Royal Cornwall Hospitals NHS
NHS Trust

Annual Report and Accounts 2010/11

Contents

Annual Report 2010/11

This annual report is published in full alongside our Annual Accounts 2010/11, Operating Financial Review, Statement of Internal Control and Remuneration Report on our website: www.rcht.nhs.uk .

Printed, text only, versions of these documents are available on application to:

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Our commitment to safer, better, good value care

Over the last financial year our staff worked harder than ever to maintain high standards of care at the same time as treating greater numbers of patients and delivering a multi-million pound service improvement and efficiency programme. Added to that has been the challenge of keeping services running as we upgrade our buildings and replace equipment, along with reviews of our staffing and plans to reduce our workforce during 2011/12.

Not surprisingly then, it has been a tough year, reflected by our staff survey results. Yet above all the commitment to patient care has remained steadfast. Patient satisfaction remains high with 93% rating their overall care as excellent, very good or good.

This report highlights some of the positive progress we made during 2010/11, not least our achievement of unconditional registration with the Care Quality Commission. Improvements in performance – quality and financial - are helping us to deliver safer, better and good value care.

We still have much more to do. As we look forward we, like all parts of the NHS, have further challenges ahead. Becoming an NHS Foundation Trust is a top priority for us. It will drive us to show we can consistently provide safer and better care. Our success will keep our hospitals locally managed. It will give us more freedom to invest in services to meet the future needs of our patients, offering more care, closer to home.

Our staff, our volunteers and our local community will all have a part to play. With everyone's support we can secure a successful future for our hospitals.

Martin Watts
Chairman

May 2011

Delivering 'Our Plans' – making the words reality

Our strategic plan was launched in April 2010, following extensive consultation with our staff, stakeholders and our local community. 'Our Plans 2010-2014' sets out our commitment to the delivery of better, safer, good value care. Its priority is the safety and quality of the care we provide and leading from that increased efficiency and improved value for money.

The service developments and investment in buildings and equipment highlighted in this report are examples of how we have been delivering that strategy. We have made more services available to patients closer to their own homes and increases in day surgery and the introduction of new techniques and treatment are shortening the time patients spend in our hospitals.

- A new re-ablement service at West Cornwall Hospital, led jointly by senior clinicians and a dedicated nurse consultant, is setting the example for future care of patients with complex needs as they prepare to leave hospital when they are no longer in need of specialist acute care.

Allied to this is our work with our partners in community and social care, where we are better integrating services to offer patients treatment in the setting that is most appropriate to their clinical need. To this end, the development of health and social care hubs during 2011/12 and a new referral management centre will create new ways to offer emergency and planned care, reducing the numbers of people coming needlessly into hospital.

- During 2010/11 our staff worked hard to realise savings of just over £15 million – around 5% of our total budget. The continued increase in the proportion of operations carried out using keyhole surgery techniques offers a shorter stay and faster recovery for patients. The procedure is more cost effective so we can provide more treatments for less money.

Improving our performance, in both the quality of our services and financial management, has laid the platform for us to begin the process of applying to be an NHS Foundation Trust. During 2011/12 we will launch our public consultation and membership scheme. This will offer our local community the opportunity to become more involved in the planning of our services so that we can better meet their needs for the future and keep local control of acute hospital services.

Listening, involving, acting

We have been working with patients, the Adult Health and Social Care Overview and Scrutiny Committee (OSC), Local Involvement Networks, our own patient ambassadors and others to improve our services in response to the needs of the community.

One of the projects has been a detailed review by the OSC on patient access to outpatient clinics and day care, highlighting the social and economic impact the long distances that some need to travel to our hospitals. In response we have changed our car parking tariffs at our hospitals in Penzance and Hayle. We are working hard to improve our booking systems so that patients are offered more convenient appointments, closer to home, wherever this is possible. The review has also led to county-wide changes to the hospital transport scheme. These are being introduced in 2011/12 and will ensure fairer access for patients with a medical need for transport.

The Cornwall Local Involvement Network has undertaken its first 'enter and view' study at our hospitals and we will be taking forward a programme of actions and improvements during 2011/12.

Our patient ambassadors have continued to participate in regular audits of cleanliness, catering and the environment, as well as representing patients in the development of services, including our clinical site development plan and the introduction of a retail pharmacy outlet for outpatient prescription dispensing.

Better buildings, new equipment

Over £26 million was spent on new facilities and equipment, enabling us to offer better and safer treatment for patients. At the same time this has improved the efficiency of our services through this investment.

The complex, and ongoing, programme of building works across our three hospitals has to be delivered with minimal disruption to our services and inconvenience to patients. It is a tribute to our staff that it has been possible to achieve so much whilst caring for increasing numbers of patients.

Projects completed during 2010/11 included:

- **Headland Unit** – a new facility for patients receiving chemotherapy and specialist haematology treatments. Designed with the help of patients the unit offers greater privacy and dignity and a safer environment in which to attain the high levels of infection prevention required for vulnerable patients.

- Around 10,000 patients each year will benefit from facilities in the new Headland Unit, officially opened in May 2011 by HRH Princess Alexandra

- **Expanded and upgraded Renal Unit** – The Aubery Williams Renal Unit at West Cornwall Hospital underwent an £800,000 refurbishment to upgrade and extend facilities. Additional dialysis stations and isolation facilities allow more patients, who generally need treatment 3 times each week, to be treated nearer their own homes.

- Setting up a dialysis machine in the refurbished Renal Unit at West Cornwall Hospital

  - **Ward upgrade programme** – as part of the long term plan to redesign the Royal Cornwall Hospital site, locating emergency patients in the Trelawny Wing and planned care in the Tower Block, a £3 million programme of ward upgrades and refurbishments has taken place. Works have included additional shower and toilet facilities to increase privacy for patients and access to same sex accommodation, as well as further infection prevention measures.
  - **Digital imaging improving diagnosis** – breast cancer patients are benefiting from the latest development in screening after the Mermaid Centre and the Cornwall Breast Screening Programme became the first in the south west to install digital mammography imaging. Offering improved clarity of images the system is being used both at the Mermaid Centre as well as the mobile screening units. Patients now benefit from improved early detection of breast cancers, particularly for younger women with more dense breast tissue.

- One of two mobile breast screening units equipped with the latest digital mammography equipment.

  - St Michael's Hospital has also taken advantage of digital imaging technology with a £400,000 upgrade of x-ray facilities to become the first completely digital general x-ray unit in Cornwall. The x-ray unit supports inpatient and outpatient services for patients at the hospital, allowing specialists instant access to images from any of our hospital sites through the secure NHS IT network.

- The Friends of St Michael's Hospital contributed £30,000 to the digital x-ray project.

- **IT speeds up diagnosis** – a new system for online referrals for x-ray and other diagnostic imaging examinations went live on the wards. Wireless 'computers on wheels' allow doctors and nurses to make instant referrals from the patients' bedside, speeding up examinations and diagnosis.

- 'Computers on wheels' give instant access to images and test results at the patient bedside.

- **Hybrid CT and Gamma Camera** - among the first of its kind in the UK, an innovative new camera for molecular imaging was put into action in February. A fusion of CT (computerised tomography) and nuclear medicine technology it allows specialists to look at the cellular function in patients without an invasive procedure.

Its wide-ranging capabilities can be used in the diagnosis of diseases such as cancer, and neurological and cardiovascular diseases.

So far we have made a total investment of £30 million in our clinical site development programme as part of over £80 million of investment in equipment, informatics and buildings our hospitals over the last 3 years.

Reducing our environmental impact

The NHS has a commitment to reduce its carbon emissions by 80% by the middle of this century. As one of the largest employers and a major utility user, we are actively working towards that goal. As well as having a positive impact on our local environment, the actions we take will also help us to reduce our costs and to give us some protection from escalating utility bills.

- Installation of a 20Kw photovaltic system on the roof of the Tower Block is generating renewable electricity.

The biomass boiler on the Royal Cornwall Hospital site is powerful example of the work we have been doing. Over the last 12 months it has reduced our carbon emissions by more than 380,000 tonnes, if the same amount of energy had been generated using gas, and saved the equivalent of just over £32,000. During the last year we have also upgraded hot water systems and windows, installed solar panels, introduced low energy lighting and rationalised printers.

Setting an example for others, the renal unit team has reduced carbon emissions by 33,000 tonnes and saved as much in £'s in the cost of providing services and energy costs at the same time.

Underway and on the way

The investment programme continues into 2011/12. Work is nearing completion on a redesigned day case unit and interventional radiology suite at Royal Cornwall Hospital; works to create a new treatment centre at West Cornwall Hospital, enabling the further expansion of services, is due for completion by autumn 2011; and the Surnise Centre is being extended ready for installation of a new linear accelerator, in partnership with the Sunrise Appeal, to provide the latest in radiotherapy treatments.

- Cancer specialists and contractors review plans in readiness for the installation of a new linear accelerator.

Among projects to get underway during 2011/12 will be a £3 million scheme to remodel our critical care facilities, providing integrated and expanded intensive care and high dependency care facilities. A further project will see a £1.6 million investment to provide 5 integrated theatres, equipped with the latest in key surgery technology.

Future phases of the clinical site development plan will need continued capital investment. The Trust has benefited considerably in recent years from successful bids from the Department of Health's fund for financially challenged Trusts. For the coming years, achievement of Foundation Trust status will be critical to securing the further capital resource to continue to deliver our plans.

New services and clinical developments

Specialist teams at our hospitals have led the introduction of new techniques and treatments for patients, providing better care and bringing new services closer to home.

Continuing the advances in breast care at the Mermaid Centre and the surgical service provided from St Michael's Hospital, our breast cancer surgeons introduced a new technique which allows them to assess the spread of cancer whilst patients are in theatre. Further surgery can be done straight away, avoiding an anxious wait for results and a second operation.

A highly specialist procedure to unblock the major blood vessels around the heart within 150 minutes of a heart attack has been made available 24 hours a day. The Primary Percutaneous Coronary Intervention (Primary PCI) service introduced at the Royal Cornwall Hospital is offering better care for heart attack patients suitable for this procedure. Primary PCI can lessen long-term damage to the heart after a heart attack, aid speedier recovery and shorten the length of time patients need to stay in hospital.

Reviewing our clinical care and research for the future

Taking part in over 200 national and local audits of our clinical services helps lets us compare our standards of care with others in the UK and further a field. We can share our own expertise and our specialists take part in a wide range of activities to develop new skills and techniques.

- In 2010 our gynaecology and gastrointestinal specialists were the first in the UK to take part in a live surgery broadcast across the internet demonstrating their skills to colleagues in countries around the world.

Research activity continues to expand as we take advantage of our status as a teaching hospitals Trust. The number of active studies has increased by 25% and more than 2957 people were recruited to take part.

Safer, better care

Mark of quality

Standards and quality of care were given a seal of approval when the Care Quality Commission awarded the Trust unconditional registration. This marked a major milestone in improving our performance, putting behind us a history of poor ratings under the former assessment process.

As part of the planned national programme of inspections, the Care Quality Commission(CQC) made its unannounced visit to our hospitals in February 2011. The CQC inspectors found the hospitals were meeting all of the essential standards of quality and safety reviewed.

CQC inspectors found people using our services praised the nursing and care staff and were highly complimentary of the patient meal service, noting comments including 'the food is better than in some hotels'.

Quality Accounts are now an important part of the annual assessment of our ongoing performance and improvement plans. These are published in June each year and provide an 'annual report' specifically on quality of care and services. These highlight where we are doing well and the areas where we have identified a priority for further improvement and development over the year ahead. Our Quality Accounts are published on our website at: www.rcht.nhs.uk

Safer care

Measures to improve safety have obvious benefits for patient care, reducing the risk of harm and prolonged hospital stays, and leading to faster recovery. They also contribute greatly to providing more cost effective care. Some of our income is also dependent on achieving specific quality improvements agreed with NHS Cornwall and Isles of Scilly as our lead commissioner.

Some key quality improvements during 2010/11:

- ***More than 90% of patients admitted to our hospitals are now accurately reviewed and assessed for risk of Venous Thromboembolism (VTE) and treatment given where needed.***
- ***Over 82% of our staff have received training in the awareness of Dementia, assisting the identification and appropriate care of patients.***
- ***Introduction and roll out of the Productive Theatre programme across all theatre areas to ensure safety and reliability of care whilst also improving efficiency.***
- ***Being in the top 20% for participation in Patient Reported Outcome Measures (PROMS), where patients are asked to rate their health and wellbeing before and after their treatment.***
- ***Reduced use of urinary catheters from 22% to 15%, with the wider aim of reducing healthcare acquired infection.***

Renewed focus on preventing patient falls in hospital has heightened awareness among staff. Better patient assessment and learning from incidents is improving safety for vulnerable patients. It has however seen varied improvement throughout the year and this work will therefore continue in 2011/12.

Efforts to reduce the incidence of hospital associated infection has seen a continued improvement. MRSA bloodstream infections have been reduced by 50 percent, with two cases throughout the year. Clostridium difficile also reduced but at a slower pace (down by 16 percent) and this will be the focus of attention during the coming year. Better control of Norovirus has seen a reduced impact on services this year, supported

by public awareness campaigns for both Norovirus and Influenza in partnership with the other NHS trusts in Cornwall.

Dignity and safeguarding

Caring for patients in facilities shared only with others of the same sex has presented a challenge for our hospitals when balancing clinical need against bed availability at times of peak demand. We have invested in improved facilities and renewed focus will help us to meet this important standard during 2011/12.

- More shower and toilet facilities and clear signage are helping to raise standards of privacy and dignity.

Dementia and stroke are two services where we have directed efforts to provide better care for patients. Developments in stroke services over the last 2 years have seen a marked improvement in the standard of care. Patients are being diagnosed more quickly (almost 90% having a brain scan within 24 hours); they have 24/7 access to specialist clinics and increasing numbers are admitted directly to a specialist stroke ward. During 2011/12 the focus on a wide range of services to support stroke services, including the launch of a countywide fundraising appeal, will support further investment in specialist equipment and stroke care in hospital and in the community.

New facilities at Bodmin Hospital have created more rehabilitation beds for stroke patients. Once fully opened this will mean patients can be discharged sooner to be cared for closer to home, freeing up acute stroke beds for patients needing specialist care immediately after their stroke.

National statistics estimate up to a quarter of patients in hospital at any time will have confirmed or as yet undiagnosed dementia. A Trust-wide education programme has been used to raise awareness of dementia so all staff are equipped to identify and respond to the needs of dementia patients. In 2011/12 plans include the introduction of new patient information and a development programme for Dementia Link Workers.

Priorities for quality and safety improvement during 2011/12 include avoiding unnecessary admissions to hospital and discharging patients as soon as they no longer need specialist acute care. This will be helped by the introduction of health and social care hubs, where integrated services will more easily identify patients in need of early intervention before their condition deteriorates to the extent of needing hospital admission. We will also be doing more to ensure planned patients are well-prepared for their procedures so that we can further reduce the time they need to spend in hospital. This in turn reduces their risk of complications and infection, leads to better outcomes and more cost effective care.

We will also be focussing on improving the experience of young patients moving from children's to adult services; doing more to meet individual's needs in end of life care; as well as continuing our work on stroke and dementia care.

Performance

Access to treatment

How many patients we treated during 2010/11

Inpatients	
Emergency	56,510
Elective	13,666
Daycase	50,353
Day Treatments	15,685
Total	**136,214**

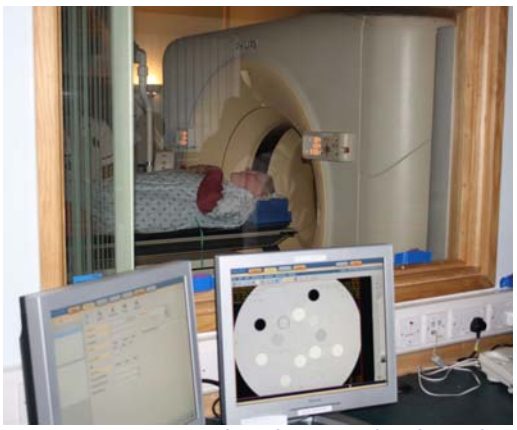
Outpatients	
New	163,575
Follow up	301,499
Total	**465,074**

A&E	
Attenders	**72,147**

Total patient contacts	**673,435**

Feedback from our patients tells us the time waiting for treatment is a top issue of concern. The NHS Constitution sets a standard of 18 weeks from the time a patient is referred by their GP, to seeing a specialist, having their condition diagnosed and any necessary treatment to begin.

Waiting times have been longer in specialties where increased referrals and a backlog of activity have meant our capacity has not kept up with demand. During 2011/12 plans have been made to catch up and make sure our patients are not waiting longer than the 18 week commitment. The major investment in our theatres will help us to treat more patients, more quickly.



- A new treatment planning CT simulator for the Sunrise Centre is one example of ongoing investment in our cancer services which help us to make sure patients receive speedy treatment. We exceed national targets to see all urgent cancer referrals within 2 weeks and of the 2,693 patients diagnosed with cancer 98.1% began treatment within 31 days of the date of decision to treat and 86.1% started treatment within 62 days of being referred with suspected cancer against a target of 85%.

Faster diagnosis and treatment for patients with a fractured hip has also been a priority during 2010/11. Marked improvements have been made in the percentage of patients diagnosed within 1 hour and operated on within the national standard of 36 hours. Further work will continue during 2011/12 to make sure the different services and specialists involved in diagnosis, surgery and post-operative care are able to work together to offer patients with hip fractures better and more effective treatment.

Measuring Up

Key targets met during 2010/11

- At least 95% of patients were assessed and treated or admitted within 4 hours of arrival at our emergency or casualty departments
- 50% reduction in cases of MRSA bloodstream infection
- 16% reduction in cases of clostridium difficile
- Meeting new waiting time targets for cancer treatment by 31 March 2011

- Maintaining a rating of 'performing' in the Department of Health assessment
- Meeting all our statutory financial targets
- Making our required loan repayments for 2010/11
- Delivering a £26 million capital investment programme in buildings and equipment

Key targets for 2011/12

- Meeting the NHS Constitution commitment on waiting time for routine treatment so that at least 90% of patients needing day case or inpatient treatment are seen within 18 weeks of referral by the GP
- Achievement of a £4.4 million financial surplus, supported by the delivery of a £19 million savings programme

What our patients say

Our 2010 national patient survey results revealed 93% of patients rated their overall experience of care at our hospitals as being excellent, very good or good.

The survey results are reflected by the number of compliments received; outweighing complaints by more than 11:1 (3459 to 302). This does not detract from the importance we place on learning from less positive experiences of our services and our commitment making improvements to patient care.

During the year our Patient Advice and Liaison team dealt with just under 4,000 enquiries. These range from signposting patients and relatives to other services, providing information and importantly the early resolution of issues or concerns.

Having adopted the Principles for Remedy we aim to ensure we respond appropriately and fairly to any concerns raised by individuals about our services. Since then an increasing number of complaints resolved through local resolution is demonstrating the benefit of face to face discussion in satisfactorily addressing concerns.

Where complaints were not resolved locally, seven cases were referred to the Parliamentary Health Service Ombudsman. Of these 4 were dismissed, 2 were referred back to the Trust for resolution and 1 case remained in progress at the year end.

You said, we did

Here are some of examples of changes we have made in response to comments from patients, relatives, carers and visitors to our hospitals:

- Introduction of matron ward rounds to improve communication with patients
- 'Customer service' training in handling of concerns and complaints
- More robust telephone assessment process for women in labour at home
- Reinforcing of checks of documentation prior to release under Data Protection regulations
- Improved process to speed up dispensing of drugs when patients are discharged from hospital
- Recruitment of 4 trauma-coordinator nurses to facilitate timely surgery for emergency patients
- Recording of all falls or injuries sustained by patients on the Trust's incident reporting system
- Improvements to patient privacy and dignity

Our workforce

Leadership and personal development

Investment in leadership and personal development has enabled a year of positive change for workforce development in RCHT which, despite the challenges and changes we face, is the mainstay of support for our staff as they carry out their essential roles in the Trust.

