Trust Board in Public

Thu 02 July 2026, 09:30 - 13:00

Royal Cornwall Hospitals NHS Trust

Members of the public are welcome to join the meeting via this link:

Agenda

09:30 - 09:31
1 min

1. Welcome and apologies (26/27.42)

Information *Chair*

*To **receive** apologies for the meeting from members of the Board and those usually in attendance.*

09:31 - 09:31
0 min

2. Declarations of Interest (26/27.43)

Information *Chair*

To receive any declarations of interest in regards matters on the agenda.

09:31 - 09:35
4 min

3. Minutes of the previous meeting (26/27.44)

Decision *Chair*

- *To **approve** the minutes of the 5 March 2026.*

03.0_Draft Mins of Public Board 07.05.2026 (Chair approved).pdf (27 pages)

09:35 - 09:40
5 min

4. Action log and matters arising (26/27.45)

Decision *Chair*

*To **review** the updates to actions and **agree** those actions proposed as complete*

04_In Public Action Log.pdf (2 pages)

09:40 - 10:00
20 min

5. Board Story (26/27.46)

Discussion *Acting Chief Nursing Officer*

- ***Receive** and **note** the Board Story*

10:00 - 10:10
10 min

6. Chair's Report (26/27.47)

Discussion *Chair*

- ***Receive** and **note** the Chair's report.*
- ***Endorse** the Trust's participation in Cohort 1 of the NHS Board Development Programme;*
- ***Support** the commitment to a whole-Board development session within the programme timeframe; and*
- ***Delegate authority** to the Chair and Chief Executive to finalise arrangements, including coordination with system partners, to ensure effective delivery and alignment with organisational priorities.*

06_Chair's Report July 2026 V3 (Chair approved).pdf (4 pages)

Neave,Lynsey
30/06/2026 09:31:26

10:10 - 10:25
15 min

7. Chief Executive's report (26/27.48)

Discussion *Interim Chief Executive*

- ***Receive and note** the report and the update on the Governance Improvement Plan;*
- ***Note** NHS Trusts are asked to confirm adoption of the IHRA definition of antisemitism and the Government definition*

of anti-Muslim hostility by 31 July 2026 ***noting*** *Trust is in the process of considering this through its Trust governance.*

- ***Note*** *NHS Trusts are asked to deliver and submit a Band 5 Job Evaluation plan by 31 July 2026* ***noting*** *Trust is in the process of considering this through its Trust governance.*

07.1_July CEO report public July 2026.pdf (13 pages)

Section A: Matters for Discussion and Decision

10:25 - 10:40
15 min

8. Urgent and Emergency Care (UEC) Performance (26/27.49)

Discussion *Chief Operating Officer*

- ***Note*** *the additional assessment being completed by the Acting Chief Executive and Chief Operating Officer in response to the performance not improving which will be finalised to be shared with the Vice Chair on 30 June*
- ***Note*** *the target to have updated modelling of the impact of existing improvement initiatives and an assessment of bed capacity to be shared with the Vice Chair on 30 June*
- ***Note*** *the significant operational pressures experienced during May 2026, including deterioration in Urgent and Emergency Care performance when compared with April 2026 which have continued in June.*
- ***Note*** *the increased emphasis on daily ward- and specialty-level capacity and demand reviews to support delivery of the Getting It Right First Time Clinical Operational Standards.*

08_Urgent Care Performance and ending corridor care.pdf (11 pages)

10:40 - 11:00
20 min

9. Staff Survey Action Plan (26/27.50)

Decision *Dual Chief People Officer*

- ***Note*** *the progress on Trust action plan to address the 2025 Staff Survey Priorities and* ***note*** *the development of Divisional and Corporate action plans;*
- ***Note*** *further consideration will be given to addressing the advocacy response percentage uptake as per the last pulse survey response.*

09_Board staff survey and action plan paper v6.pdf (14 pages)

Section B: Reports and Matters from Committee

11:00 - 11:20
20 min

10. Quality Assurance Committee Assurance Report and Matters Escalated from Committee (26/27.51)

Discussion *Committee Chair*

To present a summary of decisions made and assurance sought by Quality Assurance Committee on behalf of the Board of Directors at its recent meetings.

- ***Receive and note*** *the Committee assurance report from the May and June meeting*

10_QAC Assurance Report May26v2.pdf (11 pages)

10.1. Learning from Deaths Q4 Report (26/27.52)

Discussion *Chief Medical Officer*

- ***Receive and note*** *the Q4 Learning from Deaths assurance report*

10.1_Learning from Deaths Q4 report Draft V11.pdf (34 pages)

10.2. Maternity and Perinatal Safety Report (26/27.53)

Neave,Lynsey
30/06/2026 09:31:26

Discussion *Acting Chief Nursing Officer*

- ***Discuss for assurance*** *the concerns raised regarding discriminatory conduct within the Perinatal Service and the actions being undertaken to address this and improve the culture.*
- ***Note for assurance*** *the NHS Resolution scorecard.*
- ***Discuss*** *and* ***note*** *the complexity and necessary wide-ranging support of our perinatal mortality cases.*
- ***Note the*** *continued engagement with Kernow Maternity and Neonatal Voices Partnership in ensuring that patients*

voices are represented in our services.

- ***Note** the dashboard data for both Maternity and Neonatal services in Appendix 1 which was reviewed at the Quality Assurance Committee with no escalations to the Trust Board.*

10.02_Perinatal Safety Report June 2026 Final Trust Board.pdf (28 pages)

10.3. Health and Safety Strategy (26/27.54)

Discussion *Chief Operating Officer*

- ***Note** that although the Trust operates with a single Trust Strategy and works to avoid having multiple 'strategies' there is a requirement for the Trust to have a designated Health and Safety Strategy.*
- ***Note** that the Health and Safety Strategy has been considered through the Quality Assurance Committee and is provided to the Trust Board in full. The Quality Assurance Committee has recommended that the Trust Board approves the strategy.*
- ***Note** the further action to be reported to the Quality Assurance Committee on progress to improving Health and Safety from the equalities perspective.*
- ***Approve** Health and Safety Strategy.*

10.03_Health and Safety Strategy 2026 Cover Sheet.pdf (5 pages)
10.03_Health and Safety Strategy 2026-2029 V6.0_Final 3.pdf (30 pages)

11:20 - 11:40
20 min

11. Finance and Performance Committee Assurance Report and Matters Escalated from Committee (26/27.55)

Discussion *Committee Chair*

To present a summary of decisions made and assurance sought by Finance and Performance Committee on behalf of the Board of Directors at its recent meetings.

11.0_FPC Assurance Report May v2.pdf (11 pages)

11.1. Month 2 Revenue Financial Report (26/27.56)

Discussion *Chief Finance Officer*

The purpose of this report is to present an update on the Trusts revenue financial position as at 31 May 2026 (Month 2).

- ***Note** the May (month 2) financial position which represents the second month of the 26/27 financial year position.*
- ***Note** that the reported year to date financial position remains adverse to plan by c£0.42m which is due to the unfunded costs of Industrial Action in April.*
- ***Note** the financial risks outlined in the paper.*

11.01_Trust Board - Revenue Report - Month 2.pdf (13 pages)

11.2. Month 2 Capital Report (26/27.57)

Decision *Chief Finance Officer*

The purpose of this report is to provide an update on delivery of the 2026/27 capital programme as at 31 May 2026 (Month 2).

- ***Note** the financial position for the capital programme for the period to 31 May 2026 (Month 2), including that the Trust does not currently have an affordable capital programme and is therefore at risk of operating outside the available Capital Departmental Expenditure Limit (CDEL) funding. A separate update report has been provided on the 2026/27 capital programme.*
- ***Note** the increase in risk 8521 to from High (16) to Extreme (20) linked to how an overspend could result in the breach of a statutory financial duty which could be seen as a failure to achieve a key financial metric.*
- ***Approve** the receipt of £323k in relation to the Women and Children's Programme Pathology scheme (11KV Cable).*

11.02_Trust Board - Capital Programme report - Month 2.pdf (10 pages)

Neave,Lynsey
30/06/2026 09:32:26

11.3. Medium Term Financial Plan (public version) (26/27.58)

Decision *Chief Finance Officer*

To share the public version of the Trust's Medium Term Financial Plan.

- ***Note** the public version of the Medium Term Financial Plan (MTFP).*

11.03_Royal Cornwall Hospitals NHS Trust - Public Medium Term Financial Plan (May 2026).pdf (20 pages)

11:40 - 11:55
15 min

Break

11:55 - 12:00
5 min

12. People and Culture Committee Assurance Report and Matters Escalated from Committee (26/27.59)

Discussion *Committee Chair*

To present a summary of decisions made and assurance sought by the People and Culture Committee on behalf of the Board of Directors at its recent meeting.

- ***Receive and note** the Committee assurance report from the May meeting*

12_People and Culture Committee Assurance Reportmay26.pdf (4 pages)

12:00 - 12:10
10 min

13. Audit and Risk Assurance Committee Assurance Report and Matters Escalated from Committee (26/27.60)

Discussion *Committee Chair*

To present a summary of decisions made and assurance sought by Audit and Risk Assurance Committee on behalf of the Board of Directors at its recent meeting.

- ***Receive and note** the Committee assurance report from the June meetings*

13_Audit and Risk Assurance Committee_June26_Final.pdf (4 pages)

13.1. Board Assurance Framework (26/27.61)

Decision *Company Secretary*

To receive, discuss and approve changes to the Board Assurance Framework as discussed by Committee meetings.

- ***Note** the reporting, including new gaps in assurance and mitigating actions;*
- ***Approve** the closure of:*
  - ***Propose closure of action 7c (BAF 2 Workforce) -** Culture Taskforce has concluded and evolved into the Culture Group which met in May.*

13.1_BAF ARAC June296.pdf (11 pages)
13.2_BAF 1_Standards of Care_May261v.pdf (9 pages)
13.3_BAF 2-Workforce_May26.pdf (9 pages)
13.4_BAF 3_Integrated health services_May.pdf (6 pages)
13.5_BAF 4_Finance_June26.pdf (4 pages)
13.6_BAF 5_Digital Infrastructure Strategic_May26.pdf (5 pages)
13.7_BAF 6_Physical Infrastructure and Supply Chain_May26.pdf (5 pages)

12:10 - 12:15
5 min

14. Remuneration and Appointments Committee Assurance Report to Board (26/27.62)

Information *Committee Chair*

To present a summary of decisions made and assurance sought by Remuneration and Appointments Committee on behalf of the Board of Directors at its recent meeting.

- ***Receive and note** the Committee assurance report from the June meeting*

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14_Assurance Report from Rem Com to the Trust Board_June.pdf (2 pages)

12:15 - 12:35
20 min

15. Integrated Performance Report (26/27.63)

Discussion *Chief Operating Officer*

To inform Trust Board of the overall performance of the Trust about the key indicators for performance in Safe, High Quality

Care; Supported and Valued People; and Improving Together.

- ***Discuss*** *and* ***consider*** *the Trust Board Section of the Integrated Performance Report.*
- ***Note*** *that the relevant sections have been discussed at Committee, further* ***noting*** *that the People and Culture Committee meets bi monthly and that section of the report has therefore not been to Committee at the time of the Board.*

15.0_IPR cover sheet for Board.pdf (4 pages)
15.2_IPR June 2026 2.pdf (67 pages)

Corporate Trustee

12:35 - 12:40
5 min

16. Charitable Funds Committee Assurance Report (26/27.64)

Discussion *Committee Chair*

To present a summary of decisions made and assurance sought by Charitable Funds Committee on behalf of the Board of Directors at its recent meeting.

- ***Receive and note*** *the Committee assurance report from the June meeting*

16_Charitable Funds Committee_June26.pdf (3 pages)

Section C: Matters of Report - Reports within this section are to be received as read/for information and will not be discussed unless any member of the Board requests the item is un-starred ahead of the meeting

12:40 - 12:40
0 min

17. Corporate Risk Register (26/27.65)

Information *Acting Chief Nursing Officer*

To present a position statement regarding the major and exceptional risks currently identified for the Trust on the Corporate Risk Register.

- ***Note*** *the risk profile for RCHT that underpins the Corporate Risk Register and information included at the request of the Audit and Risk Assurance Committee*
- ***Note*** *the risks approved onto the Corporate Risk Register*
- ***Note*** *the presented updates including changes to scoring*

17.1_CRR for Board Jun 2026 v2.pdf (14 pages)
17.2_CRR dashboard Tracker for Board - Jun 2026 v1.pdf (2 pages)

12:40 - 12:40
0 min

18. Risk Management Strategy and Policy Update (26/27.66)

Decision *Acting Chief Nursing Officer*

Matter reserved for Board

- ***Note*** *the changes made to the policy in line with best practice and Internal Audit recommendations*
- ***Note*** *the updates made following organisational changes*
- ***Note*** *the requirement for further updates pending go-live of the new Risk Management System*
- ***Approve the amended*** *policy with a further update coming to the August meeting with the revised risk appetite sections*

18.1_Risk policy update cover sheet for Board Jun 2026 v2.pdf (16 pages)
18.2_Risk Assessment and Management Strategy and Policy V10.2 - Draft with track changes.pdf (53 pages)

Neave,Lynsey
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12:40 - 12:40
0 min

19. Safe Management of Patient Property Policy (26/27.67)

Decision *Acting Chief Nursing Officer*

Matter reserved for Board

- **Approve** the Patient Property Policy.

19.0_Patient Property Policy Board June 2026.pdf (5 pages)
19.0_Patient Property Policy V11.01.pdf (45 pages)

12:40 - 12:40
0 min

20. Safeguarding Annual Report (26/27.68)

Information *Acting Chief Nursing Officer*

- ***Note** the Safeguarding Annual Report*

20.1_Safeguarding annual report 25.26.pdf (4 pages)
20.2_Safeguarding annual (full) report 25-26 Final.pdf (38 pages)

12:40 - 12:40
0 min

21. Infection Prevention and Control Annual Report (26/27.69)

Information *Acting Chief Nursing Officer*

- ***Note** the Annual Report noting the end of year reportable Infection cases, noting improvements in meeting the Clostridioides. Difficile (C.Difficile) trajectory for the first time in a number of years.*

21.0_IPAC Trust Board Annual Report (002).pdf (55 pages)

12:40 - 12:40
0 min

22. Health and Safety Annual Report (26/27.70)

Information *Chief Operating Officer*

- ***Note** the Health and Safety Annual report.*

22_Health and Safety Annual Report 2026 for Trust Board.pdf (12 pages)

12:40 - 12:40
0 min

23. Annual Register of Interests (26/27.71)

Information *Company Secretary*

- ***note** publication of the Trust's registers of interest for the Trust Board of Directors and other decision-making staff.*

23_Cover Report Registers of Interest at at 31 March 2026.pdf (2 pages)

Section D: Other Matters

12:40 - 12:42
2 min

24. Summary consideration of risk (26/27.72)

Discussion *Company Secretary and Executive Director owners of risks*

- *To **identify** any risks raised during the meeting that may need to be escalated to the Board Assurance Framework or Corporate Risk Register.*

12:42 - 12:57
15 min

25. Questions from the Public (26/27.73)

Discussion *Chair*

25_Protocol for Questions from Members of the Public.pdf (2 pages)

12:57 - 13:00
3 min

26. Meeting effectiveness evaluation (26/27.**)

Discussion *Chair*

Neave,Lynsey
30/06/2026 09:31:26

- *What worked well?*
- *Even better if?*
- *Consideration of health inequalities ('triple aim'), equality, diversity and inclusion?*
- *Consistency with board etiquette?*
- *Contribution to patient safety?*
- *Any matters to communicate with system partners?*

13:00 - 13:00
0 min

27. Date of next meeting and move to Board in Private (26/27.74)

Information *Chair*

Date of next Board in Public: 3 September 2026

The Board will now move to its Board in Private meeting per the following resolution:

That, under the provision of Section 1, Sub-Section 2, of the Public Bodies Admission to Meetings Act, 1960, the public will be excluded from the meeting as the Trust is in Committee on the grounds that publicity would prove prejudicial to the public interest by reason of the confidential nature of the business to be transacted. The issues to be discussed involve, for example, matters relating to individuals and patient confidentiality.

One of more the following criteria must be met to for a Trust Board in Committee discussion:

- *The document contains employee identifiable information;*
- *The document contains patient identifiable information;*
- *The document contains information relating to legal proceedings;*
- *The documentation is in draft format for future publication / remains in early stages of development;*
- *The document is commercially sensitive*

Neave,Lynsey
30/06/2026 09:31:26

Minutes of the **Trust Board Meeting in Public** of the **Royal Cornwall Hospitals NHS Trust** held on **Thursday 7 May 2026 at 09.30 – 13.30 p.m.** G09 Knowledge Spa and MS Teams

Voting Directors Present:

David Allen (DA), Chair (G09)

Kim O'Keeffe (KOK), Acting Chief Executive (G09)

Richard Kramer (RK), Non-Executive Director (G09)

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

Bernadette George (BG), Acting Chief Nursing Officer (G09)

Meridith Kane (MK), Chief Medical Officer (G09)

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

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

Adrian Davis (AD), Non-Executive Director G09)

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

Uzma Bozai (UB), Non-Executive Director (MS Teams)

Dr Rebecca Hopkins (RH), Non-Executive Director (G09)

In Attendance:

Paul Hargreaves (PH), Deputy Dual Chief People Officer (G09)

Ella Stracey (ES), Chief Strategy Officer (G09)

Aled Jones (AJ), Associate Non-Executive Director (G09)

Rae Hall (RH), Associate Non-Executive Director (MS Teams)

Jonathan Foster (JF), NExT Director (G09)

Kelvyn Hipperson (KH), Chief Information Officer (G09) (until 12.52 hours)

Neal Lynsey 30/06/2026 09:31:26

Brian Johnson (BJ), Director of Estates and Facilities (G09)

Lynsey Neave (LN), Company Secretary (G09)

Emily Callan (EC), Dietician (for item 5 MS Teams)

Aneurin Campbell-Dowrick (ACD), Specialist Dietician (for item 5 MS Teams)

Joanne Burton (JB), Freedom to Speak Up Guardian (for item 10 MS Teams)

Sarah Coulter (SC), Guardian of Safe Working Hours (for item 11 MS Teams)

Minutes:

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

The order of the minutes may not reflect the order of the discussion.

1. Welcome and Apologies for Absence (26/27.01)

a. Apologies for absence from Trust Board members were **noted:**
   i) None.

b. Apologies for absence from those usually in attendance were **noted:**
   i) Alison Thorne-Henderson, Dual Chief People Officer and Niamh Lamond, Associate Non-Executive Director.

c. The Chair extended welcomes as follows:
   - (KOK) to her first public Board as Acting Chief Executive.
   - (RH) was welcomed as Clinical Non-Executive Director, noting the value of GP representation to strengthen community links and neighbourhood health. (RH) shared background information as well as her work in community health optimisation.
   - (RHa) as Chief Executive of Volunteer Health in Cornwall and an Associate Non-Executive Director to enhance voluntary sector engagement. (RH) gave thanks for the opportunity to increase volunteer linkages.
   - (BJ) as Director of Estates and Facilities who would bring expertise to support enabling strategies. (BJ) welcomed joining the Board and contributing.
   - (BG) in her new role as Acting Chief Nursing Officer.

d. The Chair extended thanks as follows:
   - (PH) for attending as Deputy Chief People Officer and for his contribution to the Trust, with best wishes extended for his new role as Chief People Officer at Portsmouth and the Isle of Wight.
   - (SMcF) at her final public Board meeting for her significant contribution, high standards in governance, and many years of service to the Trust and NHS.

Neave,Lynsey
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2. Declaration of Interest in relation to Agenda Items (26/27.02)

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

3. Minutes of Previous Board meeting (26/27.03)

a. The minutes of the public meeting held on 5 March 2026 were confirmed as a correct record.

4. Matters Arising and Action Log (26/26.04)

a. The Board **agreed** to close all actions proposed as complete and noted updates on actions in progress. Individuals were asked to provide updates in advance of the next meeting regarding actions remaining in progress.

5. Board Story (26/27.05)

a. The Acting Chief Nursing Officer (BG) introduced the Board Story, gave background context on the patient's reason for admission to hospital, and welcomed Emily Callan, Dietician and Aneurin Campbell-Dowrick, Specialist Dietician to the meeting.

   i) A story relating to Mr Peter Clift and his experience as an inpatient with nutritional needs and the support provided by staff to maintain his nutritional requirements during a challenging time as an inpatient (for 10 weeks) with colon cancer.
   ii) The good experience Mr Clift received particularly in the high intensity ward but also complexities experienced with maintaining nutrition due to his health complications.
   iii) Feeding which occurred via tubes which was unpleasant and difficulties with taking medication. The tubes were needed to enable Mr Clift to sustain himself. Mr Clift liaised with his consultant to have the tubes removed, which staff were nervous about but Mr Clift subsequently thoroughly enjoyed his first roast dinner.
   iv) Mr Clift progressed well and was able to enjoy different varieties and ranges of food. Mr Clift saw a nurse specialist about his swallowing as part of a review and it was confirmed that he was able to eat food in the normal way.
   v) That the support provided by the nutrition specialist was extremely welcomed and enabled Mr Clift to get back to normal more quickly. Mr Clift fed back he felt listened to which was important for his patient experience.
   vi) The link to the story can be found here: https://youtu.be/Si0l1eTcivE

b. The Board **discussed**:

   i) (ACD) welcomed the showcase of the Nutrition Team's patient centred care, highlighting the importance of listening to patient wishes. It was noted that Mr Clift was recovering well following a complex hospital admission
   ii) (EC) emphasised the critical role of nutrition in patient recovery and the importance of respecting patient preferences regarding feeding. The contribution of the Nutritional Steering Group was highlighted, alongside recognition of the Trust's strong commitment to prioritising nutrition.
   iii) (BG) thanked (EC) and (ACD) for their leadership and support provided to Mr Clift.
   iv) (ID) as Chair of Quality Assurance Committee (QAC) commended the team for meeting Mr Clift's needs through patient centre care and emphasised the importance of sustaining the approach taken to prevent deconditioning. (BG) confirmed continued prioritisation of nutrition within the Trust's ongoing programme.
   v) (RJ) gave thanks to Mr Clift for sharing his story and the team for delivering patient-centred care. The importance of patient feedback and engagement was reinforced, with plans to extend this approach to UEC through QR enabled feedback as part of Getting It Right First Time (GIRFT) improvement work the Trust was undertaking

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vi) (KOK) thanked the Nutritional Steering Group and emphasised the need to sustain focus on nutrition. (EC) highlighted the importance of acting on patient feedback, timely escalation, and appropriate dietetic referrals to improve outcomes and reduce length of stay, alongside continued multidisciplinary engagement to maintain progress.
vii) (UB) thanked the team for the patient story and emphasised the importance of effective communication to reinforce the value of nutrition. It was noted that recent campaigns (e.g. deconditioning and nutrition week) had been impactful, with a need to maintain focus on nutrition as a core priority.
viii) (DA) extended thanks to (EC), (ACD) and the team for their work, and asked that appreciation be conveyed to Mr Clift for sharing his experience, with best wishes to him and his family.

c. The Board **resolved** to:

i) **Receive** and **note** the Board story.

6. Chair's Report (26/27.06)

a. The Chair introduced the report, and the Board **noted:**

i) Committee membership updates: approval sought for (RH) to join QAC and (NL), Associate NED, to join Finance and Performance Committee (FPC), with intention for (NL) to become Audit and Risk Assurance Committee Chair upon (AB)'s tenure ending due to her accounting qualification and background.
ii) Appointment of (AJ) for a fourth year as Associate Non-Executive Director; future intention to rotate membership every 3–4 years, with next recruitment likely from Exeter University.
iii) Congratulations to Cornwall Partnership NHS Foundation Trust (CFT) for achieving a regional neighbourhood health award.
iv) Congratulations to former Chief Executive, Steve Williamson (SW) for being named a top 50 Chief Executive by HSJ. (SW) had shared best wishes with the Trust.

b. The Board **discussed:**

i) (AD) highlighted a previous bereavement team presentation relating to an award that had been won and emphasised the importance of recognising and celebrating positive achievements. It was proposed that award recipients be invited to Board meetings for certificate presentation, which (DA) supported.
ii) (DA) highlighted the need to proactively seek award opportunities, with (KOK) emphasising the importance of supporting teams in completing submissions. (ES) noted the referenced award reflected contributions from both the Trust and system partners, demonstrating the impact of effective system-wide collaboration.
iii) (UB) supported the sharing of positive stories, noting this as a key priority for the Communications Team, and committed to considering further opportunities to strengthen this work.

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c. The Board **resolved** to:

i) **Receive** and **note** the Chair's report.

ii) **Approve:**
   - Dr Rebecca Hopkins, Non-Executive Director as a member of Quality Assurance Committee.
   - Niamh Lamond, Associate Non-Executive Director as a member of Finance and Performance Committee.

d. The Board agreed the following **action:**

i) The Chief Strategy Officer, with Executive colleagues, to review arrangements to support award submissions and strengthen recognition of success, including opportunities for award recipients to attend Board. This would include liaison with (UB), NED Strategic Communications Lead, to enhance communication of positive stories

7. Chief Executive's Report (26/27.07)

a. The Acting Chief Executive introduced the report. The Board **noted:**

i) Over the past two weeks meeting teams within the Trust and thanks extended for the warm welcome received. Two key questions being posed to staff during these visits were what you are most and least proud of. Welcomed invitations to visit more wards and departments.
ii) Attendance at the House of Commons Select Committee visit to Cornwall, focused on the collective use of estates to support neighbourhood care which received positive feedback. The West Cornwall Hospital (WCH) team were commended for showcasing innovative UEC delivery closer to home. The visit also included the team being shown the new WCH outpatient facility.
iii) Commitment to staff, leadership and culture, with a focus on ensuring staff feel valued, safe and supported to come to work and deliver high quality patient care.
iv) Determination to hear the voices of patients and act on feedback provided.
v) Opening of two new linear accelerators at the Sunrise Centre, the first funded through contributions from RCHT Charity, NHS England (NHSE) and others, with the second delivered early following an NHSE award. Both were formally opened by a patient, who shared how moved he and his family were by the care received.
vi) Operational flow challenges were highlighted, with a commitment to refresh the Clinical Vision for Flow. The Trust remains focused on eradicating corridor care as an unacceptable experience for both patients and staff.
vii) The financial and operational plan and Board Assurance assessment were submitted in February 2026, with final approval awaited and information would be provided at a future meeting.
viii) Updates provided on the e-Care programme and that following a 60-day clinical and operational risk assessment, a decision was taken to pause the June 2026 go live. The Trust remained committed to implementing a revised start date, with patient and staff safety as the overriding priority.
ix) For industrial action 34.35% of the Trust's resident doctors participated during 7-13 April 2026. The Trust continued to support those who choose to take this action as well as those that decided to remain at work.
x) That the British Medical Association (BMA) had just notified the Trust of a ballot for consultant action which would open on 9 May 2026.
xi) Michelle Bateman, Deputy Chief Nursing Officer for NHSE, visited Cornwall and the Isles of Scilly and was shown around by (BG), Acting Chief Nursing Officer and Alison Bartlett, Interim Director of Nursing and Allied Health Professionals, from

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CFT. Particular interest was shown in the Dual Chief Nursing Officer role as well as joint collaboration and partnership work being undertaken whilst moving to neighbourhood health. How proud (KOK) was on behalf of the Trust and CFT so thanks were extended to nursing and midwifery teams for coming together.

xii) Noted the increase in the UK terrorism threat level to “severe” following recent national events, with emphasis on maintaining vigilance to ensure staff and patient safety, including use of ID badges, appropriate challenge of unknown individuals, and robust out-of-hours security arrangements.

b. The Board **discussed**:

i) (AB) referenced page 4 of the report and the Senior Information Responsible Officer update and national requirements to have a data handling and complaints process in place by 19 June 2026 and sought assurance if this would be achieved.
ii) (AB) raised the NHS overhaul of clinical standards to reduce maternal deaths and the requirement for full implementation by March 2027 and sought clarity on Board oversight. It was confirmed that updates would be provided through the Acting Chief Nursing Officer’s maternity and neonatal safety report.
iii) (RK) highlighted the importance of engaging directly with staff to foster compassion, support wellbeing and enable flourishing. It was suggested that a future update be brought to the Board on staff experience and how people are feeling.
iv) (JF) commented on how wonderful the expansion of the therapeutic apparatus service was as it provided less disruption to Cornwall and Isles of Scilly residents.
v) (JF) raised industrial action and extended thanks to all staff in terms of overall management as well as minimising disruption for patients citing the important role of the rota co-ordination team which was acknowledged by (KOK).

c. The Board **resolved** to:

i) **Receive** and **note** the report.

d. The Board agreed the following **actions:**

i) Dual Chief People Officer as Senior Independent Risk Owner (SIRO) to provide assurance to the Board that the Trust will have a data handling and complaints process in place by 19 June 2026 following the recent change in legislation.
ii) Acting Chief Executive to arrange for walk round findings to be included in future reports.

Section A: Matters for Discussion and Decision

8. Urgent and Emergency Care (UEC) Performance (26/27.08)

a. The Chief Operating Officer introduced the report. The Board **noted:**

i) Type 1 Emergency Department (ED) 4 hour performance improved to 51.1% in March. However the Trust continued to aspire to recover and achieve the constitutional standard.
ii) ED all type 4hr performance was 79.6% in March, below the plan trajectory of 85.9%, although meeting the 78% standard. All type is the ED, the system Urgent Treatment Centre (UTC) and Minor Injury Unit (MIU) combined performance.
iii) Average ambulance handovers improved to 35 minutes but the need to

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acknowledge challenges with some patients having long handovers (485 minutes) which was not a standard the Trust wished to deliver to patients.

iv) The percentage of patients spending more than 12 hours in ED was 14.7% in March, vs trajectory of 5.2%, and comparable to the same month last year.
v) For 'red lines' a change in terminology to 'improvement goals' and ambitions to end long stays within the ED.
vi) Introduction of a transparent internal reporting tool relating to corridor care so all staff can see the information. This enables celebration when spaces are not being used.
vii) Actions detailed in the report focussed on the ambition to reduce corridor care.
viii) Reference to section 3.5 where (BG), (MK) and (RJ) had agreed individual actions to lead to support improvements to UEC performance.
ix) Inclusion of an appendix (GIRFT) and clinical and operational standards which are a key route to delivering UEC performance. Work was being undertaken with clinical leaders to make improvements. The importance of thank you and the how can I help approach.
x) The intention to put posters up within the hospital containing a QR code so patients and staff can provide feedback and enable improvements to patient care.

b. The Board **discussed**:

i) (DA) commended the huge amount of work being undertaken and for (RJ) being transparent on this within the report.
ii) (KOK) reported the establishment of an Executive Leadership Team (ELT) aligned to the four new Divisions, with inclusion of Clinical Chairs to strengthen clinical leadership, support change delivery and inform decision making. Emphasis was placed on ensuring actions are impactful. Visits to sites other than Treliske by (BG), (MK) and (RJ) had enabled meaningful engagement with clinicians and staff to support service improvements, enhance patient care, safely eliminate corridor care and inform service redesign.
iii) (IDe) referenced the trajectory table on page 5, noting some targets were achieved by the end March 2026 but asked about confidence to deliver further progress by May 2026. Progress at WCH was recognised, alongside the importance of openly discussing areas where improvements had not yet been achieved. (RJ) outlined the Project Team's work, including plans for comprehensive user communications on improvement progress and incorporating patient and staff stories to enhance impact. It was noted that messaging should be balanced, recognising challenges such as long waits and the importance of supporting staff. Communications would be led by (KOK) as Acting CEO.
iv) (ID) commended the leadership approach and proposed solutions. Emphasis was placed on the patient experience of extended waits (e.g. over 12 hours), with the importance of capturing and sharing patient stories and care experiences during this time. Focus should also be given to actions to improve the qualitative experience for patients and families, even where waits remain prolonged.
v) (RK) expressed assurance that strong grip and oversight are being applied to address flow issues, and sought clarity on progress in eradicating 24 hour stays and corridor care in ED. The inclusion of staff stories and wellbeing elements in future reporting was welcomed. (RJ) advised that challenges remain with 24 hour stays, split between physical and mental health patients due to differing response requirements, with recent focus on physical health patients. Key improvement actions included development of the Acute Medical Model and optimisation of AMU functionality.

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vi) (RH) thanked the team's work, highlighting opportunities to strengthen the discharge pathway, including earlier identification of complex patients, improved discharge planning, and closer engagement with primary care and the voluntary sector. (RJ) confirmed partner organisations are embedded within teams, with coordination through system (Bronze and Silver) calls involving the voluntary sector to support discharge. Work was underway to identify patients earlier in pathways to enable timely referrals and avoid delays once medically fit for discharge. A system wide exit protocol was being developed, including direct engagement with patients and families.

vii) (BG) agreed to facilitate a Board story relating to a 12 hour wait. The importance of roadshows was highlighted, with reflection on how leadership roles can influence improvement and support delivery, underpinned by a strong link to organisational culture.

viii) (RH) queried whether partner involvement in ward rounds, previously trialled, could be embedded to support earlier discharge. (RHa) agreed there was further opportunity to strengthen voluntary sector involvement to support patient care and prevent avoidable admissions. A walkaround would be arrange for (RH) and (RHa) with the teams.

ix) (KOK) confirmed the process had previously been approved and should be revisited and refined as required. In light of the new national operating framework and ongoing improvement work, including GIRFT, a session would be arranged for the wider senior leadership team to ensure understanding of how these elements interrelate to support improved patient care and experience.

x) (BJ) highlighted that the work of teams extended beyond flow and corridor care to include wider patient safety consideration such as evacuation. It was noted that the scope of work was broader than reflected in the work, with a continued focus on maintaining patient safety across all care environments.

xi) (DA) referenced attendance at a national summit with (KOK), which emphasised corridor care and understanding patient flow origins, noting a high proportion of frail patients with comorbidities, potentially reflective of the Cornwall population. Key themes included staff and patient experience, strengthened working with primary care and the voluntary sector, and the use of new dashboards and weekly management statistics, which are shared with the Board.

c. The Board **resolved** to **note** the following:

i) The performance improvements delivered in Urgent and Emergency Care to include progress towards the ambitious 'red lines'.

ii) The creation of a dedicated Corridor Care dashboard to provide live information to support clinical and operational teams actions in real time to reduce usage.

iii) The current areas of focus for the improvement programme.

iv) The actions and impact of the work to reduce the patients with a length of stay over 14 days.

v) The assessment of the Model Acute Pathway and the first 72 hours will be completed and presented to the May 2026 Quality Assurance Committee which will review the assessment on behalf of the Board.

vi) The actions being specifically led by the Chief Medical Officer, Acting Chief Nursing Officer and Chief Operating Officer to end corridor care.

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d. The Board agreed the following **actions:**

i) Acting Chief Nursing Officer to arrange for the Board to receive a Board story relating to a patient who had experienced a 12 hour ED waiting time.
ii) Chief Operating Officer to facilitate a walk around with teams for Rebecca Hopkins, Clinical Non-Executive Director and Rae Hall, Associate Non-Executive Director.

9. Staff Survey Outcomes and Action Plan (26/27.09)

a. The Deputy Chief People Officer introduced the report. The Board **noted:**

i) Results from the national NHS Staff Survey (conducted October/November 2025), with results received the following year. It was noted the survey took place during a period of organisational change.
ii) Overall results were disappointing and accepted as such, particularly in relation to staff experience and likelihood to recommend the Trust as a place to work or receive care.
iii) Bank staff reported more positive experiences; results for ethnic minority staff improved but remained below expected standards.
iv) Concerns persist regarding staff confidence in raising concerns.
v) Appraisal compliance had declined and required improvement despite operational pressures, recognising its importance as a key staff engagement touchpoint.
vi) Improvements were noted in staff wellbeing and team support.
vii) Unwanted sexual behaviour remained an area of significant concern and was a key focus within broader cultural improvement work being undertaken.
viii) Work with the Divisions to strengthen line management, staff relationships, and management development, alongside simplifying policies and processes. A dual approach was being taken to address Trust wide themes while enabling targeted local interventions, with further development of the improvement plan underway.

b. The Board **discussed**:

i) (DA) emphasised the need for greater focus on improving staff willingness to recommend the Trust as a place to work and receive care, highlighting this as a key message for staff and the public. (DA) proposed professionally facilitated focus groups to better understand staff experience and stressed the importance of recognising the impact of vacancies and sickness on workforce pressures within an already stretched organisation.
ii) (KOK) highlighted the importance of triangulating data (as per slide 7), noting that managers play a critical role in shaping both performance and the day to day staff experience, with appraisal behaviours influencing team culture. With a limited timeframe of 3–4 months, it was emphasised that priorities must be focused and achievable. Divisional teams had identified a need for greater support and training in managing difficult conversations, with Clinical Chairs and senior leaders key to driving improvement. Further detailed analysis was required to clarify expectations and strengthen messaging to clinical leaders to maximise impact.
iii) (ID) supported the previous comments and, given the urgency and short timeframe, emphasised the need for professionally facilitated engagement to understand staff experience. It was proposed that leadership teams engage directly with staff to identify gaps and priority actions to deliver meaningful improvement, with increased appraisal uptake highlighted as a key enabler of progress.
iv) (DA) highlighted NHS mandated processes and confirmed his intention to raise these with Gill Morgan, Southwest Regional Director, during her forthcoming visit,

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particularly in relation to potential leverage.

v) (DA) highlighted that eliminating corridor care and improving the quality and uptake of meaningful two-way conversations as well as good appraisals would significantly enhance staff experience.

vi) (KH) emphasised the need to simplify the appraisal process, align it with staff survey feedback on the support required for staff to perform effectively, and also recognise that appraisals should not be solely linked to career progression.

vii) (RK) emphasised the need for clear Board oversight and strong prioritisation, identifying key focus areas including raising concerns, appraisal and speaking up. It was noted that the culture programme should align closely with staff survey findings, with further work required to support staff to raise concerns confidently, ensuring they are listened to and provided with feedback and support.

viii) (DA) expressed deep concern regarding the survey results, highlighting a disconnect with the Trust's standing as a leading acute provider. He emphasised the need for a focused, accelerated improvement plan, with a clear priority on the key staff experience metrics and rapid, targeted action and suggested an additional resolution be added in this regard.

c. The Board **resolved** to **receive** with deep concern and **note** the following:

i) National Staff Survey results for RCHT for 2025 and comparator benchmarks.
ii) Trust priorities for 2026 and draft action plan (Appendix 4).
iii) **Approve** the proposed engagement approach for the organisation.
iv) The draft action plan in response to the staff survey results but strongly reinforced the requirement to have a focused, and accelerated approach to demonstrate the required improvements
v) Regional Trends (Appendix 5).

d. The Board agreed the following **action:**

i) Dual Chief People Officer to lead on the provision of a revised accelerated improvement plan with a clear priority on the key staff experience metrics with rapid and targeted actions.

10. Freedom to Speak Up Guardian Annual Report and Board Self Assessment (26/27.10)

a. The Freedom to Speak Up Guardian introduced the report. The Board **noted:**

i) It was noted positively that the Freedom to Speak Up (FTSU) function was operating effectively across all three hospital sites. A Deputy FTSU Guardian is now in place, actively visiting sites, engaging with colleagues and promoting the service.

ii) It was noted that FTSU themes often reflect issues not resolved at local team level. The growing network of nearly 100 Champions, including five medical colleagues, was supporting constructive, confidential discussions with staff.

iii) It was noted that staff confidence in the FTSU process remains fragile, reflected in the number of anonymous cases, although this has reduced compared to previous reports, with some cases now converted to non-anonymous submissions.

iv) Looking forward to the culture work due to be undertaken and encouraging work and conversations within the Divisions with the aim of reducing the complexity of cases and minimise escalation into formal processes.

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b. The Board **discussed**:

i) (DA) advised he promoted FTSU through Trust communications, pod casts etc to reinforce that staff should feel safe to speak up, and invited ideas to further encourage openness and engagement.
ii) (KOK) emphasised the importance of visibly role modelling speaking up and fostering a psychologically safe culture close to where staff work, encouraging early conversations. A zero tolerance approach to detriment or retribution was reinforced.
iii) (DA) shared he raised at consultant interviews the importance of applicants being open to receive challenge.
iv) (IDe) welcomed additional resource to support the ongoing work and highlighted the absence of medical and dental reporting in section 8 and gave support for the inclusion of medical champions feedback to strengthen insight and routes for speaking up. (JB) noted targeted communications would be developed to support this.
v) (RK) welcomed his role as NED lead supporting (JB) and, drawing on lived experience, emphasised the need to strengthen staff confidence to speak up and ensure clarity of the Guardian role. (JB) confirmed Guardians did not engage in formal HR processes but provide support alongside them, noting capacity pressures within people teams. A focus was placed on embedding 'speaking up' cultures within Divisions, sharing positive stories, and ensuring managers listen and respond effectively at the earliest stage.
vi) (ES) provided assurance of close alignment with (JB) on culture work, using soft intelligence to identify areas for improvement, and supporting leaders to normalise speaking up by thanking staff, responding to concerns and setting out clear actions.
vii) (PH) highlighted the link between culture and HR processes, confirming regular engagement with teams to ensure appropriate management and support. Themes and cases are reviewed for learning, with an emphasis on maintaining professional boundaries.
viii) (RJ) requested closer engagement with (JB) and Divisions to support delivery and assurance, including dedicated sessions with teams to enable focused time for engagement and open conversations.
ix) The Board unanimously reaffirmed its support for staff to speak up, emphasising the importance of cascading this message to ensure staff feel safe to do so with their managers. (DA) extended thanks to (JB) and the Deputy Guardian, reiterating strong Board support for all staff who raise concerns.

c. The Board **resolved** to:

i) **Note** the key issues identified in the report.
ii) **Discuss for assurance** the greatest number of concerns being raised continues to be behaviours and relationships.
iii) **Receive and note** the annual Freedom to Speak Up reflection and planning tool and the high level actions to bring about improvement.
iv) **Note** the Board's consistent message that speaking up is encouraged and welcomed across the organisation, and it reaffirmed the Board's commitment to supporting colleagues who speak up.

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11. Guardian of Safe Working Hours Annual Report 2025/26 (26/27.11)

a. The Guardian of Safe Working Hours introduced the report. The Board **noted:**

i) Focus during the past year on the introduction of exception reporting with changes summarised in the report.
ii) Responsibility for clinical supervision of resident doctors had transferred to HR, providing assurance on appropriate use of funds; transition was smooth and thanks were extended to the HR team.
iii) Three areas of concern were identified (Respiratory – now mitigated with additional doctor from April; Oncology and Cardiology – resolved promptly).
iv) That many issues are resolved locally and therefore not reflected within the report.
v) Fines continued to be monitored.
vi) No immediate patient safety concerns were identified.
vii) Good access to post shift accommodation for doctors was noted.
viii) Trelawny rest facilities remains open with a request for any further updates made.

b. The Board **discussed**:

i) (DA) extended thanks to (SC) for all the work she undertakes.
ii) (MK) raised emails in train with the aim of obtaining clarity in relation to Trelawny rest facilities.
iii) (UB) queried the use of fatigue modelling, as applied in other industries and Trusts. (SC) confirmed this was not currently utilised but she would welcome further information. (UB) agreed to share articles and resources accordingly.
iv) (AJ) welcomed the prompt resolution of issues and queried whether data is analysed through an equality lens. (SC) confirmed this was not currently undertaken but could be explored with HR, noting strong existing HR support. (PH) advised systems can flag concerns and data could be triangulated with patient outcomes, supporting closer working with HR.
v) (AJ) queried the impact of industrial action and BMA activity on reporting; (SC) advised further analysis would be required, noting industrial action is not captured through exception reporting and that any impact is more likely linked to locum activity. (PH) and (MK) highlighted that proactive planning mitigated disruption, with lower strike participation than peers enabling sufficient staffing cover.
vi) (AB) queried how to sustain the absence of immediate safety concerns given historical variation. (SC) advised that past concerns were largely linked to staffing levels and the need to ensure appropriate support is in place at the right times.
vii) (DA) commended the excellent report and thanked (SC) for all her work as the Guardian of Safe Working Hours.

c. The Board **resolved** to:

i) **Receive** and **note** the Annual Report (2025/26) from the Guardian of Safe Working Hours.

d. The Board agreed the following **action:**

i) Uzma Bozai, Non-Executive Director to share fatigue modelling articles/resources with the Guardian of Safe Working Hours.

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Section B: Reports and Matters from Committee

12. Quality Assurance Committee (QAC) Assurance Report and Matters Escalated from Committee (26/27.12)

a. Isobel Down, Non-Executive Director and Committee Chair introduced the report. The Board **noted**:

i) The Committee extended thanks to members and attendees for their contributions and high quality debate throughout the year, and acknowledged the support provided by the Corporate Governance team.
ii) The Committee highlighted the breadth of its agenda, drawing Board attention to two significant incidents (fire and asbestos), with assurance provided on actions taken in response to these and three recent incidents overall.
iii) Ongoing risks relating to Freedom of Information (FOI) and Subject Access Requests (SARs) backlogs were noted, with an action plan requested to address these issues and continued monitoring to be undertaken.
iv) Highlighted performance challenges in UEC, stroke and 7 day services, including delivery against standards. Issues within the symptomatic breast service were noted, with assurance provided through a recent report and action plan, supported by clinician attendance which was welcomed.
v) Good annual review of the effectiveness of the Committee with areas of improvement highlighted for the following year.

b. The Board **discussed**:

i) (DA) gave thanks to (ID) for chairing the Committee and her ongoing role in this regard.
ii) (AB) sought clarification on whether any issues required Board debate or escalation. It was confirmed the report was for information at this stage, with potential for further discussion depending on progress.
iii) (KOK) reported that relevant issues had been escalated to the Executive Review Group (ERG), demonstrating triangulation of concerns. It was noted that prompt action or escalation via QAC to the Board would be taken where required, with further escalation to the Board if issues remain unresolved.
iv) (DA) extended thanks to (BJ) and his team for the way incidents are responded to when they arise.

c. The Board **resolved** to:

i) **Receive** and **note** the Quality Assurance Committee assurance report from the March and April 2026 meetings.

12.1 Maternity and Perinatal Safety Report (26/27.13)

a. The Acting Chief Nursing Officer introduced the report. The Board **noted**:

i) A summarised report in a new format and that the full report submitted to QAC was available to all Board members on request. Feedback on the content of the report was welcomed.
ii) 4 areas being brought to the Board's attention which included Clinical Negligence Scheme for Trusts (CNST) 8 year requirements, the quarterly Perinatal Mortality Review Tool (PMRT) report which advised of no stillbirths since November, 90 days without a death and only 1 death in the past 4 months. This was an improvement

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compared to previously. Sadly 3 infant deaths had been recorded and whilst not perinatal these had been referenced in the PMRT report.

iii) An appendix 3 which included the Trust's response to EMBRACE. The bereavement team had completed the response and the neonatal service's peer review response would follow the next month. This showed an increase in neonatal deaths over the reporting period placing the Trust as an outlier with comparable Trusts.

iv) A comprehensive PMRT assessment had been completed for all deaths occurring in 2024, with an external review present in more than 90% of cases (by another Trust). No themes and systematic issues had been identified. There was a low still birth rated with comparator groups. All actions from reviews were closed and learning had been shared widely across teams.

v) Data for 2025 was assuring with a decrease in the number of neonatal deaths.

vi) Qualified in specialty neonatal staffing remained challenging. The newly appointed neonatal manager was working to develop a different approach to recruitment and thanks were extended to HR for supporting this process. There had been an increase in recruitment to post and work was being undertaken with the team on a trajectory to exit incentive arrangements.

vii) The Trust had received notification of CNST compliance for year 7 so thanks were extended to the perinatal team who aided delivery which had been exceptional.

b. The Board **discussed**:

i) (KOK) thanked midwives and staff for achieving CNST and raised the recent International Day of the Midwife celebrations as well as the launch of the Silent Hospital initiative.

ii) (DA) raised concerns regarding neonatal staffing pressures and wider impacts across paediatrics. (BG) confirmed challenges were being managed with appropriate support, including accelerated staff competency development and foundation training, with divisional oversight through safer care processes.

c. The Board **resolved** to:

i) **Discuss for assurance** the Perinatal Mortality Review Tool (PMRT) Quarterly Board Report and our response to MBRRACE-UK 2024.

ii) **Discuss** and **note** the dashboard data for both Maternity and Neonatal services in Appendix 1.

12.2 Patient Safety Incident Response Strategy Extension (26/27.14)

a. The Acting Chief Nursing Officer introduced the report. The Board **noted**:

i) Thanks to Naomi Burden, Patient Safety Specialist. The Patient Safety Incident Response Framework (PSIRF) required a plan and the Trust had been an early adopter. National learning indicated that longer timeframes are needed to embed improvements, and QAC endorsed an extension on this basis.

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b. The Board **discussed:**

i) (KOK) raised the link between discharge processes and safeguarding, confirming that safeguarding had been appropriately involved in the relevant PSII.

ii) (AB) sought assurance that the Trust was not alone in requesting an extension to the PSIRF work; (BG) confirmed this aligned with the wider national position.

c. The Board **resolved** to:

i) **Approve** the proposed extension of the PSIRP to March 2027.
ii) **Approve** updated delivery milestones, to be incorporated into the refreshed plan once capacity modelling work is completed.

12.3 Patient Experience Strategy Extension (26/27.15)

a. The Acting Chief Nursing Officer introduced the report. The Board **noted**:

i) The strategy was due for renewal, with a new national quality strategy and forthcoming 10 Year NHS Plan placing greater emphasis on patient experience. Due to delays in national publication, the Trust would review and align once issued, with no impact on current delivery.

b. The Board **discussed:**

i) (RK) sought assurance that patient experience work would continue, which was confirmed. (BG) advised more work was being undertaken by the Trust and an advert was presently out for a National Director of Patient Safety.

c. The Board **resolved** to:

i) **Approve** the proposed temporary pause on renewing the Patient Experience Strategy to ensure consideration of the patient experience elements of the forthcoming publication of future National Quality Strategy are taken into consideration.
ii) **Approve** an extension to the current strategy until November 2026 with no material risk to current delivery.

12.4 Learning from Deaths Q4 Report (26/27.16)

a. The Chief Medical Officer introduced the report. The Board **noted**:

i) Thanks to Clinical Director Safety, Quality and Clinical Effectiveness and Becky Cooper, Clinical Effectiveness Manager for the comprehensive report provided, noting overall mortality and core indicators were within expected ranges, with a continued downward trend in Hospital Standard Mortality Ratio (HSMR) and no crude mortality alerts.
ii) Summary Hospital Mortality Indicator (SHMI) remained within national limits but showed an upward trend; a deep dive attributed this to pathway changes, with a retrospective audit underway to confirm no additional concerns.
iii) A single HSMR alert relating to hip fracture (#NOF) which was being monitored via QAC, with recognition of HSMR limitations for specific conditions and that #NOF does not take into account the frailty index of the population of Cornwall, or delays in discharges; performance was also tracked through the national hip fracture database.
iv) Four reviews of deaths in priority groups (learning disability and autism) indicated good or excellent care.

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v) Two deaths reviewed through the patient safety process identified learning relating to handover and communication as well as recognition and diagnosis of ketoacidosis which has been shared with relevant clinical teams.
vi) Quarter 3 included 18 coronial inquests and three Prevention of Future Deaths (PFD) notices. Details were provided but with particular focus on one PFD related to a bottle feeding case, which resulted in national learning following identification of inappropriate feeding practice and further information was provided.
vii) Bereavement care within perinatal and maternity services was recognised as a strength with thanks extended to the relevant teams.
viii) Structured Judgement Reviews (SJRs) were noted as per the report (32 completed in quarter 3), with further work required to improve timeliness and completion, supported by updates within the revised Learning from Deaths Policy with clarity provided on changes being made to the policy and why.
ix) Mortality reviews are currently completed in 65% of cases, below the required level. The Clinical Effectiveness Team were working with Divisional Chairs to improve timeliness and ensure full completion going forward.
x) Medical examiners had scrutinised over 80% of cases with the remainder referred to the coroner.

b. The Board **discussed:**

i) (DA) emphasised the importance of the report.
ii) (RK) highlighted links between SJRs and health inequalities, referencing autism-related cases; (MK) confirmed reviews are complete and inequality data is routinely considered.
iii) (RH) noted the learning from the bottle feeding case shared with primary care via the coroner; (MK) described this as strong system working.
iv) (RJ) reinforced the value of SJRs in supporting learning and speaking up to drive improvement.
v) (ES) emphasised the need for more robust sharing of learning through clinical governance.
vi) (KOK) welcomed improvements to support more timely SJR reporting.
vii) An amendment required to the report on page 10 where it should state quality of life rather than quality of lie.

c. The Board **resolved** to:

i) **Discuss for assurance** the Q3 Learning from Deaths assurance report.
ii) **Note** the important learning that occurred and strong system working following a bottle feeding case.

13. Finance and Performance Committee (FPC) Assurance Report and Matters Escalated from Committee (26/27.17)

a. Adrian Davis, Non-Executive Director and Committee Chair introduced the report. The Board **noted**:

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i) Women and Children's Programme and recent changes to Senior Responsible Officer arrangements.
ii) 3 identified items for escalation to the Board which comprised Women and Children programme risks (which had now been addressed), e-Care risk profile and assurance on next steps and the revised plan, the positive transition from CIP to

FSP.

iii) Congratulations extended to the Finance Team and all staff in the Trust who enabled the Trust to deliver a financial breakeven plan for the seventh consecutive year.

iv) Concerns raised regarding the level of non-recurrent Cost Improvement Programme (CIP) noting the intended focus in the coming months as Financial Sustainability Programme (FSP) plans are developed.

v) A deep dive of the Integrated Performance Report (IPR), with a focus on actions to eradicate corridor care given associated safety and financial risks, alongside continued delivery of the Clinical Vision for Flow.

b. The Board **discussed**:

i) (DA) supported the achievement of the financial breakeven position and thanked everyone involved that the Trust had achieved this for the seventh year in a row adding it was unusual in the NHS.

c. The Board **resolved** to:

i) **Receive** and **note** the Finance and Performance Committee Assurance report from the March and April 2026 meetings.

13.1 Month 12 Revenue Financial Report (26/27.18)

a. The Chief Finance Officer introduced the report. The Board **noted**:

i) Year end position to March 2026 (subject to external audit) to be finalised at an Extraordinary Board in June 2026.

ii) Delivery of a breakeven plan on a £760m budget, achieving a £92k surplus, representing a significant achievement against a challenging savings requirement and fulfilling the Trust's statutory duty. Thanks extended to all who enabled this achievement.

iii) The wider system also achieved breakeven, with the Trust receiving £4.9m non-recurrent support as an incentive, improving the bottom line and reducing the cumulative historic deficit (not available for expenditure). This supported wider capital and revenue incentives, including investment in e-Care and staff benefits.

iv) Focus had now shifted to 2026/27 delivery, with risks including industrial action (£425k cost pressure per period of action) and ongoing use of escalation capacity, requiring continued focus on quality, safety and financial balance.

v) FSP continued as a multi year programme to support future delivery.

b. The Board **discussed**:

i) (DA) gave thanks for the forensic line of sight relating to cash and the deep dives undertaken throughout the year.

c. The Board **resolved** to **note** the following:

i) The draft March (month 12) financial position which represents the closing 2025/26 financial year position and is achievement of a small favourable variance to the breakeven plan.

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ii) The financial position is now subject to the year end process including full external audit review, the outcomes from this will be reported in the normal way via the Audit and Risk Assurance Committee.
iii) The outturn for 2025/26 in relation to the cost improvement programme and the current status of the Financial Sustainability Programme (FSP).
iv) The financial risks outlined in the paper.
v) Thanks extended to the Finance Team and Trust staff who aided delivery of the 2025/26 position.

11.3 Month 12 Capital Report (26/27.19)

a. The Chief Finance Officer introduced the report. The Board **noted**:

i) £53m capital investment delivered to enhance digital and physical assets and progress strategic schemes.
ii) That overall the position was broadly on plan, with a small variance (£228k overspend, including £250k within the system).
iii) Key areas of spend included fire safety improvements across the estate and major programmes such as e-Care and Women and Children's.
iv) Further investment included linear accelerator replacements and robotic surgery.
v) Thanks extended to the Finance Team and Capital Sub Groups for oversight and delivery.
vi) That Board approval was sought for Public Dividend Capital (PDC) relating to Women and Children's project fees in line with the Memorandum of Understanding (MOU).

b. The Board **discussed**:

i) (DA) highlighted comparatively low NHS capital investment relative to other countries as a contributory factor to current challenges.
ii) (ID) queried variances and whether delays to medical equipment purchases had impacted delivery. (IDe) confirmed this reflected programme reprioritisation and timing differences, with any undelivered items to be incorporated into the following year's programme. It was confirmed there was no impact on clinical services, with equipment remaining safe for continued use and that a "blue smoke" process was in place to enable urgent replacement where required.

c. The Board **resolved** to:

i) **Note** the financial position for the capital programme for the period to 31 March 2026 (month 12) which is an overall overspend of £0.228m against a target overspend of £0.25m.
ii) **Approve** the receipt of £6.719m of PDC for the Women and Children's Hospital project fees for 2026/27.

Break 12.00 to 12.15 (15 minutes)

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14. People and Culture Committee (PCC) Assurance Report and Matters Escalated from Committee (26/27.20)

a. Richard Kramer, Non-Executive Director and Committee Chair introduced the report. The Board **noted**:

i) Focus on key workforce metrics, strengthening divisional accountability for improvements in appraisal, sickness and training compliance.
ii) Reconnection of teams following organisational change.
iii) Delivery of a culture programme to improve connection, productivity and wellbeing across the Trust, with pace of implementation emphasised.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Receive** and **note** the People and Culture Committee assurance report from the March 2026 meeting.

14.1 Medium Term Workforce Plan (26/27.21)

a. The Deputy Chief People Officer introduced the report. The Board **noted**:

i) Transition from a one year to a 3 to 4 year planning horizon to support longer-term workforce planning.
ii) Acknowledgement of support from the Committee and Finance Team.
iii) Substantive workforce below plan due to vacancy controls, with posts now being filled; safer staffing maintained through bank and agency use, with agency spend at 1.4% (below the 2% target) and on a downward trajectory.
iv) Focus on reducing reliance on temporary staffing and improving staff retention, alongside continued investment in health and wellbeing following organisational change.
v) Planning complexity noted due to the shift towards neighbourhood health, with further detail to be developed.
vi) Continued emphasis on effective onboarding and growing the local workforce.

b. The Board **discussed**:

i) (DA) advised it would be useful to have more information on what the future workforce would look like in 2036.
ii) (KOK) emphasised the need to further develop the plan and that launch of the workforce strategy would aid this. The need for a stronger focus on leadership, staff experience (suggested adding into appraisal) and the adaptability of skills to enable individuals to work differently or in another setting.
iii) (ES), (DA) and others highlighted alignment with the Trust strategy and NHS 10-Year Plan, including implications for skills gaps, new models of care, Artificial Intelligence (AI), and strengthening workforce pipelines with education partners.
iv) (RHa) raised broader opportunities around voluntary sector integration, co-creation, management development and cross-sector working.
v) (AB) raised the document would be iterative, with ongoing refinement required to reflect neighbourhood working, future service models and long term recruitment needs, and he welcomed seeing updated versions at PCC.
vi) (RK) and (DA) reinforced that workforce plans are enabling strategies to support delivery of the overall Trust strategy and should remain live and responsive.

Neave,Lynsey
30/06/2026 09:34:26

vii) (RJ) highlighted the need to consider future service models, including infrastructure and early engagement with schools to promote long term career opportunities, workforce pipelines and required training programmes.
viii) (RH) placed emphasis on co-creation, cultural alignment, and leveraging organisational insight and connections.
ix) (ID) advised of opportunity to address skills gaps, look at the population as well as utilising expertise across the system.
x) (RK) noted this as an early stage, iterative strategy aligned to the Medium Term Financial Plan (MTFP), with further refinement required to reflect priorities such as neighbourhood working and AI.
xi) (DA) and (ES) reinforced that workforce plans are enabling strategies to support overall Trust delivery and should remain dynamic and be continuously updated.

c. The Board **resolved** to:

i) **Note** the content of the Medium-Term Workforce plan.
ii) **Note** the workforce plan will be updated to align with the Trust's strategy.

d. The Board agreed the following **action:**

i) Dual Chief People Officer to ensure the Medium Term Workforce Plan is updated in light of Board discussions and that PCC regularly receives an updated version for scrutiny, i.e. a minimum of twice a year.

14.2 Board Diversity Plan Bi Annual Report (26/27.22)

a. The Company Secretary Officer introduced the report. The Board **noted**:

i) A structured approach to improving senior diversity was noted, with some progress made, including bespoke EDI and autism training delivered in April 2026.
ii) Delivery to date has been slower than planned, with further work underway alongside the Communications Team to embed actions, and increased focus proposed going forward.
iii) Regular oversight was provided through PCC, and approval was sought to close the Equality, Diversity and Inclusion (EDI) action.

b. The Board **discussed**:

i) IDe) noted formatting errors on page 329 and suggested the inclusion of target dates for each action, with republication of the pack for public use.
ii) (BG) emphasised the importance of communicating back to the organisation on impactful EDI progress, reflecting workforce diversity.
iii) (UB) raised concerns regarding terminology (e.g. use of 'minority'), noting potential confusion from a communications perspective, with further discussion to take place offline with (LN).

c. The Board **resolved** to:

i) **Receive** and **note** the Board Diversity Plan Bi Annual update.

Neave,Lynsey 30/06/2026 09:34:16

13. Audit and Risk Assurance Committee (ARAC) Assurance Report and Matters Escalated from Committee (26/27.23)

a. Adam Broome, Non-Executive Director and Committee Chair, introduced the report. The Board **noted**:

i) Strong year end reporting was noted, including positive feedback on Committee performance with thanks to members, external contributors and the Corporate Governance Team.
ii) Annual Accounts, Annual Report and Annual Governance Statement for 2025/26 were presented, with appreciation for early delivery; currently progressing through external audit, with outcomes to be reported to an Extraordinary Board in June 2026, including Value for Money conclusions.
iii) Forward planning for 2026/27 included a three year internal audit plan aligned to key risks, with further benchmarking against peer Trusts requested.
iv) Governance matters, including Standing Orders, the Corporate Risk Register, Use of the Trust Seal and Policy on Policies, which were on the agenda for Board discussion.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Note** the report from the April 2026 meeting of the Audit and Risk Assurance Committee.

15.1 Board Assurance Framework (BAF) (26/27.24)

a. The Company Secretary introduced the report. The Board **noted**:

i) Track changes which denote amendments and that the BAF was presented to Committees in March and April 2026.
ii) Level of risk to ability to comply with regulatory requirements for FOI and SARs.
iii) An increase in Never Events so a need to understand common themes.
iv) Risks associated with pausing e-Care go live, financial risks due to industrial action, as well as impacts on the Devon position to the Cornwall and Isles of Scilly system.
v) Severe weather impacts and known fire and health and safety matters.
vi) That the BAF would be further updated through Executive review and in accordance with new Trust strategy.
vii) Work being undertaken to develop a system assurance framework to align with assurance statements which remains ongoing and was being monitored by ARAC.

b. The Board **discussed**:

i) (KOK) highlighted ED Risk 25 (ID 9048) for review, noting its longevity and the need for reassessment.

Neave, Lynsey
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c. The Board **resolved** to:

i) **Note** the reporting, including new gaps in assurance and mitigating actions;
ii) **Approve** the closure of:

- **gap in assurance and action 10 of BAF element 1 (Quality of Care)** regarding HSMR coding, which is being mitigated through business as usual activities but replaced with a new risk regarding coding resource and the impact the backlog;
- **action 2a of BAF element 3 (integration)** relating to the Women's and Children's Board as governance arrangements have been embedded into the programme and is replaced a new action 2a relating to the overall level of risk of delivery of the scale and breadth of transformation at RCHT.

15.2 Standing Orders, Standing Financial Instructions, Scheme of Delegation and Matters Reserved for Board Annual Review (26/27.25)

a. The Company Secretary introduced the report. The Board **noted**:

i) Amendments made to provide better clarification which had been identified using track changes.
ii) That ARAC had approved for onward approval by the Board.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Approve** changes to Standing Orders, Standing Financial Instructions and Scheme of Delegation and Matters Reserved for Board.

16. Remuneration and Appointments Committee Assurance Report to Board (25/27.26)

a. Isobel Down, Non-Executive Director and Committee Chair introduced the report. The Board **noted**:

i) Committee formed by NEDs with exception of ARAC chair to maintain independence. However the ARAC Chair had recently attended a meeting where recruitment of a Trust Chief Executive had been discussed.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Note** the items considered by Remuneration and Appointments Committee at its March 2026 meetings and the decisions taken on behalf of the Board as per the Committee's terms of reference.

Neave Linney
30/06/2026 09:30:26

17. Integrated Performance Report (26/27.27)

a. The Chief Operating Officer introduced the report. The Board **noted**:

i) For breast cancer discussion at Committee that 28 day faster diagnostic and 62 day standard performance were below national requirements. Breast, urology and lung deep dives would be received by FPC (performance lens) and by QAC (quality lens).

b. The Board **discussed**:

i) (IDe) highlighted elective performance, noting 10 patients were waiting over 65 weeks, with a target to reduce this to zero by September 2025. Continued Board oversight was welcomed, alongside broader UEC performance given ongoing national focus.

c. The Board **resolved** to:

i) **Discuss for assurance** the Month 12 performance under the domains of Safe, High Quality Care; Supported and Valued People; and Improving Together.
ii) **Note** further detail including actions planned and underway to improve performance is provided in the narrative attached to each section of the main report.

Corporate Trustee

18. Charitable Funds Committee (CFC) Assurance Report to the Board (25/26.28)

a. Richard Kramer, Non-Executive Director and Committee Chair, introduced the report. The Board **noted**:

i) Fundraising income exceeded the 2025/26 target (£516k vs £512k) despite the challenging financial climate, although community fundraising performance was below expectations.
ii) Team restructure to strengthen priorities and targets, including development of the charity lottery and increased use of beneficiary stories to drive engagement.
iii) Funding secured from NHS Together to support wellbeing initiatives at SMH, informed by staff network input.
iv) Successful London Marathon participation, with seven runners raising just under £19k with some context provided on challenges faced by some of the runners involved.
v) Promotion of the Great Cornish Cuppa fundraising campaign (26 June 2026), with the aim of expanding this to approximately 50 events across Cornwall. More information was available on the website and via social media.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Note** the report from the April 2026 meeting of the Charitable Funds Committee.

