10.4 Property, plant and equipment financing 2023-24

Net book value at 31 March 2024	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Owned - purchased	8,710	145,487	11	20,402	36,893	383	12,061	975	**224,922**
On-SOFP LIFT contracts	435	836	0	0	0	0	0	0	**1,271**
Owned - donated / government granted	27	8,013	0	0	2,232	22	3	43	**10,340**
Total	**9,172**	**154,336**	**11**	**20,402**	**39,125**	**405**	**12,064**	**1,018**	**236,533**

10.5 Property, plant and equipment assets subject to an operating lease (Trust as lessor) - 2024-25

Description	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Subject to an operating lease	347	11,431	0	0	0	0	0	0	**11,778**
Not subject to an operating lease	8,825	138,130	11	39,438	39,231	347	4,102	1,576	**231,660**
Total Net Book Value at 31 March 2025	**9,172**	**149,561**	**11**	**39,438**	**39,231**	**347**	**4,102**	**1,576**	**243,438**

10.6 Property, plant and equipment assets subject to an operating lease (Trust as lessor) - 2023-24

Description	Land £'000	Buildings excluding dwellings £'000	Dwellings £'000	Assets under construction £'000	Plant and machinery £'000	Transport equipment £'000	Information technology £'000	Furniture and fittings £'000	Total £'000
Subject to an operating lease	347	9,145	0	0	0	0	0	0	**9,492**
Not subject to an operating lease	8,825	145,191	11	20,402	39,125	405	12,064	1,018	**227,041**
Total Net Book Value at 31 March 2024	**9,172**	**154,336**	**11**	**20,402**	**39,125**	**405**	**12,064**	**1,018**	**236,533**

10.7 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 2025 by Montagu Evans LLP. 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.

There have been no changes to the valuation methods used by the Trust in 2024-25.

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 £18.8m (2023-24: £28.6m).

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 in Note 23);
- The Friends of The Royal Cornwall Hospital;
- Roche Products Ltd.

Other than the conditions imposed by Macmillan Cancer Support (referred to in Note 18), no restrictions or conditions have been imposed by the donors in the current or preceding years.

11. Leases - The Trust as a lessee

The Trust leases equipment and property in order to deliver its services. There are no individually material leases, which are arranged under standard NHS terms and conditions.

11.1 Right of use assets 2024-25

Description	Property (land and buildings) £'000	Plant and machinery £'000	Information technology £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Valuation / gross cost at 1 April 2024	**6,486**	**2,325**	**1,499**	**10,310**	**6,059**
Additions	5,630	1,819	0	7,449	5,527
Remeasurements of the lease liability	108	11	0	119	109
Revaluations	39	9	0	48	39
Disposals / de-recognition	(125)	0	0	(125)	0
Valuation / gross cost at 31 March 2025	**12,138**	**4,164**	**1,499**	**17,801**	**11,734**
Accumulated depreciation at 1 April 2024	**1,024**	**1,585**	**909**	**3,518**	**1,711**
Provided during the year	729	725	214	1,668	701
Disposals / de-recognition	(56)	0	0	**(56)**	0
Accumulated depreciation at 31 March 2025	**1,697**	**2,310**	**1,123**	**5,130**	**2,412**
Net book value at 31 March 2025	**10,441**	**1,854**	**376**	**12,671**	**9,322**
Net book value at 1 April 2024	5,462	740	590	6,792	4,348

Description	Total £000
Net book value of right of use assets leased from other NHS providers	8,084
Net book value of right of use assets leased from other DHSC group bodies	1,238

11.2 Right of use assets 2023-24

Description	Property (land and buildings) £'000	Plant and machinery £'000	Information technology £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Valuation / gross cost at 1 April 2023	**4,021**	**2,275**	**1,499**	**7,795**	**4,953**
Additions	1,359	0	0	1,359	**0**
Remeasurements of the lease liability	1,099	49	0	1,148	1,099
Revaluations	7	1	0	8	7
Valuation / gross cost at 31 March 2024	**6,486**	**2,325**	**1,499**	**10,310**	**6,059**
Accumulated depreciation at 1 April 2023	**504**	**796**	**695**	**1,995**	**1,092**
Provided during the year	520	789	214	1,523	619
Accumulated depreciation at 31 March 2024	**1,024**	**1,585**	**909**	**3,518**	**1,711**
Net book value at 31 March 2024	**5,462**	**740**	**590**	**6,792**	**4,348**