A well structured annual appraisal, plays a vital role in making sure our staff feel valued and are able to use their skills and expertise. A new, simpler personal development review (PDR) has been introduced which better supports our organisational objectives and is properly aligned with the developments needs of individuals to support their role in the Trust. This new system has seen the biggest increases in PDR take-up that we have seen for some years (from 22% to over 68%) and our staff have welcomed the time to reflect on upon their practice and consider future needs in their busy working lives. This is a key area for further work during 2011/12.

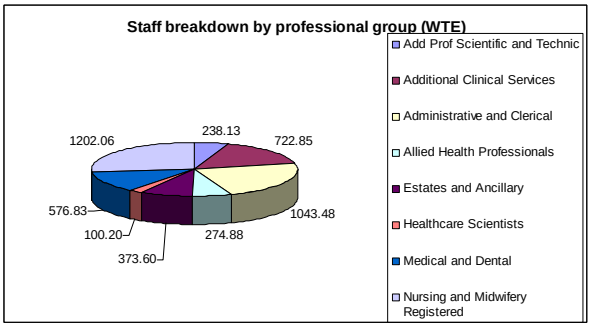
Allied to this is the launch of a broad programme of leadership and management development programmes, investing in our current and future leaders and teams so they can be well-equipped to meet the challenges we face. This has included participation in the Cornwall Leadership Academy, offering us a wide range of leadership programmes in conjunction with partners from the public sector in the County, offering the chance to work collaboratively with colleagues from outside of our hospitals.

In addition, we have enhanced our education, training and development over a number of other areas, including a strengthened focus on professional development, the enhancement of our vocational development (2010/2011 has seen RCHT gain three key awards for our vocational delivery including the Education & Skills Council Large Employer of the Year) and the streamlining of our mandatory and core training for all staff.

Our dynamic and hard-working learning and development team has a broad skills portfolio and is in demand for its team building delivery, group facilitation (including action learning), mediation, mentoring, coaching and other bespoke and targeted development offerings to all of our staff.

Our workforce

The total number of staff employed by RCHT at 31 March 2011 was 4532.02 whole time equivalents.



Overall sickness absence throughout the year averaged 4.19%, marginally higher than the 4% target set for the year, but reduced from 4.7% in 2009/10.

Staff engagement

The feedback from our annual staff survey was clear in its message that we need to do more to engage our workforce, communicate more clearly and offer our staff the support and development opportunities to be able to feel more fulfilled, valued and involved.

- The 'Extra Mile' Excellence and Innovation Awards are set to become an annual event to recognise the outstanding contribution of individuals and teams.

New lines of communication have been welcomed, including small group meetings with the Chairman and Chief Executive and an increased number of executive team visits to wards and clinical areas. The start of 2011/12 has seen the introduction of a monthly team brief process and a plan for a range of other measures to be introduced within the first half of the year that will increase accessibility and visibility of Executive Directors, as well as developing the communication channels from ward to Board.

Our Foundation Trust application presents an ideal environment in which to develop staff engagement and involvement and this will be an important element in the success of our bid.

Equality and Diversity

In July 2010 we published our single equality and human rights scheme. This includes our equality and diversity strategy and an action plan to take forward full implementation of the scheme over the next 2 years. It sets out our commitment to ensuring that our services and employment practices are fair, accessible and appropriate for the diverse patient community we serve and the workforce we employ.

Overall the purpose of the scheme is firstly to provide an environment for patients in which there is equal access and they can reach their full potential for recovery and wellbeing. Alongside this we aim to ensure their dignity, individuality and preferences are respected and their needs met. Secondly, it provides a framework for managers and staff to ensure that current and potential employees are treated with dignity, respect and fairness, regardless of their background.

Management and governance

Our Trust Board members (as at 31 March 2011):

Non-executives	**Executives**	
Martin Watts, Chairman	Peter Colclough	Chief Executive
Rik Evans, Vice-Chairman[1]	Paul Upton	Medical Director
Roger Gazzard*	Christine Rashleigh	Director of Nursing, Midwifery and AHPs
Susan Hall**		
Douglas Webb	Jo Gibbs	Chief Operating Officer
Mike Higgins*	Karl Simkins	Director of Finance
	Jon Sparkes	Director of Human Resources and Organisational Development

** Audit Committee Chair
* Audit Committee Member
1 – to 30 March 2011

Profiles of our directors and details of committee members, please visit our website: www.rcht.nhs.uk

Protecting personal data

We place utmost importance on protecting the personal information we hold on our patients. Any incident where a breach of confidentiality has occurred is reported to the Information Commission and recorded and investigated as a serious incident. During 2010/11 there were two incidents, where incorrect disclosure was made to a third party. As a result of our investigations the Information Commissioner was satisfied with actions taken to minimise the risk of the error being repeated.

Preparing for the unexpected

During the last year we have continued to refine our emergency preparedness plans and published an updated Major Incident Plan in December. This plan sets out the roles and responsibilities of individuals and teams in the event of a major incident, responding to an event that has occurred in outside of our organisation or in our own hospitals. It provides a structure for command and communication within the hospital, to ensure that the necessary action is taken to meet the needs of the incident.

How we spend our money

We achieved our revised end of year target of a £7.5m surplus and repaid, in full, the required 2010/11 loan repayment on our historic debt. Within this savings of £15.3 million were made, although this was £4.4 million below our plan.

During 2011/12 we have to meet a savings plan of £19 million to support the delivery of a £4.4 million surplus.

Further information on our financial management is published alongside this report on our website: www.rcht.nhs.uk

APPENDIX 1

Royal Cornwall Hospitals NHS Trust
Remuneration Report

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

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

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

The Remuneration and Terms of Service Committee
The terms of reference for the Remuneration Committee were updated and approved by the Board in May 2011 under the review of governance arrangements. The membership of the remuneration committee consists of the Trust Board Chairman and all Non Executive Directors. In the absence of the Board Chairman a nominated Non Executive Director will act as Chair.

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

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

Details of remuneration and pensions for Non Executive and Executive Directors are detailed in Annex 1.

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

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

Employees above the minimum retirement age who themselves request termination by reason of early retirement are subject to the normal provisions of the NHS Pension Scheme.

Details of termination packages, for all staff, paid by the trust in are detailed in Annex 2.

Non-Executive Directors

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

Name	Appointment start date	Appointment end date	Reappointment start date	Reappointment end date
Mr Martin Watts Chairman	19 March 2009	18 March 2012		
Mr Roger Gazzard	8 October 2007	7 October 2010	8 October 2010	31 October 2014
Mr Rik Evans	8 October 2007	7 October 2010	8 October 2010	31 October 2014
Susan Hall	1 October 2009	30 September 2013		
Sheila Healy	1 September 2009	31 January 2011		
Mike Higgins	25 March 2010	24 March 2014		
Mr Douglas Webb	16 December 2007	15 December 2011		

There is no period of notice required for Non Executive Directors

ANNEX 1: Salary and Pension Entitlements of Senior Managers - 2010-11 and 2009-10

Salaries and allowances

	2010-11			2009-10		
Name and Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind Rounded to the nearest £100**	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind Rounded to the nearest £100
	£000	**£000**	**£**	£000	£000	£
Watts, M Chairman	**25-30**	**0**	**0**	25-30	0	0
Evans, R Non Executive Director	**5-10**	**0**	**0**	5-10	0	0
Gazzard, R Non Executive Director	**5-10**	**0**	**0**	5-10	0	0
Hall, S Non Executive Director	**5-10**	**0**	**0**	0-5	0	0
Healy, S Non Executive Director *to 31 January 2011*	**5-10**	**0**	**0**	0-5	0	0
Higgins, M Non Executive Director	**5-10**	**0**	**0**	0-5	0	0
Webb, D Non Executive Director	**5-10**	**0**	**0**	5-10	0	0

	2010-11			2009-10		
Name and Title	**Salary (bands of £5,000)**	**Other Remuneration (bands of £5,000)**	**Benefits in Kind Rounded to the nearest £100**	Salary (bands of £5,000)	Other Remuneration (bands of £5,000)	Benefits in Kind Rounded to the nearest £100
	£000	**£000**	**£**	£000	£000	£
Colclough, P Chief Executive	**170-175**	**0**	**0**	175-180	0	0
Gibbs, J Chief Operating Officer *from 1 April 2010*	**125-130**	**0**	**8,000**	0	0	0
Simkins, K Director of Finance *from 5 July 2010*	**100-105**	**0**	**8,000**	0	0	0
Hollinshead, P Interim Director of Finance *from 30 April 2010 to 5 July 2010*	**0**	**70-75**	**0**	0	0	0
Teape, J V Director of Finance *to 30 April 2010*	**10-15**	**0**	**0**	130-135	0	0
Rashleigh, C Director of Nursing, Midwifery & Therapies	**95-100**	**0**	**0**	85-90	0	0
Shaw, G Interim Director of Human Resources *to 8 October 2010*	**0**	**120-125**	**0**	0	45-50	0
Sparkes, J Director of Human Resources and Organisational Development *from 8 November 2010*	**40-45**	**0**	**0**	0	0	0
Upton, P Medical Director	**20-25**	**145-150**	**0**	20-25	145-150	0

Note: No bonus payments were made to Directors or Non-Executive Directors in 2010-11 or 2009-10.

Pension Benefits

Name of Senior Manager	Real increase in pension at age 60 (bands of £2,500)	Real increase in pension lump sum at aged 60 (bands of £2,500)	Total accrued pension at age 60 at 31 March 2011 (bands of £5,000)	Lump sum at age 60 related to accrued pension at 31 March 2011 (bands of £5,000)	Cash Equivalent Transfer Value at 31 March 2011 as provided by NHSPA	Cash Equivalent Transfer Value at 31 March 2010	Real increase in Cash Equivalent Transfer Value
	£000	£000	£000	£000	£000	£000	£000
Colclough, P	0 – 2.5	2.5 – 5	70 – 75	220 – 225	1,540	1,620	(80)
Gibbs, J	7.5 – 10	25 – 27.5	30 – 35	95 – 100	426	357	69
Rashleigh, C	5 – 7.5	15 – 17.5	30 – 35	95 – 100	531	494	37
Simkins, K	5 – 7.5	20 – 22.5	40 – 45	125 – 130	629	565	47
Sparkes, J	0 – 2.5	-	0 – 5	-	16	4	5
Upton, P	0 – 2.5	5 – 7.5	40 – 45	120 – 125	674	735	(62)

There were no employers' contributions to stakeholder pensions.

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

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

Real increase in CETV

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

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

ANNEX 2: Reporting of other compensation schemes - exit packages

	NHS Body		Royal Cornwall Hospitals NHS Trust		
	a	*b*	*c*	*d*	*e*
1	**Exit package cost band (including any special payment element)**	**Number of compulsory redundancies**	**Number of other departures agreed**	**Total number of exit packages by cost band (total cost)**	**Number of departures included in (b) and (c) where special payments have been made (special payment element (totalled))**
2	**<£20,001**	0	24	24 (£174,000)	0
3	**£20,001 - £40,000**	0	1	1 (£30,000)	0
5	**£40,001 - 100,000**	0	3	3 (£191,000)	0
6	**£100,001 - £150,000**	0	0	0	0
7	**£150,001 - £200,000**	0	0	0	0
8	**Total number of exit packages by type (total cost)**	0 (0)	28 (£395,000)		
9				**Total number (and cost) of exit packages**	**Total number of special payments (and total cost of special payment element)**
				28 (£395,000)	0 (£0)

APPENDIX 2

Royal Cornwall Hospitals NHS Trust
Management Commentary 2010/11

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1. Introduction

1.1. This report formally presents the Directors analysis of the business of Royal Cornwall Hospitals NHS Trust (the Trust), for the year ended 31 March 2011. This commentary focuses on the financial activities and performance of the Trust whereas the remainder of the Annual Report provides details on operational aspects.

1.2. In writing this commentary, the Directors have sought to give the reader an 'easy to understand' narrative supporting the Trust's annual financial accounts for the year, highlighting any significant issues within the accounts; and link these to the key objectives and activities of the Trust for the year. The commentary also looks forward to the key developments planned for the coming year from a financial perspective.

1.3. The main elements of this commentary are as follows:

- assessment of the Trust's achievement of its key financial objectives and financial performance in 2010/11 and its plans and objectives for 2011/12;
- explanation and analysis of the Trust's annual financial statements; and
- assessment of the Trust's financial and operational 'health' looking forward; called the 'going concern' assessment.

1.4. The Trust's Annual Report, which incorporates this Management Commentary, therefore provides a comprehensive narrative of the Trust's achievements in 2010/11 and of its plans for the future.

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2. Nature of the business, objectives, strategies and environment within which we operate

2.1. The Trust is the major provider of acute health services to the population of Cornwall. It is the most remote acute NHS trust in England, with the nearest NHS acute Trust over one hour's drive away. Cornwall is recognised to be an area of dispersed communities, with pockets of deep poverty, which led to the county being awarded Objective One status for the period 2000 to 2006, by the European Union. At the same time, Cornwall is a major tourist attraction, with significant peaks of population occurring during the summer months.

2.2. The Trust operates from three sites:

- Royal Cornwall Hospital, in Truro, which deals with around 90% of the Trust's activity
- St Michael's Hospital, Hayle
- West Cornwall Hospital, Penzance

2.3. The Trust forms part of the health service community in the South West of England, which is performance managed by NHS South West.

2.4. In its annual plan for 2010/11, the Trust identified 6 strategic objectives which focus both on national targets and local priorities. The Trust's performance against these objectives is described in section 3 of this commentary. Underlying these strategic objectives is the requirement to deliver the contractual arrangements, as set out in the service level agreements (SLA) with NHS Cornwall and Isles of Scilly (NHSCIOS) and other organisations.

2.5. The key finance related objective is to deliver a financial surplus annually; a number of specific deliverables were identified to achieve this in 2010/11:

- To deliver in full the Trust's income targets.

- To deliver a surplus of £9.69m in order to meet historic debt repayments in 2010/11.
- To deliver a savings plan consistent with the delivery of the Trust's targeted surplus.
- To maintain a Use of Resources assessment equivalent of good (although the rating was removed from the compliance framework in year by the Department of Health.
- To maintain adequate cash position throughout the year in line with agreed plans.
- To ensure informatics strategy and implementation programme is optimised to provide maximum support to efficiency and productivity.

2.6. During the year the financial surplus target was reduced to £7.5m in agreement with NHS South West and the Department of Health. This revised target and other key measures were achieved including delivery of the required loan repayment for 2010/11 in full.

2.7. Additionally, the Trust was informed that the Use of Resource assessment process would cease with no external assessment carried out in 2010/11. The Trust continues to use the principles underlying the Use of Resources assessment in order to deliver continued service improvements.

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3. Developments and performance of the Trust's business during the financial year

Key Financial performance in 2010/11

3.1. This section sets out the key financial information covering the 2010/11 financial year.

3.2. The Trust has a plan, agreed with NHS South West, to achieve its breakeven duty over a five year period. The final year of this plan is 2012/13. During 2010/11, the Trust delivered a surplus of £7.5m towards the overall breakeven position of the Trust.

3.3. During 2010/11 the Trust has operated within its External Financing Limit set by the Department of Health (DoH).

3.4. During 2010/11 the Trust has operated within its Capital Resource Limit set by the Department of Health.

3.5. The Statement of Financial Position shows net assets of £142.7m. There are no going concern issues facing the Trust.

3.6. During the year the Trust repaid the required cash payments (totalling £9.69m) relating to its historic debt loan, meeting its 2010/11 obligation in full. This included an agreed overpayment of £1.8m.

3.7. In 2010/11 the Trust earned £310.5m income from activities and delivered a surplus before impairments of £7.5m. This was in accordance with the Trust's revised financial plans.

3.8. In 2010/11 total income exceeded budgeted levels by £0.5m. Income on the Trust's contract with its main commissioner, NHS Cornwall and Isles of Scilly was as planned in total, with significant over performance in non elective admissions being off set by a lower level of activity than planned in elective services.

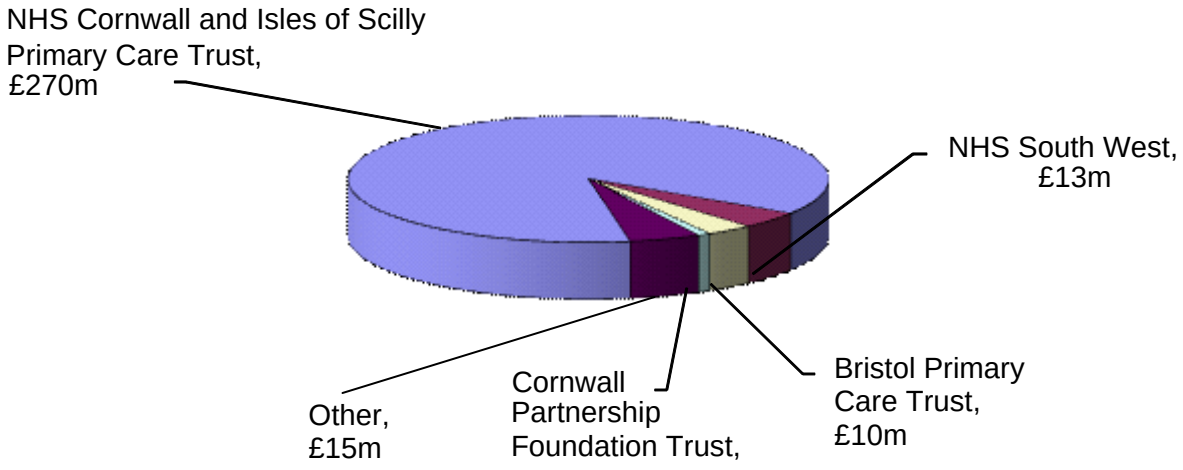
3.9. During the year the Trust has been required to revalue its land and buildings in order to comply with Department of Health guidance. This has impacted on the Trust's accounts with

impairments of £7.1m charged to operating expenses in the period, As a result of this charge, the Trust's financial statements show a retained surplus of £0.4m.

3.10. Overall, the revaluation has resulted in an overall reduction in the Trust's asset values by £9.9m. This is made up of downward revaluations of £15m and upward revaluations of £5.1m.

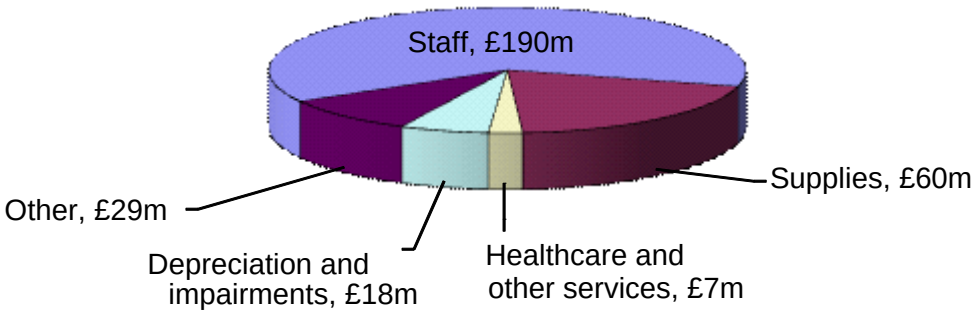
3.11. The chart below shows where the Trust's income came from.

Where the Trust's income comes from (£m)



3.12. Operating expenditure amounted to £303.5m. Payroll costs account for 63% of this total, as included in the chart below.

The Trust's expenditure (£m)



Corporate performance

3.13. The Trust set out its key objectives for 2010/11 in its five year Strategic Plan, which was approved by the Board in March 2010.