Neave,Lynsey
30/06/2026 09:11:26

19. Committee Annual Reports, Evaluations and Effectiveness and Terms of Reference (26/27.29)

a. Lynsey Neave, Company Secretary, introduced the report. The Board **noted**:

i) Report taken as read so not discussed.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Receive** and **note** the summary of the 2025/26 Committee Annual Reports, which were presented to the relevant Committee.
ii) **Approve** the Committee Terms of Reference.

Section C: Matters of Report

20. Trust Strategy Bi Annual Report (26/27.30)

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Discuss** the proposed strategy communications plan as set out in Appendix 1, with intended launch in May 2026.
ii) **Note** the strategic priorities identified for 2026/27.
iii) **Note** that the new Trust strategy will form part of the 'We are RCHT' culture transformation launch events and inform the development of a Strategic Communications and Engagement Plan.
iv) **Approve** the proposed bi annual strategy monitoring and reporting approach.

21. Corporate Risk Register (26/27.31)

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Note** the underlying risk profile for RCHT that informs the Corporate Risk Register.
ii) **Note** the addition of two new risks to the Corporate Risk Register during this reporting period.
iii) **Note** the removal of two risks from the Corporate Risk Register.
iv) **Note** the updates presented, including the proposed revisions to scoring.
v) **Consider** requesting assurance regarding significant risks to the Trust, particularly in situations where progress does not meet expectations.

22. Research and Development Strategy Annual Review (26/27.32)

Weave Live 30/06/2026 09:31:26

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Note** the Research and Development Strategy Annual Review.
ii) **Note** that the annual report and the strategy review will be combined into one report and will be received by the Board in October/November 2026.

23. Trust Seal Bi Annual Report (26/27.33)

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Receive** and **note** the use of the Trust Seal Bi Annual Report for 1 October 2025 to 31 March 2026.

24. Matters Reserved for Board: Trust Policies

24.1 Learning from Deaths Policy (26/27.34)

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Approve** the Learning from Deaths Policy.

24.2 Clinical Audit Policy (26/27.35)

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Approve** the Clinical Audit Policy.

24.3 Policy on Policies (26/27.36)

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Approve** the Policy on Policies (Development and Management of Knowledge Procedural and Web Documents) V9.0 and supporting ‘Guidance on Developing, Formatting and Accessibility for Policy Documentation’.

24.3 Complaints Policy (26/27.37)

Neave, Lynsey
30/06/2026 07:31:26

a. This was a starred item so not for discussion unless requested unstarred prior to the meeting by a member of the Board.

b. The Board **resolved** to:

i) **Approve** the updated Complaints Policy.

Section D: Other Matters

25. Summary consideration of risk (25/26.38)

a. The Company Secretary introduced this item. The Board **noted**:

i) UEC, symptomatic breast pathway, fines referenced within the GOSWH report.
ii) Risk for ED crowding.
iii) E-Care and delays with go live.
iv) Industrial action financial costs.

b. The Board **discussed**:

i) No specific questions or issues raised and discussed.

c. The Board **resolved** to:

i) **Identify** any risks raised during the meeting that may need to be escalated to the Board Assurance Framework or Corporate Risk Register.

26. Questions from the Public (26/27.39)

The Company Secretary introduced this item. The Board **noted**:

i) That nearly 50 people had viewed the Board meeting.

Q. David Wring, via Health and Overview Scrutiny Committee. Given that the Administration consultation has now been withdrawn, can the Trust confirm how much public money was spent on a process that delivered no outcome, and why such a resource-intensive programme was pursued when the anticipated financial benefit was reportedly less than 1% of required savings?

A. (RJ) advised that proposed changes to clinical administration form part of wider service realignment and efficiencies, including cost reduction. The consultation remained paused to allow further engagement with staff and trade unions, and it was noted that it would be inappropriate to comment further whilst the process remained ongoing. Resource allocation was internal and aligned to the broader financial recovery programme.

Q. Jane Bernal congratulated all involved and welcomed, albeit modest improvements in flow through ED and corridor care. Jane asked that given that the problems are clearly across the NHS/Social care system what resources are needed to ensure patients, on wards as well as ED, see real improvements and that the problem is really dealt with rather than pushed round the Trust, and indeed the wider system. What measures and solution will reduce the use of corridor care, on wards as well as ED, does not increase ambulance turn round times, flow through ED, demand on ED, or readmissions for the same condition?

Neave Brisco
30/06/2025 09:41:26

A. (RJ) explained delivery of the GIRFT clinical operational standards which are best practice across the Country. These standards help achieve a shorter length of stay which is key critical to reduce corridor care. Additionally, learning from other centres in relation to some of the medical models in use as well as working with system partners on a range of initiatives from doing things differently to preventing attendance in the first instance. Also better alignment and work relating to patients who need to exit the hospital with the provision of ongoing support. There was focus on what is within the Trust's gift to change so it acts as efficiently and effectively as possible. The best bed for a patient being their own bed at home. Working collectively to not push the problem around the hospital or system. (ID) extended thanks to Jane Bernal for her active contribution and intelligent and thought provoking questions.

27. Evaluation of Effectiveness of the Meeting (26/27.40)

a. The following comments were received from Board members.

i) **Worked well:**

- (AD): Board story was excellent and showed the value of patient centred care and strength of a patient's voice. Negative 850 pages of papers to read noting the high number within section C which contributed to the pack size.
- (IDe) timing of the break was helpful and welcomed. Opportunity was identified to streamline papers through clearer prioritisation and potential use of digital/AI tools as well as a library function within Admin Control.
- (RK) fed back staff experience was noted as a consistent and important theme across Board discussions.
- (ID) welcoming new Board members and well chaired.
- (KOK) raised the importance of Board visibility and role modelling. Speaking up was encouraged and that Board members are accessible if not always visible.
- (UB) valued the deep dive discussions and suggested reflecting these within the pack to demonstrate the depth of Board scrutiny to the public.

28. Date of next meeting and move to Board in Private (26/27.41)

a. The Board noted its next meeting in public would be on **2 July 2026** and moved to its private session per the notice of motion on the agenda.

The meeting closed at 13.30 hours.

The minutes were duly approved by:

Category	**Information**
Name	
Signature	
Date	

Neave Halsey 30/06/2026 09:31:26

KEY:
Action complete or proposed complete
Action in progress
Action overdue/incomplete

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NHS Trust

Trust Board in Public Action Log

Min Ref	Action	Lead	Status	Due date	Update
May-26					
26/27.06	**Chair's report:** The Chief Strategy Officer, with Executive colleagues, to review arrangements to support award submissions and strengthen recognition of success, including opportunities for award recipients to attend Board. This would include liaison with (UB), NED Strategic Communications Lead, to enhance communication of positive stories.	Chief Strategy Officer with Executive Colleagues & Strategic NED Comms Lead	Propose complete	Jul-26	**Update July 2026**: links with the culture work and the development of the Communications appraoch. UB in regular discussion with the CSO. Propose complete
26/27.07	**Chief Executive's Report:** Dual Chief People Officer as Senior Independent Risk Owner (SIRO) to provide assurance to the Board that the Trust will have a data handling and complaints process in place by 19 June 2026 following the recent change in legislation.	Dual Chief People Officer (as SIRO)	Propose complete	Jun-26	**Update July 2026:** Complete.
26/27.07	**Chief Executive's Report:** Acting Chief Executive to arrange for walk round findings to be included in future reports.	Acting Chief Executive	Propose complete	Jul-26	**Update July 2026:** Complete, walkrounds included in CEO Report
26/27.08	**Urgent and Emergency Care (UEC) Performance:** Acting Chief Nursing Officer to arrange for the Board to receive a Board story relating to a patient who had experienced a 12 hour ED waiting time.	Acting Chief Nursing Officer	Propose complete	Sep-26	**Update June 2026:** The Acting Chief Nursing Officer has confirmed that Corridor Care Board stories are in place for July's Board meeting. Propose complete.
26/27.08	**Urgent and Emergency Care (UEC) Performance:** Chief Operating Officer to facilitate a walk around with teams for Rebecca Hopkins, Clinical Non-Executive Director and Rae Hall, Associate Non-Executive Director.	Chief Operating Officer	In progress	Jul-26	**Update June 2026**: The COO's Executive Assistant is liasing with the PA to the Non-Executive Directors. Operational pressures has caused a delay to this action.
26/27.09	**Staff Survey Outcomes and Action Plan:** Dual Chief People Officer to lead on the provision of a revised accelerated improvement plan with a clear priority on the key staff experience metrics with rapid and targeted actions.	Dual Chief People Officer	In progress	~~01/05/2026~~ Aug-26	**Update July 2026:** Divisional plans in development.
26/27.11	**Guardian of Safe Working Hours:** Uzma Bozai, Non-Executive Director to share fatigue modelling articles/resources with the Guardian of Safe Working Hours.	Non-Executive Director	Propose complete	May-26	**Update July 2026:** complete
26/27.21	**Medium Term Workforce Plan:** Dual Chief People Officer to ensure the Medium Term Workforce Plan is updated in light of Board discussions and that PCC regularly receives an updated version for scrutiny, i.e. a minimum of twice a year.	Dual Chief People Officer	Propose complete	Jun-26	**Update July 2026:** To be included on PCC workplan. Propose complete.
Mar-26					
25/26.187	**Chief Executive's Report:** Chief Operating Officer to provide a summary to the next People and Culture Committee on the Divisional appointment processes (i.e. mechanisms put in place, provision of support, feedback etc).	Chief Operating Officer	Propose complete	~~01/04/2026~~ Jul-26	**March 2026 update:** Deputy Company Secretary has apprised People and Culture Committee Secretary of this requirement by email to ensure the information is provided to the Committee and it will be added to the cross escalation log accordingly so provision can be closed once completed. **May 2026 update:** Chief Operating Officer will be providing a report to the next People and Culture Committee following liaison and discussion with Executive colleagues. **June 2026 update:** The COO has provided an update to PCC. The orginisation charts are being updated with names of the current appointed staff and a learning appraoach being developed. Propose complete as this will be scheduled for PCC after the summer
25/26.193	**Safer Staffing Bi Annual Report:** Dual Chief Nursing and Deputy Chief Executive to liaise with the Director of Nursing, Midwifery and Allied Health Professionals to provide a precis at the front of the report (given its technical nature) and review the resolutions to mitigate these being lengthy in the future.	~~Dual Chief Nursing Officer and Deputy Chief Executive~~ Acting Chief Nursing Officer	In progress	~~01/05/2026~~ Sept-26	**Update May 2026:** Timescale updated to reflect the due date for the next bi annual report to the Board.
Jan-26					
25/26.157	**Urgent and Emergency Care (UEC) Performance:** Chief Operating Officer and Executive colleagues to look at the physical layout of ED, MRATs and other emergency areas to see whether spaces could be reconfigured to benefit patients using capital incentive funding if available.	Chief Operating Officer and Executive colleagues	In progress	~~01/03/2026~~ Jul-26	**Update January 2026:** Chief Operating Officer will be undertaking a visit to look at the physical layout of ED, MRATs and other emergency areas on 10 February 2026 with a view to seeing whether any spaces could be reconfigured to better support and benefit patients. The Walk Through team will consist of the Chief Operating Officer, Emma Bellam, Deputy Head of Nursing AEM, Toby Slade, ED Consultant and Dan Bawden, Specialty Lead for ED. **March 2026:** Chief Operating Officer to consider and progress. Action remains in progress. **May 2026 update:** A walk around has occurred and some options identified and outline costs have been requested from the Estates Team. **Update June 2026:** The Estates Team are working up options. The Chief Operating Officer is reviewing external funding options.

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30/06/2026 09:31:26

KEY:

Action complete or proposed complete
Action in progress
Action overdue/incomplete

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Trust Board in Public Action Log

Min Ref	Action	Lead	Status	Due date	Update
25/26.170	**Board Assurance Framework:** Company Secretary with executive colleagues to review the BAF in totality following approval of the refreshed Trust strategy.	Company Secretary and Executive colleagues	Propose complete	~~01/05/2026~~ Jul-26	**March 2026:** The BAF will be reviewed before end of Q4 of 2024/25 and presented to Board in May 2026. **May 2026 update:** Remains in progress. **June 2026:** Risk appetite session held in June 2026 and the BAF being aligned to the new strategy, and these statements - scheduled for August Audit and Risk Assurance Committee and Board. Propose complete as on the workplan
Sep-25					
25/26.85	**Guardian of Safe Working Hours Q1 Report:** Director of Estates and Facilities and Chief Operating Officer (or designated colleague) liaise with the Guardian of Safe Working Hours and undertake further work to identify rest facilities for doctors within Trelawny Wing and any other matters requiring addressing in relation to facilities presently available within Tower.	Director of Estates and Facilities and Chief Operating Officer	In progress	~~01/11/2025~~ ~~Jan-26~~ ~~May-26~~ Aug-26	**October 2025 update:** Guardian of Safe Working Hours report identifies that some areas in Trelawny wing have been identified which could possibly be used as a rest facility for junior doctors. Work is ongoing to secure them and once confirmed the Trust can proceed to purchase suitable furniture. **March 2026 update:** No suitable alternative space has been identified to date. The option of using the Outpatients area overnight as a rest space is currently being explored, with ongoing discussions taking place with the Clinical Matron to determine its feasibility. The held funds can be utilised to upgrade the existing rooms in Tehidy. **May 2026 update:** Guardian of Safe Working Hours report advises that this remains in progress although a solution may be imminent. **June 2026 update:** The Deputy COO (Clinical) has undertaken a walkaround of this area with the Director of Estates. The Chief Medical met with the Chief Resident and their deputy on 16 June. A rest area in the Trelawney Wing is still to be identified and there are some housekeeping issues to be addressed within the current rest rooms.
25/26.91	**Board Diversity Plan 2025/26:** Chair, Chief Executive and Company Secretary to discuss how to accelerate progress of the Board Diversity Plan actions (for e.g. discussion at a forthcoming Remuneration and Appointment Committee) and reflect on where and how the Trust can make improvements. Additionally consider additional measures that could be taken to avoid the carry forward of actions brought forward from the 2023/24 and 2024/25 plans.	Chair, Chief Executive and Company Secretary	In progress	~~01/01/2026~~ May 2026	**October 2025 update:** Update to be provided through the next Board Diversity report to Board in May 2026. **June 2026:** Report scheduled for July PCC. Aim to close action through assurance to this meeting.

Neave,Lynsey
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Chair's Report – July 2026

1. Walkarounds

I visited the Emergency Department on 27 May, where I observed continued high levels of demand and pressure on services. I would like to thank staff for their professionalism and commitment in maintaining patient care in challenging circumstances. I am keen to continue visiting as many areas of the hospital as possible to better understand frontline experiences.

2. Trust Podcast Recording

Following the Trust Board in Public meeting at the beginning of May, the Acting Chief Executive (CEO) and I recorded a podcast to help publicise the work of the Board. During the discussion, we reflected on key themes from the meeting, including staff survey feedback, organisational culture and priorities for the coming months.

The discussion reinforced the importance of fostering a culture where colleagues feel supported, valued and able to speak up. It highlighted the Board's continued commitment to openness and accountability, including the role of public questions in maintaining focus on issues that matter most. It also emphasised the need to translate feedback into tangible improvements across the Trust, from cultural and leadership visibility to practical changes across our sites.

A link to the podcast recording can be found here: https://youtu.be/01L4MjU_oK0

3. Board Story

At the Trust Board in Private in June, we received a Board story on the contribution of our volunteers. Over 250 volunteers support the Trust, making a meaningful difference to patients, visitors and colleagues every day. I would like to thank them for their time, care and commitment.

4. Board Development Sessions

A Board Development Session was held on 4 June to engage with Divisions on their current priorities, future direction and approaches to making the Trust a great place to work. Discussions included the Divisions' response to Staff Survey feedback. The session provided a valuable opportunity to strengthen understanding of Divisional priorities and identify areas where Board support may be required. The Board also

Neave,Lynsey
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reviewed and discussed the Trust's risk appetite and updated Board Assurance Framework to ensure alignment with the refreshed Trust strategy.

A further Board Development Session was held on 18 June. The session focused on strengthening Board effectiveness, including building trust, psychological safety and clarity of roles and purpose. It explored how challenge and collaboration operate in practice, alongside the behaviours required for high-performing teams. The use of Insights Discovery profiles supported greater understanding of individual working styles and will help inform how the Board works together going forward.

5. Board Development Programme - NHS Board Development Programme (South West Cohort 1)

The Trust has been invited to participate in the first cohort of the NHS England Board Development Programme, a national initiative led by NHS England to strengthen Board effectiveness, governance practice and impact, with a particular focus on quality and the future delivery of healthcare. The programme offers a structured 12-month development package, including a facilitated whole-Board development session.

Both Kim and I support participation in this opportunity as it represents a valuable investment in strengthening governance and leadership capability.

Engagement has also taken place with system partners, including Cornwall Partnership NHS Foundation Trust (CFT) and Devon and Cornwall Integrated Care Board . Discussions have confirmed a similar level of interest and support, with CFT leaders indicating their intention to participate, subject to practical considerations such as alignment with existing development commitments and programme timelines. Coordination between organisations is underway to ensure a coherent approach and to maximise the value of the programme across the local system.

The Board is asked to:

- Endorse the Trust's participation in Cohort 1 of the NHS Board Development Programme;
- Support the commitment to a whole-Board development session within the programme timeframe; and
- Delegate authority to the Chair and Chief Executive to finalise arrangements, including coordination with system partners, to ensure effective delivery and alignment with organisational priorities.

Neave, Lynsey
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6. Meetings and Events (including system meetings)

The below activities occurred during May and June 2026:

Peninsula Acute Provider Collaborative

The Peninsula Acute Provider Collaborative met on 8 June, bringing together Trust leaders from across the Peninsula. Discussions included the future of the Peninsula Pathology Service and the development of a collaborative approach. The future of the collaborative itself was also considered in the context of wider system transformation. The importance of continued partnership working across the Peninsula was recognised.

Dame Gill Morgan, Regional Chair, Visit 13th May

The NHS England Regional Chair, Dame Gill Morgan, visited RCHT and Cornwall Partnership NHS Foundation Trust (CFT) on 13 May. The visit provided a valuable opportunity to discuss how the Regional Chair role can support Trust Chairs and strengthen leadership across the system.

Discussions focused on leadership expectations, succession planning and opportunities to support both new and experienced Chairs, alongside strengthening collaboration and shared learning across organisations. There was positive recognition of strong partnership working within Cornwall and across the wider system.

The visit also provided an opportunity to reflect on local priorities, including progress in reducing ambulance handover delays and improving performance against the four-hour standard. Ongoing challenges were acknowledged, alongside wider discussions on system working, Integrated Neighbourhood Teams and the potential to simplify processes through appropriate delegation. Feedback following the visit was positive, with discussions described as constructive and beneficial.

Local Authority / RCHT Political Touch Point

RCHT has occasional meetings with Cornwall Council. The latest took place on 26 May and included the Leader of the Council, Councillor Leigh Frost, and Councillor Jim McKenna, portfolio holder for Adult Social Care and Health Partnerships. Cornwall Council's CEO, Kate Kennally, and Ali Bulman, Strategic Director for Safe and Caring Communities also attended. I attended alongside the Chief Operating Officer who was representing the Acting CEO.

We had a very engaging and positive discussion, where we recognised the importance, not least as two major employers of working in close partnership, across a wide range of issues in addition to health and social care. These included, for example, climate change, education, transport, infrastructure and economic development.

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30/06/2026 09:31:26

As a result of this positive meeting, RCHT and Cornwall Partnerships NHS Foundation Trust (CFT) have agreed to meet Cornwall Council together at least quarterly to develop strong partnership across Cornwall.

Quarterly Health and Members of Parliament Meeting

I attended the above meeting on 29 May. Key discussions focused on ongoing Integrated Care Board changes and transition planning, including the implications for local governance and system working. Updates were also received on the development of Neighbourhood Health Centres as part of wider system transformation.

The meeting provided an opportunity to reflect on local priorities across partner organisations and reinforced the importance of continued collaboration in delivering integrated health and care services.

Cornwall Partnership NHS Foundation Trust Chair Visit

Matthew Taylor, CFT Chair, visited the Trust on 3 June. Matthew visited a number of clinical areas such as the Emergency Department, Psychiatric Liaison and Older People's Mental Health services. The visit provided a valuable opportunity to observe patient pathways across services and engage with clinical teams.

I was able to greet Matthew at the end of the visit and I know he found it a very positive experience. I am grateful to all those who made it possible.

Recommendation

The Board is invited to:

- **Receive** and **note** the Chair's report.
- **Endorse** the Trust's participation in Cohort 1 of the NHS Board Development Programme;
- **Support** the commitment to a whole-Board development session within the programme timeframe; and
- **Delegate authority** to the Chair and Chief Executive to finalise arrangements, including coordination with system partners, to ensure effective delivery and alignment with organisational priorities.

Neave,Lynsey
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Royal Cornwall Hospitals NHS Trust

Chief Executive's Report to Board in Public – July 2026

Chief Executive Visits

As Acting Chief Executive Officer, I continue to spend as much time as possible visiting teams in wards and departments across our hospitals. This enables me to hear from them about what makes them proud to work at RCHT, speak openly about some of the frustrations and issues we need to improve patient and staff experience. Making time to connect with our people is something as Acting Chief Executive Officer, I am committed to continuing over the coming months.

1. Chief Executive Walk Rounds

Since our last public Board meeting in May, I have visited several Trust departments, observing local innovations and continuous improvements such as enhancements in maternity and staff facilities, progress on the "silent hospital" initiative, and some well spent time with our SABA colleagues regarding their updates to parking policies. Lastly, with our Post Graduate Education Centre who are focusing on optimising space, supporting learning, and developing apprentices with some recent challenges being supported by our colleagues in estates regarding some repairs.

During June, I have had the opportunity to visit several more departments including Paediatrics, Wheal Proposer and our Facilities team. I heard from the staff the challenges that they are facing as well as the things that they are proud of. It was inspiring to witness the passion and commitment that the teams bring to provide great care for our patients and the dedication and teamwork; everyone is working hard to make a difference. One observation I made when visiting Wheal Prosper is the ward could do with a paint refresh, and our estates team are liaising with the ward to enable this. Our Facilities team colleagues were committed, passionate and totally dedicated to improving both patient and staff experience. Many of them have come through their service ranks and are transforming their communication and service offerings. I was deeply inspired.

RCHT / CFT Annual Health Care Supporter Conference - On the 16 June 2026, I had the opportunity to both open and attend the annual Healthcare Support Worker Conference. This was a vibrant show casing event of the incredible roles that Health Care Support Workers undertake in both organisations. Hearing their journeys and experience, given with such pride, compassion and professionalism it is clear that the future is bright. Their roles in both the community demonstrated the support and for patients, families, colleagues, in their treatment plans and overall wellbeing; this

Neave Lukey 30/06/2026 13:34:26

makes a tremendous difference and our colleagues dedication shone through.

NHS ConfedExpo conference – On the 10 and 11 June, as Acting Chief Executive Officer, I attended the NHS ConfedExpo conference which took place in Manchester. The conference was a fully packed two days, with over 10,000 delegates, and the agenda included population health and prevention, quality and improvement, neighbourhood health, technology and innovation. I was joined at the conference by Ella Stracey, Chief Strategy Officer, Alison Thorne-Henderson, Chief People Officer and two of Ella's team members Natalie Purchase and Abigail Parsons. The opportunity to network and consider cultural change and innovation, neighbourhood health and the digital agenda, will assist us in the year ahead.

Veterans event - on the 22 June 2026, I had the privilege to attend the Armed Forces Day flag raising ceremony at County Hall, Cornwall Council. It was a wonderful occasion where I met many people, involved with supporting our veterans. John Clague, Chair of the Armed Forces at RCHT was also in attendance. 36,000 is the number of regular service personnel living in the South West, this includes about 3,000 service personnel in Cornwall and over 7000 in Devon.

There are almost 73,000 Armed Forces Households in Cornwall. These households where one or more of the family are part of the Armed Forces Community (serving, veteran, reservist, adult cadet volunteer, or a direct family member of one of these groups)

There were 30,229 veterans in CIOS reported in the 2021 census. This is 6.7% of the population (around twice the national average). This is partly due to bases at Culdrose, St Mawgan, Torpoint and Plymouth and partly due to people retiring and moving to Cornwall.

I was fortunate to meet a wide variety of veterans, reservists and spouses today at the stand in Trelawney. It always amazes me how many of our staff have a connection, particularly the number of nursing staff who's parents (normally their dad) was based at Culdrose of St Mawgan, they grew up in Cornwall, went to university and then returned to the South West.

News items

1. St. Austell Surgical Hub

On the 20 May we were notified from NHS England that following a visit from the 'Get it Right First Time' (GIRFT) team in March, the St Austell Surgical Hub (SASH) was approved as an accredited site. SASH has two operating theatres, four recovery bays and six pre-operative assessment rooms and carry's out Ophthalmology and gynaecology procedures/

Neave Lawson 30/06/2026 09:31:18

The GIRFT programme is a national NHS England programme designed to improve

the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change.

PocketTalk improves communication in maternity care

Our maternity teams are now using PocketTalk, a small handheld device that provides real-time, two-way translation in over 90 languages. When a family arrives in maternity and English is not their first language, even simple conversations can feel overwhelming and, in an emergency, those barriers can become frightening. PocketTalk means staff can communicate clearly and quickly when an interpreter can't be arranged in time, ensuring families understand what's happening and feel supported throughout their care.

Inspiring the next generation of hospital designers and engineers

Our Women and Children's Hospital design and programme teams were out and about in schools in March, inspiring the next generation of hospital designers and engineers across Cornwall. Operation Cornwall was launched as part of our new Women and Children's Hospital's social value programme, giving local young people a chance to explore what goes into designing a modern hospital.

More than 400 pupils aged 9 and 10 took part in hands-on workshops, exploring project management, teamwork and different aspects of design using modelmaking, drawing and even Lego. Along the way, their experiences we documented, together with those of the team who delivered the programme and created a short film.

Vaccination and Health Promotion team secures three-year contract to deliver outreach vaccination programme

The RCHT Vaccination and Health Promotion team has successfully secured a three-year contract to deliver an outreach vaccination service, which will begin from 1 September 2026. This marks an exciting new chapter in the team's continued evolution and commitment to improving population health. Originally established in 2020 to deliver mass vaccination programmes during the pandemic, it has since expanded its offer to include seasonal vaccination delivery, penicillin de-labelling services, staff health reviews, and health checks for GP colleagues.

RCHT contributes to UK study that confirms less intensive radiotherapy is safe and effective for early breast cancer

A landmark UK study has revealed that women aged 50+ with low-risk early breast cancer after breast-conserving surgery, can safely receive less intensive radiotherapy without compromising treatment effectiveness. The 10-year results were led by Dr Duncan Wheatley, former Consultant Oncologist at the Royal Cornwall Hospital, offer new hope for thousands of patients seeking gentler treatment options. The study, which followed over 2000 women including 136

Neave, Lynsey 30/06/2026 09:31:26

participants were recruited from the Royal Cornwall Hospitals NHS Trust (RCHT) between 2007 and 2021.

RCHT launch major new programme for preventive care

We have begun using a new digital tool to help find people who may be at risk of liver disease, potentially before symptoms appear. The system, called hepatoSIGHT®, is now being used by NHS clinicians at RCHT to support preventative care and earlier diagnosis. It works by securely analysing patterns in historic blood test results that are already held within NHS systems.

hepatoSIGHT helps doctors look for patterns that may suggest someone could benefit from further checks of their liver health. These patterns are often hidden in routine blood test results and may not be obvious during standard care.

Performance

1. Urgent and Emergency Care

We continue to experience considerable pressure across urgent and emergency care, which has been further intensified by the recent heatwave. I recognise the significant impact this has on patients, families and colleagues, and I want to offer my sincere thanks to all staff for their continued compassion, professionalism and commitment during this challenging period. Noting the Board will consider the Urgent Care Update and the new Integrated Performance Report which provides Divisional input and has been through relevant Committee meetings, the main points to draw attention to is the ongoing urgent care position; noting risk ID 9048(ED Crowding) remain the highest risk score of 25. The Chief Medical Officer, Acting Chief Nursing Officer and the Chief Operating Officer continue to work with teams on the actions as set out in the Clinical Vision of Flow. The significant driver of actions at the current time is embedding the Getting It Right First Time (GIRFT) Clinical Operational Standards. At the time of writing this report we are responding to a national heatwave, noting the impact on crowding across the sites and the impact on both staff and patients as the temperatures rise.

2. Senior Information Responsible Officer Update

Recent guidance from UK regulators highlights a material shift in the risk landscape driven by artificial intelligence (AI), with implications for Freedom of Information (FOI), cyber security, and organisational resilience.

Neave Lukey 30/06/2026 04:31:18

The Information Commissioner's Office (ICO) has reported a rise in AI-generated FOI requests, which are often higher in volume and complexity and may misinterpret legislation. This creates additional burden for FOI teams and risks delays,

inconsistencies, and increased complaints. The ICO has issued practical guidance, including use cases and template responses, to support compliant and efficient handling:

In parallel, the National Cyber Security Centre (NCSC) has published guidance on the adoption of “agentic AI”, which can independently plan and act. While offering potential operational and cyber defence benefits, these tools introduce new risks if not tightly governed. Current advice is to limit deployment to low-risk use cases, ensure strong cyber controls from the outset, and maintain clear human accountability:

The cyber threat environment is also evolving rapidly. The ICO has highlighted the increasing use of AI in cyber-attacks, including sophisticated phishing and automated exploitation tools. It has set out five practical steps to strengthen organisational resilience.

More broadly, national intelligence and survey data indicate a sustained increase in cyber risk, with nation states targeting critical infrastructure and persistent gaps in organisational preparedness, particularly in supply chain oversight.

Implications for the Trust are as follows:

i. Increasing operational pressure on FOI processes requiring strengthened governance, consistency, and resource planning.

ii. Need for cautious, controlled adoption of AI tools, with clear accountability and risk assessment.

iii. Requirement to enhance cyber resilience across the organisation and its supply chain, recognising the growing sophistication of AI-enabled threats.

iv. Importance of embedding a strong security culture and awareness across the workforce (supported by tools such as the NPSA Security Culture Tool: Security Culture Tool).

3. Women and Children’s Hospital update

The programme continues to make good progress, during June the Trust had initial meetings with the alliance contractor assigned to the scheme as well as a stocktake meeting with the CEO advisor to the NHP Programme, NHP, NHSE regional and ICB colleagues to discuss the current position of the scheme and options to support continued and improved pace of delivery.

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The Trust are invited to a parliamentary launch event on the 29 June in London for the Hospital 2.0 Alliance and are being represented by Ian Dean as SRO for the programme at this event.

4. Electronic Patient Record (eCare)

The Trust is now in the latter stages of agreeing a new go live date which is anticipated, but not yet confirmed to be, Spring 2027. Full communications of the new go live date will be shared once the new programme plan is agreed and it will be confirmed this month.

5. Organisational change

The Care Group to Divisions and the Corporate changes have now concluded, there are some posts not yet filled and active recruitment is ongoing. The Chief Operating Officer will be ensuring lessons learnt are considered by the People and Culture Committee.

The Clinical Administration consultation commenced on 24 June, having shared the document with colleagues the week before so that they had time to begin considering the content before the consultation commenced. The updated proposal is as a result of ongoing engagement with colleagues and staff side representatives. The new job roles in the proposal are the result of co-design with staff representatives, staff side and the project team. There is a process in place to capture feedback from those staff directly impacted as well as key internal stakeholders and I encourage all impacted staff to review the proposal, attend a briefing session or if they would like to have a one-to-one meeting with a manager to make sure your thoughts are included in this consultation phase.

6. Equality Diversity and Inclusion

Inclusion and belonging remain a core priority in improving staff and patient experience. This is driven through the *We Are RCHT* Culture Transformation programme, particularly its Inclusion and Equality pillar, which focuses on:

- Inclusive recruitment training
- Inclusive leadership support
- Improved access and engagement with staff networks

We are also partnering to strengthen staff experience:

- **Inclusive Companies (with CFT):** improving outcomes for Global Majority staff
- **Kindling Interventions (with DPT):** delivering active bystander training

A second inclusion conference is planned for Quarter 3, featuring key partners to support delivery of this agenda.

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A sincere thank you to John Clague for his leadership as Chair of the Armed Forces Network. He has made a significant contribution to strengthening connections and improving experiences for Armed Forces staff and patients. As he steps down from the role, we thank him for his dedication and look forward to his continued involvement as a valued network member.

7. Governance Improvement Plan

The Trust Board in January 2026 approved the 2026/2027 Governance Improvement Plan noting this included the amalgamation of 6 actions from the 2024/2025 plan. Given the timing of the production of the plan, it focussed on 2026/2027 Governance Improvements and was developed in response to the External Well Led Development Review undertaken in autumn 2025.

The Governance Improvement Plan 2026/2027 comprises eight actions grouped in five areas, with various target dates for completion.

A summary progress table can be found below:

Complete	Proposed complete	In progress	Overdue	Not yet started	Total
0	1	6	1	0	8

The Governance Improvement Plan 2026/2027 is progressing across all five areas, with six of the eight actions in progress, one proposed for completion and one overdue. Good progress has been made in strengthening the Trust's governance infrastructure, including the establishment of the Culture Sub-Group, development of terms of reference for the Inclusive Wellbeing Group, implementation of the new divisional and corporate structure, and development of a revised assurance report template. The revised template responds to learning from the external well-led development review, repatriation of services and recent Board and Committee feedback, with a stronger emphasis on risk, the Triple Aim, public involvement, environmental sustainability and clearer links to the Corporate Risk Register and Board Assurance Framework.

There has also been clear progress in relation to stakeholder engagement, strategic alignment, organisational culture and performance assurance. The refreshed Trust Strategy has been approved and communicated through a structured communications and engagement plan, with the strategic communications action now proposed for completion. Work continues to strengthen partnership arrangements and stakeholder involvement, including improved engagement with the Health and Adult Social Care Scrutiny Committee, appointment of an Associate Non-Executive Director for the voluntary and community sector, and further work with Cornwall Partnership NHS Foundation Trust on collaborative and integrated health

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and care opportunities. The Board has approved the culture transformation approach, with the People Plan and Health and Wellbeing Strategy in development, and the revised Performance Assurance Framework was approved by the Board in June 2026. The principal area requiring revised timescales is the wider review of the Executive Governance Structure, which has been paused to allow the new organisational arrangements to embed before completion later in 2026.

National and Policy Updates

1. Resident Doctors Industrial Action

On the 13 June 2026, the Trust received a letter from Sir Jim Mackey, Chief Executive Officer at NHS England confirming that the planned industrial action by the resident doctors due to begin on the 15 June 2026 had been suspended.

Prior to receipt of confirmation on Saturday evening, the Trust had developed robust contingency arrangements to ensure the safe delivery of services over the planned five-day period. These plans included the establishment of appropriate clinical cover across all services, with patient safety as the overriding priority.

Following notification that the industrial action would not proceed, work was undertaken over the weekend to:

- Contact resident doctors to ensure the national position was clearly communicated; and
- Stand down arranged cover shifts and supporting arrangements in a controlled manner.

Further work was undertaken to ensure that all planned elective and outpatient activity proceeded as scheduled.

2. Abortion Law Crime and Policing Act

On the 8 June 2026, a letter was received from the Department of Health and Social Care regarding the change in law regarding abortion. The letter sets out a change in the law regarding abortion, following the passing of the Crime and Policing Act 2026. During the passage of the Crime and Policing Act through parliament, two sections related to abortion were added. The act received Royal Assent on 29 April.

3. Lord Mann Review

On the 4 June 2026, Sir Jim Mackey, Chief Executive of NHS England confirmed that Lord Mann had published his review into tackling racism and antisemitism within the NHS with recommendations to support safe services for all patients, communities and colleagues.

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Lord Mann's review sets out comprehensive recommendations to strengthen leadership, accountability and the NHS response to racism. NHS England has accepted these in full, focusing on improving staff support, enhancing training and capability, standardising data, and setting clear expectations on inclusion and political expression.

Immediate national actions include:

- Adopting the NHS Race and Health Observatory Seven Anti-Racism Principles
- Establishing clear Staff Standards on experiences of racism
- Strengthening accountability through appraisals and the NHS Oversight Framework
- Expanding datasets to include additional protected characteristics (e.g. Jewish and Sikh)
- Delivering targeted training (including for PALS/complaints teams and Board-level leadership)
- Publishing national uniform guidance following engagement on politicised symbols

Expectations of NHS organisations:

- Implement anti-racism principles and Violence Prevention and Reduction Standard
- Prepare for new Staff Standards and adopt the definition of anti-Muslim hostility
- Ensure staff completion of Equality, Diversity and Human Rights (EDHR) training and new modules
- Secure Board commitment to ongoing anti-racism training
- Strengthen communication and engagement with staff, patients and communities
- Use staff survey data to identify and address racism-related issues

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Governance and assurance: Boards must demonstrate oversight of workforce experiences, act on identified issues, and monitor progress. Organisations are also asked to confirm adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility by **31 July 2026**. The Trust is in the process of

being considered through its internal Trust governance.

Lord Mann's review sets out comprehensive recommendations to strengthen leadership, accountability and the NHS response to racism. NHS England has accepted these in full, focusing on improving staff support, enhancing training and capability, standardising data, and setting clear expectations on inclusion and political expression.

4. UK Supreme Court judgment on what constitutes a deprivation of Liberty

On the 18 June the Trust received an email from the Deputy Chief Nursing Officer for England, Professional and System Leadership confirming that following the UK Supreme Court Judgment on what constitutes a deprivation of liberty, delivered on 2 June 2026, the Department of Health and Social Care (DHSC) has published the following statement UK Supreme Court 2026 judgment on what constitutes a deprivation of liberty - GOV.UK.

In the meantime, the national NHS Safeguarding team is engaging with national adult statutory safeguarding partners and working collaboratively with ADASS and the DHSC Adult Social Care team to consider the implications of the Supreme Court judgment.

The NHS Safeguarding team will also be convening additional Safeguarding Adults National Network (SANN) sessions, alongside the NHS Safeguarding Strategic Mental Capacity Act (MCA) Groups, to explore this further, including the impact on self-funders and on 16- to 18-year-olds.

NHS Safeguarding's initial action will focus on maintaining close collaboration across the system. NHS providers, ICBs and NHS England will continue to work with DHSC, ADASS and exemplar local authorities (LAs) to develop a consistent, single approach. Providers should also continue to work with LAs to submit DoLS referrals, recognising that the 'multifactorial approach' represents good quality care planning in the pre-DoLS space, as set out in Chapter 2 of the MCA Code of Practice. In parallel, the NHS Safeguarding team will undertake a rapid review of all MCA and DoLS e-learning content, with an updated module to be published between 30 July and 30 December 2026, including approved infographics and examples of local protocols agreed through the NHS Strategic MCA Group.

Nursing band 5 job evaluation (placeholder)

A joint delivery plan is being developed by RCHT and Cornwall Partnership NHS Foundation Trust to review all Agenda for Change Band 5 nursing roles in line with national job evaluation requirements. The programme will support fair, consistent and evidence-based application of the NHS Job Evaluation Scheme, with all relevant roles reviewed by October 2028 and the delivery plan submitted nationally by 31 July 2026.

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Delivery will be phased from mobilisation in June–July 2026 through to finalisation by October 2028, with oversight through a Joint Programme Board, People and Culture Committee and Trust Board. The programme will be undertaken in partnership with staff side colleagues and trade unions, with further training planned to strengthen job evaluation capacity across both organisations. Key risks relate to workforce capacity, availability of trained job evaluators, staff side engagement and potential financial impact, with mitigations including targeted training, joint working and structured partnership engagement. The programme is expected to support workforce fairness, role clarity, staff experience, recruitment and retention, and sustainable service delivery.

5. NHS Oversight Framework 2026/27

On 11 June 2026 NHS England published an update to the NHS Oversight Framework 2026/27. The main updates to the framework for this year are:

- ICB segmentation returns after a pause in 2025/2026, and mirrors the approach taken to trusts. The framework confirms ICBs will be league tabled, meaning leaders should prepare for heightened media and political scrutiny. A new capability assessment for ICBs will be co-developed for 2027/2028.

- NHS England has broadened the previously narrow range of metrics used to segment and rank mental health, community and ambulance trusts, in response to extensive feedback from the NHS Alliance. It has also sought to increase alignment of metrics with the medium-term planning framework, and the aims of the 10-Year Health Plan and strategic commissioning framework.

- Segmentation and a growing number of metrics are now scored according to fixed thresholds rather than quartiles. This aims to improve the predictability and fairness of how performance changes are calculated and reported.

- The financial override remains, despite concerns about its bluntness and past evidence that financial pressure can divert focus from care quality and safety.

- The framework aims to clarify what organisations can expect from regional teams, including clearer entry criterion to the national provider improvement programme (NPIP) (segment 4 and 'red' for capability) and a six-month grace period for trusts achieving advanced foundation trust status (AFT) to resolve non-urgent issues. There is currently no targeted improvement offer for the most challenged ICBs.

- The framework, applied to statutory NHS organisations, remains focused on activity and finance metrics. Using its outputs to drive league tables, an incentive regime and integrated health organisation (IHO) eligibility rewards organisations for prioritising institutional performance over system-wide goals.

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This will not support ambitions for organisations and their partners to focus on population health outcomes and new models of care.

6. National Oversight Framework 2026/27 and 2025/26 Q4 segmentation results

On the 11 June, NHS England published the 2025/26 Q4 segmentation results which includes acute, mental health, community and ambulance trusts. The Royal Cornwall Hospitals NHS Trust has moved from segment 1 into segment 2 which is a deteriorated position due to access to services, finance and productivity, effectiveness and experience.

Our executive team are working on how we can take action to recover our position. Details of the Q4 segmentation results can be found here: NHS England » Segmentation and league tables

7. Advanced Foundation Trust Programme – Updated Guidance

As set out in the 10-year health plan, the aim of the Advanced Foundation Trust Programme (AFT) is to redistribute power to the frontline through a rules-based approach that re-empowers high-performing provider boards. Aspirant AFTs are expected to focus on their core purpose, maintain and improve quality of care, and, if approved, use their greater autonomy to improve population health, tackle health inequalities. The ambition set out in the 10-year health plan is that all providers become AFTs by 2035.

NHS England consulted on an initial guide for applicants over Winter 2025/26 and has produced an updated package of guidance to support the (AFT) programme. The updated guidance has a stronger focus on patient and public voice, stakeholder engagement, system working and the role of AFTs in improving population health and tackling health inequalities.

AFTs gain greater operational autonomy and space to plan long-term improvements, while committing to strong local leadership.

Assessment Process and Eligibility

- The assessment process will be kept under review, with board statements updated over time to maintain alignment with the provider capability framework and other relevant guidance.
- Trusts with a CQC ‘requires improvement’ rating older than three years may now apply, provided they commission an independent governance review demonstrating that historical issues have been addressed. This must be shared with NHS England and CQC.

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- Trusts must continue to meet eligibility criteria throughout the assessment process, including remaining in NOF segment 1 or 2 and achieving a score of 3 or higher in each NOF quality domain for the previous two consecutive quarters.

Regional and Integrated Care System Context

1. Southwest Peninsula Board Meeting

In May, in my current role as Acting Chief Executive Officer, I became a partner member of the Southwest Peninsular Board and although I was not able to attend the May meeting, I will be attending future meetings as a provider member for The Royal Cornwall Hospitals NHS Trust, South West Ambulance Foundation Trust and University Hospitals Plymouth.

2. Internal Critical Incident

On the 27 May, the Trust declared an internal critical incident due to pressures within our emergency department which also impacted our ambulance handovers. Due to the actions taken we were able to improve our position by the 28 May which resulted in an improvement in the number of patients in our emergency department and ambulance handover performance. This meant that as of the 28 May we were no longer in internal critical incident.

The Board is recommended:

- **Receive and note** the report and the update on the Governance Improvement Plan;

- **Note** NHS Trusts are asked to confirm adoption of the IHRA definition of antisemitism and the Government definition of anti-Muslim hostility by **31 July 2026 noting** Trust is in the process of considering this through its Trust governance.

- **Note** NHS Trusts are asked to deliver and submit a Band 5 Job Evaluation plan by 31 July 2026 **noting** Trust is in the process of considering this through its Trust governance.

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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 08

Title of Report: Urgent Care Update and Ending Corridor Care

Executive Director Lead: Robin Jones, Chief Operating Officer

Author and Job Title: Robin Jones, Chief Operating Officer

Email Address: robin.jones2@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☒ **Assurance** ☒ **Information** ☒

To provide the Committee with the action to end Corridor Care, improve Urgent and Emergency Care performance, and an update on progress to date.

Consultation:

The urgent care performance and ending corridor care update was presented to the June Quality Assurance Committee. As a result of that committee review and ongoing discussions between the Acting Chief Executive and the Chief Operating Officer this paper is summary of those reviews.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?		X		This programme aims to improve access to services, staff
Quality Impact		X		

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Assessment completed?				wellbeing, and the quality of care for all patients and staff.
Data Protection Impact Assessment completed?		X		

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	N/A
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	N/A
Sustainable and efficient use of NHS resources by RCHT	N/A

Recommendation(s):

The Board is recommended to:

- **Note** the additional assessment being completed by the Acting Chief Executive and Chief Operating Officer in response to the performance not improving which will be finalised to be shared with the Vice Chair on 30 June
- **Note** the target to have updated modelling of the impact of existing improvement initiatives and an assessment of bed capacity to be shared with the Vice Chair on 30 June

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- **Note** the significant operational pressures experienced during May 2026, including deterioration in Urgent and Emergency Care performance when compared with April 2026 which have continued in June.
- **Note** the increased emphasis on daily ward- and specialty-level capacity and demand reviews to support delivery of the Getting It Right First Time Clinical Operational Standards.

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Urgent Care Update and Ending Corridor Care

1. Situation / Executive Summary

Urgent and Emergency Care performance deteriorated during May 2026 and has continued to remain challenged into June, with Type 1 ED 4-hour performance falling to 42.4%, all-type 4-hour performance reducing to 75.7%, patients spending more than 12 hours in ED increasing to 18.4%, and average ambulance handover time rising to 82.4 minutes. These indicators remain a significant negative variation to the agreed operational trajectories and are contributing to sustained crowding, continued use of corridor care and escalation areas. ED crowding remains the Trust's highest scored risk, with risk 9048 continuing to score 25.

In response to the continued underperformance, the Acting Chief Executive and Chief Operating Officer are undertaking a further assessment of the current improvement approach, including updated modelling of the impact of existing improvements and bed capacity. The Trust is increasing leadership visibility, strengthening medically led delivery of the GIRFT Clinical Operational Standards, introducing daily ward and specialty capacity and demand reviews, reviewing OPEL action cards, pursuing greater use of community and Acute Care at Home capacity, and increasing learning from corridor care root cause reviews.

2. Background

The Trust is continuing to experience poor performance on the Urgent and Emergency Care standards and continuing to use corridor care spaces.

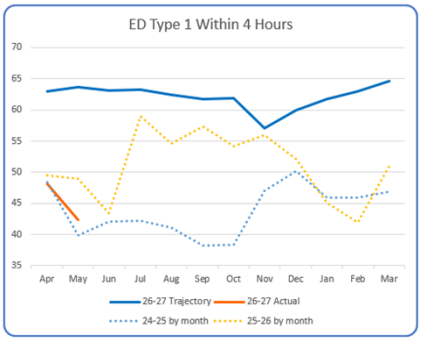
To support delivery of the Timely Handover Protocol 45-minute standard, the Trust has implemented a number of surge areas to manage risk from the Emergency Department through the hospital. Many of these areas do not meet the definition of corridor care.

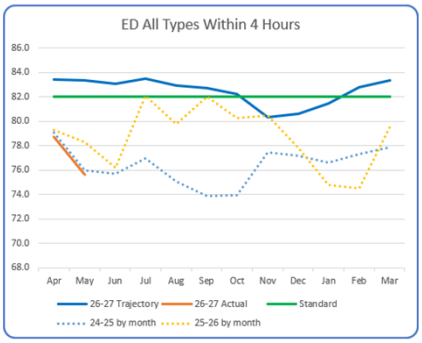
Although ambulance handover times have improved overall, the Emergency Department remains crowded, and risk 9048 continues to score 25.

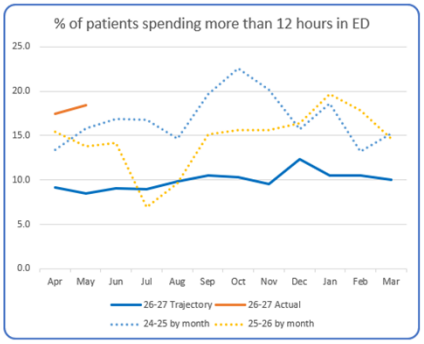
The graphs below show:

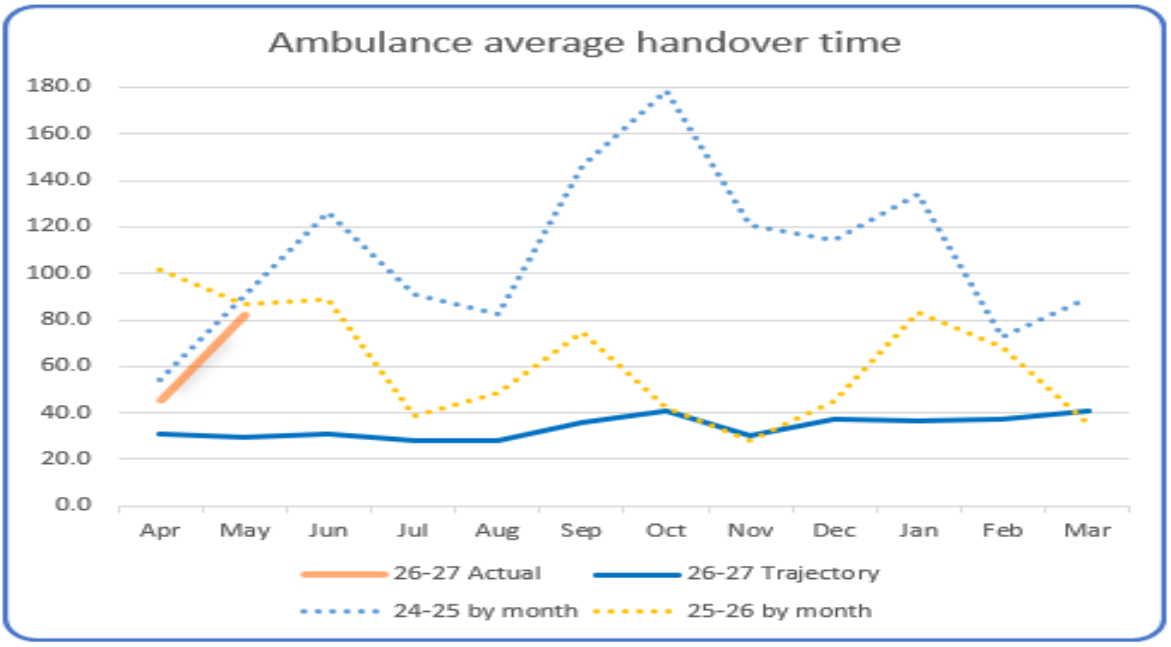
- Current year, with reference lines for 2024/25 and 2025/26 with the trajectory
- Type 1 ED 4-hour performance fell to 42.4% in May compared to 48.2% in April (51.1% in March), below the operational plan trajectory of 63.7%.
- ED all type 4 hour performance deteriorated to 75.7% in May (78.7% in April), below plan trajectory of 83.3%, and lower than the same month in the last 2 years.
- The percentage of patients spending more than 12 hours in ED increased to 18.4%, above trajectory of 8.5% and higher than the same month in the last 2 years.
- The average handover time increased by 37 minutes, at 82.4 minutes in May, above trajectory of 29.5 minutes

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The Trust has not met the improvement objectives set for the end of May, the grid below outlines the improvement objectives agreed with clinical leaders in the Clinical Vision of Flow and therefore there is a need to re-assess the approach being taken as feedback of the clinical operating models proposed indicate they will deliver improved performance of reduced delays in ED and reduced use of corridor care spaces.

Immediate (by end of March 2026)	Within the next 3 months (by end of May 2026)	Within the year (by end of March 2027)
• Eradicate 24 hour department stay (regardless of presentation) • Operate with less than 10% of department stay over 12 hours • Deliver a maximum ambulance handover of 45 minutes consistently 24 hours a day, 7 days a week • Achieve a maximum time in ED corridor of 2 hours • End the use of TES overnight • Close MDU/PCU/CT area • Achieve 3 midnights maximum on AMU	• Achieve 30 minute average ambulance handover, maintaining 45 minute maximum • End the use of ED corridor except for short term (less than 45 minutes) surge capacity • Deliver 95% 4 hour performance at WCH • Deliver 60+% 4 hour performance in ED • Achieve the 2 midnights maximum on AMU • Move to TES used to support 'your next patient' model with maximum time of 45 minutes • Have improved to less than 100 Patients over 14 day LOS (172 on 25th February)	• Deliver 90% of ambulance handovers within 15 minutes • Eradicate 12 hour department stay (regardless of presentation) • Maintain delivery of 95+% 4 hour performance at WCH • Deliver 80% 4 hour performance in ED

The Trust's current Urgent Care access standards performance is also having a negative impact on the National Oversight Framework (NOF) score.

3. Assessment

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Previous reports have highlighted the need to consistently deliver he Getting It Right First Time (GIRFT) Clinical Operational Standards. The learning from other Trusts is this has to be medically led in every clinical service. The adoption of these standards has been challenging for the Trust and there has been a stop, pause and reflection of the approach.

This has resulted in revised materials and expectations being published and shared through the clinical teams. There is a workshop of 50 of the Trust's clinical leaders on 26 July led by the Associate Medical Director for Urgent and Emergency Care as part of this relaunching of the standards. An example of one of the new materials is the GIRFT poster in appendix 1.

A self-assessment has been completed for every speciality to give a baseline so that progress can be tracked and interventions as required.

The Acting Chief Executive and Chief Operating Officer are undertaking a review of the approach being used and will be finalising a range of changes in response to performance of this key Trust priority not improving. The Chief Operating Officer has a scheduled meeting with the Vice Chair in her capacity as Chair of the Quality Assurance Committee on 30 June where a detailed update will be provided.

The summary of the assessment being finalised for change are

- Leadership visibility to increase support to teams and respond to issues in real time
- Sustained delivery of the Clinical Operational Standards
- Senior leadership support for longer length of stay patients
- Workforce actions using capacity and demand to match workforce to the demand profile which would support staff pressure/risk of burnout and overall performance
- Opportunities for changes in the Emergency Department applying for capital funds that may be available
- Work with system partners to increase capacity of Acute Care at Home
- Finalise bed modelling gap analysis and prediction of impact of the existing workstreams
- Increased frequency of the learning reviews from the Route Cause Analysis implemented for patients in corridor care spaces

The first priority of these actions will be to return performance to trajectory as shown in the background section and then progress to delivery of the improvement objectives.
This change in approach is to create the environment where performance begins to improve so that improvement trajectories can be produced and shared openly to the Trust as we know our staff are focused on ending corridor care and the pressures being experienced.

Modelling of the forecasted impact of the existing initiatives is scheduled for 29 June and will include an assessment of overall bed capacity. This assessment will be shared with the vice chare in the meeting scheduled for 30 June.

3.1 Key drivers impacting performance

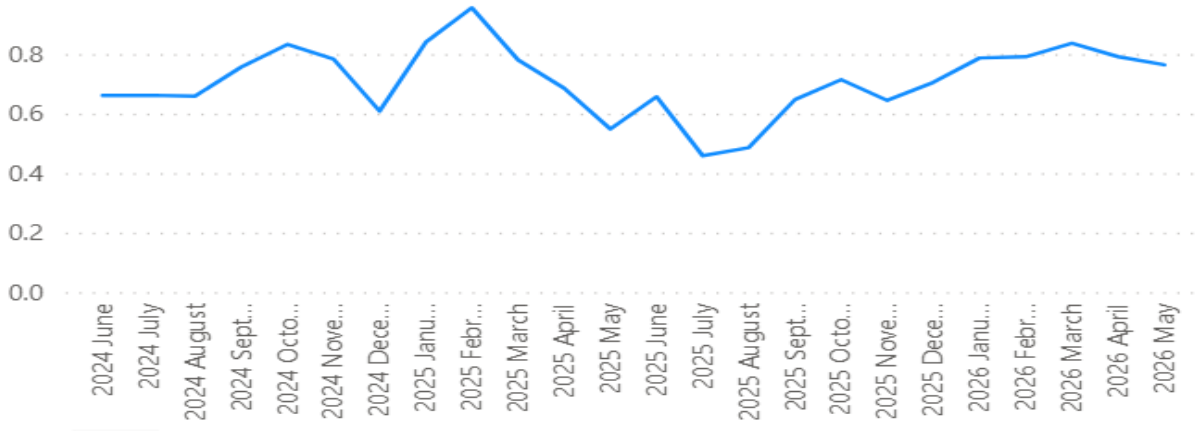
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In response to the high number of patients who are medically fit for discharge but remain in the acute hospital awaiting community pathways, the Medical Director is convening a clinical summit to ensure all available community capacity is used effectively. The summit will focus on three priorities:

- Exit Timely Handover Protocol (THP) expectations, asking partners to ensure that patients awaiting discharge on Pathway 1 leave within one day, those on Pathway 2 within two days, and those on Pathway 3 within four to six days.
- Emergency Department arrivals, using Aggregated Patient Delay as a measure and confirming that no alternative care settings are available where appropriate.
- Corridor care usage, recognising the national requirement to eliminate this practice.

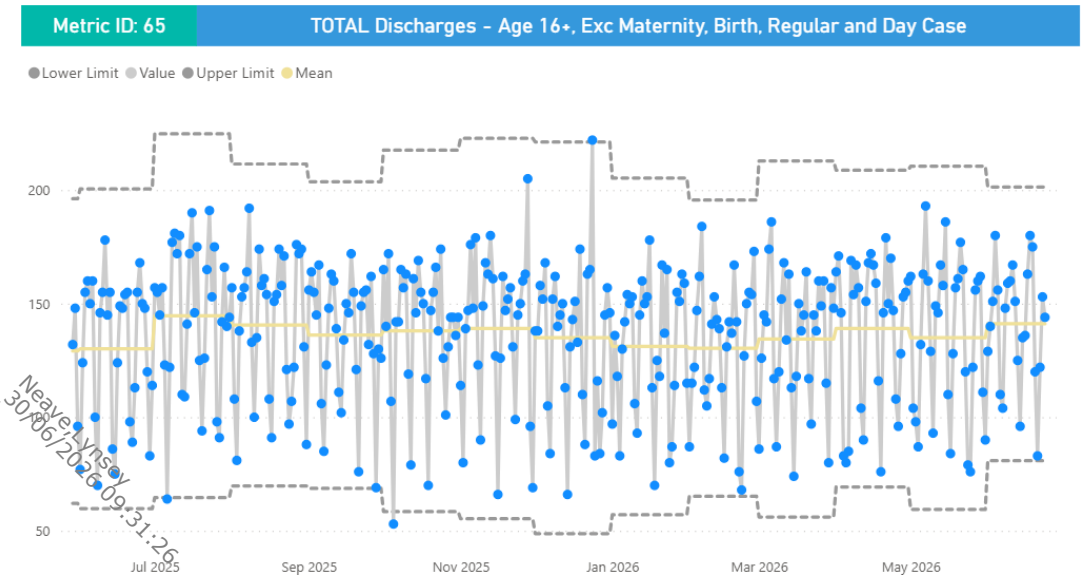
A steady increase has been seen since July 2025 in the number of days patients remain in hospital after becoming medically fit for discharge.

Average delay (days) all pathways



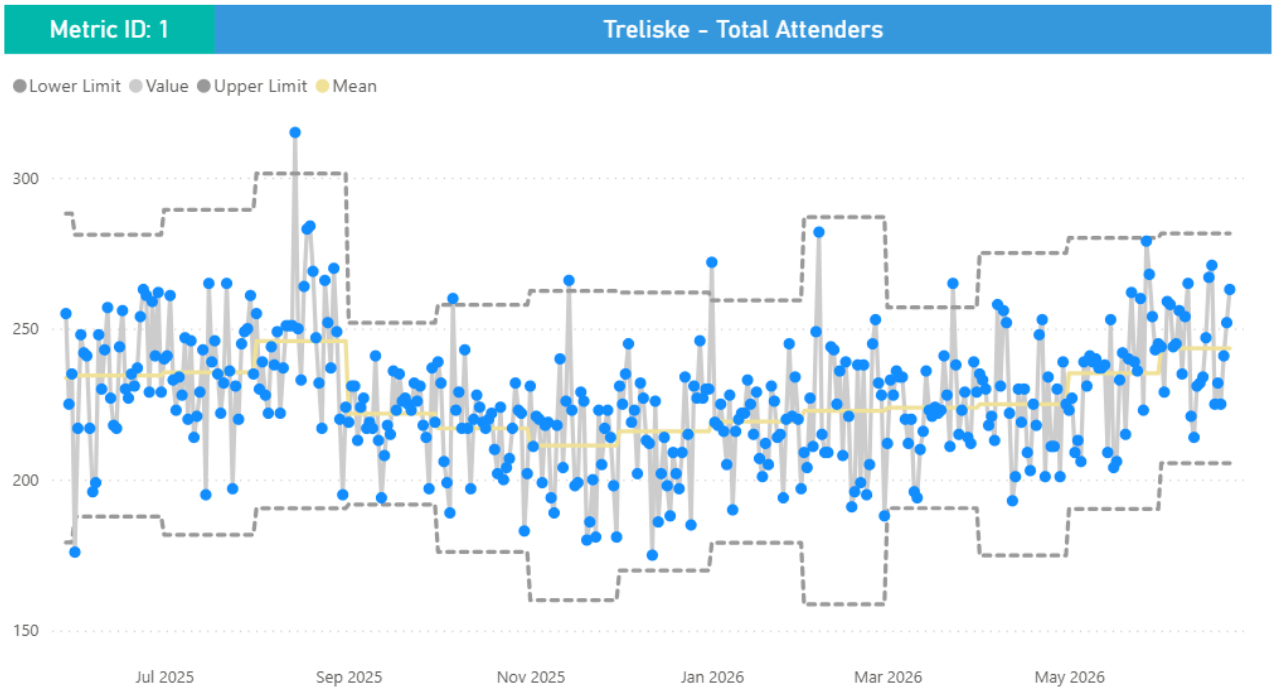
There is a constructive challenge with system partners with regards to the wider system capacity utilisation with the need to maximise the out of hospital capacity to reduces pressures within the hospital. Whilst there is a need for full validation this work has identified an opportunity if capacity was increased in the Acute Care at Home model it would reduce inpatient activity.

The chart below shows that there is a significant variation in total daily discharges. Whilst the daily mean has improved from 130 in June 2025 to 141 in 2026. The concern is the variation in daily discharges needs to reduce to give a more consistent discharge profile day by day.



A detailed review of absence profiles by staff group and area has commenced. Absence rates increased in the second half of June which is being triangulated to the additional pressures seen with the Amber heat warning in Cornwall.

Attenders to ED has also been increasing as shown in the chart below. the mean daily attenders in June 2025 was 234 and in June 2026 is 243. The significance of the variation in discharges is further demonstrated as the arrivals has much less variation.



3.2 Demand and Capacity

The Trust has introduced more detailed daily capacity and demand reviews in response to evidence that some wards and specialties were unclear about their specific contribution to ending corridor care. This work has made clear the discharge targets are by individual wards, through the last 2 weeks this has enabled the identification of the specific area not achieving the discharge numbers and resulting in a review to understand the underlying reasons why so that action can be taken

3.3 Key actions presented to Quality Assurance Committee

Below is a summary of the key actions presented to Quality Assurance Committee which would continue, the additional oversight and focus outlined at the beginning of section 3 would enhance the delivery of the actions set below

- Clinical Operational Standards – the Trust has reflected the first launch of these standards has not been as effective as desired, a re-launch has commenced with a clear face to face engagement with consultant teams from 17 June 2026 including an away day on 24 June
    - Materials to improve engagement including the poster in Appendix 1
    - Expectations briefing for how the Trust expects consultations to lead the clinical area each day
    - Self assessments returned from each service and mapped, these will be used to assess impact/delivery over the coming weeks and target further

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actions
    - Briefing to leaders that it is expected that areas will be identifying non compliance with the standards and that is to be encouraged to enable issues to be resolved. Expected response to issues being flagged is 1) “thank you” and 2) "how can I help”
- Converting one, possibly two ward areas into a Discharge Ready Unit – ward(s) to care for patients with no criteria to reside. It is a model used in other Trusts which can be medically staffed with a lower ratio of doctors that can be re-deployed to other areas of the Trust to support flow
- New capacity and demand analysis shared to the medical wards setting daily discharge numbers
- Recruiting a new Clinical Lead for the Acute Medical team, support to the interview panel requested from national expert as the changes needed in acute medicine are critical to success, examples of the changes the new lead will need to champion and implement are
    - Ensuring ward rounds start at 0900 every day
    - Control of the medical take to divert to alternatives
    - Re-allocation of medical resources within the existing budget to align capacity to demand improving discharge/turnover and general flow from AMU to reduce delays from ED
- Review of the escalation cards. The Chief Operating Officer is leading a review of the Operational Pressures Escalation Level (OPEL) action cards, these are not currently having the impact needed to avoid escalating site pressure. The review will look to take best practice from other Trusts
- Chief Medical Officer leading work across the system to understand why community capacity is not being fully utilised when the Trust is so over capacity
- Route Cause Analysis used for patients who have a corridor care episode over 12 hours for implementing learning
- System drive for the delivery of exit THP performance and operational governance wrap around the medical actions to use system capacity
- Further capacity and demand analysis being completed to identify impact to ED crowding and corridor care with he action plans to then allow review of further options
- Clinical Site team transferring to the Medical Division to improve alignment
- Update to the Route Cause process to include triangulation of workforce data and patient experience feedback with themes to be included in the next report

4. RISK

These risks are captured in Board Assurance Framework 1 and, at an individual risk level, in risk 9048 (ED Crowding), which remains the Trust’s only score 25 risk.

The overarching risk themes remain the same:

- Patient experience, including timely access to the right care setting and time spent in corridors or escalation areas.
- Staff experience and pride in the services the Trust provides.
- Trust reputation and failure to deliver national standards

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5. Accountability

The Chief Operating Officer retains accountability for operational performance. However, GIRFT and national examples of successful corridor care elimination demonstrate that sustained improvement is driven through strong medical and wider clinical leadership.

6. Recommendations

The Board is recommended to:

- **Note** the additional assessment being completed by the Acting Chief Executive and Chief Operating Officer in response to the performance not improving which will be finalised to be shared with the Vice Chair on 30 June
- **Note** the target to have updated modelling of the impact of existing improvement initiatives and an assessment of bed capacity to be shared with the Vice Chair on 30 June
- **Note** the significant operational pressures experienced during May 2026, including deterioration in Urgent and Emergency Care performance when compared with April 2026 which have continued in June.
- **Note** the increased emphasis on daily ward- and specialty-level capacity and demand reviews to support delivery of the Getting It Right First Time Clinical Operational Standards.

