Royal Cornwall Hospitals NHS Trust

Annual Report & Accounts
2011 - 2012
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Summary Annual Review

2011-2012
Good afternoon ladies and gentleman and thank you very much indeed for joining us at today’s Annual General Meeting, which allows us to reflect on the positive development of the Trust during the financial year 1 April 2011 to 31 March 2012, and most recently for the first six months of this financial year 1 April 2012 to 31 March next year, 2013, which significantly marks the 21st anniversary of RCHT.

It is with enormous pleasure that I am able to confirm that further considerable progress has been made over the past 18 months, building upon the stable platforms that were being established in the years 2009/10 and 2010/11.

It goes without saying that more needs to be achieved before we attain the consistent standards of excellence to which we aspire. However, due particularly to the two big strides that we have taken forward both in operational performance and financial delivery, we have put ourselves into a position that the achievement of becoming licensed as a Foundation Trust in 2013 is more than an aspiration but, subject to further stringent examination over the coming months by the independent regulator, Monitor, a realistic and tangible expectation.

Such significant progress since the troubled days of just 48 months ago, is due to the unstinting hard work and dedication of all of our 4,700 staff. From Surgeons to Ward Sisters, from Physicians to Project Managers, from Cleaners to Consultants, from Specialty Leads to Secretaries etc etc, all of our staff have risen and excelled to the challenge of providing safer and better care to everyone of the 620,000 patient appointments and/or treatments that we have provided over the past 52 weeks.

Under the exceptional leadership of our Chief Executive, Lelzi Boswell and our Executive Directors, together with our senior clinicians and managers, our standards and consistency are daily improving - our performance expectations are now green, amber is considered failure, red is totally unacceptable. Momentum is increasing and confidence is growing - in other words this is an organisation that now firmly believes in a successful and independent future with the quality of its care and attitude to all its patients and staff, being the hallmark and the benchmark by which it would wish its reputation to be measured by.

The Board is not naive and understands the size of the challenges that we face and have to overcome. Higher standards delivered with lower income, higher staff morale with probably less staff on toughening terms and conditions, increasing public expectations and increased market competition than at any time in the 64 year history of the NHS.

Notwithstanding all of these challenges, RCHT and indeed Cornwall is probably as well placed as any organisation or any county to deliver success.

Our strength and Cornwall’s strength is the pride and stability of its workforce, reflected here at RCHT by its loyal staff which is indeed replicated throughout the health and social care sector in the county.

Coupled to that is both the desire and the need by all key Stakeholders to better integrate their services in order to improve the quality and efficiency of their work, to make patient pathways easier and closer to home wherever possible, and finally of course, to make every pound work harder and thus release more money for reinvestment into new equipment and facilities, together with innovative research and staff training and development.

In that regard the Trust has done very well indeed, delivering a bottom line surplus of £4.4million in 2011/12 whilst investing £9.75million into new state of the art equipment and facilities, the five most significant being:

- The expanded and upgraded Critical Care Unit at Treliske.
- The new Treatment Centre at West Cornwall Hospital.
- The new Interventional Radiology Suite & Newlyn Surgical Day Unit at Treliske.
- Re-provision of the Therapies Department at Treliske.
- Refurbishment of wards and departments.

That momentum has carried forward into this financial year 2012/13 with the following five key projects underway or scheduled at a cost of £12.45million:

Summary Annual Review 2011-12
The new True Beam Linear Accelerator at Treliske.

The new Laparoscopic Theatres at Treliske and West Cornwall Hospital.

The shortly to commence Phase 1 expansion and modernisation of the Emergency Department to Single Point of Access at Treliske.

The re-provision of the Ophthalmology Department at Treliske.

The creation of the Trelawny Wing Surgical Floor at Treliske.

Such substantial investment and progress allows us to state, with clarity and confidence, our vision for the future in our strategic document 'Our Plans 2012-2017', which I commend for consideration by all staff and stakeholders, as it clearly explains our objectives for the next five years.

In order to fully maximise the benefits of our substantial investments and strategic plans, it is essential that the clinical strategies of both the Commissioners and the Providers are fully aligned.

We were therefore delighted that Professor Sir Roger Boyle joined the Trust Board as a Non Executive Director last December, bringing with him his twelve years of experience as the national NHS Director of Heart Disease and Stroke and before as both a medical and operations Director of Acute Hospital Trusts.

Sir Roger's appointment coincided with the establishment of our new Clinical Cabinet which is tasked with bringing to the Board their recommendations for clinical improvements and the clinical strategy of the Trust going forward.

At the same time, the creation of the new GP led commissioning body - Kermo Clinical Commissioning Group (KCCG) - replacing the former Primary Care Trust, will further assist clinical alignment through the joint working of KCCG's Clinical Forum and our own Clinical Cabinet, with Sir Roger sitting on both together with our Medical Director, Dr Paul Upton.

I am confident that these three significant 'clinical' developments will prove to be a milestone in the better working and integration of the health system in Cornwall.

And finally, may I conclude by saying a number of very important thank you's -

- Thank you first and foremost, to all our skilled and dedicated Staff, our wonderful Volunteers and indeed my very hard working Board colleagues. Through all of their efforts, substantiated through external verification and from patient feedback, RCHT is now improving through 'Good' towards its ambition of 'Excellence'.

- Thank you to all our key Stakeholders, for their proactive involvement and constructive support.

- Thank you to all our Patients, their families and the people of Cornwall, for their huge generosity and support of our Phoenix Stroke Appeal in particular, together with all our other individual charities which they so readily support on an ongoing basis.

- And finally a warm welcome and thank you to all our new Public, Staff and Stakeholder Members for joining and expressing their active support for the future of our Royal Cornwall Hospitals as we progress to Foundation Trust status and appoint our 20 strong Council of Governors.

Working together with the common aim of consistently trying to improve patient care, is the worthwhile purpose that binds us all together, and on behalf of the Trust may I thank you all.

Onwards and upwards.

Martin Watts
Chairman
A Year in highlights

- Faster access to surgery as waiting times are reduced to among some of the shortest in the NHS South region.

- Patient experience improves as dignity champions take the lead and same sex accommodation breaches are wiped out.

- Infection prevention efforts are underlined with no cases of MRSA bloodstream infection during 2011-12 and none reported since November 2010.

- Better care for stroke patients as national targets are reached for the first time.

- Safer care as pre-operative checklists are reinforced and targets for assessing patients to reduce their risk of venous thrombo-embolism are met.

- Unconditional registration with the Care Quality Commission maintained along with ‘performing status’ against Department of Health national measures.

- Application for Foundation Trust status begins and more than 8,000 staff and patients sign up as members.

- Financial targets met and a year end surplus of £4.4 million achieved.

- 27 of the projects in the first phase of the Clinical Site Development Programme of building works and new equipment installations are completed.

- 31 individuals and teams recognised in the ‘Extra Mile’ Excellence and Innovation Awards

- The Phoenix Stroke Appeal launched to raise funds to provide ‘gold standard’ care for stroke patients in hospital and in the community.

- Successful partnerships with the Leagues of Friends enable major schemes of improvement.

- 27 of the projects in the first phase of the Clinical Site Development Programme of building works and new equipment installations are completed.