Description	Property (land and buildings) £'000	Plant and machinery £'000	Information technology £'000	Total £'000	Of which: leased from DHSC group bodies £'000
Net book value at 1 April 2023	3,517	1,479	804	5,800	3,861

Description	Total £000
Net book value of right of use assets leased from other NHS providers	2,967
Net book value of right of use assets leased from other DHSC group bodies	1,381

11.3 Reconciliation of the carrying value of lease liabilities

Lease liabilities are included within borrowings in the Statement of Financial Position.

Description	2024 to 2025 £'000	2023 to 2024 £'000
Carrying value at start of year	**6,669**	5,604
Lease additions	**7,449**	1,359
Lease liability remeasurements	**119**	1,148
Interest charge arising in year	**253**	135
Early terminations	**(69)**	0
Lease payments (cash outflows)	**(1,792)**	(1,577)
Carrying value at end of year	**12,629**	6,669

Lease payments for short term leases, leases of low value underlying assets are recognised in operating expenditure. These payments are disclosed in Note 5.1.

Cash outflows in respect of leases recognised on-SoFP are disclosed in the reconciliation above.

11.4 Maturity analysis of future lease payments

Undiscounted future lease payments payable in:	Total 31 March 2025 £'000	Of which leased from DHSC group bodies: £'000	Total 31 March 2024 £'000	Of which leased from DHSC group bodies: £'000
not later than one year	1,666	962	1,368	697
later than one year and not later than five years	5,257	2,857	3,164	2,046
later than five years	11,331	10,735	2,727	1,983
Total gross future lease payments	**18,254**	**14,554**	**7,259**	**4,726**
Finance charges allocated to future periods	(5,625)	(5,305)	(590)	(471)
Net lease liabilities at 31 March	**12,629**	**9,249**	**6,669**	**4,255**

Undiscounted future lease payments payable in:	Total 31 March 2025 £'000	Of which leased from DHSC group bodies: £'000	Total 31 March 2024 £'000	Of which leased from DHSC group bodies: £'000
of which: leased from other NHS providers	**7,994**		2,862	
of which: leased from other DHSC group bodies	**1,255**		1,393	

12. Inventories

Current	31 March 2025 £'000	31 March 2024 £'000
Drugs	4,800	4,188
Consumables	8,174	7,587
Energy	246	292
Total inventories	**13,220**	**12,067**
Of which: held at fair value less costs to sell	**0**	**0**

Inventories recognised in expenses for the year were £131,585,000 (2023-24: £115,145,000). Write-down of inventories recognised as expenses for the year were £479,000 (2023-24: £449,000).

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 2023-24 the Trust received £130,000 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. Distribution of inventories by the Department ceased in March 2024.

13. Receivables

Current	31 March 2025 £'000	31 March 2024 £'000
Contract receivables	11,426	17,755
Allowance for impaired contract receivables / assets	(3,105)	(2,495)
Allowance for other impaired receivables	(925)	(681)
Prepayments	5,952	5,320
PDC dividend receivable	363	156
VAT receivable	1,223	1,317
Other receivables	1,045	991
Total current receivables	**15,979**	**22,363**

Non-current	31 March 2025 £'000	31 March 2024 £'000
Contract receivables	712	550
Allowance for impaired contract receivables / assets	(174)	(127)
Prepayments	193	377
Other receivables	654	656
Total non-current receivables	**1,385**	**1,456**

Of which receivables from NHS and DHSC group bodies:	31 March 2025 £'000	31 March 2024 £'000
Current	6,115	10,897
Non-current	654	656
Total	**6,769**	**11,553**

The majority of trade is with commissioners. As these bodies 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 2024-25 or 2023-24.

14. 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.