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Appendix 1 – Getting It Right First Time Poster



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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 9

Title of Report: Staff Survey 2025 Action Plan

Executive Director Lead: Alison Thorne-Henderson, Dual Chief People Officer

Author and Job Title: Christiern Francis, People Engagement Lead

Email Address: Christiern.francis1@nhs.net

Purpose of the Report:

Decision ☒ **Discussion** ☐ **Assurance** ☐ **Information** ☒

This report provides on progress against the staff survey action plan.

Consultation:

Initial results have been seen by Executives and Executive Leadership Team (ELT) in presentation format. Reported to People and Culture Committee (PCC) on the 26/03/2026. This action planning paper was taken to PCC on 21/05/2026. Divisions have shared and discussed their staff survey results and priorities in two of the PPPP – People meetings since the launch of the new performance framework.

Board approved the plan at its May 2026 Trust Board in Public meeting and the action plan is monitored at People and Culture Committee.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☒

Reputational ☐ **Legal / Regulatory** ☐

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?		x		

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Quality Impact Assessment completed?		x		
Data Protection Impact Assessment completed?		x		

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Equality and Diversity Statement Information: The Staff Survey collects two main pieces of information regarding Equality Diversity and Inclusion, the Workforce Race Equality Standard (WRES), and the Workforce Disability Equality Standard (WDES). This information is used to monitor the experience of these two groups of staff and influence action to address inequalities. The survey also enables the monitoring of the experience of people with other protected characteristics too.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	N/a
Sustainable and efficient use of NHS resources by RCHT	Method: At RCHT, the NHS Staff Survey is conducted using a census approach, meaning that all staff had the opportunity to take part. The survey is available online to most staff, with some areas receiving paper copies where computer access may be limited. Where people had difficulties with either the online method or the paper option, they were able to use the provider's helpline, improving accessibility to all staff. Environmental considerations: less than 20% of surveys issued were paper copies. To mitigate the

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Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
	impact, paper copies were only targeted to areas that requested them.

Recommendation(s):

The Board **is recommended to:**

- **Note** the progress on Trust action plan to address the 2025 Staff Survey Priorities and **note** the development of Divisional and Corporate action plans;
- **Note** further consideration will be given to addressing the advocacy response percentage uptake as per the last pulse survey response.

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Staff Survey 2025 Action Plan

1. Situation / Executive Summary

The NHS Staff Survey is one of the world's largest workforce surveys. Each year, RCHT participates in the survey which informs the Trust, regulators, and public on the views of our people, which contributes to an overall national understanding. We complete a census approach across our substantive staff and bank colleagues.

The initial results of the 2025 NHS Staff Survey indicate a decline in overall staff experience, continuing patterns seen nationally and reflecting the significant organisational change underway at RCHT during the fieldwork period. While some staff groups and areas report improvements, particularly among bank colleagues, most indicators show reduced advocacy, concerns about safety climate, and lower confidence in raising concerns.

To ensure a focused and effective organisational response, three areas were identified as potential priorities:

1. **Appraisals** (largest gap compared to comparator organisations)
2. **Raising Concerns**
3. **Health and Safety Climate**

2. Background

RCHT participates annually in the NHS Staff Survey using a census methodology across substantive and bank colleagues. Early results are provided each year to enable timely action planning. The 2025 NHS Staff Survey was undertaken during a period of significant organisational restructure and sustained operational pressure. It is therefore likely that these factors influenced staff perceptions at the time of the survey. The Trust has subsequently launched a large-scale Clinical Administration consultation in June 2026, which will continue to impact organisational capacity and pace of delivery, and this will need to be carefully managed alongside the progression of the 2025 action plan and preparation for the 2026 survey cycle

3. Assessment

Action planning context and assumptions

Evidence shared by NHS England shows it is only after 18-24 months that employee advocacy will start to recover after organisational change (Advocacy is how "I recommend the organisation as a place to work and receive care and Care of patients / service users is my organisation's top priority"). The national engagement metrics from the latest Trust internal pulse survey data from Q1 2026/27 shows RCHT is on that 18-24 month journey with the Pulse survey identifying only 23.1% of total number of respondents (281) would now recommend us as a place to work (appendix 2).

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Given the corporate and divisional organisational change process is being embedded, we fully recognise that less time has been available for teams to address at pace, the staff survey action planning. Furthermore, the Trust recently commenced (June 2026) the Clinical Administration review; the Trust is also currently in a period of review associated with the eCare project timeline and is in the first quarter of the 2026/27 financial, operational and workforce plan with a focus on financial sustainability – there remains a commitment but recognition of the challenging position. It is projected that the 2026 staff survey will not significantly improve but will see more of a sustained position noting the cultural programme remains to be in its infancy.

The Trust priority it so ensure the 2025 Staff Survey Action Plan (Appendix 1) is complete during 2026. It is recognised the future 2027 and 2028 milestone improvements are heavily reliant on delivery of the cultural programme in 2026.

The cultural programme (We are RCHT) is driving change and currently providing support to the divisions in working through their Staff Survey Actions to deliver change locally. Divisions were invited to the Trust Board development session in June which was an excellent opportunity for leaders to engage with the Board regarding their culture programme and priorities.

The Trust is working on a new leadership and organisational development programme which is one of the Trust strategic priorities. Oversight is through the Culture Programme Group and workstreams have been formed and have been delivering since May 2026, key headlines include;

- Senior leader's forum established with 2 being held to date;
- One and All session launch;
- Communication tone and style change;
- Executives thank you cards;
- Values awards relaunch and refresh

Engagement and Action Planning Update:

Divisional Action Plans

Support and oversight of development of Divisional Action Plans has been through the newly established People Divisional performance meetings (the 4 P's – People, Pounds, Performance and Patients). Divisions have also been asked to set up independent divisional listening and action forums as part of the organisational staff survey action plan, however this timescale has exceeded and will be reviewed and the action plan updated (appendix 1).

It is recognised that due to the Corporate organisational change process, there remains several roles that have yet to be filled in the People and OD Team; these roles will be

pivotal in the co-ordination of action plans. Divisional progress to date is below:

Medicine

- The Strategic Business Partner and the Urgent and Emergency Medicine (UEM) nursing consultant have met to discuss the results;
- Results were analysed in June and shared on the 26 June with the divisional leadership team;
- Divisional priority has been identified as “Compassionate leadership” – the Division will focus on upskilling and enabling managers;
- A draft action plan is in development which will be reported to the People Performance meeting, however progress achieved to date includes:
    - Ward leaders away day 4 June
        - Appraisals – band 6 Appraisal capability boost to support returning the ownership of wards to ward leaders.
    - Compassionate leadership - Recruitment of Senior leadership nursing team
    - Specialty Lead and ward manager away day 26 June
    - Clinical Practice Educator away day scheduled

Women and Children Division

- Staff survey action planning being led by Group Support Service Lead;
- Results analysed and shared and action plan in development;
- Conversation held with leaders and areas of focus;
    - Priorities taken from Staff Survey - Wellbeing, flexibility and psychological safety
    - Next steps form 1-3 actions around their priorities.

Clinical Support and Cancer

- Action Planning in infancy, recognising the organisational change process;
- Presented the cultural approach to Trust Board in Q1 for safe high-quality care based around:
    - Establishing divisional community;
    - Cultivating growth;

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- Releasing capacity.

Surgery

- Culture reviews completed at WCH and SMH;
- Leadership and team development work underway in trauma following detailed review of the two wards. Full staff engagement in the process;
- Improved engagement with booking and operational teams via a workshop with the admin teams to ensure we are hearing what they say.
- Strengthening communication and visibility of divisional leadership with introduction of senior leadership walkarounds at all sites
- Staff engagement programme being developed following the forming of the senior leadership team in May and June.
- Action plan in development.

Engagement

The People and Engagement Lead has supported each of the Divisions and Corporate Directorates to analyse and share results as well as provide best practice approach to development of action plans. To date there has been positive engagement with at least 20 areas including specialties and departments.

5.Risk

The main risk associated with the survey is cultural which also impacts upon reputation, including our ability to attract, recruit and retain. The organisational restructure has affected divisions' capacity to implement timely actions as they fully complete their teams structure.

Mitigations include:

- Clear Culture Programme – work began in July 2025 led by Chief Strategy Officer including listening events in August 2025 and again with Divisions in 2026.
- Clear strategic communication plan aligned to Trust values.
- Small number of clear priorities agreed by Divisions and Board,
- Support for divisions through People Engagement Lead and when appointed Strategic Business Partners

6. Accountability

Author / Person of responsibility: People Engagement Lead

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Accountable Executive director**:** Dual Chief People Officer

Assurance and monitoring - Action plans and updates will be reported back through the People and Culture Committee.

7. Recommendations

- **Note** the progress on Trust action plan to address the 2025 Staff Survey Priorities and **note** the development of Divisional and Corporate action plans;
- **Note** further consideration will be given to addressing the advocacy response percentage uptake as per the last pulse survey response.

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Royal Cornwall Hospitals NHS Trust

Appendix 1 – Trust Action Plan for Staff Survey in additional to Divisional Plans

Area	Action	By whom	By when	Progress	Milestones and Metrics (measure)
Appraisals	Monthly sample of completed appraisals scored against quality.	Governance leads and Strategic Business Partners when appointed	August 2026	2 People "PPPP" meetings held and conversation at Divisional PPPP meeting regarding appraisals and priority	**Baseline –** 2025 Staff Survey • Q24d ~47% • Q23b ~21% **Milestones:** 2026/27 – Complete Actions 2026 SS – Flat position 2027 SS – Improvement by 2% 2028 SS – National Average
	Options paper with routes for providing all colleagues with a timely appraisal conversation.	DCPO	May 2026	Reviewed with Executive Directors and scheduled for internal governance in June/July	
	All colleagues have received an up-to-date Appraisal conversation	Divisional and corporate Leadership Teams	August 2026	Links with above action Monitoring by People Performance dashboard % at PPPP meeting Coaching and Training will be provided by the new Divisional Strategic Business Partners when appointed (noting that first	

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				recruitment campaign failed to attract, and second, targeted recruitment campaign has commenced	
	Align new management competencies to management hub ready to adopt from CFT **(new)**	CFT OD team	August 2026	Management hub in place by September 2026	
	When received - Adopt and roll out new national appraisal process	POD	End 2026	There are two parts to the action: a new appraisal system due and a new HR system with appraisal element Not yet received from national team – Appraisal process due this summer.	
Teamworking & Psychological Safety / speaking up	Launch a 'Teaming' tool hub for leaders	People Engagement Lead And OD practitioner	End of Q2 New Timeline changed to align with cultural programme	Ensure a set of resources are available to managers to upskill on making better team environments	**Speaking up:** Baseline 2025 Staff Survey (SS): • Q20a ~68% • Q20b ~48% • Q25e ~52% • Q25f ~36% Milestones:
	10 places for Braver than Before and review for onward investment	Associate Director of	**Complete** And expanded	Braver than Before is a national leadership	

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		Workforce Transformation	offer being discussed through CPD monies	programme - 10 places offered and completed The Trust has expanded its offer to 50 (35 RCHT and 15 CFT being discussed)	2026/27 – Complete Actions 2026 SS – Flat position 2027 – Improvement by 2% to each Question 2028 – National Average for each question **Team working:** Baseline: 2025 SS, People Promise (PP) team working sub score – 6.55 Milestones: 2026/2027 – Complete actions 2026 SS – Flat position 2027 SS - +0.2 2028 - +0.2 on 2027
	Culture Transformation Programme	Chief Strategy Officer	August 2026	Culture Transformation Programme is supported by the Board and is a strategic priority. Workstreams formed, progress is being made through the Culture Programme Group and resource to be secured. Suite of agreed benefit measures in development	
	Divisions to implement their own quarterly local listening and action forums	Divisional SLT	June 2026	Divisions to ensure local listening and action forms take place (as part of their action plans and monitored at PPPP meetings). In progress	

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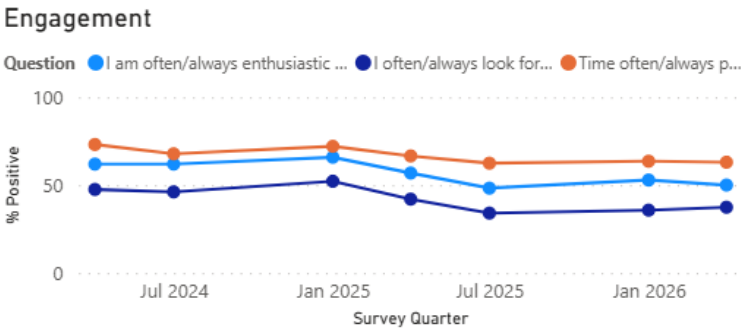
	Hold FTSU month	FTSU Guardian	October 2026	The Trust commits to hold a FTSU month annually. The 2026 FTSU month will focus on key themes to support improvements in raising concerns and will be focused in visits to priority areas.	
Health and Safety Climate	Deep dive on burnout and co-creation of new solutions	POD	August 2026	In progress	**Base line:** 2025 Health and Safety Climate Sub score 4.99 Milestones: 2026/2027 – Complete actions 2026 SS – Flat position 2027 SS - +0.2 2028 - +0.2 on 2027
	Hot-spotting: identify wards/services with highest work-pressure national SS scores and sickness rates; deploy focused actions (roster optimisation, break protection, task reallocation,).	Divisional and corporate SLT	August 2026	Staff Survey 2026 H&S climate sub score in progress Engagement with Divisions to take place	
	Update, refresh and relaunch RCHT wellbeing initiatives and menu of offers	Wellbeing & OH	August 2026	Inclusive Wellbeing Group being established and a Health and Wellbeing Strategy in development (working its way through internal governance).	

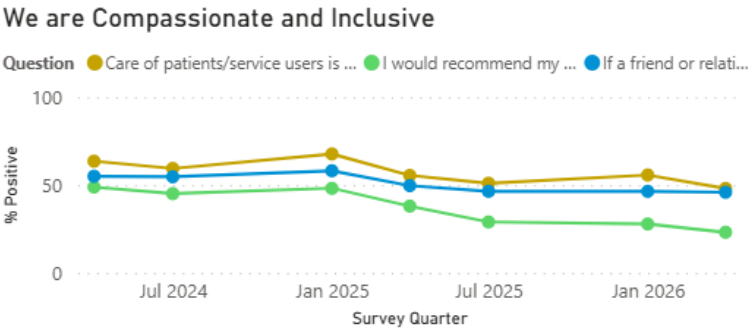
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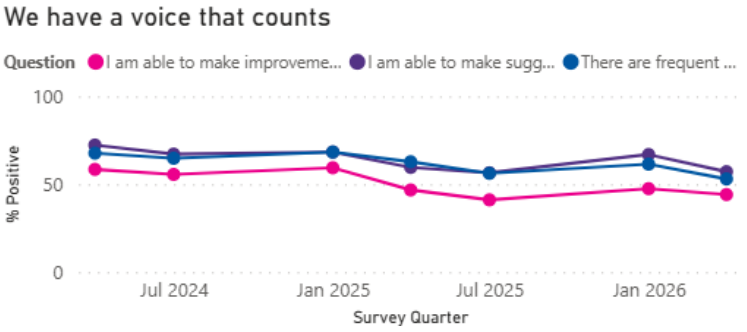
				Engagement with Divisions in progress	

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Appendix 2 – Latest Pulse Survey









Q1 figures:

I look forward to going to work	37.4%
I am enthusiastic about my job	50.0%
time passes quickly when I am working	63.0%
frequent opportunities to show initiative	53.0%
There are frequent opportunities for me to show initiative in my role.	53.0%
I am able to make suggestions to improve the work of my team or department	57.1%
I am able to make improvements happen in my area of work.	44.1%
Care of patients / service users is my organisation's top priority	48.0%
I would recommend my organisation as a place to work.	23.1%
If a friend or relative needed treatment I would be happy with the standard of care provided by this organisation.	45.9

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 10

Title of Report: Quality Assurance Committee Assurance Report – May and June 2026 meetings

Committee Chair: Isobel Down, Non-Executive Director

Author and Job Title: Company and Deputy Company Secretary

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

The purpose of this report is to present a summary of decisions made and assurance sought by Quality Assurance Committee on behalf of the Board of Directors at its recent meetings.

Key agenda items and decisions/actions taken on behalf of the Board

There following were recommended to refer for decision by the Board.

Issues for escalation or notification to the Trust Board

The Committee requested to escalate to Board:

- The Committee requested six-monthly updates and agreed that any material deterioration or emerging risk should be escalated to the Board as required regarding cancer performance;
- Highlight the need to review the Clinical Vision for Flow and UEC performance, including consideration of alternative actions in response to sustained operational pressures, high ED attendances, and continued prevalence of patients with No Criteria to Reside, particularly in the context of the shift towards neighbourhood health models.

Summary of assurance and risk

Quality Assurance Committee (QAC) Assurance Report – May 2026

Neave Lyons 30/06/2026 09:43:24

The Committee received the **Chief Nurse Officer and Chief Medical Officer local and national key headlines presentation.** The Committee noted the Trust's downgraded NOF segmentation, driven mainly by IPAC metrics and Staff Survey results, while recognising that national data does not yet reflect recent improvements

or clinical review of avoidability. Assurance was provided on targeted IPAC and divisional improvement actions, with continued oversight of NOF performance and trajectories to be maintained through the IPR.

Summary of assurance and risk

Quality Assurance Committee (QAC) Assurance Report – June 2026

The Committee received the **Urgent and Emergency Care Performance/Clinical Vision of Flow report;** Urgent care performance remains under significant pressure, with Type 1 ED performance at 48.2%, ambulance handover times increasing to 45 minutes, and extreme delays still evident despite improvement on the prior year. The report highlights a renewed focus on practical actions to improve flow and reduce length of stay, including targeted review of long-stay patients, implementation of Moving Medicine, and more detailed divisional oversight against clinical operational standards. Leaders acknowledged that current plans are not yet delivering sufficient impact and are therefore strengthening the use of capacity and demand data, ward-level discharge planning and divisional support to better align staffing and operational delivery with predictable demand. Members sought assurance on themes or complexities and discussed the threshold; below 9,000 hours average,

30 day rolling was the trigger to move from Corporate Risk Register score 25 risk to score 20.

Received an update on the ongoing **Health and Safety** matters relating to asbestos management. The Committee also received for assurance an update on the **Fire Safety Investigation** action log, noting only two outstanding actions. Received for assurance the updates provided and recommended a further assurance report in June with the aim of received adequate assurance that all actions were closed.

Stroke Mortality Assurance report set out the Trust SSNAP score of D but the Trust continues to provide a level of assurance regarding its robust action plan. The report set out the risks and mitigations, noting limited progress on actions (on the stroke action plan) and sought greater assurance on therapy access on Phoenix, capacity versus demand and the overall pathway (and what this model looks like across the entire stroke pathway). Members asked for stronger assurance about the system task force, including its outputs and timescales and expressed concern about performance against the access standard, highlighting that current performance at 38.8% is far below the 90% standard, and asked for assurance on the actions being taken to improve this.

Neave, Lynsey
30/06/2026 09:33:26

The Committee received from the **Controlled Drugs Accountable Officer (CDAO)** on a case of misappropriation of drugs. The Committee sought assurance on the medicines management, noting actions being taken to improve systems and processes of control. Challenge focused on system vulnerabilities, particularly

reliance on paper-based processes, and the need for broader organisational learning.

The Committee noted the assurance report on the process for **management of harm** and that there had been a reduction in compliance; the Divisional Performance review meetings would be a good source of check and challenge and assurance on compliance.

Following an external Audit of **Unlicensed Aseptic Preparation Services** the Trust risk elevated from low risk to medium risk associated with capacity and demand and estates limitations. Members challenge focused on the sustainability of the service, capital investment requirements, and the risk of further deterioration ahead of the next audit. Noted the action plan in response and the Committee would have oversight through the External Review Report on a quarterly basis.

Patient Safety Incident Response & Oversight Group Assurance Report set out the incidents and complaints position and that no significant harm as a consequence of corridor care. Falls summits have taken place regarding falls prevention and pressure ulcers with the aim of sharing good practice. Noted the update on the ongoing investigations and actions being taken in response to the two Never Events.

Received the **Legal Spend report** noting increased claims activity and rising legal exposure. The Committee requested further exploration of the current benchmark against similar size acute Trusts and a review of resourcing models, and continued monitoring of high-risk claim areas. Discussed value for money and how the Trust was aiming to secure roles within its in-house service.

The Committee endorsed updates to the Statement of Purpose and noted progress against **CQC** actions, including improvements in amber-rated actions. Challenge focused on ensuring alignment with broader governance frameworks and maintaining visibility of red risks. Risks remain in urgent care, stroke, medicines management and staffing.

Welcomed the final draft of the **Quality Account** which had been subject to much scrutiny and feedback. Noted the final version would be presented to the Audit and Risk Committee on the 4 of June 2026 for onward approval to the Trust Board on 18 June with a due date for publication being the 30 of June 2026.

The **Ward to Board Quarter 4 report** provided assurance that quality and safety performance has continued to improve across most areas, with positive ASPIRE trajectories and a reduction in wards rated white, although Acute and Emergency Medicine remains the most challenged area. The Committee noted the transition from Care Group to Divisional structures and sought assurance on Divisional engagement in shaping future quality and performance metrics. Early feedback from new governance forums indicates a more interactive and thematic approach is

Neave Ainsley
30/06/2026 09:32:26

supporting discussion of quality, safety, complaints, harm reviews and workforce training. The Committee welcomed the move towards a more flexible, coaching-based assurance framework which should strengthen Divisional ownership, improve the articulation of key risks and priorities, and provide more meaningful insight over time.

Committee received the Month 1 **Integrated Performance Report** and noted areas of improving performance, including sepsis audit results, Right Patient Right Pathway metrics and strong nursing workforce fill rates. However, assurance was limited by continuing concerns regarding ED initial assessment times, pressure ulcers, falls resulting in moderate to severe harm, and the inclusion of recently reported Never Events. The Committee welcomed the positive direction of travel, including improvement in fractured neck of femur performance, but emphasised the need for sustained delivery and more detailed assurance on underlying causes and improvement actions, with potential for focused insight sessions on key quality issues such as pressure ulcers and falls.

The Committee received a detailed **cancer performance deep dive** and noted that performance had deteriorated from a previously strong position to being broadly aligned with the national average. The Committee recognised that this was being driven by a combination of sustained demand, workforce pressures and diagnostic capacity constraints. Members sought assurance on the drivers of variation in conversion rates, the effectiveness of pathway improvement work, and the impact of high volumes of non-cancer referrals on diagnostic capacity and timely access. The Committee noted continuing risks relating to delayed diagnosis and treatment, workforce sustainability and pressure on diagnostic services, and agreed that these areas should remain subject to ongoing oversight. The Committee was assured that actions are being taken to support recovery, including pathway redesign, diagnostic investment and workforce development, including the use of non-medical roles. The Committee requested six-monthly updates and agreed that any material deterioration or emerging risk should be escalated to the Board as required.

The Committee reviewed updates to the **BAF**, noting alignment with current risk profile including urgent care pressures, harm review backlog, and governance risks such as data breach and industrial action. Members were assured that the BAF reflects the key areas of risk discussed during the meeting.

Recommended further review of the **Health and Safety Strategy** and how it links to the wider Trust Strategy and recommended it was presented to the June Committee.

Received the **External Visits, Accreditation and Peer Review Assurance Report** and approved the **Patient Safety Incident Response and Oversight Group** and the **External Reviews Policy**

Neave Lyons
30/06/2026 09:36:36

The Committee received the **Chief Nurse Officer and Chief Medical Officer local and national key headlines presentation.** Key matters of interest included:

- No change in contractual position following the last contract quality review meeting at present.
- A review of all pressure ulcers in May 2026 to determine any correlation relating to corridor care and it had been identified this was not the case.
- A Task and Finish Group established in relation to Controlled Drugs Safe Handling of Medicines and updates would be provided to the Committee.
- Ockenden 3 report published the previous day, and written communication was expected as a result. There would be 3 main areas of focus nationally; Martha's Rule, candour, and human tissue oversight.
- Publication of the Oversight Framework which includes more indicators relating to the patient safety domain. The Board will be provided with an assurance statement.
- Publication of the CQC statement on the Supreme Court's judgement on deprivation of liberty. The Trust is reviewing requirements and will bring information through the next Safeguarding report to the Committee.
- Provision of an overview relating to the National Quality Strategy. The Committee were provided with the main elements of 'call to action' requirements which asks something of everyone who leads, delivers or shapes NHS funded care. The strategy has over 180 metrics contained within.

Assurance was sought in relation the Controlled Drugs Safe Handling in relation to potential associated costs and it was confirmed nothing specific had been identified.

The Committee queried whether they had been any associated impacts relating to the heatwave about specific equipment not working do to overheating given recent media reporting of matters at other Trusts. It was confirmed nothing specific had occurred and the Committee were briefed on associated operational pressures as a result of the heatwave and associated actions being undertaken to ensure staff as well as patients wellbeing remained prevalent.

Neave Lukey 30/06/2026 09:31:48

The Committee received the **Urgent and Emergency Care Performance/Clinical Vision of Flow** report and were briefed on the ambulance handover performance which had improved but remained off trajectory. 4 Hour performance had declined and the number of patients in the Emergency Department (ED) over 12 hours had increased. Actions were underway to reduce length of stay as well as actions to

address and bring performance back into an acceptable position. A Clinical Vision of Flow had been held on 24 June 2026 where staff feedback had been provided and was being acted upon about pressures within ED.

The Committee sought assurance in relation to the no criteria to reside patient numbers noting these remained at over 100 on most days and the system agreement had been to have no more than 50.

The Committee asked that further information be incorporated within the next report on RAG rating achievement of 'red lines'. A forward look in relation to Getting It Right First Time was also requested particularly with regards to how it was being embedded.

The Committee commended implementation of Discharge Readiness Units (DRUs) in order to congregate patients ready to leave the hospital thus providing improvements to patient experience and better utilisation of medical staff resource. The Committee would be briefed on ongoing learning as a result of liaison with other Trusts in the next report received. Assurance was sought and obtained that learning from root cause analyse of long stays was being undertaken.

The Committee discussed the ongoing clinical summit led by the Chief Medical Officer to optimise use of community capacity and noted that work had begun with Cornwall Partnership NHS Foundation Trust (CFT) to increase acute care at home provision and reallocate resources accordingly.

The **Integrated Performance Report** in its new format was discussed. Updates had been provided on specific indicators to aid Committee focus as well as draw the Board's attention to specific matters. Thanks were extended for all the work undertaken and the helpful commentary provided by Executives.

Roll out of the new Laboratory Information Management System (LIMS) system was raised and an update was sought that the issues identified by the microbiology and infection prevention and control (IPAC) team were being addressed which was confirmed. A Quality Summit was being undertaken in relation to associated impacts for IPAC given the impending implementation of e-Care.

Deterioration in stroke activity performance was raised and concern raised about delays with the system wide review that was due to be undertaken, and the Committee were advised the timeline on when the work would commence remained awaited. The Trust continued to undertake work internally in relation to timely intervention and ring fencing stroke beds noting associated challenges with moving patients back off the unit when it was identified they had not experienced a stroke due to the ongoing operational pressures.

Neave Hunsey
30/06/2026 09:11:28

Assurance was sought regarding Fractured Neck of Femur performance following improvements previously made and the recent decline in performance. Challenges

associated with capacity on the Trauma Unit were discussed as well as the different pathways in place. It was noted that various actions were being undertaken and also that demand had increased on the unit for community hospital beds. The Committee expressed concern about traction for good service provision but noted the further work being undertaken to address.

The Committee noted there was no longer a requirement for a **Seasonal Plan** (just a winter plan) as requirements had changed nationally the previous year.

Receipt and **supported Trust Board approving** the **Health and Safety Strategy** and assurance were received that all changes requested by the Committee had been implemented. Assurance was sought about better integrating equality considerations into the strategy and its supporting documents. There was discussion on the Equality Impact Assessment process, and it was agreed a prompt further review of processes would be undertaken by relevant Executives with input from Non-Executives. The outcome would be brought to the next Health and Safety update to the Committee so as not to delay approval of the strategy.

Discussed the **Senior Information Risk Owner Q4 Report** and that Cyber Security remained a high risk (score of 20) to the Trust. Updates were provided on the Freedom of Information (FOI) and Subject Access Requests (SARs) backlog and the Committee noted the improved position. The Committee sought assurance on actions plans in place to address external review recommendations and the Committee requested a robust improvement plan be devised for discussion at the next meeting.

An update was received on the large data breach that had occurred noting that the report received from the independent investigation undertaken was being checked for factual accuracy and the breach was being handled as a Patient Safety Investigation Incident (PSII).

The Committee asked for information and assurance in future reports about whether the risk was reducing as well as granular detail in relation to delivery following the independent review undertaken. It was noted that the Information Governance Lead was presently liaising with core personnel to strengthen reporting requirements.

Receipt of the outcome relation to the **Data Protection and Security Toolkit** following the ASW internal audit undertaken which identified that 4 low levels areas of improvement had been identified, and the Committee noted the work in place to address. The overall opinion from the audit was the ability for the Trust to submit a ‘standards met’ for submission to NHSE. The Committee noted NHSE challenge and that their view was a submission of ‘approaching standards met’ submission be made. It was noted other Trusts who also had backlogs were taking the same approaching with regards to submitting ‘standards met’.

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The Committee discussed proceeding with a different submission status following NHSE feedback but understood the intent to follow guidance following the ASW internal audit undertaken and that the Senior Information Risk Owner supported the submission status as Executive Lead. It was proposed further discussion occurs with NHSE in this regard noting that the standards continue to change and evolve.

The Committee sought assurance on contingency plans should a 'standards met' submission be made and be rejected by NHSE and were assured of plans in place should this arise.

The Committee received the **Q4 Learning from Deaths Report** and noted that HSMR and SHIME performance were within control limits with one current alert relating to fractured neck of femur. The National Hip Database provides a more accurate local picture, though the rate remains above the national average.

33 structured judgement reviews were undertaken during the quarter with 1 case identifying avoidable issues. Plans were in place to establish a cohort of 6 reviewers to improve timeliness and consistency of such reviews.

Medical examiner cases and divisional mortality reviews were discussed. The Committee noted 81% of deaths were reviewed by the Medical Examiner, with efforts underway to improve the timely provision of paperwork. Divisional mortality review processes were being strengthened through organisational changes.

The Committee asked about actions to improve escalation processes identified in reviews and it was explained learning was being embedded through regular governance communications specialty level discussions, and a more formal approach to using investigation outcomes for organisational learning.

The Committee extended sincere thanks to the work that the Mortality Review Group undertakes.

Noted the **Patient Safety Incident Response and Oversight Assurance Report (Previously IRLG)** and that its format had been updated. Incident profiles remained unchanged. A thematic review of corridor care incidents was being undertaken and core matters identified thus far related to patient comfort.

The Committee asked about correlating pressure ulcers with ambulance waiting times and it was agreed the next UEC would include details on ED safety checklists and patients experience standards.

Receipt of the **CQC Assurance Report** with an update provided on two ongoing investigations into patient deaths, with information requests being managed and meetings scheduled with CQC specialists. It was confirmed that PSII action plans were being monitored and families updated on progress.

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The Committee sought assurance in relation to ongoing must do actions for mandatory training and appraisal compliance in medicine, and the need for a clear approach to clinical supervision. Information on current efforts to improve compliance and develop a plan to nursing supervision was provided with updates expected in future reports.

It was clarified that for Clinical Supervision actions outlined relating specifically to nursing and the Clinical Cabinet was reviewing the present approach. A plan would be provided back to the Clinical Cabinet in 2 months' time which would include competency maintenance. The Committee requested a report be received on this topic in 6 months' time.

The Committee discussed the **Allied Health Professionals Safer Staffing Bi Annual Report** and noted improvements in vacancy rates, reductions in agency spend, and upcoming national guidance. It was noted the Trust employs fewer AHPs than national averages but mitigates gaps with support worders. No incident themes relating to AHP staffing were identified. National guidance on AHP staffing was expected in September 2026.

The Committee discussed the challenge of measuring unmet need and the importance of system wide efforts, particularly in stroke services. It was noted that the report would be considered further by the Executive Leadership Team (ELT) prior to receipt by the Trust Board.

Receipt of the **Perinatal Safety Report** for June 2026 in relation to May 2026 data. The Baroness Amos report was expected the following week and would be considered as well as the recent Ockenden report that had been issued. The Trust had communicated with planned approach to staff in relation to both reports and the importance of focus on families.

Progress on addressing racism and discrimination within the Division was shared, including targeted work with individuals, information gathering, and the development of an ongoing action plan.

A summary of the month's PMRT findings, including three complex terminations, no stillbirths or neonatal deaths, and one patient safety incident under review. Initial learning had been identified with no causative link to outcomes found. The incident did not meet the criteria for an MNSI relating to care provision.

Continued strong engagement and relationship with Kernow Maternity Voices Partnership who had done a 15 steps report with young parents and families and had provided insight in relation to signage and wayfinding, so actions were in place and were being embedded into the maternity improvement plan. The use of

Neave Rynn
30/06/2026 09:01:26

language translator devices was also discussed as a positive development with plans for wider roll out within the Trust.

The Committee discussed neonatal nurse staffing risk and the forthcoming improvement and noted the fresh eye approach being brought by the new Matron. The plan would be presented to the Division and then to the Committee.

The Committee noted that the claims scorecard and that no new identified themes or trends had been identified for May 2026. Teaching in bladder care had been undertaken as a result of this being identified earlier as an area requiring strengthening.

Assurance was sought in relation to workforce impacts and it was confirmed significant work was being undertaken with the new matron and actions being taken and proposed changes would be reported through the maternity improvement plan.

Noted receipt of the **Health and Safety Executive (HSE) Action Log Update** and the status of the action plan.

Noted the **Fire Safety Investigation Action Log Assurance Report** and the status of the action plan.

Discussed the **Safe Management of Patient Property Policy** and recommended for **approval by the Board**. The policy remained compliant with best practice guidance, had been reviewed by ELT and the only core change noted related to firearms.

For the **Board Assurance Framework** the need to review further in light of discussions relating to Fractured Neck of Femur, Stroke, UEC (eradicating corridor care) as well as the number of no criteria to reside patients that continued to remain in acute hospital beds. Additionally the outcomes following the external review undertaken relating to the FOI, SARs service.

Reviewed and approved the Terms of Reference for the CQC Scrutiny Group, Patient Experience Group, Health and Safety Committee and Integrated Safeguarding Group. It was agreed the Terms of Reference for the Integrated Service Group be strengthened to reflect it was an integrated service with CFT.

Noted deferral **of the Security Management Update.**

Noted and endorsed the **Clinical Effectiveness Group Bimonthly Assurance Report.**

Neave, Lynsey
30/06/2026 09:47:26

Noted the content and assurances provided in the **Health and Safety Group Exception Report** and the mitigation relating to mattress decontamination facility and loading bay safety.

Noted the **End of Life Care Annual/Q4 Report** received for assurance.

Neave,Lynsey
30/06/2026 09:31:26

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 10.1

Title of Report: Learning from Deaths Q4

Executive Director Lead: Dr Meridith Kane

Author and Job Title: Dr Ray Sinclair Clinical Director Safety, Quality & Clinical Effectiveness and Becky Cooper, Clinical Effectiveness Manager

Email Address: Becky.Cooper@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☒ **Assurance** ☒ **Information** ☐

The National Learning from Deaths Guidance sets out the requirement for NHS providers to report a quarterly Learning from Deaths report to Trust Board.

Consultation:

The content of this report has been reviewed and discussed by the Mortality Review Oversight Group (MROG) which has clinical representation. The report is then included in Executive Leadership Team papers prior to scrutiny by the Quality Assurance Committee, then to the public Trust Board

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☐ **People** ☐

Reputational ☒ **Legal / Regulatory** ☐

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?				

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Quality Impact Assessment completed?				
Data Protection Impact Assessment completed?				

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	
Sustainable and efficient use of NHS resources by RCHT	

Recommendation(s):

The Board is recommended to:

- **Receive and note** the Q4 Learning from Deaths assurance report

Neave,Lynsey
30/06/2026 09:31:26

Learning from Deaths Quarter 4 (January 2026 – March 2026) Assurance Report

1. Situation / Executive Summary

1.1 Overall Hospital Mortality

This report includes Healthcare Evaluation Data (HED) monitored by the Mortality Review Oversight Group (MROG). The latest data is for the year to January 2026. It also includes Crude Mortality up to April 2026.

All overall hospital mortality indices are within control limits.

1.2 Mortality Alerts

Fractured Neck of Femur mortality is still an outlier against nationally reported HED data using HSMR, however National Hip Fracture Database (NHFD) gives a more accurate representation of the mortality position. The mortality rate following fractured neck of femur remains above the national average (5) at 6.1 and is within control limits.

1.3. Learning from Deaths

1.3.1 Priority Deaths

Priority deaths are defined by National Learning from Deaths Policy and reporting is mandatory.

1.3.1 .1 Learning Disability or Autism (LeDeR)

3 deaths have been reported at RCHT for Q4 in this patient group

1.3.1.2 Deaths subject to Patient Safety Review

We track all deaths that have raised concerns and have been subject to a patient safety review to ensure learning is captured in the safety action plans.

4 deaths in this group have been closed

1 death has an ongoing review

2 new deaths have been reported

1.3.1.3 Learning from deaths coming from complaints

We track all deaths that have raised concerns as part of the complaints process to ensure learning is captured.

1 death has been reported in Q4 in this patient group. Identification of learning has not yet completed

Neave Lynch 30/06/2026 09:34:26

1.3.1.4 Severe Mental Health

The National learning from deaths policy requires all trusts to report all inpatient, outpatient and community patient deaths of people with severe mental illness (SMI).

In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

4 deaths have been reported in this group. Identification of learning has not yet completed.

1.3.1.5 Child Deaths

All Child Deaths are subject to review as part of the Child Death Review Process. This is a statutory process under the Children Act 2004.

No deaths have been reported in this group

1.3.1.6 Perinatal and Neonatal Mortality

It is a nationally mandated UK system used by maternity and neonatal services to review the deaths of babies from 22 weeks of pregnancy onwards, helping teams understand what happened, support families with clear answers, and identify improvements to make care safer.

4 deaths have been reported in this group

1.3.1.7 Deaths following concerns raised by clinicians.

No deaths have been reported in this group

1.4 Structured Judgement Review

33 SJRs were completed in Q4, with most care rated as good, one case identified as avoidable with actions in place

1.5 Medical Examiner

In Q4, the Medical Examiner reviewed 81% of deaths, with a small proportion identified for further review and no consistent themes or trends detected, while improvement work is ongoing.

1.6 Learning and Feedback from Inquests

In Q4, 29 inquests generated learning on system capacity and medicines safety, with actions underway through defined workstreams to strengthen governance, patient tracking, and clinical oversight.

1.7 Divisional Governance Mortality Review process

Mortality review processes are being strengthened following divisional restructure, with work underway to standardise M&M meetings and improve governance, reporting, and organisational learning.

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1.8 QI and Clinical Audit

The Trust is undertaking a range of quality improvement projects focused on enhancing patient safety, clinical documentation, care processes, staff wellbeing, and service efficiency across departments including emergency care, maternity, renal, surgery, and

acute medicine.

There have been 7 national clinical audits presented to the Clinical Effectiveness Group meeting during this quarter.

2. Background

This report is produced quarterly in line with national Learning from Deaths guidance and provides assurance on mortality outcomes, mortality review processes, and how learning is identified, acted upon, and embedded to improve the quality and safety of care across the Trust.

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3 .Assessment

Overall Hospital Mortality Data

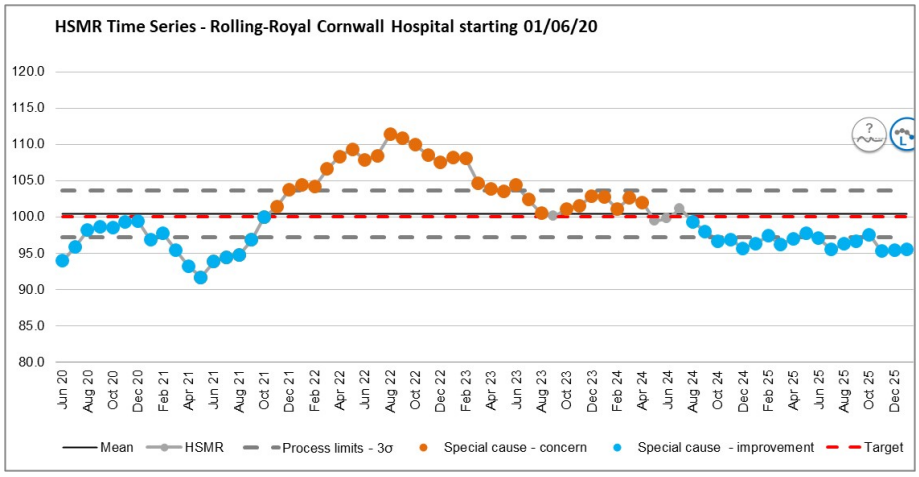
3.1 RCHT Hospital Standardised Mortality ratio (HSMR)

Healthcare Evaluation Data (HED) uses national NHS data on hospital admissions and deaths, which is automatically provided through NHS England systems rather than entered locally.
It applies standard NHS methods to monitor mortality, using charts to track trends over time and compare performance with other organisations. The limits used reflect normal variation in the data, rather than performance targets.

HSMR Status

Hospital Standardised Mortality Ratio (HSMR) trend for Royal Cornwall Hospitals NHS trust (RCHT) over a five-year period is shown below.

RCHT's HSMR is 95.37; a sustained downward trend since August 2022.



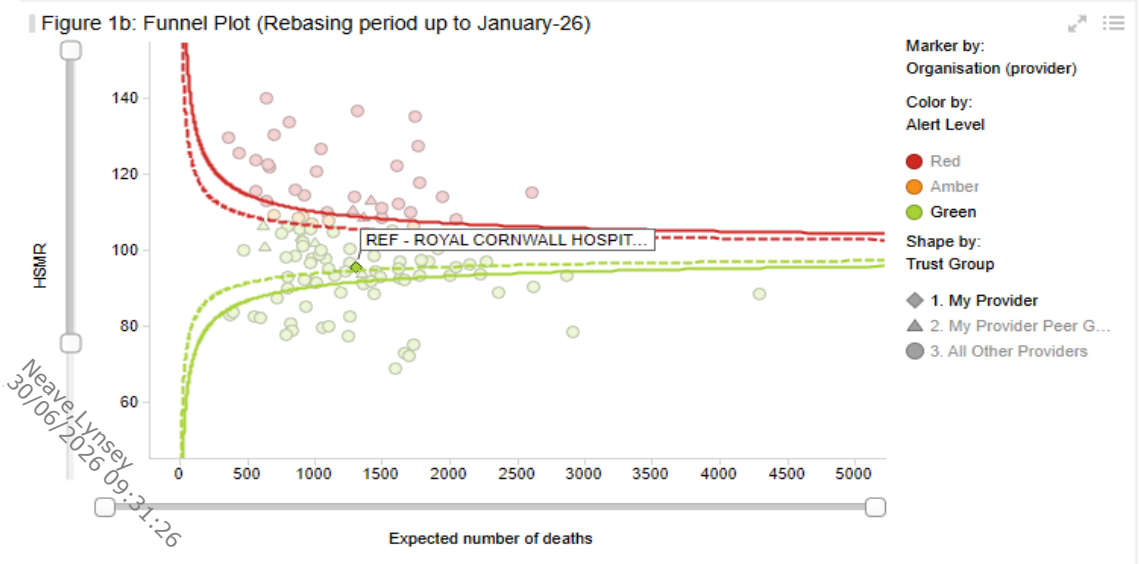
Upper 3 δ process limit – 97.24

Lower 3 δ process limit – 103.67

Average HSMR – 100.5

Please note – these process limits relate to RCHT only as a statistically methodology to trigger a response

Hospital Standardised Mortality Ratio (HSMR) data from other UK acute trusts in a funnel plot (same data and period as the previous SPC Chart):



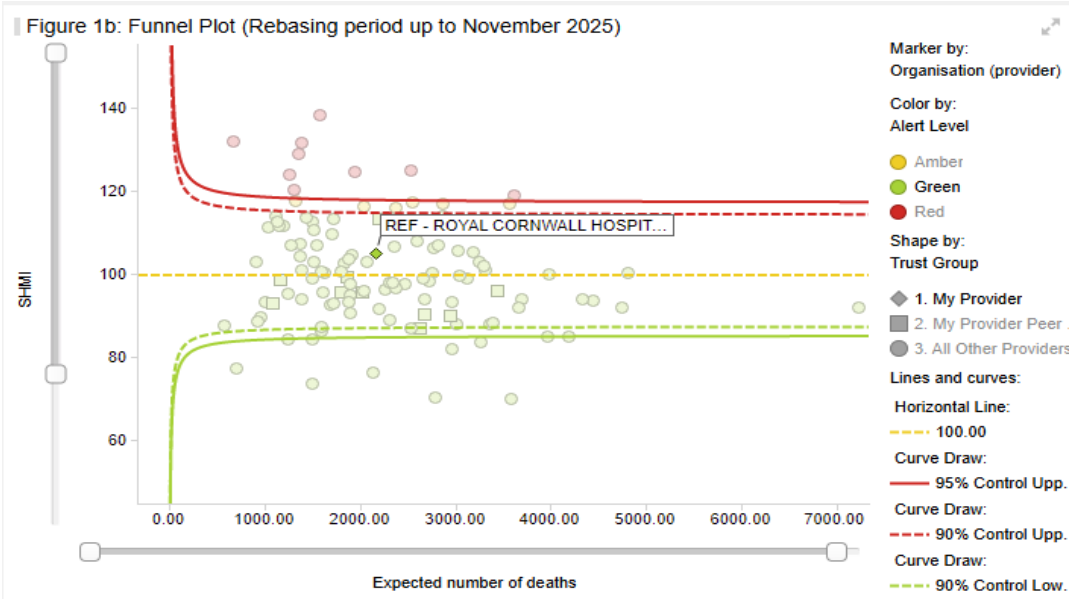
3.2 Summary Hospital Mortality Indicator (SHMI)

SHMI is a nationally published ratio of observed to expected deaths for patients admitted to each non-specialist acute trust in England. Unlike HSMR, which records deaths in hospital) SHMI records deaths in hospital and within 30 days of discharge, with expected deaths modelled from case-mix (e.g., diagnosis, age, comorbidity, admission method) using linked HES - ONS data.
Interpretation uses funnel-plot control limits centred on 100:

- Results within the 95% limits are “as expected” mortality – (dotted red and green lines)
- Results above the 99.8% upper limit (or below the 99.8% lower limit) (solid red and green lines) are flagged “higher than expected” (or “lower than expected”) mortality, allowing for normal statistical variation that narrows with larger volumes.

The latest SHMI data reported are for the year up to the end of January 26 is 104.84.
The data are represented as both a funnel plot and SPC chart.

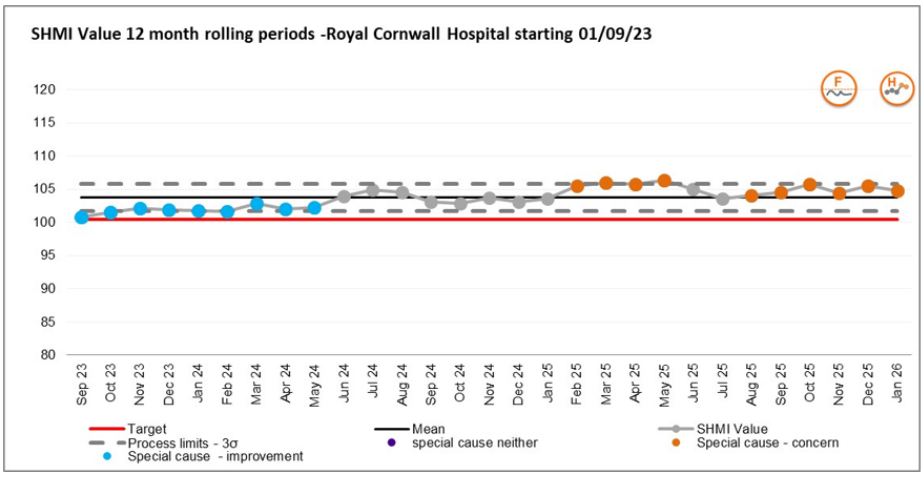
Funnel Plot.
Benchmarked data from the national dataset including all UK acute trusts. RCHT SHMI data is within control limits.



Statistical Process Chart (SCP):

The SPC chart is more sensitive to change over time than a funnel plot and illustrates a slow trend upward in SHMI from September 2023 to January 2026.

Neave,Lynsey
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Upper 3 δ process limit – 105.78

Lower 3 δ process limit – 101.66

Average HSMR – 103.7

Please note – these process limits relate to RCHT only as a statistically methodology to trigger a response

Following a recent deep dive into our data, we have identified that patients admitted via Medical Rapid Assessment and Treatment Service (MRATS) and Same Day Medical Admission (SDMA) have, in some cases, been incorrectly admitted as elective rather than emergency. This inconsistency has led to data inaccuracy in our reporting for SHMI with a decrease in expected mortality. This leads to an inaccurate overestimation of the SHMI mortality index

Corrective action is underway with staff on SDMA and MRATS. We expect the data to reflect this work in the next six months as the reporting lag works through.

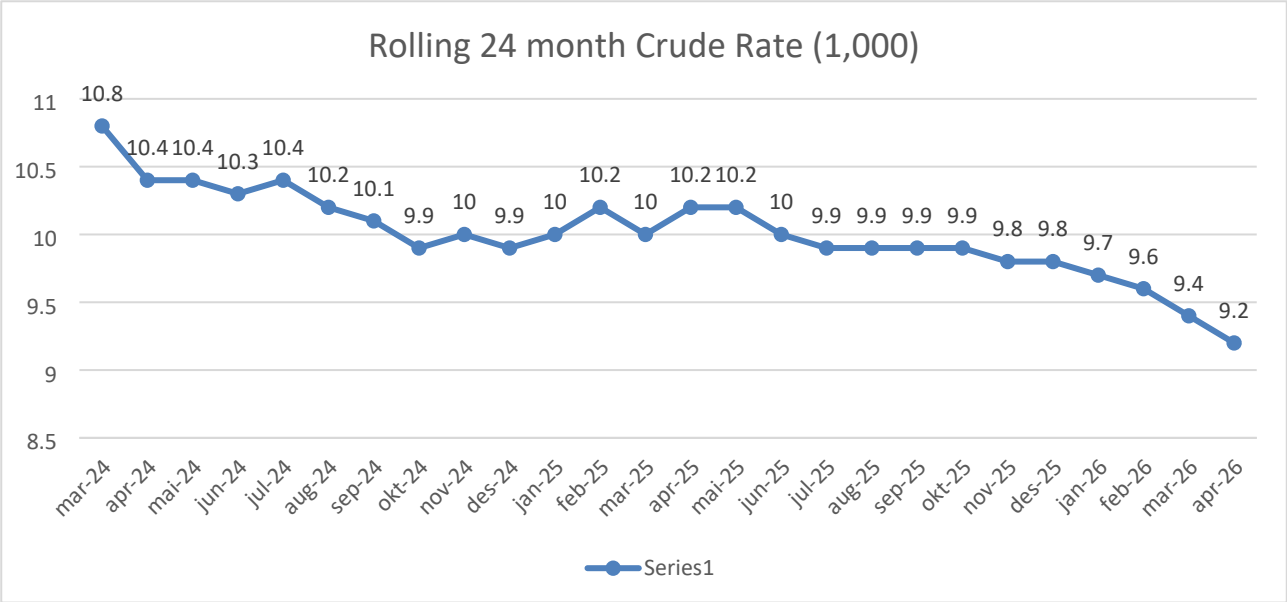
3.3 Crude Mortality

Crude mortality is used as an early warning for potential areas for concern.

RCHT non case mix adjusted crude mortality data as deaths per 1000 admissions is included here as it can act as a non-specific, unsophisticated early warning of significant change. The data set includes emergency and elective admissions, but not Emergency Department admission and deaths.

RCHT Crude Mortality is currently not alerting concerns with an overall fall in death rate from 11.4 per 1000 admissions in October 2023 to 9.2. per 1000 admissions in April 2026 with a stable downward trend.

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3.4 Mortality Alerts

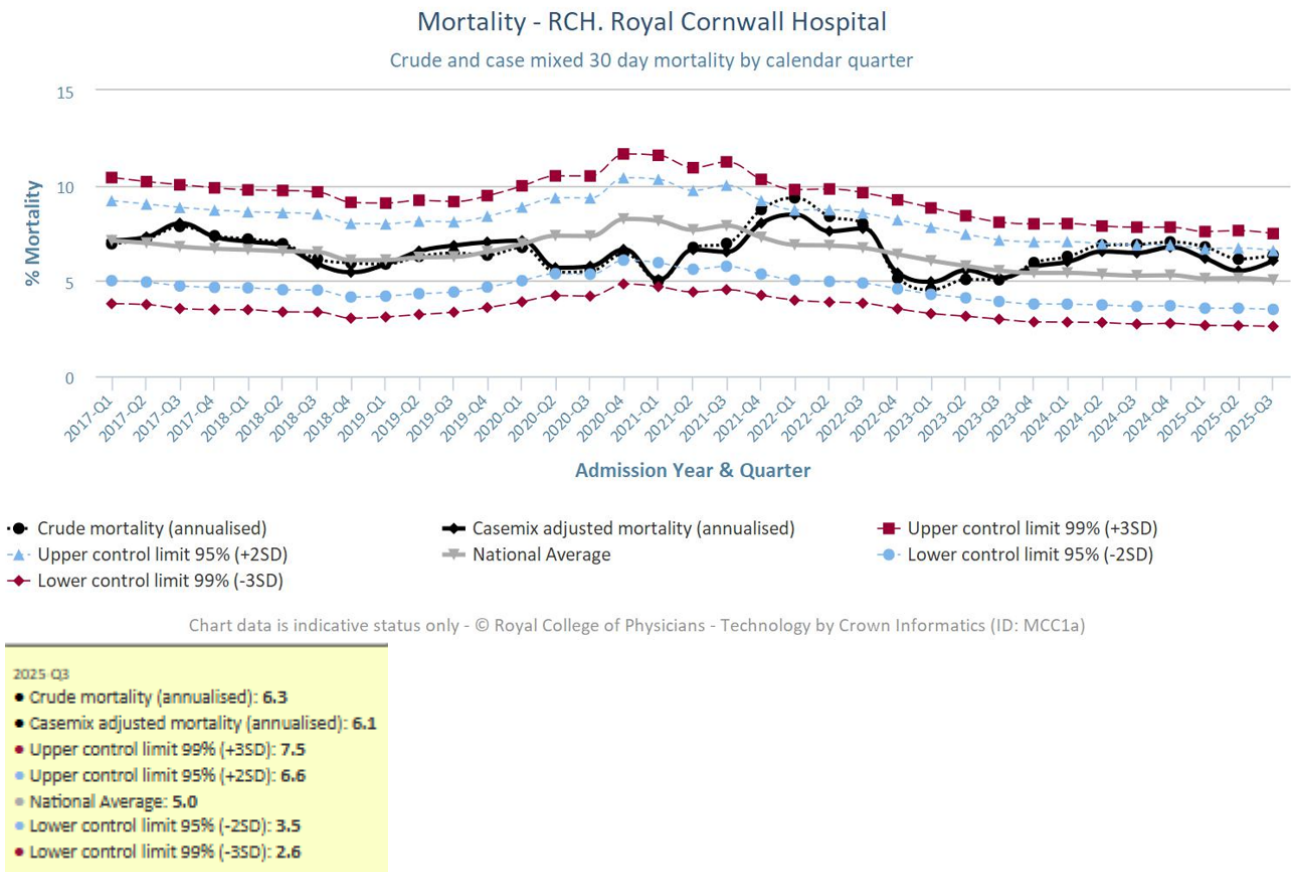
3.4.1 Fractured Neck of Femur

3.4.1.1 National Hip Fracture Database

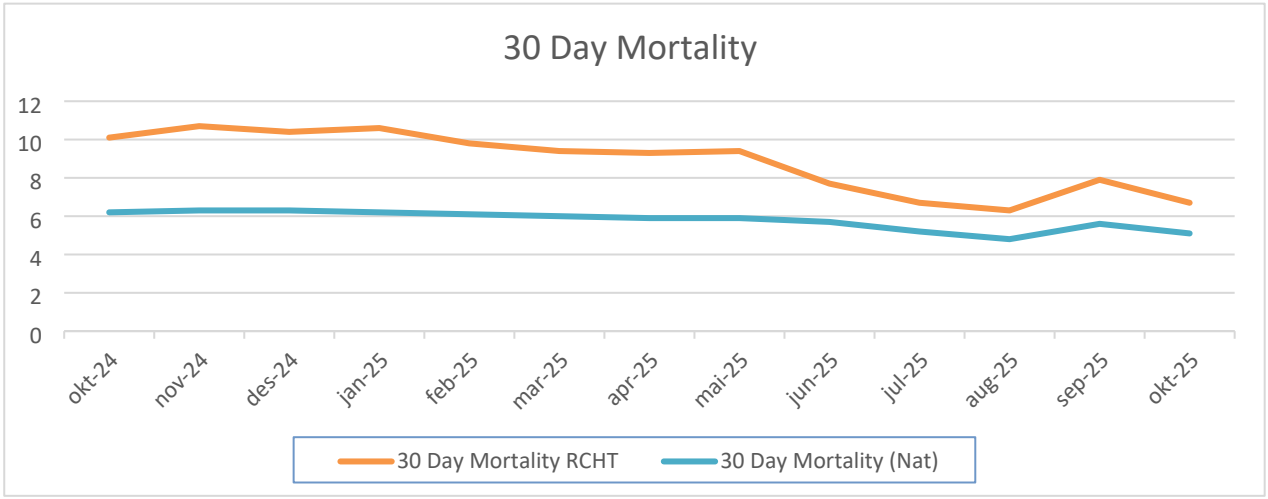
National Hip Fracture Database (National Falls and Fragility Fracture Audit Programme (FFFAP) is the most accurate methodology for tracking fractured neck of femur mortality. It is accurately case mix adjusted and provides nationally benchmarked data reporting 30-day mortality as a percentage.

- Case-mix adjusted mortality at 6.1% remains above the national average of 5.0%, though within NHFD confidence limits.
- These data have been reported to QAC in April 2026.

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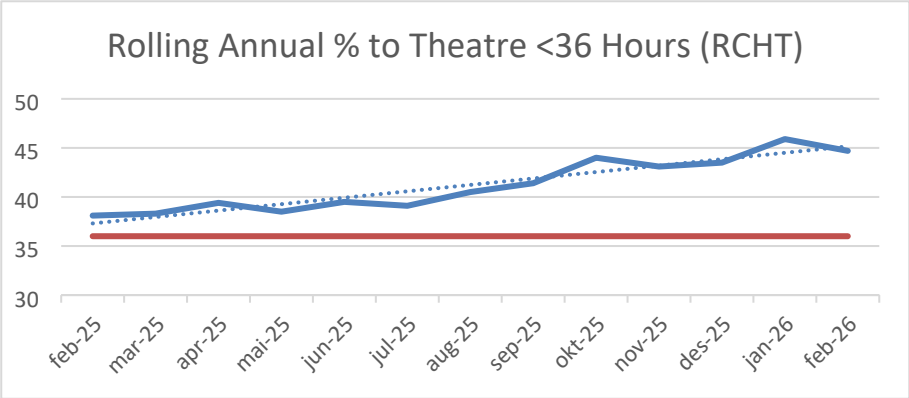


Data for the last complete year (2024) demonstrates a 30 day #NOF mortality for RCHT of 93.24% against the NHFD average of 94.7% and, whilst not out with the NHFD confidence limits, continues to be underpinned by continued challenges to deliver the time to theatre 36-hour standard.



Q4 National Hip Fracture Database (NHFD) data shows prompt surgery, a key mortality determinate, annualised compliance at 45%, remaining below the NHFD overall of 57%. Improvement has, however, been realised in the annualised NHFD report with a 10% increase in prompt surgery since June 2025, with improvement work ongoing.

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HSMR is a useful high-level indicator of overall mortality but is not a reliable measure for assessing fractured neck of femur outcomes, due to limitations in case-mix adjustment, sensitivity to coding variation, exclusion of post-discharge deaths, and small sample sizes; in contrast, the National Hip Fracture Database (NHFD) provides a more accurate and clinically meaningful assessment through risk-adjusted 30-day mortality and pathway-specific measures, and is therefore used as the primary source of assurance for hip fracture care and improvement.

3.5 Learning from Deaths

1359 patients died as inpatients at RCHT and a further 755 up to 30 days following hospital discharge in the year from 01 Feb 2025 to the end of January 2026.

Most of these deaths were expected or because of life-threatening illness unresponsive to treatment. Clinical teams prepare and care for these patients and their families and always reflect on whether how they might have avoided the fatal outcome.

There are always cases where patients die where the clinical teams identify that there is something to learn when reflecting on the patient's journey. It is crucial that these cases are reviewed in a culture of openness, without blame, within their teams and with the patient's relatives, to ensure learning identifies where the system of care has not been what it should have been and where recognised standards of care have not been met.

It is vital that this learning generates actions. This forms the basis of the formal specialty clinical governance mortality review process.

In addition, National frameworks mandate that all deaths are reviewed by the Medical Examiner's Office who can raise concerns about care independently and that a Structured Judgement Review be conducted where agreed conditions are met, for example when a concern is raised by staff or relatives or when the criteria for 'Priority Death Review' is met.

All of these process pathways are tracked and reported to the Mortality Review Oversight Group (MROG) which meets monthly and reports to QAC every quarter. We have been strengthening the MROG structure over the past six months, ensuring it sits within the new Divisional structure.

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Finally, learning from deaths related to patient safety incidents is captured in two ways. First, the Patient Safety Incident Review Oversight Group (PSIROG) meets every 2 weeks. It has as a structured review process where all learning and associated actions for the

highest level PSR2 and PSII safety incident reviews are tracked and signed off on completion. Second, the Executive Quality and Safety Huddle (EQSH) meet weekly to review all lower level PSR1 incident reports. It has a similar process of tracking and sign off.

Population statistical methods are long established in the NHS. The Health Evaluation Data reported in sections 1 and 2 of this paper is used to identify where care systems have observed death rates which are higher than expected, benchmarked against peer organisations. At a deeper level, Specialty Clinical Audit, both National and Local provides data, again benchmarked with National peers, identify where there is unexpected or unexplained high mortality in specific patient diagnostic groups.

Learning from deaths reporting is complex across all these data sources. Reporting completed learning from some of these sources within a three-month time frame is often not possible due to the time required for thorough investigation, including completion of strong action plans. We are therefore reporting all mortality review processes which are 'live' in Q4 (some of which have yet to complete) rather than just reporting individual cases where the clock starts within the quarter reported. In this and future reports, we will continue to report all cases up until their completion and final sign off.

3.5.1 Priority Deaths.

Priority deaths are defined by National Learning from Deaths Policy and reporting is mandatory. There are seven categories.

3.5.2 Learning from lives and deaths – people with a learning disability and autistic people (LeDeR)

In Q4 2025-2026 there have been 3 deaths in this group.

Patient 1.
An 82-year-old woman was admitted after a week of being very tired, having a chesty cough, and eating and drinking less than usual. She was diagnosed with pneumonia. She was reviewed by the Speech and Language team due to difficulties swallowing and coughing during meals, and was started on antibiotics and other appropriate treatment. Her condition worsened during her stay, and she was later cared for on an end-of-life pathway.

Patient 2
A 68-year-old woman was admitted with shortness of breath. An initial chest X-ray showed abnormalities, and a CT scan identified a large mass in the womb that had likely spread to other parts of the body.
An attempt to take a tissue sample was unsuccessful. After discussion, a decision was made to focus on comfort, and the patient was referred to palliative care.

Weaver
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Patient 3
A 67-year-old man was admitted with shortness of breath after a recent fall. He was diagnosed with a chest infection (bronchopneumonia) and an existing lung condition affecting the air sacs (bullous emphysema).

The Structured Judgement Reviews have yet to be reported and discussed at MROG.

3.5.6 Learning from Patient Safety Reviews

There are 4 PSR 2 and PSII completed incident reports related to the death of a patient with the Patient Safety Incident Review Oversight Group oversight of safety action plans. There is 1 ongoing and 2 new. All are on track to complete; some will require up to 4 months to embed and audit efficacy.

Patient 1 –
The patient died unexpectedly shortly after being discharged from Critical Care, following treatment for severe breathing problems and kidney failure. A post-mortem examination suggested the cause of death was related to lung injury and likely aspiration (breathing in stomach contents).
The review identified learning around improving communication with families, managing confusion (delirium), monitoring patients after discharge from Critical Care, safe transfer of medications, and strengthening governance processes.

Patient 2 -
The patient died from a serious tear in the main artery (aortic dissection), alongside existing complex heart disease and kidney problems. There had been delays in routine heart monitoring due to service capacity pressures.
The review identified learning around timely follow-up, managing transitions between services, recognising and responding to deterioration, addressing staffing pressures, and strengthening overall system governance to reduce future risk.

Patient 3 – MNSI
This review looked at the death of a baby at 10 days old who had been transferred to Bristol shortly after birth.
The investigation found missed opportunities to fully assess risks and involve the family in decisions about delivery, particularly when a planned emergency caesarean section was changed despite several risk factors for mother and baby.
The baby's care was also affected by treatment that did not follow guidelines at the start, although care after this was appropriate.

Patient 4 MNSI -.
This investigation reviewed the death of a mother at 18 weeks of pregnancy.
Although individual aspects of care followed guidance, there was a lack of coordinated teamwork, meaning that the overall level of risk was not fully recognised.
Poor information sharing, delays in investigations, limited awareness of safeguarding concerns, and the impact of health inequalities all contributed to missed opportunities to provide joined-up and holistic care for a vulnerable patient.

Patient 5 PSII -
Following day-case vascular surgery, a high-risk patient with kidney failure and severe sleep apnoea was kept in hospital overnight but did not receive key treatments, including breathing support, regular medications, or a full clinical review.
She was given pain medication that built up in her body due to her kidney condition, leading to breathing problems, cardiac arrest, and death.

Learning highlights the need for thorough assessment, medication checks, and senior review when patients move from day-case to inpatient care, alongside safer prescribing and better recognition of high-risk conditions. This review is ongoing.