Mike Frost and Garth Weaver represent the Capital Planning Team – winners of the Chairman and Chief Executive’s Award at the 2012 Extra Mile Excellence and Innovation Awards.
Becoming hospitals of choice

Our hospitals are fully accredited with the Care Quality Commission and also have a seal of approval from the 9 out of 10 patients who rated their overall experience as excellent, very good or good in the most recent national survey of inpatients.

Improving quality and safety

Our hospitals provide care for well over 100,000 inpatient and day case patients each year. The nature of their treatment ranges from the relatively straightforward to those with critical and complex conditions, frequently made more so by other underlying medical problems. When compared to other hospitals our outcomes and survival rates are among the top 25% in the UK.

A hand hygiene campaign supports our commitment to infection prevention.

Reducing the risk of infection is essential to offering high quality care. We met our targets for reducing cases of clostridium difficile and MRSA bloodstream infections, with no cases of MRSA bloodstream infection for well over a year.

During the year we re-launched our commitment to the World Health Organisation safety checklists, designed to cut out avoidable risks during surgery and invasive procedures, and have reinforced processes for learning from untoward incidents.

Timely access to emergency care is a further measure of quality care. Waiting time targets in our emergency departments and for patients referred with suspected cancer were met.

Alongside this there was major improvement in the percentage of stroke patients spending at least 90% of their time in a specialist stroke unit, rising to 83% over the year, exceeding the national target. Assessment of patients for risk of potentially life-threatening venous thrombo-embolism too, met the latest national standards.

Rapid access to head scans are key to stroke diagnosis and treatment

Many services have also been independently reviewed through national audit and quality assurance assessments. Among those recognised for high standards and examples of good practice were our breast screening and lung cancer teams. As part of the national review of emergency services, our emergency department achieved designation as a trauma unit.

Summary Annual Review 2011-12
Access to services

Our patients expect to have easy access to services when they need them, to have services close to home wherever possible and to know that their treatment pathway will run smoothly.

Over the last year we have made significant improvements in waiting times, increasing our activity to provide treatment for a large number of patients who had waited longer than the 18 week commitment in the NHS Constitution. The largest of these was in orthopaedics where around a third of patients were waiting longer than 18 weeks was reduced to less than 5 percent, including those choosing to wait longer for personal reasons.

Overall we now have among the shortest waiting times in the NHS South region and innovations such as our accelerated hip and knee service, providing fast-track treatment for low risk patients, are leading the way for future models of care. Added to this, further expansion of pre-operative assessment clinics, direct admission to theatre on the day of surgery and enhanced recovery programmes which allow better prepared and informed patients to go home sooner, are offering better care to our patients.

Providing more services at peripheral locations has also been a key objective. A new treatment centre at West Cornwall Hospital, together with a new integrated laparoscopic theatre has presented the opportunity to expand the range and volume of services on offer in the west of the county.

Privacy and dignity

Being cared for in accommodation with other patients of the same sex is important to many of our patients. This is something we have worked hard on in the last year to the extent that same sex accommodation breaches have been wiped out, other than in situations where critical or highly specialist treatment needs are greater than the need for a single sex ward area.

Improving care for patients with dementia has also been a key focus. Our network of dementia champions are trained to provide advice and support for colleagues in meeting individual needs.
What our patients say

Eighty-nine percent of RCHT patients responding to the national inpatient survey rated their overall care as excellent, very good or good. Alongside this we received 5980 letters or expressions of thanks. The majority of patients recording their views on the NHS Choices website said they would recommend our hospitals.

Set against the context of more than 620,000 patient contacts, during the year we received 382 complaints. It is always our aim to learn from any experience that does not live up to our patients’ expectations and each complaint is thoroughly investigated, action plans for improvement put in place and followed-up. Five complaints were referred to the Health Service Ombudsman and of these one was upheld.

During 2012-13 we intend to increase the channels for feedback through the adoption and local adaptation of the Patients Association CARE campaign, allowing us to refocus on the fundamental aspects of patient care.

- Our CARE campaign, launched in partnership with the Patient’s Association
Building for the future

By the end of 2011-12 we had completed 27 of the developments from the first phase of our clinical site development plan, having invested over £28.4 million in new equipment and building projects. These represent a key part of our strategy, ‘Our Plans 2010-14’, allowing us to achieve our aim to provide better, safer, good value care.

Completed projects include:

- Relocation of the therapies department to new facilities in the Princess Alexandra Wing.
- The first interventional radiology suite of its kind in the south west, allowing the expansion of complex and delicate surgical procedures, including treatment for repair of abdominal aneurysms.

- A redesigned and expanded critical care unit, bringing together intensive care and high dependency care.

- £3.5 million of developments at West Cornwall Hospital since beginning our clinical site development programme, including a new treatment centre and refurbished and enlarged renal unit.

- Major advances in clinical imaging including a new digital x-ray suite at St Michael’s Hospital and the latest imaging equipment for oral surgery.

- Investment in modern IT systems has a vital role to play in the development of better and safer services. Advances such as real time bed management, a new patient administration system for the emergency department and improved data quality help our staff provide safer care, whilst the move towards paperless environments in our critical care and sexual health services is leading the way in more efficient record keeping.

The clinical site development plan continues as we move in 2012-13 with the next phase of projects to be completed including the arrival of a new linear accelerator for radiotherapy treatments and a suite of 5 integrated laparoscopic theatres.

As our plan moves forward in the coming years we will continue to establish our ‘hot’ and ‘cold’ hubs on our main site in Truro and increasingly move more routine care to locations both in the West and East of the county. We will reflect the changing face of NHS care where our acute hospitals will concentrate on the most specialist services, shrinking in size as ever more care becomes community and home based. A crucial influence on our plans will be the availability of capital funds. As Department of Health funding continues to fall, attainment of Foundation Trust status will open new opportunities to support future development of our estate.
- Our expert teams perform life-saving surgery in the Donald Gregory Interventional Radiology Suite

- Our surgeons take advantage of the latest in hi-tech laparoscopic theatres for keyhole surgery including green-lighting to reduce eye strain and voice-controlled equipment.
Launching our Foundation Trust application

The most important milestone of our year was the launch of our application for Foundation Trust status in June. This in itself acknowledged the significant improvement on historic performance in being able to meet the criteria for an application to be taken forward.

The transition to Foundation Trust status is seen as particularly important for RCHT. Through the standards that we will be required to meet it will:

- endorse high standards of care,
- show that we are responsive to the needs of our local community,
- allow us quicker and smarter local decision making,
- let us keep our surpluses to put back into patient care,
- give us the freedom to be innovative with the services we provide and
- help us to build better relationships with our staff and our community.

The support of local people is an essential part of our successful bid to become a Foundation Trust. By the end of March 2012 we had gained the support of over 3000 public members and with a number expressing interest in future elections to become Governors.

In February we had passed the first test of our application and it was sent on to the Department of Health for scrutiny before being put to the independent watchdog for NHS Foundation Trusts, Monitor, later in 2012. The expectation is for RCHT to achieve Foundation Trust status during 2013.
Committed to research and development

The growth of research within RCHT is bringing benefits for patients and new investment to develop local services. Patients have the opportunity to take advantage of the newest treatments in an environment of safety that affords them more personalised care and monitoring.

RCHT was the third biggest recruiter to new trials in England last year. The extra medical and nursing specialists this brings allow us to develop and expand services in their areas of interest, so that many more than those patients involved in research trials can benefit from their presence.