Cash and cash equivalents	31 March 2025 £'000	31 March 2024 £'000
Opening balance	16,868	24,620
Net change in year	13,510	(7,752)
Closing balance	**30,378**	**16,868**

Cash and cash equivalents comprise:	31 March 2025 £'000	31 March 2024 £'000
Cash with commercial banks and in hand	56	38
Cash with the Government Banking Service	30,322	16,830
Cash and cash equivalents as in the Statement of Financial Position	**30,378**	**16,868**
Bank overdraft - commercial banks and Government Banking Service	(7)	(5)
Cash and cash equivalents as in the Statement of Cash Flows	**30,371**	**16,863**

15. Trade and other payables

Current trade and other payables	31 March 2025 £'000	31 March 2024 £'000
Trade payables	5,004	13,760
Capital payables (including capital accruals)	23,561	18,864
Accruals (revenue only)	24,194	24,096
Social security costs	4,172	4,118
Other taxes payable	4,911	4,948
Pension contributions payable	5,503	5,001
Other payables	2,346	1,844
Total current trade and other payables	**69,691**	**72,631**
Of which payables to NHS and DHSC group bodies:	1,495	2,279

There are no amounts included above to buy out early retirement liabilities in either 2024-25 or 2023-24.

16. Borrowings

Current borrowings	31 March 2025 £000	31 March 2024 £000
Bank overdrafts	7	5
Loans from the Department of Health and Social Care	0	795
Lease liabilities	1,303	1,242
Obligations under LIFT contracts	148	122
Total	**1,458**	**2,164**

Non-current borrowings	31 March 2025 £000	31 March 2024 £000
Lease liabilities	11,326	5,427
Obligations under LIFT contracts	2,516	2,600
Total	**13,842**	**8,027**

16.1 Reconciliation of liabilities arising from financing activities 2024-2025

Description	DHSC loans £'000	Lease liability £'000	LIFT scheme £'000	Total £'000
Carrying value at 1 April 2024	**795**	**6,669**	**2,722**	**10,186**
Cash movements: Financing cash flows - payments and receipts of principal	(794)	(1,539)	(125)	**(2,458)**
Cash Movements: Financing cash flows - payments of interest	(6)	(253)	(599)	**(858)**
Non-cash movements: Additions	0	7,449	0	**7,449**
Non-cash movements: Lease liability remeasurements	0	119	0	**119**
Non-cash movements: Remeasurement of LIFT liability resulting from change in index or rate (taken to financing costs)	0	0	67	**67**
Non-cash movements: Interest charge arising in year (application of effective interest rate)	5	253	599	**857**
Non-cash movements: Early termination	0	(69)	0	**(69)**
Carrying value at 31 March 2025	**0**	**12,629**	**2,664**	**15,293**

16.2 Reconciliation of liabilities arising from financing activities 2023-2024

Description	DHSC loans £'000	Lease liability £'000	LIFT scheme £'000	Total £'000
Carrying value at 1 April 2023	**2,143**	**5,604**	**1,382**	**9,129**
Cash movements: Financing cash flows - payments and receipts of principal	(1,347)	(1,442)	(105)	**(2,894)**
Cash movements: Financing cash flows - payments of interest	(23)	(135)	(583)	**(741)**
Non-cash movements: Application of IFRS16 measurement principles to LIFT liability on 1 April 2023	0	0	1,376	**1,376**
Non-cash movements: Additions	0	1,359	0	**1,359**

Description	DHSC loans £'000	Lease liability £'000	LIFT scheme £'000	Total £'000
Non-cash movements: Lease liability remeasurements	0	1,148	0	**1,148**
Non-cash movements: Remeasurement of LIFT liability resulting from change in index or rate (taken to financing costs)	0	0	68	**68**
Non-cash movements: Interest charge arising in year (application of effective interest rate)	22	135	584	**741**
Carrying value at 31 March 2024	**795**	**6,669**	**2,722**	**10,186**