Patient 6 – PSR2 -
A patient who was considered medically fit after hip fracture surgery was moved to a ward while waiting to be discharged. On 4 January, their condition worsened, with signs of possible infection.
Although they were seen by a doctor, antibiotics were not started and escalation to specialist teams was unclear or delayed. Documentation and senior review were limited, and the Critical Care Outreach Team was not called.
Monitoring overnight was reduced despite earlier concerns, with no observations recorded for several hours before the patient died in the early hours of 5 January.
Key concerns include delays in treatment, poor escalation, and inadequate monitoring. This review is ongoing.

Patient 7 – PSII & External MNSI -
A first-time mother with an IVF pregnancy chose not to attend regular antenatal appointments and declined recommended monitoring and induction, planning to give birth at home after 42 weeks. Despite being advised of the risks, she chose to continue with this plan.
When midwives attended during labour, they were unable to find a fetal heartbeat and arranged urgent transfer to hospital. On arrival, the baby was confirmed to have died before birth and was delivered stillborn.
Care largely followed expected pathways, but learning identified the need to improve engagement, risk assessment in planned home births, and care planning for women who decline recommended care. This review is ongoing.

Please see appendix 1 for further case details

3.5.7 Learning from Complaints

There was 1 death of a patient who died during Q4 whose family raised a complaint. The learning from this death is captured and is part of an ongoing process which will report to MROG.

Patient 1 – a 62-year-old lady.
The family raised concerns about poor communication, limited involvement in care decisions, and unsafe discharge planning during their mother's hospital stay.
They were concerned that she was declared medically fit for discharge after an unexplained episode where she became unresponsive. There were also repeated failures to act on clinical concerns, inconsistent information, and last-minute changes to discharge plans.
These issues caused significant distress to the family and contributed to a decline in the patient's ability to function, without timely rehabilitation support.

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3.5.8 Severe Mental Illness

There were 4 patients who died with severe mental illness. On completion, these will be reported to MROG, learning captured and disseminated as appropriate. This learning will be reported to QAC as it completes in future LFD reports.

Patient 1 – 81 year old man
Patient 2 – 85 year old lady
Patient 3 – 61 year old lady
Patient 4 – 60 year old lady

3.5.9 Child Deaths

There were no child deaths reported in RCHT within Q4.

3.5.9.1 Child Death Overview Panel (CDOP) is a statutory body responsible for reviewing all child deaths. It reports to MROG every 6 months. We have included the latest action plan in appendix 4.

Key themes for learning raised from these reviews include:

- Clinical Governance
- Bereavement Support
- Staff Wellbeing
- Education & Equipment:
- Policy Gaps

3.5.9.2 PFD – Regulation 28 – Child Death

Following the Regulation 28 Report issued after the inquest into a child death, the Trust has implemented a series of system-wide improvements to address identified concerns relating to incomplete infant feeding histories and inadequate use of interpreter services.

Key actions include strengthening clinical assessment through standardised questioning about feeding practices (including mandatory clarification of bottle contents), embedding professional curiosity across paediatric, ED and maternity pathways, and enhancing communication with families through improved access to interpreter services.

This has been supported by the introduction of enhanced continuity pathways, routine auditing of compliance, and deployment of translation technology across maternity services.

Collectively, these measures aim to improve early identification of risk, ensure equitable communication, and reduce the likelihood of similar incidents in future.
Please see appendix 5 for full action plan.

3.5.10 Perinatal Mortality

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Four perinatal deaths (3 infant, 1 neonatal) were reviewed in January–March 2026 using the Perinatal Mortality Review Tool (PMRT). Senior Clinical staff are mandated to use the national perinatal mortality review tool (PMRT). It aims to ensure consistent, thorough reviews of baby deaths from 22 weeks' gestation onwards to provide clear answers for

bereaved families about the care received and whether outcomes might have differed, while also driving learning to improve future care and reduce preventable deaths. Used across UK maternity and neonatal services, it supports multidisciplinary reviews, active parent involvement, structured investigation and reporting, and the generation of local and national insights to identify trends, enhance safety, and inform improvements in care.

Case 1: Infant death following delivery at 34+4 weeks after in-utero transfer for significant congenital abnormalities. Baby required intensive care and died following palliative management. Review ongoing regarding appropriateness of transfer prior to delivery.

Case 2: Infant death in a high-risk twin pregnancy complicated by maternal diabetes and congenital cardiac anomaly. Baby died unexpectedly on arrival at RCHT following inter-hospital transfer. Care graded as good; learning identified around MDT planning and communication for tertiary delivery pathways.

Case 3: Neonatal death following term delivery with maternal risk factors (social complexity and Group B Strep positive). Baby initially well but died suddenly at home on day 26. Identified care issues included incomplete intrapartum antibiotics and suboptimal neonatal observations/escalation.

Case 4: Infant death following preterm birth (33+5 weeks) with risk factors including smoking and GBS. Baby discharged after transitional care but died at home on day 35. Learning relates to lack of postnatal home review and discharge processes in higher-risk infants.

Overall themes:

- Opportunities to strengthen care coordination across sites (transfers and tertiary pathways)
- Importance of adherence to clinical guidelines (antibiotics, observations)
- Need for improved postnatal follow-up and risk-based discharge planning

For full details please see appendix 3

3.6 Deaths reporting concerns raised by clinicians

There were no deaths in this category reported in Q4.

3.7 Structured Judgement Reviews (SJR)

SJRs are currently commissioned for specific patient groups:

- Priority Deaths: Learning Disability & autism, Complaints,
- Child Deaths,
- Patient Safety Incident Investigations,
- Deaths where concerns have been raised
- Deaths associate with Severe Mental Illness.
- Concerns raised by the Medical Examiner review.
- Concerns raised from a mortality screening review.

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In addition, Critical Care use SJR methodology for all their deaths as part of their specialty mortality review process

36 SJRs completed for Quarter 4 (January 2026 – March 2026). 29 of these were Critical Care SJRs which sit outside of the formal mandated LFD process.

Of the 36 SJRs,5 were a priority death and 5 SJRs are outstanding. The expected completion date for these is end of June 2026.

(*priority deaths include Perinatal/stillbirths which are reviewed using the Perinatal Mortality Review Tool - PMRT).

The table below shows scores and avoidability for all SJRs completed for deaths in Q4.

SJR Score	Total Number of SJRs	Avoidability*	Total Number of SJRs
1 – Very Poor Care		1 – Definitely Avoidable	
2 – Poor Care	1	2 – Strong evidence of avoidability	1
3 – Adequate Care	3	3 – Probably avoidable (50:50)	
4 – Good Care	20	4 – Possibly avoidable but not likely (<50:50)	1
5 – Excellent Care	12	5 – Slight evidence of avoidability	1
		6 – Definitely not avoidable	33

In this quarter one case was identified using SJR where poor care was judged to have taken place with strong evidence of avoidability.

The patient was admitted to the emergency resuscitation area with a flare-up of COPD and a hip fracture. After initial treatment and a CT scan, they returned to the department. Shortly afterwards, they were found with very low oxygen levels and severe breathing difficulties.
The case has been reviewed, and a safety action plan has been developed, which is being monitored through the Trust's quality and safety processes.

Breakdown of activity for quarter 4 is shown here. This does not include reports provided from the legal services department to the coroner (summary reports).

	Deaths in Q4	ME Datixes in Q4	Priority death SJRs requested	Priority death SJRs completed	Nonpriority death SJRs requested	Nonpriority death SJRs completed	New inquests Opened	Inquests Heard
SSS	91	3	3	1	0	0	5	11
AEM	271	27	7	4	0	0	16	22
ACCT	29		0	0	0	0	5	1
WC, HIV	1	1	0	0	0	0	4	2

T&O, SMH, WCH	19	2	0	0	0	0	7	3
GSC	42	2	0	0	0	0	2	2
CSS	0		0	0	0	0	1	2
Corp	0		0	0	0	0	0	0
SWAST	0	5	0	0	0	0	n/a	n/a
TOTAL	438	40	10	5	0	0	40	43

MROG is working to strengthen the implementation of National SJR process (not including Critical Care, which lies outside national guidance). Currently SJRs are allocated on an ad hoc basis to clinicians which has led to inconsistent quality and delay in completion. There has been a longstanding backlog of 5 SJRs awaiting completion

We are proposing to appoint a team of six consultant reviewers, trained in the national methodology with a time allocation in Job plans to ensure targeted completion (and clear the backlog within weeks, appropriate sharing and discussion with the clinical teams and MDT involved in each case, and a network for problem sharing and solving in difficult cases where nuanced judgements are require – a second or third opinion. The team will sit on MROG to bring additional clinical input into the Learning from death process. An investment case has been completed and submitted.

The proposed changes have been written into a revised Learning from Deaths Policy which has been signed off at QAC in April and at Trust Board.

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3.8 Medical Examiner

In Quarter 4 2025-2026, the Medical Examiner office reviewed 443 deaths, equating to 81.04% of RCHT deaths. The remaining 18.96% (84 deaths) were referred to the Coroner.

25 deaths were reported to the patient safety team for further review of inpatient care (5.64% of the deaths reviewed by the medical examiner).

Areas of concerns highlighted as scrutiny are reported through datix. The Lead Medical Examiner or one of the team attends the Mortality Review Oversight Group Meeting. No themes or trends have been identified. (see appendix 3 for full breakdown).

Work is ongoing to improve the quality of the medical examiner referral. This process is due to complete by the end of July 2026. The action holder is the Trust Mortality Lead.

Please see appendix 2 for further details.

3.9 Learning and Feedback from Inquests

In Q4 there were 29 Inquests which were attended by 24 trust witnesses, and the Trust was involved in 3 Pre-Inquest Review Hearings.

- One Prevention of Future Death related to stroke care highlighted delays due to limited system capacity across admission, rehabilitation, and discharge pathways.
- Learning: while improvements have been made (e.g. ringfenced beds, better admission performance), ongoing issues with rehabilitation capacity and system modelling require further system-wide action, with the ICB reviewing capacity and staffing.

There is a PFD ongoing – in response to the PFD received a multidisciplinary group has been established to strengthen governance and processes related to safe, accurate, and timely medicines management for this patient group. A safety action plan in response to this PFD has been included in the PSII action plan and is reviewed every 2 weeks at PSIROG. .

This table shows the number of inquests by Care group then division in Q4.

Care Group	Q4 – Number of requests received
AEM	15
ACCT	5
Peripheral Sites	7
GSC	2
SSS	6
WCSH	4
Unknown**	11

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Moved to Divisions March 2026 - Medicine	8
Surgery	3

** for these cases, the deceased died in the community and therefore not affiliated with a care group. Summary reports provided where appropriate.

3.10 Divisional Governance Mortality Review Process

Following divisional restructure, we are strengthening the quality and impact of its mortality review processes, focusing on governance, clinician engagement and learning.

Improvement work is underway to standardise Specialty Morbidity and Mortality (M&M) meetings, led by the Trust Mortality Lead and MROG. We aim to build a consistent structure across the divisions with accurate review, clear actions, clinical ownership and dissemination of learning.

We plan to strengthen the reporting structure to MROG above tracking meetings and including learning from deaths and identified themes with actions.

Please see appendix 6 for M&M Meeting frequency.

3.11 Quality Improvement

The Quality Improvement portfolio demonstrates a broad range of active projects across the organisation, with strong involvement from junior doctors and nursing staff, particularly focusing on improving documentation, communication, patient safety, and specific clinical pathways. Key areas of work include enhancing the quality of clinical records and handovers, reducing risks such as falls and fatigue, strengthening treatment escalation planning, and improving care pathways for defined patient groups such as amputees, renal patients, and surgical cases. Ongoing initiatives also support staff training and patient wellbeing.

3.12 National Audits and Indicators of Care

The following summaries of National Audit Reports have been scrutinised at the bi-monthly Clinical Effectiveness Group (CEG) which in turn reports to QAC Any areas of concern related to mortality are tracked through CEG.

The following summaries of National Audit Reports have been scrutinised at the bi-monthly Clinical Effectiveness Group (CEG). Each has had a bearing on mortality rates, hence their inclusion in this report. Consideration of impact and learning from each report has been confirmed at the relevant CEG meeting.

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RCHT is fully engaged with the 77 national clinical audits.

These audits are monitored and scrutinised at the Clinical Effectiveness Group, and we focus on any with a flag within our alerts or those that highlight us as an outlier. see Appendix 8 for full audit details).

Bowel Cancer - Very low 90 day mortality rate - <1% for 3 years (national 2.2%, Plymouth 4%)
Inflammatory Arthritis - Nil relating to mortality

Lung Cancer - One year survival (2024 trust level): 52.3% (adjusted 52.9%) versus 51% England, indicating RCHT is at or above national performance in the latest available year.

Maternity and Perinatal Audit - Nil specific to mortality (This is reported in a separate Perinatal Mortality Audit).

Pancreatic Cancer - Nil specific to mortality

Sentinel Stroke (SSNAP) - Discharge Destination – Died in hospital RCHT 14.4% vs 9.6% nationally.

Primary Breast Cancer - 3 year all cause survival in RCHT – 97%, England & Wales – 92%

RCHT is fully engaged with the 77 national clinical audits.

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4. Risk

The Board Assurance Framework (BAF) Standard 1:

- Risk 8585 - Increased Fractured neck of Femur mortality rate
- Risk 9048 - ED waits

5. Accountability

Accountability for the Learning from Deaths agenda sites with the Chief Medical Officer, who is supported in this by the monthly Mortality Oversight Review Group. MROG reports to the Quality Assurance Committee for assurance.

6. Recommendations

The Board is recommended to:

- **Receive and note** the Q4 Learning from Deaths assurance report

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Appendix 1 – Learning from Patient Safety Reviews

Patient 1
Incident Summary
A Patient Safety Review was undertaken following the unexpected death of a patient approximately 14 hours after transfer from Critical Care to a ward.
The patient had been admitted with severe breathing problems, likely caused by inhaling stomach contents into the lungs, and developed serious complications including acute lung injury, kidney failure, and muscle breakdown. They required intensive treatment in Critical Care, including breathing support and dialysis.
The patient's condition improved, and they were transferred to the ward following a multidisciplinary team decision, with stable observations and a clear care plan. However, the patient was later found unresponsive on the ward and could not be resuscitated. A post-mortem examination confirmed severe lung injury but did not identify a single clear cause of death; a sudden breathing event, most likely aspiration, was considered the most likely explanation.
What went well

- Rapid and effective care before and on arrival at hospital
- Appropriate and timely treatment in Critical Care
- Good multidisciplinary working, including specialist input
- Compassionate support for the patient's family after death

Key learning

- Communication: Communication with the family was not always clear or consistent, particularly during the move from Critical Care to the ward
- Delirium management: The patient experienced confusion and agitation, and staff lacked clear guidance to manage this effectively
- Monitoring: Observations and care checks were not consistently completed after discharge from Critical Care
- Medicines safety: Medication processes during transfer were not followed correctly
- Governance: The review process lacked consistency and multidisciplinary oversight

Actions
Actions focus on improving communication, strengthening delirium management, standardising medication transfer processes, ensuring clear escalation when patients deteriorate, and improving governance of mortality reviews.
Key message
The death was sudden and not clearly preventable, but there are important system improvements identified to reduce future risk and improve patient and family experience.

Patient 2
Incident Summary
This review followed the death of a young adult with complex heart and kidney conditions. The patient required ongoing specialist heart monitoring but experienced significant delays in follow-up due to service capacity pressures.
The patient later presented with heart failure and deteriorated. There was a delay in recognising a serious condition (a tear in the main artery), although expert review concluded that earlier diagnosis would not have changed the outcome due to the severity of underlying disease.
Key learning

- Delays in routine follow-up due to capacity constraints
- Lack of a robust system to monitor patients waiting for follow-up
- Gaps in transition between children's and adult services

- Fragmented communication between specialist teams
- Delays in escalation and senior clinical review during deterioration

Actions

Actions include improving follow-up systems, strengthening transition pathways, increasing specialist workforce (including a dedicated nurse role), improving escalation processes, and enhancing oversight of high-risk patients.

Patient 3

Incident Summary

This review examined the care of a baby who suffered a lack of oxygen around the time of birth and later died.

While many aspects of care followed guidance, there were missed opportunities to fully assess risks and involve the mother in shared decision-making when a planned emergency caesarean section was changed.

There was also a delay in recognising the full level of risk, and some aspects of early treatment after birth did not follow guidance, although later care was appropriate.

Key learning and actions

- Improve holistic risk assessment when plans change
- Strengthen shared decision-making with parents
- Improve documentation and communication
- Introduce checklists to support decision-making
- Enhance staff training in risk awareness and human factors

These changes aim to ensure clearer decisions and better involvement of families in care.

Patient 4

Incident Summary

This review examined the death of a pregnant woman who collapsed and died at home.

Post-mortem findings showed a combination of severe chest infection and a blood clot.

The patient had multiple vulnerabilities, including social challenges, mental health needs, and increased medical risk, and had several contacts with services before her death.

While individual episodes of care generally followed guidance, there was no overall coordination of care, meaning the full level of risk was not recognised.

Key learning

- Poor sharing of information between teams
- Delays in investigations due to system pressures
- Limited visibility of safeguarding concerns
- Lack of coordinated care for a high-risk, vulnerable patient
- Impact of health inequalities on access and outcomes

Actions

- Assign a named lead consultant for vulnerable patients
- Improve sharing of care plans and safeguarding information
- Strengthen multidisciplinary coordination
- Improve access to investigations
- Ensure more personalised and joined-up care

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Patient 6 –

Learning ongoing – to be shared when identified.

Patient 7 –

Learning ongoing – to be shared when identified

Appendix 2 – Medical Examiner

Number of cases reviewed by medical examiner team in Q4 - 443
Number of incidents reported by medical examiner team – 25

Department/Ward	Number and type of incidents
Emergency Department = 6	1 – Discharge – inappropriate 1 – Care plan/assessment missing/inadequate/illegible 1 – Delay/failure to order correct tests/images 1 – Delay in obtaining patient records 1 – Delay/failure to monitor 1 – Lack of/delayed availability of beds
Respiratory Medicine = 5	2 - Inadequate handover of care 2 – Delay in diagnosis 1 – Unexpected transfer
Eldercare = 6	1 – Readmission 1 – Treatment/procedure inappropriate 1 – delay in diagnosis 1 – Unexpected transfer 1 – communication failure with patient 1 – inadequate assessment
Surgery = 4	1 – Treatment/procedure inappropriate 1 – Urgent appointment not available 1 – Inadequate handover of care 1 – Delay in action on complication of treatment
Rheumatology = 1	1 – Delay to treatment
Corporate = 1	1 – Controlled drugs discrepancy
Women's and Children's = 1	1 – Discharge planning failure
Out of hospital care unit = 1	1 – Inadequate handover of care

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Appendix 3 – Perinatal Mortality review

Case 1 – Infant Death

Clinical background: In-utero transfer at 34+4 from Plymouth due to severe bilateral ventriculomegaly and abnormal Dopplers. Delivered same day by Caesarean Section following recommendation for urgent delivery.

Condition: Multiple congenital abnormalities (neurological, craniofacial, renal, skeletal)

Course: Required resuscitation, ventilation, and neonatal intensive care. Consideration for surgical management; ultimately transitioned to palliative care and died at 32 days

Risk factors: Congenital anomalies, raised maternal Body Mass Index (BMI), out-of-area transfer

Key learning:

- Appropriateness and timing of in-utero transfer prior to delivery requires further review.

Status: Joint PMRT review pending with referring tertiary centre.

Case 2 – Infant Death

Clinical background: High-risk Monochorionic twin pregnancy with maternal type 2 diabetes and recurrent Diabetic Ketoacidosis. Antenatal diagnosis of congenital cardiac anomaly (Twin B).

Delivery: Emergency Caesarean section at 32+3 weeks due to preterm labour and abnormal Cardiotocography (CTG).

Neonatal course:

- Transferred to Bristol for cardiac surgery and prolonged tertiary care
- Subsequent interventions including stent and balloon dilation
- Died unexpectedly following transfer back to RCHT despite normal pre-transfer assessment

Risk factors: Multiple pregnancy, maternal diabetes, congenital anomaly, extreme growth restriction (0.1 centile).

Care quality: Graded A throughout (good care). Positive parental feedback.

Key learning:

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- Need for improved MDT communication and planning, particularly when care is shared across tertiary and local centres
- Earlier involvement of neonatal teams following antenatal diagnosis
- Guideline update for hyperemesis management (Xonvea use)

Actions: Ongoing MDT pathway improvement work and bereavement process review.

Case 3 – Neonatal Death

Clinical background: Term infant born to mother with complex social factors, Post Traumatic Stress Disorder (PTSD), and Group B Strep (GBS) positivity.

Delivery: Rapid labour; antibiotics not administered due to speed of delivery. Meconium present. Initial neonatal condition stabilised quickly.

Postnatal course: Observed for 24 hours (meconium + Selective serotonin reuptake inhibitors (SSRI) exposure). Found unresponsive at home on day 26 and died.

Risk factors: Social complexity, maternal mental health history, GBS positive.

Care quality: Graded B (some improvements identified).

Key learning:

- Missed opportunity for full intrapartum antibiotic prophylaxis
- Incomplete neonatal observations and escalation not in line with guideline
- Need to strengthen safe sleep advice and individualised care planning

Actions: Focus on patient engagement, safe sleeping assessments, and personalised care plans.

Case 4 – Infant Death

Clinical background: Preterm labour at 33+5 weeks; appropriate antenatal management including steroids, Magnesium Sulfate, antibiotics. Required transfers due to cot capacity before returning for delivery.

Delivery & neonatal course: Vaginal delivery; transitional care for 5 days.

Outcome: Found unresponsive at home on day 35.

Risk factors: Prematurity, maternal smoking, GBS positivity, low birthweight.

Care quality:

- Pre-death: A (good care)
- Post-death processes: B

Key learning:

- Lack of postnatal home visit despite risk factors
- Telephone discharge inappropriate for risk profile

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Actions:

- Review of community follow-up processes (including health visitor involvement)

- Emphasis on risk-based discharge and postnatal review

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Appendix 4 – CDOP Action Plan

CDOP Review date	Theme	Issue/focus	Recommendations	Cornwall / IoS – Action taken / re-assurances	ICB Cornwall	Timeline
21/05/2025	Road Traffic Collisions	Car seat sizes in the UK based on weight - not so in other countries, e.g. Sweden, USA, Australia. This is potentially confusing. CDOP note and endorse the recent calls for better guidance around car seat fitting and advice e.g. https://roadsafetygb.org.uk/news/uk-parents-unknowingly-putting-children-at-risk-with-early-forward-facing-switch/ . Information and training be afforded to Professionals who are transporting children as part of their role.	To share the current and up to date guidance on car seats with our Partners with a view to education for professionals who are transporting children as part of their role, this may include (but not limited to): Social Care, Early Years Providers, Children's Care Home Staff See: https://www.childseatsafety.co.uk/ https://www.carseatsmarter.co.uk/ For further information on car seat safety and training outside partners in car seat safety, Partners can link in with the D&C Road Casualty Reduction Team – xx.xx @devonandcornwall.pnn.police.uk	Cornwall have been in contact and xx has facilitated placed to run sessions, they are currently identifying professionals to attend. Business support have been involved in work to check all company car seat ISBN numbers to ensure they are compliant. They envisage this will become part of a 2-3 year check.	Lead will scope if midwifery would need any car seat training, but the feeling was that it was the parents responsibility to secure their child. Unlikely to be a role. Additional Actions: We currently have guidance – Car Seat Challenge for at Risk Infants, including those weighing less than 2.0kg at discharge SOP – but need to review how we direct families to investigate suitability of car seats antenatally.	31/03/2025
18/09/2024	support for professionals after the death of a child	Recognising the psychological impact of a child death on professionals. Lack of support for staff, especially those working with acute trusts after a child dies.	Any professional involved with the death of a child should have access to structured support. There are processes for structured support already available in agencies other than Health i.e. TRIM [police] that are used and can be utilised for this purpose.	RCHT/CFT MIU learning. CIOS ICB have undertaken a sepsis mapping exercise and are looking to implement any changes needed.	CIOS health there is support available for practitioners including counselling, OT. Line manager and specialist supervision. CIOS complete. Additional actions: RCHT to ensure that there is a clear, available TRIM trained staff list for matrons and ward leaders that can be accessed at any time to ensure best trained people are there to support our teams.	28/02/2026

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					Develop business care to ensure that we have a consistent agreed number of available TRIM trained staff available to support our teams. Develop a SOP to ensure that there is clear guidance regarding the best way to support team members	

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Appendix 5 – Action plan for PFD

Action plan – Response to Regulation 28 Report to Prevent Future Deaths, dated 9 December 2025 and received on the 10 December 2025. This was issued following the inquest into the death of xx which was heard over 17-18 November 2025 and concluded on 09 December 2025.

xx died on 7 September 2024 at the age of 9 months.

The recorded cause of death was:

1. Acute on chronic decompensated heart failure
2. Cardiomyopathy
3. Iron deficiency anaemia (treated with a blood transfusion)

It was recorded that xxx died from complications caused by her treatment for profound iron-deficiency anaemia in turn due to her consumption of cow's milk.

Action Plan

Concern / recommendation	**Action**
There was a failure to recognise that 'bottle fed' is an incomplete description and requires an additional question of 'what is in the bottle?' – there was a lack of professional curiosity	xx case has been widely shared across the organisation and has increased professional awareness, knowledge and confidence in asking the appropriate question on feeding in infants. The Emergency Department are to change their language when asking parents about how babies are fed from 'bottle' to 'formula' – e.g. 'is your baby formula or breast fed?' In addition, ED documentation in terms of proformas for paediatric clerking in the ED by both medical and nursing staff will reflect this change. In relation to our paediatric team, completion of routine enquiry will be embedded into the admission proforma use for our inpatient children's ward. "What is in the bottle?" has become a standard enquiry all in paediatrics and will be included in their admission documentation. Support can then be provided for families if indicated.

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	Maternity services use routine enquiry about the exact nature of bottle feeding as a mandatory question at every safe opportunity making the identification of need or risk earlier.
During ante-natal and post-natal visits with a woman who did not speak English, no interpreter was involved, contrary to guidance.	Since xx tragic death, the Trust has already undertaken and has in place the following: a. Enhanced Continuity Pathway developed and implemented b. Pregnancy Circles implemented with face-to-face translators c. Strengthened interpreter and language support in maternal care d. Audits of interpreter and language support will be reported to the Clinical Audit Assurance software (AMaT) and through Perinatal Safety Trust Board report. This commenced in January 2025 and will continue to be audited every 3 months. <u>Pocketalk Devices</u> This is a translation device that we are now able to use. This looks like a mobile phone and can be used to translate all discussions. It currently has nearly 100 languages to choose from. All Porth midwives (continuity of care for complex cases, including those where English is not the first language) will have one, as well as: • Delivery suite • Wheal Rose • Wheal Fortune • Telephone triage • Diabetic team • Wren team • Midwife sonography team These devices on the wards are kept in a designated place along with a quick ‘how-to’ guide. It is very simple and intuitive to use, so we do not need training to use it. With these available, we now expect that any person/family who is identified as needing a translator should have access

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	to this device. The use of Pocketalk is recorded on the patient's electronic record. By the time most families come to RCHT, they should know that these are available and be used to their Porth midwife using them.

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Appendix 6 - Specialty M&M

Specialty	Frequency	Oct 25	Nov 25	Dec 25	Jan 26	Feb 26	March 26
Cardiology	Monthly	No	Yes	Yes	Yes	Yes	Yes
Endocrine	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Respiratory	quarterly	x	x	x	Not required	Yes	Not required
Renal	Bimonthly	Yes	n/a	Yes	No	No	No
Breast	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Gen. Surg.	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Haem.	Quarterly	Yes	No	No	Yes	Not required	Not required
Oncology	Quarterly	Yes	Not required	Not required	Yes	Not required	Not required
Urology	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Vascular	Monthly	Yes	Yes	Yes	Not required	Not required	Yes
ENT	Monthly	No	No	No	Not required	Not required	Not required
Gastro	Quarterly	Yes	Yes	Yes	Not required	Not required	Yes
Oral/maxfax	Monthly	No	No	No	Not required	Not required	Not required
Anaesthetics	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Crit Care	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
AMU	Quarterly	No	Yes	No	Not required	Yes	Not required
ED	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Eldercare	Monthly	Yes	No	No	Yes	No	Yes
Gynae.	Weekly	Yes	Yes	No	No	Yes	Yes
Maternity	Weekly	Yes	Yes	Yes	Yes	Yes	Yes
Neonatal	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
Paeds	Monthly	Yes	Yes	Yes	Yes	Yes	Yes
T&O	Monthly	Yes	Yes	Yes	Yes	Yes	Yes

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board In Public

Date of Meeting: 02 July 2026

Item Number: 10.2

Title of Report: Perinatal Safety Report

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Josie Dodgson, Director of Midwifery / Ellie Lawes, Neonatal Specialty Lead Consultant / Michael Cross, Project Manager – Compliance and Governance, Naomi Wakely, Neonatal Governance Lead

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Purpose of the Report:

Decision ☒ **Discussion** ☒ **Assurance** ☒ **Information** ☒

This paper provides the Committee with an update on Maternity and Neonatal Services in relation to the safety of mothers, birthing people, babies, and families.

Consultation:

- Obstetric and Maternity Business and Governance Meeting
- Neonatal Business and Governance Meeting
- Divisional Board
- Quality Assurance Committee 25 June 2026

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☐ **Legal / Regulatory** ☒

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Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			X	
Quality Impact Assessment completed?			X	
Data Protection Impact Assessment completed?			X	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Progress against the standards outlined within this report will have a positive impact on the health and wellbeing of the population of Cornwall.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Progress against the standards outlined within this report will have a positive impact on greater quality and accessibility of services provided or arranged by RCHT.
Sustainable and efficient use of NHS resources by RCHT	Progress against the standards outlined within this report will improve the way in which the Maternity/Neonatal service utilises its resources including staffing, in a sustainable and efficient manner.

Recommendations:

The Board **is recommended to:**

- **Discuss for assurance** the concerns raised regarding discriminatory conduct within the Perinatal Service and the actions being undertaken to address this and improve the culture.
- **Note for assurance** the NHS Resolution scorecard.
- **Discuss** and **note** the complexity and necessary wide-ranging support of our perinatal mortality cases.
- **Note the** continued engagement with Kernow Maternity and Neonatal Voices

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Partnership in ensuring that patients voices are represented in our services.

- **Note** the dashboard data for both Maternity and Neonatal services in Appendix 1 which was reviewed at the Quality Assurance Committee with no escalations to the Trust Board.

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Perinatal Safety Report

1. Situation / Executive Summary

The purpose of this paper is to provide assurance of safety in Royal Cornwall Hospitals Trust (RCHT) Maternity and Neonatal Services, to the Quality Assurance Committee and Trust Board of Directors.

Key safety information for May 2026:

- There was 1 reportable Patient Safety Incidents (PSI or PSII) in May 2026.
- There were 0 Maternity and Neonatal Incidents reported to Maternity and Newborn Investigations (MNSI) in May 2026.
- There were 0 Stillbirths (SBs) in May 2026.
- There were 0 Neonatal Deaths (NND) in May 2026.

2. Background

The purpose of the report is to inform the ICB Board and Trust Board of present or emerging safety concerns or activity to ensure safety with a two-way reflection of 'ward to board' insight across the multi-disciplinary, multi-professional maternity services team.

This report outlines locally and nationally agreed measures to monitor maternity and neonatal safety, as outlined in the NHSE Perinatal Quality Oversight Model (August 2025). The reporting mechanisms contained in the report have been reviewed against the national guidelines published in 2025 and is therefore presented in a revised format. The new maternity reporting dashboard is in Appendix 1.

The report was discussed in full at the Quality Assurance Committee meeting 25 June 2026 with no matters of escalation to the Trust Board.

Perinatal Mortality

Perinatal

Stillbirth (Pre-term)	0
Stillbirth (Term)	0
Intrapartum Stillbirth	0
Neonatal death < 7 days	0
Neonatal death > 7 days	0
Perinatal Mortality %	
Miscarriage 14-21+6	1
Late fetal loss 22-23+6	0
Total Termination of Pregnancies for Medical Reasons (TOPMR)	**4**
TOPMR < 24 weeks	1
TOPMR >24 weeks SB certificate issued	2 (case 2 and 3)

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TOPMR resulting in livebirth (MCCD issued)	1 (Case 1)
Maternal death	0

Case 1

TOP – Neonatal Death 19+6 weeks gestation.

A first-time mother presented to Delivery Suite at 19+5 weeks' gestation with protruding amniotic membranes. Speculum examination showed advanced cervical dilatation of around 5 cm, exposed membranes and a visible fetal vertex. She had no contractions and minimal pain. The Obstetric team provided prompt counselling on the clinical situation and maternal risks. The patient was then transferred to the bereavement suite, where she consented to termination of pregnancy, agreed by two doctors.

The baby was delivered with signs of life. The Obstetric Registrar attended, confirmed signs of life at birth and later certified death. As the termination resulted in a live birth, the case was referred to HM Coroner in line with statutory requirements. A paper inquest has since concluded. As the gestation was below 20 weeks, the case did not meet MBRRACE-UK reporting criteria.

Index of Multiple Deprivation Decile based on postcode – **3** overall
(Below local average of 4 for education and skills - 4, barriers to housing - 1)

Case 2

TOP > 24 weeks Stillbirth

MBBRACE-UK 103698

The patient attended the Termination of Pregnancy Clinic after seeing her GP with abdominal pain, when investigations identified a pregnancy. She reported amenorrhoea while taking desogestrel for Polycystic Ovary Syndrome and had been unaware of the pregnancy. Ultrasound confirmed a gestation of about 25 weeks. During consultation, the patient described significant psychosocial concerns and multiple vulnerabilities. She stated that continuing the pregnancy would seriously worsen her mental health.

Alternatives, including continuation of the pregnancy, were explored in detail, but the patient did not agree to these options. Urgent assessment by the Psychiatric Liaison Team confirmed a high and credible risk of suicide if the pregnancy continued. The patient had capacity and expressed consistent, clear wishes. Senior obstetric review and counselling covered the risks, options and legal framework.

Following multidisciplinary discussion, it was agreed that the criteria under the Abortion Act 1967 were met, specifically Ground A (risk to life) and Ground B (risk of grave permanent injury to mental health). Given the gestation, fetocide followed by induction of labour was planned in line with national guidance. As the patient had two previous caesarean sections, she was managed as high risk on Delivery Suite.

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After delivery, the patient continues to receive support from the Bereavement and Psychiatric teams. A stillbirth certificate has been completed and the case reported to MBRRACE-UK. As this was a termination of pregnancy, it does not require review through the Perinatal Mortality Review Tool (PMRT).

Index of Multiple Deprivation Decile based on postcode – **4** overall
(Below local average of 4 for employment – 3, living environment – 1)

Case 3

TOP > 24 weeks Stillbirth

MBBRACE-UK 103893

In her second pregnancy, the patient transferred maternity care to the Royal Cornwall Hospital at 24 weeks from the Royal Berkshire Hospital after a diagnosis of Trisomy 9, confirmed by chromosomal microarray at the John Radcliffe Hospital in Oxford.

A 20-week anomaly scan at the Royal Berkshire Hospital identified multiple fetal anomalies, prompting referral to the Fetal Medicine Unit at the John Radcliffe Hospital. Following multidisciplinary assessment, including fetal cardiology and genetic counselling, Trisomy 9 was confirmed and the patient received counselling on prognosis and management options, including termination. The clinical geneticist confirmed that the condition met Clause E of the Abortion Act, indicating a substantial risk of serious fetal abnormality, and supported the option of termination.

The RCHT Fetal Medicine team worked with colleagues in Oxford to coordinate transfer of care to Cornwall, reflecting the patient's wish to be closer to family support and away from social isolation in Berkshire. Fetocide was carried out without complication, followed by induction of labour. A stillborn baby was delivered at 25 weeks' gestation.
Postnatal care has included ongoing Bereavement Team support. A stillbirth certificate has been completed and the case reported to MBRRACE-UK.

As this was a termination of pregnancy for fetal anomaly, it is not subject to review under the Perinatal Mortality Review Tool (PMRT).

Index of Multiple Deprivation Decile by postcode – **6** overall
(Below local average of 4 for living environment – 1)

3. The Maternity and Newborn Safety Investigation Programme (MNSI) and Maternity Patient Safety Incidents (PSIs)

3.1 Investigation progress update

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MNSI Ref	Reason for referral	Date of confirmed investigation	Family Informed	Duty of candour complete Y/N	Early notification, external notifications and other investigations
MI-047951	Stillbirth	22/10/2025	Yes	Y	PMRT
MI-051647	Suspected brain injury	27/01/2026	Yes	Y	Early Notification Scheme
MI-053370	Suspected brain injury	24/02/2026	Yes	Y	Early Notification Scheme
Does not meet MNSI criteria	Late neonatal death (Outside the hospital – 26 days)	06/03/2026	Yes	N	PMRT
Completed PMRT – May 2026					
Does not meet MNSI criteria	Stillbirth	27/11/2025 Report completed 27.05.2026	Yes	Y	PMRT

3.2 Patient Safety Incidents and Learning from Investigations (PSI)

Maternity Patient Safety Incidents during the period of April 2026.

Case 1

A baby required therapeutic cooling and transfer to a tertiary unit. This case was discussed at the Maternity Patient Safety Multi-Disciplinary meeting in May 2026 and a PSR1 was requested due to the baby's condition after birth.

Identified learning points:

- Liaise with Treating Tobacco Dependency Specialist Midwife regarding sharing learning around referral to the smoking cessation team where there has been cigarette use in the two weeks prior to booking.
- Liaise with the Perinatal Mental Health team to explore whether there is learning regarding the care of the mother's mental health antenatally.
- Share learning with staff regarding the need for an obstetric review and oxytocin proforma prior to commencing oxytocin (in this case, there had been a period of nearly four hours since the obstetric review and commencement of oxytocin,

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meaning that a more recent review, taking into the account the changing clinical picture, was indicated).

This did not meet criteria for referral to the MNSI due to the baby's gestation not being full term (the baby was born at 36+6 weeks gestation).

3.3 Coroners' report

Identifier	Date Listed	Summary
N/A	N/A	There are no approximate or confirmed dates at present.

3.4 Regulation 28 report issued

Identifier	Action required	Progress	Responsible role	By when
N/A	N/A	None to report in April 2026	N/A	N/A

3.5 Review of NHS Resolution Scorecard

Themes identified from Claims Scorecard (10 years)	**Themes identified from Claims Scorecard (10 years)**
(By Volume of incident - RCHT) • Stillborn • Brain Damage • Hypoxia • Psychiatric/ Psychological Drug • Bowel damage/ dysfunction	(By value of incident - RCHT) Hypoxia Brain Damage Erb's Palsy Cerebral Palsy Stillborn

There have been no new identified trends or themes identified in the legal teams' quarter 4 inquest report. Positively, we have continued to see in the past 6 months no stillborn cases. Since refresher training and bespoke learning following the close review of incidents of bladder injury following birth, we have not seen additional cases related to bladder care. Whilst there has been intense information and guidance sharing with our teams since these incidents, we will be scheduling further refresher sessions during the year to ensure that this is a standard area of focus.

3.6 Maternity Outcomes Safety Signals System (MOSS)

We have received 0 MOSS alerts in May 2026.

3.7 Safety Improvement plan (Progress updates from National reports / Thematic review action plans as required

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We have received the implementation tool for the new Maternity Care Bundle. Although publication was delayed, we have been planning and evidencing compliance within our remit, while working with Primary Care and commissioners to

support joined-up care for women in Cornwall. Progress is monitored through the Patient Safety Champions Board and the Maternity Improvement Plan.

Actions from the KMNVP 15 Step report are progressing, with early improvements completed on Princess Alexandra Ward. These include work with Estates to improve signage and reduce clutter so essential, age-appropriate information is clearer for service users.

The Neonatal Improvement Plan will be presented to Divisional Board on 30 June, before final scrutiny by the Safety Champions Board in July 2026.

4.0 Performance Metrics

4.1 Service Suspensions

	04/05/2026	11/05/2026	18/05/2026	25/05/2026
Obstetric unit	0	0	0	0
Neonatal unit (internal)	0	0	0	0
Neonatal unit (external)	0	0	0	0

4.2 Number of Opel 4 days:

	04/05/2026 – 17/05/2026	18/05/2026 – 31/05/2026
Neonatal unit - Opel 3	4	1
Neonatal unit - Opel 4	2	3

Reasons/ Mitigations:

The Neonatal Unit (NNU) did not close or reduce cot capacity in May 2026. OPEL days remained high, mainly due to low numbers of Qualified in Specialty (QiS) nurses per shift and the high acuity of admitted babies. In May 2026, 22.58% of days were at OPEL 3 and 25.81% at OPEL 4, continuing the downward trend seen since the start of the year.

4.3 Women experiencing delays to commencement of induction >24hrs

	Fortnight commencing				
	04/05/2026	11/05/2026	18/05/2026	25/05/2026	01/06/2026
Delays to commencing induction >24hrs	0	0	0	0	0

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4.4 Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training

	Midwives	Obstetricians (split by consultant/ other Dr)	MSWs	Anaesthetists (split by consultant/ other Dr)	Neonatal medics (split by consultant / other Dr)	Neonatal nurses (Nrs/ ANNP)
Saving Babies Lives Care Bundle	94%	90%/ 82%	99%			
Fetal monitoring and surveillance	100%	100%				
Maternity Emergencies and multi professional training	93%	90%/ 94%	90%	100%/ 53%		
Neonatal Life Support (NLS) training	93%		90%		Tier 3 = 100% Tier 2 = 94% Tier 1 = 100%	B5 = 57% B6 = 83% ANNP = 100%

Updates/ action planning

Two dates will be presented to Trust Board for review: September 2026 and a final review in November 2026. Training compliance and progress will continue to be reported through the Perinatal Safety Report and Safety Champions. We continue to work with the anaesthetic lead to book new resident doctors onto relevant PROMPT training earlier. This has been escalated through Maternity Safety Champions to the Division.

Neonatal nurse training remains a priority, focusing on mandatory training compliance, NLS for Band 5 nurses, completion of the Neonatal Foundation Programme, and skill development for the Qualified in Specialty course.

Actions include:

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- Progress recruitment of an additional Band 6 Neonatal Skills Facilitator to support education on the NNU
- Continued targeted support for those Band 5 nurses who have not yet completed their NFP including Personal Development Plans for individuals.

4.5 Safe Maternity Staffing

Fill rates – planned verses actual

The Maternity Incentive Scheme Year 8 requires "planned vs actual" hours for midwifery staffing and obstetric cover on the delivery suite to be presented monthly to Trust Board. Please see below:

May 2026	Acute Registered Midwives		Acute Maternity Support Workers	
	Day	Night	Day	Night
Planned Hours	7161	4774	2464.5	2046
Actual Hours	6357	4389	1984.5	1342
Planned vs Delivered Fill Rate	89%	92%	81%	66%

Actions taken and impact on care:

- We are continuing to expect to have a 3-month average of 94% for midwives and 80% for MSW's by the end of Quarter 1.
- Following a successful recruitment day, we are working to ensure that recruitment checks are completed at the earliest opportunity to allow for June start dates for both Maternity Support workers and Midwives.
- The Maternity team have been able to work with the MSW team to move staff to where the demand is needed most. There have been no patient safety issues during this time of reduced fill rate for MSW's but we have recognised the increased demand on this staff group offering support from the MSW clinical skills facilitator who has supported clinically, other midwives supporting with the role, team leader and the Professional Midwifery Advocate (PMA).
- Continue to review rotas and planning for new midwives for Q2 and Q3.

Obstetric Medical Staffing

This remains a challenging position. This is despite successful interviews and offering 2 consultants posts. This is confirmed in the risk section.

There were 0 Caesarean section lists uncovered during May 2026.

Appraisal Rates for April 2026

Appraisal rates for maternity fell to 70.8% in May 2026, from 82.4%. Neonatal Unit appraisal rates improved to 52.1% in May 2026, from 42% the previous month. Although below the required level, they remain on track to reach 80% by the end of July 2026.

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Actions taken and impact on care

- **Neonatal appraisal improvement plan** – The Neonatal Clinical Matron will present an improvement plan to the Division on 30 June, ahead of review by

Patient Safety Champions in July. Appraisals, and ensuring staff feel valued, are central to this plan.

- **Maternity appraisal review** – A meeting with supervising midwives was held on 10 June 2026 to gather feedback and identify ways to improve both appraisal completion rates and the quality of the process, in response to staff survey feedback. This will be followed up at the July Band 7 meeting and the June 2026 Triangulation meeting.

- **Practical actions** – Protected appraisal slots have been introduced during clinical shifts, Band 7 staff have been allocated admin time, and team meetings have reinforced the importance of appraisals and the quality of the conversation. Staff have also been reminded to book appraisals with their line manager.

4.6 Staffing Vacancy Rates

Staff group	Vacancy rate
Midwifery	9 WTE (4.9 recruited)
Midwife Support workers	9.2 WTE (8 recruited)
Transitional Care Team	5.06 WTE
Neonatal Nurses	B7 = 0 WTE Band 6 = under-recruited by 2.2 WTE Band 5 = under recruited by 2.57 WTE Band 4 = 1.26 WTE
Neonatology consultants	Fully recruited
Neonatal resident doctors	Under recruited by 0.5WTE

Tier 2 doctors have been successfully recruited to fill rota gaps across Neonatal and Acute Paediatrics. The Neonatal Unit Matron is working with the finance team to balance recruitment and budget across Band 6 and Band 5 posts, with the aim of maximising recruitment of Band 6 nurses who already hold Qualified in Specialty (QiS). The unit currently has 14.79 whole-time equivalent QiS nurses, representing 41.17% of the neonatal nursing workforce.

Six nurses have been identified to start the 2026/2027 QiS course. One additional nurse achieved QiS status in May 2026 and will receive support to build confidence in independent practice.

4.7 Red flags, actions and mitigations (Maternity and Neonatal)

There are no new red flags currently. There is commentary on current risks, actions and mitigation in the ‘Risk’ section.

4.8 Other Perinatal exception reporting

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Tackling Racism and Discrimination

We have seen concerns raised in our Perinatal Service about racism and discrimination. These concerns were escalated to the Senior Leadership Team. The Perinatal Leadership Team recognise that creating a culture where people can raise concerns without fear is essential and that whilst listening is important, but we need

to turn that listening into meaningful action to prevent racism and discrimination becoming embedded in the workplace. The Maternity Senior Leadership Team have begun exploring the work undertaken by other Trusts who have faced similar issues, so that we can learn from approaches that have been effective elsewhere. We have also reached out to our Equality, Diversity and Inclusion Lead, to begin forming a steering group with the right people and expertise around the table.

This steering group will focus on:

- Creating safe spaces for honest conversations about racism and discrimination
- Using a just culture approach when individuals have been named, ensuring fairness, accountability and learning
- Reviewing the themes emerging from the concerns raised
- Bringing together the outputs of our information-gathering
- Co-producing an Anti-Racism and Anti-Discrimination Action Plan for maternity

This work will not be a one-off exercise. It will be a sustained commitment to cultural improvement, equity and psychological safety for staff and for the families we serve.

Response to National Maternity and Perinatal Audit Findings

NMPA notification

The Trust has been notified by the National Maternity and Perinatal Audit (NMPA) of potential alarm-level outlier status for the PPH ≥1500 ml indicator.
Our Estimated Blood Loss (EBL) completeness for 2024 is 67%, below the 70% threshold required for inclusion.

Cause

This reflects a data collection and system configuration issue, not clinical performance or safety. Our electronic maternity system records initial and subsequent blood loss separately and does not automatically calculate a total EBL, leading to missing values within the NMPA methodology.

Action taken

We have formally asked Euroking to implement a configuration change so that a total EBL is calculated and submitted for every birth. This should improve completeness in future reporting cycles, although no implementation date has yet been confirmed.

Current assurance

In the meantime, we continue to maintain strong internal oversight of all PPH ≥1500 ml cases through our dashboard, case reviews and triangulation.

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4.9 Perinatal Safety Champions meetings

Meeting log

Date	Role	Attendance
09/06/2026	Board Safety champion – Bernadette George	Yes
09/06/2026	Board Safety Champion – Rebecca Hopkins	Yes
09/06/2026	Perinatal Obstetric lead – Tom Smith-Walker	No
09/06/2026	Perinatal Midwifery lead – Josie Dodgson	Yes
09/06/2026	Perinatal Neonatal lead – Ellie Lawes	Yes
09/06/2026	Perinatal Management team – Caroline Chappell	Yes
09/06/2026	MNVP lead – Morwenna Gee	Yes

Additional Attendees: Zita Warren (Neonatal Matron), Mel Gilbert (Head of Nursing),

4.10 Perinatal Safety Champion Feedback:

Feedback raised by staff	Action and progress
There has been a concern raised regarding discriminatory language used by members of staff whilst at work.	The Perinatal Leadership Team are developing an action plan, engaging with team members across the Perinatal Service and forming a multi-disciplinary steering group to respond appropriately. This is directly linked to on-going culture development work.
Feedback raised by service users	Action and progress
The KMNVP provided feedback from those people accessing the PORTH team. This included issues regarding transport and also the wide range of languages used by those engaged in focus groups.	Continue to develop our translation service. Progress continues to be monitored via the Patient Safety Review Group
Additional safety champions intelligence	Action and progress
With the new Maternity Bundle Implementation Tool being published we discussed the challenges in engaging with Primary Care regarding VTE	Director of Midwifery will be liaising with the Maternity Non-Executive Director to establish lines of communication with LMC to cordially discuss roles in ensuring safe care for women.

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4.11 Insights from service users and Kernow Maternity & Neonatal Voices Partnership (KMNVP) co-production

KMNVP remains actively involved across the perinatal service. It continues to contribute to the 15 Steps Report, including work to improve signage and

communication for patients and staff. As part of this, KMNVP members, a non-executive director and the governance team will carry out maternity walkarounds from a CQC inspector's perspective while reviewing progress against the 15 action areas. KMNVP has also provided valuable feedback on the expansion and impact of pregnancy circles across Cornwall.

4.12 Additional Service User Feedback and Triangulation

We continue to receive feedback via the friends and family test, Learning from Excellence pathway and via our birth reflections team. Feedback continues to be cross-referenced and actioned as part of our Triangulation meetings.

Debriefs / Birth Afterthoughts	Action and progress
There have been keen discussions on how best to improve our review of incidents at Maternity Patient Safety Meetings and also to ensure that actions derived from these meetings are sharper and have true measurable value. This has fully involved the KMNVP and links to PSIRF and projects with the Trust Patient Safety Team in which AI can be utilised to drive improvements. This is following engagement with the region.	Revise the Terms of Reference for the Maternity Patients Safety Meeting with the KMNVP
Friends and Family test	**Action and progress**
The Neonatal Unit have continued to engage excellently with families to ensure the best experience at often the most challenging of times. This has included positive feedback when at times families have moved between Transitional Care (TC) and the Neonatal Unit at times of risk (extreme heat on TC).	Capture more feedback via the new QR codes to further understand the views of families' experience on the Neonatal Unit.
Complaints and compliments	**Action and progress**
There have been no complaints received by the Neonatal Unit and the number of complaints regarding maternity have halved in May. Communication and confidence in engaging with and reassuring patients early remains a theme and was discussed how best to improve at Perinatal Triangulation in May 2026.	Complete new thematic reviews of incidents and complaints in tandem to better identify learning actions both to prevent complaints and ensure comprehensive and suitable responses to those affected.

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4.13 Trust Transitional Care

The Transitional Care pathway is now embedded as business as usual.

There are 3.83 WTE Band 5 vacancies with 3.19 WTE currently out to advert.

5. Red Risks/ Risk Register highlights

Risk ID	Risk Title	Update	Score
9006	Neonatal Nurse Staffing	The Neonatal Nurse staffing position remains challenging, with an increase in short term sickness reflecting the working conditions on the unit. The Neonatal Leadership Team are presenting the draft Neonatal Improvement Plan to the Division on the 30 June 2026 and further at the next Patient Safety Champions Board in July 2026.	20
10080	Obstetric Medical Staffing	We are awaiting the start of 2 successful consultant candidates. The first of which is scheduled for September 2026. This is key to reducing the overall risk but will require further aggressive recruitment to occur in line with supportive retention of our Obstetric Consultant team. At this time, and following presentation at the Executive Review Group in May 2026, the risk is remaining the same all though it is positive that the controls and actions continue to be preventing further risk. Severity at this time.	20
9524	Maternity Triage	We will be reviewing the severity rating during April following the audit scores and further review of the data regarding response times. There remain further actions, including those related to Central monitoring of CTG and further clinician involvement.	16
9284	AHP and Pharmacy Support for NNU	Completed investment request to be represented to Division Board with updated position: • Business case presented at NNU Business and Governance meeting. Continue discussions with services to highlight priority of adequate Neonatal provision. Support business planning as needed:	12

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		Regular discussions taking place, all services in similar financial constraints.	
9940	Lack or Ward Clerk Cover	This risk has continued as 1 member of staff has left and another has gone on maternity leave. Vacancy has been advertised and some shifts have been covered by our remaining ward clerk team however this is not sustainable over the long term.	12
9792	Maternity Staffing	We have seen a 3% increase in fill rates for midwives in May. This tracks with improved sickness and recruitment. There has been a drop in the drop in the fill rates of Maternity Support Workers (MSW) during the nighttime in May which has impacted the ability to reduce the staffing risk. This is expected to be improved with the embedding of new MSW's in June.	12
8086	Middle grade staffing on the neonatal unit	Recruitment into middle grade vacancy has been successful, awaiting start date for new recruit. Band 6 QiS nurse has been enrolled on ANNP course for 2026: Rota is now split from the Paediatric rota 13 hrs per day, 7 days per week. Further rota changes will be considered as part of MIS year 8.	12
9853	Sinks in Neonatal Nurseries are not fit for purpose	We are continuing to await a decision from the Estates Team about remedial options and works to be completed. Escalated via Division Board. Issues continuing to recur intermittently.	12
9487	Transitional Care Incubators for low-birth-weight neonates	Funding solutions have not been identified. Requested via Capital Bids process but is unlikely to be successful. Considering plans for charitable funding, however, it may be viewed that the equipment is essential and should be funded by the Trust.	12

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6. Accountability

The Director of Midwifery and Head of Nursing for Women's and Children's Services and Clinical Directors for Women, Children and HIV Services are responsible for delivering the actions in this report.

The Acting Chief Nursing Officer is responsible for the oversight of maternity services.

7. Recommendations

The Board is recommended to:

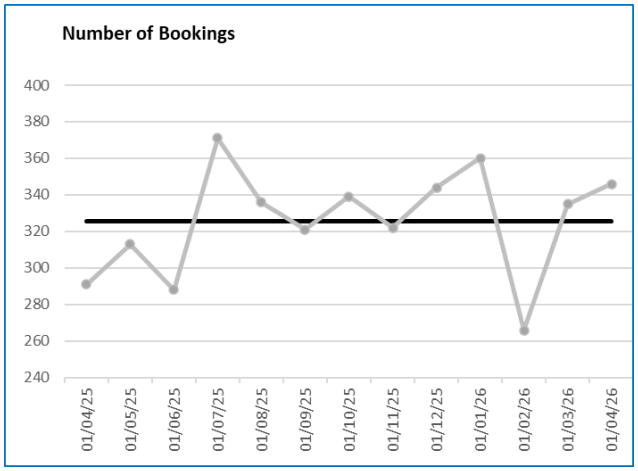
- **Discuss for assurance** the concerns raised regarding discriminatory conduct within the Perinatal Service and the actions being undertaken to address this and improve the culture.
- **Note for assurance** the NHS Resolution scorecard.
- **Discuss** and **note** the complexity and necessary wide-ranging support of our perinatal mortality cases.
- **Note** the continued engagement with Kernow Maternity and Neonatal Voices Partnership in ensuring that patients voices are represented in our services.
- **Note** the dashboard data for both Maternity and Neonatal services in Appendix 1 which was reviewed at the Quality Assurance Committee with no escalations to the Trust Board.

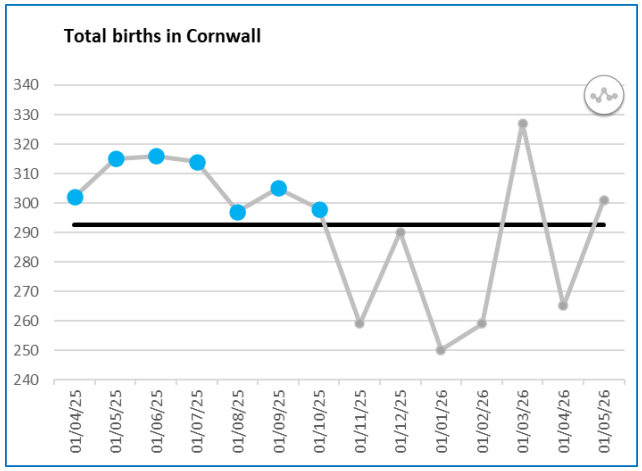
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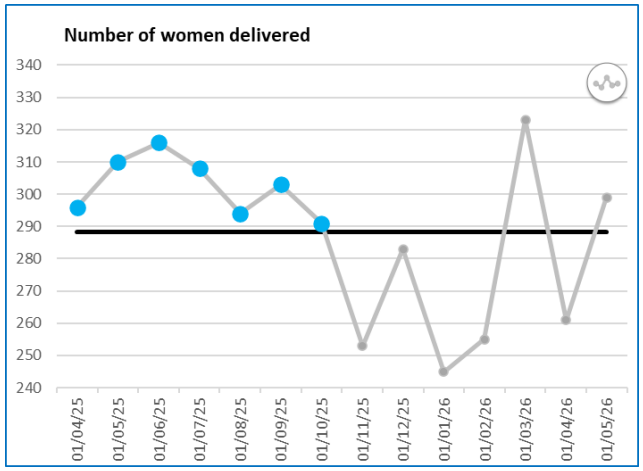
Appendix 1. Maternity and Neonatal SPC charts

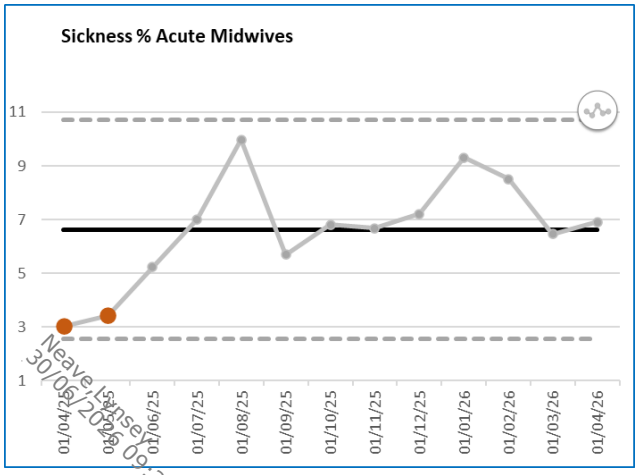
Please find below nationally recognised metrics taken from our maternity and neonatal dashboards. We will be providing further charts and measurements for review in future reports.