- RCHT is a partner in a new Peninsula-wide network with Quintiles which is set to bring more international research and investment to the Trust. Medical Director, Dr Paul Upton - pictured second from right – represented RCHT at the network’s launch.
Working towards financial stability

Reflecting the general economic climate, as a public service we have to ensure we make the very best use of the resources available to us in order that we can meet our efficiency and savings targets and fulfil our obligations to repaying historic debt.

By the end of the year the considerable efforts of our staff had made it possible to deliver savings of £19 million and to achieve a surplus of £4.4 million.

Among the initiatives making this possible were:

- reducing the time patients are in hospital with more efficient care pathways and better infection prevention and control;
- savings made in our drug bill;
- securing lower prices through standardisation of ‘every day’ products;
- reducing energy bills by installing solar, biomass and other green technologies

Looking ahead our financial stability will be critical to a successful bid for foundation trust status and we will have to be responsive to changes in the way our services are commissioned as the new GP-led commissioning groups are established.

Our full accounts and financial statements can be found on our website at: www.rcht.nhs.uk/annualreport11_12
Caring today, caring for our tomorrow

Caring for the community where you work is no longer seen as optional by successful businesses. Hand in hand with our commitment to better, safer care, we want to contribute to our environment as well, which in turn will support the wellbeing of our patients and local people.

We have invested in energy efficient lighting and are committed to recycling more, throwing away less and using less water. A network of staff volunteers are helping us as ‘environmental champions’ in their areas of work, looking out for ways of cutting waste and saving energy.

Over the last 3 calendar years our carbon emissions for gas and electricity use have reduced by 28 percent. Our use of renewal energy sources has also increased and during 2011 accounted for 9 percent of total energy consumed.

We have also focused on reducing waste and we are now recycling over 32 percent of our waste materials.
Vital statistics

We offer services from our three hospitals:

Royal Cornwall Hospital, Truro
St Michael’s Hospital, Hayle
West Cornwall Hospital, Penzance

...as well as outpatient clinics at community hospitals across Cornwall and the Isles of Scilly and maternity services at Penrice Hospital in St Austell and Helston Community Hospital.

During 2011-12 we provided care and treatment for:

- 478,717 outpatient appointments
- 13,035 planned inpatients
- 53,481 day case patients
- 72,618 emergency and casualty department attendances

With 4,690 employees our skilled and highly professional workforce is one of the largest in Cornwall.

Our annual turnover is £314 million.

We recruited over 1700 people to clinical trials and were actively involved in more than 300 research projects and clinical trials.

We have been recognised as one of the leading providers of apprenticeships in Cornwall.

The proportion of energy we get from sustainable sources has grown from 2% in 2009 to 9% in 2011.
Working together

Our Apprenticeships programme has been recognised for quality

Our staff

We have continued to work on the cultural change needed to improve morale and sense of value among our workforce. This is being led through recognition of achievement and expanding and making more accessible the range of opportunities for personal development. The second year of our ‘Extra Mile’ Excellence and Innovation Awards showcased a wealth of talent and innovation.

The Trust received recognition for its Apprenticeships programme and the beginnings of our aim to provide a better work/life balance were acknowledged with the bronze Healthy Workplace award. This latter initiative will be an important aspect in further reducing sickness absence levels which averaged at 4.4 percent during 2011-12.

Increasing staff engagement is a top priority for 2012-13 with a programme of developments to improve communication and involvement of staff at all levels being seen as fundamental to RCHTs future success.
Partnerships and integration

At a time of major reform in the NHS we have been working closely with the evolving Kernow Clinical Commissioning Group which will take on the role of commissioning services from 2013. At the same time we have sustained our relationship with NHS Cornwall and Isles of Scilly to ensure we meet agreed improvements and efficiencies in the delivery of our services and continue to work closely with primary care and ambulance services to improve patient flow.

We also have key partnerships with adult and social care services and continue to work closely with community care providers on the evolution of better integrated health and social care services. In the long term these will lead to more care being provided close to, or at home, with a consequential reduction in bed numbers at RCHT hospitals, allowing us to concentrate expertise on complex care and specialist acute services.

Other relationships with bodies including our Leagues of Hospital Friends, the Health and Adults Overview and Scrutiny Committees, the Local Involvement Networks (to become Health Watch), and other patient support groups and community forums, will continue to be key part of our ongoing engagement programme.

- A partnership with Lloydspharmacy has improved services for outpatients at the Royal Cornwall Hospital needing to collect prescriptions before going home.

- Our partnership with SmokeFree South West led to re-affirmation of our commitment to our sites being entirely smoke free.

- One of the most significant partnerships of the year has been with our Leagues of Friends, BBC Radio Cornwall and our colleagues in wider NHS Community who have supported our Phoenix Stroke Appeal. The Appeal was launched in June 2011 to raise £500,000 towards the aim of providing 'gold standard' stroke services for people in Cornwall and the Isles of Scilly. By the end of March 2012 the appeal total had reached £235,425 and patients were already benefiting from investment in new equipment. For more information or to support the Phoenix Stroke Appeal, visit www.rcht.nhs.uk/phoenixstrokeappeal
Our Trust Board
During the second half of 2011-12 Lezli Boswell took over as Chief Executive at RCHT. Formerly in a similar position at the Cornwall Partnership NHS Foundation Trust, Lezli has many years experience in the NHS and in successful leadership in the transition to Foundation Trust status.

As at 1 September 2012 the RCHT Trust Board members are:

Non-Executive Directors

Martin Watts (Chairman)
Rik Evans
Prof Sir Roger Boyle
Roger Gazzard
Susan Hall
Mike Higgins
Douglas Webb

Executive Directors

Lezli Boswell – Chief Executive
Dr Paul Upton – Medical Director
Andrew MacCallum – Interim Nurse Executive
Jo Gibbs – Chief Operating Officer and Executive Lead for Human Resources
Karl Simkins – Director of Finance and Performance
Ethna McCarthy – Director of Strategy & Business Development

For member profiles and full details of RCHT Board Members during 2011-12, please see our website - www.rcht.nhs.uk – and the Remuneration Report which forms part of our Annual Report and Accounts 2011-12.
Management Commentary 2011-12

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 2012. This commentary focuses on the financial activities and financial 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. Summarised financial statements have also been included at Appendix 1 and these provide more detail of income, expenditure and investments during the year.

1.4. The main elements of this commentary are as follows:
   - assessment of the Trust’s achievement of its key financial objectives and financial performance in 2011-12 and its plans and objectives for 2012-13;
   - 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.

1.5. The Trust’s Annual Report, which incorporates this Management Commentary, provides a comprehensive narrative of the Trust’s achievements in 2011-12 and of its plans for the future.

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

2.1. The Trust is the major provider of acute healthcare 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, 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 of England.

2.4. In its annual plan for 2011-12, 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:

- To deliver a revenue surplus of £4.4m;
- To mitigate a number of financial pressures and avoid costs of c£7m;
- To deliver recurrent savings of c£19m;
- To meeting ongoing obligations to repay historic debt;
- To mitigate income, cost and implementation risk inherent within the business plan; and
- To ensure the Trust’s liquidity position is managed through the year.