17.1 Provisions

Description	Pensions - early departure costs £'000	Pensions - injury benefits £'000	Legal claims £'000	Other £'000	Total £'000
Balance at 1 April 2024	**1,041**	**2,063**	**161**	**2,366**	**5,631**
Change in the discount rate	(29)	(87)	0	(8)	(124)
Arising during the year	149	308	113	1,009	1,579
Utilised during the year	(153)	(205)	(14)	(49)	(421)
Reversed unused	0	0	(23)	0	(23)
Unwinding of discount	22	46	10	70	148
Balance at 31 March 2025	**1,030**	**2,125**	**247**	**3,388**	**6,790**
Expected timing of cash flows	**Pensions - early departure costs £'000**	**Pensions - injury benefits £'000**	**Legal claims £'000**	**Other £'000**	**Total £'000**
No later than one year	154	205	247	2,734	3,340
Later than one year and no later than five years	578	773	0	87	1,438
Later than five years	298	1,147	0	567	2,012
Total	**1,030**	**2,125**	**247**	**3,388**	**6,790**

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.

17.2 Clinical negligence liabilities

At 31 March 2025, £141,405,000 was included in provisions of NHS Resolution in respect of clinical negligence liabilities of Royal Cornwall Hospitals NHS Trust (31 March 2024: £157,645,000).

18. Contingencies

Value of contingent liabilities	31 March 2025 £'000	31 March 2024 £'000
NHS Resolution legal claims (1)	54	41
Other (2)	2,444	3,055
Net value of contingent liabilities	**2,498**	**3,096**

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

(2) The Trust received funding between 2015-16 and 2018-19 totalling £3,055,000 from Macmillan Cancer Support, to fund the building of the Cove Cancer Information Centre on the main hospital site in Truro. Under the terms of the agreement with Macmillan, the Trust is obliged to use the building for its intended purpose for a period of 15 years. Should the Trust not do so, the Trust will be obliged to repay a percentage of the funding to Macmillan. As at 31 March 2025, this percentage stands at 80% (31 March 2024: 100%).

The Trust has no contingent assets.

19. Contractual capital commitments

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

Description	31 March 2025 £'000	31 March 2024 £'000
Property, plant and equipment	7,489	2,097
Intangible assets	3,444	6,984
Total	**10,933**	**9,081**

Individually significant capital commitments

Included within property, plant and equipment commitments is £2,800,000 relating to the relocation of the Cardiology department. The total cost of the project is expected to be £4,481,000, of which £3,324,000 is with the main construction contractor. As at 31 March 2025, the Trust has incurred £921,000 of capital expenditure on the project, which includes £491,000 with the main contractor. Construction is expected to be complete by November 2025.

Intangible asset capital commitments above relate to the Electronic Patient Record (eCare) Project. The total cost of this project is expected to be £43,161,000. This figure includes £13,290,000 with the main software provider. As at 31 March 2025 the Trust has incurred £33,897,000 of capital expenditure on the project, which includes £9,846,000 with the main supplier. Implementation is expected to be completed by June 2026.

20. 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.

20.1 Total on-SOFP LIFT arrangement commitments

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

Description	31 March 2025 £'000	31 March 2024 £'000
Total future payments committed in respect of the LIFT arrangement	**9,184**	**10,049**
Of which liabilities are due: not later than one year	1,063	1,020
Of which liabilities are due: later than one but not later than five years	4,526	4,341
Of which liabilities are due: later than five years	3,595	4,688
Total future payments	**9,184**	**10,049**

21. Financial instruments

21.1 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 commissioners and the way those commissioners 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 has previously borrowed from the Government for both capital and revenue expenditure. Interest charges were fixed at the National Loans Fund rate for the life of the loan. Having fully repaid it's last remaining loan in 2024-25, the Trust is no longer exposed to interest rate risk on loans, however it remains exposed to the risk associated with fluctuating interest rates and their impact on interest receivable balances.

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 2025 are in receivables from customers, as disclosed in the receivables note.

Liquidity risk

The Trust's operating costs are incurred under contracts with commissioners, which are financed from resources voted annually by Parliament. The Trust funds its capital expenditure from funds generated by depreciation charges and investment from the Government in the form of public dividend capital. 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.