3.14. The Trust identified 6 key corporate objectives for the year. Good progress has been made against many of these objectives. The Trust's progress is summarised in the table below and in more detail in the main body of the Annual Report:

Key corporate objectives for 2010/11
To remain the preferred provider of acute and specialist healthcare to the people of Cornwall and the Isles of Scilly • The Trust has continued to be assessed as a 'Performing' organisation by the Department of Health in 2010/11. The main performance challenge in 2010/11 has been waiting times in some specialities, but there is a clear expectation that this will be resolved during 2011/12. • During 2010/11, changes have been made to our facilities to virtually eliminate mixed sex accommodation. The intention during 2011/12 is to eliminate inappropriate breaches in full. • Evidence from the Trust Patient Experience survey for the period Sept 2010 – Feb 2011 suggests that most patients experience the care they get from the Trust in a positive way, with a total of 93% describing it as excellent, very good or good. • The Trust has also made progress in its ability to collect real time patient feedback, for instance through the use of bedside monitors. • The range of services provided by the Trust has been extended. In January 2011 our new primary PCI service was launched, meaning that the population we serve now has access to the best available treatment for heart attacks. • The Trust is working towards achieving Foundation Trust status allowing the Trust increase freedom and flexibility to manage its provision of service.
To focus relentlessly on quality care and patient safety. • During 2010/11 the Trust achieved unconditional registration with the Care Quality Commission – the maximum possible achievement. The Trust's intention is of course to maintain this during 2011/12 • A relentless focus on the quality of patient care and safety is, and always will be, the Trust's highest priority. With this in mind, the major reduction in healthcare acquired infections which began in 2009/10 was sustained and further improved in 2010/11. • The Trust is now in the best performing 25% of Trusts nationally for both MRSA and C Difficile rates, a remarkable turnaround over the last two years and testament to the transformational progress the Trust can achieve. The aim in 2011/12 is to eliminate MRSA bacteraemias. The Trust is extending its root cause analysis approach to other infections such as MSSA. • The Trust's mortality rates have continued to remain below the national average. Participation in the Quality and Patient Safety Improvement Programme and its work streams is key, and the Trust continues to develop and improve its clinical

Key corporate objectives for 2010/11

governance structures at both a Trust and Divisional level. The Trust has also enhanced its commitment to transparency and public accountability through the publication of its Quality accounts.

- Significant improvements in the risk assessment of venous thromboembolism have been introduced during 2010/11 and the Trust will need to sustain and further improve this in 2011/12.

- In 2010/11, the Trust met the majority of agreed Commissioning for Quality and Innovation targets with the PCT, meaning that all required outcomes have been achieved. Improvements on the stroke and fractured neck of femur pathways have been achieved, and expectations that all cancer standards will be met.

- The Trust during the year has developed nursing and midwifery metrics. These allow the Trust to monitor its quality and safety performance. The Trust has also rolled out a CQC compliance procedure which is supported by a restructured Clinical Governance team. Furthermore the Trust's incident reporting policy has been strengthened.

To work as a constructive partner in the community, promoting the integration of health and social care.

- Improving working arrangements with partners has continued to be a critical focus for this year, and together the Trust with partners has agreed in principle a direction of travel towards the development of Heath and Social Care Hubs, which will bring together a number of existing service teams from across organisations to offer patients a single point of contact and simplify the care system.

- The Trust has also established links with emerging Clinical Commissioning Group leads, which we expect to strengthen as commissioning transfers from the PCTs in the future.

To value and improve the working lives of our staff, promoting education, training and research.

- During the year new Human Resources leadership was strengthened, improving the function and support provided to the Trust.

- The Trust Board has acknowledged that the well being of staff is a core activity of the Trust and approved an Organisational Development Plan in February 2011.

- In 2010 the Extra Mile (Innovation and Excellence) Awards were established to recognise the many examples of staff achieving outstanding levels of care.

- The importance of training and education has been recognised with a definite increased focus on Mandatory training across the Trust.

- The Trust Board has also acknowledged research as a core activity of the Trust as such regular reporting of research activities is made by the Deputy Medical Director to the Board.

To work towards sustainable, low carbon future

- During the 2010/11 the Trust Board formally approved a Sustainable Development Strategy. The implementation of this strategy will be the main focus of attention of the Trust in working towards a low carbon future. (Treasury guidance on sustainability can be found at http://hm-treasury.gov.uk/frem_sustainability.htm)

Key corporate objectives for 2010/11
• This strategy aims to ensure that the Trust continually improves its sustainability by encouraging all staff to play an active part in environmental stewardship. • Actions are planned to improve the design of buildings, consider the carbon consequences of procurement decisions, encourage prudent use of natural resources and improve waster management.
To deliver financial surplus annually • For the start of financial year 2011/12 the Trust is implementing an enhanced performance management regime. There will be even closer monitoring of delivery against key targets with effect from 1st April 2011. As part of this the Trust will continue to closely monitor its Service Improvement Plan throughout the year to ensure the necessary savings are met. • The Trusts Patient Level Costing System (PLICs) is being rolled out to Divisions and will allow the Trust to have a greater understanding of the profitability of services provided. • Financial support to the Trust's non finance managers has again been strengthened through improved training provided by the Finance Department. • The Trust is working with the NHS South West and the Department of Health to re-schedule its loan over a longer period.

3.15. The Strategy of the Trust is underpinned by the detailed Clinical Site Development Plan, setting out intended future developments including the provisions of a third linear accelerator machine, the completion of day case theatres the development of level 2 and 3 critical care and the provision of the West of Cornwall Treatment Centre all being planned for 2011/12. The Trust has applied for access to further national funding and if it is successful in its bid, further elements of the Trust's capital plan will be brought forward and delivered in 2011/12.

Benefits from capital investment during 2010/11

3.16. Despite the financial challenges facing the Trust it has delivered considerable improvements in its infrastructure through its capital programme in 2010/11, spending £26m on estate projects, estate improvements and medical and information technology equipment. Good progress has been made towards the Trust's Clinical Site Development Plan, with £15m of capital being spent in 2010/11 on this project.

3.17. The Trust delivered a significant number of key capital schemes in 2010/11 including:

- New Chemotherapy centre;
- Improvements to the West of Cornwall Hospital, including newly opened renal unit;
- New gamma camera;
- The commencement of a project upgrading day case theatres; and
- Significant investment in theatres and other medical equipment.

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4. Resources, principal risks, uncertainties and relationships that may affect our longer term delivery of services

4.1. The Trust receives the majority of its income from NHS Cornwall and Isles of Scilly and this is unlikely to change in 2011/12, however changes will be made in commissioning arrangements through national policy in 2012/13 and beyond. The Trust works very closely with NHS

Cornwall and Isles of Scilly to ensure that it's operational and financial plans are aligned, and that these reflect the planned changes in healthcare provision. The main body of the Annual Report sets out the type of developments expected in the future.

4.2. As the Trust operates within a 'payment by results' framework, and given the inherent challenge in determining the number of procedures that the Trust may need to carry out, there is always a level of risk and uncertainty over the exact level of income which will be received. One of the primary outcomes from the close working between the Trust and NHS Cornwall and Isles of Scilly is the development of agreed plans setting out the level of service the Trust is expected to provide. This in turn helps the Trust set expenditure levels, improve service design and offer high quality care.

4.3. In addition to working with NHS Cornwall and Isles of Scilly, the directors have regular meetings with senior officers, patients and other interested parties across the local health community, including:

- regular meetings with the Chief Executive and Directors of the SHA and of the PCT;
- monthly performance monitoring meeting with the SHA and NHS Cornwall and Isles of Scilly (the PCT);
- joint meetings with Cornwall health and social care providers;
- regular meetings with service users' representative groups, including the patient ambassadors through the Local Involvement Network (LInK); and
- regular attendance at the Health and Adult Social Care Overview Scrutiny Committee meetings.

4.4. These forums will continue to ensure that the Trust plays a key role in the delivery of healthcare across the local community.

4.5. In the short term the Trust is also optimistic that it will continue to benefit from additional capital funding as part of the Exceptional Capital programme. As set out earlier, this has enabled the Trust to deliver major capital projects which it would otherwise not be able to deliver. The Trust is hopeful that this funding will continue to enable it to deliver the early stages of the Clinical Site Development Plan. A risk remains that, should the funding not be made available, the capital schemes planned to take place will need to be re-assessed.

4.6. All of the Trust's risks, both financial and non-financial, are managed through a Trust-wide risk management system, and ultimately through a framework designed to provide assurance to the Trust Board.

4.7. The Trust faces a challenging future with expectation that the income received for services will reduce and yet costs will continue to increase. The delivery of significant savings through service re-design is crucial and in 2011/12, the Trust will need to make savings of at least £19m. Delivery of this programme is critical to the success of delivering a £4.4m surplus. The service improvement programmes for 2012/13 and beyond are expected to be at a similar or higher level.

4.8. The Trust monitors the achievement of these savings very closely within Trust Board reports, in particular the Integrated Performance Report, and the Trust's Assurance Framework.

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5. Position of the business in the financial year and in the future, including capital structure, treasury policy and liquidity

5.1. The Trust has agreed a 2011/12 contract with NHS Cornwall totalling £270.7m. This represents a 0.5% reduction on the 2010/11 contract value.

5.2. The Trust has an income and expenditure plan to achieve a £4.4m surplus for the year. The surplus will be used to repay the Trust's historical debt and strengthen its working capital position.

5.3. The capital resources available through the Trust's own internally generated mechanisms will give the Trust a capital programme of approximately £13.7m for 2011/12. The Trust has plans to spend around 75% of this funding internally on projects that include on a third Linear Accelerator, Level 2 and 3 critical care equipment, and improvements to the West Cornwall Treatment Centre. Each of these schemes forms part of the £7m Clinical Site Development Plan. Remaining cash will be used to strengthen the Trust's working capital position.

5.4. At the 31 March 2011 the Trust held cash balances of £0.8m. The Trust's cashflow is monitored on a daily basis and cash flow reports presented to the Board each month. As stated earlier in the commentary, the Department set an External Financing Limit which is used to control cash expenditure was achieved in the year.

5.5. At 31 March 2011 the Trust carried a loan of £24.46m. This relates to the historic deficits incurred prior to 2007/08.

5.6. The 2011/12 plans for the Trust assumes the formal loan from the Department of Health will be re-scheduled over a period of 15 years as per agreement with NHS South West. The Trust has therefore planned to deliver a £4.4m surplus in 2011/12. £1.6m of this surplus will be set aside to service the re-scheduled loan (depending on terms agreed with the Department of Health).

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6. Our annual accounts explained

6.1. All NHS bodies have a statutory duty to produce annual financial accounts. They are also required to produce an annual report, which describes the key activities and performance for the year. The annual report incorporates the full annual accounts and this Management Commentary.

6.2. The annual accounts represent the main way in which NHS trusts deliver their obligation to report to taxpayers and service users the results of their stewardship of public money for the year. The board of each trust is required to approve the annual accounts formally, once they have been audited.

6.3. The format of each NHS trust's accounts is specified by the DH. Trusts have very few flexibilities locally to change this specification. The content of the accounts is as follows:

Four key statements:

- Statement of Comprehensive Income
- Statement of Financial Position
- Statement of Changes in Taxpayers Equity
- Statement of Cash Flows

Additional information included in the financial statements

- Accounting Policies
- Notes to the accounts
- Statement on Internal Control
- Directors' Statement of Responsibilities
- Auditor's Report

6.4. Section 3 of this commentary provides key information on the Trust's performance for the 2010/11 financial year. This section provides some background into the some of the key accounting issues facing the Trust in preparing the financial statements.

High level messages regarding the financial statements

- The retained surplus of £0.4m is lower than the planned outturn due to impairments charged to operating expenses of £7.1m during the year. However for performance management purposes the Trust is assessed on its surplus before impairments of £7.5m.

- The Statement of Comprehensive Income (SOCI) shows a deficit of £1.3m overall and £0.4m at the retained surplus level.

- The overall deficit of £1.3m as shown in the lower half of the SOCI is due mainly to asset impairments charged to reserves of £6.8m, although this has been offset by gains charged to reserves of £4.0m and two other reserve based movements.

- Although a retained deficit is shown on the SOCI, note 30.1 to the financial statements sets out the Trust's performance against the statutory breakeven duty. This note requires the Trust to remove the impact of impairments and shows that the in-year statutory breakeven duty has been achieved.

- The Trust has an agreed plan to achieve its breakeven duty by March 2013. The Trust contributed £7.5m towards delivery of this cumulative duty in 2010/11.

- Note 30.3 shows that the Trust has operated within its External Financing Limit set by the Department of Health.

- Note 30.4 shows that the Trust has operating within its Capital Resource Limit set by the Department of Health and undershot this by £2.7m in line with its agreement with NHS South West.

- The Statement of Financial Position shows net assets of £142.7m. There are no going concern issues facing the Trust.

- During the year the Trust made repayments totalling £9.690m relating to its loans.

Performance against the Better Payments Practice Code

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

6.6. The Trust has continued to make improvements in year on paying its suppliers and, at the end of the financial year, the Trust had paid 92% cumulatively of all non-NHS invoices against the Code. This compares with 88% in 2009/10. The Trust continues to strive for further improvements to meet the 95% target cumulatively for 2011/12. The Trust achieved 95% in month for March 2011 in accordance with its plan.

6.7. Note 11 to the Trust's accounts provides detail on payment performance.

6.8. The Trust has been accepted as a signatory to the Prompt Payment Code during the financial year 2010/11.

External audit arrangements

6.9. The Trust's external auditor is appointed by the Audit Commission. Currently this role is carried out by the Operations Directorate of the Audit Commission. The external auditors are required to comply with the Code of Audit Practice (the Code), which is laid before Parliament on a five year cycle; and the International Standards on Auditing, United Kingdom and Ireland. Through the Code, external audit is set two main objectives:

- to complete the audit of the annual financial accounts and statement on internal control
- to assess whether the Trust has made adequate arrangements for securing economy, efficiency and effectiveness (value for money) in the use of resources

6.10. The audit report gives the auditor's opinion stating whether the accounts give a 'true and fair' view of the Trust's financial position for the year and as at the end of the financial year. This opinion includes an assessment of whether the annual report is consistent with their knowledge of the Trust.

6.11. The audit opinion, for 2010/11 was that the accounts do give a 'true and fair' view. Accordingly, an unqualified audit opinion has been given by the District Auditor. The Audit Commission also concluded that in all significant respects the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

6.12. In 2010/11, the Trust's external audit fees totalled £217,000 compared to £205,000 in 2009/10.

Setting Charges for Public Information

6.13. The Trust has complied with Treasury's guidance on setting charges for access to information.

Peter Colclough
Chief Executive

Karl Simkins
Director of Finance

May 2011

APPENDIX 3

Royal Cornwall Hospitals NHS
NHS Trust

Financial Statements and Statement on Internal Control

for the year ended
31 March 2011

Royal Cornwall Hospitals NHS
NHS Trust

Contents

STATEMENT OF COMPREHENSIVE INCOME FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	**2010-11 £000**	2009-10 £000
Revenue			
Revenue from patient care activities	4	**279,727**	272,319
Other operating revenue	5	**30,744**	31,606
Operating expenses	7	**(303,476)**	(297,100)
Operating surplus/(deficit)		**6,995**	6,825
Finance costs:			
Investment revenue	12	**21**	23
Other gains and losses	13	**(6)**	(193)
Finance costs	14	**(2,110)**	(2,485)
Surplus/(deficit) for the financial year		**4,900**	4,170
Public dividend capital dividends payable		**(4,458)**	(4,257)
Retained surplus/(deficit) for the year		**442**	(87)
Other comprehensive income			
Impairments and reversals		**(6,785)**	(30,397)
Gains on revaluations		**3,963**	10,482
Receipt of donated/government granted assets		**1,070**	3,581
Reclassification adjustments:			
- Transfers from donated and government grant reserves		**(6)**	(585)
Total comprehensive income for the year		**(1,316)**	(17,006)

The notes on pages 1 to 37 form part of these accounts.

Reported NHS financial performance position - Adjusted retained surplus/(deficit)

	£000	£000
Retained surplus/(deficit) for the year	**442**	(87)
IFRIC 12 adjustment	**57**	66
Impairments	**7,045**	8,369
Reported NHS financial performance position		
Adjusted retained surplus/(deficit)	**7,544**	8,348

A Trust's Reported NHS financial performance position is derived from its Retained surplus/(Deficit), but adjusted for the following:-

a) Impairments to Fixed Assets: 2009/10 was the final year for organisations to revalue their assets to a Modern Equivalent Asset (MEA) basis of valuation. An impairment charge is not considered part of the organisation's operating position.

b) The revenue cost of bringing PFI and LIFT scheme assets onto the balance sheet (due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009/10) - NHS Trusts' financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to PFI and LIFT, which has no cash impact and is not chargeable for overall budgeting purposes, should be reported as technical. This additional cost is not considered part of the organisation's operating position.

STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2011

	NOTE	31 March 2011 £000	31 March 2010 £000
Non-current assets			
Property, plant and equipment	15	**182,405**	177,546
Intangible assets	16	**3,270**	2,960
Trade and other receivables	20	**1,610**	882
Total non-current assets		**187,285**	181,388
Current assets			
Inventories	19	**6,879**	6,400
Trade and other receivables	20	**11,278**	13,111
Cash and cash equivalents	21	**800**	633
		18,957	20,144
Non-current assets held for sale	22	**250**	434
Total current assets		**19,207**	20,578
Total assets		**206,492**	201,966
Current liabilities			
Trade and other payables	23	**(26,043)**	(24,633)
Borrowings	24	**(6,176)**	(8,104)
Provisions	26	**(1,614)**	(1,964)
Total current liabilities		**(33,833)**	(34,701)
Net current assets/(liabilities)		**(14,626)**	(14,123)
Total assets less current liabilities		**172,659**	167,265
Non-current liabilities			
Borrowings	24	**(19,922)**	(27,865)
Trade and other payables	23	**(6,396)**	(7,159)
Provisions	26	**(3,646)**	(3,980)
Total non-current liabilities		**(29,964)**	(39,004)
Total assets employed		**142,695**	128,261
Financed by taxpayers' equity:			
Public dividend capital		**163,352**	147,602
Retained earnings		**(71,177)**	(74,687)
Revaluation reserve		**38,634**	43,740
Donated asset reserve		**7,652**	7,576
Government grant reserve		**4,234**	4,030
Total taxpayers' equity		**142,695**	128,261

The financial statements on pages 1 to 37 were approved by the Board on 6 June 2011 and signed on its behalf by:

Signed: **Peter Colclough (Chief Executive)** Date: **6 June 2011**

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2010

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Total
	£000	£000	£000	£000	£000	£000
Balance at 31 March 2009	134,677	(74,714)	62,177	8,818	1,384	132,342
Changes in taxpayers' equity for 2009-10						
Total comprehensive income for the year:						
Retained surplus/(deficit) for the year	0	(87)	0	0	0	(87)
Transfers between reserves	0	114	(114)	0	0	0
Impairments and reversals	0	0	(28,008)	(1,492)	(897)	(30,397)
Net gain on revaluation of property, plant, equipment	0	0	9,685	703	94	10,482
Receipt of donated/government granted assets	0	0	0	99	3,482	3,581
Reclassification adjustments:						
- transfers from donated asset/government grant reserve	0	0	0	(552)	(33)	(585)
New PDC received	12,925	0	0	0	0	12,925
Balance at 31 March 2010	147,602	(74,687)	43,740	7,576	4,030	128,261