2.6. The business plan recognised that 2011-12 was expected to be a challenging and pivotal year for the Trust. Building on recent progress, 2011-12 was seen as a year in which the Trust aims to further improve the services offered to patients, whilst meeting challenging financial targets. The Service Improvement Programme was very much focused on delivering that challenge, and consequently enabling progress towards becoming a Foundation Trust.

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

3.1. This section sets out the key financial information covering the 2011-12 financial year.

3.2. The Trust has a plan, agreed with NHS South of England to achieve its breakeven duty over a five year period. The final year of this plan was originally 2012-13. Whilst the Trust made excellent progress in delivering significant surpluses from 2008-09 to 2010-11 so as to be able to achieve a cumulative breakeven position by 31 March 2013, the impact of QIPP, national and local savings expectations resulted in the Trust re-assessing its commitment to meeting the 31 March 2013 target. As a result, the Trust is in discussions with NHS South of England to change the date to achieve a cumulative breakeven position to 31 March 2017.

3.3. During 2011-12, the Trust delivered a surplus of £4.4m, operated within its External Financing Limit set by the Department of Health (DH) and operated within its Capital Resource Limit set by the Department of Health.

3.4. The Statement of Financial Position shows net assets of £137.2m. There are no going concern issues facing the Trust.

3.5. During the year the Trust made repayments of £1.6m against its historic debt loan, the Trust fully expects its debt of £22.8m in relation to historic debt to be rescheduled over 13 years by 31 March 2013. This will reduce the level of annual repayments and ensure that the Trust is both ready for Foundation Trust status, but also progressing on a sound and sustainable financial basis.

3.6. The Trust received a short term Working Capital Loan of £4m in March 2012. This is repayable by 31 May 2012 and is linked to the ongoing rescheduling of the Trust’s historic debt.
3.7. In 2011-12 the Trust earned £314.2m income from activities and delivered a surplus before impairments of £4.44m. This was in accordance with the Trust's financial plans.

3.8. In 2011-12 total income exceeded originally budgeted levels by £9.8m. The increase was due mainly to increased training and education income (£3.2m) and activity related income from the Trust’s main commissioner, NHS Cornwall and Isles of Scilly (£4.2m).

3.9. During the year the Trust once again revalued its land and buildings in order to ensure that its highest value assets were included on the Statement of Financial Position at an up to date valuation. This has impacted on the Trust’s accounts with impairments of £4m charged to operating expenses in the period. As a result of this charge, the Trust’s financial statements show a retained surplus of £0.6m.

3.10. Overall, the revaluation has resulted in an overall reduction in the Trust’s asset values by £10.1m. This is made up of downward revaluations of £11.2m and upward revaluations of £1.1m.

3.11. The Summary Financial Statements provide more information on the Trust's income, expenditure and assets.

Corporate performance

3.12. The Trust set out its key objectives for 2011-12 in its Annual Business Plan which was approved by the Board in April 2011.

3.13. 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:

<table>
<thead>
<tr>
<th>Key performance objectives for 2011-12</th>
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</thead>
<tbody>
<tr>
<td><strong>To remain the preferred provider of acute and specialist healthcare to the people of Cornwall and the Isles of Scilly</strong></td>
</tr>
<tr>
<td>• The Trust has continued to be assessed as a ‘Performing’ organisation by the Department of Health in 2011/12.</td>
</tr>
<tr>
<td>• During the second half of 2011/12 the Trust eliminated same sex accommodation breaches.</td>
</tr>
<tr>
<td>• Evidence from the National Inpatient Survey for 2011 suggests that most patients experience the care they get from the Trust in a positive way, with a total of 89% describing it as excellent, very good or good.</td>
</tr>
<tr>
<td>• The range of services provided by the Trust continued to expand. A new interventional radiology suite is offering the latest in procedures for endovascular aneurysm repair and offers potential for development of more specialist techniques. New integrated theatres across 2 sites will enhance minimally invasive surgery, faster recovery and short lengths of stay.</td>
</tr>
<tr>
<td>• The Trust has passed the first stages in achieving Foundation Trust status which will ultimately allow increased freedom and flexibility to manage its provision of service.</td>
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**To focus relentlessly on quality care and patient safety.** |

• During 2011/12 the Trust retained its unconditional registration with the Care Quality
Key performance objectives for 2011-12

Commission – the maximum possible achievement. The Trust’s intention is of course to maintain this during 2012/13.

- In addition to work on introducing the new 16 Care Quality Commission essential standards and outcomes, the Trust has concentrated on the delivery of key areas for improvement as indicated in its 2010/11 Quality Accounts.

- The reduction in Healthcare Acquired Infections has continued and further improved in 2011/12. Targets for reduction of clostridium difficile were met and there have been no reported cases of MRSA bloodstream infection for well in excess of 12 months.

- The Trust is now in the best performing 25% of Trusts nationally for both MRSA. The aim in 2012/13 is further reduce the incidence of clostridium difficile and other hospital associated infections.

- The Trust’s mortality rates have continued to remain below the national average. There has been continued participation in the Quality and Patient Safety Improvement Programme with a focus on 5 target areas: general wards, peri-operative care, critical care, medicines management and leadership. Patient safety briefings have been strengthened through the re-launch of World Health Organisation safety checklists and work has been done to improve recording of observations and VTE assessment.

- Each of the Trust’s Division has lead on a CQUIN with performance measures covering a wide range of quality aspects including VTE, patient experience, cancer, emergency admissions, stroke and development of electronic discharge systems.

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

- The Trust has been working to develop a single point of access for emergency admissions and to work across organisational boundaries on admissions avoidance and earlier discharge. This continues to be an area of challenge for the health community and will be the focus for further work during 2012/13.

- Developing relationships with the emerging clinical commissioning group and the newly established community interest company – Peninsula Community Health – now managing community hospital and community care services, has been a priority through the year.

- The Trust has continued to contribute to the development of health and social care hubs, better integrated services and where appropriate, co-located key staff. These evolving hubs are designed to reduce duplication and provide a more cohesive service for patients as they move between hospital and community based services.

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

- The ‘Extra Mile’ Excellence and Innovation Awards were again a focus for celebrating the achievements and exceptional efforts of Trust staff, with recognition for 31 teams and individuals. These awards are seen as a key part of the Trust’s strategy to change its internal culture to one in which staff feel more engaged and better rewarded for their work.
### Key performance objectives for 2011-12

- Communication is another key element of this strategy. During 2011/12 the team brief process was refreshed as were processes for feedback and involvement in planning and decision making.

- A leadership development programme has been developed and the personal development review process further refined to improve the quality of reviews, their relationship to Trust objectives and achievable personal development plans.

- In continuing the Trust Board’s recognition of the importance of supporting staff in making work-life balances and supporting health and wellbeing at work, the Trust has achieved a bronze Healthy Workplace award. This is seen as an important first step in an ongoing programme of work which will develop further during 2012/13.

- Continued effort has been made to work in partnership with staff representatives and involving people in decisions which may affect them. Examples have included the restructure of leadership and roles within nursing management, theatres and radiography.

- The Trust has continued its role as a teaching provider through its partnerships with the Peninsula College of Medicine and Dentistry and the University of Plymouth Faculty of Health and Social Work. These links play an important part in attracting research activity and supporting our recruitment of high calibre health care professionals.