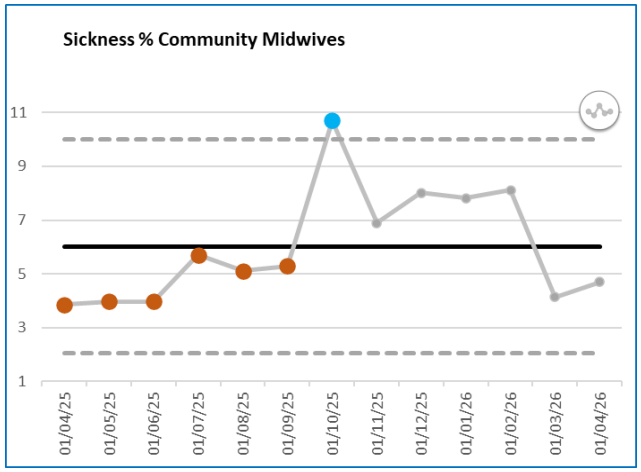
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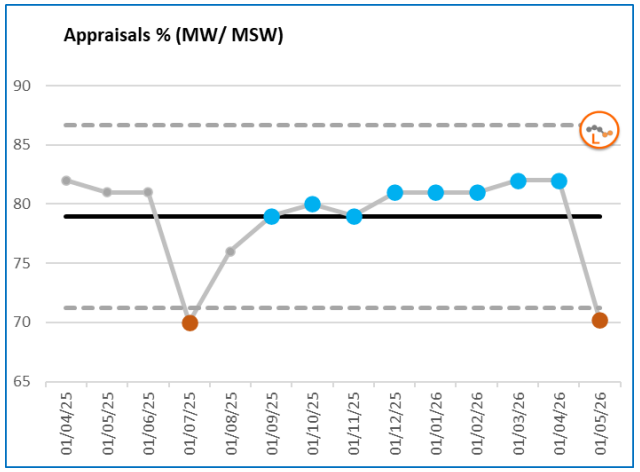


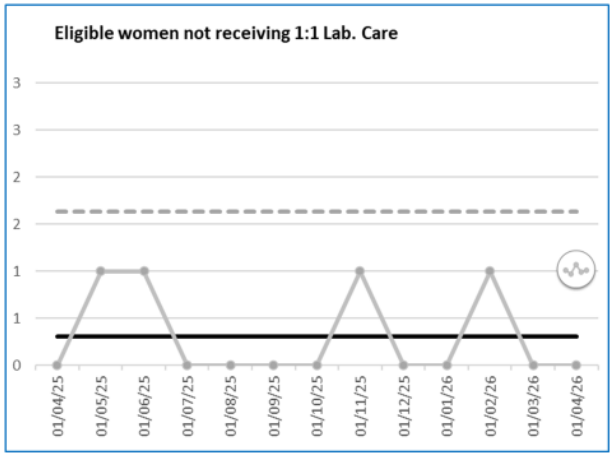


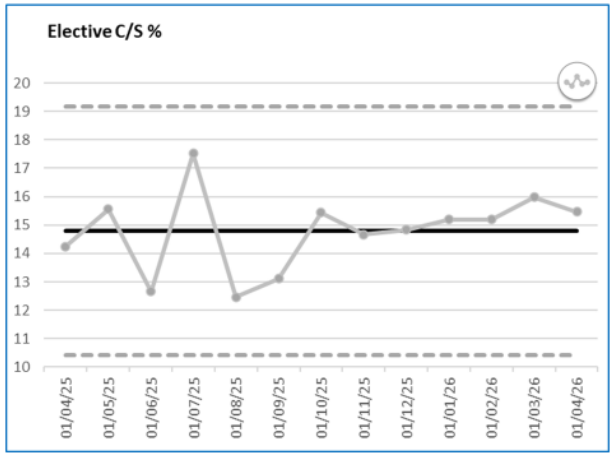


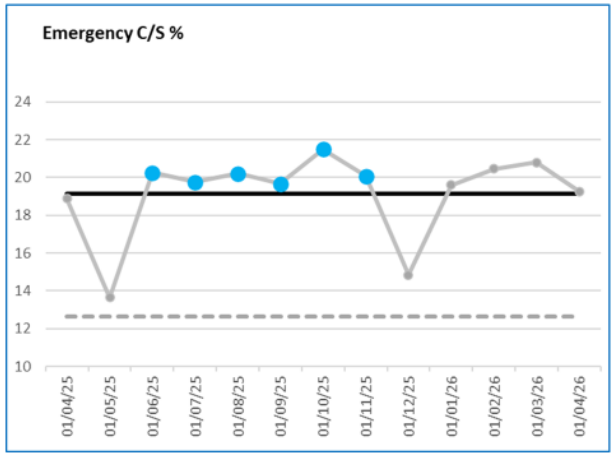


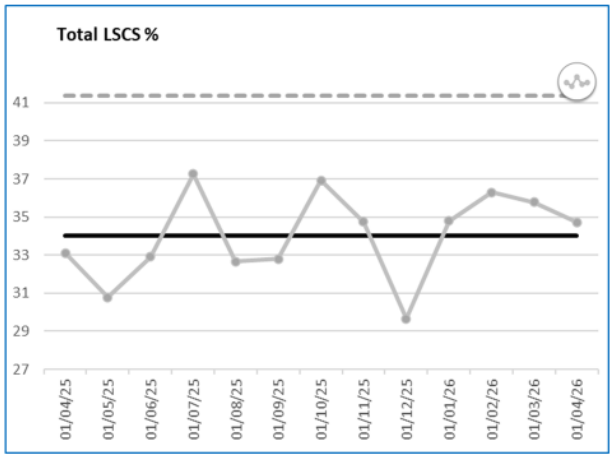


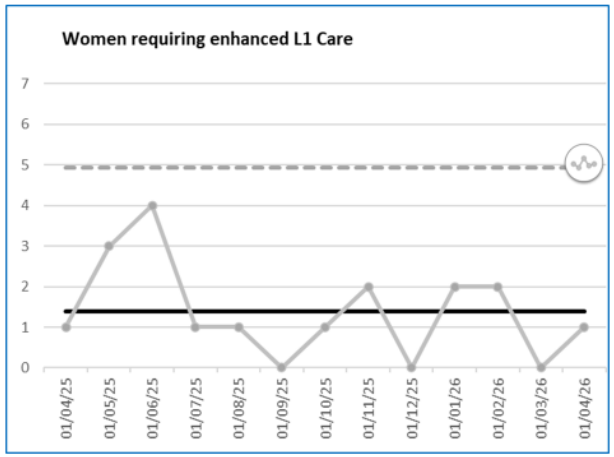


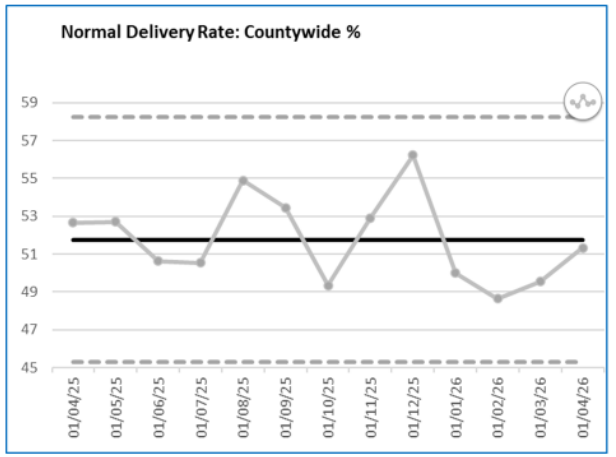




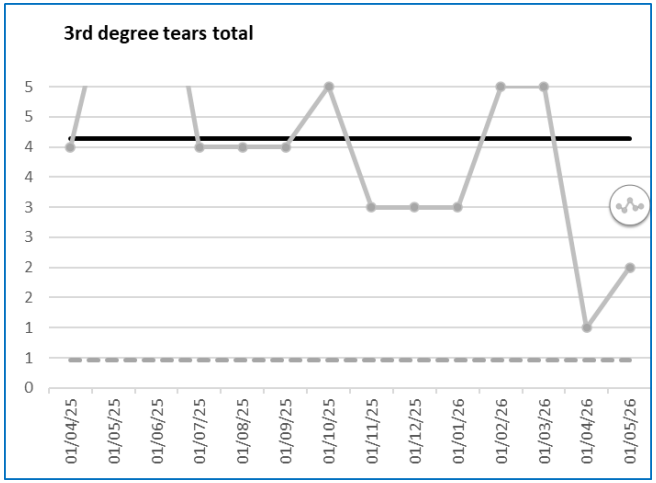


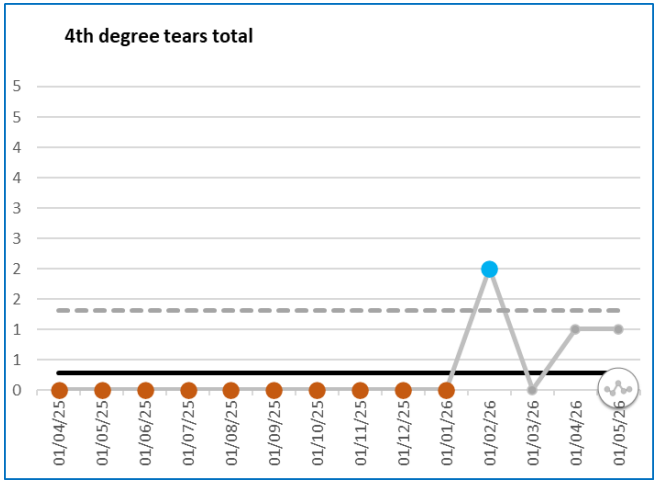


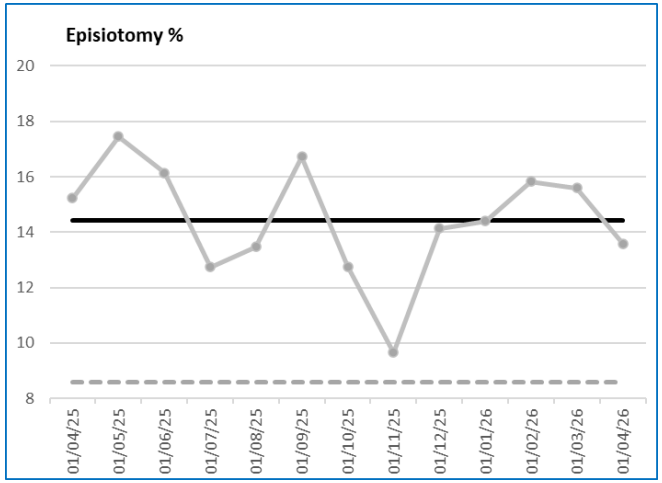


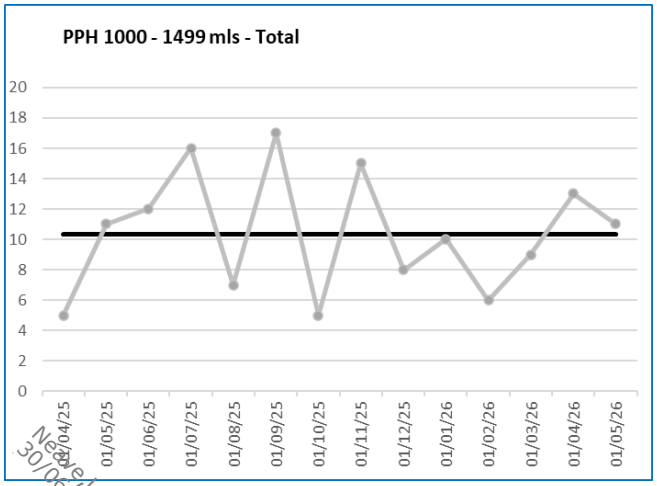


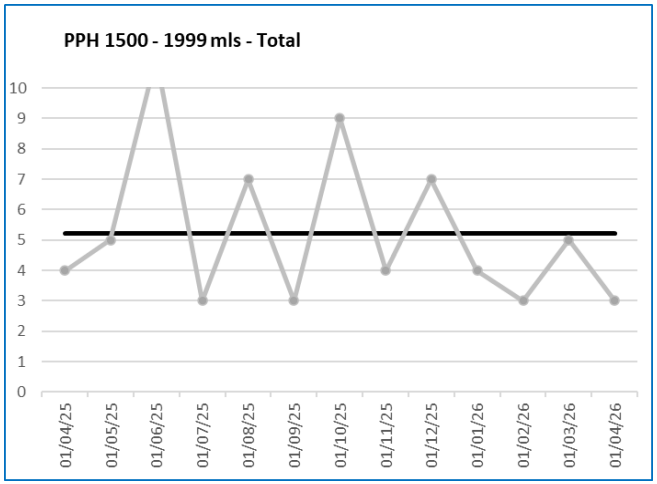
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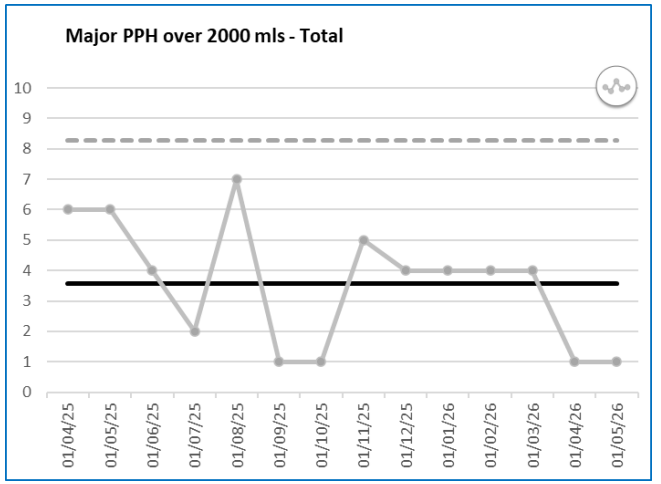




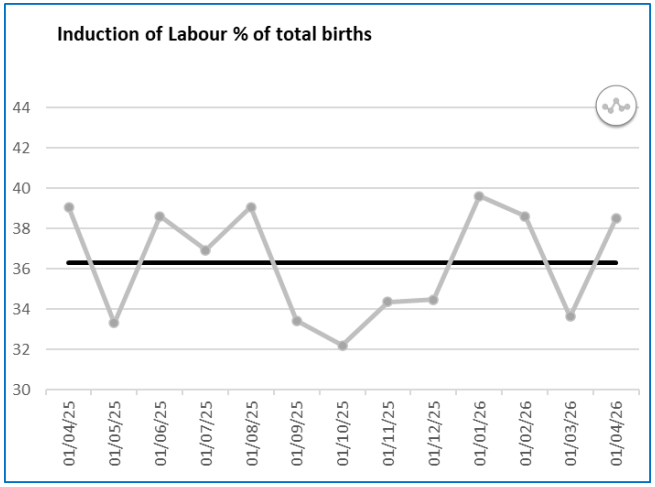


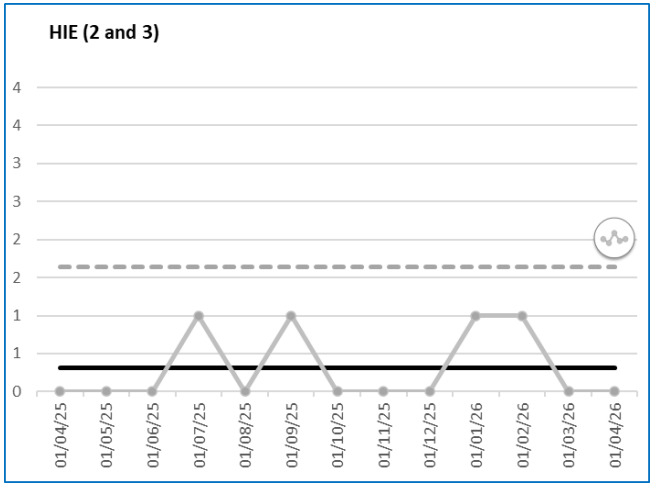


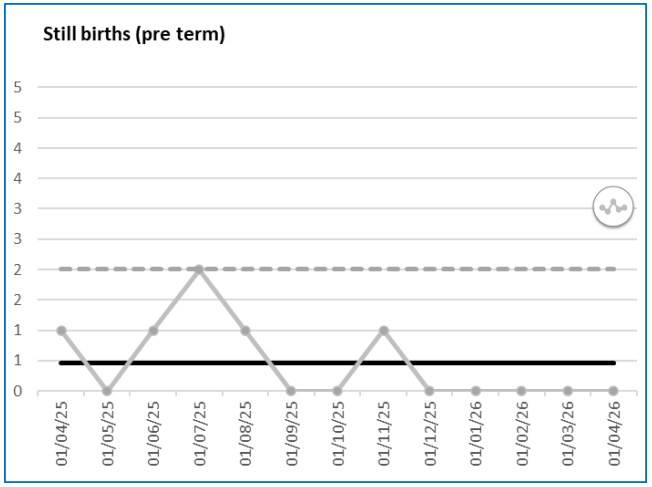


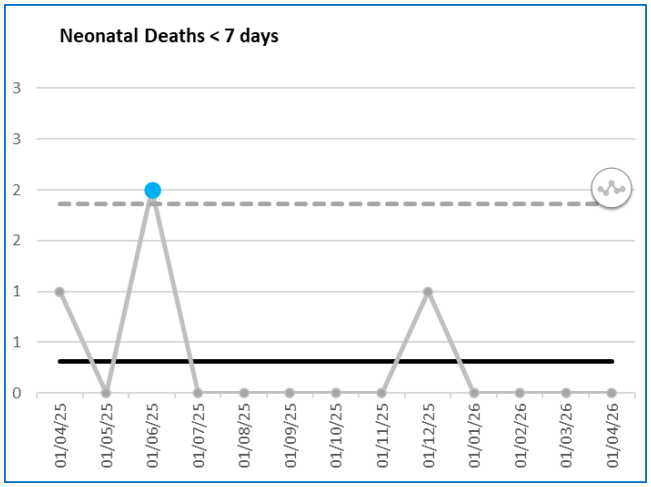


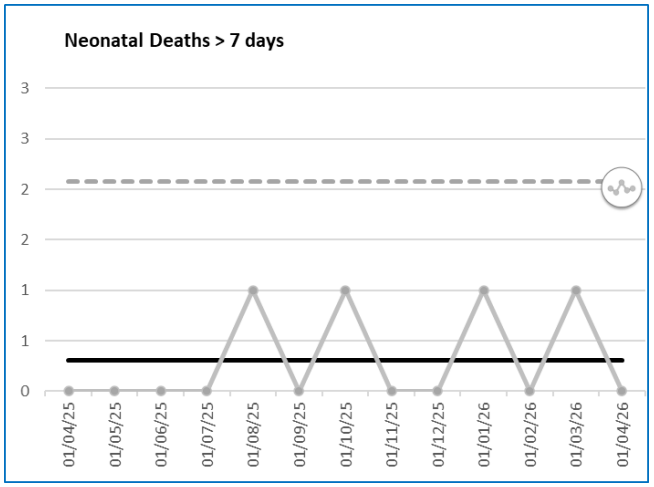
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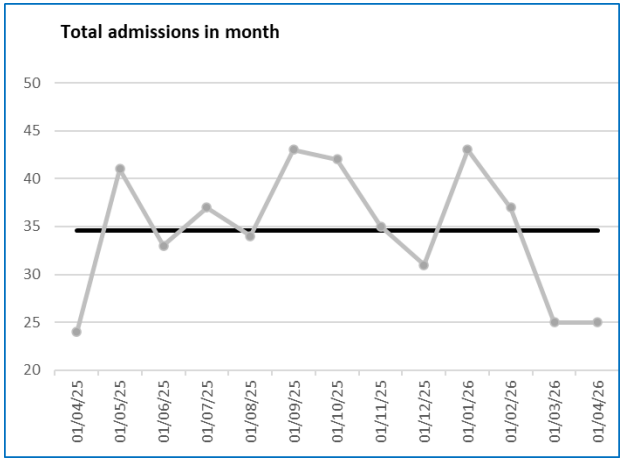


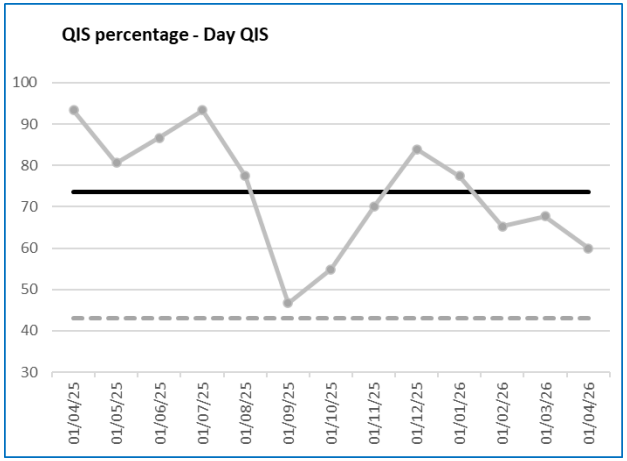


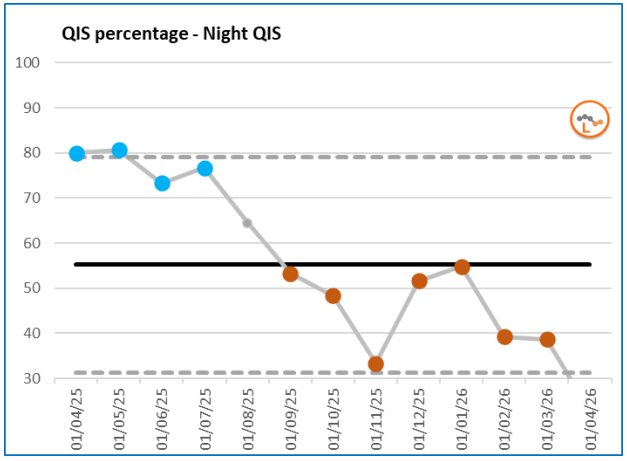


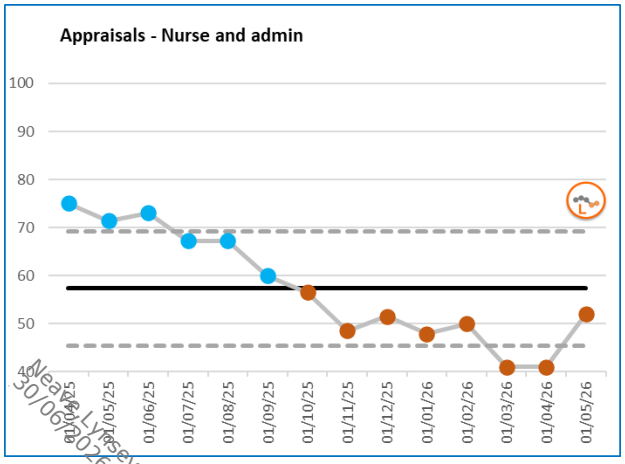
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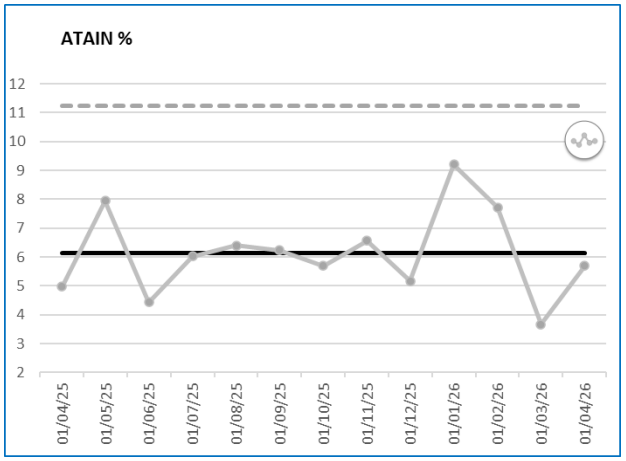
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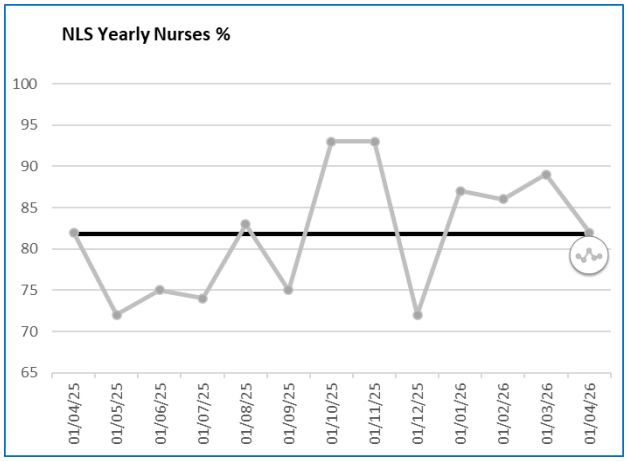




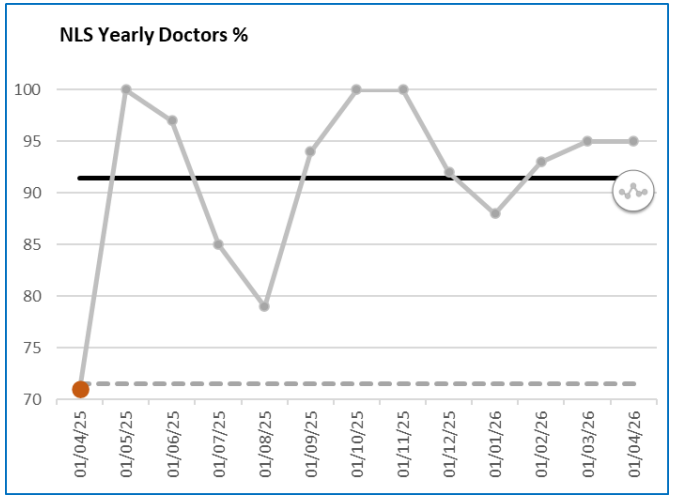


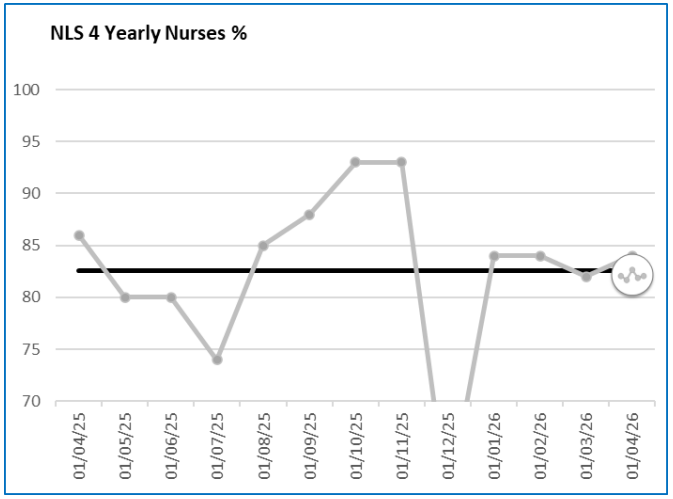


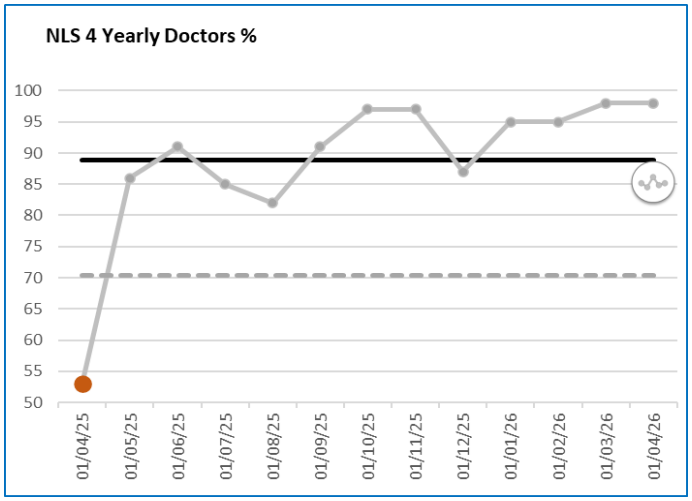




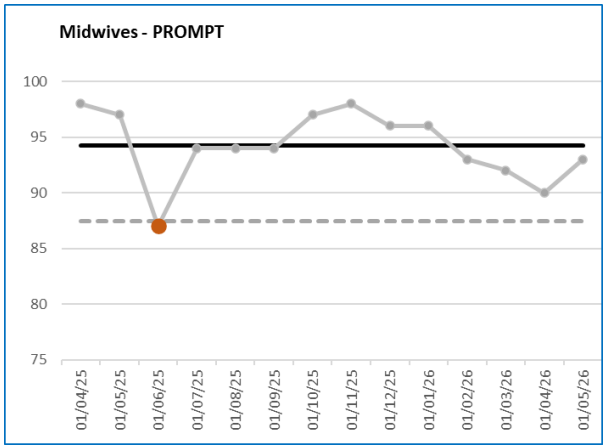
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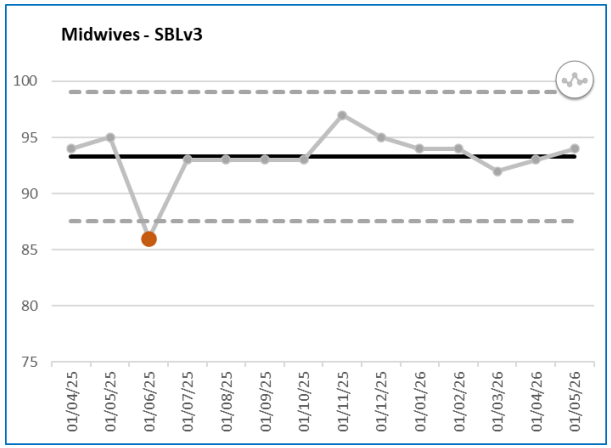


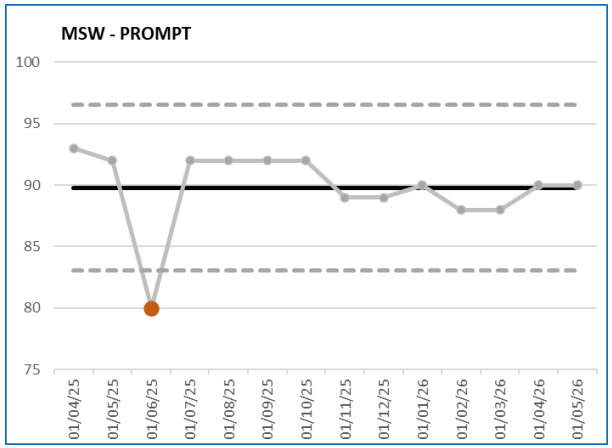


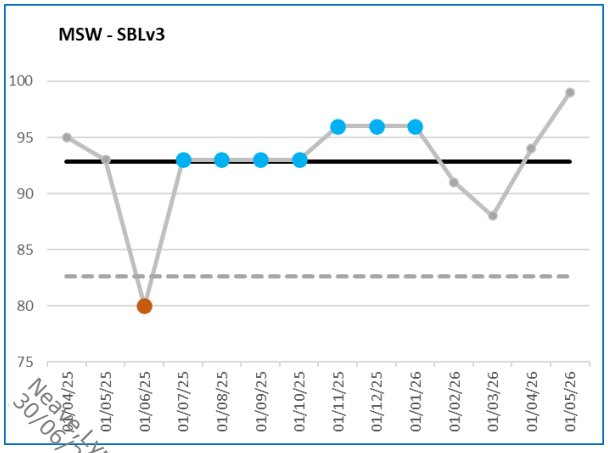


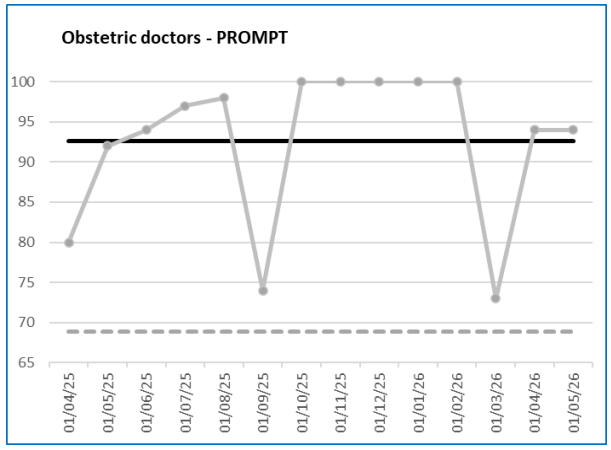
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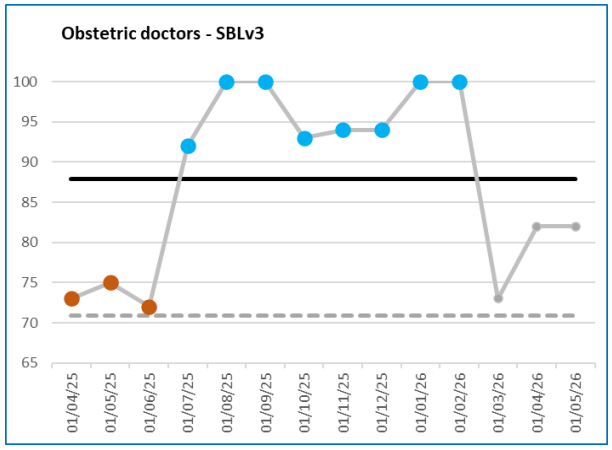




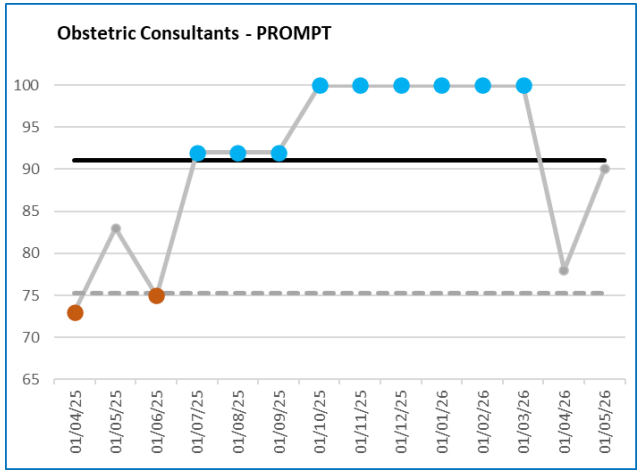


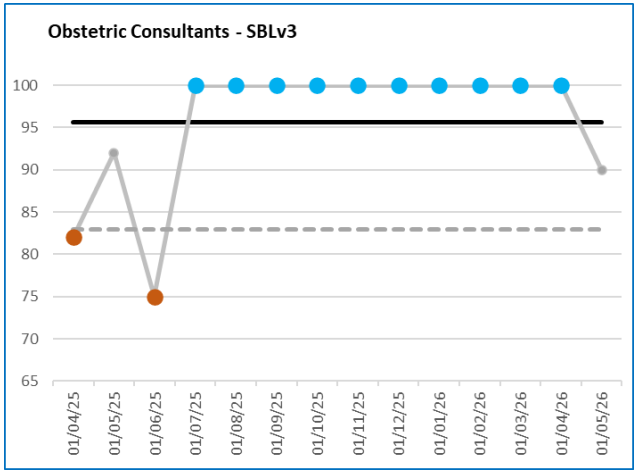


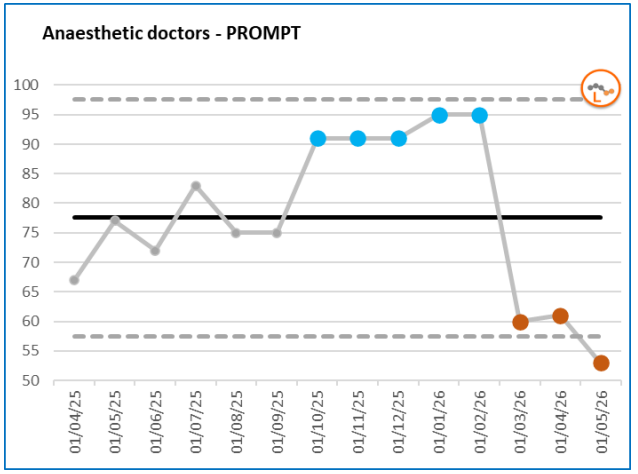


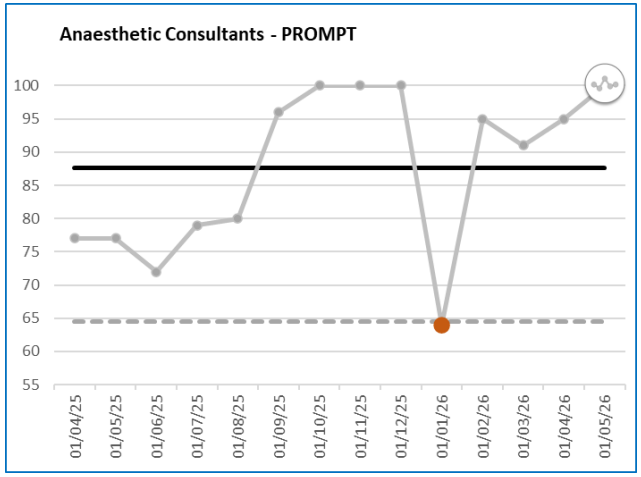


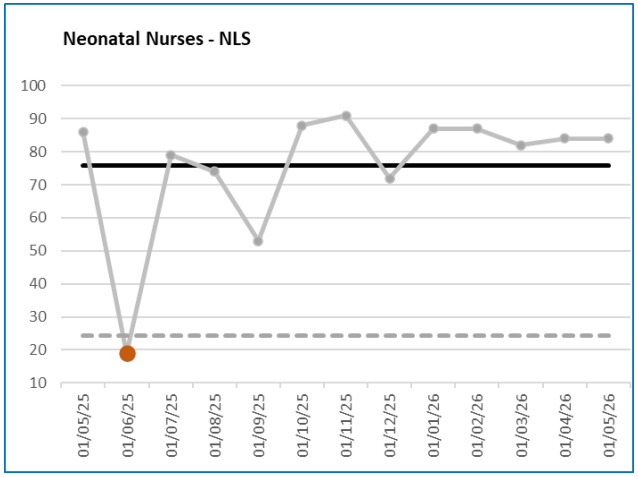
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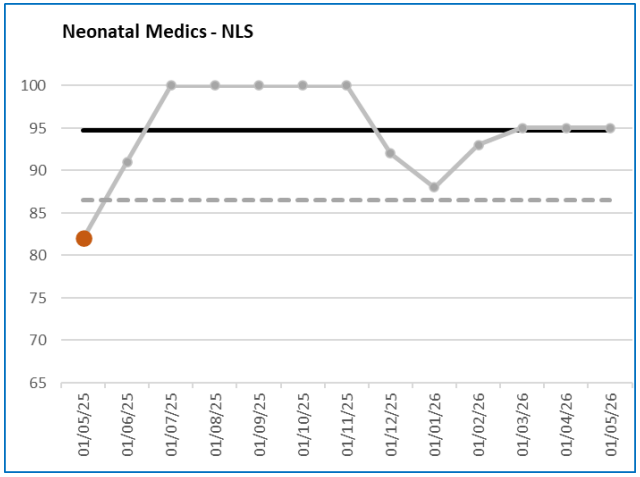




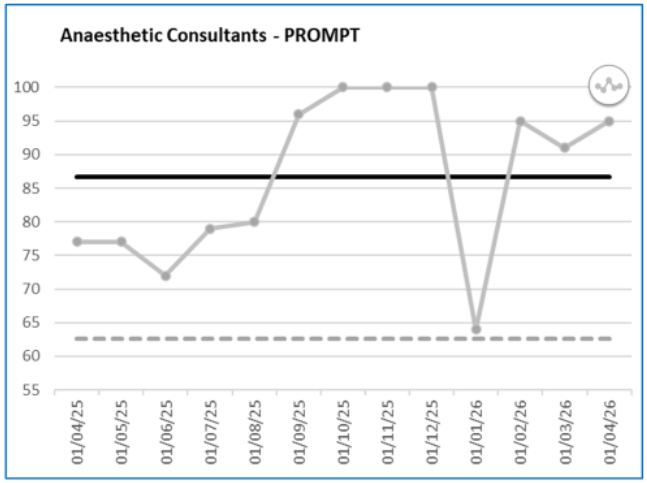


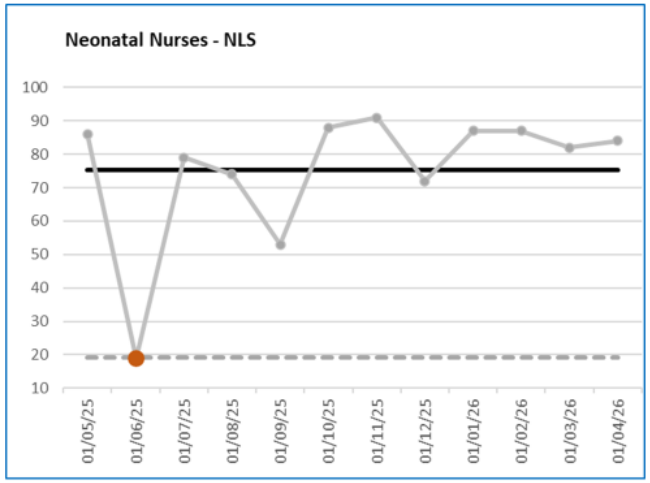


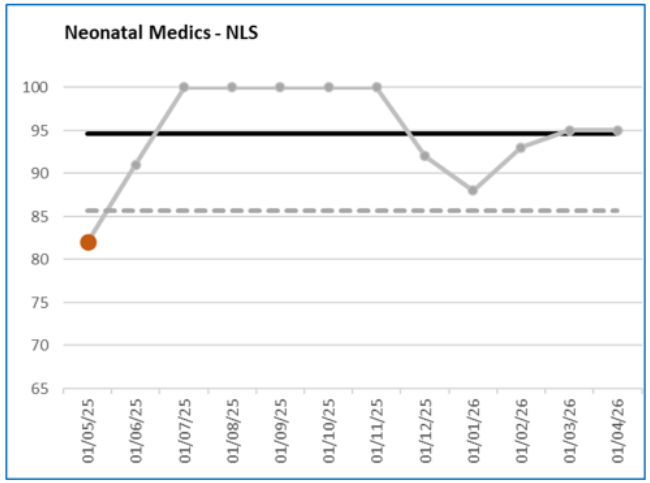




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There have been delays in providing fully validated data which we are working to ensure that this is provided in a timely way.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 10.3

Title of Report: Health and Safety Strategy

Executive Director Lead: Robin Jones, Chief Operating Officer

Author and Job Title: Gavin Griffiths, Head of Health and Safety

Email Address: gavin.griffiths@nhs.net

Purpose of the Report:

Decision ☒ **Discussion** ☐ **Assurance** ☐ **Information** ☐

Resubmission to this Committee following action to further review the Quality Equality Impact Risk Assessment.

Consultation:

The Health and Safety Strategy was first presented to the Quality Assurance Committee in May 2026. Following feedback from the Committee, the Strategy has been revised accordingly and was represented to the June 2026 Quality Assurance Committee. Detail of the Quality and Equality Impact Assessment was also provided to the Quality Assurance Committee as requested from the May meeting.

This Strategy was reviewed and approved by the Chief Operating Officer on 17 June 2026.

The author has also liaised with the Trust Strategy Team to ensure full alignment with the Trust Strategy.

The Quality Assurance Committee reviewed the updates to the Strategy in the June meeting and approved the Health and Safety Strategy. The Committee supported the strategy with the action to further review how the Health and Safety work plan to incorporate updates to the Committee on the progress with improving inequalities

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☒

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Reputational ☐ **Legal / Regulatory ☒**

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?	X			
Quality Impact Assessment completed?	X			
Data Protection Impact Assessment completed?			x	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Not applicable.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Not applicable.
Sustainable and efficient use of NHS resources by RCHT	Not applicable.

Recommendations:

The Board is recommended to:

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- **Note** that although the Trust operates with a single Trust Strategy and works to avoid having multiple 'strategies' there is a requirement for the Trust to have a designated Health and Safety Strategy.
- **Note** that the Health and Safety Strategy has been considered through the Quality Assurance Committee and is provided to the Trust Board in full. The Quality

Assurance Committee has recommended that the Trust Board approves the strategy.

- **Note** the further action to be reported to the Quality Assurance Committee on progress to improving Health and Safety from the equalities perspective.
- **Approve** Health and Safety Strategy.

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Health and Safety Strategy 2026

1. Situation / Executive Summary

This strategy outlines the high-level approach to health and safety management for the Trust for the next three years. It aligns with the overarching Trust strategy in terms of language and intent. It sets the requirement for health and safety issues to be proactively managed to prevent incidents and injuries, protecting staff from harm and ill health to ensure their rights as employees and their ability to perform their duties for the patients of Cornwall to the best of their abilities.

The Strategy is a development from the previous version and has been scrutinised through the Quality Assurance Committee.

It should be noted that the Committee's feedback related to the Quality Impact Assessment requirements. This has now been completed and approved by the Quality, Equality Impact and Risk Assessment (QEIRA) Panel.

The Trust operates under a single strategy and avoids having multiple 'strategy' documents. The Trust has a requirement to have a designated Health and Safety Strategy.

2. Background

This strategy is an update from the previous strategy and focuses attention on the practical application of the Plan-Do-Check-Act cycle detailed in the Health and Safety Executive issued guidance document HSG65.

3. Assessment

Details in the Strategy.

4. Risk

The strategy aims to reduce all health and safety risks to as low as is reasonably practicable and ensure that staff are provided with information, instruction, training and supervision to enable them to safely complete their duties and achieve the Trust objectives to the best of their ability.

5. Accountability

The Chief Operating Officer has executive accountability to the Chief Executive Officer for all matters regarding health and safety. The Head of Health and Safety in the appointed competent person for health and safety advice, in accordance with regulation 7 of the Management of Health and Safety at Work Regulations 1999.

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6. Recommendations

The Board **is recommended to:**

- **Note** that although the Trust operates with a single Trust Strategy and works to

avoid having multiple ‘strategies’ there is a requirement for the Trust to have a designated Health and Safety Strategy.

- **Note** that the Health and Safety Strategy has been considered through the Quality Assurance Committee and is provided to the Trust Board in full. The Quality Assurance Committee has recommended that the Trust Board approves the strategy.
- **Note** the further action to be reported to the Quality Assurance Committee on progress to improving Health and Safety from the equalities perspective.
- **Approve** Health and Safety Strategy.

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Royal Cornwall Hospitals
NHS Trust

Health and Safety Strategy 2026-2029

V6.0

June 2026

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation.

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team.

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

1. Introduction

Health and Safety Strategy Summary

Our Vision: To create and maintain an environment across all RCHT work areas that is healthy and safe for staff, patients, visitors and anyone who may be affected by our activities.

Our Priorities:



As a Trust we are committed to providing outstanding care for one and all. Fundamental to this, is ensuring that we have a strong safety culture, so we can operate effectively and safely - whether this is in how our teams go about their business, how we identify, manage and mitigate the safety risks in our complex estate, or how we support individuals to safely complete everyday tasks. The Health and Safety Strategy therefore describes our overarching approach to health and safety at RCHT, and where we will seek to make improvements to this approach to support the wellbeing of our staff patients and visitors over the next 3 years.

Our Responsibilities: To manage, so far as is reasonably practicable, the health, safety and welfare of all those affected by our activities. We will take a proactive approach to identifying, assessing and controlling risks arising from our work. As an acute NHS Trust, we undertake activities that involve high hazards (anything with the potential to cause harm); however, high hazard does not necessarily equate to high risk (the likelihood and impact of that hazard resulting in harm) when effectively managed.

There are many sources of information that inform the Trust's moral, legal and financial responsibilities for health and safety management. These begin with Acts of Parliament and extend to regulations, guidance and recognised standards.

To support the Trust in meeting its obligations over the next three years, **seven key priorities** have been established to guide leaders, managers and staff in the discharge of their duties. All staff, at every level, share responsibility for creating and maintaining a safe and healthy working environment. Everyone has a voice in how the Trust meets—and strives to exceed—the standards expected by UK law, our workforce and our patients.

Our priorities are defined as 7 key areas:

1. **Positive and visible leadership.**
   An effective approach to a healthy and safe organisation requires commitment at every level, starting from the top. Our senior leaders demonstrate this by leading from the front and working alongside our workforce to place safety at the centre of

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everything we do.

2. **Safe people doing things in a safe way.**
   This focuses on preventing harm before it occurs. We provide clear **information** on workplace hazards, **instruction** on safe systems of work, **training** to develop the necessary skills, and appropriate **supervision** to ensure work is carried out safely and effectively. These four elements form the foundation of health and safety **management**, supported by suitable and sufficient **risk assessment**.



3. **Reducing harm to staff.**
   Despite best efforts, incidents may still occur. As an organisation committed to a Just Culture, we learn from these events through thorough and proportionate investigation. Our focus is on learning rather than blame, identifying underlying system causes and implementing improvements that enable staff to work safely and effectively. We value the experiences of our workforce and encourage open challenge where improvements can be made.

4. **Working with others.**
   This priority reflects how we manage information and relationships to ensure mutual understanding of expectations. Contractors and external partners must understand and meet our safety requirements. We work collaboratively to foster an open and fair healthcare system that learns and improves through shared experience.

5. **Consultation and communication.**
   The Trust hold regular Health and Safety Committee meetings, chaired by an Executive Officer and attended by senior leaders from all divisions. These meetings review issues, share learning from incidents, and agree proactive measures to reduce risk. The Trust also convenes Health and Safety Leadership Team meetings, where Divisional Governance Managers and departmental leaders implement agreed actions and monitor performance.

   Both groups include trade union representatives and staff safety representatives, ensuring that information is shared with the wider workforce about the actions being taken to provide a safe working environment that meets both legal requirements and staff expectations.

   We also engage with external stakeholders and contractors regarding our safety requirements while they operate on our premises. We rely on subject matter experts across a range of areas—from construction to the maintenance of clinical and non-clinical systems—to support service delivery. While these activities may introduce hazards, effective management ensures that risks are reduced to as low as is reasonably practicable, in line with UK legal standards.

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6. **Safe premises.**
   The Trust is committed to providing a safe and appropriate environment for both

staff and patients. Buildings and equipment will be maintained to ensure they are safe, functional and fit for purpose.

Ongoing site developments, including major programmes and infrastructure improvements, involve multiple contractors. Staff and visitors are kept informed through communications, and it is essential that all individuals adhere to safety requirements relating to construction and engineering activities.

Regular inspections and a proactive preventative maintenance programme are in place to ensure that facilities and equipment remain safe and effective.

7. **Improving together.**
   Improvement is driven not only by learning from incidents, but also through proactive measures informed by leading indicators such as staff surveys, audits, safety tours and training.

   Where investigations take place, outcomes and learning are shared openly, ensuring that staff can see the impact of raising concerns and contributing to safer ways of working.

This version supersedes any previous versions of this document.

Purpose of this Strategy.
This strategy is produced to enable staff, patients and all those affected by our duties to understand the legal responsibilities held by the organisation and those held by individuals, and the strategies in place within the Trust to meet these obligations.

The strategy should be read in conjunction with the Trust Strategy, Health and Safety General Policy, and the range of specific health and safety policies such as those for the Control and Management of Substances Hazardous to Health (CoSHH), Driving at Work, and the Provision and Use of Work Equipment (PUWER).

2. Scope

This strategy applies to every member of Trust staff and all those who complete works on the Trusts' behalf.

3. Definitions/Glossary

For the purposes of this document the following terms will, unless otherwise stated, apply.

The Trust	The Royal Cornwall Hospitals NHS Trust.
Trust sites	All areas, sites, buildings or premises owned, occupied or controlled by the Trust.
Health and Safety Executive	The British public body responsible for the regulation and enforcement of workplace health, safety, and welfare.

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Staff	All persons who are employed by the Trust whether on permanent or temporary contracts (written or implied), paid or unpaid, and shall include persons employed through recruitment and employment agency providers to assist the Trust in delivery of services but excluding contractors and third parties undertaking works for or on behalf of the Trust.

4. Deciding on what we should and shouldn't do

4.1 The Law.
Health and safety in the UK is governed by a plethora of Acts of Parliament, Regulations and Guidance documents. The legal status of these changes depending on which type of document you are reading.

Acts of Parliament.

The overarching legal base for health and safety law in the UK is the Health and Safety at Work etc Act 1974 (HASWA). It places obligations on employers and employees to complete certain duties. It introduces certain standards such as 'so far as is reasonably practicable', meaning that employers need to assess the level of risk against the resources needed to mitigate it to a tolerable level.

Acts of Parliament are Statute Law and must be adhered to. To fail in completing your duty is a criminal offence and can be punished by imprisonment, fines, or both.

The Health and Safety at Work etc. Act 1974 specifies many General Duties and does not go into fine detail on specifics of things like workplace dimensions and occupancy. Those are detailed in other documents.

Regulations.

The Management of Health and Safety at Work Regulations 1999 is where you are introduced to the term risk assessment, the foundation of good health and safety management.

Regulations give practical details necessary for an employer (and employee) to understand how far they need to go to manage health and safety effectively. Failure to comply with regulations such as the Management of Health and Safety at Work Regulations 1999 is a criminal offence.

Guidance Documents.

There are many guidance documents in existence and some have a higher legal standing than others. Approved Codes of Practice (ACOPs) retain a quasi-legal status in UK law and if you follow the ACOP, it is often sufficient evidence to prove you have complied with the law. If you do not comply with the ACOP, you are required to prove how you have met or exceeded the standard laid down in the ACOP by another means.

Nicole Lynsdale
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Example: Office occupancy rates.

The Health and Safety at Work etc. Act 1974 states that 'It shall be the duty of every employer to ensure, so far as is reasonably practicable, the health, safety and welfare at

work of all his employees.' This is a very general term and is usually the section that will be directly quoted on a prosecution as the overarching offence.

The Workplace Regulations 1992 adds to this requirement by compelling employers to provide *sufficient floor area, height and unoccupied space for purposes of health, safety and welfare* in Regulation 10.

There is still no detail here of the specifics for office occupancy, for that we go to the ACOP titled Workplace health, safety and welfare. Workplace (Health, Safety and Welfare) Regulations 1992. Approved Code of Practice and guidance. Here, we find the finite detail in paragraph 97:

97 In most workplaces 11 cubic metres (11 m3) of space per person should be taken as a minimum. This calculation should not take into account ceiling heights in excess of 3 m. A space of 11 m3 per person may be insufficient if much of the space is taken up with furnishing or equipment.

As we can see from this, there is a requirement to provide each worker eleven cubic metres of space as a minimum, capped at a three-metre ceiling height.

So how far do we go?

The Trust is committed to complying with Acts of Parliament and Regulations and recognises the quasi-legal status of ACOPs and will adhere to them wherever possible. If it is not possible, the responsible manager for the work must provide a written justification of how they have met or exceeded the standard by another means and therefore met their statutory obligation.

4.2 Strategic Processes.
A clear and robust management process is key to the successful implementation of our strategy. These principles will be adopted into all our policies, procedures, and guidelines.

The Trust will maintain competent specialist advice on all matters related to and impacting upon the safety, health and wellbeing of our staff and stakeholders.

The Health and Safety Committee meetings includes robust consultation and discussion with stakeholders. The Health and Safety Committee reports to the Trust Board, via the Quality Assurance Committee.

The Trust Board receives regular reports of generic health and safety progress in addition to exception reports and updates as requested by the Board and/or in response to specific issues or concerns.

We adopt the "Plan – Do – Check – Act" management model[1] (Figure 1 Plan-Do-Check-Act Safety Management Model). This model is a well-established management tool based on continual improvement.

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- **Plan** – determine the organisation's plan and policies.
- **Do** – identify risks, report incidents and near misses, organise work for the promotion of a safe and healthy workplace
- **Check** – measure performance, monitor events, investigate incidents
- **Act** – Review performance, learn from incidents, and act on lessons learnt



HSG65

To evaluate our progress, the Trust carries out regular 'check and challenge' assessments and audits to monitor our progress. The outcomes are reported to the Leadership Team and the Health and Safety Committee.

The foundation for sound and proactive health and safety management is *suitable and sufficient* risk assessment. All activity that presents a hazard to those affected by the activity must have a valid assessment of the risk posed and actions taken to control that risk. This assessment is a departmental responsibility and must be completed by a person who is competent in the task being assessed and knowledgeable in the workplace and activity.

Following the production of a suitable and sufficient risk assessment, Information, Instruction, Training and Supervision (known as IITS in health and safety methodology) must be provided to members of staff to ensure competency in the execution of their duties.

There is a Health and Safety Improvement Plan to support delivery of the Health and Safety Strategy, aligned to the strategic priorities. This action plan is owned by the Head of Health and Safety, with progress reported to the Operational Leadership Group (monthly) and Quality Assurance Committee (quarterly). The plan is not an integral part of this Strategy document as it is a live action plan, with tasking added and closed as appropriate.

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5. Delivering On Our Priorities

5.1 Priority 1 – Positive and Visible Leadership

Successful health and safety management comes from the top of an organisation therefore health and safety leadership must also start here. Visible and active commitment from the Trust Board, Executive Leadership Team and managers to health and safety clearly demonstrates a commitment which will be embraced by all staff. This commitment must invigorate and galvanise attitudes and behaviours at all levels.

Actions:

5.1.1 The Trust Board and Senior Managers will ensure that the promotion of a safe and healthy culture is maintained throughout the Trust through robust two-way communication.[1][6]

5.1.2 Health and Safety will feature on the agenda of all Trust Boards.[1]

5.1.3 The Trust Board will receive regular reports on matters related to safety.[1]

5.1.4 Managers, at all levels, will lead by example to promote and lead in establishing a safe and healthy workplace.[2]

5.1.5 Health and Safety matters will feature on all Divisional meetings as an agenda item.[5]

5.1.6 Senior Managers from each Division will attend or nominate a Deputy to attend on their behalf at the Health and Safety Leadership Groups.[5]

5.1.7 Senior Managers will ensure appropriate representation at the Health and Safety Committee.[7]

5.1.8 Senior Managers will lead by example ensuring they have attended all appropriate Health and Safety Courses.[15]

5.1.9 Senior Health and Safety representation at all statutory compliance groups to ensure all legislative requirements are met.[7]

Outcomes:

Positive and Visible Leadership Performance Indicators		
Indicator	**Responsibility**	**What good looks like**
Maintain proactive Executive Lead for all Health and Safety Management issues.	Chief Executive.	Delegate to Head of Health and Safety to feed information and escalated issues into the Health and Safety Leadership Team (HSLT) meeting with minutes and action log updated and available for audit. Six Committee and six Leadership Team meetings to be held per year.

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Executive Directors, Non-Exec Directors, Corporate Department and Divisional leads will complete a one day Health and Safety course.	Chief Executive.	Register of training and attendees to be maintained by Health and Safety. Information delivered to Learning & Development Team (L&D) for Electronic Staff Record (ESR) update. 80% competence to be achieved within in 3 years.
Annual Health and Safety Management report to the Trust Board.	Nominated Executive Director and Head of Health and Safety Management.	Each area within Health and Safety and Moving and Handling will have their own Key Performance Indicators (KPIs) against which they can be measured.
Bi-monthly Executive walkabouts with key leads from Health and Safety and Estates.	Chief Operating Officer.	Outcomes to be shared with Divisional leads after each walkabout. Findings to be reported to the Leadership Groups.
Health and Safety matters to be a “standing agenda” item of all Divisional and Departmental Meetings.	Divisional and senior managers.	A sample of agendas and minutes to be checked monthly from the Divisions regularly. Minute templates to have as lead items on any agenda Health and Safety incidents. Any Health and Safety incidents that cannot be resolved at the local level will be reported and escalated to the Health and Safety departmental.
All staff with responsibility for managing or supervising staff to complete the approved Health and Safety Management programme.	Divisional and senior managers.	Delegate to Head of Health and Safety to ensure the associated course is fit for purpose, required attendees identified and trained. 80% to be trained within 2 years.
Maintain the Health and Safety Leadership Team to meet as directed to address health and safety issues.	Chief Operating Officer.	Minutes and action log of the HSLT meeting reflect a proactive approach to H&S management. Actions set with target dates and completion by those dates with clear evidence available for audit.

5.2 Priority 2 – Safe People doing things safely

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Ensure that our staff are trained and competent to undertake all activities in a safe manner. Where students and less experienced staff are working, competent professional colleagues will provide supervision. Those employed on duties at home or working on remote sites require an assessment of the activity they complete to ensure their working environment (so far as is reasonably practicable) remains free from unmitigated risk. Increased safety in the actions of our staff

reduces the risk of work-related absence through injury or ill health, and as such, increases the capacity for patient facing activity that directly improves patient safety.

Actions:

5.2.1 Risk assessments for all work-based activities held and maintained on an electronic database. Risk assessment is to be easily accessible to all staff.[11]

5.2.2 The Trust to provide appropriate equipment to enable people to carry out their work safely, maintained and serviced in line with the manufacturer's guidelines and the health and safety legislative requirements.[3]

5.2.3 Ensure all staff are trained in the use of all equipment, by competent persons and electronic records are maintained surrounding this training.[3]

5.2.4 Clear training matrix identifying the training requirements of all posts within the Trust.[5]

5.2.5 All staff are trained in alignment to the matrix, by people deemed competent to deliver this training. [5]

5.2.6 All training courses provided by the Trust are in alignment with the guidance issued by professional bodies and are in consultation with the Subject Matter experts in the Trust. [5]

5.2.7 Regular check and challenge walkabouts by Managers and key members from the H&S Team to promote best practice. [5]

5.2.8 Provide an easily accessible 'Health and Safety Hotline' to enable and empower staff to seek advice and without recrimination report poor practice. [5]

5.2.9 Provide all staff with a "Safe and Healthy RCHT" handbook (online reference guide), as a quick reference guide to common issues. [5]

5.2.10 Monthly checks completed by Health and Safety Leadership Team of compliance rates for Health and Safety related courses. [5]

Outcomes:

The identification of hazards and the timely resolution will result in proactive reporting, reduced incidents, accidents, harms, and claims. The provision of appropriate health and safety courses to equip and empower staff will knowledge, information, and skills to enable them to carry out work related tasks.

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Safe People doing things Safely Performance indicators		
Indicator	**Responsibility**	**What good looks like**
Risk assessments to be carried out on work-based activity. Data to be stored electronically and Risk Assessment is to be easily accessible to all staff.	Head of Health and Safety.	Monthly audits of the database analysing the number of risk assessments in the databases. Outcomes to be shared with the Leadership Team.
Training for Managers in risk assessment and the use of the database.	Director of People and Organisational Development.	Monthly audits of the database to monitor attendance levels of Managers on the risk management course.
All staff who deemed as Display Screen Equipment (DSE) users to complete the training and assessment package using the Cardinus Management System.	Head of Health and Safety.	DSE users to be identified by line managers and assessments complete by within one month of appointment.
The Trust should provide equipment sufficient in quantity and form as per the associated risk assessment.	Head of Health and Safety.	Department audits by H&S measuring equipment availability against risk assessments.
Training Matrix of all Health, Safety and Moving and Handling training, as per job role.	Director of People and Organisational Development.	Monthly random samples of the training matrix against staff records on ESR. Reports to Senior Managers informing them of performance.
Appropriate levels of training in all aspects of Health, Safety and Moving and Handling.	Director of People and Organisational Development.	Monthly monitoring of the provision of training courses to ensure sufficient numbers. Activity to be monitored through the Health and Safety Committee.
Ensure all staff have attended the appropriate Health, Safety and Moving and Handling Training courses.	Director of People and Organisational Development.	Monthly monitoring of the attendance and competency levels at training courses to ensure sufficient numbers. Activity to be monitored through the Health and Safety Committee. 80% Staff trained and competent within 2 years
Matrices to be used to demonstrate skills	Divisional and senior managers.	Divisional leads to measure ESR data against training matrices. Outcome to be reported to Health and Safety Committee.

Mayo Lynsey 30/01/2026 09:51:26

required and training provided.		
Annual staff survey to include questions to measure staff morale and empowerment.	Management teams.	Responses to be analysed and information fed into the Health and Safety Committee for further action.
All staff and new starters to receive a copy at induction issue of a “Safe and Healthy RCHT” guide.	Director of People and Organisational Development.	Records to be checked for completion.
Implement a reward scheme to encourage best practice.	Head of Health and Safety.	Records to be checked of vouchers issued.

5.3 Priority 3 – Reduce harm to Staff

To reduce the number and severity of incidents resulting in harm to our staff based around the identified key risks **(Appendix 4 – Key Risks and Evidence Schedule**). Ensure that clear lessons are learnt and shared from incidents within the Trust. Increased clinical staff attendance directly increases patient care ratios, improving patient safety. Increased non-clinical staff attendance improves support services to clinical staff and therefore has an indirect benefit to patient safety.

Actions:

5.3.1 Improve work related sickness reporting to provide accurate meaningful data which can be understood.[12]

5.3.2 Promote reporting of all incidents, accidents, near misses and hazards in a timely manner through simple, accessible systems and processes.[16]

5.3.3 Ensure robust and appropriate level of investigation is carried out to identify and address the cause.[18]

5.3.4 Share the lessons learnt across the department, Division, and organisation to help reduce the chance of a similar situation arising.[14]

5.3.5 Maintain a Health and Safety Hotline to enable staff to report and seek advice surrounding health and safety issues.[14]

5.3.6 Health Surveillance for all employees who are exposed to noise or vibration, ionising radiation, solvents, fumes, dusts, biological agents, and other substances hazardous to health.[12]

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Outcomes:

To move towards: simple and clear reporting of incidents and near misses, thorough and robust investigation of reports; the sharing of meaningful findings with others throughout the organisation; learning from peer groups, partner organisations and other healthcare providers; reduction in staff sickness absence and improved wellbeing.

Reduce harm to Staff – Performance Indicators		
Indicator	**Responsibility**	**What good looks like**
Regular reports to Health and Safety Committee from Health and Wellbeing Group.	Health and wellbeing group leads.	Scheduled reporting received at each Health and Safety Committee meeting.
Improved work-related sickness absence data quality, through promotion to all groups on the importance of reporting.	Director of Integrated Governance.	ESR records to be checked against incident reporting system to ensure work related sickness is reported and acted upon.
Reduction in work related sickness absence, the provision of risk assessment and work-related Health and Safety training for areas of concern.	Director of People and Organisational Development.	Sickness records and associated actions to be checked and reported through the H&S Committee.
Improved quality of incident investigation reviewed and monitored through Divisional and Department safety forums.	Director of Integrated Governance.	Regular reports to the Health and Safety Committee.
Outcomes of investigations to be shared throughout the Trust to avoid repetition and to reduce the numbers of accidents, incidents and near misses.	Head of Health and Safety.	Communications messages to be checked and reported to the Leadership Team.
Improved options for the reporting of incidents, through a 'Safety Hotline.'	Head of Health and Safety.	Health and Safety Committee to monitor the effectiveness of the hotline.
Occupational Health to begin Health Surveillance in all risk areas, using national guidelines.	Head of Occupational Health.	To be reviewed in line with risk assessments that highlight specific Health Surveillance needs.

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5.4 Priority 4 – Working with others

All contractors and partner organisations are aware of Health and Safety duties and requirements. We will only work with organisations that are committed to attaining the highest standards of safety and wellbeing of their staff and stakeholders.

Actions:

5.4.1 All staff responsible for the appointment and management of contracts that bring personnel on to site will be trained and supported to actively manage contracts.[8][9]

5.4.2 All contractors and other partner's personnel will receive a copy of the site rules and undertake a Trust Induction prior to attempting to undertake work on any site. [8][9]

5.4.3 All contractors will display a valid Trust photographic ID badge when on site, the management of ID badges will be tightly controlled.[8][9]

5.4.4 Improve communication between commissioning departments and others affected by third party activities.[9]

5.4.5 Periodic audit of contractor arrangements to ensure compliance.[9][18]

5.4.6 All agency workers to receive the appropriate training before attempting to work on any of our sites.[17]

5.4.7 Effective communication exists throughout the Trust, partner bodies and external organisations. [8][9]

Outcomes:

Establish clear and robust arrangements for the selection and management of contractors that supports both the Trust and partners to maintain high standards of work, health and wellbeing of Trust and contractors' personnel.

Working with Others Performance Indicators		
Indicator	**Responsibility**	**What good looks like**
Clear, consistent, and accurate contractor information is held (Contractor Database).	Director of Estates coordinate with Divisional and Department Governance Leads.	Contractor Database to be monitored by Estates Department and included in reports to the Health and Safety Committee.
Contractor Risk Assessment Method Statement (RAMS), qualifications, training records, equipment servicing and inspections	Director of Estates.	Documents to be kept in a folder and to be checked each month by Health and Safety personnel any shortcomings to be reported to the Head of Estates.

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certificates to be produced before work commences.		
All contractor personnel attend Trust Contractor Induction and be issued with a Trust photographic Identity Document (ID)	All staff with responsibility for contract commissioning and Estates Department (Dept).	Health and Safety staff to check records for compliance during audits.
All Contractors must wear their ID badge when on site.	All staff with responsibility for contract commissioning and Estates Dept.	All Trust staff to check and challenge and report any contractor without an ID badge to the Trust security officer. Outcomes to be shared with the Health and Safety Committee through the Trust security officer's report.
Training to be provided for all contractors in basic H&S awareness.	Senior Health and Safety Advisor.	Training records to be checked by Head of Head of Health and safety.
Robust pre award health and safety analysis of contractors.	Head of Procurement.	Process and outcomes to be shared with the Health and Safety Committee.
Planned unannounced audit of third-party sites/works.	Head of Estates.	Outcomes of audits to be shared with the Health and Safety Committee in the Estates officers report.

5.5 Priority 5 – Consultation and Communication

Support and facilitate safety representatives to undertake duties and activities to support the organisation, improving standards of safety throughout all Trust activities and locations. To enhance good communications across and outside the Trust. Acting on lessons identified from our workforce through formal and informal meetings, committees and focus groups reduces hazards in the workplace, improves working practices and increases patient safety.

Actions:

5.5.1 The Trust will formally support staff-side health and safety representatives and work with them in their duties.[19][20]

5.5.2 The Trust will support staff representatives in premises inspections and audits and assisting with formal risk assessments of premises. Health and safety representatives will have full membership of the Health and Safety Committee in accordance with the Terms of Reference and statutory provision.[19][20]

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5.5.3 Local safety representatives will attend meetings where safety related items are discussed as agenda items.[19][20]

5.5.4 Establish a process for non-union appointed representatives to be given the same protected time and resources as Trade Union appointed representatives to provide support to the organisation on matters of safety, health, and wellbeing.[19][20]

5.5.5 Encourage improved communications with Contractor Management Teams and Trust Managers. Ensure consultations take place between all parties.[8][9]

5.5.6 Increased communication to partnerships outside the Trust, such as the Cornwall and Devon Police force.[13]

5.5.7 The Leadership Team and Health and Safety Committee are consulted over health and safety issues.[6]

5.5.8 Compliance with external organisations and auditors is well communicated and the legislative requirements detailed to the Trust from these reports are met and evidenced.[1][14]

Outcomes:

Achieve high standards of communication between management and staff side representatives at all levels. Establish and maintain high levels of communication with partners and other professional groups.

Consultation and Communication Performance Indicators		
Indicator	**Responsibility**	**What good looks like**
Improved staff side attendance at Health and Safety Committee through negotiation with Union staff groups.	Head of People and Organisational Development and Head of Health and Safety.	Minutes to be checked for attendance levels.
Staff side to be active members of the Leadership group monthly meetings.	Head of Health and Safety.	Attendance to be monitored and reported to the Health and Safety Committee
Improved interaction from staff side at Divisional and Department and corporate safety meetings.	Staff side reps.	Monitor and measure attendance at Health and Safety Leadership Groups and Health and Safety Committee.
Trust to encourage good communications between themselves and Devon and Cornwall Police to promote safety on all our sites.	Local Security Management Specialist (LSMS)	Datix records to be checked to ensure all appropriate information is shared with the Police.

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Compliance with external audits, notices, and legal actions to be managed effectively via established management groups, communications to agencies to be regular and clear on actions taken to address issues.	Chief Operating Officer, via Head of Health and Safety.	Records of all inbound notices to be kept by the H&S department. Records of outbound communications to be kept by the H&S department. All timescales detailed in audits, notices, and legal actions to be adhered to and reported on through the H&S Committee.

5.6 **Priority 6 - Safe Premises**

To ensure our buildings and equipment are safe and secure and all risks are managed through processes or assessment, maintenance, and inspection. The maintenance of safe working premises reduces both the likelihood and consequence of an unwanted event that could present a severe risk to patients, staff, visitor, and contractor safety.

Actions

5.6.1 The Trust will manage its plant and equipment through robust systems of maintenance, inspection, and servicing.[3]

5.6.2 The Trust will maintain an asset register for safer management of equipment and plant.[3]

5.6.3 The Trust will meet its legal obligations in relation to the management, of specialist assessments, such as, asbestos, and legionella.[4][22]

5.6.4 The Trust will fulfil its legal obligations in relation to all legal duties relating to fire management.[1]

5.6.5 The Trust will manage the risk assessment process.[1][11]

5.6.6 The Trust will ensure all buildings are secure and access is controlled.[9]

5.6.7 Fire risk assessments will be carried out on an annual basis, findings will be implemented, and any risk maintained on a risk register.[20]

Outcomes

The Trust will meet fulfil all its legal duties to provide a safe, well-maintained plant and premises where risk is measured, managed, recorded, and audited.

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Safe Premises Performance Indicators		
Indicator	**Responsibility**	**What good looks like**
Carry out risk assessments on all premises and plant and record all findings on an electronic system where the assessments can be monitored and audited.	Director of Estates. Head of Health and Safety.	Electronic system to be purchased and implemented. Risk assessments to be implemented and monitored.
Robust systems to manage the maintenance (including backlog maintenance), servicing and inspection of all plant in line with the requirements.	Director of Estates.	Checking electronic recording systems to ensure compliance.
Ensure all premises meet legal requirements and relevant standards.	Chief Operating Officer.	Measure a sample of office, space allocation, against HTM and H&S legal requirements. Reported through the H&S Committee to the COO.
All assessments of water and asbestos are carried out in line with legal requirements.	Director of Estates.	Reports to be produced outlining these duties have been completed through the Asbestos and Water Safety Groups to the Health and Safety Committee.
Fire risk assessments of all premises to be carried out and outcomes highlight, shared and action plans developed to address.	Head of Fire Safety	Monthly audits of risk assessments, managed through the Fire Safety Group and reported to the Health and Safety Committee.
Assessments of compartmentation and fire doors.	Director of Estates.	Monthly audits of assessments and outcomes through the Fire Safety Group reported to the Health and Safety Committee.
Remedial work to be carried out to ensure fire safety compliance.	Director of Estates.	Monthly audits of action plans for fire safety completed and reported through the Fire Safety group to the Health and Safety Committee.
Effective maintenance, servicing, and inspection of all work equipment.	Director of Estates.	Monthly auditing of all documentation to ensure equipment is maintained, inspected, and serviced as required.