STATEMENT OF CHANGES IN TAXPAYERS' EQUITY FOR THE YEAR ENDED 31 MARCH 2011

	Public dividend capital (PDC)	Retained earnings	Revaluation reserve	Donated asset reserve	Government grant reserve	Total
	£000	£000	£000	£000	£000	£000
Changes in taxpayers' equity for 2010-11						
Balance at 1 April 2010	147,602	(74,687)	43,740	7,576	4,030	128,261
Total comprehensive income for the year						
Retained surplus/(deficit) for the year	0	442	0	0	0	442
Transfers between reserves	0	3,068	(2,029)	(416)	(623)	0
Impairments and reversals	0	0	(6,785)	0	0	(6,785)
Net gain on revaluation of property, plant, equipment	0	0	3,708	149	106	3,963
Receipt of donated/government granted assets	0	0	0	879	191	1,070
Reclassification adjustments:						
- transfers from donated asset/government grant reserve	0	0	0	(536)	530	(6)
New PDC received	15,750	0	0	0	0	15,750
Balance at 31 March 2011	163,352	(71,177)	38,634	7,652	4,234	142,695

STATEMENT OF CASH FLOWS FOR THE YEAR ENDED 31 MARCH 2011

	NOTE	**2010-11 £000**	2009-10 £000
Cash flows from operating activities			
Operating surplus/(deficit)		**6,995**	6,825
Depreciation and amortisation	15-16	**11,121**	11,736
Impairments and reversals		**7,045**	8,369
Transfer from donated asset reserve		**(536)**	(552)
Transfer from government grant reserve		**530**	(34)
Interest paid		**(2,035)**	(2,400)
Dividends paid		**(4,706)**	(4,267)
(Increase)/decrease in inventories		**(479)**	(1,150)
(Increase)/decrease in trade and other receivables		**1,821**	(1,927)
Increase/(decrease) in trade and other payables		**2,567**	2,266
Increase/(decrease) in provisions		**(758)**	861
Net cash inflow/(outflow) from operating activities		**21,565**	19,727
Cash flows from investing activities			
Interest received		**20**	23
(Payments) for property, plant and equipment		**(27,278)**	(25,861)
Proceeds from disposal of plant, property and equipment		**30**	5
(Payments) for intangible assets		**(651)**	(943)
Net cash inflow/(outflow) from investing activities		**(27,879)**	(26,776)
Net cash inflow/(outflow) before financing		**(6,314)**	(7,049)
Cash flows from financing activities			
Public dividend capital received		**15,750**	12,925
Loans repaid to the DH		**(9,690)**	(7,982)
Other capital receipts		**602**	2,367
Capital element of finance leases and PFI		**(166)**	(166)
Net cash inflow/(outflow) from financing		**6,496**	7,144
Net increase/(decrease) in cash and cash equivalents		**182**	95
Cash (and) cash equivalents (and bank overdrafts) at the beginning of the financial year		**585**	490
Cash (and) cash equivalents (and bank overdrafts) at the end of the financial year	21	**767**	585

NOTES TO THE ACCOUNTS

1. Accounting Policies

The Secretary of State for Health has directed that the financial statements of NHS trusts shall meet the accounting requirements of the NHS Trusts Manual for Accounts, which shall be agreed with HM Treasury. Consequently, the following financial statements have been prepared in accordance with the 2010-11 NHS Trusts Manual for Accounts issued by the Department of Health. The accounting policies contained in that manual 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 NHS Trusts Manual for Accounts permits a choice of accounting policy, the accounting policy which 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 by the trust are described below. They have been applied consistently in dealing with items considered material in relation to the accounts.

1.1 Accounting convention

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

1.2 Acquisitions and discontinued operations

Activities are considered to be 'acquired' only if they are taken on from outside the public sector. Activities are considered to be 'discontinued' only if they cease entirely. They are not considered to be 'discontinued' if they transfer from one public sector body to another.

1.3 Critical accounting judgements and key sources of estimation uncertainty

In the application of the trust's accounting policies, management is required to make judgements, estimates and assumptions about the carrying amounts of assets and liabilities that are not readily apparent from other sources. The estimates and associated assumptions are based on historical experience and other factors that are considered to be relevant. Actual results may differ from those estimates and the estimates and underlying assumptions are continually reviewed. Revisions to accounting estimates are recognised in the period in which the estimate is revised if the revision affects only that period or in the period of the revision and future periods if the revision affects both current and future periods.

1.3.1 Critical judgements in applying accounting policies

Critical judgements, apart from those involving estimations (see below), that management have made in the process of applying the trust's accounting policies and that have a significant effect on the amounts recognised in the financial statements have been undertaken in relation to the trust's leasing arrangements, the estimation of asset lives for depreciation purposes and estimations used for accruals.

Management has concluded that those assets leased to other organisations have not transferred substantially all of the risks and rewards of ownership to the lessees and therefore have decided that the leasing arrangements are operating leases.

Asset lives, other than those identified by professional valuation, have been estimated by management based on their expected useful lives and the trust's own accounting policies.

Accruals have been included in the financial statements to the extent that the trust recognises an obligation at the balance sheet for which it had not been invoiced. Estimates of accruals are undertaken by management based on the information available at the balance sheet date, together with past experience.

1.3.2 Key sources of estimation uncertainty

Key assumptions concerning the future, and other key sources of estimation uncertainty at the end of the reporting period, that have a significant risk of causing a material adjustment to the carrying amounts of assets and liabilities within the next financial year are contained within the calculation of provisions. Those uncertainties are disclosed in note 26.

Further uncertainty exists as to the timing and accuracy of accrued expenditure.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.4 Revenue

Revenue in respect of services provided is recognised when, and to the extent that, performance occurs, and is measured at the fair value of the consideration receivable. The main source of revenue for the trust is from commissioners for healthcare services. Revenue relating to patient care spells that are part-completed at the year end are apportioned across the financial years on the basis of length of stay at the end of the reporting period compared to expected total expected costs.

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

The Trust receives income under the NHS Injury Cost Recovery Scheme, designed to reclaim the cost of treating injured individuals to whom personal injury compensation has subsequently been paid e.g. by an insurer. The Trust recognises the income when it receives notification from the Department of Work and Pension's Compensation Recovery Unit that the individual has lodged a compensation claim. The income is measured at the agreed tariff for the treatments provided to the injured individual, less a provision for unsuccessful compensation claims and doubtful debts.

1.5 Employee Benefits

Short-term employee benefits
Salaries, wages and employment-related payments are recognised in the period in which the service is received from employees.
The cost of leave 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.

Retirement benefit costs
Past and present employees are covered by the provisions of the NHS Pensions Scheme. The scheme is an unfunded, defined benefit scheme that covers NHS employers, General Practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to expenditure at the time the Trust commits itself to the retirement, regardless of the method of payment.

1.6 Other expenses

Other operating expenses are recognised when, and to the extent that, the goods or services have been received. They are measured at the fair value of the consideration payable.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.7 Property, plant and equipment

Recognition

Property, plant and equipment is capitalised if:

- it is held for use in delivering services or for administrative purposes;
- it is probable that future economic benefits will flow to, or service potential will be supplied to, the trust;
- it is expected to be used for more than one financial year;
- the cost of the item can be measured reliably; and
- the item has 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; or
- items form part of the initial equipping and setting-up cost of a new building, ward or unit, irrespective of their individual or collective cost.

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

Valuation

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

Land and buildings used for the trust's services or for administrative purposes are stated in the Statement of Financial Position at their revalued amounts, being the fair value at the date of revaluation less any subsequent accumulated depreciation and impairment losses. Revaluations are performed with sufficient regularity to ensure that carrying amounts are not materially different from those that would be determined at the end of the reporting period. Fair values are determined as follows:

- Land and non-specialised buildings – market value for existing use;
- Specialised buildings – depreciated replacement cost.

Until 31 March 2008, the depreciated replacement cost of specialised buildings has been estimated for an exact replacement of the asset in its present location. HM Treasury has adopted a standard approach to depreciated replacement cost valuations based on modern equivalent assets and, where it would meet the location requirements of the service being provided, an alternative site can be valued.

Properties in the course of construction for service or administration purposes are carried at cost, less any impairment loss. Cost includes professional fees but not borrowing costs, which are recognised as expenses immediately, as allowed by IAS 23 for assets held at fair value. Assets are revalued and depreciation commences when they are brought into use.

Until 31 March 2008, fixtures and equipment were carried at replacement cost, as assessed by indexation and depreciation of historic cost. From 1 April 2008 indexation has ceased. The carrying value of existing assets at that date will be written off over their remaining useful lives and new fixtures and equipment are carried at depreciated historic cost as this is not considered to be materially different from fair value.

Notes to the Accounts - 1. Accounting Policies (Continued)

An increase arising on revaluation is taken to the revaluation reserve except when it reverses an impairment for the same asset previously recognised in expenditure, in which case it is credited to expenditure to the extent of the decrease previously charged there. A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter to expenditure. Gains and losses recognised in the revaluation reserve are reported as other comprehensive income in the Statement of Comprehensive Income.

Subsequent expenditure
Where subsequent expenditure enhances an asset beyond its original specification, the directly attributable cost is capitalised. Where subsequent expenditure restores the asset to its original specification, the expenditure is capitalised and any existing carrying value of the item replaced is written-out and charged to operating expenses.

1.8 Intangible assets

Recognition

Intangible assets are non-monetary assets without physical substance, which are capable of sale separately from the rest of the trust's business or which arise from contractual or other legal rights. They are recognised only when it is probable that future economic benefits will flow to, or service potential be provided to, the trust; where the cost of the asset can be measured reliably, and where the cost is at least £5,000.

Intangible assets acquired separately are initially recognised at fair value. Software that is integral to the operating of hardware, for example an operating system, is capitalised as part of the relevant item of property, plant and equipment. Software that is not integral to the operation of hardware, for example application software, is capitalised as an intangible asset. Expenditure on research is not capitalised: it is recognised as an operating expense in the period in which it is incurred. Internally-generated assets are recognised if, and only if, all of the following have been demonstrated:

- the technical feasibility of completing the intangible asset so that it will be available for use;
- the intention to complete the intangible asset and use it;
- the ability to sell or use the intangible asset;
- how the intangible asset will generate probable future economic benefits or service potential;
- the availability of adequate technical, financial and other resources to complete the intangible asset and sell or use it;
- the ability to measure reliably the expenditure attributable to the intangible asset during its development.

Measurement
The amount initially recognised for internally-generated intangible assets is the sum of the expenditure incurred from the date when the criteria above are initially met. Where no internally-generated intangible asset can be recognised, the expenditure is recognised in the period in which it is incurred.

Following initial recognition, intangible assets are carried at fair value by reference to an active market, or, where no active market exists, at amortised replacement cost (modern equivalent assets basis), indexed for relevant price increases, as a proxy for fair value. Internally-developed software is held at historic cost to reflect the opposing effects of increases in development costs and technological advances.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.9 Depreciation, amortisation and impairments

Freehold land, properties under construction, and assets held for sale are not depreciated.

Otherwise, depreciation and amortisation are charged to write off the costs or valuation of property, plant and equipment and intangible non-current assets, less any residual value, over their estimated useful lives, in a manner that reflects the consumption of economic benefits or service potential of the assets. The estimated useful life of an asset is the period over which the Trust expects to obtain economic benefits or service potential from the asset. This is specific to the Trust and may be shorter than the physical life of the asset itself. Estimated useful lives and residual values are reviewed each year end. Assets held under finance leases are depreciated over their estimated useful lives.

At each reporting period end, the trust checks whether there is any indication that any of its tangible or intangible non-current assets have suffered an impairment loss. If there is indication of an impairment loss, the recoverable amount of the asset is estimated to determine whether there has been a loss and, if so, its amount. Intangible assets not yet available for use are tested for impairment annually.

A revaluation decrease that does not result from a loss of economic value or service potential is recognised as an impairment charged to the revaluation reserve to the extent that there is a balance on the reserve for the asset and, thereafter, to expenditure. Impairment losses that arise from a clear consumption of economic benefit should be taken to expenditure. This is a change in accounting policy from previous years where all impairments were taken to the revaluation reserve to the extent that a balance was held for that asset and thereafter to expenditure. Where an impairment loss subsequently reverses, the carrying amount of the asset is increased to the revised estimate of the recoverable amount but capped at the amount that would have been determined had there been no initial impairment loss. The reversal of the impairment loss is credited to expenditure to the extent of the decrease previously charged there and thereafter to the revaluation reserve.

1.10 Donated assets

Donated non-current assets are capitalised at their fair value on receipt, with a matching credit to the donated asset reserve. They are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the donated asset reserve and, each year, an amount equal to the depreciation charge on the asset is released from the donated asset reserve to offset the expenditure. On sale of donated assets, the net book value is transferred from the donated asset reserve to retained earnings.

1.11 Government grants

Government grants are grants from government bodies other than revenue from NHS bodies for the provision of services. Revenue grants are treated as deferred income initially and credited to income to match the expenditure to which they relate. Capital grants are credited to the government grant reserve and released to operating revenue over the life of the asset in a manner consistent with the depreciation and impairment charges for that asset. Assets purchased from government grants are valued, depreciated and impaired as described above for purchased assets. Gains and losses on revaluations and impairments are taken to the government grant reserve and, each year, an amount equal to the depreciation charge on the asset is released from the government grant reserve to the offset the expenditure.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.12 Non-current assets held for sale

Non-current assets are classified as held for sale if their carrying amount will be recovered principally through a sale transaction rather than through continuing use. This condition is regarded as met when the sale is highly probable, the asset is available for immediate sale in its present condition and management is committed to the sale, which is expected to qualify for recognition as a completed sale within one year from the date of classification. Non-current assets held for sale are measured at the lower of their previous carrying amount and fair value less costs to sell. Fair value is open market value including alternative uses.

The profit or loss arising on disposal of an asset is the difference between the sale proceeds and the carrying amount and is recognised in the Statement of Comprehensive Income. On disposal, the balance for the asset on the revaluation reserve is transferred to retained earnings. For donated and government-granted assets, a transfer is made to or from the relevant reserve to the profit/loss on disposal account so that no profit or loss is recognised in income or expenses. The remaining surplus or deficit in the donated asset or government grant reserve is then transferred to retained earnings.

Property, plant and equipment that is to be scrapped or demolished does not qualify for recognition as held for sale. Instead, it is retained as an operational asset and its economic life is adjusted. The asset is de-recognised when it is scrapped or demolished.

1.13 Leases

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

The trust as lessee

Property, plant and equipment held under finance leases are initially recognised, at the inception of the lease, at fair value or, if lower, at the present value of the minimum lease payments, with a matching liability for the lease obligation to the lessor. Lease payments are apportioned between finance charges and reduction of the lease obligation so as to achieve a constant rate on interest on the remaining balance of the liability. Finance charges are recognised in calculating the trust's surplus/deficit.

Operating lease payments are recognised as an expense on a straight-line basis over the lease term. Lease incentives are recognised initially as a liability and subsequently as a reduction of rentals on a straight-line basis over the lease term.

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

Where a lease is for land and buildings, the land and building components are separated and individually assessed as to whether they are operating or finance leases. This is a change in accounting policy from previous years where leased land was always treated as an operating lease.

The trust as lessor

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

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

1.14 Inventories

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

Notes to the Accounts - 1. Accounting Policies (Continued)

1.15 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.

1.16 Provisions

Provisions are recognised when the Trust has a present legal or constructive obligation as a result of a past event, it is probable that the Trust will be required to settle the obligation, and a reliable estimate can be made of the amount of the obligation. The amount recognised as a provision is the best estimate of the expenditure required to settle the obligation at the end of the reporting period, taking into account the risks and uncertainties. Where a provision is measured using the cash flows estimated to settle the obligation, its carrying amount is the present value of those cash flows using HM Treasury's discount rate of 2.2% in real terms. Early retirement and injury benefit provisions both use the HM Treasury's pension discount rate of 2.9% in real terms.

When some or all of the economic benefits required to settle a provision are expected to be recovered from a third party, the receivable is recognised as an asset if it is virtually certain that reimbursements will be received and the amount of the receivable can be measured reliably.

Present obligations arising under onerous contracts are recognised and measured as a provision. An onerous contract is considered to exist where the Trust has a contract under which the unavoidable costs of meeting the obligations under the contract exceed the economic benefits expected to be received under it.

A restructuring provision is recognised when the Trust has developed a detailed formal plan for the restructuring and has raised a valid expectation in those affected that it will carry out the restructuring by starting to implement the plan or announcing its main features to those affected by it. The measurement of a restructuring provision includes only the direct expenditures arising from the restructuring, which are those amounts that are both necessarily entailed by the restructuring and not associated with ongoing activities of the entity.

1.17 Clinical negligence costs

The NHS Litigation Authority (NHSLA) operates a risk pooling scheme under which the trust pays an annual contribution to the NHSLA which in return settles all clinical negligence claims. The contribution is charged to expenditure. Although the NHSLA is administratively responsible for all clinical negligence cases the legal liability remains with the trust. The total value of clinical negligence provisions carried by the NHSLA on behalf of the trust is disclosed at note 26.

1.18 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 the NHS Litigation Authority 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 as and when they become due.

1.19 EU Emissions Trading Scheme

EU Emission Trading Scheme allowances are accounted for as government grant funded intangible assets if they are not expected to be realised within twelve months, and otherwise as other current assets. They are valued at open market value. As the NHS body makes emissions, a provision is recognised with an offsetting transfer from the government grant reserve. The provision is settled on surrender of the allowances. The asset, provision and government grant reserve are valued at fair value at the end of the reporting period.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.20 Contingencies

A contingent liability is a possible obligation that arises from past events and whose existence will be confirmed only by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust, or a present obligation that is not recognised because it is not probable that a payment will be required to settle the obligation or the amount of the obligation cannot be measured sufficiently reliably. A contingent liability is disclosed unless the possibility of a payment is remote.

A contingent asset is a possible asset that arises from past events and whose existence will be confirmed by the occurrence or non-occurrence of one or more uncertain future events not wholly within the control of the trust. A contingent asset is disclosed where an inflow of economic benefits is probable.

Where the time value of money is material, contingencies are disclosed at their present value.

1.21 Financial assets

Financial assets are recognised when the Trust becomes party to the financial instrument contract or, in the case of trade receivables, when the goods or services have been delivered. Financial assets are derecognised when the contractual rights have expired or the asset has been transferred.

Financial assets are initially recognised at fair value.

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

Loans and receivables

Loans and receivables are non-derivative financial assets with fixed or determinable payments which are not quoted in an active market. After initial recognition, they are measured at amortised cost using the effective interest method, less any impairment. Interest is recognised using the effective interest method.

Fair value is determined by reference to quoted market prices where possible, otherwise by valuation techniques as specified in the NHS manual for accounts.

The effective interest rate is the rate that exactly discounts estimated future cash receipts through the expected life of the financial asset, to the initial fair value of the financial asset.

At the end of the reporting period, the trust assesses whether any financial assets, other than those held at ‘fair value through profit and loss’ are impaired. Financial assets are impaired and impairment losses recognised if there is objective evidence of impairment as a result of one or more events which occurred after the initial recognition of the asset and which has an impact on the estimated future cash flows of the asset.

For financial assets carried at amortised cost, the amount of the impairment loss is measured as the difference between the asset’s carrying amount and the present value of the revised future cash flows discounted at the asset’s original effective interest rate. The loss is recognised in expenditure and the carrying amount of the asset is reduced directly or through a provision for impairment of receivables.

If, in a subsequent period, the amount of the impairment loss decreases and the decrease can be related objectively to an event occurring after the impairment was recognised, the previously recognised impairment loss is reversed through expenditure to the extent that the carrying amount of the receivable at the date of the impairment is reversed does not exceed what the amortised cost would have been had the impairment not been recognised.

Notes to the Accounts - 1. Accounting Policies (Continued)

1.22 Financial liabilities

Financial liabilities are recognised on the Statement of Financial Position when the trust becomes party to the contractual provisions of the financial instrument or, in the case of trade payables, when the goods or services have been received. Financial liabilities are de-recognised when the liability has been discharged, that is, the liability has been paid or has expired.

Loans from the Department of Health are recognised at historical cost. Otherwise, financial liabilities are initially recognised at fair value.