### To work towards sustainable, low carbon future

- During the 2011/12 the Trust has been implementing its Sustainable Development Strategy and is the main focus of attention in working towards a low carbon future. (Treasury guidance on sustainability can be found at [http://hm-treasury.gov.uk/frem_sustainability.htm](http://hm-treasury.gov.uk/frem_sustainability.htm))

- This strategy aims to ensure that the Trust continually improves its sustainability by encouraging all staff to play an active part in environmental stewardship.

- The action plan is being used to actively monitoring, measure and improve environmental performance by setting out a series of goals following the Good Corporate Citizen self assessment model and the Department of Health document ‘Saving Carbon, Improving Health’. These include a plan for reducing carbon emissions in line with the Government framework and periodic review of the Trust’s Good Corporate Citizen rating.

- A number of measures have been taken to reduce the consumption on utilities, including the installation of renewable energy sources. Energy from renewable sources generated on site now accounts for 9% of overall use.

- During 2011 the Trust recycled 32% over its overall waste total.

### To deliver financial surplus annually

- The Trust delivered a retained surplus before impairments of £4.4m. This was achieved by making savings of £19m during 2011-12.

- The Trust has now embedded long term financial modelling arrangements as part of its Foundation Trust application. This has enabled the Trust to project savings...
Key performance objectives for 2011-12

<table>
<thead>
<tr>
<th>Requirements to 2018 and develop savings schemes over the medium term.</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Financial support to the Trust’s non finance managers continues to be strengthened through improved training provided by the Finance Department.</td>
</tr>
<tr>
<td>• The Trust continues to work with NHS South and the Department of Health to re-schedule its loan over a longer period.</td>
</tr>
</tbody>
</table>

Benefits from capital investment during 2011-12

3.14. Despite the financial challenges facing the Trust it has delivered considerable improvements in its infrastructure through its capital programme in 2011-12, spending £15.6m on estate projects, estate improvements and medical and information technology equipment.

3.15. The Trust delivered a significant number of key capital schemes in 2011-12 including:

- Installation of a third Linear Accelerator - £2.1m
- Improvements to West Cornwall Treatment Centre - £1.3m
- Level 2 and 3 critical care equipment - £1.9m
- MRI upgrade - £0.3m
- Significant investment in theatres and other medical equipment.

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 2012-13, although commissioning arrangements will undoubtedly evolve following the demise of NHS Cornwall and Isles of Scilly on 31 March 2013. 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 Executive 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 NHS South of England;
- monthly performance monitoring meeting with NHS South of England and NHS Cornwall and Isles of Scilly (the PCT Cluster);
• joint meetings with Cornwall health and social care providers (including Cornwall Council and Peninsula Community Health);
• regular meetings with the Chief Executive and Directors of NHS Cornwall & Isles of Scilly;
• regular meetings with service users’ representative groups, including Local Involvement Network (LINks), Independent Patient Ambassadors and numerous patient groups throughout the Trust;
• regular attendance at the Health and Adult Social Care Overview Scrutiny Committee meetings; and
• regular meetings with Kernow Clinical Commissioning Group.

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. For the three years to 2010-11, the Trust benefited from additional capital funding as part of the Financially Challenged Trust programme. This has enabled the Trust to deliver major capital projects which it would otherwise not be able to deliver. The funding from this programme has now ceased, although through its status as a Foundation Trust, the Trust will be able to progress its Clinical Site Development Plan through other funding mechanisms.

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 2012-13, the Trust will need to make savings of at least £17m. The service improvement programmes for 2012-13 and beyond are expected to be at a similar 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 Board Assurance Framework.

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 2012-13 contract with NHS Cornwall & Isles of Scilly totalling £270.7m. This represents a broadly consistent position against the 2011-12 contract value.

5.2. The Trust has an income and expenditure plan to achieve a £3.8m 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 £13m for 2012-13, although expenditure is expected to be £3m below this level as part of the Trust’s working capital plan. The Trust has plans to spend this funding on the creation of two wards in the Trelawny wing, a single point of access for the Emergency Department, reconfiguration of Trelawny theatres, plus medical capital equipment and improved IT equipment.

5.4. At the 31 March 2012 the Trust held cash balances of £6.7m. This was high due to the
late receipt of a short term Working Capital Loan linked to the Trust's Foundation Trust application.

5.5. 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 of Health sets External Financing Limit which is used to control cash expenditure was achieved in the year.

5.6. At 31 March 2012 the Trust carried a loan of £26.8m. Of this, £22.8m relates to historic deficits incurred prior to 2007/08 and the remaining £4m relates to a short term Working Capital Loan.

5.7. The 2012-13 budget for the Trust assumes the historic debt loan from the Department of Health will be re-scheduled over a period of 13 years. The Trust has therefore planned to deliver a £3.8m surplus in 2012-13 and £1.6m of this surplus will be set aside to service the re-scheduled loan (depending on terms agreed with the Department of Health). An additional £1.1m will be set aside for the repayment of additional borrowing during 2012-13.

5.8. The Trust's treasury management functions are fit for purpose and not expected to require change in the lead up to the Trusts Foundation Trust application.

6. Summary financial statements and an explanation of our annual accounts

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 Department of Health. 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 2011-12 financial year. Appendix 1 to this report contains a summarised version of the financial statements and 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 after adjusting for impairments and technical adjustments is £4.4m against a target of £4.4m.

• The Trust spent £15.6m on capital items in the year and operated within its Capital Resource Limit.

• The Trust operated within its External Financing Limit.

• The Trust has not yet achieved a cumulative breakeven position and does not expect to do so until 31 March 2017 at the earliest. This is due to the planned surplus levels of c£4.5m per year for the medium term, which is in turn linked to the planned rescheduling of the Trust’s historic debt.

• The Trust received a short term Working Capital Loan (WCL) of £4m in the year and this will be repaid by 31 May 2012. The Trust’s medium term financing arrangements will be confirmed closer to the repayment of this loan.

• The Trust ended the year with a cash balance of £6.7m. This is due to the receipt of the WCL on 28 March 2012 and the benefit of working capital management (reduction in debtor balances, higher than expected year end accruals).

• Based on the financial statements the Trust’s financial metrics have not improved year on year, and the Trust would remain at level 2 for Foundation Trust purposes. This is entirely due to the fact that the historic debt has not yet been rescheduled. If this had been rescheduled, the Trust would be assessed at level 3.

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 94% cumulatively of all non-NHS invoices against the Code. This compares with 92% in 2010-11. The Trust continues to strive for further improvements to meet the 95% target cumulatively for 2012-13.

6.7. Note 10 to the Trust’s accounts provides details on payment performance.

6.8. The Trust has been accepted as a signatory to the Prompt Payment Code during the financial year 2011-12.

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 2011-12 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 2011-12, the Trust's external audit fees totalled £194,000 compared to £217,000 in 2010-11.

6.13. All audit issues have been reported to the Audit Committee, with significant issues raised to the attention of all directors as required. There is no relevant audit information which the directors are not aware of.
Summary Financial Statements

The following summary financial statements are an extract from the full audited accounts of the Trust. These have been made available to provide stakeholders of RCHT with a manageable array of data to give a clear indication of the financial position of the Trust. However the summary financial statements may not contain sufficient information to give a full understanding of the Trust’s financial position and performance.