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5.7 Priority 7 – Improving Together

To monitor and review the effectiveness of the Trust's arrangements and where appropriate to implement improvements:

Actions:

5.7.1 The Trust will monitor the effectiveness of this strategy against the Key Performance Indicators which are contained within this document.

5.7.2 Monitor on-going performance through Executive led Health and Safety Committee.

5.7.3 Facilitate a comprehensive external review of arrangements across the organisation.

5.7.4 Improvements identified by the review will be acknowledged and implemented as changes to strategy/policy/procedure or any other appropriate documents or training.

5.7.5 Annual review of all health and safety training to ensure compliance with current legislation, best practice, and Trust performance.

Outcomes:

To ensure actions put in place work and provide the outcomes required to ensure statutory and best practice compliance.

Continual Improvement - Monitor and review Performance Indicators		
Indicator	**Responsibility**	**What good looks like**
The Health and Safety Leadership Team will monitor the progress of the implementation of the H&S review.	Chief Operating Officer.	Check the minutes of the Leadership Team for progress, outcomes to be reported to the H&S Committee.
Self-auditing by Cornwall IOSH Group.	Chief Operating Officer.	Audit outcomes produced by IOSH Auditors to be shared with the H&S Leadership Team and Committee.
Health and Safety Committee to monitor progress of the implementation of H&S action plan.	Head of Health and Safety.	Head of Health and Safety to report to the Health and Safety Committee on progress made through the H&S implementation plan.

6. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Actions will be tracked through the Health and Safety Improvement Plan and reported.
Lead	Gavin Griffiths, Head of Health and Safety

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Information Category	Detail of process and methodology for monitoring compliance
Tool	Health and Safety Improvement Plan. **"S:\TR13\Safety Health Moving and Handling\Health & Safety\Gavin\H&S Improvement Plan\Consolidated Plan Project\Health and Safety Plan 2026.xlsx"**
Frequency	Health and Safety Management Report is submitted to the Health and Safety Committee four times per year.
Reporting arrangements	Health and Safety Committee receive reports and an outcome report of the committee is submitted to the Quality Assurance Committee.
Acting on recommendations and Lead(s)	Health and Safety Committee delegate actions to the Health and Safety Leadership Team.
Change in practice and lessons to be shared	Lessons identified will be shared with the Health and Safety Committee and Health and Safety Leadership Team.

7. Updating and Review

7.1. This Strategy will be reviewed every three years,

8. Equality and Diversity

8.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

8.2. Equality Impact Assessment

The initial Equality Impact Assessment Screening Form is at Appendix 2.

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Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Health and Safety Strategy (2026-2029)
This document replaces (exact title of previous version):	Health and Safety Strategy and Delivery Plan (2023-2025)
Date Issued/Approved:	Month and Year document is approved to be added following approval
Date Valid From:	Month and Year document is approved to be added following approval
Date Valid To:	Month and Year document is approved to be added following approval
Author/Owner:	Gavin Griffiths, Head of Health and Safety
Contact details:	gavin.griffiths@nhs.net rch-tr.healthandsafety@nhs.net
Brief summary of contents:	Formal health and safety strategy outline for guidance on general health and safety compliance and management,
Suggested Keywords:	Health, Safety, Moving and Handling, Manual Handling, CoSHH, Risk, Risk Management, Risk Assessment, Law, Regulations, ACOPs.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Operating Officer
Approval route for consultation and ratification:	Quality Assurance Committee Executive Leadership Team Health and Safety Committee
Manager confirming approval processes:	Gavin Griffiths, Head of Health, Safety and Moving and Handling
Name of Governance Lead confirming consultation and ratification:	Jemma Dunstan, Senior Health and Business Support Advisor
Links to key external standards:	Health and Safety at Work etc Act 1974
Related Documents:	Health and Safety Policy

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Information Category	Detailed Information
Training Need Identified:	Yes – IOSH Managing Safely. Health and Safety training for Leaders.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Chief Operating Officer/ Health and Safety

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
March 2023	V5.0	Partial update – referencing delivery plan targets.	Gavin Griffiths, Head of Health and Safety
June 2026	V6.0	Full Update detailing the requirements of the law and adopting PDCA plans.	Gavin Griffiths, Head of Health and Safety

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus six years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

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Appendix 2. Quality and Equality Impact Assessment (QEIA) Guidance Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

E11 QEIA Policy.

For guidance, please see the QEIA Essentials – Quick Reference Guide or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net.

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

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Appendix 3. Health and Safety Committee Reporting Structure



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Appendix 4. Key Risks and Evidence Schedule

Risk Topic	Actions	Evidence
1.Slips, Trips and Falls, Patients and Staff	Each patient is assessed for falls risk on admission to area. Appropriate care plan actions in place to minimise risk of falling.	Documented in patient notes.
	Flooring regularly checked for hazards and maintenance requests made in a timely manner.	Estates to carry out regular audits.
	Routes kept clear of obstructions or contamination that may contribute to falls.	Soft monitoring to carry out monthly safety checks.
	Staff to adhere to the uniform Policy and wear appropriate footwear.	Management practice of check and challenge.
	Staff tasks include assessment of falls risk.	Risk assessments to be uploaded onto the system.
2. Sharps – use of safer sharps	All devices used have been assessed and replaced with a safety device where reasonably practicable.	Documented risk assessment.
	All staff have been trained in the use of relevant sharps devices.	Training record (ESR and local record).
	Where a safety device cannot be used for clinical reasons, the following actions relating to the non-safety device are completed: • Device assessed and recorded • Staff are trained in the safe use • Market is monitored for safer alternative • Alternatives are trialled and trials recorded with outcomes Risk assessment is reviewed every 6 months	Risk Assessment Trial documentation Training records Speciality/Care Group and Department meeting notes
	All sharps' incidents are accurately recorded in a timely manner.	Datix records Action plan recorded and maintained
	Needlestick pager is contacted for every sharp's incident.	
	Comprehensive investigation is conducted into every incident and appropriate action taken.	
3. Dermatitis and Occupational skin conditions	All staff have direct access to approved hand care products.	Adequate provision of soap, emollient, and gel in appropriate locations.
	Staff not using own or other staff products.	No personal products in work area.
	Annual screen via Appraisal/PDR process.	PDR records (pfile and ESR).
	High risk (including all clinical) staff visual check by manager at 6 months.	Pfile information/ occupational health referral.
	Occupational Health referral for any staff reporting issue.	Pfile information.
	Implementation of recommendations from Occupational Health.	Provision of alternative products.
	Attendance at occupational health appointments as required.	Occupational Health records.
4.Repetitive Strain and Vibration	Clear identification of equipment with potential for causing harm.	Training for all staff.

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Risk Topic	Actions	Evidence
Injuries		
	Robust risk assessment for equipment and tasks using equipment.	Documented risk assessments.
	Records of training for use.	Training records.
	Competency assessment for using equipment.	
	Maintenance and service records for equipment.	Service and maintenance reports at local level.
	On-going market monitoring for improved/safer devices.	Meeting notes. Equipment trial. Business case.
	Occupational Health referrals for staff reporting injury.	Pfile information.
	Attendance at Occupational Health appointments.	Occupational Health records.
	Proactive monitoring and support of staff through general supervision and PDR process.	PDR records and local H&S meeting notes.
5. Radiation, lasers, and MRI Safety	Staff understanding of risks and controls.	Training records. Safety Briefing.
	Clear inventory of equipment	Documented and accessible by all relevant staff. SOPs signed by all relevant staff confirming understanding.
	Clear safe working procedures (SOPs/SSOW/etc.)	
	Accessible clearly documented risk assessment.	Local and electronic record.
	Proactive health monitoring.	Management practices. PDR process.
	Occupational Health referrals for staff reporting issues or concerns.	Pfile information.
6. Moving and Handling – handling patients and inanimate loads	All patients routinely assessed for manual handling risks.	Patient notes. Documented process.
	All tasks involving handling of inanimate loads assessed.	Documented moving and handling assessments.
	Appropriate equipment available.	Detailed in moving and handling risk assessment.
	Equipment services tested and maintained.	Maintenance records. Test certificates.
	Staff training and competency in tasks and equipment.	Training records.
	Provision of appropriate protective equipment.	Equipment available. Training records (local and ESR).
	Key workers appointed, trained, and supported.	Training records (local and ESR) Staff perception.
	Staff awareness of key workers.	Staff understanding. Notices identifying key workers.
7. Workstations and Display Screen Equipment – Computers, laptops, handheld devices	All PC Users must complete DSE training.	Training records.
	Self-assessments completed by user.	Self-assessment. Pfile information.
	Management review of self-assessment with user.	
	Actions implemented based on assessment.	
	Escalation of complex assessment needs.	Self-assessment. Referral to Occupational Health or Health and Safety Management. Online DSE assessment.
	Workstations dimensions meet the requirements laid down with the DSE Regulations.	
	Appropriate space per user 11cubic metres per User.	
	Appropriate work equipment provided and utilised (footrests, specialist keyboards etc).	

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Risk Topic	Actions	Evidence
	Work environment suitable for work activities.	
8.Hazardous Substances – Chemicals, Biological agents, bi-products	Ventilation maintenance.	Routine and emergency maintenance and test records held locally Estates Operations data.
	Provision of personal protective equipment (PPE).	Audit
	Provision of appropriate respiratory protective equipment (RPE).	Training records (local and ESR).
	Inventory of substances documented and accessible	Documented and accessible.
	Assessments in central database and accessible.	Alcumus/Q-Pulse database.
	Training – including use/handling of substances, PPE/RPE, emergency procedures.	Local and ESR training records.
	MSDS accessible with substance and task assessments.	Clear, accessible current records and documents held with Alcumus/Q-Pulse. Audit and self-inspection returns.
	Spillage/emergency procedures.	
	Clear and accessible SOP's.	
	Task risk assessments documented and accessible.	
	Appropriate and accessible secure PPE/RPE storage.	
9. Violence and Aggression – physical and verbal	Local violence and aggression risks assessed.	Clear, accessible current records and documents.
	Staff training at appropriate level for risk.	Training records (local and ESR).
	Security risk assessment.	Clear, accessible current records and documents.
	Panic/personal safety alarm systems in situ, tested and maintained.	Local records of maintenance and test. Estates records.
	Clear SOP's for dealing with aggression/alarms.	Clear and accessible documents.
10. Stress Management	Stress assessment completed and documented.	Stress assessments.
	Opportunities for staff to raise issues in open and safe environment.	Staff perception – audit Annual Staff Survey.
	Robust management of concerns.	Pfile information. Occupational Health referral. Sickness records.
	Proactive and supportive management of stress related sickness.	
	Formal and informal arrangements for destressing opportunities with department.	Staff perception – internal and external audit.
11. Knowledge and Understanding - training	Staff have access to and understand the procedures and risk assessment relevant to their activities.	Accessible current records and documents.
	Where staff have specialist responsibilities, they have appropriate training and opportunities to effectively deliver on the tasks required (i.e., M and H key workers trained, attend support sessions, are given time and management support to train and assess other staff).	Clear details of staff responsibilities. Training records (local and ESR).
	Staff with additional/special requirements (i.e., young workers, new and expectant mothers,	Appropriate risk assessments completed, updated, and communicated.

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Risk Topic	Actions	Evidence
	disability) have appropriate assessments recorded and regularly updated.	
	Managers and supervisors have clear understanding of their responsibilities.	Training records. Incident management. Self-audit returns.
	Clear and accessible local records for training undertaken, refreshed dates and competencies.	Local records. Staff reporting access and understanding during audits and discussion.

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Appendix 5. Legal References

1. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(1) General duties of the employer to their employees
2. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(2) General duties of the employer to their employees
3. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(2) (a) General duties of the employer to their employees – Maintenance of plant and systems of work
4. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(2) (b) General duties of the employer to their employees – Management of harmful substances
5. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(2) (c) General duties of the employer to their employees – information, instruction, training, and supervision
6. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(6) Consultation with Safety Representatives and Representatives of Employee Safety
7. Health and Safety at Work etc. Act 1974 – Part 1 - Section 2(7) General duties of the employer to their employees – Formation of a Health and Safety Committee
8. Health and Safety at Work etc. Act 1974 – Part 1 – Section 3 – General duties of employers and self-employed to persons other than their employees
9. Health and Safety at Work etc. Act 1974 – Part 1 – Section 4 – General duties of persons concerned with premises to persons other than their employees
10. Health and Safety at Work etc. Act 1974 – Part 1 – Section 7 – General duties of employees at work
11. The Management of Health and Safety at Work Regulations 1999 – Regulation 3 – Risk Assessment
12. The Management of Health and Safety at Work Regulations 1999 – Regulation 6 – Health Surveillance
13. The Management of Health and Safety at Work Regulations 1999 – Regulation 9 – Contacts with External Services
14. The Management of Health and Safety at Work Regulations 1999 – Regulation 10 – Information for Employees
15. The Management of Health and Safety at Work Regulations 1999 – Regulation 13 – Capabilities and Training
16. The Management of Health and Safety at Work Regulations 1999 – Regulation 14 – Employees' Duties
17. The Management of Health and Safety at Work Regulations 1999 – Regulation 15 – Temporary Workers
18. HSG 65 – Managing for health and safety
19. Safety Representative and Safety Committee Regulations 1977
20. Health and Safety (Consultation with employees) regulations 1996
21. Regulatory Reform Order 2005 – Regulation 9 – Risk Assessment
22. The Control of Asbestos Regulations 2012

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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 11

Title of Report: Finance and Performance Committee Assurance Report to the Board – May and June 2026 meetings

Committee Chair: Adrian Davis, Non-Executive Director

Author and Job Title: Company Secretary

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

The purpose of this report is to present a summary of decisions made and assurance sought by Finance and Performance Committee on behalf of the Board of Directors at its recent meetings.

Key agenda items and decisions/actions taken on behalf of the Board

- Committee recommended the Trust Board approve:
  - The Fire Improvement Works business case
  - The refresh of the performance accountability framework
  - The updated medium-term financial plan
  - The Commercial Strategy
  - The reprioritised capital programme for 2026/27
  - The revised submission of the plan to 81% RTT performance by the end of March 2027.

Issues for escalation or notification to the Trust Board

The Committee recommended the Board note:

- The risks associated with the eCare Programme

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Summary of assurance and risk

Finance and Performance Committee Assurance Report – May 2026

The Committee received an update on national **Advanced Foundation Trust (AFT)and Integrated Health Organisations (IHO) developments** and that the criteria for AFT has recently changed and the Trust has further work to do.

The Committee received the **Minimal Viable Hospital and Immutable Back Ups** business case noting the implementation of immutable backups and minimum viable infrastructure capability represents a critical investment in organisational resilience, necessary to mitigate increasing cyber risk and ensure continuity of clinical services. While financial constraints remain material, the proposal was supported in principle on a risk and patient safety basis, with further work required to refine affordability, phasing, and funding options. The Committee approved the business case and expenditure up to £1.8 million, noting the need to revisit the case as the capital programme develops and to manage updates through the Committee.

The Committee discussed the **Fire Improvement Works business** case and Committee concluded that the proposed fire improvement programme represents a necessary and time-critical investment in statutory compliance and patient safety. Subject to final national funding confirmation, the Committee supported, and recommended Trust Board approve the full £3.1m programme and the Committee further endorsed early mobilisation funding of £310k CDEL to mitigate delivery risk. The Committee noted appropriate governance arrangements were in place to ensure oversight of spend, delivery, and risk.

Month 1 Revenue (including Financial Sustainability Programme) report highlighted a £1.87 million deficit for April, £0.42 million adverse to plan primarily due to unfunded industrial action costs. The Committee noted that break-even remains achievable if early recovery is secured and risks are managed. Regarding FSP; the Trust delivered £2.02 million savings in month 1 against a £2.2 million target. Committee requested assurance on the level of recurrent schemes, noting Trust performance last year. Members requested detail of the FSP governance to manage schemes in the next report.

Month 1 Capital Report highlighted the total programme as £47.358m and at month 1 the Trust was just below plan. Noted agreement of £4.159m of system capital incentive funding.

The Committee noted the importance and the governance routes to review the **Capital Programme Reprioritisation** (as approved by the Board). Impact of eCare delay is the most significant risk and the report sets out the key mitigations to address the overall gap. Key risks also include the inability to deliver the plan i.e. delays in schemes and having **no contingency within the capital programme**

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which limits flexibility to absorb emerging pressures or scheme overrun. Members recognised the level of the risk and this was reflected on the Corporate Risk Register and agreed to strengthen this on the Board Assurance Framework due to the level of organisational impact. The Committee requested a deeper review of the practical consequences, particularly from a quality perspective.

Recommended Trust Board Approve the update of the **medium-term financial plan** which provides a view on the size and scale of the financial challenge for the next five years. Noted the savings target for 2027/28 would be £33.7m based on the assumptions applied - this was 4.6% of operating expenditure. Noted that based on the MTFP assumptions the Trust would achieve cumulative breakeven over the MTFP period.

Received an update via the **Quarterly Digital Assurance Report** which set out progress against schemes and providing assurance on services being fit for the future. Received the Trust **Federated Data Platform Assurance Statement** and agreed to provide any updates on this matter though the digital assurance report.

Welcomed the **Integrated Performance Report** and the improvement in Fracture Neck of Femur but highlighted the level and concern regarding the continued growth in waiting list size, which is now materially above the level required to achieve a sustainable RTT position.

The Committee noted that whilst there has been improvement in a number of operational metrics, overall performance remains significantly below required standards and in some areas off trajectory. Of particular concern were sustained pressures in urgent and emergency care, including long ambulance handover delays, high numbers of patients experiencing 12+ hour waits, and performance against national standards remaining materially below expectation. The discussion emphasised that these performance issues are not solely operational but are also driving financial pressure, notably through the continued use of escalation areas and associated costs.

Noted performance remains fragile and off trajectory in several areas, with associated financial and regulatory risks. Further strengthening of reporting through the revised IPR will improve transparency and oversight.

The Committee reviewed the proposed refresh of the **performance accountability framework** and supported its direction. The revised approach strengthens assurance through clearer alignment of responsibilities across committees, improved integration of data, narrative and actions, and enhanced triangulation from operational to Board level. Reporting will now present performance metrics alongside actions, timescales and delivery risks in a single view, enabling more effective scrutiny of whether recovery plans are sufficient. The framework places increased emphasis on forward-looking risk and trajectory to plan, supporting earlier

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identification of performance concerns and escalation where required. Implementation will be iterative, with further refinement brought back to Committee to ensure the framework continues to meet Board assurance requirements. Committee members welcomed the revised framework which provides a stronger, more coherent basis for performance oversight and assurance to the Board.

The Committee received a **cancer performance deep dive,** noting deterioration in key standards, particularly the 31-day decision to treat and 62-day referral to treatment pathways, driven by histopathology and radiology capacity constraints and workforce pressures across several specialties, including breast, gynaecology, dermatology and urology.

The Committee noted strengthened oversight through the Cancer Action Delivery Board, improved alignment with planned care transformation, new divisional leadership and greater operational grip. Recovery actions include specialty deep dives, daily PTL tracking, weekly performance oversight, radiology recruitment, extended workforce models, use of Community Diagnostic Centres and externally funded support for histopathology turnaround times.

The Committee was moderately assured that recovery actions and governance arrangements are in place, while noting delivery remains dependent on workforce recruitment, sustained diagnostic capacity and effective pathway redesign, particularly the planned breast one-stop model. Residual risks include reliance on non-recurrent capacity, ongoing workforce constraints and further slippage if recruitment or diagnostic improvements are delayed. Continued close monitoring through strengthened reporting and the enhanced IPR was endorsed.

Committee considered an update on the **eCare programme** following the decision to defer go live. Assurance was provided that the previously proposed November implementation date had undergone detailed review, including external input, and was now assessed as not clinically safe or operationally deliverable, leading to agreement that this option should not be pursued.

The Committee challenged the implications of deferral, noting that a later go live window, most likely February–March, would increase capital costs and place additional pressure on the Trust's capital programme. It was recognised that while there remains a net positive revenue position, planned efficiency benefits associated with eCare will need to be replaced within the Financial Sustainability Programme, increasing delivery risk. The Committee also emphasised the need to move rapidly to a confirmed go live date to provide clarity and prevent further escalation of both financial and operational risk.

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Members explored the risks associated with extending reliance on legacy systems and were advised that several core systems are end of life, creating a constrained window for safe delay and introducing parallel risks in both continuing and upgrading

existing platforms. This reinforced the importance of maintaining delivery pace once a revised date is agreed.

The Committee supported the conclusion that November go live is not viable and endorsed further work to develop a February–March 2027 option, subject to affordability and assurance. It was agreed that detailed financial modelling of the revised timeline should be completed and brought back to a future meeting, alongside an updated delivery plan. In addition, work is ongoing to mitigate additional costs through supplier discussions and to manage risks associated with legacy systems and deferred benefits realisation.

Women and Children's Programme Update Report set out the Trust remains on track for contract award following the allocation of Willmott Dixon Construction as the H2 Alliance Contractor for the Royal Cornwall Hospitals NHS Trust (RCHT) Women and Children's Hospital. Noted the ongoing discussions regarding the value of the build and the Committee received positive assurance regarding the ongoing revenue position. Members requested greater clarity on the roadmap for the progamme, with the deadlines which will provide a greater level of assurance.

Noted the **Capital Projects Programme Report** which set out the progress against plan, noting considerations aligned to the reprioritisation of the over capital programme.

Approved a **Contract over £5m** relating to pathology manged services.

The **Board Assurance Framework** set out the changes to BAF elements following Finance and Performance Committee review and Board approval in May 2026. A wider BAF review is planned in June 2026 to align with the refreshed Trust Strategy.

BAF 3 continues to progress the Women's and Children's Programme, New Hospital Programme and culture transformation, although eCare go-live remains paused pending review. BAF 4 highlights financial risks linked to industrial action, deferred eCare go-live and delivery of the Women's and Children's Programme within the revised budget. BAF 5 remains focused on the eCare delay, including financial, operational and training risks, alongside ongoing assurance on AI governance. BAF 6 continues to reflect assurance gaps in severe weather resilience, fire safety systems and health and safety controls, including statutory compliance and accountability. Overall, actions are progressing; however, evolving gaps in financial, digital, estates and health and safety assurance require continued Committee oversight.

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Integrated Health Organisation, Neighbourhood Progress and Advanced Foundation Trust (AFT) – noted national guidance issues in June 2026 regarding Advanced Foundation Trusts. Trust still has a strategic intent to become an AFT however, met with Regional Team and the Trust is currently not eligible due to the change in criteria. Noted development of the approach and the Trust remains committed regarding progressing neighbourhood and partnership models as well as integrated care. Agreed to continue to discuss on a monthly basis, noting that National Oversight Framework metrics are included in the IPR; suggested including additional information regarding delivery against strategic objectives.

Commercial Strategy sets out the ambition within our Trust Strategy for commercial growth which will support longer term financial sustainability; with delivery of the commercial strategy in the short term being picked up through the Financial Sustainability Programme. Will bring together the current disparate elements of commercial activity at the Trust into a more strategic and coordinated model including a new approach to grow paying patients. Agreed to an indicative percentage in year one and beyond which would be monitored by FSP and agreed to provide an update to Committee on a bi-annual basis on delivery against the strategy. Committee recommended Trust Board approve the strategy.

Committee reviewed the proposed **reprioritised capital programme**, noting that a balanced plan of £31.8m is only achievable through a combination of internal mitigations and a high-dependency on securing up to £5m of external brokerage. The Committee recognised that this represents a pragmatic but high-risk position, balancing the operational risks of not having an approved capital programme against the financial risks of approving a plan that is not fully funded at the point of agreement.

Members challenged the level of affordability risk and the implications for the Board in approving a plan that relies on uncertain assumptions, emphasising the need for explicit articulation of risk appetite and full transparency regarding the dependency on brokerage and delivery of mitigations. Particular concern was raised regarding the deliverability of required savings within the eCare capital allocation, with acknowledgement that this creates complex trade-offs which may impact programme delivery and broader organisational priorities.

The Committee also noted the potential consequences of not achieving a balanced position, including regulatory escalation and future impacts on capital allocations, reinforcing the importance of robust risk management and engagement with NHS England and auditors. In light of this, the capital risk score has been increased to reflect the heightened level of exposure.

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The Committee agreed to recommend approval of the reprioritised capital programme to the Board, on the basis that the risks are clearly articulated and actively managed. It was emphasised that the plan will require close and ongoing scrutiny, including regular reporting on progress with brokerage, delivery of mitigating actions and any movement in the underlying risk position, with the expectation that the programme will continue to be dynamically reprioritised as the financial position evolves.

Month 2 Capital Report recognised the level of risk associated with the capital programme in light of the current reprioritisation of the plan.

The Committee noted that the **Month 2** position is broadly in line with plan for the month but already adverse year to date, reflecting underlying structural pressures and early signs of delivery risk. The primary driver remains the **Financial Sustainability Programme,** where delivery is below target and heavily weighted towards non-recurrent savings, creating a significant risk to achieving a sustainable financial position.

The key challenge is the scale and pace of FSP delivery. Despite improvements in governance through the new gateway assurance framework, recurrent savings remain low and there is a substantial gap between required and identified savings, with variable progress across divisions and reliance on pipeline development. This is compounded by emerging run-rate risk, operational pressures driving unfunded costs, and uncertainty around income linked to activity and coding performance, all of which heighten the risk to full-year delivery.

The Committee had limited assurance at this stage that the programme will deliver the required level of recurrent savings without further intervention, noting the need for clearer forecasting and stronger articulation of the trajectory and underlying financial risk.

Actions agreed focus on strengthening grip and transparency, including development of a more robust monthly forecasting approach linking FSP, run-rate and activity; enhanced reporting of recurrent versus non-recurrent savings trajectories; continued embedding of the gateway framework to accelerate scheme maturity; and further work to improve cross-divisional delivery and pipeline generation, alongside clearer articulation of the medium-term financial outlook.

Received and noted the **National Cost Collection Pre Submission** which set out 96% compliance with costing standards, and prioritisation of remaining gaps post-submission, with committee approval for the process and anticipation of a post-submission report.

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Noted that the **eCare programme** remains a critical delivery risk, currently in reset with a proposed March–April 2027 go-live that requires final confirmation and external assurance.

The key challenge centres on balancing delivery confidence against financial pressure, given the significant weekly cost of delay alongside the need to avoid further compromise to programme quality or readiness. This is compounded by uncertainty around national approvals and the requirement to demonstrate readiness close to go-live, creating a material risk of further slippage and additional cost.

There is also a significant operational challenge, with unavoidable productivity impacts during training and go-live needing to be mitigated against a backdrop of demanding RTT recovery expectations, where performance deterioration is not acceptable.

The Committee highlighted ongoing financial pressures within the programme, including the difficulty of identifying further savings without increasing delivery risk, and the need to clearly articulate trade-offs.

Agreed actions are to finalise the go-live date through programme governance, strengthen Board reporting on financial implications and risks of timing decisions, continue development of mitigation plans for productivity impact, and maintain regular, detailed oversight by the Committee given the programme's scale and cross-cutting impact.

The **integrated performance report (IPR**) confirms that the Trust remains under significant operational pressure, with high occupancy, workforce constraints and rising demand impacting performance across multiple domains. While the revised format has improved transparency, it highlights a key risk that stable RTT performance is resulting in a growing waiting list, including an increase in long waits, which is not sustainable and will not meet national expectations.

The principal challenge is the interdependence of operational, workforce and financial pressures, alongside specific issues such as underutilisation of external diagnostic capacity and continued demand growth. There is a need to move beyond describing performance to clearly demonstrating how benchmarking, segmentation and performance data are driving tangible improvement, with particular focus on addressing waiting list growth and patient flow.

In response, enhanced oversight arrangements have been implemented, including a twice-weekly assurance process with divisions to drive delivery and accountability. Actions are focused on deeper analysis of waiting list growth, strengthened controls on patient pathway management, and resolving system and contractual issues affecting diagnostic capacity. The Committee has also emphasised the need to further strengthen the IPR by improving clarity on actions arising from benchmarking

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and ensuring stronger alignment between performance, workforce and financial planning to support sustainable recovery

Discussed the risks and dependencies regarding the **RTT Recovery Plan** and the delivery of 81%. The Committee agreed that it provides a credible trajectory to achieve 81% by March 2027, with strengthened governance and clear alignment to wider operational and financial priorities identified.

The principal challenge is the level of delivery risk, particularly the heavy reliance on workforce capacity, productivity improvements and system support. There remains uncertainty within the plan, including an element of unidentified delivery, and significant interdependencies with financial performance, elective recovery funding and the eCare programme. The Committee noted that performance must improve while reducing the waiting list, and that failure to do so would undermine sustainability and increase risk to NOF segmentation and income.

The Committee agreed that further work is required to strengthen assurance, including clearer integration of RTT delivery with activity, income and the financial sustainability programme, additional scrutiny of workforce assumptions through the People Committee, and continued regular oversight through FPC with a focus on trajectory delivery, waiting list growth and mitigation of eCare-related impacts. The need for ongoing system alignment and clarity on funding assumptions will be escalated to the Board.

Committee received the **Quarter 4 segmentation** update which confirmed the Trust has moved to Segment 2 which was a deterioration. The Committee recognised that increasing national requirements, including an expansion in the number of metrics, will heighten the challenge and introduce further uncertainty in future assessments.

Members challenged the risk of focusing on metric management rather than resolving underlying operational issues, emphasising that sustained improvement will only be achieved through strengthening core service delivery, particularly in relation to patient flow, RTT performance, emergency care pressures and workforce constraints. There was specific concern regarding the continued growth in the waiting list and long waits, with the committee clear that achieving performance trajectories without reducing the waiting list would not be acceptable and presents a material risk to segmentation performance and regulatory oversight.

The committee supported the executive approach of prioritising operational improvement, underpinned by a strengthened assurance framework including twice-weekly divisional performance reviews to drive accountability and pace. Actions include maintaining enhanced scrutiny of RTT delivery and waiting list growth, progressing targeted interventions to improve patient flow and reduce emergency

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care delays, and incorporating segmentation risk explicitly within the Board Assurance Framework to ensure clear alignment with strategic risks.

The Committee noted strong progress in the **Women and Children's Programme**, with formal confirmation of the £418.8m funding envelope representing a critical milestone that enables the scheme to proceed with greater certainty, alongside continued advancement of design options and positive national and regional engagement to support delivery momentum.

Members challenged the level of uncertainty within the reported revenue affordability position, highlighting that the current estimate is based on evolving assumptions and requires clearer articulation of risks and sensitivities as design and workforce models develop. There was also a focus on ensuring robust financial control during early delivery phases, including the management of contractor costs and proportional use of resources, and the need to evidence learning from comparable schemes to inform staffing and operational planning.

The Committee agreed that future reporting should strengthen transparency on the affordability gap, including clearer articulation of underlying assumptions and emerging cost pressures, with iterative updates aligned to Outline Business Case development. Ongoing assurance will continue to be provided through regular reporting on programme milestones, delivery timetable, cost management and risk mitigation as the scheme progresses.

Noted the Trust was reviewing the NHP Alliance Contract and undertaking due diligence associated with contractual risks. Received assurance on the practical steps being taken.

Received and noted the **Capital Projects Programme Report** and suggested future assurance should be reported through the Capital Programme report (rather than a standalone report).

Members discussed the **Committee Self Assessment Outcomes from Annual Reporting process** and the key areas in making the Committee's work more strategic, better focused, and more efficient—particularly through lighter agendas, shorter and sharper papers, clearer business case and risk processes, and more time for discussion of key performance and financial issues.

Committee members noted the updates on the **Board Assurance Framework** particularly relating to eCare, elective recovery, capital planning and cyber security oversight. It was agreed to include a gap in assurance relating to national oversight framework segmentation impacts and the impact of the Devon financial challenge on Cornwall. The Board reviewed its Risk Appetite in June 2026, further work is being undertaken to develop the risk appetite statements. The Board will be invited to

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approve the statements in July/August with the aim of the BAF being updated to align to them.

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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 11.01

Title of Report: Trust Finance Report 2026-27: Part A: Month 2 Revenue Position

Executive Director Lead: Ian Dean, Chief Finance Officer

Author and Job Title: Graeme Booth (Deputy Chief Finance Officer), Lisa Rodda (Associate Director of Finance) and Jon Foxwell (Financial Planning and Reporting Manager).

Email Address: graeme.booth@nhs.net / ian.dean@nhs.net

Purpose of the Report:

Decision ☒ **Discussion** ☐ **Assurance** ☐ **Information** ☐

The purpose of this report is to present an update on the Trusts revenue financial position as at 31 May 2026 (Month 2).

Consultation:

The financial position is reported each month to the Trust Board as well as the Finance and Performance Committee. It is also reported to Trust executive meetings. There is no need for further consultation on this report.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☒ **People** ☐

Reputational ☐ **Legal / Regulatory** ☐

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact			X	

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Assessment completed?				
Quality Impact Assessment completed?			X	
Data Protection Impact Assessment completed?			X	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	The operational and financial plan includes improvements across several performance metrics, all of which will support the overall health and wellbeing of the population.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The operational and financial plan includes improvements across several performance metrics, all of which will support the quality of service provided.
Sustainable and efficient use of NHS resources by RCHT	The operational plan includes ambitious financial improvements, supporting the Trust to be more sustainable and efficient.

Recommendations:

The Board is recommended to:

- **Note** the May (month 2) financial position which represents the second month of the 26/27 financial year position.
- **Note** that the reported year to date financial position remains adverse to plan by c£0.42m which is due to the unfunded costs of Industrial Action in April.
- **Note** the financial risks outlined in the paper.

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Summary of the Financial Performance for 2026-27: May ’26 – Month

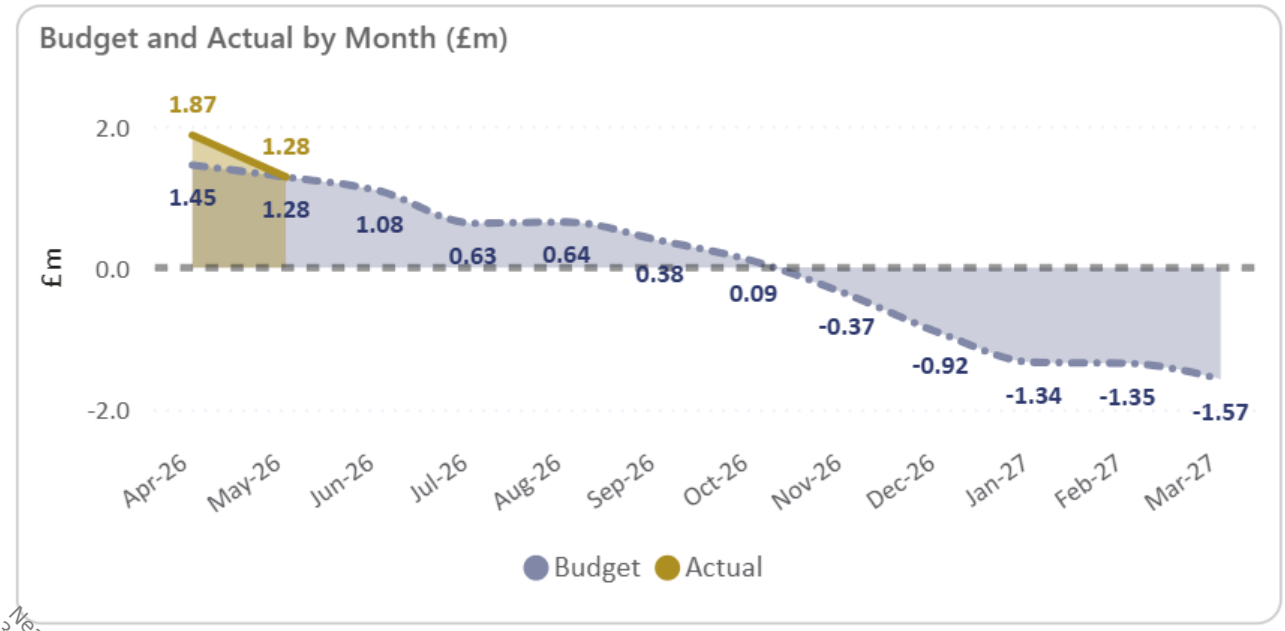
1. Situation / Executive Summary

KPI	Status	Actual	Comment
YTD Position	🔴	£0.4m	May remains at £0.42m adverse to plan, due to April industrial action.
Forecast Outturn	🟢	£0.0m	Trust remains on plan to deliver breakeven
FSP Delivery	🟠	90.5%	FSP under-delivered in Month 2 and remains the key financial risk.
Recurrency	🔴	9.9%	Low recurrent delivery increases risk to the full-year plan.
Agency Spend	🟢	£1.1m	Agency spend was below plan and the Trust’s target.
Cash Balance	🟢	£39.0m	Capital cash driven favourable £18.7m variance to plan

The Trust reported a deficit of £1.28m in May, in line with plan and delivering a marginal positive variance. Year to date (months 1–2), there is an adverse variance of £0.42m, driven by the cost of April industrial action. While a formal forecast has not yet been completed, current assessment indicates that delivery of the breakeven plan remains achievable but with risk, subject to recovery of the in-month shortfall and improved savings delivery.

Trust Summary £000 - M1-M2

Current Mth Actual	Current Mth Budget	Current Mth Variance	YTD Actual	YTD Budget	YTD Variance
1,278.15	1,279.62	-1.47	3,144.11	2,727.07	417.04



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The principal risk to delivery remains the Financial Sustainability Programme (FSP), where performance for both April and May below the initial 2026/27 target and the proportion of recurrent savings remains low. Management action is focused on strengthening programme delivery, increasing recurrent savings and closely monitoring run-rate performance through the early part of the year.

2. Detailed Monthly Breakdown

In May, Clinical Divisions reported an adverse variance of £0.59m against plan, increasing the year-to-date adverse variance to £1.15m. The overspend is within pay and primarily driven by FSP shortfall, medical pay, escalation spaces, and the April industrial action.

During May, £0.23m of costs were incurred in relation to escalation spaces of which £0.15m was unfunded. It included spaces such as the discharge lounge, Phoenix Stroke Ward and the Planned Care Unit. These remain a key financial risk within the plan and will be closely monitored.

Corporate departments reported a favourable variance of £0.05m in month, increasing the year-to-date favourable position to £0.12m. This reflects small variances across Corporate Directorates, partially offset by Estates, which reported a £0.17m adverse variance driven by utilities.

Income and divisional income were £0.06m above plan in month, reducing the adverse variance from April to £0.20m. Underperformance against the income target has been mitigated using a corresponding expenditure reserve to maintain alignment between ERF income and expenditure. Reserves were underdrawn in Month 2, primarily relating to Health Education England funding, with an offsetting position in divisions. Action is underway to ensure full drawdown of these funds and improve clarity of the reported position.

Subjective Summary £000 - M1-M2

Line	Current Mth Variance	YTD Budget	YTD Actual	YTD Variance
Pay	555.8	73,485.0	74,486.7	1,001.6
Non-Pay	-87.2	45,894.0	46,101.6	207.7
Reserves	-408.7	2,344.3	1,356.5	-987.7
Total Expenditure	59.8	121,723.3	121,944.8	221.6
Total Income	-61.3	-118,996.2	-118,800.7	195.5
Net Position	-1.5	2,727.1	3,144.1	417.0

Agency expenditure remains below plan in May across all staff groups, most notably within Medical and Dental. In month, agency spend was £0.01m favourable to plan, increasing the margin from April despite a reducing plan, reflecting the continued effectiveness of controls in place.

The Trust remains on track to deliver the NHS England agency target of 1.1% of pay and continues to work towards zero agency usage through FSP delivery and Divisional performance meetings.

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Period	Plan £000	Actual £000	Variance £000	Agency % of Pay
YTD	1,233.0	1,078.2	-154.8	1.76%
Clinical (NM)	819.0	753.2	-65.8	2.06%
Medical &	414.0	325.1	-88.9	1.32%
Current Mth	606.0	509.9	-96.1	1.67%
Clinical (NM)	399.0	337.8	-61.2	1.85%
Medical &	207.0	172.1	-34.9	1.40%

Bank expenditure remains above plan in May across all staff groups, reflecting the offsetting impact of reduced agency usage, with increased bank utilisation through additional ADHs. Expenditure increased by £0.05m in month against a reducing plan, further increasing the adverse variance.

The Trust continues to exceed the bank spend target percentage, with the current plan requiring a reduction in 2026/27 to achieve compliance.

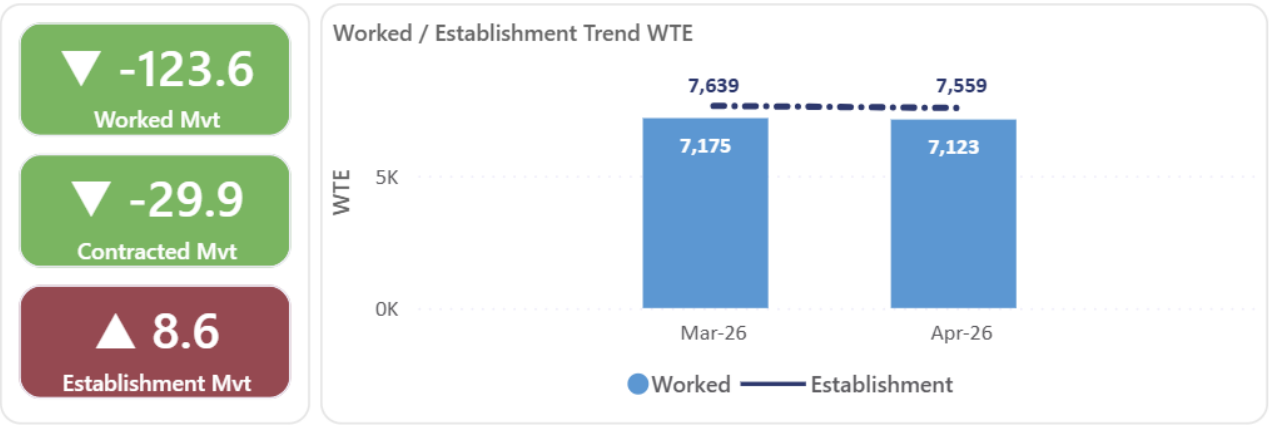
Period	Plan £000	Actual £000	Variance £000	Bank % of Pay
Current Mth	2,190.0	2,987.5	797.53	7.91%
Clinical (NM)	1,117.0	1,155.9	38.86	6.33%
Medical & Dental	798.0	1,529.8	731.82	12.40%
Non-Clinical	275.0	301.9	26.85	4.19%
YTD	4,429.0	5,927.1	1,498.06	7.84%
Clinical (NM)	2,277.0	2,339.1	62.14	6.41%
Medical & Dental	1,596.0	2,960.2	1,364.23	11.99%
Non-Clinical	556.0	627.7	71.69	4.35%

In May, establishment increased by 8.6 WTE, reflecting approved business cases, particularly within Estates (security staffing) and Women's and Children's (CNST). Contracted WTE reduced by 30, with marginal reductions observed across divisions and corporate areas, reflecting underlying workforce movement.

Worked WTE saw the most significant change, decreasing by 124, predominantly across healthcare support workers, nursing and junior medical staff. This movement reflects a combination of workforce adjustments, April data corrections, and a shift in non-medical bank utilisation. While overall WTE has reduced, medical expenditure remains elevated.

For central reporting, this position will be normalised to a monthly view; however, the weekly movement is retained here to align directly with spend trends.

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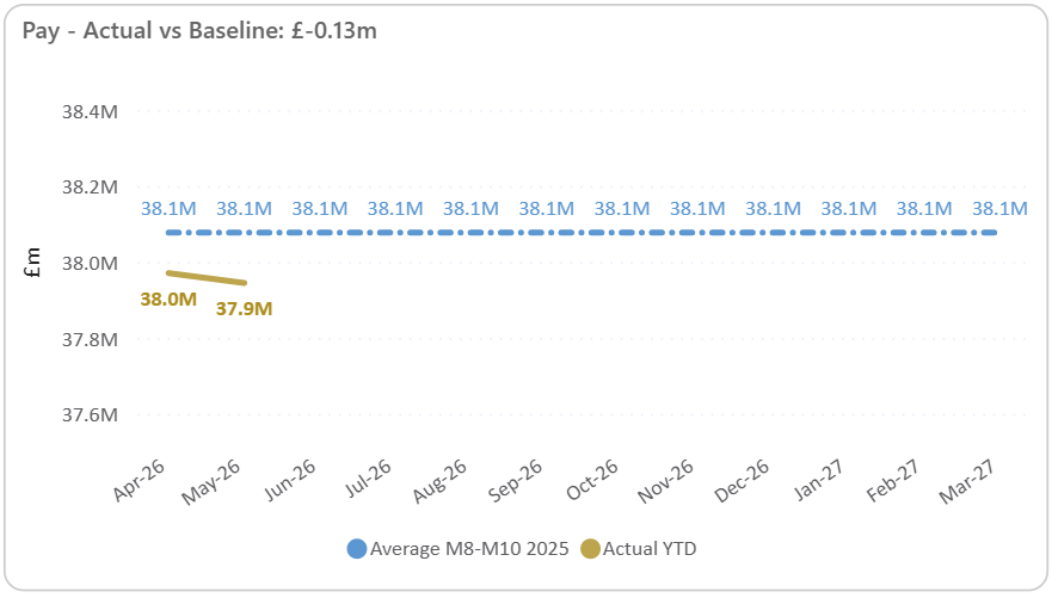


3. Run-Rates

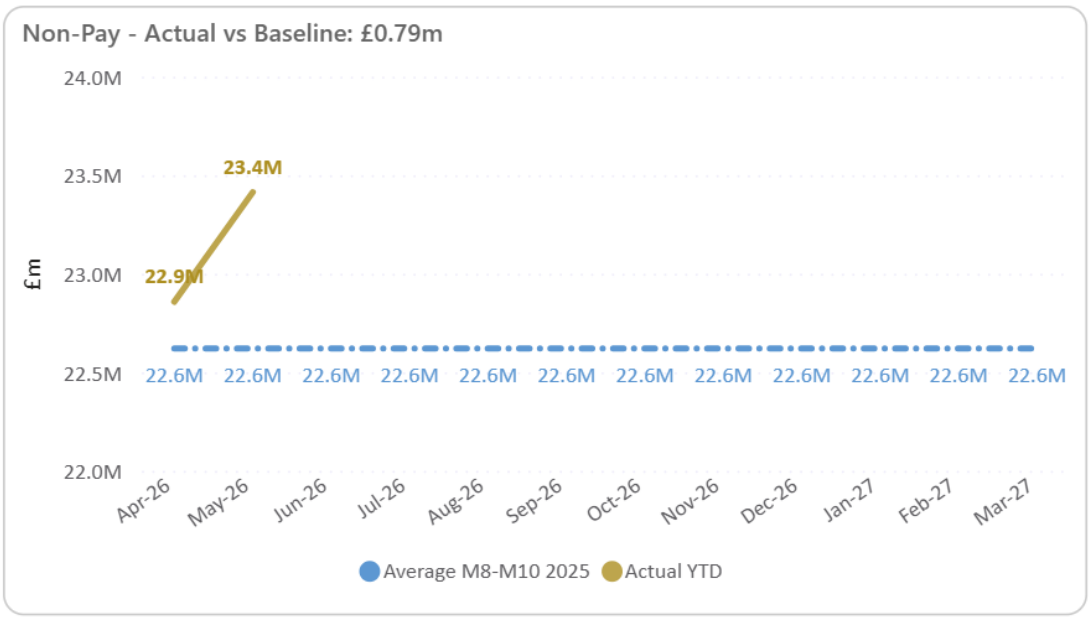
The October to December 2025 average has been used as a baseline comparator, uplifted for pay awards and inflation to provide a like-for-like view. Reserves and other financing items have been excluded to present a clearer picture of underlying pay and non-pay expenditure.

In May, pay was £0.13m below this adjusted baseline and broadly in line with April, reducing marginally by £0.01m. It should be noted that April expenditure was impacted by industrial action; however, pay has not reduced in May despite the absence of disruption, with medical pay remaining elevated. Overall, the underlying pay position remains broadly stable, reflecting the impact of divisional restructuring and continued administrative vacancies.

Non-pay expenditure totalled £23.4m in May, £0.79m above the adjusted baseline and £0.5m higher than April. The increase is primarily attributable to eCare related costs and higher drug spend. The latter remains subject to refinement as updated drug data is processed following recent changes to classification between passthrough and non-passthrough categories.



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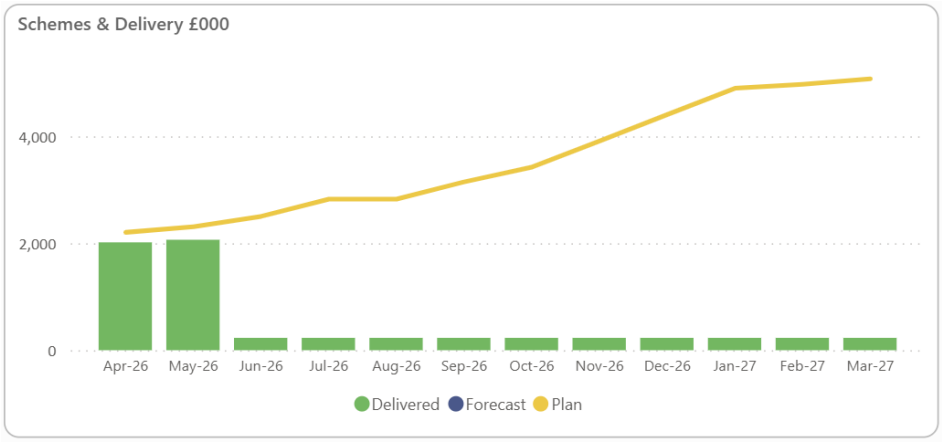
4. Underlying position

The underlying deficit has remained at the month 1 position of £43.49m.
As expected at this early stage of the year, the position continues to reflect planned assumptions, including the phasing of non-recurrent items and provider support. A full FSP forecast is yet to be finalised and currently assumes delivery in line with plan; consequently, movement in the underlying position remains minimal.

5. Financial Sustainability Programme

The 2026/27 financial plan set a total savings requirement of £42.5m. In May, the FSP programme delivered £2.07m against a target of £2.31m, resulting in a £0.24m shortfall and increasing the year-to-date variance to £0.41m against the £4.51m plan.

While delivery improved marginally in-month, the rising monthly target has led to a widening variance. As Quarter 1 represents the lowest point in the annual delivery profile, this underperformance signals an early risk to achievement of the full-year programme. Recovery will require in-month improvements and a strengthened recurrent delivery position, particularly across underperforming workstreams.



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Nursing, Medical and Estates continue to be the main areas of under delivery in May, with several other workstreams also showing only partial delivery. Delivery in month

has been supported by increased non-recurrent delivery in Divisions and Finance Technical through a release of reserves, which has helped support the May and year-to-date FSP position but does not address the underlying gap in recurrent scheme delivery.

Workstream / Theme	Plan	Delivered	Variance to Plan
FSP - Divisional Initiatives	1,177.0	1,851.2	674.3
FSP - Finance Technical	82.0	591.7	509.7
FSP - eCare	36.0	0.0	-36.0
FSP - Corporate Services	414.0	321.8	-92.2
FSP - Commercial and Income	163.0	0.0	-163.0
FSP - Operational Productivity	794.0	626.4	-167.6
FSP - Non-Pay Initiatives	787.0	617.6	-169.4
FSP - Estates	294.0	5.5	-288.5
FSP - Medical Value for Money	311.0	6.4	-304.6
FSP - Nursing Value for Money	455.0	61.3	-393.7
Total	**4,513.0**	**4,081.9**	**-431.1**

Recurrent delivery also remains low, at 9.9% against plan and 11% of total delivery, which increases the risk to sustainable achievement of the programme.

Recurrent/Non-Recurrent	Plan	Delivered	%	Variance to Plan
Non-Recurrent	1,267.0	3,633.5	89%	2,366.5
Recurrent	3,246.0	448.4	11%	-2,797.6
Total	**4,513.0**	**4,081.9**	**100%**	**-431.1**

The Financial Sustainability Programme has reviewed the early programme position, with the current focus on strengthening delivery assurance, governance and scheme mobilisation.

- Completion of Project Initiation Documents remains central to programme assurance, helping clarify ownership, test deliverability, reduce duplication between workstreams and support risk-based escalation where progress is insufficient.

- A practical and supportive approach is being taken to accelerating PID completion, including sharing learning from existing schemes, use of digital tools, and stronger coordination between scheme leads and finance teams so that realised benefits are transacted promptly and reflected accurately in reporting.

- Progress across workstreams remains variable. Encouraging traction is emerging in some areas, particularly where divisional ownership is strengthening, but

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several schemes remain dependent on wider operational, workforce or strategic enablers, which continues to constrain confidence in near-term delivery.

- Maintaining momentum ahead of quarter end remains important, with continued focus on credible schemes, proportionate governance and active executive support where barriers to progress remain.

- A potential strategic risk is emerging if the Financial Sustainability Programme is positioned separately from the launch of the Trust's strategy and wider culture work, as this could weaken engagement, reduce organisational ownership and limit the extent to which financial sustainability becomes embedded within the Trust's future culture and ways of working. It is therefore important that FSP remains visibly aligned to the Trust's strategic and cultural agenda.

FSP Governance and Gateway Framework

The Finance and Performance committee had asked for further details on the revised FSP governance structure including integration of the gateway framework within programme reporting. The following is a summary of the Divisional Gateway Assurance Framework.

1. Purpose

This document sets out how divisions will apply the Gateway Assurance Framework locally and use the divisional spreadsheet as the primary management tool. The approach supports consistency, transparency and stronger delivery oversight.

2. Governance Model

Divisional Delivery → Divisional P Meeting → Executive P Meeting → FSP Board → Executive Oversight.

3. Roles and Responsibilities

- Finance Managers maintain and validate data.
- Scheme Leads deliver schemes and provide evidence.
- FSP Team provides challenges, support and assurance.

4. Gateway Lifecycle

G1 Pipeline → G2 Approved → G3 Mobilised → G4 Delivering → G5 Realised

Each stage requires defined evidence before progression.

5. Spreadsheet Overview

- Single source of truth for all schemes.
- Data captured includes gateway, phasing, plan vs actual and RAG.
- Variance calculated as Actual minus Plan.

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6. Monthly Divisional P Meeting

- Review overall position, delivery performance, risks and actions.
- Focus on movement through gateways and recovery actions.

7. RAG Ratings

- Green – high confidence of delivery.
- Amber – recoverable risk.
- Red – material risk requiring intervention.

8. Expectations

- Maintain accurate monthly data.
- Ensure clear ownership and accountability.
- Focus on delivery and progression.

9. What Good Looks Like

Ownership, pace, grip and credibility in scheme delivery.

6. Income and Activity

Month 1 activity and income data is available but due to the material levels of uncoded activity the data is not reliable so an assumed breakeven position for variable and blended activity has been reflected in the month 2 position. At this stage of the financial year, this is a reasonable position to take.

At month 2 the income position is £195k deficit which is an improvement from month 1 position of £257k deficit. This is mainly due to the utilisation of investment reserves partially offsetting the Elective Recovery Fund (ERF) stretch target which has now reduced from £2.1m for the year, to £1.85m resulting in £95k in month pressure.

Interim guidance was published on 30th April stating an increase in contract uplift factor (inflationary pressures less efficiency factor) from 0.03% to 1.16%. This increase is to fund agenda for change and medical pay awards as well as job evaluation process for band 5 nurses, mileage rate change and exception reporting or resident doctors. 0.7% for AFC pay inflation has been reflected in both income and expenditure but the remaining increase will be reflected from June in line with commissioner and payroll payments.

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Income	Annual Budget	Budget to Date	Actual	Variance
	£000	£000	£000	£000
CIOS ICB - Contract	(505,108)	(84,042)	(84,041)	0
Devon ICB - Contract	(1,753)	(300)	(300)	0
Specialist Services (including delegated)	(119,322)	(20,549)	(20,549)	(0)
Public Health	(8,549)	(1,434)	(1,434)	(0)
Military	(676)	(113)	(113)	0
LVA	(7,837)	(1,306)	(1,306)	0
Health Education England (HEE) - Training	(32,216)	(5,371)	(5,371)	(0)
Cornwall Partnership Foundation Trust	(6,686)	(1,127)	(1,096)	32
Other Trust Income				
- Private Patients	(1,338)	(251)	(192)	60
- Overseas Patients	(210)	(35)	(44)	(9)
- Car Parking	(2,360)	(390)	(436)	(46)
- Catering	(1,824)	(308)	(359)	(51)
- Research & Development	(5,726)	(924)	(863)	61
- Other	(17,874)	(2,846)	(2,698)	148
Total	**(711,479)**	**(118,996)**	**(118,801)**	**195**

7. Cash

The Trust ended May 2026 with a cash balance of c.£39m (31 March 2026 c.£44.3m) compared with a planned balance of c.£20.3m, resulting in an c.£18.7m favourable variance.

	PLAN	ACTUAL	Variance
	£'000	£'000	£'000
Cash Balance at 31 March 2026	**31,486**	**35,414**	3,928
Capital Payments	-13,373	-8,100	5,273
PDC income received	2,081	370	-1,711
Capital Lease payments	-208	-182	26
Finance Charges (including PDC)	-174	-162	12
Interest Received	178	434	256
Provider Revenue PDC Support	0	0	0
Net Revenue cash movements	260	11,222	10,962
Cash Balance at 31 May 2026	**20,250**	**38,996**	**18,746**

The opening cash balance at 31 March 2026 was c.£3.9m greater than plan and working capital balances generated a c.£11.7m favourable cash benefit as set out in the tables below. Capital Spending was c.£3.6m below plan.

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	Cash Flow Variances Month 2	Forecast Cash Variance (£000)
Revenue	Opening Cash Variance	3,928
Revenue	Operating surplus/deficit variance	-782
Revenue	Working Capital variance	11,744
Revenue	Provider Revenue Funding variance	0
Revenue	Financing Variance	294
Revenue	Depreciation and Impairements	0
Capital	Capital spend v. funding variance	3,562
	Total Cash Variance against forecast	**18,746**

Movements in revenue creditors have increased by c.£11.7m compared to the plan, with c.£7.2m of this change due to training and education income received in April 26 that was originally expected in June 26. Additionally, there has been an increase of c.£7.3m in trade payables during Month 1, which is attributed to large payment runs in March 26 clearing year-end trade liabilities. Revenue Debtors have increased by c.£6.0m predominantly due to an increase in income accruals c.£4.7m NHS Income Accrual.

Balance Sheet Cash Variances	Revenue debtors	Revenue creditors	Deferred income	Inventories	Provisions	Total
Planned movement	£'000	£'000	£'000	£'000	£'000	£'000
31-Mar-26	27,253	(60,058)	(4,079)	13,085	(4,708)	(28,507)
31-May-26	27,253	(57,096)	(4,079)	13,085	(4,708)	(25,545)
Planned increase/(Decrease) in Cash	**0**	**(2,962)**	**0**	**0**	**0**	**(2,962)**
Actual movement						
31-Mar-26	19,138	(48,439)	(4,312)	13,380	(5,534)	(25,767)
31-May-26	25,153	(54,403)	(13,045)	13,191	(5,445)	(34,549)
Increase/(Decrease) in Cash	**(6,015)**	**5,964**	**8,733**	**189**	**(89)**	**8,782**
Variance between plan and actual	**(6,015)**	**8,926**	**8,733**	**189**	**(89)**	**11,744**

8. Double Lock Investments

There are currently no business cases approved, awaiting Double lock approval.

9. Financial Risks

- Section 3 – Run Rates, identified that pay run-rate is tracking below the 2025/26 baseline. Despite this, at M2 the Trust recorded an actual deficit of c£3.14m. This run rate indicates a forecast risk in the region of c£19m which will need to be mitigated by a significant step-up in FSP delivery.

- The Financial Sustainability Programme was included in the plan submission at c£42.5m which, represents c5.7% of operating expenditure. The programme is also based on 75% of schemes being delivered recurrently. Whilst a programme board has been established, at the end of Month 1 there was:

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- A shortfall in the cumulative target to date. Months 1 and 2 have the lowest targets.
- A shortfall in recurrent CIP delivery with only 11% of schemes being delivered recurrently.
- Whilst materially improved from plan submission, c69% of schemes are recorded as fully developed, leaving 31% in progress or opportunities. The status of the scheme percentage does not correspond with the expected FSP outturn.
- There is a significant full-year-effect of schemes from 2025/26 still to be delivered.

- The plan submission included significant risk connected to variable contract income such as elective activity. No activity data was available in advance of writing this report for Month 1 so remains a risk.

- Contract growth within the financial plan was capped at Office of National Statistics level which year-on-year has proved lower than actual growth. The contract constructs include a blended approach for activity income above base level which may result in the Trust undertaking activity for which it is not fully paid.

- Significant operating pressures and inflationary pressures remain risks in 2026/27 as they were in 2025/26. We continue to see the use of escalation capacity which is driving a cost pressure with a Critical Incident declared in June, and long periods at OPEL 4.

- The financial and operating plan was submitted based on no Industrial Action. Month 1 saw Industrial Action costs of c£0.425m and a further strike planned for 15 to 19 June 2026.

10. Recommendations

The Board is recommended to:

- **Note** the May (month 2) financial position which represents the first month of the 26/27 financial year position.
- **Note** that the reported financial position is adverse to plan by c£0.42m which is due to the unfunded costs of Industrial Action.
- **Note** the financial risks outlined in the paper.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 11.2

Title of Report: Trust Finance Report 2026-27: Part B: Month 2 Capital Position Update

Executive Director Lead: Ian Dean, Chief Finance Officer

Author and Job Title: Danielle Chapman, Deputy Finance Manager and Adam Wheeldon, Associate Director of Finance

Email Address: Danielle.chapman@nhs.net, adam.wheeldon@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☒ **Assurance** ☒ **Information** ☐

The purpose of this report is to provide an update on delivery of the 2026/27 capital programme as at 31 May 2026 (Month 2).

Consultation:

The financial position of the capital programme is reported monthly to the Trust Board and the Finance and Performance Committee. It is also reported to Trust Executive meetings. The Trust's capital position is reviewed regularly by the Capital Approvals Group, which has executive, operational and clinical representation.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☒ **People** ☐

Reputational ☐ **Legal / Regulatory** ☐

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	
Quality Impact Assessment completed?			x	
Data Protection Impact Assessment completed?			x	

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Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Whilst this report does not request a decision, the monitoring of the capital programme assists the health and wellbeing of the population by providing assurance that the highest priority investment as set out in the capital programme is being delivered.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Whilst this report does not request a decision, the monitoring of the capital programme assists the quality of services by providing assurance that the capital investment needed to ensure that services are provided is being delivered.
Sustainable and efficient use of NHS resources by RCHT	Whilst this report does not request a decision, the monitoring of the capital programme ensures that capital investment is maximised within the resources available.

Recommendations:

The Board is recommended to:

- **Note** the financial position for the capital programme for the period to 31 May 2026 (Month 2), including that the Trust does not currently have an affordable capital programme and is therefore at risk of operating outside the available Capital Departmental Expenditure Limit (CDEL) funding. A separate update report has been provided on the 2026/27 capital programme.

- **Note** the increase in risk 8521 to from High (16) to Extreme (20) linked to how an overspend could result in the breach of a statutory financial duty which could be seen as a failure to achieve a key financial metric.

- **Approve** the receipt of £323k in relation to the Women and Children's Programme Pathology scheme (11KV Cable).

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Trust Finance Report 2026-27: Part B: Month 2 Capital Position Update

Executive Summary

Key messages

- The Trust has total capital funding of £47.358m for 2026/27, comprising £25.013m of Capital Departmental Expenditure Limit (CDEL) funding and £22.345m of non-CDEL funding, excluding donations.
- At the date of this report, the Trust does not have an affordable capital programme and is therefore at risk of operating outside the funding available.
- At Month 2 (31 May 2026) CDEL spend totals £4.197m and is £1.821m behind plan; overall capital expenditure is £3.334m behind plan.
- There is currently no contingency within the capital plan; mitigations include Tower Fire VAT recovery (£0.866m), over programming (£1.043m) and reallocation of Estates Safety funding (£1.981m).
- Capital risk (risk register item 8521) has been reviewed and the score has increased from 16 (High) to 20 (Extreme) given that the failure to achieve a statutory financial duty could constitute failure to achieve a key financial metric.

Considerations for the Board

- Future review: the impact of the eCare programme delay on delivery, in-year phasing and the requirement to identify or secure any additional funding.
- Future review: whether the level and pattern of early-year slippage (overall £3.334m behind plan at Month 2) indicates broader deliverability risks, and whether rephasing assumptions remain realistic.
- Future review: the adequacy and deliverability of mitigations in the absence of contingency (Tower Fire VAT recovery £0.866m, over programming £1.043m, and reallocation of Estates Safety funding £1.981m), and any additional mitigations required.
- Future review: the governance and monitoring arrangements for 2026/27, including how the Board will track progress, manage the capital risk (risk 8521, score 20), and oversee delivery of the revised programme.

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1. Situation

This paper provides an update on delivery of the 2026/27 capital programme as at 31 May 2026 (Month 2), including the current position against CDEL and non-CDEL funding, key variances, and associated risks.