1.23 Value Added Tax

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

1.24 Foreign currencies

The Trust's functional currency and presentational currency is sterling. Transactions denominated in a foreign currency are translated into sterling at the exchange rate ruling on the dates of the transactions. At the end of the reporting period, monetary items denominated in foreign currencies are retranslated at the spot exchange rate on 31 March. Resulting exchange gains and losses for either of these are recognised in the trust's surplus/deficit in the period in which they arise.

1.25 Third party assets

Assets belonging to third parties (such as money held on behalf of patients) are not recognised in the accounts since the trust has no beneficial interest in them. Details of third party assets are given in note 32 to the accounts.

1.26 Public Dividend Capital (PDC) and PDC dividend

Public dividend capital represents taxpayers' equity in the NHS trust. At any time the Secretary of State can issue new PDC to, and require repayments of PDC from, the trust. PDC is recorded at the value received. As PDC is issued under legislation rather than under contract, it is not treated as an equity financial instrument.

An annual charge, reflecting the cost of capital utilised by the trust, is payable to the Department of Health as public dividend capital dividend. The charge is calculated at the real rate set by HM Treasury (currently 3.5%) on the average carrying amount of all assets less liabilities, except for donated assets and cash balances with the Office of the Paymaster General. The average carrying amount of assets is calculated as a simple average of opening and closing relevant net assets. Prior to 2009/10 the PDC dividend was determined using forecast average relevant net assets and a note to the accounts discloses the rate that the dividend represents as a percentage of the actual average carrying amount of assets less liabilities in the year. From 1 April 2009, the dividend payable is based on the actual average relevant net assets for the year instead of forecast amounts.

1.27 Losses and Special Payments

Losses and special payments are items that Parliament would not have contemplated when it agreed funds for the health service or passed legislation. By their nature they are items that ideally should not arise. They are therefore subject to special control procedures compared with the generality of payments. They are divided into different categories, which govern the way that individual cases are handled.

Losses and special payments are charged to the relevant functional headings in expenditure on an accruals basis, including losses which would have been made good through insurance cover had NHS trusts not been bearing their own risks (with insurance premiums then being included as normal revenue expenditure).

Notes to the Accounts - 1. Accounting Policies (Continued)

1.28 Subsidiaries

For 2009-10 and 2010-11 in accordance with the directed accounting policy from the Secretary of State, the Trust does not consolidate the NHS charitable funds for which it is the Corporate Trustee.

1.29 Research and Development

Research and development expenditure is charged against income in the year in which it is incurred, except insofar as development expenditure relates to a clearly defined project and the benefits of it can reasonably be regarded as assured. Expenditure so deferred is limited to the value of future benefits expected and is amortised through the Operating Cost Statement on a systematic basis over the period expected to benefit from the project. It should be revalued on the basis of current cost. The amortisation is calculated on the same basis as depreciation, on a quarterly basis.

1.30 Accounting Standards issued but not yet adopted

IFRIC 19 “Extinguishing financial liabilities with equity instruments” is effective from 1 July 2010. Neither the Treasury FReM nor the Department of Health’s Manual for Accounts require this standard to be applied in 2010-11. The application of the IFRIC would not have a material impact on the trust accounts in 2010-11, were it applied in that year.

2. Operating segments

The Trust has considered IFRS8 (Operating Segments) and has taken the view that its activities should be reported as a single entity rather than in a segmental manner. Although financial performance is reported to the Chief Executive at a divisional level, the key financial information for decision making purposes is based on the entity as a whole. Furthermore, the trust's business is the delivery of acute healthcare across a single economic environment. No separate reportable segments have therefore been identified.

3. Income generation activities

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

4. Revenue from patient care activities	**2010-11 £000**	2009-10 £000
NHS trusts	**58**	79
Primary care trusts	**276,614**	270,010
Foundation trusts	**57**	66
Local authorities	**260**	0
Non-NHS:		
Private patients	**783**	666
Overseas patients (non-reciprocal)	**68**	79
Injury costs recovery*	**1,491**	1,067
Other	**396**	352
	279,727	272,319

* Injury cost recovery income is subject to a provision for impairment of receivables of 9.6% to reflect expected rates of collection. Debts raised in 2004/05 and earlier have been reviewed based on their recent rates of collection and higher provisions for impairment have been made to reflect their age.

5. Other operating revenue	**2010-11 £000**	2009-10 £000
Education, training and research	**13,076**	14,375
Charitable and other contributions to expenditure	**68**	872
Transfers from donated asset reserve	**536**	552
Transfers from government grant reserve	**(530)**	33
Non-patient care services to other bodies	**8,245**	8,298
Rental revenue from operating leases	**1,114**	919
Other revenue	**8,235**	6,557
	30,744	31,606

6. Revenue

Revenue is almost totally from the supply of services. Revenue from the sale of goods is immaterial.

7. Operating expenses

	2010-11 £000	Restated 2009-10 £000	
Services from other NHS trusts	**1,415**	4,271	
Services from PCTs	**2,723**	2,594	
Services from foundation trusts	**2,809**	260	
Purchase of healthcare from non NHS bodies	**71**	392	
Trust chair and non executive directors	**68**	66	^
Employee benefits	**189,797**	182,339	^
Supplies and services - clinical	**55,313**	52,639	
Supplies and services - general	**4,545**	4,064	
Consultancy services	**570**	965	
Establishment	**4,527**	4,638	
Transport	**1,601**	1,493	
Premises	**7,562**	7,527	
Provision for impairment of receivables	**267**	520	
Inventories write down	**262**	129	
Depreciation	**10,602**	11,074	
Amortisation	**519**	662	
Impairments and reversals of property, plant and equipment	**6,861**	6,572	
Impairments and reversals of intangible assets	**0**	1,797	
Impairments and reversals of non current assets held for sale	**184**	0	
Audit fees	**217**	205	
Other auditor's remuneration - medical staffing benchmarking	**19**	0	
Clinical negligence	**5,404**	4,939	
Research and development	**563**	1,464	*
Education and Training	**747**	645	
Other	**6,830**	7,845	
	303,476	297,100	

* 2009-10 Research and development expenditure included £1,290,000 employee costs. Employee costs totalling £1,288,000, relating to research and development, are included within Employee benefits in 2010-11.

^ balances restated for 2009-10 in accordance with the NHS Manual for Accounts. Directors' Costs (formerly shown separately) are now combined with Employee benefits costs and Trust chair and non-executives' costs are now disclosed separately, having previously been included within Employee benefits.

8. Operating leases

8.1 As lessee

The Trust leases medical equipment, vehicles and property under operating lease arrangements. There are no individually material leases.The lease terms range from 1 to 6 years and are arranged through Leaseguard under standard NHS terms and conditions.

Many of the leasing arrangements contain provisions for the option to renew or purchase at the end of the arrangement.

Payments recognised as an expense	**2010-11**	2009-10
	£000	£000
Minimum lease payments	**1,422**	1,755

		2010-11			2009-10
Total future minimum lease payments	**Buildings**	**Land**	**Other**	**Total**	Total
	£000	**£000**	**£000**	**£000**	£000
Payable:					
Not later than one year	**0**	**0**	**1,285**	**1,285**	1,573
Between one and five years	**0**	**0**	**2,393**	**2,393**	3,445
After 5 years	**0**	**0**	**108**	**108**	212
Total	**0**	**0**	**3,786**	**3,786**	5,230

Total future sublease payments expected to be received: £nil (2009-10: £nil)

8.2 As lessor

The Trust has three significant lessor arrangements: for the leasing of the main hospital site car park, space within the Knowledge Spa and space within the Peninsula Dental School. These leases have 11, 20 and 24 years remaining respectively. There are no new leases in 2010/11.

Rental revenue	**2010-11**	2009-10
	£000	£000
Contingent rent	**0**	0
Other	**1,114**	919
Total rental revenue	**1,114**	919

Total future minimum lease payments	**2010-11**	2009-10
	£000	£000
Receivable:		
Not later than one year	**1,114**	1,118
Between one and five years	**4,105**	4,188
After 5 years	**10,101**	11,228
Total	**15,320**	16,534

9. Employee costs and numbers

9.1 Employee costs

	2010-11			2009-10		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	£000	**£000**	**£000**	£000	£000	£000
Salaries and wages	**159,937**	**151,509**	**8,428**	154,842	145,482	9,360
Social security costs	**11,872**	**11,872**	**0**	11,408	11,408	0
Employer contributions to NHS Pension scheme	**19,183**	**19,183**	**0**	18,369	18,369	0
Other pension costs	**(104)**	**(104)**	**0**	129	129	0
Termination benefits	**395**	**395**	**0**	133	133	0
Employee benefits expense	**191,283**	**182,855**	**8,428**	184,881	175,521	9,360
Of the total above:						
Charged to capital	**1,486**			1,246		
Employee benefits charged to revenue	**189,797**			183,635		
	191,283			184,881		

9.2 Average number of people employed

	2010-11			2009-10		
	Total	**Permanently employed**	**Other**	Total	Permanently employed	Other
	Number	**Number**	**Number**	Number	Number	Number
Medical and dental	**587**	**570**	**17**	583	548	35
Administration and estates	**1,119**	**1,051**	**68**	1,098	1,040	58
Healthcare assistants and other support staff	**461**	**458**	**3**	462	450	12
Nursing, midwifery and health visiting staff	**1,225**	**1,177**	**48**	1,232	1,183	49
Nursing, midwifery and health visiting learners	**522**	**466**	**56**	520	461	59
Scientific, therapeutic and technical staff	**763**	**753**	**10**	728	717	11
Total	**4,677**	**4,475**	**202**	4,623	4,399	**224**
Of the above:						
Number of whole time equivalent staff engaged on capital projects	**32**			30		

9.3 Staff sickness absence

	2010-11	2009-10
	Number	Number
Total days lost	**43,527**	47,558
Total staff years	**4,520**	4,420
Average working days lost	9.6	10.8

9.4 Management Costs

	2010-11	2009-10
	£000	£000
Management costs	**10,231**	10,062
Income	**306,168**	299,631

9.5 Exit Packages for staff leaving in 2010-11

	2010-11			2009-10		
Exit package cost band (including any special payment element)	***Number of compulsory redundancies**	***Number of other departures agreed**	**Total number of exit packages by cost band**	*Number of compulsory redundancies	*Number of other departures agreed	Total number of exit packages by cost band
	Number	**Number**	**Number**	Number	Number	Number
<£20,001	0	24	**24**	**0**	**5**	**5**
£20,001 - £40,000	0	1	**1**	**0**	**1**	**1**
£40,001 - 100,000	0	3	**3**	**0**	**1**	**1**
£100,001 - £150,000	0	0	**0**	**0**	**0**	**0**
£150,001 - £200,000	0	0	**0**	**0**	**0**	**0**
>£200,000	0	0	**0**	**0**	**0**	**0**
Total number of exit packages by type (total cost	**0**	**28**	**28**	**0**	**7**	**7**
Total resource cost (£000s)	0	395	**395**	**0**	**133**	**133**

Redundancy and other departure costs have been paid in accordance with the provisions of the NHS MARS Scheme and NHS contracts of employment. Exit costs in this note are accounted for in full in the year of departure. Where the trust has agreed early retirements, the additional costs are met by the trust and not by the NHS pensions scheme. Ill-health retirement costs are met by the NHS pensions scheme and are not included in the table.

This disclosure reports the number and value of exit packages taken by staff leaving in the year. Note: The expense associated with these departures may have been recognised in part or in full in a previous period.

10. Pension costs

Past and present employees are covered by the provisions of the NHS Pensions Scheme. Details of the benefits payable under these provisions can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/pensions. The scheme is an unfunded, defined benefit scheme that covers NHS employers, GP practices and other bodies, allowed under the direction of the Secretary of State, in England and Wales. The scheme is 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, the scheme is accounted for as if it were a defined contribution scheme: the cost to the NHS Body of participating in the scheme is taken as equal to the contributions payable to the scheme for the accounting period.

The scheme is subject to a full actuarial valuation every four years (until 2004, every five years) and an accounting valuation every year. An outline of these follows:

a) Full actuarial (funding) valuation

The purpose of this valuation is to assess the level of liability in respect of the benefits due under the scheme (taking into account its recent demographic experience), and to recommend the contribution rates to be paid by employers and scheme members. The last such valuation, which determined current contribution rates was undertaken as at 31 March 2004 and covered the period from 1 April 1999 to that date. The conclusion from the 2004 valuation was that the scheme had accumulated a notional deficit of £3.3 billion against the notional assets as at 31 March 2004.

In order to defray the costs of benefits, employers pay contributions at 14% of pensionable pay and most employees had up to April 2008 paid 6%, with manual staff paying 5%.

Following the full actuarial review by the Government Actuary undertaken as at 31 March 2004, and after consideration of changes to the NHS Pension Scheme taking effect from 1 April 2008, his Valuation report recommended that employer contributions could continue at the existing rate of 14% of pensionable pay, from 1 April 2008, following the introduction of employee contributions on a tiered scale from 5% up to 8.5% of their pensionable pay depending on total earnings.

On advice from the scheme actuary, scheme contributions may be varied from time to time to reflect changes in the scheme's liabilities.

b) Accounting valuation

A valuation of the scheme liability is carried out annually by the scheme actuary as at the end of the reporting period by updating the results of the full actuarial valuation.

Between the full actuarial valuations at a two-year midpoint, a full and detailed member data-set is provided to the scheme actuary. At this point the assumptions regarding the composition of the scheme membership are updated to allow the scheme liability to be valued.

The valuation of the scheme liability as at 31 March 2011, is based on detailed membership data as at 31 March 2008 (the latest midpoint) updated to 31 March 2011 with summary global member and accounting data.

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

c) Scheme provisions

The NHS Pension Scheme provided defined benefits, which are summarised below. This list is an illustrative guide only, and is not intended to detail all the benefits provided by the Scheme or the specific conditions that must be met before these benefits can be obtained:

The Scheme is a "final salary" scheme. Annual pensions are normally based on 1/80th for the 1995 section and of the best of the last three years pensionable pay for each year of service, and 1/60th for the 2008 section of reckonable pay per year of membership. Members who are practitioners as defined by the Scheme Regulations have their annual pensions based upon total pensionable earnings over the relevant pensionable service.

With effect from 1 April 2008 members can choose to give up some of their annual pension for an additional tax free lump sum, up to a maximum amount permitted under HMRC rules. This new provision is known as "pension commutation".

Annual increases are applied to pension payments at rates defined by the Pensions (Increase) Act 1971, and are based on changes in retail prices in the twelve months ending 30 September in the previous calendar year.

Early payment of a pension, with enhancement, is available to members of the scheme who are permanently incapable of fulfilling their duties effectively through illness or infirmity. A death gratuity of twice final year's pensionable pay for death in service, and five times their annual pension for death after retirement is payable.

For early retirements other than those due to ill health the additional pension liabilities are not funded by the scheme. The full amount of the liability for the additional costs is charged to the statement of comprehensive income at the time the trust commits itself to the retirement, regardless of the method of payment.

Members can purchase additional service in the NHS Scheme and contribute to money purchase AVC's run by the Scheme's approved providers or by other Free Standing Additional Voluntary Contributions (FSAVC) providers.

11. Better Payment Practice Code

11.1 Better Payment Practice Code - measure of compliance

	2010-11		2009-10	
	Number	**£000**	Number	£000
Total Non-NHS trade invoices paid in the year	**69,896**	**94,256**	78,002	87,572
Total Non NHS trade invoices paid within target	**64,400**	**77,620**	68,479	65,636
Percentage of Non-NHS trade invoices paid within target	**92%**	**82%**	88%	75%
Total NHS trade invoices paid in the year	**2,412**	**47,973**	2,228	49,016
Total NHS trade invoices paid within target	**2,081**	**44,121**	1,812	45,142
Percentage of NHS trade invoices paid within target	**86%**	**92%**	81%	92%

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

11.2 The Late Payment of Commercial Debts (Interest) Act 1998	**2010-11**	2009-10
	£000	£000
Amounts included in finance costs from claims made under this legislation	**1**	0
Total	**1**	0

12. Investment revenue

	2010-11	2009-10
	£000	£000
Interest revenue:		
Bank accounts	21	23
Total	21	23

13. Other gains and losses

	2010-11	2009-10
	£000	£000
Gain/(loss) on disposal of property, plant and equipment	**(6)**	(193)
Total	**(6)**	(193)

14. Finance costs

	2010-11	2009-10
	£000	£000
Interest on loans and overdrafts	**1,673**	2,042
Interest on obligations under finance leases	**0**	11
Interest on obligations under LIFT / PFI contracts:		
- main finance cost	**333**	333
- contingent finance cost	**29**	15
Interest on late payment of commercial debt	**1**	0
Total interest expense	**2,036**	2,401
Other finance costs	**74**	84
Total	**2,110**	2,485

15. Property, plant and equipment

2010-11	Land	Buildings excluding dwellings	Dwellings	Assets under construction and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2010	18,177	114,987	1,520	11,026	58,503	347	30,785	5,181	**240,526**
Additions purchased	0	11,464	10	4,420	5,455	26	2,585	327	**24,287**
Additions donated	0	312	0	468	99	0	0	0	**879**
Additions government granted	0	191	0	0	0	0	0	0	**191**
Reclassifications	300	6,350	229	(10,992)	3,825	0	0	111	**(177)**
Disposals other than by sale	0	0	0	0	(1,182)	0	0	0	**(1,182)**
Revaluation/indexation gains	669	3,159	135	0	0	0	0	0	**3,963**
Impairments charged to reserves	(1,755)	(4,759)	(271)	0	0	0	0	0	**(6,785)**
At 31 March 2011	**17,391**	**131,704**	**1,623**	**4,922**	**66,700**	**373**	**33,370**	**5,619**	**261,702**
Depreciation at 1 April 2010					43,519	264	15,612	3,585	**62,980**
Disposals other than by sale	0	0	0		(1,146)	0	0	0	**(1,146)**
Impairments charged to operating expenses	290	7,752	0	0	0	0	0	0	**8,042**
Reversal of impairments charged to operating expenses	0	(1,181)	0	0	0	0	0	0	**(1,181)**
Charged during the year	0	4,557	81		3,200	25	2,427	312	**10,602**
Depreciation at 31 March 2011	**290**	**11,128**	**81**	**0**	**45,573**	**289**	**18,039**	**3,897**	**79,297**
Net book value									
Purchased	**17,101**	**109,767**	**1,533**	**4,454**	**20,560**	**84**	**15,331**	**1,700**	**170,530**
Donated	**0**	**6,575**	**9**	**468**	**567**	**0**	**0**	**22**	**7,641**
Government granted	**0**	**4,234**	**0**	**0**	**0**	**0**	**0**	**0**	**4,234**
Total at 31 March 2011	**17,101**	**120,576**	**1,542**	**4,922**	**21,127**	**84**	**15,331**	**1,722**	**182,405**
Asset financing									
Owned	**16,801**	**119,276**	**1,542**	**4,922**	**20,893**	**84**	**15,294**	**1,722**	**180,534**
Finance leased	**0**	**0**	**0**	**0**	**234**	**0**	**37**	**0**	**271**
LIFT	**300**	**1,300**	**0**	**0**	**0**	**0**	**0**	**0**	**1,600**
Total 31 March 2011	**17,101**	**120,576**	**1,542**	**4,922**	**21,127**	**84**	**15,331**	**1,722**	**182,405**

15.1 Revaluation reserve balance for property, plant and equipment

	Land	Buildings excluding dwellings	Dwellings		Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000		£000	£000	£000	£000	£000
At 1 April 2010	**9,231**	**28,850**	**2,179**		**2,867**	**13**	**273**	**307**	**43,720**
Movements (specify)	**(1,086)**	**(1,854)**	**(138)**		**(1,666)**	**(6)**	**(107)**	**(249)**	**(5,106)**
At 31 March 2011	**8,145**	**26,996**	**2,041**		**1,201**	**7**	**166**	**58**	**38,614**

15. Property, plant and equipment continued

2009-10	Land	Buildings excluding dwellings	Dwellings	Assets under construction and poa	Plant and machinery	Transport equipment	Information technology	Furniture & fittings	Total
	£000	£000	£000	£000	£000	£000	£000	£000	£000
Cost or valuation at 1 April 2009	23,173	105,766	1,548	15,204	65,384	347	27,836	8,793	**248,051**
Additions purchased	0	12,596	8	10,144	3,216	0	2,978	0	**28,942**
Additions donated	0	70	0	0	29	0	0	0	**99**
Reclassifications	2,011	22,220	(1,054)	(14,322)	(8,237)	0	(29)	(3,612)	**(3,023)**
Reclassified as held for sale	(434)	0	0	0	0	0	0	0	**(434)**
Disposals other than by sale	0	0	0	0	(1,281)	0	0	0	**(1,281)**
Revaluation/indexation gains	96	8,893	1,493	0	0	0	0	0	**10,482**
Impairments	(6,669)	(22,751)	(369)	0	(608)	0	0	0	**(30,397)**
At 31 March 2010	**18,177**	**126,794**	**1,626**	**11,026**	**58,503**	**347**	**30,785**	**5,181**	**252,439**
Depreciation at 1 April 2009					41,844	241	13,145	4,312	**59,542**
Reclassifications		2,517	63		(1,769)	0	(990)	(1,032)	**(1,211)**
Disposals other than by sale	0	0	0		(1,084)	0	0	0	**(1,084)**
Impairments	0	4,809	0	0	1,763	0	0	0	**6,572**
Charged during the year	0	4,481	43		2,765	23	3,457	305	**11,074**
Depreciation at 31 March 2010	**0**	**11,807**	**106**	**0**	**43,519**	**264**	**15,612**	**3,585**	**74,893**
Net book value									
Purchased	**18,177**	**104,251**	**1,512**	**11,026**	**14,237**	**83**	**15,173**	**1,495**	**165,954**
Donated	**0**	**6,706**	**8**	**0**	**747**	**0**	**0**	**101**	**7,562**
Government granted	**0**	**4,030**	**0**	**0**	**0**	**0**	**0**	**0**	**4,030**
Total at 31 March 2010	**18,177**	**114,987**	**1,520**	**11,026**	**14,984**	**83**	**15,173**	**1,596**	**177,546**
Asset financing									
Owned	**18,177**	**113,387**	**1,520**	**11,026**	**14,642**	**83**	**15,131**	**1,596**	**175,562**
Finance leased	**0**	**0**	**0**	**0**	**342**	**0**	**42**	**0**	**384**
LIFT	**0**	**1,600**	**0**	**0**	**0**	**0**	**0**	**0**	**1,600**
Total 31 March 2010	**18,177**	**114,987**	**1,520**	**11,026**	**14,984**	**83**	**15,173**	**1,596**	**177,546**

15. Property, plant and equipment (cont.)

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 2011 by the District Valuers of the Revenue and Customs Government Department. 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 HM Treasury.