Following the summary financial statements is a more detailed analysis of various aspects of the statements intending to offer stakeholders a more comprehensive view of the Trust’s key figures.

A copy of the full set of accounts will be available at the Annual General Meeting or can be obtained by contacting the office of the Director of Finance on 01872 252705 or by writing to:

Director of Finance Office
Bedruthan House
Royal Cornwall Hospital
Truro
TR1 3LJ
High level messages regarding the financial statements

- The retained surplus after adjusting for impairments and technical adjustments is £4.4m as planned.

- The Trust delivered a surplus of £4.437m for 2011-12 against a target of £4.4m.

- The Trust spent £15.6m on capital items in the year and operated within its Capital Resource Limit.

- The Trust operated within its External Financing Limit.

- The Trust has not yet achieved a cumulative breakeven position and does not expect to do so until 31 March 2017 at the earliest. This is due to the planned surplus levels of c£4.5m per year for the medium term, which is in turn linked to the planned rescheduling of the Trust’s historic debt.

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- Based on the financial statements the Trust's financial metrics have not improved year on year, and the Trust would remain at level 2 for Foundation Trust purposes. This is entirely due to the fact that the historic debt has not yet been rescheduled. If this had been rescheduled, the Trust would be assessed at level 3.
<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>(restated)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Revenue</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Revenue from patient care activities</td>
<td>279,352</td>
<td>279,727</td>
</tr>
<tr>
<td>Other operating revenue</td>
<td>34,894</td>
<td>31,808</td>
</tr>
<tr>
<td><strong>Operating expenses</strong></td>
<td>(307,542)</td>
<td>(303,476)</td>
</tr>
<tr>
<td><strong>Operating surplus/(deficit)</strong></td>
<td>6,704</td>
<td>8,059</td>
</tr>
<tr>
<td><strong>Finance costs:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Investment revenue</td>
<td>23</td>
<td>21</td>
</tr>
<tr>
<td>Other gains and losses</td>
<td>156</td>
<td>(6)</td>
</tr>
<tr>
<td><strong>Finance costs</strong></td>
<td>(1,753)</td>
<td>(2,110)</td>
</tr>
<tr>
<td><strong>Surplus/(deficit) for the financial year</strong></td>
<td>5,130</td>
<td>5,964</td>
</tr>
<tr>
<td>Public dividend capital dividends payable</td>
<td>(4,512)</td>
<td>(4,458)</td>
</tr>
<tr>
<td><strong>Retained surplus/(deficit) for the year</strong></td>
<td>618</td>
<td>1,506</td>
</tr>
<tr>
<td>Technical accounting adjustments</td>
<td>3,819</td>
<td>6,038</td>
</tr>
<tr>
<td><strong>Adjusted retained surplus/(deficit) for the year</strong></td>
<td>4,437</td>
<td>7,544</td>
</tr>
</tbody>
</table>
## STATEMENT OF FINANCIAL POSITION AS AT 31 MARCH 2012

<table>
<thead>
<tr>
<th></th>
<th>31-Mar-12</th>
<th>31-Mar-11</th>
<th>01-Apr-10</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Non-current assets</strong></td>
<td>178,970</td>
<td>187,285</td>
<td>181,388</td>
</tr>
<tr>
<td><strong>Current assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inventories</td>
<td>6,707</td>
<td>6,879</td>
<td>6,400</td>
</tr>
<tr>
<td>Trade and other receivables</td>
<td>9,014</td>
<td>11,278</td>
<td>13,111</td>
</tr>
<tr>
<td>Cash and cash equivalents</td>
<td>6,729</td>
<td>800</td>
<td>633</td>
</tr>
<tr>
<td>Non Current Assets held for sale</td>
<td>115</td>
<td>250</td>
<td>434</td>
</tr>
<tr>
<td><strong>Creditors Due within one year</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(26,196)</td>
<td>(26,043)</td>
<td>(24,633)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(372)</td>
<td>(1,614)</td>
<td>(1,964)</td>
</tr>
<tr>
<td>Borrowings and loan</td>
<td>(11,632)</td>
<td>(6,176)</td>
<td>(8,104)</td>
</tr>
<tr>
<td><strong>Net current assets/(liabilities)</strong></td>
<td>(15,635)</td>
<td>(14,626)</td>
<td>(14,123)</td>
</tr>
<tr>
<td><strong>Total assets less current liabilities</strong></td>
<td>163,335</td>
<td>172,659</td>
<td>167,265</td>
</tr>
<tr>
<td><strong>Non-current liabilities</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Trade and other payables</td>
<td>(5,633)</td>
<td>(6,396)</td>
<td>(7,159)</td>
</tr>
<tr>
<td>Provisions</td>
<td>(3,700)</td>
<td>(3,646)</td>
<td>(3,980)</td>
</tr>
<tr>
<td>Borrowings and loan</td>
<td>(16,793)</td>
<td>(19,922)</td>
<td>(27,865)</td>
</tr>
<tr>
<td><strong>Total non-current liabilities</strong></td>
<td>(26,126)</td>
<td>(29,964)</td>
<td>(39,004)</td>
</tr>
<tr>
<td><strong>Total assets employed</strong></td>
<td>137,209</td>
<td>142,695</td>
<td>128,261</td>
</tr>
<tr>
<td><strong>Financed by taxpayers’ equity:</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Public dividend capital</td>
<td>163,363</td>
<td>163,352</td>
<td>147,602</td>
</tr>
<tr>
<td>Retained earnings</td>
<td>(66,495)</td>
<td>(66,865)</td>
<td>(70,400)</td>
</tr>
<tr>
<td>Revaluation reserve</td>
<td>40,341</td>
<td>46,208</td>
<td>51,059</td>
</tr>
<tr>
<td><strong>Total taxpayers’ equity</strong></td>
<td>137,209</td>
<td>142,695</td>
<td>128,261</td>
</tr>
</tbody>
</table>

Non-current assets include items of property, plant and equipment as well as intangible items such as software licenses. The vast majority of the sum for 2011-12 (£179m), is made up of property, plant and equipment.
### Statement of Cash Flows for the Year Ended 31 March 2012

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11 (restated)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td><strong>Operating Activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from operating activities</td>
<td>18,958</td>
<td>21,565</td>
</tr>
<tr>
<td><strong>Cash flows from investing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interest and revenue received</td>
<td>23</td>
<td>20</td>
</tr>
<tr>
<td><strong>Capital Expenditure</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net (Payments) for property, plant and equipment</td>
<td>(14,707)</td>
<td>(27,248)</td>
</tr>
<tr>
<td>(Payments) for intangible assets</td>
<td>(1,206)</td>
<td>(651)</td>
</tr>
<tr>
<td>Net cash inflow/(outflow) from investing activities</td>
<td>(15,890)</td>
<td>(27,879)</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) before financing</strong></td>
<td>3,068</td>
<td>(6,314)</td>
</tr>
<tr>
<td><strong>Cash flows from financing activities</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Net Public dividend capital received/(paid)</td>
<td>11</td>
<td>15,750</td>
</tr>
<tr>
<td>Loans received/(repaid) to the DH</td>
<td>2,370</td>
<td>(9,690)</td>
</tr>
<tr>
<td>Other capital receipts</td>
<td>522</td>
<td>602</td>
</tr>
<tr>
<td>Capital element of finance leases and PFI</td>
<td>(26)</td>
<td>(166)</td>
</tr>
<tr>
<td><strong>Net cash inflow/(outflow) from financing</strong></td>
<td>2,877</td>
<td>6,496</td>
</tr>
<tr>
<td><strong>Net increase/(decrease) in cash and cash equivalents</strong></td>
<td>5,945</td>
<td>182</td>
</tr>
<tr>
<td>Cash and cash equivalents at the beginning of the financial year</td>
<td>767</td>
<td>585</td>
</tr>
<tr>
<td>Cash and cash equivalents at the end of the financial year</td>
<td>6,712</td>
<td>767</td>
</tr>
</tbody>
</table>
Sources of Income 2011-12
RCHT receives income from a variety of sources, for 2011-12 this amounted to £314m. The majority of this income, £277m or 88%, originated from NHS commissioners for the delivery of patient care. Other sources of income include funding for education, training and research and revenue for provision of non-patient services to other bodies. The chart below depicts this mix.
Expenditure Analysis
Throughout 2011-12 RCHT spent £308m on operating activities, an additional £6m on financing costs and £15.6m on capital projects.