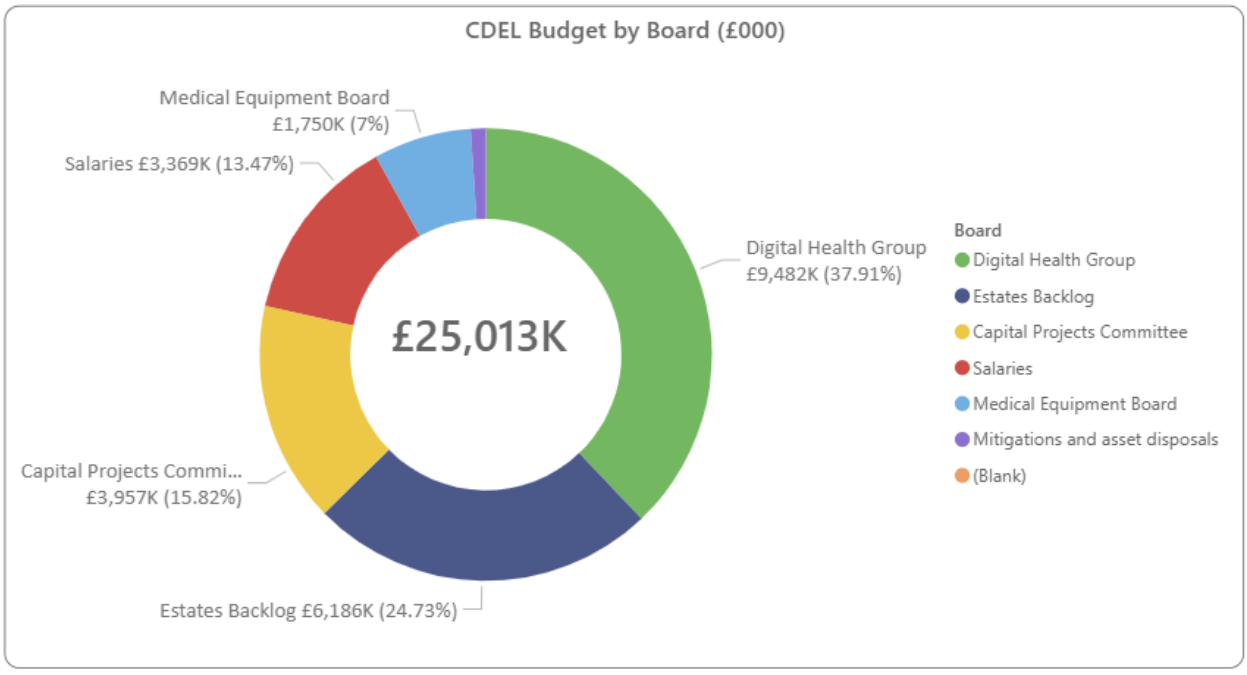
2. Introduction and CDEL funding

The Trust monitors its capital programme against the Capital Departmental Expenditure Limit (CDEL), which represents its share of the system capital envelope, and against non-CDEL funding, which comprises the estimate of Public Dividend Capital (PDC) funding to be received in the year. Donations are monitored separately.

As well as maximising the use of capital resources, the Trust has statutory requirements to operate within its Capital Resource Limit (the CDEL funding) and Cash Resource Limit. The Trust has not previously breached these requirements.

The RCHT element of the system capital envelope (CDEL) budget for the year is £25.013m. This has not changed since Month 1.

The chart below shows the split of the capital programme by capital sub-group.

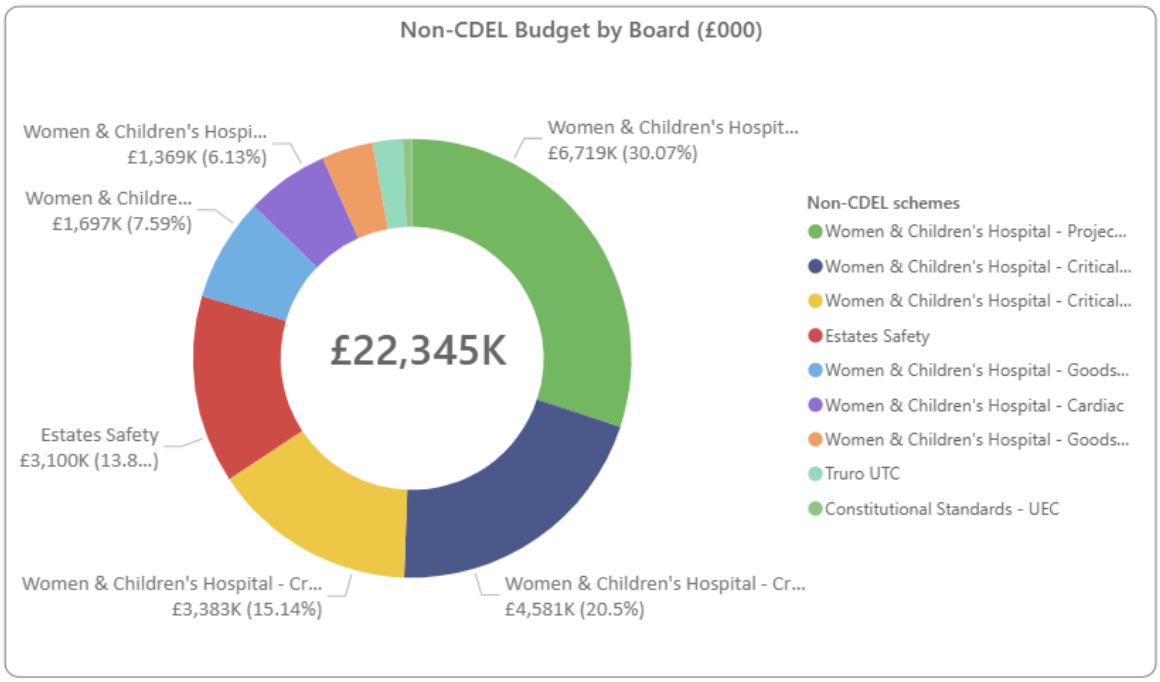


3. Non-CDEL Funding

Non-CDEL funding totals £22.345m, comprising Public Dividend Capital (PDC) funding. This has not changed since Month 1.

The total capital funding available for the year is therefore £47.358m excluding donations.

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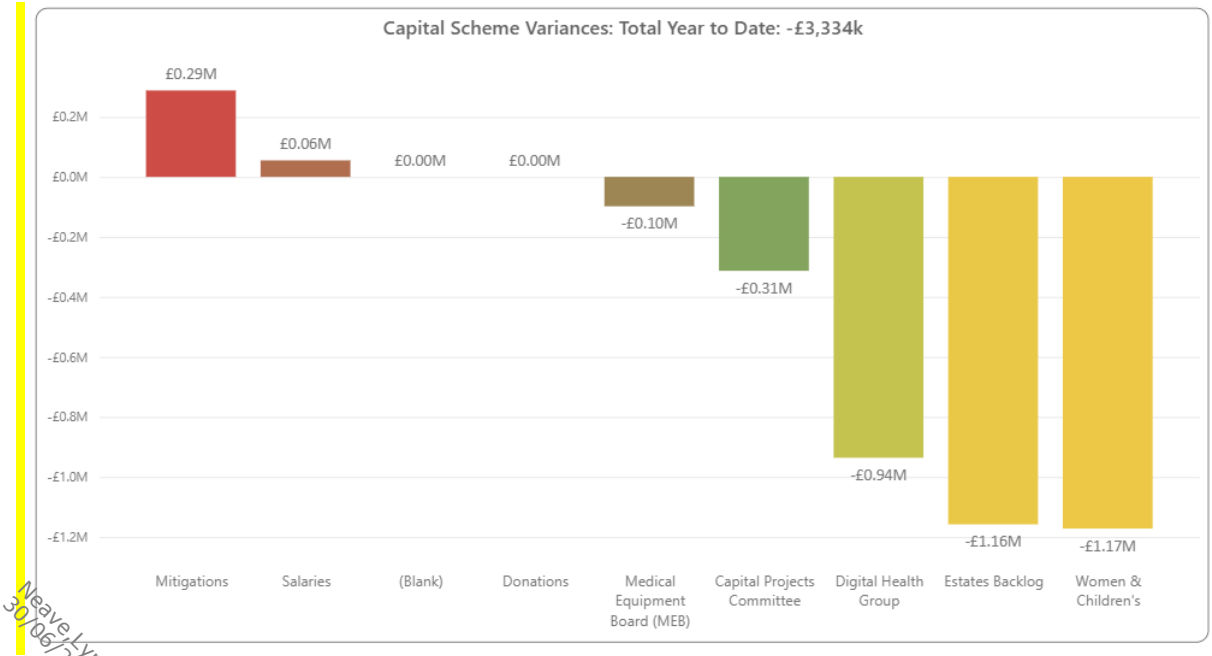
4. Year to date financial position

As at 31 May 2026, CDEL spend totals £4.197m. This is £1.821m behind plan.

As at 31 May 2026, Non-CDEL spend totals £0.782m. This is £1.513m behind plan.

As at 31 May 2026, Donations spend totals nil. This is in line with plan.

Overall, expenditure is £3.334m behind plan at the end of Month 2. The graph below shows the variance by area. Further details are set out in section 5.



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5. Key year to date variances

Women & Children's Hospital – project fees are currently £0.119m behind plan due to delays in the commencement of design works.

Estates – The Estates programme is £1.167m underspent to date. Tower Fire Phase 6 is behind plan by £0.292m and Estates Safety is behind plan by £1.046m, while some other schemes are slightly ahead of plan. The contract for the Estates Safety work has been issued and so spend will now commence on this and both schemes are expected to catch up during the year.

Capital Projects Committee – there is an underspend of £0.856m to date for this sub-group, of which £0.592m relates to Fluoroscopy Imaging Equipment replacement, Tower Imaging Rooms 5/6. The capital programme has not yet been confirmed and there will therefore be an underspend on these projects until it is confirmed whether these schemes will proceed.

Digital Health Board – there is an underspend of £0.934m to date for this sub-group, of which £0.895m relates to eCare, linked to the programme delay.

Medical Equipment Board – this programme is £0.098m behind plan.

6. Mitigations and contingency

There is currently no contingency within the capital plan. The mitigations identified for 2026/27 are set out in the table below.

Mitigation	2026/27 plan	Notes
Tower Fire VAT recovery	£0.866m	Expected to be delivered
Over programming	£1.043m	Risk. Reprioritisation of the programme will change the schemes delivered in year, making this mitigation more challenging to achieve.
Reallocation of Estates Safety funding	£1.981m	Currently on track, although delivery will depend on the reprioritisation of the capital programme.

7. Updates on capital bids for 2026/27

An update on recent capital bids is shown below:

<u>Constitutional Standards – St Michael's Hospital</u>

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The business case has been prepared and, following review by the Finance and Performance Committee, will now be submitted to NHSE for consideration once a letter of support has been sought from, and issued by, the ICB. At present, however, the scheme does not feature on the list of schemes NHSE is expecting to review.

Constitutional Standards – West Cornwall Urgent Treatment Centre

The business case is being prepared for consideration by the Finance and Performance Committee or Trust Board (depending on the final value) and then for onward submission to NHSE for approval.

The project does feature on NHSE's list of expected schemes, although at £1.625m (the original value bid for), whereas the current estimate is £3.23m. Nonetheless, the case will be submitted when ready.

Constitutional Standards – Truro UEC

The project is at a very early stage. The scope has not yet been confirmed and, whilst the Trust has been earmarked £0.15m to develop the scheme in 2026/27, the Trust would first need to have the project approved in principle and then apply for funding. The Trust is waiting for NHSE approval to progress to the next stage of the project.

8. Forward planning

The updated 2026/27 capital programme was considered by Trust Board in June 2026. Due to the additional costs linked to the eCare project, programme costs exceeded the funding available. This remains the case, and a separate update has been provided to the Board.

9. Risks

Capital risk is monitored through risk 8521 on the Trust's risk register. This risk focuses on the delivery of the capital programme and any potential overspend. Separate risks are managed within divisions and departments on the consequences of not being able to invest.

The risk score increased from 12 to 16 in Month 1 following the need to identify additional funding linked to the eCare programme.

A balanced programme with potential mitigations is being presented to Board in Private in a separate report.

Risk 8521 has been reviewed and the score has been increased further to 20 because an overspend could result in the breach of a statutory duty and be classified as a key metric not being achieved. The impact has therefore been classified as Catastrophic. The current classification is therefore:

- Likelihood – Will probably happen / recur but it is not a persisting issue – 4
- Consequence – Catastrophic - 5

Service managers are responsible for monitoring risks associated with a lack of capital funding in separate risks on Datix. As risk scores increase, these risks are escalated by the Risk Manager in line with the Trust's overall risk management process. Risk 8521 does not capture the consequences of all capital related risks for the Trust.

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10. Public Dividend Capital

Section 18 of the Trust's Standing Orders requires the Chief Finance Officer to advise the Trust on any proposed new borrowing.

The table at ***Appendix 1*** shows the PDC to be received in year and totals £22.345m from a capital perspective.

In month the Trust received confirmation of £323k of PDC for the Women and Children's Programme Pathology scheme to relocate a 11KV power cable under the Link Corridor. The Trust Board is asked to approve the receipt of this.

Public Dividend Capital is not required to be repaid although the Trust can choose to repay it. In simple terms PDC is interest bearing at a rate of 3.5% per year on the average balance between the start and the end of the year (i.e. 1.75% in the first year of receipt). The PDC interest cost for the first full year will be c£0.4m. This has been reflected in the financial plan for 2026/27.

11. Accountability

The accountable director for this report is the Chief Finance Officer. Updates are provided to the Board each month.

12. Recommendations

The Board is recommended to:

- **Note** the financial position for the capital programme for the period to 31 May 2026 (Month 2), including that the Trust does not currently have an affordable capital programme and is therefore at risk of operating outside the available Capital Departmental Expenditure Limit (CDEL) funding. A separate update report has been provided on the 2026/27 capital programme.

- **Note** the increase in risk 8521 to from High (16) to Extreme (20) linked to how an overspend could result in the breach of a statutory financial duty which could be seen as a failure to achieve a key financial metric.

- **Approve** the receipt of £323k in relation to the Women and Children's Programme Pathology scheme (11KV Cable).

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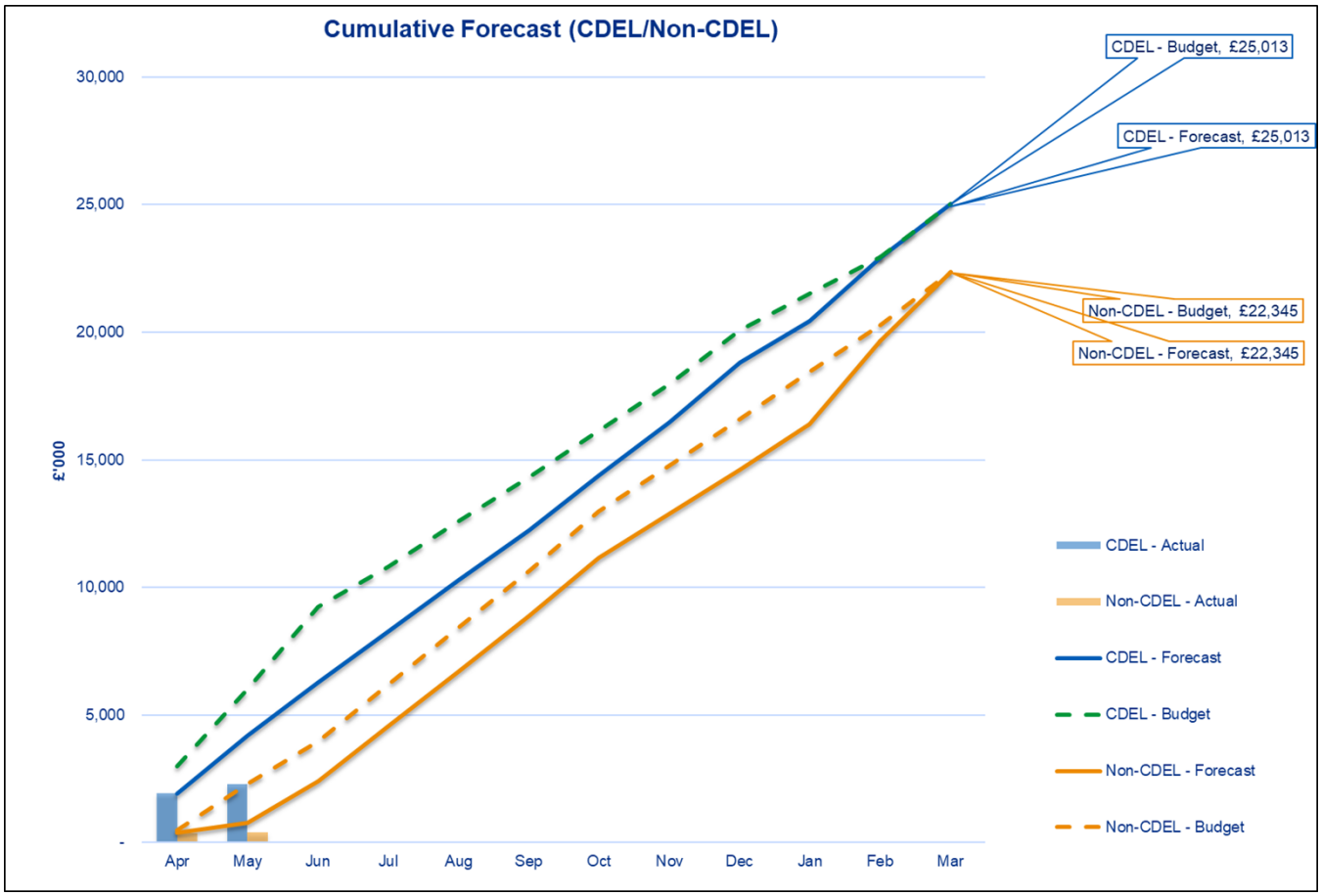
Appendix 1 – Public Dividend Capital

Project	PDC value expected 26/27 (£000)	PDC interest in 26/27	Approval route for borrowing
Women & Children's Hospital - Cardiac	1,369	24	
Women & Children's Hospital - Critical Infrastructure Phase 1	4,581	80	
Women & Children's Hospital - Critical Infrastructure Phase 2	3,383	59	
Women & Children's Hospital - Project Fees	6,719	118	
Women & Children's Hospital - Goods In Onsite	846	15	
Women & Children's Hospital - Goods In Offsite	1,697	30	
Truro UTC	500	9	
Constitutional Standards - UEC	150	3	
Estates Safety	3,100	54	
Total Non-CDEL spend	**22,345**		
Total PDC funding	**22,345**	**391**	
Donations			
Total Non-CDEL funding - Capital	**22,345**		

PDC interest for the first full year based on values above		**782**	

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Appendix 2 – Monthly plan, actual and forecast



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NHS

Royal Cornwall Hospitals
NHS Trust

Medium Term Financial Plan

2027/28 to 2031/32

Outstanding Care for **One+All**

Medium Term Financial Plan (MTFP) (baseline year 2026/27; Year 1 to Year 5: 2027/28 to 2031/32)

A plain-English summary of how we will balance our day-to-day finances and invest in services over the next five years (published May 2026).

This summary sets out our medium-term financial plan (MTFP). It uses 2026/27 as the baseline year (year 0) and explains our plan for years 1 to 5 (2027/28 to 2031/32). It describes the scale of the financial challenge, the key assumptions we have used, and the main actions needed to deliver a balanced position each year.

Who this is for: members of the public, patients, partners and staff who want to understand our financial plans in a straightforward way.

What this summary covers: our day-to-day (revenue) finances and our planned investment (capital) over the medium term. Like all medium-term plans, it is based on assumptions about funding, inflation and demand, and it will be updated as national guidance and local circumstances change.

Contents

1. Executive summary
2. Our financial plan (2026/27 to 2031/32)
3. Our services and the environment we operate in
4. Where our money comes from and what we spend it on
5. Savings: the scale of the challenge and how we will deliver
6. Workforce and productivity
7. Capital investment plan and affordability
8. Risks, uncertainties and scenarios
9. Governance, monitoring and transparency
Appendix A: Key assumptions (more detail)
Appendix B: Glossary

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1. Our financial plan (2026/27 to 2031/32)

This Medium-Term Financial Plan (MTFP) describes how we intend to deliver financially sustainable services between 2026/27 and 2031/32. It brings together our annual financial plan for 2026/27, our assumptions about funding and cost pressures, and the scale of savings required to achieve a balanced position each year.

This MTFP is one of the key enabling plans that supports delivery of our Trust Strategy and our vision of **Outstanding Care for One and All**.

In the detailed MTFP model, 2026/27 is treated as **year 0** (the baseline). **Year 1** of the plan is 2027/28, and the five-year period runs from 2027/28 to 2031/32.

Our starting point (2026/27 plan)	Breakeven plan, deliverable if we achieve **£42.5m** of savings
Savings needed in the next two years	**£33.7m** (2027/28) and **£24.3m** (2028/29), supporting a planned **£1,000 surplus** in each year (rounded)
Total additional savings (2027/28–2029/30)	About **c£73m** over years 1 to 3 (2027/28 to 2029/30), assuming **75%** of savings are recurrent each year
Potential workforce impact	A net change in workforce of c89 whole time equivalents (WTE) across 2026/27 to 2031/32.
Capital investment (10-year view)	Indicative programme of about **£627m** over 10 years, peaking around **£111m** in 2031/32 (driven mainly by the New Women & Children's Hospital)
Long-term financial position	Underlying position improves from about **£61m deficit** (31 March 2026) to about **£28m deficit** (31 March 2032), and the Trust meets its statutory cumulative breakeven duty by the end of the MTFP period

Overall, our plan shows a breakeven position in 2026/27 and very small, planned surpluses in the following years. To achieve this, we need to deliver large savings, especially in 2027/28. This is why our focus is on recurring productivity improvements rather than short-term, one-off actions.

The savings required are significant although the Trust has an excellent track record of delivering its budget and has delivered a breakeven or surplus every year since 2019-20.

Rachel Lynsey
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1.2 Our financial plan (high level)

The table below summarises the plan at a high level. Figures are shown in £m and rounded.

Financial year	Operating income	Operating expenditure	Planned retained surplus	Savings included in plan
2026/27	£735.9m	£733.5m	£0.0m	£42.5m
2027/28	£755.3m	£752.3m	£0.0m (rounded; c£0.001m)	£33.7m
2028/29	£772.3m	£768.3m	£0.0m (rounded; c£0.001m)	£24.3m
2029/30	£788.6m	£782.1m	£2.6m	£15.4m
2030/31	£805.2m	£794.6m	£6.8m	£15.7m
2031/32	£822.2m	£807.7m	£10.3m	£15.9m

1.3 What is a medium-term financial plan?

An MTFP is our best view, at a point in time, of the income we expect to receive and the costs we expect to incur over the next few years. It helps us understand what we need to do to live within the resources available and to plan improvements and investment in services.

A note on the numbers: in some places we refer to the *reported* position (the figure that would appear in our accounts) and the *underlying* position (which adjusts for one-off items such as non-recurrent income or savings). The underlying position is important because it indicates whether our finances are becoming sustainable over time.

Hayley Lynsey
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1.4 Questions people often ask

Does this plan mean services will change? The plan sets the overall financial envelope. Specific service changes (where needed) are developed through clinical, operational and public engagement processes and follow the Trust's governance arrangements.

Why do we talk about "recurrent" savings? One-off savings can help in a single year but do not fix the underlying cost base. Recurrent savings are important because they carry forward and reduce the size of the challenge in future years.

Why plan for a surplus at all? A small surplus provides resilience against in-year pressures and supports the requirement to achieve cumulative breakeven over time. It also reduces the need for short-term measures that can store up problems for later years.

How certain is the plan? The plan is a best estimate based on current guidance. Key areas of uncertainty include national funding decisions, pay awards, inflation and demand levels. We update the MTFP as assumptions change and as delivery plans become clearer.

1.5 Why this matters

- Nationally, NHS organisations are expected to plan for a **break-even or surplus** position each year and to deliver at least **2% annual efficiency** (productivity improvement).
- For our Trust, this means delivering significant recurring savings while continuing to meet quality and access standards.
- We also have a statutory duty to achieve cumulative breakeven over time. Based on the assumptions in this MTFP, we would meet that duty by the end of the planning period.

1.6 How this links to our Trust Strategy (2026–2035)

This means: the MTFP is not a clinical strategy on its own, but it sets the financial envelope and savings requirements that enable delivery of our Trust Strategy, including investment in digital, capital infrastructure, and workforce capability.

Key enabling plans: our Trust Strategy is supported by a set of linked plans and programmes. Alongside this MTFP, the key enablers include:

- The **Medium Term Workforce Plan (MTWP)** and wider people plan
- Our **digital programme** (including the electronic patient record, **eCare**)
- Our **capital and estates plans** (including the clinical site strategy and major business cases)
- Our **quality and safety approach** and how we manage and reduce risk
- Our **Financial Sustainability Programme (FSP)**, which develops and delivers the detailed savings schemes
- Our **Green Plan** and work to improve environmental sustainability

Neave Lyndsey
30/06/2026 09:31:26

Trust Strategy objective	How the MTFP supports it (examples)
Safe, high-quality care	Protects resources needed for safe staffing and core clinical services, and prioritises investment that improves safety and effectiveness (for example, digital records and essential estates maintenance).
Supported and valued people	Links the savings requirement to workforce planning, productivity and reduced reliance on premium staffing, while supporting investment in tools that reduce duplication and time spent on administration.
Improving together	Provides the financial discipline and governance to deliver recurrent savings through better flow, reduced variation, and operational improvement, so gains are sustained and can be reinvested.
Partnering with purpose	Reflects ICB-wide assumptions (for example, support funding and activity growth), and supports joint work on productivity, workforce, and capital planning across ICB partners.

In the next section, we explain the wider environment we operate in and the national requirements that shape our plan.

2. Our services and the environment we operate in

2.1 Overview

We provide a wide range of acute hospital services. Like other NHS organisations, we are managing rising demand, workforce pressures and increasing costs, while working to improve access, safety and quality of care.

National planning guidance requires organisations to deliver productivity improvement (at least 2% per year) and reduce reliance on one-off measures. Our MTFP therefore focuses on making our cost base more sustainable over time, while supporting priority investments that improve care and efficiency.

2.2 Financial pressures and national requirements

Maeve Lukey 2026/06/22 16:31:26

Our costs are driven by the workforce we need to provide safe services, the volume and complexity of patient care, and the price of supplies, drugs, utilities and contracts. These pressures can change quickly, so medium-term plans must be actively managed and regularly refreshed.

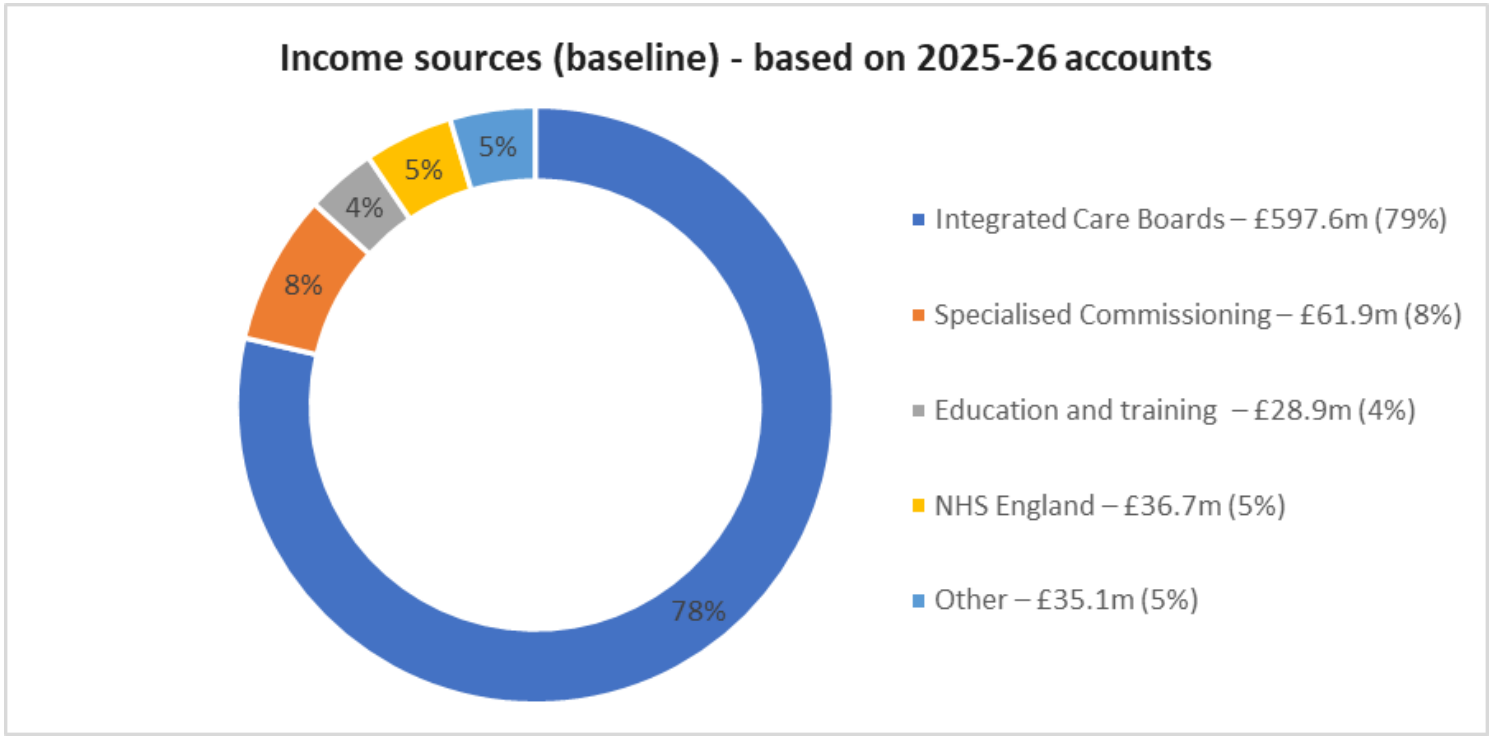
Nationally, the NHS expects organisations to deliver ongoing productivity improvements. In practice, this means reducing avoidable cost, improving how we use capacity, and making sure savings are sustainable (recurrent) rather than relying on short-term measures.

The chart below shows the type of additional costs the Trust will need to meet in the first year of the MTFP.

3. Where our money comes from and what we spend it on

3.1 Income (high level)

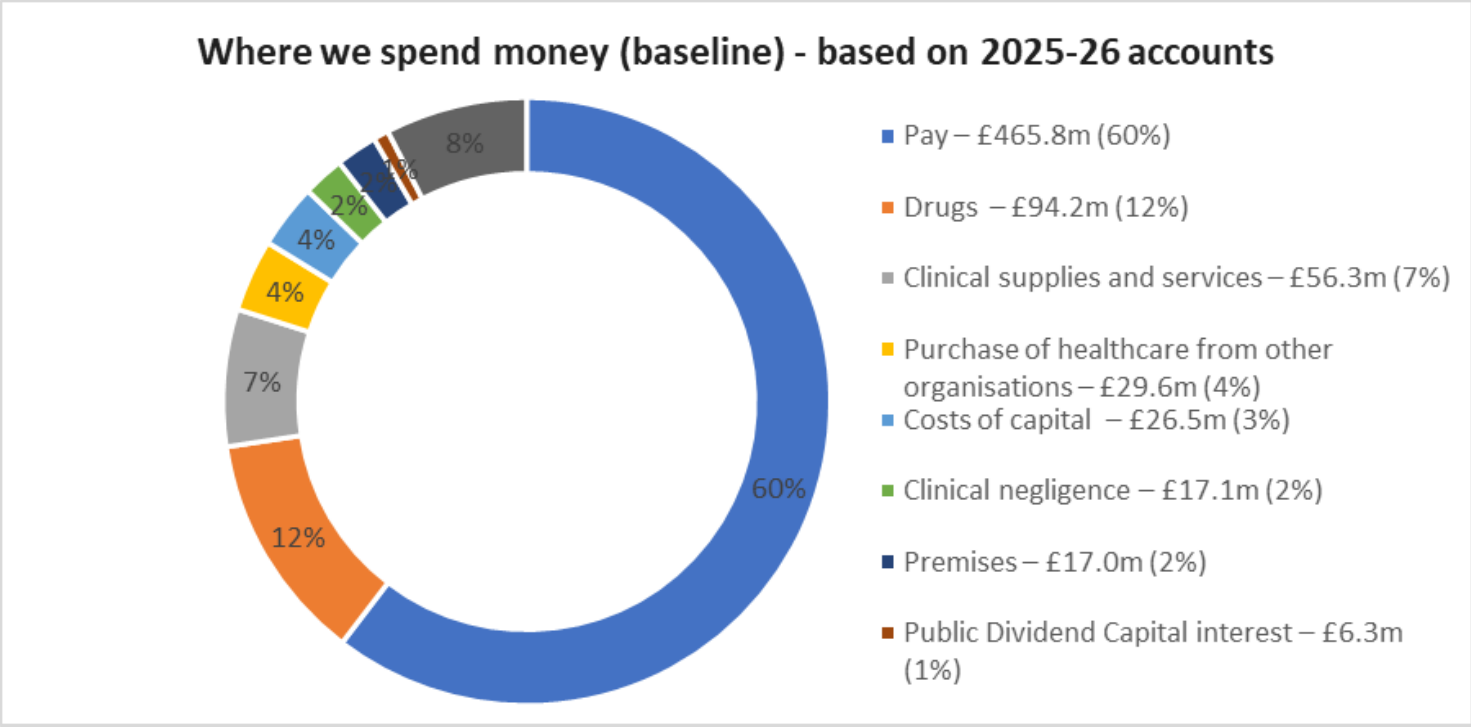
- Most of our funding comes from NHS commissioners to provide services to patients.
- We may also receive specific funding for nationally-set priorities and, in some years, ICB support funding to help manage financial pressures.



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3.2 Expenditure (high level)

- **Pay:** staff costs are our largest area of spending.
- **Non-pay:** clinical supplies, drugs, contracts, utilities and running costs.
- **Premises costs:** running our buildings including energy and water costs.
- **Digital:** investment in systems such as electronic patient records to improve safety, information sharing and productivity.



3.3 What this means in practice

The relationship between activity, income and cost is not straightforward. In some cases, providing more care brings additional income; in other cases, income is fixed or only partially linked to activity. At the same time, increased activity usually requires additional staffing and supplies. This is why productivity (getting more value from the same resources) is central to the plan.

3.4 What changes year by year (summary)

What changes each year: the plan includes different savings requirements and planned surpluses over time. The summaries below highlight what changes year by year.

2027/28: This is the most challenging year in the current plan, with £33.7m of savings included to maintain a balanced position.

2028/29: The plan includes £24.3m of savings. The emphasis remains on making savings recurrent and reducing reliance on one-off measures.

2029/30: The plan includes £15.4m of savings and a planned retained surplus of £2.6m, reflecting ongoing cost pressures and the need to continue productivity improvement.

2030/31: The plan includes £15.7m of savings and a planned retained surplus of £6.8m.

2031/32: The plan includes £15.9m of savings and a planned retained surplus of £10.3m.

3.5 Reported and underlying position

A key part of understanding financial sustainability is distinguishing between the *reported* position and the *underlying* position. The reported position reflects all income and expenditure in-year, including support funding and any one-off items.

The underlying position adjusts for items that do not repeat every year (for example, non-recurrent income or one-off savings). In this plan, ICB support income of **£28.9m** per year is treated as non-recurrent when describing the underlying position. On current assumptions, our underlying deficit improves over time and the Trust meets cumulative breakeven by the end of the MTFP period, which is why delivering recurrent savings and reviewing assumptions each year is so important.

4. Savings: the scale of the challenge and how we will deliver

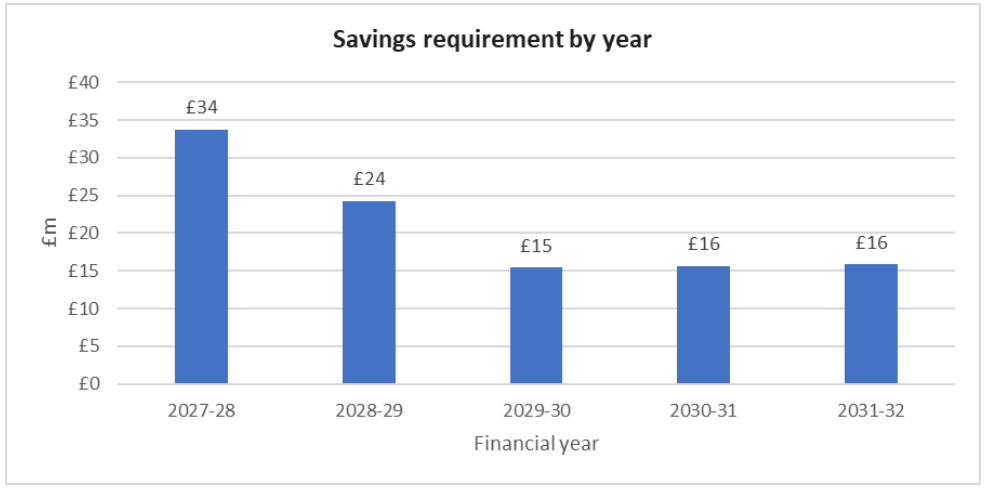
4.1 What drives the savings requirement?

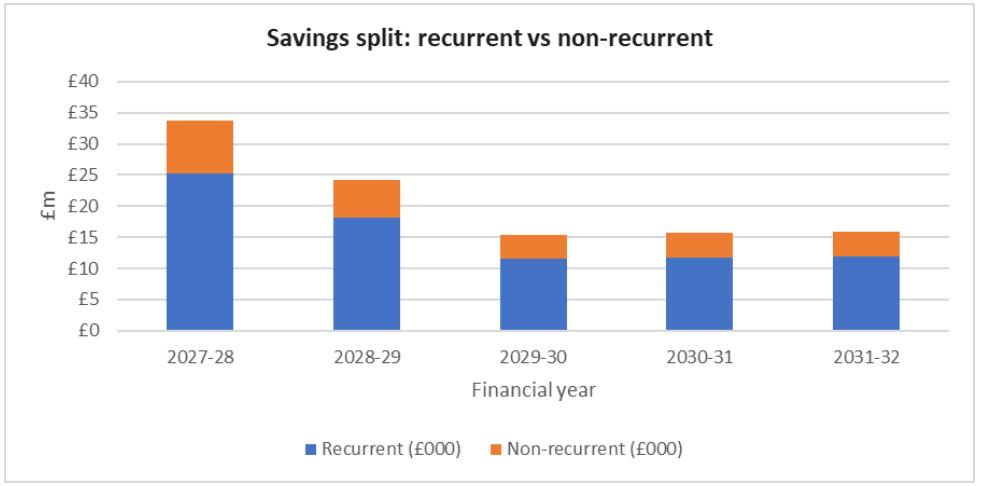
The plan assumes a balanced (or small surplus) position each year. Because costs (pay, supplies and contracts) tend to rise faster than funding, we need to deliver savings every year. We also assume that **75%** of savings in each year are **recurrent** (they continue into future years). The less recurrent savings we deliver, the bigger the challenge becomes in later years.

Neil Hussey
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4.2 Recurrent and non-recurrent savings (an example)

If we permanently change a process so that it costs less every month (for example, by reducing duplication or improving rostering), the saving repeats every year—this is recurrent. If we take an action that helps once (for example, delaying expenditure into the next year), the saving does not repeat—this is non-recurrent. Both can be used, but over-reliance on non-recurrent savings increases the scale of the challenge later.





Note that this is our target. The development of savings plans is reported to the Finance and Performance Committee regularly.

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4.3 How we expect to deliver savings

Savings schemes are developed and delivered through our Financial Sustainability Programme (FSP). The detailed schemes change over time, but typically fall into the themes below.

- **Productivity and flow:** improving patient flow, reducing delays, and using capacity more effectively.
- **Workforce and rostering:** better matching staffing to demand, reducing premium pay, and improving retention.
- **Clinical variation and pathway improvement:** standardising where appropriate to reduce unwarranted variation.
- **Procurement and contract optimisation:** getting best value from supplies and contracted services.
- **Estates and energy:** reducing avoidable running costs and improving utilisation of space.
- **Digital enablement:** using systems (including eCare) to reduce duplication and improve time spent on direct care.

4.4 Governance and assurance

Savings schemes are developed through established internal governance so that financial benefits, operational feasibility and quality impacts are considered together. Delivery is tracked through regular reporting, with clear accountability for each scheme and escalation where delivery is at risk.

4.5 Timescales and decision-making

To avoid late-year pressure, savings need to be identified early, with deliverability tested and implementation support in place. The profile of savings delivery through the year (and the balance of recurrent and non-recurrent actions) is monitored so that corrective actions can be taken in time.

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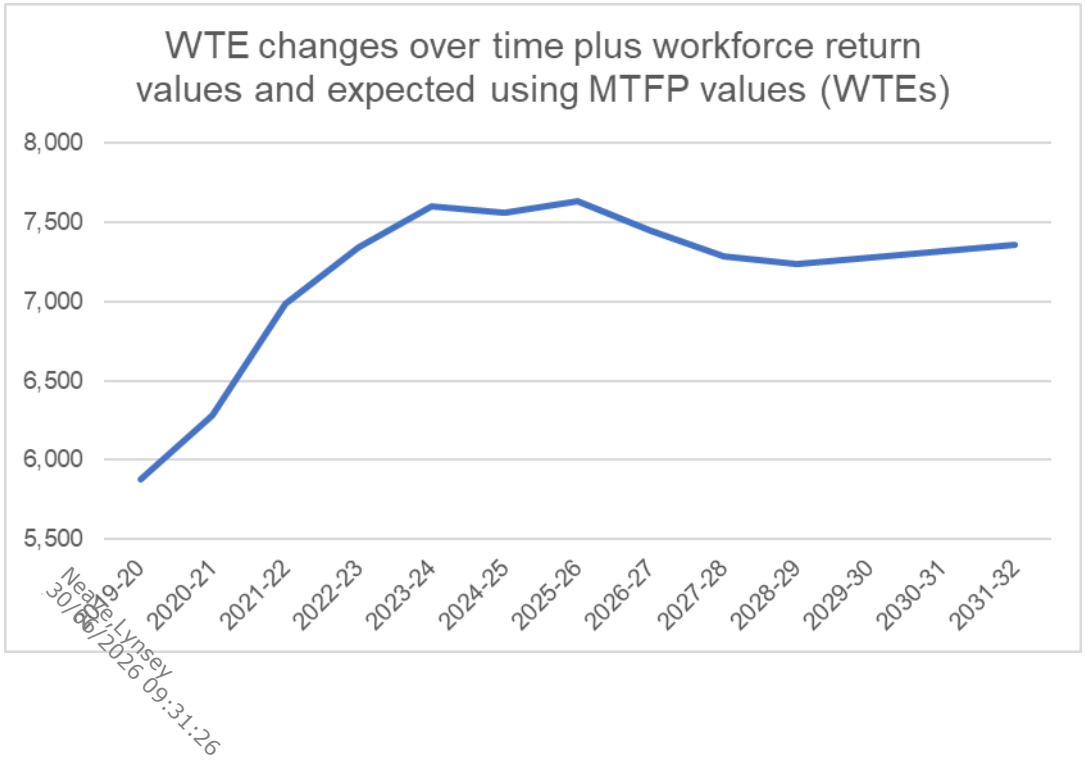
5. Workforce and productivity

A significant proportion of our costs relate to our staff. This means that, when we describe the scale of the savings challenge, we also need to be open about the potential workforce implications.

Earlier in this document we show illustrative savings values. Based on the proportion of pay related spend, if these savings were expressed as whole time equivalents (WTE) the change would be between 345 WTEs (2027/28) and 163 WTEs (2031/32). This is a way of showing the *order of magnitude* of change that would be needed if savings were delivered mainly through pay cost reductions.

However, the plan also includes workforce impacts linked to activity and service changes. When these are taken into account, the modelling shows a much smaller net change (around **89 WTE**) across 2026/27 to 2031/32.

These WTE figures are modelling outputs to help explain the plan; they are not a set of decisions about individual roles, teams or services. The actual workforce impact will depend on the detailed savings schemes developed through the **Financial Sustainability Programme (FSP)** and how they are delivered (for example, through productivity, reduced premium staffing and changes to processes). The **Medium Term Workforce Plan (MTWP)** will be updated alongside the MTFP as the detailed schemes become clearer.

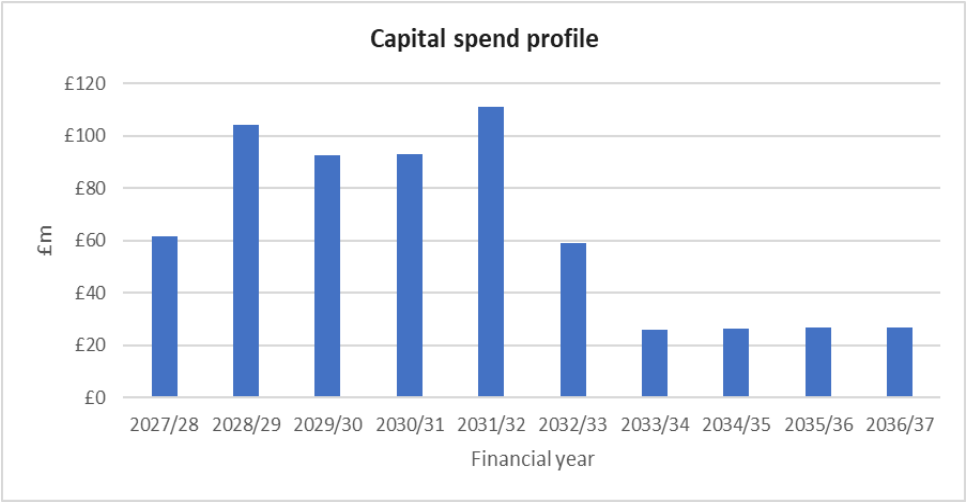


6. Capital investment plan and affordability

6.1 Overview of the programme

Alongside balancing our day-to-day budget, we must also maintain and improve our buildings, equipment and digital infrastructure. Over the next 10 years, our indicative capital programme totals around **£627m**, with the largest component being the Women & Children's Hospital.

10-year capital programme (indicative)	**Value**
Internal funding (CDEL-funded schemes)	c**£250m**
Non-CDEL (Public Dividend Capital funded schemes)	c**£377m**
Total	**c£627m**
Peak annual spend (currently modelled)	c**£111m** in 2031/32



CDEL – this stands for Capital Departmental Expenditure Limit. It is how we describe the main internal funding for the capital programme. We sometimes receive additional funding which is referred to as Non-CDEL funding.

Why capital affects revenue: new assets increase our running costs through *depreciation* (spreading the cost of an asset over its useful life) and *Public Dividend Capital (PDC) interest* (the cost of financing major investments). Across the 10-year programme, depreciation and PDC interest combined are expected to increase by around **£14.7m** between year 0 and year 10. This is why affordability and benefits are central to business cases.

Over the MTFP period the higher value investments would be the Women and Children's Hospital (c£370m in the current MTFP), Estates improvements (£184m), high value medical equipment replacement (£82m) and Digital developments (£32m).

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6.2 Affordability and ongoing running costs

Capital investment decisions must consider not only the upfront spend, but also the ongoing running costs that follow. These costs must be funded from our day-to-day revenue position, so affordability is assessed alongside the savings required to balance the plan.

7. Risks, uncertainties and scenarios

7.1 Key risks and uncertainties

- **Deliverability of savings:** the required savings levels remain very high, particularly in 2027/28. Achieving them will require sustained, organisation-wide change. Delivery is dependent on detailed schemes developed through the Financial Sustainability Programme (FSP), which is still at an early stage for 2027/28.
- **How much of the savings are recurrent:** if we rely too heavily on one-off measures, the savings requirement increases in later years.
- **ICB support funding:** the plan assumes £28.9m of support each year which is non-recurrent income which improves the financial position of the Trust. If this reduces, the reported financial position would worsen.
- **Demand and income assumptions:** if activity and income are lower than modelled, the savings requirement could increase.
- **Income and demand assumptions (including a '25% margin'):** the model assumes that for each extra **£1** of income from activity growth, costs rise by about **75p** (a 25% margin). If activity is lower than modelled, or if extra activity has to be delivered at lower/no margin (for example through outsourcing), the savings requirement could increase.
- **Workforce alignment:** the current medium-term workforce plan does not yet fully reflect the workforce changes implied by the financial plan.
- **Capital affordability:** major investments increase running costs (depreciation and PDC interest) and must be affordable alongside day-to-day budgets.

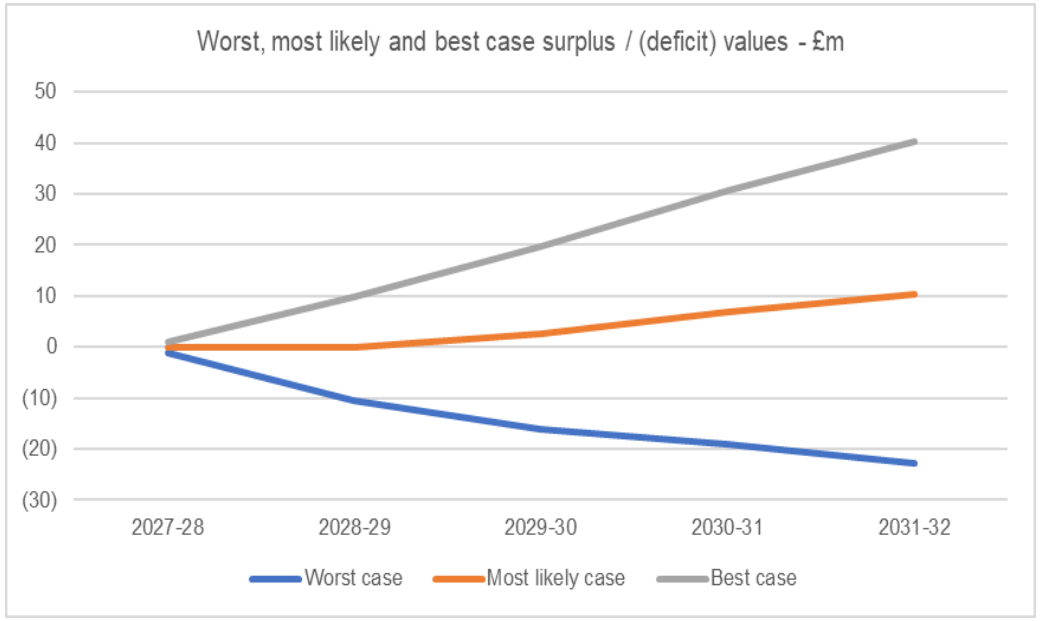
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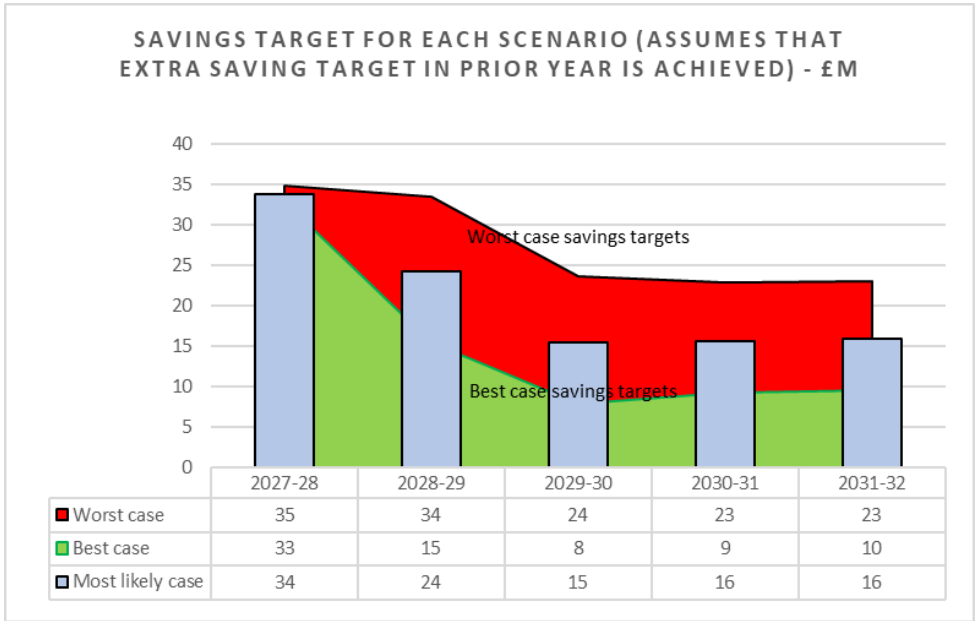
7.2 Scenarios and sensitivity

Because the MTFP is based on assumptions, it is helpful to test how the plan would change if those assumptions moved. Common sensitivities include changes to pay awards, inflation, demand/activity, and the level of non-recurrent support funding.

The chart below shows the impact of higher and lower costs and savings delivery on the reported position. In the best-case scenario, the Trust would start to report a surplus in Year 1. In the worst-case scenario, the deficit would increase and reach c£23m in Year 5.

If the sensitivity analysis was used to determine upper and lower levels of savings required, based on the savings set in each year being achieved, the savings target levels are shown below. These would average £28m per year. In the best-case scenario, they would drop to a much more deliverable average of £15m.



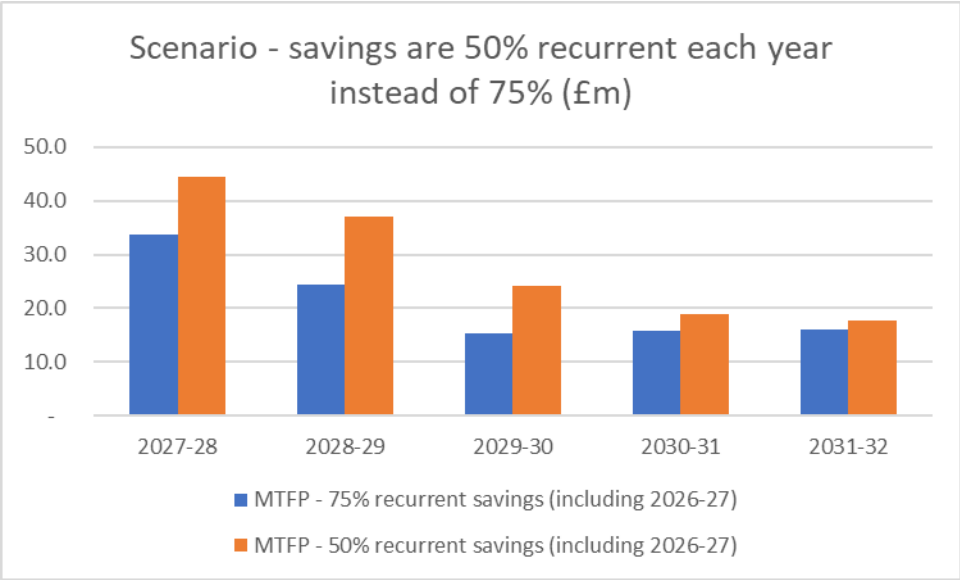


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A key assumption is the level of recurrent savings each year.

The MTFP assumes that 75% of savings are delivered each year, including in 2026/27. However, the level of savings delivered historically is generally lower.

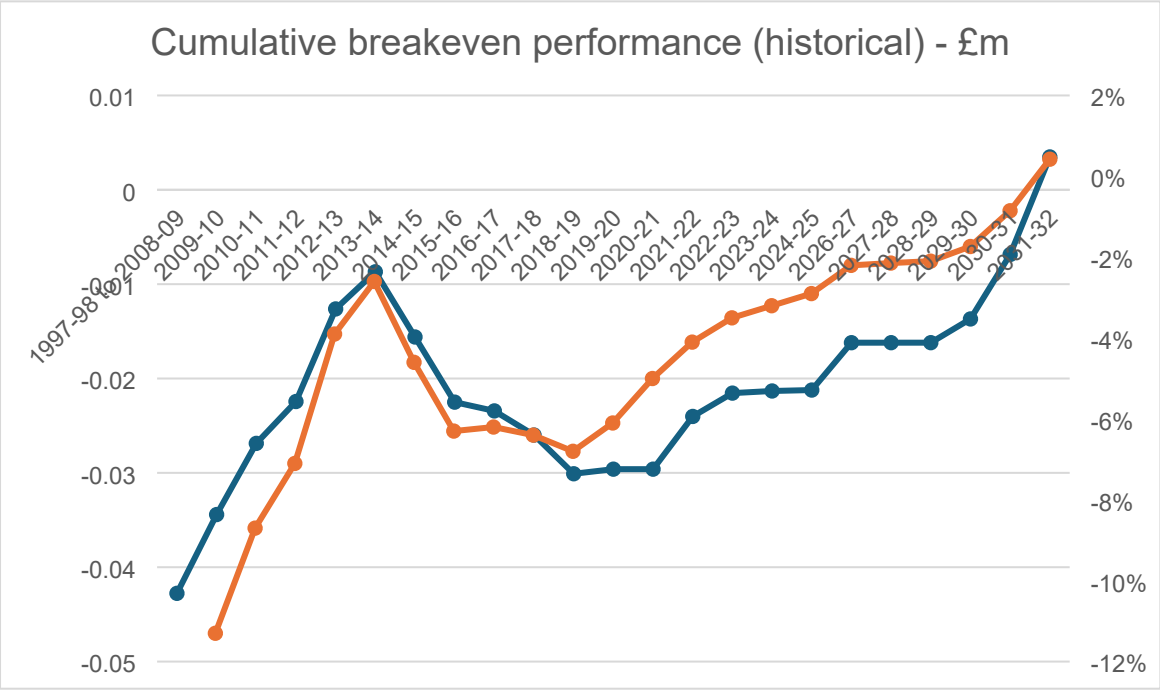
The chart below shows how the level of savings target would differ if 50% of savings were recurrent but that the overall target of a £1,000 surplus was retained. The savings target would be higher each year as the start point for each year would include the need to make good the non-recurrent savings from the previous year.



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7.3 Cumulative breakeven

Cumulative breakeven is a statutory requirement to balance our results over time, not just in a single year. Even if we plan for breakeven or small surpluses each year, one-off items (such as non-recurrent support funding) can affect the underlying position in any given year. Based on the assumptions in this MTFP, the underlying deficit reduces over the period and the Trust meets its cumulative breakeven duty by the end of 2031/32.



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8. Governance, monitoring and transparency

8.1 Monitoring and reporting

Progress against the annual financial plan and savings delivery is monitored through regular financial reporting and governance, including oversight through the Finance and Performance Committee. The MTFP will be refreshed to reflect the latest in-year forecast and any changes to national planning assumptions; the next planned update is **December 2026**.

Monitoring focuses on: (1) the in-year forecast position, (2) delivery of savings and the balance between recurrent and non-recurrent actions, and (3) delivery of key enabling programmes such as digital and capital investment. Where risks emerge, plans are updated and actions are agreed through governance.

8.2 Transparency and keeping this document up to date

We aim to present financial information in plain English and to be transparent about the assumptions and uncertainties in the plan. This document will be updated when the MTFP is refreshed; each published version should clearly state the publication date and the key changes since the previous version.

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Appendix A: Key assumptions (more detail)

Assumption	What we have assumed in this version of the plan	Why it matters
Financial target	Break-even / small surplus (rounded; c£0.001m), moving to small surpluses in later years	Sets the required level of savings and resilience
Savings recurrence	75% of savings are recurrent	Determines how the challenge carries forward into future years
Tariff	0% net uplift each year	Affects how income changes year-to-year
Activity growth	2.9% (2027/28), 3.16% (2028/29), then 2.18% per year. Please note that population modelling is considered as part of the MTFP development although the actual activity growth is an NHS assumption.	Affects income and the cost of meeting demand
Pay inflation	2.3% (2027/28) then 2.1% per year	Pay is the largest cost driver
Non-pay inflation	2.0% per year (0.7% for drugs)	Affects supplies, utilities and contracts
Agency	Reduces to nil by 2029	Impacts workforce cost and productivity assumptions
ICB support income	£28.9m per year (treated as non-recurrent for underlying position)	Impacts reported vs underlying sustainability

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Appendix B: Glossary

- **MTFP:** Medium-Term Financial Plan.
- **WTE:** Whole Time Equivalent (a way of measuring staffing based on full-time hours).
- **Recurrent / non-recurrent:** recurrent continues year-to-year; non-recurrent is one-off.
- **Underlying position:** the financial position after adjusting for one-off items to show sustainability.
- **PDC:** Public Dividend Capital, a form of government financing used for major NHS investment.
- **Depreciation:** the annual accounting charge reflecting use of an asset over its life.

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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 12

Title of Report: People and Culture Committee Assurance Report to the Board – May 2026 meeting

Committee Chair: Richard Kramer, Non-Executive Director

Author and Job Title: Company Secretary

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

The purpose of this report is to present a summary of decisions made and assurance sought by People and Culture Committee on behalf of the Board of Directors at its recent meetings.

Key agenda items and decisions/actions taken on behalf of the Board

The Committee recommended the Trust Board receive and/or approve:

- There were not matters approved by the Commtitee / recommended for Board approval.

Issues for escalation or notification to the Trust Board

- Matters to escalate to the Board included;
  - sickness absence and the deep dive requested;
  - staff survey and the pace required;
  - positive assurance regarding sexual safety;
  - the need to secure appropriate resources for OD, culture and occupational health.

Summary of assurance and risk

Received an update on the development of a business case for service investment for **Occupational Health.**

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Dual Chief People Officer's Report highlighted national and local matters including HR system transformation and the new ESR HR system and new national standards and leadership competencies. Committee members sought assurance regarding the impact of these new competencies and ensuring this was fully understand with mechanisms to monitor.

Discussed the local people metrics i.e. staff experience, staff safety and the potential impact on national oversight framework. Noted the link with the refreshed IPR and the Committee sought assurance on the alignment of people and culture metrics. Committee members raised concerns regarding the trajectory on Oliver McGowan training and requested greater assurance / detail in future reports noting the importance and the value of Oliver McGowan training.

Committee members noted the National patient experience director role expected – noting the link with patient experience and staff health and wellbeing.

The **Integrated Performance Report (IPR)** highlighted:

- Overall sickness absence reducing (4.52%) - suggested undertaking a deep dive into sickness absence;
- Stress related sickness absence increased to 30%;
- Both appraisal and training compliance are below lower control limits; appraisal reduced from 64.5% to 62.8%.

The Committee critically evaluated the data, focusing on current actions, desired outcomes, implemented controls, and their monitoring processes. While the newly established Divisional performance meeting structure facilitates a more in-depth examination of these matters, the Committee specifically requested a comprehensive review of sickness absence including stress related absence to be presented at the July Committee meeting.

Discussed workforce fatigue and requested further detail in the bi-monthly workforce report. Noted due to the e-Care go-live delay, further consideration would be necessary regarding utilising the time to improve statutory and mandatory training and appraisal.

Workforce bi-monthly report workforce levels remain above plan and substantive recruitment had improved but there remains over reliance on temporary staffing; there was continued focus on improving compliance. With regard to staff exit interviews, noted in-house solution being developed to collate information - the Committee requested the information was presented to July Committee and quarterly thereafter.

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Staff Survey discussed the focus on the three key areas (appraisal, raising concerns and health and safety climate) agreed by the Board in May 2026 and that the action plan was being developed to drive change, targeted interventions and

evidence / demonstrate improvement. The Committee supported the three priorities, moves towards divisional ownership and links to the wider culture agenda. Committee gave challenge to the lack of pace, the need for demonstrable change over the next few months and ahead of the next staff survey and suggested short, medium- and longer-term solutions. Noted Divisions are working through their local action plans in May. The Committee requested assurance on stepped change and embedding the “you said – we did” approach so that we are actively responding to ideas and concerns, and regular pulse checks to show progress. We talked about the links with the culture work and the importance of strengthening manager capability to deliver meaningful appraisals and to ensure staff feel supported and able to speak up.

With regard to **Culture transformation** received a progress update on the culture transformation programme, including the establishment of oversight and working groups, divisional engagement, leadership development, and resource requirements, with Committee discussion on implementation and support Discussed the resource to support the programme and the internal governance to oversee the work.

The Committee requested more information and assurance around implementation. Further sought assurance on the development of key milestones, and KPIs and what success looks like which would be presented to the next meeting. Requested further commentary on some of the activities, that are taking place and how they are being received, and learned learned.

Received a summary on the ongoing **Organisational Development;** noted the current position and the alignment to the culture programme and confirmed that a roadmap would be developed noting a range of activities taking place. The Committee sought clarity and assurance on what the Trust priorities are and that further information on the roadmap will be progressed.

Received an update on the **Organisational change** process, noting the mechanisms of engagement with staff, the process around the right to appeal and the ongoing work trials taking place. The Committee noted the process was ongoing as such a lessons learned would be undertaken once the change process had concluded. Recognised the challenges for those involved in the process.

Received an update on the **face to face training**, noting that due to eCare go-live delay there would be further consideration of the opportunity to improve training compliance. The Committee raised concerns about prioritising high-risk training and exploring additional training space; recommended an update at the next meeting following review of eCare go-live date;

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Noted the **Professional standards report** noting an increase in complex employee relation cases and discussed for assurance how the Trust was taking learning from these cases. The Committee requested clearer data and trends, whether case

volumes were improving or worsening and where there any “hot spot” areas.

Received the **annual internal communications framework report** which set out the communications strategy focusing on building trust, embedding values, and measuring impact through both formal and informal feedback, with suggestions for pulse surveys and increased engagement, including using video and visual storytelling instead of relying on formal documents. Discussed the benefits of less formal approaches which supports high quality conversations. There was strong support for less formal, more human communication styles to make messages feel more authentic and impactful. Sought assurance on how the Trust will see change after the 36 week programme.

Equality Diversity and Inclusion Assurance Report provided limited assurance on all the strands of information and requested clarity regarding how the actions would deliver demonstrable change. The Committee requested how activity was linked to outcomes. Reminded the link with CEO and Chair objectives and suggested there needed to be greater articulation of the link with staff networks, and integrated of EDI with the IPR

The Committee noted the report which set out the actions being progressed following an internal audit on **sexual misconduct**. Noted that cases and themes and analysis are being reported and agreement to provide quarterly reports to Committee (including trends, and learning). Noted the Trust has training, resources and policy but suggested there is a need for greater understanding of this issues through. sharing lived experience and sharing videos. Discussed the role of People and Culture Committee and alignment with Quality Assurance Committee

Noted minor amendments to the **BAF**; main developments highlighted around the start of the Culture Transformation Programme, further progress on the Medium Term Workforce Plan, updates following the eCare go-live pause, and receipt of the Staff Survey action plan. Supported the closure of action 7c, as the Culture Taskforce has now transitioned into the Culture Group.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 13

Title of Report: Audit and Risk Assurance Committee Assurance Report to the Board – June 2026 meeting and Extraordinary Audit and Risk Assurance Committee

Committee Chair: Adam Broome, Non-Executive Director

Author and Job Title: Company Secretary

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

The purpose of this report is to present a summary of decisions made and assurance sought by Audit and Risk Assurance Committee on behalf of the Board of Directors at its recent meetings.

Key agenda items and decisions/actions taken on behalf of the Board

- **Recommend** Board approve the **Risk Management Strategy and Policy;**

Issues for escalation or notification to the Trust Board

- **Corporate Risk Register -** draw to the Board's attention the level of extreme risks and the need to strengthen assurance that controls are effective and the work underway to ensure risks are actively reduced

Summary of assurance and risk

Received an update on the **ICB Cluster Arrangements/System Update** noting the collective approach to improvements through the Audit Forum across the South West; with particular interest regarding AI governance.

The **Board Assurance Framework** remains outside risk tolerance, with new gaps identified in quality of care, workforce, financial sustainability, digital delivery, and estates compliance, particularly due to e-care go live and associated risks. Following a Board development session, revised risk appetite statements are being developed and will be brought to the August Audit and Risk Assurance Committee, with further board review planned. Agreed to update the BAF in relation to the risks

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associated with the capital programme and recommended the closure of one action (BAF 2).