The trust's plant and machinery assets (with indiviual values in excess of £15,000) were last revalued at 1 April 2009, by the District Valuation Office. Since that date these assets have been carried on the Statement of Financial Position at those valuations less subsequent depreciation. The remainder of the trust's plant and equipment assets continue to be carried at depreciation historical cost as a proxy for fair value.

Property, plant and equipment is depreciated at rates calculated to write them down to estimated residual values on a straight-line basis over their estimated useful lives. No depreciation is provided on freehold land and assets held for sale. Estimated useful lives are generally applied as follows:

• Buildings - depreciated over lives determined by the District Valuer - currently 4 to 45 years;
• Short life engineering plant and equipment - 5 to 8 years (2009-10: 5 years);
• Medium life engineering plant and equipment - 10 to 14 years (2009-10: 10 years);
• Long life engineering plant and equipment - 15 to 20 years (2009-10: 15 years);
• Vehicles - 5 to 8 years (2009-10: 7 years);
• Furniture - 7 to 12 years (2009-10: 10 years);
• Office and IT equipment - 3 to 15 years (2009-10: 5 years);
• Soft furnishings - 5 to 10 years (2009-10: 7 years);
• Short life medical and other equipment - 3 to 10 years (2009-10: 5 years);
• Medium life medical equipment - 10 to 14 years (2009-10: 10 years);
• Long life medical equipment - 15 to 20 years (2009-10: 15 years);
• Mainframe-type IT installations - 8 to 15 years (2009-10: 8 years).

The changes in asset lives above have been undertaken in order to more closely reflect the useful economic lives of the trust's assets. The impact of these changes in the current year is not material. Depreciation charges in future years will also be lower as assets are generally written-off over a longer period of time.

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 £30.8m (2009-10: 38.6m)

Significant donations (in excess of £20,000) towards property, plant and equipment expenditure in the year have been provided by the following organisations:

• Friends of the Royal Cornwall Hospital
• Friends of St Michael's Hospital
• Friends of West Cornwall Hospital
• Sunrise Appeal
• Royal Cornwall Hospitals NHS Charitable Funds
• University of Plymouth
• Cornwall Council
• Duchy Health Charity

A number of other organisations have donated smaller amounts towards property, plant and equipment, particularly in relation to the creation of the 'play for life garden'.

15. Property, plant and equipment (cont.)

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

	Land £000	Buildings (excluding dwellings) £000	Total £000
Gross carrying amount	1,891	9,945	**11,836**
Accumulated impairment loss	(1,274)	(761)	**(2,035)**
Depreciation charge for the period	0	215	**215**
Impairment losses recognised for the period	(281)	(41)	**(322)**

16. Intangible assets

2010-11	Computer software - purchased £000	Development expenditure - internally generated £000	Total £000
Gross cost at 1 April 2010	7,919	3,008	**10,927**
Additions purchased	652	0	**652**
Reclassifications	177	0	**177**
Gross cost at 31 March 2011	**8,748**	**3,008**	**11,756**
Amortisation at 1 April 2010	4,959	3,008	**7,967**
Charged during the year	519	0	**519**
Amortisation at 31 March 2011	**5,478**	**3,008**	**8,486**
Net book value			
Purchased	**3,259**	**0**	**3,259**
Donated	**11**	**0**	**11**
Total at 31 March 2011	**3,270**	**0**	**3,270**

2009-10	Computer software - purchased £000	Development expenditure - internally generated £000	Total £000
Gross cost at 1 April 2009	6,976	0	**6,976**
Additions purchased	943	0	**943**
Reclassifications	0	3,008	**3,008**
Gross cost at 31 March 2010	**7,919**	**3,008**	**10,927**
Amortisation at 1 April 2009	4,297	0	**4,297**
Reclassifications	0	1,211	**1,211**
Impairments	0	1,797	**1,797**
Charged during the year	662	0	**662**
Amortisation at 31 March 2010	**4,959**	**3,008**	**7,967**
Net book value			
Purchased	**2,946**	**0**	**2,946**
Donated	**14**	**0**	**14**
Total at 31 March 2010	**2,960**	**0**	**2,960**

16. Intangible assets (cont.)
Intangible assets comprise purchased computer software which is carried at amortised historical cost, as a proxy for fair value, together with development expenditure which is carried at a nominal value.

Assets are capitalised and amortised over the useful lives on a straight-line basis. Useful lives are all finite and range from 1 to 5 years.

The gross carrying amount of fully depreciated assets still in use is £2.414m (2009-10: £2.417m).

Revaluation reserve balance for intangible assets
Revaluation reserve balances at 31 March 2011 are £0.02m (2009-10: £0.02m).

17. Impairments

The trust revalued all land, buildings and dwellings as at 31 March 2011 using the modern equivalent valuation methodology. This revaluation resulted in impairments as follows:

	Total £000
Impairments charged to reserves	**6,785**
Impairments charged to the operating expenses	8,042
Less: the reversal of impairments charged in previous years	(1,181)
Total impairments charged to operating expenses	**6,861**

All impairments relate to changes in market prices.

Only one individual asset suffered a material reduction in value, this being the Trelawney building on the main hospital site. This asset reduced in value by £4.011m of which £3.078m was charged to operating expenses and £0.933m was charged to the Revaluation Reserve.

18. Commitments

18.1 Capital commitments

Contracted capital commitments at 31 March 2011, not otherwise included in these financial statements, were £7.457m (31 March 2010: £2.781m). Included in this balance are the following significant projects:

a) Purchase and installation of a linear accelerator
The total cost of this project is approximately £5.3m, with £2.4m committed in 2011-12. The project started in 2009-10 and is due to be completed by 31 March 2012. The trust has secured funding from the Sunrise Appeal totalling £0.6m, with the remainder being funded through NHS capital funding.

b) Upgrade of critical care facilities
Work commenced in 2010-11 to refurbish the critical care facilities. Total estimated costs for the project are £2.9m. A total of £1.2m has been expended to date with the remainder committed in 2011-12. The project is being funded by NHS capital funding and is due to be completed in June 2011.

c) Upgrade of day case theatres
This upgrade of interventional radiology and head and neck theatres commenced in 2009-10 and is due for completion in June 2011. The total project costs are approximately £3.6m with £2.5m expended to date. The remainder is committed for 2011-12. The project is being funded by NHS capital funding.

18.2 Other financial commitments

With the exception of leases and a LIFT scheme, the trust has entered into no other non-cancellable contracts.

19. Inventories

19.1 Inventories	31 March 2011 £000	31 March 2010 £000
Drugs	**1,939**	2,066
Consumables	**4,875**	4,287
Energy	**65**	47
Total	**6,879**	6,400
Of which held at net realisable value:	**0**	0

19.2 Inventories recognised in expenses	31 March 2011 £000	31 March 2010 £000
Inventories recognised as an expense in the period	**56,616**	53,971
Write-down of inventories (including losses)	**262**	129

20. Trade and other receivables

20.1 Trade and other receivables	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
NHS receivables-revenue	**2,087**	**0**	4,747	0
Non-NHS receivables-revenue	**1,642**	**0**	1,465	0
Non-NHS receivables-capital	**468**	**0**	0	0
Provision for the impairment of receivables	**(906)**	**0**	(654)	0
Prepayments and accrued income	**4,268**	**333**	4,995	0
VAT	**1,006**	**0**	206	0
Other receivables	**2,713**	**1,277**	2,352	882
Total	**11,278**	**1,610**	13,111	882

The great majority of trade is with Primary Care Trusts, as commissioners for NHS patient care services. As Primary Care Trusts are funded by Government to buy NHS patient care services, no credit scoring of them is considered necessary.

20.2 Receivables past their due date but not impaired	31 March 2011 £000	31 March 2010 £000
By up to three months	**1,038**	908
By three to six months	**468**	413
By more than six months	**2,553**	2,419
Total	**4,059**	3,740

20.3 Provision for impairment of receivables	31 March 2011 £000	31 March 2010 £000
Balance at 1 April	**(654)**	(333)
Amount written off during the year	**15**	199
Amount recovered during the year	**0**	0
(Increase)/decrease in receivables impaired	**(267)**	(520)
Balance at 31 March	**(906)**	(654)

Injury cost recovery receivables are impaired in accordance with the Department of Health guidelines at 9.6% for balances between 2005-06 to 2010-11.

Debts raised in 2004-05 and earlier have been reviewed based on their recent rates of collection and higher provisions for impairment have been made to reflect their age.

20.3 Provision for impairment of receivables (cont'd)

Non-NHS receivables are impaired on the basis of their age and value, in accordance with the trust's own policies, as follows:

	31 March 2011 Impairment %	31 March 2010 Impairment %
Balances greater than £1,000 and older than 12 months	**75**	70
Balances less than £1,000 and older than 12 months	**75**	70
Balances greater than £1,000 and less than 12 months	**35**	35
Balances less than £1,000 and less than 12 months	**50**	35

21. Cash and cash equivalents	**31 March 2011 £000**	31 March 2010 £000
Balance at 1 April	**633**	490
Net change in year	**167**	143
Balance at 31 March	**800**	633
Made up of		
Cash with Government banking services	**472**	457
Commercial banks and cash in hand	**328**	176
Cash and cash equivalents as in statement of financial position	**800**	633
Bank overdraft - Commercial banks	**(33)**	(48)
Cash and cash equivalents as in statement of cash flows	**767**	585

22. Non-current assets held for sale	**Land £000**
Balance at 1 April 2010	**434**
Less impairments of assets held for sale	(184)
Balance at 31 March 2011	**250**
Balance at 1 April 2009	**0**
Plus assets classified as held for sale in the year	434
Balance at 31 March 2010	**434**

During 2009-10 the trust classified a parcel of land as being held for sale. Although originally expected to be sold in December 2010 the sale is now expected in June 2011.

The District Valuer has revalued the land at 31 March 2011 and the value has been impaired accordingly.

23. Trade and other payables	**Current 31 March 2011 £000**	**Non-current 31 March 2011 £000**	Current 31 March 2010 £000	Non-current 31 March 2010 £000
NHS payables-revenue	**2,482**	**0**	1,083	0
Non NHS trade payables - revenue	**2,336**	**0**	3,346	0
Non NHS trade payables - capital	**4,571**	**0**	1,269	0
Accruals and deferred income	**9,928**	**6,396**	12,542	7,159
Social security costs	**1,791**		1,738	
Tax	**2,293**		2,213	
Other	**2,642**	**0**	2,442	0
Total	**26,043**	**6,396**	24,633	7,159

Other payables include:
No payments due in future years (2009-10 £nil) under arrangements to buy out the liability for early retirements; and £2.407m outstanding pensions contributions at 31 March 2011 (31 March 2010 £2.339m).

Trade payables, including tax and social security costs, are expected to be settled within terms, which are anticipated to be 30 days.

24. Borrowings	**Current 31 March 2011 £000**	**Non-current 31 March 2011 £000**	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Bank overdraft - Commercial banks	**33**		48	
Loans from:				
Department of Health	**6,116**	**18,344**	7,889	26,261
LIFT	**5**	**1,578**	4	1,582
Finance lease liabilities	**22**	**0**	163	22
Total	**6,176**	**19,922**	8,104	27,865

	31 March 2011		31 March 2010	
	Interest rate %	**Value outstanding £000**	**Interest rate %**	**Value outstanding £000**
Working Capital Loan	**5.32**	**24,460**	5.32	32,851
Working Capital Roll Over Loan	**1.16**	**0**	1.16	1,299

A working capital loan was issued to the Trust by the Secretary of State for Health for £46,125,000 on 15 July 2008. The loan is for a 7 year period with repayments being made at six monthly intervals. The first instalment was repaid on 15 September 2008.

A further 2 year loan of £2,597,000 was issued to the Trust in March 2009, with repayments made at 6 monthly intervals. The final instalment was repaid in March 2011.

25. Finance lease and LIFT scheme obligations

25.1 Amounts payable under finance leases:

The Trust leases medical equipment and IT installations under arrangements the Trust has classified as finance leases. There are no significant finance leases. Details of amounts payable are disclosed below.

The reconciliation between the total future minimum lease payments and their present value can be performed using the discount rate used to represent the time value of money.

	Minimum lease payments	**Present value of minimum lease payments**	Minimum lease payments	Present value of minimum lease payments
	31 March 2011 £000	**31 March 2011 £000**	31 March 2010 £000	31 March 2010 £000
Within one year	**23**	**22**	169	163
Between one and five years	**0**	**0**	23	22
After five years	**0**	**0**	0	0
Less future finance charges	**(1)**		(7)	
Present value of minimum lease payments	**22**	**22**	185	185
Included in:				
Current borrowings		**22**		163
Non-current borrowings		**0**		22
		22		185

Future sublease payments expected to be received total £nil (2009-10 £nil)
Contingent rents recognised as an expense £nil (2009-10 £nil)

25.2 Amounts payable under LIFT schemes:

The Trust leases a food production unit under arrangements the Trust has classified as a finance lease. The term for this lease is 25 years and the Trust has the option to extend the arrangement for a further 25 years. Contingent rent is charged as a finance charge and is determined based on inflation rate changes.

	Minimum lease payments	**Present value of minimum lease payments**	Minimum lease payments	Present value of minimum lease payments
	31 March 2011 £000	**31 March 2011 £000**	31 March 2010 £000	31 March 2010 £000
Within one year	**336**	**320**	336	320
Between one and five years	**1,345**	**793**	1,345	793
After five years	**5,687**	**469**	6,023	473
Less future finance charges	**(5,785)**		(6,118)	
Present value of minimum lease payments	**1,583**	**1,582**	1,586	1,586
Included in:				
Current borrowings		**5**		4
Non-current borrowings		**1,577**		1,582
		1,582		1,586

Future sublease payments expected to be received total £nil (2009-10 £nil)
Contingent rents recognised as an expense £24,000 (2009-10 £15,000)

26. Provisions	Current 31 March 2011 £000	Non-current 31 March 2011 £000	Current 31 March 2010 £000	Non-current 31 March 2010 £000
Pensions relating to other staff	**70**	**795**	70	874
Legal claims	**1,330**	**0**	1,686	0
Other (see below)	**214**	**2,851**	208	3,106
Total	**1,614**	**3,646**	1,964	3,980

	Pensions relating to other staff £000	Legal claims £000	Other £000	Total £000
At 1 April 2010	**944**	**1,686**	**3,314**	**5,944**
Arising during the year	**52**	**43**	**228**	**323**
Used during the year	**(70)**	**(79)**	**(221)**	**(370)**
Reversed unused	**0**	**(322)**	**0**	**(322)**
Unwinding of discount	**16**	**2**	**56**	**74**
Change in discount rate	**(77)**	**0**	**(312)**	**(389)**
At 31 March 2011	**865**	**1,330**	**3,065**	**5,260**
Expected timing of cash flows:				
Within one year	**70**	**1,330**	**214**	**1,614**
Between one and five years	**259**	**0**	**799**	**1,058**
After five years	**536**	**0**	**2,052**	**2,588**

£27.582m is included in the provisions of the NHS Litigation Authority at 31 March 2011 in respect of clinical negligence liabilities of the trust (31 March 2010 £28.655m).

The following have been included in 'other' provisions:
- £2.354m for permanent injury benefits (31 March 2010 £2.536m)
- £0.771m for pre 1995 pensions (31 March 2010 £0.778m)

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 be precise regarding dates of settlement for industrial injury and other legal claims and therefore there is uncertainity over the calculation and timings of amounts due.

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

27. Contingencies

27.1 Contingent liabilities

	2010-11	2009-10
	£000	£000
Equal pay cases	**0**	0
Other (see below)	**60**	1,600
Total	**60**	1,600

During the previous year a legal claim was brought against the trust by a former employee. As at the end of the previous reporting period (31 March 2010), no decision had been made as to the outcome of the claim and the contingent liability reflected the fact that a claim had been made and was based on legal advice. Legal advice at 31 March 2011 has confirmed that this contingent liability is no longer required. A provision remains (see note 26) until the case is concluded.

The new liabilities arising in the year relate to personal injury claims made against the trust, as advised by the NHSLA.

27.2 Contingent assets

The trust has not identified any contingent assets

28. Financial instruments

28.1 Financial assets

	At fair value through profit and loss	Loans and receivables	Available for sale	Total
	£000	£000	£000	£000
Embedded derivatives	**0**			**0**
Receivables		**11,520**		**11,520**
Cash at bank and in hand		**800**		**800**
Other financial assets	**0**	**0**	**0**	**0**
Total at 31 March 2011	**0**	**12,320**	**0**	**12,320**
Embedded derivatives	0			0
Receivables		9,447		9,447
Cash at bank and in hand		633		633
Other financial assets	0	0	0	0
Total at 31 March 2010	**0**	**10,080**	**0**	**10,080**

28.2 Financial liabilities

	At fair value through profit and loss	Other	Total
	£000	£000	£000
Embedded derivatives	**0**		**0**
Payables		**28,355**	**28,355**
LIFT and finance lease obligations		**1,605**	**1,605**
Other borrowings		**24,493**	**24,493**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2011	**0**	**54,453**	**54,453**
Embedded derivatives	**0**		**0**
Payables		**27,842**	**27,842**
LIFT and finance lease obligations		**1,771**	**1,771**
Other borrowings		**34,198**	**34,198**
Other financial liabilities	**0**	**0**	**0**
Total at 31 March 2010	**0**	**63,811**	**63,811**

28.3 Financial risk management

Financial reporting standard IFRS 7 requires disclosure of the role that financial instruments have had during the period in creating or changing the risks a body faces in undertaking its activities. Because of the continuing service provider relationship that the NHS trust has with primary care trusts and the way those primary care trusts are financed, the NHS trust is not exposed to the degree of financial risk faced by business entities. Also financial instruments play a much more limited role in creating or changing risk than would be typical of listed companies, to which the financial reporting standards mainly apply. The NHS trust has limited powers to borrow or invest surplus funds and financial assets and liabilities are generated by day-to-day operational activities rather than being held to change the risks facing the NHS trust in undertaking its activities.