As with other hospitals the majority of The Trust’s spend derives from staff remuneration which accounted for £191m or 62% of all spend. Another large area of spend, accounting for £63m, was clinical and general supplies. This includes clinical consumables, drugs as well as the various day to day items needed to maintain a large Trust. The chart to the below shows the breakdown of expenditure.

As the chart above demonstrates Pay costs translate to 62% of operating expenditure. The graph below provides a better picture of how this sum is spent.

82% - percentage of total pay spend accounted for by Clinical Staff.
Capital expenditure

Throughout 2011-12 RCHT spend £15.6million on capital projects. This laparoscopic theatre is the first of five theatres being installed across the Trust. This is part of a £1.75m programme to upgrade theatres so that patients and surgical teams can benefit from purpose-designed equipment for laparoscopic procedures (also known as keyhole surgery).

Paying suppliers on time

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

The table below shows our improvement upon last year in terms of the number and values of invoices paid on time.

<table>
<thead>
<tr>
<th></th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>£000s</td>
</tr>
<tr>
<td>Total Trade Invoices paid in year</td>
<td>73,999</td>
<td>136,574</td>
</tr>
<tr>
<td>Total Trade invoices paid within target</td>
<td>69,440</td>
<td>120,642</td>
</tr>
<tr>
<td>Percentage paid within target</td>
<td>94%</td>
<td>88%</td>
</tr>
</tbody>
</table>

The Trust has is a signatory to the Prompt Payment Code.
Setting Charges for Public Information

The Trust has complied with Treasury’s guidance on setting charges for information.

Foundation Trust financial ratios

The Trust monitors its financial performance through the use of those financial ratios the Trust will be monitored against once it gains Foundation status.

The performance against these ratios is set out below.

<table>
<thead>
<tr>
<th></th>
<th>Mar-11</th>
<th>Mar-12</th>
<th>Budget Mar-13</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>EBITDA % (margin)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>8.1%</td>
<td>7.6%</td>
<td>7.8%</td>
</tr>
<tr>
<td>Rating</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>EBITDA % achieved</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>89.0%</td>
<td>96.4%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Rating</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td><strong>I&amp;E surplus margin</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>2.4%</td>
<td>1.4%</td>
<td>1.2%</td>
</tr>
<tr>
<td>Rating</td>
<td>4</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Return on Assets</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>8.2%</td>
<td>6.4%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Rating</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td><strong>Liquidity ratio</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Value</td>
<td>(0.0)</td>
<td>0.2</td>
<td>22.5</td>
</tr>
<tr>
<td>Rating</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td><strong>Overall</strong></td>
<td>Rating</td>
<td>2</td>
<td>2</td>
</tr>
</tbody>
</table>

The liquidity ratio is below that required for Foundation Trust purposes. This is because the current element of the loan is based on the Trust’s signed loan agreement (repayable within three years), rather than over the expected period of 13 years.

The Trust expects its loan relating to historic debt to be spread over a longer term during 2012-13 and the impact of this is reflected in the expected financial metric values at 31 March 2013.

External audit arrangements

In 2011-12, the Trust’s external audit fees totalled £194,000 compared to £217,000 in 2010-11. 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

The audit report is shown at the end of the summary statements.

Approval of the summary financial statements

The summary financial statements were approved by the Board on 1 June 2012 and signed on its behalf by

Lezli Boswell
Chief Executive: Date: 01.06.2012
INDEPENDENT AUDITOR’S REPORT TO THE DIRECTORS OF ROYAL CORNWALL HOSPITALS NHS TRUST

I have examined the summary financial statement for the year ended 31 March 2012 which comprises the Statement of Income and Expenditure, Statement of Financial Position and Statement of Cash Flows.

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

The Directors are responsible for preparing the Annual Report.

My responsibility is to report to you my opinion on the consistency of the summary financial statement within the Annual Report with the statutory financial statements.

I also read the other information contained in the Annual Report and consider the implications for my report if I become aware of any misstatements or material inconsistencies with the summary financial statement.

I conducted my work in accordance with Bulletin 2008/03 “The auditor's statement on the summary financial statement in the United Kingdom” issued by the Auditing Practice Board. My report on the statutory financial statements describes the basis of my opinion on those financial statements.

Opinion

In my opinion the summary financial statement is consistent with the statutory financial statements of the Royal Cornwall Hospitals NHS Trust for the year ended 31 March 2012.

Alun Williams
Officer of the Audit Commission
3-4 Blenheim Court
Lustleigh Close
Matford Business Park
Exeter
EX2 8PW
1st June 2012
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 (SOCI) – 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 after adjustments for impairments and technical items.
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 (SOCTE) – This summarises the movement on the Trust’s reserves which form the lower section of the SOFP.
Statement of Cash Flows (SOCF) – 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 9.5 – 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 10 – 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 very close to achieving the 95% target.

Note 17 – 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 31 – 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 32 – 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 33 – 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.

Note 35 – Break even performance – This note shows the history of the Trust’s financial performance from 2005-06 to 2011-12. The Trust achieved its financial targets since 2007-08.

Note 35.2 – 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 35.3 – 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 2011-12.

Note 35.4 – Capital resource limit – This is the level of capital expenditure financed in the year and is set by the Department of Health each year.

Annual Governance Statement (formerly known as the Statement on Internal Control) - 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 values 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’s 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.
Remuneration Report

2011-2012
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.

Pay Multiples
Reporting bodies are required to disclose the relationship between the remuneration of the highest-paid director in their organisation and the median remuneration of their organisation’s workforce.
The banded remuneration of the highest-paid director at RCHT in the financial year 2011-12 was £180-185,000 (2010-11: £170-175,000). This was 6.94 times (2010-11: 6.61) the median remuneration of the workforce, which was £26,309 (2010-11: £26,114).

In 2011-12, 3 (2010-11: 2) employees received remuneration in excess of the highest-paid director. Remuneration ranged from £185,418 to £197,869 (2010-11: £176,702 to £187,785).