21.2 Carrying values of financial assets

Carrying values of financial assets held at amortised cost	31 March 2025 £'000	31 March 2024 £'000
Trade and other receivables excluding non-financial assets	9,632	16,648
Cash and cash equivalents at bank and in hand	30,378	16,868
Total	**40,010**	**33,516**

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

21.3 Carrying values of financial liabilities

Carrying values of financial liabilities held at amortised cost	31 March 2025 £'000	31 March 2024 £'000
Loans from the Department of Health and Social Care	0	795
Other borrowings	7	5
Obligations under leases	12,629	6,669
Obligations under LIFT contracts	2,664	2,722
Trade and other payables excluding non-financial liabilities	49,532	58,439
Total	**64,832**	**68,630**

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

21.4 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.

Maturity of financial liabilities	31 March 2025 £'000	31 March 2024 £'000
Financial liabilities maturing in one year or less	51,927	61,299
Financial liabilities maturing in more than one year but not more than five years	8,145	5,912
Financial liabilities maturing in more than five years	13,437	5,418
Total	**73,509**	**72,629**

22. Losses and special payments

Losses and special payments	2024 to 2025 Total number of cases	2024 to 2025 Total value of cases £'000	2023 to 2024 Total number of cases	2023 to 2024 Total value of cases £'000
Losses: Cash losses	64	37	26	23
Losses: Bad debts and claims abandoned	62	43	44	184
Losses: Stores losses and damage to property	14	480	14	448
Total losses	**140**	**560**	**84**	**655**
Special payments: Special severance payments	1	5	0	0
Special payments: Ex-gratia payments	43	60	48	292
Total special payments	**44**	**65**	**48**	**292**
Total losses and special payments	**184**	**625**	**132**	**947**

There were no individual losses, special payments or gifts in excess of £300,000 in either 2024-25 or 2023-24.

No compensation payments were received in respect of the above losses and special payments in either 2024-25 or 2023-24.

23. 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 Trust has had material transactions with 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 2025	Revenue with related party £'000	Expenditure with related party £'000	Receivables with related party £'000	Payables with related party £'000
NHS Cornwall and the Isles of Scilly ICB	519,932	0	3,758	0
NHS England	147,698	14	719	1,925
Cornwall Partnership NHS FT	9,580	12,711	280	380
NHS Resolution	0	14,754	0	0

Year to 31 March 2024	Revenue with related party £'000	Expenditure with related party £'000	Receivables with related party £'000	Payables with related party £'000
NHS Cornwall and the Isles of Scilly ICB	481,578	60	8,597	0
NHS England	133,776	21	601	701
Cornwall Partnership NHS FT	9,368	11,684	288	696
NHS Resolution	0	14,615	0	0

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 receivables at 31 March 2025 is £5,000 (31 March 2024: £5,000) owed to Royal Cornwall Hospitals NHS Trust. During 2024-25 the Trust received income of £705,000 (2023-24: £791,000) from the Charity.

24. Events after the reporting date

There are no known post balance sheet events requiring disclosure.

25. Better Payment Practice Code

2024 to 2025: Non-NHS payables	Number	£'000
Total non-NHS trade invoices paid in the year	133,762	260,960
Total non-NHS trade invoices paid within target	125,026	247,636
Percentage of non-NHS trade invoices paid within target	**93.5%**	**94.9%**

2024 to 2025: NHS payables	Number	£'000
Total NHS trade invoices paid in the year	2,112	101,001
Total NHS trade invoices paid within target	2,032	99,809
Percentage of NHS trade invoices paid within target	**96.2%**	**98.8%**

2023 to 2024: Non-NHS payables	Number	£'000
Total non-NHS trade invoices paid in the year	121,499	245,681
Total non-NHS trade invoices paid within target	117,526	237,425
Percentage of non-NHS trade invoices paid within target	**96.7%**	**96.6%**

2023 to 2024: NHS payables	Number	£'000
Total NHS trade invoices paid in the year	1,921	88,364
Total NHS trade invoices paid within target	1,763	85,234
Percentage of NHS trade invoices paid within target	**91.8%**	**96.5%**

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.