The trust's treasury management operations are carried out by the finance department, within parameters defined formally within the trust's standing financial instructions and policies agreed by the board of directors. 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 may borrow from government for capital expenditure, subject to affordability as confirmed by the strategic health authority. The borrowings are for 1 – 25 years, in line with the life of the associated assets, and interest is charged at the National Loans Fund rate, fixed for the life of the loan. The trust therefore has low exposure to interest rate fluctuations.

Credit risk
Because the majority of the trust's income comes from contracts with other public sector bodies, the trust has low exposure to credit risk. The maximum exposures as at 31 March 2011 are in receivables from customers, as disclosed in the trade and other receivables note (note 20).

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

29. Events after the reporting period
There are no known post balance sheet events requiring disclosure.

30. Financial performance targets

The figures given for periods prior to 2009-10 are on a UK GAAP basis as that is the basis on which the targets were set for those years.

30.1 Breakeven performance

	2005-06 £000	2006-07 £000	2007-08 £000	2008-09 £000	2009-10 £000	2010-11 £000
Turnover	238,999	234,384	259,418	282,726	303,925	310,471
Retained surplus/(deficit) for the year	(15,687)	(36,464)	1,285	2,009	(87)	442
Adjustment for:						
Timing/non-cash impacting distortions:						
2007-08 PPA (relating to 1997-98 to 2006-07)	(507)	(151)				
Adjustments for Impairments				0	8,369	7,045
Consolidated Budgetary Guidance - Adjustment for Dual Accounting under IFRIC12*					67	57
Other agreed adjustments	1,932	0	0	0	0	0
Break-even in-year position	(14,262)	(36,615)	1,285	2,009	8,349	7,544
Break-even cumulative position	(9,447)	(46,062)	(44,777)	(42,768)	(34,419)	(26,875)

* Due to the introduction of International Financial Reporting Standards (IFRS) accounting in 2009-10, NHS trust's financial performance measurement needs to be aligned with the guidance issued by HM Treasury measuring Departmental expenditure. Therefore, the incremental revenue expenditure resulting from the application of IFRS to IFRIC 12 schemes (which would include PFI schemes), which has no cash impact and is not chargeable for overall budgeting purposes, is excluded when measuring Breakeven performance

The Trust's recovery plan, approved by the SHA aims to achieve break-even in 2013.

	2005-06 %	2006-07 %	2007-08 %	2008-09 %	2009-10 %	2010-11 %
Materiality test (i.e. is it equal to or less than 0.5%):						
Break-even in-year position as a percentage of turnover	-6%	-16%	0%	1%	3%	2%
Break-even cumulative position as a percentage of turnover	-4%	-20%	-17%	-15%	-11%	-9%

The amounts in the above tables in respect of financial years 2005-06 to 2008-09 inclusive have **not** been restated to IFRS and remain on a UK GAAP basis.

30.2 Capital cost absorption rate

Untill 2008-09 the trust was required to absorb the cost of capital at a rate of 3.5% of forecast average relevant net assets. The rate is calculated as the percentage that dividends paid on public dividend capital bears to the actual average relevant net assets.

From 2009-10 the dividend payable on public dividend capital is based on the actual (rather than forecast) average relevant net assets and therefore the actual capital cost absorption rate is automatically 3.5%.

30.3 External financing

The trust is given an external financing limit which it is permitted to undershoot.

	£000	**2010-11 £000**	2009-10 £000
External financing limit		**5,962**	4,822
Cash flow financing	**6,314**		7,050
Other capital receipts	**(602)**		(2,367)
External financing requirement		**5,712**	4,683
Undershoot/(overshoot)		**250**	139

30.4 Capital resource limit

The trust is given a capital resource limit which it is not permitted to exceed.

	2010-11 £000	2009-10 £000
Gross capital expenditure	**26,009**	29,984
Less: book value of assets disposed of	**(36)**	(197)
Less: capital grants	**(191)**	(3,483)
Less: donations towards the acquisition of non-current assets	**(879)**	(300)
Charge against the capital resource limit	**24,903**	26,004
Capital resource limit	**27,600**	26,034
(Over)/underspend against the capital resource limit	**2,697**	30

31. Related party transactions

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

The Department of Health is regarded as a related party. During the year Royal Cornwall Hospitals NHS Trust has had material transactions with the Department in respect of the Working Capital loans (disclosed in note 24).

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

Year to 31 March 2011	**Expenditure with Related Party £000**	**Income with Related Party £000**	**Payables with Related Party £000**	**Receivables with Related Party £000**
Cornwall and IOS PCT	**4,701**	**270,076**	**1,672**	**3,100**
South West SHA	**21**	**13,297**	**17**	**12**
Cornwall Partnership NHS FT	**2,645**	**2,560**	**294**	**607**
Bristol PCT	**0**	**9,770**	**0**	**87**
NHS Litigation Authority	**5,409**	**0**	**0**	**0**
NHS Business Services Authority	**8,696**	**0**	**1,011**	**0**

Year to 31 March 2010	**Expenditure with Related Party £000**	**Income with Related Party £000**	**Payables with Related Party £000**	**Receivables with Related Party £000**
Cornwall and IOS PCT	2,986	268,067	439	4,950
South West SHA	1	12,453	0	16
Cornwall Partnership NHS FT	260	207	565	298
Cornwall Partnership NHS Trust	2,918	2,577		
Bristol PCT	0	3,827	0	475
NHS Litigation Authority	4,945	0	1	0
NHS Purchasing and Supply Agency	9,193	0	323	0

In addition, the trust has had a number of material transactions with other Government Departments and other central and local Government bodies (see note 33). Most of these transactions have been with NHS Pension Scheme, National Insurance Fund, NHS Blood and Transplant and HM Revenue and Customs.

The trust has received revenue and capital payments totalling £235,502 (2009-10 £237,992) from Royal Cornwall Hospital NHS Charitable Fund, of whom the trust is the sole corporate trustee. At the year end the trust was owed £44,446 by Royal Cornwall Hospital NHS Charitable Fund (2009-10: the trust owed Royal Cornwall Hospitals NHS Charitable Fund £10,869).

During 2010-11, an interim director at was contracted through Brandhill Financial Services Limited. The trust paid £72,695 for these services (2009-10 £nil).

32. Third party assets

The Trust held £96 cash and cash equivalents at 31 March 2011 (£63 at 31 March 2010) which relates to monies held by the NHS Trust on behalf of patients. This has been excluded from the cash and cash equivalents figure reported in the accounts.

33. Intra-Government and other balances	Current receivables	Non-current receivables	Current payables	Non-current payables
	£000	£000	£000	£000
Balances with other central government bodies	2,372	0	6,315	0
Balances with local authorities	0	0	75	0
Balances with NHS trusts and foundation trusts	721	0	430	0
Balances with public corporations and trading funds	0	0	0	0
Intra government balances	3,093	0	6,820	0
Balances with bodies external to government	8,185	1,610	19,223	6,396
At 31 March 2011	**11,278**	**1,610**	**26,043**	**6,396**
Balances with other central government bodies	4,317	0	8,482	0
Balances with local authorities	45	0	13	0
Balances with NHS trusts and foundation trusts	420	0	503	0
Balances with public corporations and trading funds	10	0	2	0
Intra government balances	4,792	0	9,000	0
Balances with bodies external to government	8,319	882	15,633	7,159
At 31 March 2010	**13,111**	**882**	**24,633**	**7,159**

34. Losses and special payments

There were 205 cases of losses and special payments (2009-10: 453 cases) totalling £312,866 (2009-10: £392,628)

Glossary of terms and useful information to interpret the accounts

Explanation of the key statements and unusual or important notes to the accounts

Statement of Comprehensive Income – This replaces the Income and Expenditure Account and summarises the Trust's income and expenditure for the year. The statement also shows the impact of asset revaluations on its reserve balances and the value of donated and government grant assets received, plus the use of the donated and government grant reserves to offset depreciation on donated and government grant assets. The key figure on this statement is the retained surplus / deficit for the year.

Statement of Financial Position (SOFP) – This replaces the Balance Sheet but is very similar. The summary terms explained at the end of this document will help readers understand the terms.

Statement of Changes in Taxpayers Equity – This summarises the movement on the Trust's reserves which form the lower section of the SOFP.

Statement of Cash Flows – this replaces the Cash Flow Statement and is very similar. This statement removes any non-cash transactions (i.e. movements in trade and other payables and receivables) to determine the actual cash flows in the year.

Note 1 – Accounting policies – These set out the accounting rules that all NHS trusts are required to follow. They explain the basis on which all entries in the accounts are made. The policies are largely dictated by the Department of Health's Manual for Accounts although the Trust is able to tailor the policies as it sees fit. One of the main requirements is for the accounts to be reported on an accruals basis, which means that income and expenditure are recorded in the year they arise, regardless of when the cash is transferred.

Note 10 – Pension costs – This note sets out the provisions of the NHS pension scheme and explains that it is accounted for as a defined contribution scheme. As a result, the Trust cannot disclose any share of pension assets or liabilities in its financial statements.

Note 11 – Better payment practice code – The Trust is expected to be able to pay invoices received within 30 days of receipt. A target of 95% compliance has been set by the Department of Health. The Trust is currently just falling short of this target but has plans in place to pay suppliers more quickly and achieve the target in 2011/12.

Note 18 – Capital commitments – These are projects on the capital programme that have been approved by the Trust and legally binding contracts have been agreed with service suppliers for the project to go ahead. However, where elements of the work have not yet started; so that expenditure has not been incurred, these amounts are regarded as committed.

Note 28 – Financial instruments – This note identifies the range of assets and liabilities arising from contracts, within the accounts of the parties to the contract. Risks, such as the impact of changes in the value of money, e.g. exchange rate shifts; of interest rates, for deposits and loans; liquidity or availability of cash are shown here.

Note 29 – Events after the reporting period - This note identifies any significant events that occur, after the end of the financial year, but before the accounts are signed off. These events are likely to have a significant impact on the future activities and finances of the Trust. No such events have been identified.

Note 30.1 – Breakeven performance – This note shows the history of the Trust's financial performance from 2005/06 to 2010/11. The Trust achieved its financial targets in 2007-08, 2008-09, 2009/10 and 2010/11.

Note 30.2 – Capital cost absorption rate – The Trust is expected to absorb the cost of its capital at a rate of 3.5% of average net assets and this has been achieved.

Note 30.3 – External financing – The Trust is given a cash limit for external financing, which enables the Department of Health to keep cash payments, in the NHS overall, within the level agreed with Parliament. The annual limit is set by the DH and SHA, determining how much more, or less, the Trust can spend in addition to what funds it generates from its activities. The Trust delivered this requirement in 2010/11, reporting a £0.3 million under-utilisation of the initial planned limit.

Note 30.4 – Capital resource limit – This is the level of capital expenditure financed in the year and is set by the Department of Health each year.

Note 31 – Related party transactions – The Trust is required to identify any significant transactions that Board members, managers, or close members of their family have undertaken with the Trust. As the Department of Health is seen as a related party, all NHS organisations with which the Trust has had significant transactions during the year are also listed.

Note 34 – Losses and special payments – This note identifies financial costs that have been incurred, by the Trust, that are not planned and do not fall within the range of activities that Parliament would have intended healthcare funds being used for. All of the cases recorded in this note have been reviewed and accepted by the Audit Committee.

Statement on internal control (SIC) - The Trust's Chief Executive is responsible for maintaining a sound system of internal control that supports the achievement of the Trust's strategic plans and objectives; and ensuring the continued effectiveness of the system. Through the system of internal control, the risks facing the Trust should be identified, assessed and addressed, to ensure that they do not jeopardise the delivery of the Trust's strategic and operational aims. As the accountable officer, the Chief Executive is required to make an annual statement on the effectiveness of the system of internal control. This statement, which accompanies the annual accounts, is based on a model that is set out by the Department of Health.

How the key financial ratios are calculated

EBITDA margin – This is the retained surplus for the year before taking into account interest, taxation, depreciation and amortisation. We have also excluded impairments charged to operating expenses as this does not reflect on the Trust's operational performance in the year. The value is determined by dividing the EBITDA value by the income for the year.

EBITDA percentage achieved – This is a comparison between the EBITDA margin achieved and that budgeted.

Return on Assets – This is calculated as the retained surplus / deficit for the year, adding back PDC dividends payable and impairments charged to operating expenses, and then dividing the value by the total assets employed as shown on the SOFP.

Income and expenditure surplus margin - This is calculated as the retained surplus / deficit for the year, adding back impairments charged to operating expenses, and then dividing the value by the income received for the year.

Liquidity ratio – This is the net current assets/liabilities value divided by the costs for the year after taking into account a working capital facility that foundation trusts would have available to them.

Glossary of accounting terms

Accruals accounting – This is an accounting concept. In addition to payments and receipts of cash, adjustment is made for outstanding payments, debts to be collected and stock. This means that the accounts show all of the income and expenditure that related to the financial year.

Accrual – an estimate of an amount the Trust will owe at some point in the near future. Accruals mainly relate to goods or services received but not invoiced.

Amortisation – this is the depreciation of intangible assets.

Asset - An item that has a value in the future. For example, a debtor (someone who owes money) is an asset as they will in future pay. A building is an asset because it houses activity that will provide a future income stream.

Audit **-** The process of validation of the accuracy, completeness and adequacy of disclosure of financial records.

Average relevant net assets - Average relevant net assets are normally found by adding the opening and closing balances for the year and dividing by two. Balances consist of the total capital and reserves (total assets employed) less donated asset reserve less cash balances in Government Banking System accounts. This is used to calculate the Capital Cost Absorption Rate.

Capital - Land, buildings, equipment and other long-term assets owned by the Trust, the cost of which exceeds £5,000 and has an expected life of more than one year.

Capital Resource Limit - A control set by the Department of Health onto NHS organisations to limit the level of capital expenditure that may be incurred in year.

Contingent liability – this is an amount which could become payable but it is more than likely that no payment will be made. The payment will depend on certain events occurring. Such liabilities are included to reflect any potential liabilities the Trust might face.

External Financing Limit (EFL) – this is a fundamental element of the NHS Trusts financial regime. It is cash based public control set by the Department of Health. It represents the excess of its approved level of capital spending over the cash a Trust can generate internally (mainly surpluses and depreciation) essentially controlling the amount of "externally" generated funding.

Lease – an arrangement between parties to use assets for a set length of time.

Impairment – the reduction in the value of an asset.

Intangible – an asset with no separate physical substance (i.e. computer data).

Payable – an amount owed by the Trust which is known with certainty.

Prepayment – a payment made which relates to the following financial year.

Provisions – these are amounts which are likely to become payable by the Trust but this has not been confirmed.

Public Dividend Capital (PDC) – At the formation of NHS trusts, assets (land buildings, equipment and working capital) transferred to the new trusts. The value of these assets is in effect the public's equity stake in the trust and is known as Public Dividend Capital (PDC). It is similar to company share capital and as with company shares, a dividend is payable to the Department of Health. Each year the Trust makes a dividend payment calculated at 3.5% of forecast net relevant assets.

Receivable – an amount due to the Trust which is known with certainty.

Annex 1

Statement on Internal Control 2010-11

Section 1 - Scope of responsibility

> The Board is accountable for internal control. As Accountable Officer, and Chief Executive of this Board, I have responsibility for maintaining a sound system of internal control that supports the achievement of the organisation's policies, aims and objectives. I also have responsibility for safeguarding the public funds and the organisation's assets for which I am personally responsible as set out in the Accountable Officer Memorandum.

The Trust's Risk Management Strategy states that the Chief Executive is ultimately responsible for effective risk management within the Trust. At an operational level, this task has been delegated to the Director of Nursing, Midwifery & Allied Health Professions. Day to day responsibility for risk management has been delegated to senior managers.

Delivery of these responsibilities is scrutinised by the Trust's non-executive directors, through meetings of the Trust Board. This scrutiny role is supported by the Trust's sub-committees and working groups. Minutes and reports from these committees are reviewed in the Trust Board meetings, which are held in public. The work of the committees and the decisions of the Trust Board provide evidence of the ongoing efforts to ensure that the overall governance, risk management and clinical governance systems are operating as they are supposed to.

The Trust is part of a local and national health economy. Accountability extends not only to Government, but also to partner organisations and to patients and service users. In recognition, our planning and key objectives reflect the strong focus that is now placed on improved and expanded partnership working.

The Chief Executive and the Trust's executive directors are accountable to the NHS South West (SHA) for performance and control issues. The SHA hosts monthly meetings for chief executives and finance directors where generic and community wide issues of control are discussed and actions agreed. In addition, we have regular meetings with senior officers, patients and other interested parties across the local health community, including:

- regular meetings with the Chief Executive and Directors of the SHA;
- monthly performance monitoring meeting with the SHA and NHS Cornwall and Isles of Scilly (the PCT);
- joint meetings with Cornwall health and social care providers;
- regular meetings with the Chief Executive and directors of the PCT;
- regular meetings with service users' representative groups, including the patient ambassadors through the Local Involvement Network (LInK) and a Patient and Public Involvement (PPI) Steering Group; and
- regular attendance at the Health and Adult Social Care Overview Scrutiny Committee meetings.

Section 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 organisation's policies, aims and objectives; and
- 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 2011 and up to the date of approval of the annual report and accounts.

Section 3 - Capacity to handle risk

The Trust's Risk Management Strategy was updated in November 2010 and the requirements for reporting risks, definitions of risks, as well as the reporting process and the lines of accountability have been incorporated into the Strategy. The Strategy highlights the reporting structure for individuals as well as committees. The Strategy describes the scoring system for assessing the severity of the risk facing the Trust and the mechanisms for ensuring that the Trust Board maintains its focus on the most critical risks.

Much work has been undertaken to ensure that the Risk Management Strategy is fully up to date and that it reflects current priorities. The requirements for reporting risks, definitions of risks, as well as the reporting process and the lines of accountability have been incorporated. The Risk Management Strategy is available to all staff through the Trust's website in the documents library. The Risk Management Strategy states that all staff are responsible for managing risks. All staff are provided with risk management training as part of their induction process.

All staff are informed of the need to report incidents, via the Trust's intranet incident reporting facility, and to disseminate experience and learn from incidents. The Trust adopts the regulations for managing complaints, concerns, comments and compliments. The Trust also utilises improved incident reporting arrangements, including quarterly Complaints, Litigation, Incidents and PALS (CLIP) reports, which provide an analysis of incidents and identify action plans for addressing weaknesses identified. The reports are produced for each clinical division and for the Trust as a whole.

Section 4 - The risk and control framework

The Trust's Risk Management Strategy was approved by the Board in 2007 and has been reviewed and updated annually since. The updated Strategy was discussed at the Audit Committee in September 2010 and it was approved by the Board in November 2010.

The strategy:

- defines the Trust's attitude to risk;
- defines unacceptable and acceptable risk;
- recognises the legal basis of requirements for risk assessment and risk management;
- describes the design of the Trust's risk scoring approach;
- describes the function of the assurance framework and risk registers;
- identifies the roles and responsibilities, for risk management, of non executive and executive directors, management and staff; and
- describes the structure of assurance, delivered through the working groups and committees of the Trust Board.