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

The small increase in the pay multiple ratio was due to an increase in the clinical salary of the highest-paid director.
**Duration of contracts, notice periods and termination payments**

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

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

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

Details of termination packages, for all staff, paid by the Trust 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:

<table>
<thead>
<tr>
<th>Name</th>
<th>Appointment Start Date</th>
<th>Appointment End Date</th>
<th>Reappointment Start Date</th>
<th>Reappointment End Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr Martin Watts Chairman</td>
<td>19 March 2009</td>
<td>18 March 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Roger Gazzard</td>
<td>01 November 2007</td>
<td>31 October 2010</td>
<td>01 November 2010</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>Mr Rik Evans</td>
<td>01 November 2007</td>
<td>31 October 2010</td>
<td>01 November 2010</td>
<td>31 October 2014</td>
</tr>
<tr>
<td>Mrs Susan Hall</td>
<td>01 October 2009</td>
<td>30 September 2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Mike Higgins</td>
<td>25 March 2010</td>
<td>24 March 2014</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor Sir Roger Boyle</td>
<td>16 December 2011</td>
<td>15 December 2015</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

There is no period of notice required for Non-Executive Directors.
### ANNEX 1: Salary and Pension Entitlements of Senior Managers – 2011-12 and 2010-11

#### Salaries and Allowances

<table>
<thead>
<tr>
<th>Name and Title</th>
<th>2011-12</th>
<th>2010-11</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Salary (bands of £5,000)</td>
<td>Other Remuneration (bands of £5,000)</td>
</tr>
<tr>
<td></td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Mr M Watts</td>
<td>25-30</td>
<td>0</td>
</tr>
<tr>
<td>Chairman</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr R Gazzard</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Rik Evans</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mrs Susan Hall</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Mike Higgins</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mr Douglas Webb</td>
<td>5-10</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professor Sir Roger Boyle</td>
<td>0-5</td>
<td>0</td>
</tr>
<tr>
<td>Non-Executive Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Name and Title</td>
<td>Salary (bands of £5,000)</td>
<td>Other Remuneration (bands of £5,000)</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Colclough, P</td>
<td>70-75</td>
<td>0</td>
</tr>
<tr>
<td>Chief Executive to 31 August 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Boswell, L</td>
<td>95-100</td>
<td>0</td>
</tr>
<tr>
<td>Chief Executive from 1 September 2011</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gibbs, J</td>
<td>125-130</td>
<td>0</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinkins, K</td>
<td>135-140</td>
<td>0</td>
</tr>
<tr>
<td>Director of Finance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rashleigh, C</td>
<td>95-100</td>
<td>0</td>
</tr>
<tr>
<td>Director of Nursing &amp; Therapies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Upton, P</td>
<td>20-25</td>
<td>155-160*</td>
</tr>
<tr>
<td>Medical Director</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sparks, J</td>
<td>80-85</td>
<td>0</td>
</tr>
<tr>
<td>Director of Human Resources to 6 January 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hunt, A</td>
<td>65-70</td>
<td>0</td>
</tr>
<tr>
<td>Trust Board Secretary &amp; Joint FT Director to February 2012</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest Earnings Total Remuneration (£'000)</td>
<td>180-185</td>
<td></td>
</tr>
<tr>
<td>Median Total Remuneration</td>
<td>26,309</td>
<td></td>
</tr>
<tr>
<td>Ratio</td>
<td>6.94</td>
<td></td>
</tr>
</tbody>
</table>

*Bonus* payments disclosed above are Clinical Excellence Awards.
## Pension Benefits

<table>
<thead>
<tr>
<th>Name of Senior Manager</th>
<th>Real increase in pension at age 60 (bands of £2,500)</th>
<th>Real increase in pension lump sum at age 60 (bands of £2,500)</th>
<th>Total accrued pension at age 60 at 31 March 2012 (bands of £5,000)</th>
<th>Lump sum at age 60 related to accrued pension at 31 March 2012 (bands of £5,000)</th>
<th>Cash Equivalent Transfer Value at 31 March 2012 as provided by NHSPA</th>
<th>Cash Equivalent Transfer Value at 31 March 2011</th>
<th>Real increase in Cash Equivalent Transfer Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boswell, L</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>5 - 7.5</td>
<td>15 - 17.5</td>
<td>60 - 65</td>
<td>185 - 190</td>
<td>1,184</td>
<td>914</td>
<td>140</td>
</tr>
<tr>
<td>Colclough, P</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Chief Executive</td>
<td>-2.5 - 0</td>
<td>-2.5 - 0</td>
<td>75 - 80</td>
<td>225 - 230</td>
<td>1,307</td>
<td>1,540</td>
<td>-117</td>
</tr>
<tr>
<td>Gibbs, J</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Chief Operating Officer</td>
<td>0 - 2.5</td>
<td>2.5 - 5</td>
<td>30 - 35</td>
<td>100 - 105</td>
<td>527</td>
<td>426</td>
<td>87</td>
</tr>
<tr>
<td>Sinkins, K</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Director of Finance</td>
<td>2.5 - 5</td>
<td>7.5 - 10</td>
<td>45 - 50</td>
<td>135 - 140</td>
<td>790</td>
<td>629</td>
<td>141</td>
</tr>
<tr>
<td>Upton, P</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Medical Director</td>
<td>0 - 2.5</td>
<td>5 - 7.5</td>
<td>40 - 45</td>
<td>130 - 135</td>
<td>801</td>
<td>674</td>
<td>106</td>
</tr>
<tr>
<td>Rashleigh, C</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
<td>£000</td>
</tr>
<tr>
<td>Director of Nursing and Therapies</td>
<td>0 - 2.5</td>
<td>0 - 2.5</td>
<td>30 - 35</td>
<td>100 - 105</td>
<td>605</td>
<td>531</td>
<td>57</td>
</tr>
<tr>
<td>Sparkes, J</td>
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<td>£000</td>
<td>£000</td>
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<tr>
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<td>0 - 2.5</td>
<td>-</td>
<td>0 - 5</td>
<td>-</td>
<td>37</td>
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<tr>
<td>Hunt, A</td>
<td>£000</td>
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<td>£000</td>
<td>£000</td>
<td>£000</td>
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<td>£000</td>
</tr>
<tr>
<td>Trust Board Secretary &amp; Joint FT Director</td>
<td>0 - 2.5</td>
<td>7.5 - 10</td>
<td>5 - 10</td>
<td>15 - 20</td>
<td>80</td>
<td>35</td>
<td>40</td>
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</tbody>
</table>

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). However it should be noted that the GAD factors used to calculate CETVs at 31 March 2012 are different to those used at 31 March 2011, following MH Treasury’s decision to use the latest actuarial factors with effect from 8 December 2011.

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

#### 2011-12

<table>
<thead>
<tr>
<th>Exit package cost band (including any special payment element) 2011-12</th>
<th>Number of compulsory redundancies</th>
<th>Number of other departures agreed</th>
<th>Total number of exit packages by cost band</th>
<th>Number of departures included where special payments have been made (special payment element (totalled))</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than £10,000</td>
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<td>0</td>
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<td>Total number of exit packages by type (total cost)</td>
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<td>Total resource cost (£000s)</td>
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#### 2010-11

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<th>Number of other departures agreed</th>
<th>Total number of exit packages by cost band</th>
<th>Number of departures included where special payments have been made (special payment element (totalled))</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
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<tr>
<td>&gt;£200,000</td>
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<tr>
<td>Total number of exit packages by type (total cost)</td>
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