26. Capital Resource Limit

Description	2024 to 2025 £'000	2023 to 2024 £'000
Gross capital expenditure	56,741	45,521
Less: Disposals	(206)	(316)
Less: Donated and granted capital additions	(411)	(796)
Charge against the Capital Resource Limit	**56,124**	**44,409**
Capital Resource Limit	56,664	44,809
Underspend against the Capital Resource Limit	**540**	**400**

27. Break-even duty financial performance

Description	2024 to 2025 £'000	2023 to 2024 £'000
Adjusted financial performance surplus (control total basis)	92	99
Remove impairments scoring to Departmental Expenditure Limit	7	50
Incremental impact of IFRS16 on LIFT revenue costs in 2023-24	0	36
IFRIC 12 breakeven adjustment	0	41
Breakeven duty financial performance surplus	**99**	**226**

28. Break-even rolling duty assessment

Description	1997-98 to 2008-09 Total £'000	2009-10 £'000	2010-11 £'000	2011-12 £'000	2012-13 £'000	2013-14 £'000	2014-15 £'000	2015-16 £'000	2016-17 £'000
Break-even in-year financial performance		8,349	7,544	4,437	9,809	3,938	(6,908)	(6,906)	(929)
Break-even duty cumulative position	(42,768)	(34,419)	(26,875)	(22,438)	(12,629)	(8,691)	(15,599)	(22,505)	(23,434)
Operating income		303,925	310,471	314,246	323,341	332,819	342,503	355,815	379,462
Cumulative break-even position as a percentage of turnover		(11.3%)	(8.7%)	(7.1%)	(3.9%)	(2.6%)	(4.6%)	(6.3%)	(6.2%)

Description	2017-18 £'000	2018-19 £'000	2019-20 £'000	2020-21 £'000	2021-22 £'000	2022-23 £'000	2023-24 £'000	2024-25 £'000
Break-even in-year financial performance	(2,557)	(4,104)	487	2,784	2,804	2,472	226	99
Break-even duty cumulative position	(25,991)	(30,095)	(29,608)	(26,824)	(24,020)	(21,548)	(21,322)	(21,223)
Operating income	405,020	445,376	481,623	537,177	580,590	624,358	671,880	733,341
Cumulative break-even position as a percentage of turnover	(6.4%)	(6.8%)	(6.1%)	(5.0%)	(4.1%)	(3.5%)	(3.2%)	(2.9%)

The Trust reported a £0.1m surplus for break-even purposes in 2024-25 and holds a cumulative deficit of £21.2m at 31 March 2025. The Trust expects to fail to achieve break-even on a cumulative basis at 31 March 2026, 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

Opinion on financial statements

We have audited the financial statements of Royal Cornwall Hospitals NHS Trust (the 'Trust') for the year ended 31 March 2025, which comprise the statement of comprehensive income, the statement of financial position, the statement of changes in equity, the statement of cash flows and notes to the accounts, including material accounting policy information. 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 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and 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 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("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 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 2024-25 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 2024) 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.

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.

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.

Our responsibilities and the responsibilities of the directors with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, other than the financial statements and our auditor's report thereon. The directors are responsible for the other information contained within the annual report. 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.

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 themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

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

Under the Code of Audit Practice published by the National Audit Office in November 2024 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 requirements of the Department of Health and Social Care Group Accounting Manual 2024-25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration and Staff Report to be audited have been properly prepared in accordance with the requirements of the Department of Health and Social Care Group Accounting Manual 2024-25; and

- based on the work undertaken in the course of the audit of the financial statements, 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 15 May 2025 we referred a matter to the Secretary of State under section 30 (b) of the Local Audit and Accountability Act 2014 in relation to Royal Cornwall Hospitals NHS Trust's ongoing breach of its cumulative break-even duty for the year ended 31 March 2025.

Responsibilities of directors

As explained more fully 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 and 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.

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.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. 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 2024-25).

- 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.

  - The establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.

- We enquired of management, internal audit 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, 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 fraudulent revenue and expenditure recognition. We determined that the principal risks were in relation to:

    - journals posted by senior officers;

    - journals either side of the year end for estimated expenditure accruals;

    - accounting estimates, in particular those relating to land and buildings valuations; and

    - accruals for income and expenditure.

- 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 and those posted by senior officers.

    - Challenging assumptions and judgements made by management in its significant accounting estimates in respect of land and building valuations and income and expenditure accruals.

    - Assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.

    - Testing of expenditure and year end payables both pre and post year end.

    - Testing of income and year end receivables both pre and post year end.

- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as 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.

- We communicated relevant laws and regulations and potential fraud risks to all engagement team members. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.

- The engagement partner's 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 England'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.

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

Report on other legal and regulatory requirements –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 2025.

We have nothing to report in respect of the above matter, except on 20 June 2024 we reported a significant weakness in the Trust's arrangements for securing financial sustainability. This was in relation to the Trust identifying and delivering recurrent savings. We recommended that the Trust should continue to build on progress made on their efficiency savings plans by focusing on timeliness of identification of savings, oversight arrangements and increasing the level of recurrent savings.

As part of our assessment of the Trust's arrangements for ensuring economy, efficiency, and effectiveness in its use of resources for the year ending 31 March 2025, we reported that the Trust did not have sufficient schemes in place during 2024-25 to deliver their recurrent savings target. On 26 June 2025 we concluded that the significant weakness in the Trust's arrangements for financial sustainability remains in place for 31 March 2025. This was in relation to the increased size of efficiency savings required within the 2025-26 financial plan, coupled with the increased level of recurrent savings required and £6.2 million unidentified at the time of the plan submission. We have raised one further recommendation that the Trust, along with its system partners, must continue to work closely with system partners to progress transformational schemes that align with both its own and the wider system's objectives and financial plans.

Responsibilities of the Accountable Officer

As explained in the Statement of the Chief Executive's responsibilities as the accountable officer of the Trust, 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(2A)(c) 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 November 2024. 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 – 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 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until we have completed the work necessary in relation to the Trust's consolidation schedules, and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

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.

Beth Bowers.

Beth Bowers, Key Audit Partner.

for and on behalf of Grant Thornton UK LLP, Local Auditor.

Bristol.

Date: 26 June 2025.

Annual Report and Accounts 2024-2025

Our values

Respect

Compassion

Honesty

Teamwork

Protocol for Questions from Members of the Public

When the Trust is using Teams Live to live stream the meeting the following Protocol applies to questions from members of the public:

- Members of the public are invited to join the Trust's Board in Public / Annual Public meetings via the live stream using MS Teams. A link for each meeting is available on the agenda or on the Trust's website.
- Members of the public are welcome to log questions throughout the meeting via the Q&A function and, subject to meeting the requirements below, will be taken at the end of the meeting at item 4. The functionality to raise a question will not be available from item 5. A maximum of 15 minutes is allocated for questions from the public.
- The Trust's Company Secretary will read the questions submitted by members of the public on their behalf.
- Members of the public are welcome to provide their name to the question they wish to ask.
- Questions at the meeting must relate to papers being presented on the day and must relate to the role and remit of Royal Cornwall Hospitals NHS Trust.
- No supplementary questions are allowed.
- Questions should be kept brief and to the point.
- Questions may be submitted in advance or via the Q&A function on MS Teams Live during the meeting. If a question is logged during the meeting it may mean that it is not always possible to provide an answer at the meeting. In that case, the questioner's contact details will be requested for response.
- Questions will be taken in rotation, to ensure those wishing to raise questions have equal opportunity, within the limited time available – if a member of the public asks more than one question their first question will be asked and then their remaining question/questions returned to if no other members of the public wish to raise one and if it is within the time allocated for the item.
- We will endeavor to provide a response at the meeting which will be offered by a member of the Board to the Chair.
- An answer to an oral question under this procedure will take the form of either:
  - A direct oral answer; or
  - If the information required is not easily available a written answer will be sent to the questioner, circulated to all members of the Trust Board and included in the minutes of the meeting.

- Questions and answers will be reflected in the minutes of the meeting.
- Questions need not be answered if the Chairwoman considers that they:
  - Are not on any matter that is within the powers and duties of the Trust.
  - Are defamatory, frivolous or offensive.
  - Are substantially the same as a question that has been put to a meeting of the Trust Board in the past six months.
  - Would require the disclosure of confidential or exempt information.
- The Chairwoman's determination on whether or not to accept a question is final.