The Risk Committee is a sub-committee of the Governance Committee and its purpose is to direct the Trust's response to the management of all areas of risk and to ensure that all elements of the Risk Management Strategy are addressed within available resources. This includes management of risk in relation to the achievement of the Trust's corporate objectives and the Assurance Framework. The Committee is chaired by the Lead Director for Clinical Risk (Director of Nursing, Midwifery and Allied Health Professions) and its membership also comprises the Lead Director for Corporate Risk (Director of Finance) and other key senior managers.

4.1. Context for risk management

Risks are identified across all functions of the Trust's activity, including clinical, support services, corporate and administrative functions. Risks are not limited to insurance and health and safety issues, but include risks of non-delivery of key targets and operational objectives. The risk registers and assurance framework take account of the Trust's relationship with other NHS organisations and with patients and the public. The annual planning cycle, at all levels of the Trust, includes the requirement for specialty, divisional and departmental plans to identify and assess the risks and assurances associated with each of the key objectives identified. These risks and assurances are required to be incorporated into the relevant risk assurance registers. The profile of risk management has been revised enabling the Trust to understand the importance of risks.

All risks that are identified are assessed, for likelihood of occurrence and scale of impact should the risk occur. The assessment process uses a risk scoring system, which is defined in the Risk Management Strategy. The Trust has also designed a more detailed five-point classification of the likelihood and impact of a range of risk types, to help guide managers in determining the consequence and likelihood scores. Each risk that is recorded in the risk register is assigned to a named individual. Risks that are considered to be significant, but which cannot be addressed at the level where they are identified, are passed up to the next level of management. The highest level risks, with the most significant potential impact on the Trust, are incorporated into the Assurance Framework.

The risk registers, including the Corporate Risk Registers and Assurance Framework identify the actions planned to address the risks identified and an assessment of the likely residual risk. Risks are monitored at all levels of the Trust. Specialty and departmental risk registers are reviewed at group meetings. Locally, high level risks are discussed with executive directors at monthly meetings as part of regular assurance framework review.

4.2. Risks to data security

The Trust's overall arrangements for managing data security lie within the responsibilities of the Director of Health Informatics and ICT Services. Where key data security risks arise, they are recorded on the directorate risk assurance register and addressed as part of the overall risk assurance management processes. The Trust's annual self assessment declaration, in the information governance toolkit, indicates that it maintains a high level of security over information and data security.

4.3. Board Assurance Framework and links to the Statement on Internal Control

The Assurance Framework has been developed against the six Strategic and Principal Objectives for 2010 -11. The framework forms part of the Trust's risk management agenda and brings together the strategic priorities and objectives of the organisation to assure the Board that any risks that may jeopardise the achievement of the objectives are identified and effectively managed.

The Assurance Framework is a key source of assurance when preparing the Statement on Internal Control.

The Audit Committee plays a key role in providing the Board with the assurance it requires, with particular focus on the effectiveness of the Trust's internal control system. The Audit Committee reports regularly to the Board.

In March 2010 the Trust finalised its strategic plan for 2010 to 2014. This strategy builds on the Trust's current objectives which are reflected in the Assurance Framework in place during 2010/11. The Assurance Framework will be revisited in early 2011/12 to ensure that this reflects and supports any revision to Strategic Objectives.

4.4. Relationship with external stakeholders

Externally the Trust participates with key stakeholders, primarily the PCT, to ensure contract performance and related risks are effectively managed. The PCT performance manages the Trust in the areas of quality, access, finance and human resources through a monthly performance review also involving the SHA. The detailed monitoring and analysis of the contract is undertaken by the Technical Working Group (TWG).

In addition, the Trust works closely with partners in health and social care through the Quality, Innovation, Productivity and Prevention (QIPP) Programme and other workstreams e.g. the development of Health and Social Care Hubs and Whole Systems Resilience Network (WSRN).

In addition to the performance management arrangements set out above the PCT and Trust have established a joint strategic group which includes clinical and managerial senior leaders from both organisations to deliver whole system changes across the county. The Trust is also a member of the newly established Public Sector Group for Cornwall including leaders from all public sector bodies in the county.

4.5. Compliance with NHS Pension Scheme Regulations

As an employer with staff entitled to membership of the NHS Pension Scheme, control measures are in place to ensure all employer obligations contained within the Scheme Regulations are complied with. This includes ensuring that deductions from salary, employer's contributions and payments in to the Scheme are in accordance with the Scheme Rules, and that Trust member Pension Scheme Records are accurately updated in accordance with the timescales detailed in the Regulations. The Trust is satisfied that pension deduction and calculations are made in accordance with regulations.

4.6. *Compliance with equality, diversity and human rights legislation*

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

4.7. Compliance with Climate Change Adaptation reporting to meet the requirements under the Climate Change Act 2008

The Trust has Carbon Reduction Delivery Plans in place in accordance with emergency preparedness and civil contingency requirements, as based on UKCIP 2009 weather projects, to ensure that this organisation's obligations under the Climate Change Act and the Adaptation Reporting requirements are complied with. Additionally, Climate Change Risk Assessments will

be produced and regularly maintained in line with the NHS Reporting on Sustainability Framework.

4.8. Compliance with Care Quality Commission (CQC) – essential standards of quality and safety

The Trust is fully compliant with CQC essential standards of quality and safety, however, a risk to the Trust's compliance has been identified in May 2011. A structured action plan was put in place to address these issues within 28 days. The Trust is working closely with the Strategic Health Authority and Primary Care Trust on the implementation of this plan.

4.9. Gaps in assurance and control – Assurance Framework

The Assurance Framework sets out the Trust's objectives for 2010/11 and the controls in place to deliver these objectives. It is inevitable that work is continually ongoing to deliver the Trust's objectives as they are often cross-cutting in nature and medium or long term aims.

Whilst every effort is made to ensure that systems of internal control are in place and work effectively throughout the whole year, there are instances where controls are not fully effective and these may result in the Trust not being able to obtain the required level of assurance. The Trust is required to set out those gaps in control and assurance in this statement and confirm that action is being, or has been taken, to improve the control environment.

The key gaps in control or assurance which have been recognised in relation to the following area as at 31 March 2011 have been noted below, together with a brief description of the action required.

Risk area	**Gaps in control and/or assurance**	**Action required**
Non achievement of the 2010 -11 Clinical Site Development Plans (CSDP)	Lack of robust business cases and assurance	Robust business cases to be developed in advance of spends
Enabling new patterns of healthcare services	Not engaged as a result of Primary Care Trust (PCT) decisions re organisational form	Continued engagement on service integration and developing partnership working
Non delivery of Service Improvement Plans (SIP) for the required productivity and efficiency savings	Failure to develop medium term plans during 2010-11 and delivery of SIP/QIPP(Quality, Innovation, Productivity and Prevention)	Development of further options to meet the agreed control total. Need to establish an early process for developing Trust specific plans for 11/12 to 13/14.
Impact of CSDP on financial position of Trust does not deliver sufficient SIP benefit to mitigate revenue consequences of capital investment	Need to integrate the CSDP with SIP programme office to get integrated service development plan.	Executive team managing processes through newly appointed SIP programme Director
Lack of or poor financial support to the Trust's Managers and Clinicians	Comprehensive Financial Skills Development Programme. Finance Charter. Robust Performance	Attendance at a Finance Skills Programme and a formally documented and minuted performance review process

	Management and accountability framework in place.	established

The Assurance Framework is a live document and is regularly updated and changed. In 2011/12 the Assurance Framework will be updated to reflect the Trust's revised business objectives.

No other gaps in control or assurance have been identified which are not already reflected above or in section 6 of this statement.

4.10. Gaps in control highlighted in the Head of Internal Audit Opinion

Internal Audit is a key source of assurance on the sound operation of the Trust's internal controls.

The independent Head of Internal Audit's opinion for 2010/11 provided significant assurance that a generally sound system of internal control was in place and that this was designed to meet the organisation's objectives and the controls within it were generally being applied consistently.

4.11. Gaps in control – Scheme of delegation

In 2009-10, the Trust's auditors identified a weakness in the alignment between the Trust's ordering system for goods and services and the Trust's Scheme of Delegation. This was been addressed during 2010-11 and the controls improved. The Audit Committee received updates on this gap in control during the year. Nonetheless, a gap existed in controls for part of 2010-11. Audit testing has not identified any issues in respect of inappropriate items of expenditure. The Trust will continue to review the controls around expenditure to ensure that the control environment operates effectively.

Section 5 - Review of effectiveness

As Accountable Officer, I have responsibility for reviewing the effectiveness of the system of internal control. My review is informed in a number of ways. The Head of Internal Audit provides me with an opinion on the overall arrangements for gaining assurance through the Assurance Framework and on the controls reviewed as part of the internal audit work. Executive managers within the organisation who have responsibility for the development and maintenance of the system of internal control provide me with assurance. The integrated performance report to the Trust Board that measures the Trust performance against quality and safety, finance, local and national targets and our workforce provides me with assurance. The Assurance Framework itself provides me with evidence that the effectiveness of controls that manage the risks to the organisation achieving its principal objectives have been reviewed. My review is also informed by:

- consideration of conclusions formed by the Care Quality Commission during the year;
- consideration of the actions taken to address the issuers highlighted in the previous (2009/10) Statement of Internal Control.
- I have been advised for my review of the effectiveness of the system of internal control by the Board, Audit Committee, Governance Committee, Remuneration Committee and Executive Management Board. A plan to address weaknesses and ensure continuous improvement of the system is in place. A summary of the key actions is shown at the end of this Statement.

5.1. Process for maintaining and reviewing effectiveness of the system of internal control

The Board is engaged in reviewing internal control and risk management arrangements. This is achieved through the review of the Assurance Framework and the consideration of matters brought to its attention by the Governance Committee and the Audit Committee. Additionally, significant internal control issues continue to be reported to the Chief Executive immediately, and to the Trust Board at the earliest opportunity.

The Audit Committee is responsible for considering the systems and standards of internal control within the Trust, including control of securing economy, efficiency and effectiveness. The Committee's focus includes:

- independently and objectively monitoring, reviewing and reporting to the Trust Board on the processes of internal control across the whole of the organisation's activities.
- reviewing and approving all risk and control related disclosure statements, in particular the Statement on Internal Control (SIC) and the Head of Internal Audit Opinion, prior to endorsement by the Board
- considering the integrity, completeness and clarity of annual accounts and the risks and controls around its management.
- reviewing the work of other Committees whose work can provide relevant assurance.
- requesting and reviewing reports and positive assurances from Directors and Managers on the overall arrangements for internal controls.

The Governance Committee is responsible for rigorously keeping under review all aspects of the Trust's clinical and corporate governance. This includes, in particular, ensuring that the Trust meets all its duties and obligations under the NHS Constitution; plus all other statutory, regulatory, and best practice requirements by which it is bound as a public body and for whose good implementation it is accountable to the people and community of Cornwall. It especially includes all aspects of the risk management process regarding clinical, quality, and safety; and obtaining assurance on all aspects of the Trust's declarations. The Committee's focus includes:

- supporting the Audit Committee's role on scrutinising the effectiveness of compliance mechanisms within the Trust.
- overseeing the delivery of an integrated governance structure for the Trust
- assuring the Board on the implementation and effectiveness of governance and quality arrangements within the Trust.
- the operation of the Board's assurance framework for the management of its principal risks; and the structures, processes and responsibilities for identifying and the managing key risks facing the Trust
- confirming policies for ensuring that there is compliance with relevant regulatory, legal and code of conduct requirements and other relevant guidance
- obtaining assurance on the Trust's registration with the Care Quality Commission.

The Remuneration Committee determines appropriate remuneration and terms of service for the Chief Executive, Executive Board Directors, very senior staff managers, and staff on local terms and conditions. The committee also, following advice from the Chief Executive, evaluates corporate and individual performance of executive directors and oversees appropriate contractual arrangements for such staff.

The Executive Management Board provides executive responsibility to ensure that the Trust's services meet required performance, organisational and governance standards and to develop for Board approval the strategic plans of the Trust. The responsibilities of the Executive Management Board include strategy, quality and safety, performance, finance and workforce.

In 2010-11 the Audit Commission did not raise any specific concerns in relation to internal control arrangements.

Section 6 - Significant control issues

A single definition of a "significant internal control issue" is not possible. NHS organisations will need to exercise judgement in deciding whether or not a particular issue should be regarded as falling into this category. This section sets out the significant control issues that have arisen during 2010/11.

6.1. Significant control issues identified through the work of Internal Audit

The Head of Internal Audit opinion for 2010/11 has been received. This states that significant assurance can be given that there is a sound system of internal control which is designed to meet the organisation's objectives and that controls are being consistently applied in all the areas reviewed. No significant control issues were identified during 2010/11.

6.2. Significant control issues identified through the work of external auditors and regulators

No significant control issues have been brought to the attention of the Trust by its external auditors or other regulators.

6.3. Serious Untoward Incidents (SUIs)

Two serious untoward incidents regarding loss of data have occurred in 2010/11 which need to be reflected in this statement:

Reference SI 2010 – 12293 : Breach of Confidentiality
This was managed through to a conclusion within RCHT and signed off by the PCT in March 2011.

Reference SI 2011 - 3230 : Disclosure incidents
This incident was investigated in line with standing Serious Incident (SI) procedures and the Information Commissioner's Office (ICO) was informed.

The ICO has replied (March 2011) and a declaration signed by the RCHT Chief Executive to agree to take the required actions.

Both of these were managed through the Information Risk Management Group which reports to the Information Governance Committee.

6.4 Non-compliance with 18 week referral to treatment targets

The Trust monitors its performance against the target to treat patients within 18 weeks of referral in each Integrated Performance Report.

Whilst national performance monitoring of the 18 week target has now been removed, it remains an entitlement under the NHS Constitution and is in the Trust's 2010-11 contract with NHS Cornwall and Isles of Scilly. Performance against this target remains critical to the Trust.

Performance on the admitted pathway remains significantly off target at 31 March 2011 with a year to date achievement of 77.3% against a target of 90%.

The Trust recognises the importance of reducing waiting times for patients and reduction in waiting lists remains a critical focus for service improvement. The Trust is developing plans to guarantee compliance in 2011-12.

6.5 Theatre Safety Checklists

During a visit by the Care Quality Commission in May 2011 the Commission observed that there was not consistent and proper compliance with safety checklists recommended by the World Health Organisation and the National Patient Safety Agency in all of the Trust's operating theatres. The Trust recognises that this is a risk to its compliance and has put in place a structured action plan to ensure that there is one single checklist consistently used in every one of our Theatres and this action plan will be implemented within the next 28 days.

Section 7 - Conclusion

I am satisfied that appropriate systems of internal control are in place as at 31 March 2011 and up to the date of the approval of the annual report and accounts.

I believe the Trust has made good progress in improving the internal control environment and action plans are in place to ensure that any weaknesses identified are being addressed. The further strengthening of the systems of internal control will provide a sound basis for the Trust's application for Foundation Trust status.

Peter Colclough, Chief Executive
Royal Cornwall Hospitals NHS Trust

6 June 2011

Annex 2

INDEPENDENT AUDITOR'S REPORT TO THE DIRECTORS OF ROYAL CORNWALL HOSPITALS NHS TRUST

I have audited the financial statements of Royal Cornwall Hospitals NHS Trust for the year ended 31 March 2011 under the Audit Commission Act 1998. The financial statements comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers' Equity, the Statement of Cash Flows and the related notes. These financial statements have been prepared under the accounting policies set out in the Statement of Accounting Policies.

I have also audited the information in the Remuneration Report that is subject to audit, being:

- the table of salaries and allowances of senior managers [and related narrative notes] in annex 1 and
- the table of pension benefits of senior managers [and related narrative notes] in annex 1.

This report is made solely to the Board of Directors of Royal Cornwall Hospitals NHS Trust in accordance with Part II of the Audit Commission Act 1998 and for no other purpose, as set out in paragraph 45 of the Statement of Responsibilities of Auditors and Audited Bodies published by the Audit Commission in March 2010.

Respective responsibilities of Directors and auditor

As explained more fully in the Statement of Directors' Responsibilities, the Directors are responsible for the preparation of the financial statements and for being satisfied that they give a true and fair view. My responsibility is to audit the accounting statements in accordance with applicable law and International Standards on Auditing (UK and Ireland). Those standards require me to comply with the Auditing Practice's Board's Ethical Standards for Auditors.

Scope of the audit of the financial statements

An audit involves obtaining evidence about the amounts and disclosures in the financial statements sufficient to give reasonable assurance that the financial statements are free from material misstatement, whether caused by fraud or error. This includes an assessment of: whether the accounting policies are appropriate to the Trust's circumstances and have been consistently applied and adequately disclosed; the reasonableness of significant accounting estimates made by the Trust; and the overall presentation of the financial statements. I read all the information in the annual report to identify material inconsistencies with the audited financial statements. If I become aware of any apparent material misstatements or inconsistencies I consider the implications for my report.

Opinion on financial statements

In my opinion the financial statements:

- give a true and fair view of the state of Royal Cornwall Hospitals NHS Trust's affairs as at 31 March 2011 and of its income and expenditure for the year then ended; and
- have been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England.

Opinion on other matters

In my opinion:
- the part of the Remuneration Report to be audited subject to audit has been properly prepared in accordance with the accounting policies directed by the Secretary of State with the consent of the Treasury as relevant to the National Health Service in England; and
- the information given in the Annual Report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Conclusion on audited bodies' the Trust's arrangements for securing economy, efficiency and effectiveness in the use of resources

Trust's responsibilities

The Trust is responsible for putting in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources, to ensure proper stewardship and governance, and to review regularly the adequacy and effectiveness of these arrangements.

Auditor's responsibilities

I am required under Section 5 of the Audit Commission Act 1998 to satisfy myself that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. The Code of Audit Practice issued by the Audit Commission requires me to report to you my conclusion relating to proper arrangements, having regard to relevant criteria specified by the Audit Commission.

I report if significant matters have come to my attention which prevent me from concluding that the Trust has put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources. I am not required to consider, nor have I considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

Basis for qualified conclusion

I have undertaken my audit in accordance with the Code of Audit Practice, having regard to the guidance on the specified criteria, published by the Audit Commission in October 2010, as to whether the Trust has proper arrangements for:

- securing financial resilience; and
- challenging how it secures economy, efficiency and effectiveness.

The Audit Commission has determined these two criteria as those necessary for me to consider under the Code of Audit Practice in satisfying myself whether the Trust put in place proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2011.

I planned my work in accordance with the Code of Audit Practice. Based on my risk assessment, I undertook such work as I considered necessary to form a view on whether, in all significant respects, the *Trust* had put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In considering the Trust's arrangements for financial planning securing financial resilience, I identified that the medium-term financial strategy assumes that the Trust's debt with the Department of Health, which was £24.460m at 31 March 2011, will be re-scheduled over a 15 year period.

This is a planning assumption supported by the Strategic Health Authority and submitted to the Department of Health. However this has not been formally agreed by the Department and the Treasury.

Qualified Conclusion

On the basis of my work, having regard to the guidance on the specified criteria published by the Audit Commission in October 2010, with the exception of the matter reported in the basis for qualified conclusion paragraph above, I am satisfied that, in all significant respects, Royal Cornwall Hospitals NHS Trust put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources for the year ending 31 March 2011.

Delay in certification of completion of the audit

I cannot formally conclude the audit and issue an audit certificate until I have completed the work necessary to provide assurance over the Trust's annual quality accounts. I am satisfied that this work does not have a material effect on the financial statements or on my value for money conclusion.

Alun Williams
District Auditor
3&4 Blenheim Court
Lustleigh Close
Matford Business Park
Exeter
EX2 8PW

8 June 2011