The Committee reviewed the **Corporate Risk Register** noting progress on benchmarking against other trusts would be included in future reports. Members raised the need for clearer trend data on risks, ensuring better visibility of risk movement over time and concerns were expressed about security staff training which was subject to Executive Risk Group review. Further assurance would be provided in the next report, including clarity on the 28 risks not currently approved on to the Corporate Risk Register.

Members raised concerns that the reporting does not clearly show the most significant risks, their mitigation or progress, and also highlighted the high number of extreme risks, including some without fully developed action plans.

The Committee requested improvements to reporting clarity, introduction of trend analysis, stronger articulation of control effectiveness, clearer action planning for high risks, and better tracking of progress between meetings. Members wished to draw to the Board's attention the level of extreme risks and the need to strengthen assurance that controls are effective and risks are being actively reduced.

The Committee recommended the **Risk Management Strategy and Policy** for approval by the Trust Board (as a matter reserved for Board). Members sought assurance on the management of out of date documents and noted the Policy would undergo another review in November 2026 due to ongoing digital optimisation processes, ensuring alignment with best practice and Audit Southwest recommendations.

The **AI – Governance and Assurance report** was deferred but the Chief Information Officer provided the Committee with a comprehensive update on the Trust's approach to implementing effective governance and policies associated with the safe adoption of AI tools. Members noted a report would be presented in August which would also describe the Trust approach regarding increased training, education and security.

The 2025/26 **Data Security and Protection Toolkit (DSPT)** was scheduled for submission by 30 June 2026 with the anticipated final position being "standards met". Member recognised the efforts to improve compliance noting the greater emphasis on legal requirements in the revised toolkit. Internal Audit confirmed the final audit was scheduled for publication, and the Trust had met all minimal achievements therefore there was a high level of assurance.

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Freedom of Information (FOI) compliance was improving, noting increase to 87% compliance of the 20 days statutory timeframe but this remains below the 90% target. Members were briefed on the key issues relating to workforce stability,

variability in responses and recent impacts of organisational change but received some assurances following an external review and clear recommendations for improvement. Assurance was sought regarding accountability for FOIs and the efforts to embed accountability and improve responsiveness.

The Committee received the **Limited Assurance Report on E Roster Systems** which identified inconsistent overtime governance, unreliable net hour balances, and payroll process weaknesses. Members noted a comprehensive action plan was in place to address these issues, focusing on system controls and accountability. Further emphasised the need for cultural change, clear communication, and divisional ownership.

Internal Audit Interim Report set out the closure of the 2025-26 audit plan, details on progress on the 2026-27 plan, and Internal Audit highlighted the two outstanding recommendations on the **Internal Audit Recommendations Tracker** relating to management of sickness absence and data quality (UEC Safety Checklist).

Draft Head of Internal Audit Opinion confirmed a satisfactory assurance level. Members discussed the number of limited assurance areas during the year; clinical audit, sexual safety/misconduct, and e-rostering, with assurance that actions are being tracked and improvements are underway. Noted the Trust benchmarked well against peers and Members reflected on progress and learning in financial controls and cyber security. Internal audit emphasised the importance of tracking recommendations and learning from audits, with follow-up audits planned to confirm sustained improvements.

External Audit confirmed the near completion of the 2025/26 audit, which was subject to Trust Board review on 18 June ahead of final submission on 19 June 2026. The trust was expected to receive an unqualified opinion on the financial statements and no significant findings on value for money, indicating a positive audit outcome. Reflected on the strong collaboration with the Finance Team.

There were no actions remaining open on the 2024/25 **External Audit Recommendation Tracker.** It was noted the 2025/26 tracker would be presented to the August meeting.

Clinical Audit Progress Report Q1 2026/27 was deferred. The **Clinical Audit Year End Summary** identified 33 closed-loop audits with 46 actions delivered, improvements in patient safety, standardisation, and process reliability, and strong performance in national benchmarking. Members noted the focus on translating audit into improvement, embedding audit within divisional governance, and sustaining closed-loop learning, while noting ongoing work to ensure consistency. Sought assurance on challenges in addressing system-wide issues, such as stroke pathways, with positive collaboration across organisational boundaries supporting improvement.

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Counter Fraud Interim report set out the progress on the Economic Crime and Corporate Transparency Act review, MARA scheme compliance, and the adoption of new audit and compliance software for improved service delivery. Further raised awareness of declarations of interest through training and presentations, addressing the amber rating in the self-assessment. With regard to the **Counter Fraud Annual Self Assessment against NHS CFA Standards,** members welcomed the Green rating with good evidence of assurance.

Received the **Losses and Special Payments Report** noting a reduction in staff debt, ongoing efforts to recover overpayments, and a focus on root cause analysis for salary overpayments, with Committee members seeking clarification on pharmacy losses and debt recovery. Noted that more debt was being collected than raised, and highlighted the proactive monitoring and write-off processes in place. Members queried the significant increase in pharmacy losses and challenged the residual high number of over payments.

Single Tender Actions report set out the process of management through defined controls, with consistent recording and review, and learning captured to improve procurement practice. Members noted the need for improved trend analysis in reporting, which aligns with external audit recommendations, and the team is working to enhance visibility and oversight.

Extraordinary Audit and Risk Assurance Committee

The Committee:

- Received the Head of Internal Audit Opinion which was a satisfactory opinion;
- Received the External Audit findings report 2024/25;
- Received the External Auditor's annual report for the year ending 31 March 2025;
- Received the External Auditor draft audit report;
- Recommend the Trust Board approve the Trust's financial statements for 2024/25, including the letter of representation.
- Recommend the Trust Board approve the Trust's Annual Report for 2024/25, which includes the Annual Governance Statement and Remuneration and Staff Report.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 13.1

Title of Report: Board Assurance Framework Update

Lead: Lynsey Neave, Company Secretary

Author and Job Title: Lynsey Neave, Company Secretary

Email Address: lynsey.neave@nhs.net

Purpose of the Report:

Decision ☒ **Discussion** ☐ **Assurance** ☒ **Information** ☐

The purpose of this report is to report on the latest proposed amendments to the Board Assurance Framework and seek approval from the Committee and Board.

Consultation:

The individual elements of the Board Assurance Framework are discussed on a monthly/bimonthly basis with the lead executives and with the relevant assurance Committee.

It is of note Audit and Risk Assurance Committee now meet before the Board to better align the BAF with reporting to the Board.

The BAF was presented to the June Audit and Risk Assurance Committee.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?		X		The BAF is not a policy but the element on a sustainable workforce includes the controls and assurance actions in place to improve equality, diversity and inclusion across the Trust. Any specific initiatives would require

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	Yes	No	N/A	Summarise any adverse impacts identified
				a separate EIA.
Quality Impact Assessment completed?		X		The BAF is not a policy but the element on high-quality and safe healthcare, to be considered by Quality Assurance Committee, includes controls and assurance actions to improve quality and safety. Any specific initiatives would require a separate QIA.
Data Protection Impact Assessment completed?			X	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – *for reports requesting decisions only*:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its decisions on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

	Summary of considerations *(if one or more does not apply state 'not applicable')*
Health and wellbeing of the population, including inequalities and wellbeing	An element of the BAF specifically relates to integrated healthcare; one of the outcomes of which, with well-managed risks, would be positive impacts on health inequalities and wellbeing.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	An element of the BAF specifically relates to safe and high-quality care and will be used by the Trust Board and its committees to test the controls in place for related top-level risks and to monitor assurance actions for improvements.
Sustainable and efficient use of NHS resources by RCHT	A number of the BAF elements, specifically with regards medium term financial sustainability, integrated healthcare services, and physical and

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	Summary of considerations *(if one or more does not apply state 'not applicable')*
	digital infrastructure will help the Trust manage the risks to sustainable and efficient use of NHS resources. The BAF also aides the Board in monitoring and seeking assurance on the health, safety and wellbeing of its staff.

Recommendations:

The Committee **is recommended to:**

- **Note** the reporting, including new gaps in assurance and mitigating actions;
- **Approve** the closure of:
    - **Propose closure of action 7c (BAF 2 Workforce) -** Culture Taskforce has concluded and evolved into the Culture Group which met in May.

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Board Assurance Framework (BAF) – July 2026

1. Situation / Executive Summary

The refreshed BAF was approved by the Trust Board in January 2023 and maps to the Trust's Corporate Strategy.. The Board reviewed its Risk Appetite in June 2026, further work is being undertaken to develop the risk appetite statements, however there was positive alignment with the Trust's four strategic objectives with greater articulation of estates, finance and digital. The Board will be invited to approve the statements in July/August with the aim of the BAF being updated to align to them.

2. Assessment

In summary, the six BAF elements are:



Key	
	Safe, high-quality care
	Supported and valued people

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2.1 Purpose of the BAF

The HM Treasury Guidance on Assurance Frameworks (2012) defines an assurance framework as: 'An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect. It is common practice across the UK public healthcare sector for the term 'board assurance framework (BAF)' to be used to refer to the key document used to record and report an organisation's key strategic objectives, risks, controls and assurances to the Board.

In January 2026 the Board approved the refreshed Trust Strategy and a communication and engagement plan developed to support the publication of the strategy. The BAF is currently under review to alight to the new strategy and the refreshed strategic objectives and the supporting risk appetite statements; following the Board Development session in June 2026. It is of note the original intention was to update the BAF in Q1, however this will be delayed to Q2.

2.2 Updates to the principal risk elements of the BAF

Updates to each element of the BAF are made after each assurance Committee meeting and/or meeting with the relevant executive lead(s). These are made in track changes (from the last agreed version by the Trust Board) for transparency and are summarised in reports to the Board and Audit and Risk Assurance Committee. The Board approves the Board Assurance Framework and this was last approved in May 2026.

BAF 1 – Failure to provide safe, high-quality care to patients

Quality Assurance Committee (QAC) last reviewed BAF element 1 at the May and June meeting. The key changes include:

- Urgent and Emergency Care narrative strengthened (action 1), with expanded detail on the Clinical Vision of Flow, corridor care, system actions, and priority flow initiatives;
- Corridor care remains a significant concern despite improved ambulance handovers; further assurance, route cause analysis work, and a planned GIRFT visit scheduled (action 2);
- Harm review (action 4) downgraded from on track to off track, noting stronger executive direction from the Chief Medical Officer setting a clear expectation that progress must now be made. Active engagement with the

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Clinical Effectiveness Team across divisions has been requested with oversight through the PPPP (Patients) governance process;

- Elective recovery (gap in assurance 5) expanded to include gap around the symptomatic breast pathway and maintaining compliance with the 28-day Faster Diagnosis Standard. New action 5b added to address the symptomatic breast backlog and longer-term pathway modelling;

- Action 5a reflects the development of a trajectory to 81% RTT performance (being presented to FPC in June and July Trust Board);

- Seven-day services (action 7) updated noting only four priority standards (of the 10) were assessed, with Standard 2 remaining a concern (partially met) with performance being below the 90% threshold;

- Information governance risks expanded (action 9a), including delayed eCare benefits and the ongoing breach investigation. Action 9b further updated regarding the FOI/SAR recovery position and the external review had concluded with recommendations and active monitoring at Committee;

- New assurance gap and new action added (14) regarding Never Events associated with retained foreign objects, following two April 2026 incidents.

BAF 2 – Failure to attract, include, develop and retain a sustainable and thriving workforce that enables transformation in the workforce to support flexibility, diversity and patient-centred care

People and Culture Committee (PCC) last reviewed BAF element 2 at the May meeting. The key changes include:

- Action 1 - Culture Transformation programme commenced and inaugural meeting of the Culture Group in May 2026. The Board have received and approved a Culture transformation plan. Dual Chief People Officer produced and engaging on a draft People Plan which references OD themes strongly i.e. leadership and management development, organisational culture and workforce transformations/ new ways of working;

- Action 2a - The Committee had a deep dive discussion on the Medium Term Workforce Plan and received the first draft of the plan at its March 2026 meeting, building the structure to engage with new Divisions to develop, a bottom up, assumption based plan in Q1. The Trust Board in May received the plan; the plan remains a “work in progress” and will be updated to include current position as well as consider factors such as neighbourhood health, system reform and future workforce for the Trust. Further alignment to take place with the Medium Term Financial Plan;

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- Action 4b - Noting eCare go-live pause announced in April 2026 and a comprehensive review of the programme, impacts and revised launch taking place. People and Culture Committee sought assurance on impacts of statutory and mandatory training in May 2026 with further details being requested at the July meeting ;

- Action 7b reflected the pause of the eCare go-live;

- Action 7c – recommend closure as the Culture Taskforce as this actions had concluded and evolved into the Culture Group – which met in May;

- Action 8a - Trust Board in May received the Staff Survey results and the action plan. Agreement to prioritise key areas i.e. being a place to work and receive care as well as making improvements in appraisal; raising concerns and health and safety and the Board requested an accelerated approach to review and update the action plan. Noting alignment with Culture work. Further discussion by People and Culture Committee in May and greater board oversight agreed.

BAF 3 – Failure to optimise the advantages of integrated health services for safe, high-quality care

Finance and Performance Committee (FPC last reviewed BAF element 3 at the May meeting. The key changes include:

- Reflected change in SRO for Women's and Children's Programme Board (action 2a) which moved to the Chief Finance Officer. The Trust continues to engage in activities with the New Hospital Programme and has been allocated, subject to further governance and contractual arrangements, a provider to deliver the build;

- The eCare go-live has been paused (action 2b) following Board agreement. A full and comprehensive review was being undertaken and was scheduled to be considered by the Board in June 2026 and further development of a revised timeline;

- Culture transformation (action 2c) was progressing and remains on track.

BAF 4 – Failure to achieve the Trust's medium-term financial recovery to positively benefit quality of care

Finance and Performance Committee last reviewed BAF element 4 at the May meeting. The key changes include:

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- New gap in assurance 5 and action relating to financial risk associated with industrial action, Noting the planned industrial action w/c 15 June was

stood down;

- Update to action 1 regarding eCare and the Board decision to defer go-live. Noting action being taken to comprehensively review the programme and recommend a new timeline. This poses a significant financial risk for the Trust;

- Regarding action 2; noting the Trust is developing a an elective recovery plan which focusses on reaching 81% RTT. Scheduled for FPC consideration in June (noting Board approval required);

- With regard to the Women's and Children's Programme, NHP Executive Committee has met and confirmed its support for the scheme to progress, issuing a "Go" decision for continuation on the basis of an H2.0 design aligned to a revised budget of £418m. The programme team is now working collaboratively with NHP;

- New gap in asurance (7) relating to the reprioritisation of the 2026/27 capital programme. Until the reprioritised programme is finalised and approved, the Trust cannot demonstrate full assurance that capital resources are being prioritised, allocated and deployed in a timely and risk-based way across the year. This creates a risk of delay to essential investment decisions, slippage in delivery of priority schemes, and reduced ability to mitigate emerging risks relating to estate, equipment, digital and statutory compliance requirements. Further assurance is therefore required that interim prioritisation and control arrangements are in place to manage the period before full capital allocation is confirmed and to minimise the operational, financial and quality impacts of delay – aim to close the gap by July Trust Board.

BAF 5 – Failure to provide a robust digital infrastructure and capability, supported by effective cyber security, that enables the Trust to innovate healthcare provision

Finance and Performance Committee last reviewed BAF element 5 at the May meeting. The key changes include:

- The biggest change is the update on eCare go-live being delayed (action 1). A comprehensive review is being undertaken with greater oversight at Board. Comprehensive discussion at Board in June on the revised timeline, financial, operational and training risks to be outlined with mitigations. Agreement scheduled to be reached;

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- With regard to action 2b relating to cyber; NHSE set out clear expectations for NHS Trusts regarding board and executive oversight on cyber security

risks in June 2026. The Trust has dedicated Executive accountability through the CIO but will take learning from new directive cyber policies which will form part of the DPST toolkit.

- The Board received assurances on application of AI (action 6) and noted development of appropriate use polices being developed.

BAF 6 – Failure to transform and maintain a safe and fit-for-purpose estates infrastructure for patients, staff and visitors

Finance and Performance Committee last reviewed BAF element 6 at the May 2026 meeting. The key changes include:

- Update to gap in assurance 1 to include the gap in assurance relating to the ability to respond to severe weather impacts. The Trust experienced a range of immediate infrastructure and operational impacts associated with severe weather conditions during winter 2025/26, particularly due to Storm Goretti. These incidents, alongside power instability and lift failures, contributed to operational pressures and required activation of Business Continuity arrangements to maintain patient safety and service continuity. A review and reprioritisation of the capital programme is being undertaken;

- With regard to fire risks, action 5 has been updated to include the internal investigation (overseen by Quality Assurance Committee) relating to fire alarm activation system faults which have been mitigated and assurance provided to Cornwall Fire and Rescue Service. Continue to be monitored at QAC;

- New gap in assurance (6) regarding the adequacy and consistency of health and safety controls, particularly in relation to statutory compliance, maintenance systems, asbestos management, and the monitoring of remedial actions. Assurance gaps remain in the control framework for asbestos management, contractor oversight, training compliance, record integrity, and formal accountability, with further work needed to evidence sustainable control improvement and provide board-level assurance on delivery and effectiveness. An action plan has been developed and is being monitored by Quality Assurance Committee.

2.3 Common Gaps in Assurance across BAF elements

A review across the BAF highlights common themes with regards either gaps in assurance or mitigation actions remain consistent with the previous report, they include:

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- Financial and operational challenge – delivery of the financial and operational requirements as set out in the agreed 2026/27 plan, particularly regarding

addressing elective recovery (RTT);

- Agreed culture transformation programme but strong alignment with an OD and leadership programme is required; recognising the actions being taken to put in place a programme of work to improve culture in response to the staff survey results but the lack of pace of this action plan has been raised;

- Delivery of the required workforce efficiencies, particularly delivery of headcount reduction to achieve the efficiency savings and ensure a workforce fit for the future and the impact and learning from the organisation as part of that change process;

- Responding to and addressing the pressures on quality of care and the continued focus on improving urgent and emergency care performance and the requirement to eradicate corridor care.

2.4 Development of the System Assurance Framework

The Devon and Cornwall Audit Chair's informal meeting has met on several occasions and is primarily focussed on shared learning, is considering the development of system assurance framework. The new Cluster ICB have reviewed and approved their revised Board Assurance Framework and the Company Secretaries have yet to meet to consider the benefits of NHS organisations across the NHS CIOS and NHS Devon ICB Cluster to use the same definitions with regard to levels of assurance and the actions to be taken when different levels of assurance can be taken.

The ICB have stated that further work will be undertaken with the NHS providers in both systems to ensure that they are content that the BAF reflects the risks to their system's strategic objectives, however we have yet to receive any invitation to a meeting. The aim was to seek a willingness to adopt a system BAF, together with a shared view on risk appetite and an agreement on assurance definitions. Progress has been slow since the announced departure of the ICB Company Secretary.

3 Risk

The Board Assurance Framework is the tool through which the Trust Board scrutinises and manages the key risks to the Trust's strategic objectives. It includes the internal controls and assurance mechanisms through which the Board can determine how well the risks are being managed and what might threaten the implementation of the Trust's strategy or cause it to pivot from its original intended direction.

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4 Accountability

The Company Secretary is responsible for coordinating the development and updating of the Board Assurance Framework on behalf of the Board. The Chief Nursing Officer is responsible, via delegated authority from the Chief Executive, for the Trust's overall approach to risk management and, in turn, delegates day-to-day responsibility to the Director of Nursing, Midwifery and AHP.

The nominated Executive Director lead is responsible for the updating of the relevant BAF element risk and for providing assurance to the Board on the controls and mitigations in place. The assurance Committees of the Board seek assurance on the actions being taken to close any gaps in assurance and tests the three lines of defence assurance model.

The Audit and Risk Assurance Committee seeks assurance on the approach to development and updating of the Board Assurance Framework and on the robustness of the internal controls in place to mitigate the principal risks.

5 Recommendations

The Committee is recommended to:

- **Note** the reporting, including new gaps in assurance and mitigating actions;
- **Approve** the closure of:
    - **Propose closure of action 7c (BAF 2 Workforce) -** Culture Taskforce has concluded and evolved into the Culture Group which met in May.

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BAF 1. Failure to provide safe and quality care to patients

Risk cause(s)	• Challenged medical workforce vacancy position in a few key specialities. • Registered nurse vacancy position improving, although remains static in AEM Care Group • Sustained pressures in unscheduled care resulting in risk of compromises in safety or quality and/or mistakes • Insufficiently skilled and competent workforce, • Lack of management development for those who hold supervisory positions • Lack of Trust wide consistent, congruent leadership development programme • Negative individual behaviours or team/department/not living Trust values, lack of bystander training • Lack of consistent OD support and organisational culture that is not inclusive • Lack of or inconsistent access to the right information about patients (cross-reference to BAF 5, Digital) siloed systems
Impacts if risk realised	• Breach of national patient safety and care standards, resulting in potential or actual harm to patients • Breach of national Urgent and Emergency Care access standards (15 minute handover from ambulance arrival and 4 hour stay in the emergency department), breach of national elective access standards (18 week referral to treatment and 52 week maximum wait) and the Cancer access standards (faster Diagnostic Standard, 31 day and 62 day standards) • Negative impact on staff morale and motivation – negative staff experience directly impacts on patient experience and mortality outcomes • Health and wellbeing of staff impacted resulting on higher levels of stress and burnout • Increased patient safety incidents resulting in moderate harm and above and/or never events • Regulatory intervention • Reputational damage • Patient experience with delays in admissions areas and use of escalation spaces such as ED corridor and the Boarding/Holding spaces on wards
Strategic Objectives Affected: Year 3	**Safe, High-Quality Care** • Improve safety and quality across the CIOS system by supporting the development and delivery of the system-wide Flow Programme (now split into two functions of the Reform Programme and the 7 Pillars work and The Trust's Clinical Vision of Flow, these programmes of work cut across attendance avoidance, Admission avoidance, Discharge performance and End of Life. The Clinical Vision of Flow has four key workstreams of 1. ED processes, 2: short stay, 3. Sick General Patients and 4. Sick Frail patients. • Improve waiting times for elective and cancer care and provide more care closer to home through the Elective Recovery Programme • Through provider collaboratives with Cornwall Partnership NHS Foundation Trust, the Peninsula Acute Providers Provider Collaborative and Integrated Care Areas work with system partners to improve clinical pathways of care

Lead Director	Chief Nursing Officer and Chief Medical Officer *with Chief Operating Officer*	**Lead Committee**	Quality Assurance Committee	**Date of last review by Committee**	~~March~~ May 2026 (last approved by Board, ~~March~~ May 2026)

BAF risk scoring

Initial risk score Q3 2022/23	25	**Risk appetite**	Minimal - Cautious	**Tolerable risk score**	6-8	**Target date to tolerable score**	September 2025

Risk controls or mitigations	A. Clinical governance structure in place including Clinical Effectiveness and Mortality Review. B. Clinical Audit Plan in place. C. Maternity governance structures in place. Submitted Yr 7 compliance with actions plan for 2 safety actions D. Risk and incident reporting framework including incident review and learning. Year 2 PSIRP plan in plan. E. Urgent and Emergency Care Quality Commission / Tier 1 Emergency Support Programme / / New medical model and Clinical Vision of Flow (chaired by CEO and meeting weekly). Executive led ED Corridor Care improvement plan agreed. Release to Rescue Protocol for ambulance arrivals and pathway 1 discharges from RCHT F. Infection Prevention and Control Board Assurance Framework and related policies and procedures. G. Safeguarding children and adults' policies and structures in place. H. Harm review process using retrospective and prospective methodology managed by CMO office and reported to Quality Assurance Committee

Actual and prospective scores	**Actual**			**Projected**
	~~Q2~~Q1	~~Q3~~Q2	~~Q4~~Q3	Q1
Consequence	~~4~~ 4	~~4~~4	~~4~~4	4
Likelihood	~~4~~ 3	~~4~~4	~~4~~4	4
Current risk score (LxC)	~~12~~ 12	~~16~~12	~~16~~12	16

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	I. Referral To Treatment meetings (Tuesday service level reviews and Thursday COO lead with all Care Groups for management of waiting lists. J. Monthly COO lead Elective Recovery Programme meeting K. Specialties where further review of the Patient Tracking List (PTL) required. L. Use of patient portal to highlight deteriorating symptoms for patients on PTL M. Statutory and mandatory training in place for clinical and non-clinical staff. N. Once daily SAFER meetings to review staffing levels for nursing staff. O. Standard Operating Procedures for key functions related to flow through the hospitals, including Internal Professional Standards, Board Rounds and Ward Rounds P. Twice daily Site Safety Meetings Q. Implemented 22:00 daily conference call with onsite Clinical Site Managers, Senior Manager on Call and Director on Call to ensure safety and performance plan in place for the night R. Out of hours shift lead implemented for the Clinical Site team S. System Coordination Centre. T. Care Group structure implemented U. Cornwall system has implemented “SHREWD” (information system to enable transparent whole system visibility) which is under review V. RCHT and system stroke improvement group W. RCHT Fractured Neck of Femur task and finish group X. ‘shape and form’ defined and agreed in Executive Leadership Team to support the right model to drive efficiency (for example no longer accepting a patient remaining in SDMA overnight) Y. Commenced the 45 minute release to rescue to support 999 response to the community Z. Daily review of 8 key performance indicators with CFT, jointly chaired by the 2 CEOs with both Trusts CMO/CNO/COO. this is a 5 AA. . day a week process to be on the day responsive BB. 2 hourly escalation process lead by Heads of Nursing through Whole Hospital Review Process CC. Daily review of 8 core indicators (4 RCHT and 4 CFT) jointly with CFT, jointly chaired by the two CEOs and representation from the two Trust’s CMO/CNO/COO

Assurance framework – three lines of defence (links to mitigations identified by letter reference)

	First line of defence ***Care Group/operational level***	**Second line of defence** ***Oversight/corporate***	**Third line of defence** ***Independent/external***
Assurance	• Daily situational reports (A) • Daily nurse safe staffing report – Safer care staffing process (J) • Clinical Harm Review process for RTT (H) • Incident reporting (incident review and learning group) (D/H) • Freedom to Speak Up (FTSU) • Referral to Treatment Patient Tracking List (PTL) • Cancer PTL • Radar reports to enable easy access to information for targeted actions • Twice weekly CNO/CMO/COO session • Weekly UEC update from CEU to Trust Board members	• Clinical Audit outcomes to Quality Assurance Committee (A) • Corporate Risk Register reports to Audit and Risk Assurance Committee (C) • Scrutiny of Integrated Performance Report by assurance committees and Trust Board, including quality and harm dashboard and overview of performance against NHS Oversight Framework (B, C, E, G, H) • Board Walkabouts for triangulation of evidence • Key quality and safety assurance reports to Quality Assurance Committee and/or Trust Board: ▪ Monthly Perinatal Safety (B/C) ▪ Quarterly Patient Experience and Annual Complaints ▪ Care Quality Commission action plans assurance reports (D) ▪ Ward to Board (A)	• Clinical Governance internal audit (A) • Care Quality Commission responsive and targeted Inspections (A, B, C, D, E, F, G, H, I) • External Reviews e.g. Royal Colleges and Peer Reviews (A, G) • Cornwall and Isles of Scilly Urgent and Emergency Care Board Assurance Framework (D) • Local Maternity and Neonatal System (LMNS) • Operational Delivery Networks for the South West (including ODN for Neonates) • System ICB Quality Group & ICB System Quality Improvement Group (A, B, C, D, E, F, G, H, I) • System and regional mortality and morbidity Group • Reports for assurance to the Cornwall and Isles of Scilly Integrated Care System Planned Care Board Urgent and Emergency Care group and System Quality Group (A, C, D, E, F, G, H, K, L)

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		▪ Biannual Safer Staffing (J) ▪ Referral to Treatment process and Elective Recovery programme ▪ harm review Process(H) ▪ Incident Review and Learning Group (D) ▪ EQIA process and Star Chamber • Scrutiny of mandatory and statutory training compliance by People and OD Committee (I) • Scrutiny of workforce planning by People and Culture Committee (J) • Performance Assurance Framework • Executive Leadership Team • Clinical effectiveness Group • Development of the winter plan using national guidance and linking to system wide winter plan. Detailed Board Assurance Framework due to be presented to Trust Board in September. Region wide winter scenario testing scheduled to assess plans. Trust winter plan will be presented to the August QAC as part of development into the final plan for review at Trust Board	• Dedicated update on Urgent Care added to Trust Board Agenda • Dedicated Urgent Care update provided to Quality Assurance Committee • Weekly update from CEO to Trust Board on the three key UEC indicators (4 hour type 1 performance, 12 hour performance and average ambulance handover performance)

Gaps in assurance	1. Ability to consistently deliver the emergency and urgent care access standards 2. The ability to eradicate corridor care consistently across all areas of the Trust and sustain this 3. No longer an outlier for Fracture Neck of Femur mortality, but National Hip Fracture Database metrics not all consistently improving 4. A robust and effective harm review process specifically related to retrospective harm review completion in care groups 5. Delivery of the elective recovery programme and deterioration of 52 week waits – in particular assurance that the current mitigations will deliver a sustainable recovery of the symptomatic breast pathway and maintain compliance with the 28-day Faster Diagnosis Standard 6. Workforce plan to reduce nursing, medical consultant workforce gaps in key specialties and AHP gaps~~,~~ 7. Ability to deliver standard 2 of the Seven Day Services Framework: Time to first consultant review – reaudited to demonstrate good improvement on weekdays and at the weekend since implementation of the new medical model. 8. Stroke Performance, SNAPP (4 hour performance and 90% stay) and stroke thrombolysis rates – RCHT and system action plans in place and monitored, with enhanced surveillance status from the ICB 9. Information governance: management of breaches relating to misappropriation of information and the capacity and resource required to deliver compliance with Subject Access Requests and Freedom of Information Act requests 10. HSMR coding resource issue 11. 10 white wards now on ASPIRE Ward Accreditation Programme, and ensuring correct coding of elective and emergency attenders in the advent of new ways of working 12. Trust response to addressing the breaches in the Care Quality Commission (CQC) - Urgent Care & Medical Services inspection report 13. Impact of organisational change on patient safety ~~13.~~14. Assurance that controls designed to prevent retained foreign objects are consistently embedded, complied with, and sustained across services
Overall level of assurance	Medium

Actions to address gaps in assurance

No.	Action required	Executive Lead	Due date	Progress Report	On or off track
1	Implementation of the Clinical Vision for flow and embedding change	Chief Operating Officer	March 2025	ED Crowding (9048) Risk score: 25. Mitigating actions in place and Executive Risk Group oversight/monitoring. Risk Score increased to 25 following increases in marker (Aggregated Patient Delay) in October 2025. Established and embedded Clinical Vision of Flow Programme	Actions on track Performance indicators on track (to trajectory) Performance indicators off track (to national standards)

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				New medical model fully implemented to support the medical take coming out of the Emergency Department and a change in hours of availability of the General Internal Medical on call with the intention of aligning capacity to the demand profile of arrivals There are three programmes that link to the overall improvements in UEC performance which also link to our strategic aims and our agreed operational and financial plan. These include: • Internal RCHT clinical vision for flow / ED corridor Care • 7 UEC Actions • Reform programme Phase 2 of the clinical vision of flow programme has been agreed with key milestones and actions agreed, and a review of key actions by workstream now required. A dedicated steering group meeting to review the medical model and take was held, with key actions including a rapid review of the AMU/SDMA/MRATS Standard Operating Procedure, followed by its promotion and ensuring all are aware of it. Key meetings to be held between clinicians, nursing teams, acute medics, and frailty consultants to improve communication and improve relationships. We are working with the Deputy Medical Director of Chelsea & Westminster who is an Acute medic to support embedding our MRATS standard operating procedure and sharing best practice on managing the acute medical take. Clinical Vision of Flow Steering Group embedded into governance with monthly reporting on UEC performance to the Trust Board and a weekly assurance update to Board members. CVOF focussing on: • Progress in integrating the site team with Divisions, primarily Medicine, and learning from GIRFT on command-and-control principles. • Progress on the West Cornwall Hospital (WCH) model in partnership with the Penwith Integrated Neighbourhood Team (INT). ▪ Including capital for Urgent Treatment Centre (UTC) works. • Progress with system partners on exit from the Timely Handover Protocol (THP) for pathways 1, 2 and 3. • Admission avoidance schemes. • Other priority areas for change. ▪ Creation of a discharge-ready unit. ▪ Co-located UTC with RCH ED. ▪ Potential for a frailty unit. ▪ Potential for specialty wards to have short-stay areas. • Review of the ED and Corridor Care risk register. The Trust has embedded mechanisms of monitoring UEC performance with oversight at Quality Assurance Committee and Trust Board. The Rapid Quality Review actions being progressed (through the ICB)	System wide performance on track Type 1 (ED) performance off track
2	Manage risks associated with and eradicate corridor care and ultimately avoid all use of escalation spaces	Chief Operating Officer	May 2026	This links with the UEC actions through the clinical vision of flow to eradicate escalation spaces Letter from NHSE received March 2026 which set out actions regarding to eliminate corridor care, with clear guidance on the definition of corridor care and robust guidance for improvement by GIRFT. This improvement plan with identified Executive leads will report through the clinical vision for flow delivery group and UEC update to QAC (and Board).	New

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				Although ambulance handover times have improved overall, the Emergency Department remains crowded, and risk 9048 continues to score 25. Using the national GIRFT improvement guide, the Trust is applying the same methodology as the external visits team to track standards and ensure actions are supported by evidence of improvement. From 12 May 2026, the Trust is implementing a 12-week staged approach to moving to a Route Cause Analysis (RCA) for patients who have a 45 minute or longer stay in a corridor space. As a result of the ongoing performance pressures the national Getting It Right First Time team are planning a visit to the Trust week commencing 13 July. Quality Assurance Committee continue to receive a dedicated assurance report to Committee which is further presented to Board for monitoring and assurance.	
3	See sustained improvement in #NOF	Chief Medical Officer	~~March 2025~~July 2026	**Fracture Neck of Femur** With regard to #NOF a mortality review undertaken at MROG and outcome of deep dive resulting in a #NOF Improvement Board. Improvement plan progressing and improvement metrics being developed. Traction being achieved and report to Quality Assurance Committee monthly. Achievement of Hip Fracture Database primary aim. Targeted focus by Senior Responsible manager-Nichol Freestone and Senior Responsible Officer Gavin Bartlett Refining further with audit and data compliance within a more detailed action plan. Particularly focusing on the key objectives as outlined above. With nominated leads and timescales. HSMR reduced slightly for #NOF in July. Position remains improved regarding prompt surgery compliance from NHFD data. **March 2026: Fractured Neck of Femur (NOF) Pathway:** A total of 64 frailty fractures were treated, 46 #NOF and a total of 19 Peri prosthetic which was lower than January. The rolling annualised NHFD data shows prompt surgery at 46% against the NHFD overall of 57%. The RCHT 36-hour target to theatres dropped in the month from 66% of patients in January to 44% in February. Delays remain with insufficient theatre space affecting 21 delayed patient treatments with an average time to theatre of 44 hours and there was a significant increase in time to theatre for 12 patients over 60 hours waiting time to theatre at an average wait of 97 hours, owing to medical reasons and availability of hip surgeons. An audit is underway to review the lack of theatre space to identify key reasons for delays and actions to reduce the impact going forward. A total of 20 days had allocated NOF and periprosthetic fractures with an average of 3 patients per day planned for surgery and the increase in peri prosthetic fractures impacted on 3 elective clinics being cancelled to allocate appropriate hip surgeons to trauma. Prompt mobilisation after surgery improved in January to 69% but is still not back to achieving the NHFD KPI target of 82% even with weekend physiotherapy reinstated. The consultants have raised concern that they are not seeing an improvement in mobilisation 24 hours after surgery, and at Directorate it was decided to audit 12 months of data to identify trends in mobilisation delays and any links to increased LOS, which will be presented at the March T&O Governance Audit meeting. The locum Trauma Consultant started 9th March and should support trauma delivery over the coming months. Continue to monitor the KPIs against the national hip fracture database. Continued report to Quality Assurance Committee	Off track and mitigations to improve

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4	Ensure consistent approach to Harm Review	Chief Medical Officer	April 2026	All care groups have either addressed the backlog or have a trajectory. Noted that continued review of areas with granted exceptions is being undertaken by Clinical Director for Quality Safety and Effectiveness. ~~This links to Divisional changes~~ Chief Medical Officer written to the Divisional Leadership Teams to highlight the significant number of outstanding harm reviews and to set a clear expectation that progress must now be made. Active engagement with the Clinical Effectiveness Team across divisions has been requested with oversight through the PPP (Patients) governance process.	Off track ~~On Track~~
5.a	Sustained improvement through the Elective recovery plan	Chief Operating Officer	Achieve no 65 week waits by Dec 2025 Achieve no 52 ww by March 2026	Weekly RTT meetings remain in place along with monthly elective recovery meeting (Chaired by COO) The Integrated Performance Report monitors key metrics and provides information and assurance through ELT, Committee and Trust Board. **Elective Recovery Programme – Actions and Progress** The Trust continues to focus on delivery of the 25/26 plan and delivery of the 74% RTT performance by March 2026. However, the waiting list size and overall RTT performance remain off plan at 72.5% and continue to be a key area of focus and action, particularly as a sustainable waiting list size will be important for eCare implementation. Divisions continue to focus on actions to improve non-admitted pathways through mega clinics, pathway redesign, converting follow-up capacity to new outpatients for March sprints and more sustainably into 26/27. New outpatient sprints continue across a number of specialties in order to improve productivity and income as well as improve RTT performance. The Trust continues to participate in the *GIRFT Further Faster Follow-Up Collaborative cohort 2*. In March the Trust has moved to the new Trust management structure, ensuring the delivery of new Trust wide strategy including the strategic Clinical Vision for Planned Care. **For 52-week waits**, recovery plans remain in place following earlier increases in the year, with RCHT slightly behind plan in February, across Orthopaedics, Gynaecology and General Surgery and showing month on month increases. Mitigating actions include weekend operating for Gynaecology, theatre template changes at St Austell Surgical Hub (SASH) for Ophthalmology, exploration of additional Orthopaedic locum capacity, focus on eliminating single digit specialties through targeted booking and focusing on reducing non admitted pathways. A new theatre template review is being scoped out for 26/27, aiming to maximise peripheral site operating and maximising physical capacity. **Key Risks** remain largely consistent with previous months and include potential disruption associated with eCare implementation, diversion of capacity from planned care, and reliance on operational efficiencies assumed within the 2025/26 plan. There is a risk that efficiencies take longer to realise or prove insufficient, which could impact RTT and DM01 and delivery of the plan care 25/26 requirements. In addition, there is a risk that as a result of operational and admin restructures the Trust's capacity maybe impacted by recruitment, retention and appointment of roles. In addition, there is a risk that as a result of operational and admin restructures there may be reduced staffing levels or gaps in rostered posts due to delayed recruitment, retention of existing staff and timely appointment of new roles which could lead to an impact in capacity either to book or utilise theatre sessions, diagnostic and outpatient capacity. Trust developed and refreshing its trajectory to deliver 81% RTT performance.	On track
5b	Addressing backlog and review of modelling of symptomatic breast pathway	Chief Operating Officer	July 2026	Insufficient radiology capacity is the main constraint in the symptomatic breast pathway, this has been mitigated by additional evening and weekend capacity, but this is not sustainable and a review of the pathway has commenced – including a working group in May 2026 is planned to develop a longer-term model, including any business case or training requirement.	New

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6	Plan to address workforce gaps, particularly in hard to recruit to areas e.g. registered nursing	Chief People Officer	~~September 2025~~	RN vacancy position remains positive but has increased to 74 WTE vacancies.. Recruitment restrictions currently impacting on recruitment but closure of some escalation areas has contributed to reduction in agency spend. For nursing workforce, timeframe to stop using agency is dependent on closure of escalation areas and future workforce modelling. As above, registered nurse position improved again in month. Agency reduction plans continue and with AEM ward closure plans and changes to skill mix in the Emergency Department, we should see this gap close in September. Targeted recruitment continues for medical hard to fill roles. Specialist recruitment event for registered and non-registered nurses being held in November. Greater level of assurance being sought regarding triangulation of people and financial metrics As of February 2026 the position for Health Care Support Worker and Registered Nurse gap deteriorated. A recruitment summit during January with an action plan in place. Actions from recruitment summit continue. Decrease starting to be seen in HCSW vacancies but not in RN. Divisions currently working up zero agency plans.	Off track
7	Ensure compliance with standard: Time to first consultant review	Chief Medical Officer	September 2026	Restructure of Consultant evening cover in Medical Specialties to match demand with capacity completed and implementation of the new medical model in 2025 supported improvements in compliance but further actions were required. QAC have continued to have oversight of improvements. As of November 2025 the Trust was delivering standard 2 of time to first consultant review. Full review of seven day standards (10) ~~will be undertaken and report to QAC by April 2026.~~was not undertaken in this audit cycle, the Trust has chosen to assess its performance against four of the ten priority standards, as these have been determined to offer the most significant clinical impact at this time. Standard 2 remains an area of concern as its currently only being partially met; performance is below the 90% threshold. Medical take was happening in ED instead of MRATS, so the new medical model is not working as intended as such there are plans to re-audit Standard 2 once the medical take is back in MRATS.	on track
8	Improving Stroke Performance including mortality, SNAPP (4 hour performance and 90% stay) and stroke thrombolysis rates	Chief Medical Officer / Director of Nursing Midwifery and AHP	September 2025	RCP review completed April 2025. Royal College review initial outcome scheduled for May 2025 QAC. Royal Cornwall Hospitals NHS Trust has been selected as one of the 12 sites working with the Thrombolysis in Acute Stroke Collaboration (TASC) over the coming 12 months to implement a quality improvement project to improve thrombolysis and mechanical thrombectomy rates. Sustained improvement in mortality within normal range, however Trust compliance with 4 hour standard remains a challenge due to operational pressures. Escalated to ICB the outstanding system actions that pertain to the onward flow of patients on the stroke pathway that releases capacity. Trust has been accepted for the first cohort Thrombolysis in Acue Stroke Collaborative (TASC) national programme to improve thrombolysis and mechanical Thrombectomy rates. Latest position: Stroke unit stay improved slightly - 81.0% in April up from 78.3% in March but still below the 90% national standard	

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9a	Development of a unified approach to the proactive management of data breaches	Senior Information Responsible Officer	December 2025	Ongoing process of surveillance to monitor breaches. SIRO quarterly and annual report provide monitoring updates. SIRO taking action to expedite interventions to ensure adequate resource available to mitigate risk (link with 8b) Noting that with introduction of eCare there will be greater monitoring mechanisms, but this programme has been delayed ~~.~~ Of note the Trust is engaging with independent experts to investigate the data breach identified in late 2025. To support this investigation, the Trust is inviting those affected to share their experiences to help understand the impact of the incident, learn from what happened, and reduce the risk of similar situations in the future.	off track
9b	Address the capacity and resource requirements to address the backlog and deliver a compliant position relating to SAR and FOI	Senior Information Responsible Officer	April 2026	Management actions to address and monitor the backlog of FOI and SAR. Risk added to the Corporate Risk Register. SIRO report to Committee ~~(January 2026)~~ on a regular basis to provide assurance on mitigations. ELT and QAC to receive assurance (ahead of Audit and Risk Assurance Committee) on the level of risk and mitigations. Information Governance Group have regular update on actions being taken. Trajectory for addressing the backlog (through an action plan) to be developed QAC in March ~~to~~ received an assurance report and action plan to address/mitigate the risk as RCHT is failing to provide responses consistently within the legal timeframe and has a backlog of requests. NHS England has confirmed that the backlog constitutes an automatic failure of the Data Security and Protection Toolkit, which presents significant operational and reputational risks for the Trust. Risk on the Corporate Risk Register being reviewed and will be a high risk (20/25). The Trust's Freedom of Information compliance has recovered from around 35% previously to an average of 89% since January 2026, and 91% from February onward, which is close to or within the acceptable range. SAR backlog has fallen by 6.7% with additional fixed-term staff increasing output and remains a key risk. External Review was underway to take learning and there remains a risk the Trust will not be compliant with the DPST toolkit which is actively being considered. QAC retain stringent oversight, requesting further assurance on the actions plan (with clear trajectories). External review concluded with action plan in place.	Off track
10	Coding resource	Chief Medical Officer / Chief Finance Officer	November 2026	There remains a risk to the Trust with the ability to adequately resource the coding team to ensure appropriate management of coding patient information and addressing the current backlog. There remains a national shortage of clinical coders in the NHS and not having the appropriate resource impacts on the backlog, delayed patient submissions and financial uncertainty.	New
11	White Ward ASPIRE Accreditation position	Deputy Chief Executive / Dual Chief Nursing Officer	November 2025	The Dual Chief Nursing Officer / Deputy Chief Executive Officer RCHT has had an initial scoping meeting with the Directors of NMAHP's / NAHP's to look at potential internal quality summits and a re-set over September 2025, focusing on the ASPIRE programme improvement plans, integrated falls, and pressure ulcer improvement plans, quality priorities, and the deconditioning programme. This will include as appropriate bespoke advanced practice / corporate / learning and development sessions / support. Improved position mid-September with 10 white wards an improvement from previous month. Quality Review for AEM set up for 17th September 2025. AEM quality review undertaken with follow up in November. Targeted actions underway through AEM. Reduced to 8 white wards in November. Continue to report to Committee The overall picture as of the end of quarter 3 2025-2026 is that there are 7 areas that are rated as white, 17 areas as bronze, 8 areas as silver, and 1 area as gold	Ongoing
12	Action plan in response to the CQC Urgent and Emergency Care Inspection Report	Deputy Chief Executive / Dual Chief Nursing Officer	March 2026	Draft action plan developed to address regulatory breeches. Submitted for delegated approval to Quality Assurance Committee and will be tracked/monitored by CQC Scrutiny Group.	New

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				Action Plan continues to be monitored through Quality Assurance Committee. Making progress but remain in fully escalated hospital site; this has been escalated to interim CNO ICB and will be discussed at Rapid Quality Review during February.	
13	Review of patient safety impacts of the Trust organisational change process	Chief Nurse Officer	December 2026	As part of the consultation process considerations will be made to ensure patient safety remains paramount. The consultation process enables colleagues to provide comment and feedback on the proposed changes. An EQIA was completed as part of the process and the monitoring aspects will continue to be monitored. Any final proposal will require an Equality, Quality Impact Assessment. EQIA undertaken as part of Board approval process of Care Group and Corporate change; assessment centres have commenced. Action being taken to address gaps in medical leadership to ensure appropriate oversight of organisational priorities including delivery of UEC and eradicating corridor care.	New
14	Understanding controls and addressing any common themes associated with Never Events	Chief Nurse Officer	June 2026	In April 2026, two incidents met the national criteria for Never Events involving retained foreign objects after invasive procedures. Immediate actions have been taken, including Trust-wide safety communications, reinforcement of checking and documentation processes, and a formal investigation to identify learning and support further improvement. Quality Assurance Committee retains oversight through its patient safety and incident response reporting arrangements.	New

Links to Corporate Risk Register (CRR) – Safe and high-quality care

CRR reference	Title	Executive Lead	Current risk score	Target risk score	Review date
9106	Delivery of the Children in Care service and related statutory duties	Chief Nurse Officer	16	6	July 2026
9048	The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.	Chief Medical Officer	25 (extreme)	8	December 2025
8922	Lack of security at RCHT	Director of Estates and Facilities	16 (extreme)	12	March 2026
8711	Compliance with NHSE National Standards for healthcare cleanliness 2021 guidance	Chief Nursing Officer		6	April 2027
8585	NOF mortality increases	Chief Medical Officer	12	9	October 2025
8339	Increase activity in safeguarding referrals	Chief Nursing Officer	16 (extreme)	6	November 2025
6487	Reduced stroke mortality rate	Chief Medical Officer	12	6	April 2026
6418	Referral to treatment time (RTT) and planned care long waits	Chief Operating Officer	16 (extreme)	12	March 2026
9736	(ECPR) patient safety lessons learnt ecare	Chief Strategy Officer	16	8	March 2026
9524	Maternity Triage	Chief Nursing Officer	16	6	July 2026

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BAF 2. Failure to attract, include, develop and retain a sustainable and thriving workforce that enables transformation in the workforce to support flexibility, diversity and patient centred care	
Risk cause(s)	• Short-term or sustained operational pressures with inability to resource right numbers and skill sets. • Remote geographic location, transport and housing challenges makes it more difficult to attract talent from outside of county. • National skills shortages in key areas including nursing, medicine and clinical imaging and skills drain from the NHS to better paid roles outside of the sector. • Industrial action and lack of support from media. • Lack of system alignment on workforce needs and/or system workforce planning focussed too much on the short-term. • Insufficient recognition or reward. • Poor organisation-wide communication. • An organisational culture that is driven by blame not learning and/or by short-term financial planning. • Lack or actual or perceived parity in benefits and rewards with other NHS bodies in Cornwall. • Lack of organisational development and leadership development support impacting on leadership capability. • Sexual Misconduct , harassment Bullying of patients or harassment of staff. • A lack of belonging, diversity , inclusion and equity in treatment, processes and/or opportunities inside and outside the workplace • Recruiting staff with wrong values not aligned to Trust values • Insufficient resourcing of the People and OD directorate to support workforce planning and recruitment, HR matters and organisational culture.
Impacts if risk realised	• Detraction from long-term strategic workforce and associated financial planning across health and social care. • Demanding CIP/unsustainable staff turnover levels impacting on safe, high-quality care and support services. • Absence levels impacting on safe high quality care • Increased agency/bank targets resulting in a breach of the national threshold. • Negative impact on staff morale, engagement, health, safety and wellbeing, including behavioural and cultural impacts on individuals or teams (as evidenced by staff survey results). • RIDDOR reporting/MSK • Single points of failure and duplication of processes or systems. • Negative impacts on staff mental health resulting in high levels of sickness related to stress and anxiety and resultant demand increases for occupational health support. • Increased number of incidents, absence and turnover, low motivation and morale leading to poor staff experience, poor patient experience, poor patient outcomes and higher mortality • Fear of speaking up and not learning lessons creating cultures that are not psychologically safe – leading to greater mental wellbeing concerns/stress/burnout and staff suicide • Increased number of freedom to speak up cases and/or grievances also staff complaints and unhappy patients and families • Reduced innovation and transformation of clinical pathways and reform across the system leading to gaps in service and poor patient safety and experience.
Strategic Objectives Affected: Year 2	**Supported and valued people** • Support the development of our staff and embed a safety culture that ensures people feel safe and supported to speak up. Delivered through the implementation of our Organisational Development Plan, with a focus upon three key areas: Values and Behaviours; Civility and Respect; and Leadership and Management Development. • Deliver system-wide workforce transformation through the Workforce Efficiencies programme, with a focus on collaboration, reducing agency, developing our workforce and enabling new models of care and recruiting less agency staff and investing in the development of stable substantive workforce. • Make it easier for our staff to do their jobs through the delivery of the Workforce Systems Transformation programme, ensuring our ESR system effectively supports staff. This has been supported by the roll-out of Manager Self Service.

Lead Director	Chief People Officer	**Lead Committee**	People and Culture Committee	**Date of last review by Committee**	May 2026 (last approved by Board May 2026)

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BAF risk scoring										
Initial risk score (Q3 2022/23)	20	**Risk appetite**	Minimal to cautious	**Tolerable risk score**	6-8	**Target date to tolerable**	December 2026~~5~~	**Actual and prospective risk**	**Actual**	**Projected**

		score
Risk controls or mitigations	A. Strategic workforce plan – Trust and system to address Darzi Report through reform B. Updated apprenticeships programme. C. Succession plans in place for executive directors and non-executive directors. D. Board skills survey to ensure the right skills at Board level. E. Effective organisational structure and clarity of portfolios. F. Strategic staff accommodation plan agreed by Trust Board. G. Use of Model Hospital and other available benchmarking to check staffing levels. H. Implementation of the People Promise and Just Culture approaches. I. Wellbeing and Occupational health offer in place, including 24/7 access to support. J. Freedom to Speak Up Guardians, framework and policy compliant with national standards. K. Guardian of Safe Working Hours for junior doctors. L. Dual Chief People Officer role across RCHT and CFT to help bring alignment on benefits, rewards and policies. M. Division and Trust-wide actions against Staff Survey outcomes and pulse surveys. N. Training in inclusive recruitment shortlisting and panels O. Annual appraisals and staff performance management through regular 1:1s. P. HR People Partners in place to support line managers and Divisions. Q. Implementation of actions to support and promote equality, diversity and inclusion (including Board Diversity Plan) and Staff Networks for colleagues from underrepresented groups. R. Engagement with staff unions via JCNC and JLNC. S. Statutory and mandatory training for clinical and non-clinical staff. T. Better onboarding, induction, career conversations, exit interviews. U. Pensions options and total reward statements V. Staff health and safety risk assessments. W. Workforce planning at Division level to ensure effective management of resources and keep focus on long term workforce planning not short term resourcing solutions.	

scores (as at end of quarter)	Q2~~Q1~~	Q3~~Q2~~	Q4~~Q3~~	Q1
Consequence	4~~4~~	4~~4~~	4~~4~~	4
Likelihood	4~~4~~	4~~4~~	4~~4~~	4
Current risk score (LxC)	**16**~~16~~	16~~**16**~~	16~~16~~	16

Assurance framework – three lines of defence (links to mitigations identified by letter reference)			
	First line of defence ***Division/operational level***	**Second line of defence** ***Oversight/corporate***	**Third line of defence** ***Independent/external***
Assurance	• Division oversight of staffing levels and skills mix (B, C, E, H) • Division Boards' review of engagement, appraisal and mandatory/statutory training data and staff survey outcomes (I, K, N, T)	• People performance report to People and Culture Committee (B, C, H, K, N, O, Q, S, V) • Scrutiny of Trust workforce plan by POD Committee (A) • Review of Board skills survey outcomes by Remuneration and Appointments Committee (E) • Staff survey data scrutinised by People and Culture Committee and Trust Board (F, UI, J, K, N, O, Q) • Performance Review meetings with Divisions (B, C, F, G, K, N, O, S) • Freedom to Speak Up Guardians biannual reports to Trust Board (K, Q) • Guardian of Safe Working Hours Reports to Trust Board (L) • Quarterly equality, diversity and inclusion reports to People and Culture Committee and annual report through to Trust Board (Q)	• Care Quality Commission inspections (well-led) (A, B, D, E, F, H, I, J, K, G, N, O, Q, R, S, T) • Staff Survey outcomes (benchmarked) • Care Quality Commission inspections (well-led)

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Gaps in assurance	1. Capacity within the People and OD directorate to support the Organisational development, culture, recruitment and retention and employee relations and ensure and support the ongoing culture and large scale organisational transformation and change capacity and capability across the Trust. 2. In the context of the Financial, Operational and Workforce Plan ~~2025/26~~2026/27, the ability to manage, monitor and retain hard to fill posts across the wider workforce and the impacts of the associated agency costs 3. System-wide gap in resource allocation, commissioning and budgets 4. Compliance with suitable and sufficient supervision, instruction and training i.e. Appraisal and statutory and mandatory training completion rates. 5. Capacity and resources available to successfully support and improve staff wellbeing and sickness rates (particularly stress and anxiety). 6. Staff safety is paramount and responding to the sexual safety charter and the violence and prevention and reduction requirements are still evolving 7. Having appropriate resource to support and develop as well as appropriate indicators to measure improvement in organisational inclusive culture 8. Responding to the staff survey
Overall level of assurance	Limited

Actions to address gaps in assurance

No.	Action required	Executive Lead	Due date	Progress Report	On or off track
1	Consider and develop an appropriate OD plan	Dual Chief People Officer / Chief Strategy Officer	June 2026	The Culture Task Force to consider the key priorities and next steps for September 2025 and beyond to September 2026 The Culture Sub-Committee in development with the primary focus on embedding a Quality Improvement Culture. People and Culture Committee in March to receive the Culture Sub-Group TOR The development of the Organisational Development Plan will be considered as part of the Strategic Workforce Development Group roles and responsibilities. The Trust paused its OD plan in 2025/26 and a People Plan (aka OD Plan) will be developed as part of the refreshed Trust Strategy and in line with the new Corporate structures which will include a range of key components. Discussions commenced to develop OD and culture plan. Culture Transformation programme commenced and inaugural meeting of the Culture Group in May 2026. The Board have received and approved a Culture transformation plan. Dual Chief People Officer produced and engaging on a draft People Plan which references OD themes strongly i.e. leadership and management development, organisational culture and workforce transformations/ new ways of working.	Off track
2a	Development of a Medium-Term Workforce Plan	Dual Chief People Officer	April 2026	NHS 10 Year Plan requires 3. 5 and 10-year workforce plans; revisiting the original development of a 5 year plan. CPO engaging with ICB about developing a longer-term (2040) workforce plan. The Trust is engaging with NHSE Consultation on the 10 year workforce plan. The Trust completed the annual workforce plan (national submission) this will then feed the Medium Term Workforce Plan in Q1 of 2026/27	Ongoing

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				The Committee received a deep dive discussion on the Medium Term Workforce Plan and received the first draft of the plan at its ~~in~~ March 2026 meeting ~~and scheduled to be presented to Committee at the end March 2026.~~ Building the structure to engage with new Divisions to develop, a bottom up, assumption based plan in Q1. The Trust Board in May received the plan; the plan remains a "work in progress" and will be updated to include current position as well as consider factors such as neighbourhood health, system reform and future workforce for the Trust. Further alignment to take place with the Medium Term Financial Plan (due in May 2026).	
2b	Agency controls to efficiently and effectively reduce agency usage and costs	Dual Chief People Officer	May 2026	Developed agency and bank control mechanisms, management information, interventions and monitoring to reduce overall cost. Monitoring continues and national targets achieved. Routine Bank and Agency weekly report to provide high level assurance at Executive/Management level. Temporary staffing has increased during October in response to operational escalation pressures. Management actions / controls are in place to mitigate risk. Continued focus on medical agency and responding to sickness absence through the Trust Bank arrangements. Note the 2026/27 plan requires a reduction in bank spend. National requirement: 30% reduction in agency 2026/27 with 10% reduction year on year for Bank and by 2029 a requirement for no bank usage. Temporary staffing i.e. escalation and staffing sickness is primary usage. Noted medical staff remains an issue but to a much lesser extent and action being taken to ensure job plans are in place. The Trust continues to breach its bank and agency target with a plan to deliver the year end position. Board level focus on sickness absence.	Ongoing
3a	System-wide approach to developing a workforce at "place"	Dual Chief People Officer	April 2027/8	Clinical Strategy forms part of the 2025/26 refreshed Trust Strategy. Commissioning Intention to have Integrated Neighbourhood Teams and work to develop the operational model being undertaken; workforce implications will then be understood to support the model. National discussions continue regarding INTs and the Trust, with system partners are engaged with neighbourhood discussions. Developed infrastructure to support including system wide recruitment portal which allow all vacancies to be listed in one place; redeployment hub (for staff at risk) and developing transfer hub which will include a transfer window to enable movement within health providers in Cornwall.	Off track

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				Asked ICB to coordinate a new system workforce plan for April 2026 16 Integrated Neighbourhood teams are in development with five active INTs but impacts are not yet realised. Further exploration required to ensure joined up system approach with the development of a blue-print. Continue to have separate organisational plans but there is a greater level of integration and collaboration and the 2026/27 Plan has been approved.	
4 a	Establish and implement a robust action plan to improve appraisal rates across the Trust (noting link to well-led) and embed to see sustained improvement	Dual Chief People Officer	April 2026	Manager self-service is operational and helps to identify gaps; greater level of data through ESR will enable greater grip and control on hotspot areas where additional support can be deployed. Monitoring continues through IPR and oversight through People and Culture Committee. Performance remains to fluctuate alongside operational challenges and organisational change and Committee/Board oversight through IPR. Recognised that during a period of change this will impact on compliance. Continue to monitor through People and Culture Committee and through the IPR (at Board) National procurement of a new HR system to replace ESR is ongoing and as part of this new system, expectation there will be an appraisal platform. New People and OD operational model will come into place from 2026/27 which will push accountability to organisational structures. New performance management arrangements in place through the new Divisional structure assurance framework. Survey to be commenced in Trusts February 2026 on the introduction of a new national appraisal approach. New national management and leadership framework to be introduced in 2026.	Off track
4b	Establish and implement a robust action plan to improve mandatory and statutory training rates across the Trust (noting link to well-led and patient and staff safety)	Dual Chief People Officer	April 2026	Increased performance over last 12 months; part of the national group to standardise approach across the NHS. Strategic Workforce Group will have a Part 2 focussed on training (as per NHSE requirements). Reviewed all Statutory and Mandatory Training and revisited the timescales for training and changes will be implemented onto ESR ongoing. Compliance with statutory and mandatory training has deteriorated which is attributed to large scale organisational change process.	Off track

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				RCHT has compliance to national core skills framework on stat/man training and monitored by Strategic Workforce Committee. To support the delivery of eCare Training the Trust is reviewing its face to face training requirements and developing a compliance trajectory. Noting go-live pause announced in April 2026 and a comprehensive review of the programme, impacts and revised launch taking place. People and Culture Committee seeking assurance on impacts of statutory and mandatory training in May 2026 As part of the new Divisional structures, there will be recovery trajectory plans developed for People Metrics which will form part of the routine Divisional performance monitoring mechanisms.	
5a	Review and strengthen occupational health and wellbeing offer for staff	Dual Chief People Officer	July 2025	Review of occupational health completed in 2023/24. Received in October 2023, consideration of the report and an action plan to be developed in January 2024. Note business case(s) have been developed, including an options appraisal undertaken. Improving health surveillance and focus on developing a robust options appraisal due to continued level of challenge regarding pace. Wider considerations around a Wellbeing Plan underway and improved the accessibility of information for staff (consolidated into one place). New Sharepoint putting wellbeing into one place launched. New Wellbeing offers being communicated weekly working with voluntary sector partners Developing a Wellbeing and Inclusivity Group – TOR to go to PCC New wellbeing plan to be developed by new Group. CFT agreed to outsource, Lead Consultant for OH In place. The Trust will be considering the future service requirements and appropriate resource in line with new Divisional and Corporate structure changes. Considerations / progress around future options for OH Building.	In progress .
5b	Develop a plan to improve attendance management	Dual Chief People Officer	April 2026	Consideration regarding options to support staff and managers with sickness absence and management. Plan developed and going to ELT for discussion and further updates. Financial Sustainability Plan Group have considered a bespoke attendance management plan with the aim of implementation with the new Divisional and Corporate Structures. Monitoring through newly established performance meeting arrangements.	new

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				New absence target set.	
6	Having a safe environment for staff and patients	Dual Chief People Officer/ Chief Operating Officer / Dual Chief Nurse Officer	April 2026	At the end of 2024/25, Trust declared full compliance with 42/43 indicators against NHSE VPR standard V1. NHSE VPR Standard V2 now been released and is much more wide ranging. Full mapping has taken place with series of meetings in place to work through accountabilities. Continue to take papers to relevant Committee meeting with next outcome paper being presented to QAC in September. Current unvalidated position is 18/43 fully achieved. Sexual Safety and Domestic Violence arrangements and policy established. Recent engagement exercises have proven helpful and informative; resources have been established and clear leadership in place. National letter regarding Sexual Safety and sets out clear actions required by providers. Audit completed and actions being followed up. Dual CPO attending sexual misconduct roundtables to bring back learning.	On track
7a	Utilising lived experiences and shared learning, using the EDI Networks and promoting staff education	Dual Chief People Officer	April 2026	Networks are starting to mature and further solidarity events scheduled. Follow up sessions held in February 2025; this will return to business as usual mechanisms. Research into ethnic minority colleagues leaving roles in the NHS. Disability Network progressing a passport to support reasonable adjustments. Link with the Culture Taskforce and an EDT session to be scheduled and the Annual EDI Report to Board. In the process of introducing Bystander Training at RCHT and the Trust has a robust reverse mentoring scheme in place. Annual reporting on WRES, DES, Gender Pay Gap is well established but there remains a gap with regard to improvement actions. Options appraisal regarding supporting ethnic minority colleagues. Paper to ELT on Inclusive support for staff networks. Dual CPO taking over chairing of Intersexuality meeting across the system.	In progress
7b	Cultural change readiness to support transformational change i.e. eCare	Dual Chief People Officer / Chief Performance, Partnerships and	April 2026	Engaging through Organisational Change programme board to ensure organisational readiness. Culture Taskforce to review aspects of organisational culture around change/transformational	To be developed further

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		Transformation Officer		change/change management. Listening Events scheduled for October 2025 which will include Executive and Non-Executive Directors. Link with action 8c regarding development of a Sub-Committee regarding culture which will report to People and Culture Transformation change in eCare; HR support roles being established and funded to support the change programme as part of the eCare programme. eCare report to People and Culture Committee being reviewed. eCare go-live paused.	
7c	Culture Taskforce to evolve into a Culture Sub-Committee (reporting to People and Culture Committee	Dual Chief People Officer/ Chief Performance, Partnerships and Transformation Officer	April 2026	Primary focus of the Culture Sub-Group will be to embed QI culture into the organisation Organisational Development, including an inclusive culture, management and leadership development will remain under the leadership of the Dual Chief People Officer through the Strategic Workforce Development Group New leadership development paper in draft. TOR ~~scheduled to be~~ presented to People and Culture Committee in March 2026 with a proposal to Trust Board in April received and supported. Inaugural meeting of Culture Group in May 2026	Propose complete ~~New~~
8a	A robust action plan that delivers improvements in the staff survey	Dual Chief People Officer	April 2026	People and Culture Committee monitor progress against the staff survey. The Trust Pulse Survey's provide valuable insight into the organisation – immediate actions being progressed. You Said We Did staff engagement sessions scheduled throughout October and November to outline progress against staff survey outcomes. Programme of engagement events scheduled as part of the launch of the 2025 Staff Survey. Staff survey closed with a c50% compliance rate. Staff survey results will go to PCC and Board to agree priorities. Staff Survey results issued 12 March 2026; report to People and Culture Committee in March and action plan to Board in May/June. Lets Talk Sessions scheduled w/c 16 March. Trust Board in May received the Staff Survey results and the action plan. Agreement to prioritise key areas i.e. being a place to work and receive care as well as making improvements in appraisal; raising concerns and health and safety and the Board requested an accelerated approach to review and update the action plan. Noting alignment with Culture work. Further discussion by People and Culture Committee in May (post Board).	~~New~~ Ongoing / off track

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Links to Corporate Risk Register (CRR) – Sustainable workforce					
CRR reference	**Title**	**Executive lead**	**Current risk score**	**Target risk score**	**Review date**
8769	Microbiology medical workforce risk	Chief Medical Officer	16 (extreme)	6	June 2026 (overdue)
8693	Blood Sciences Workforce and Training Capacity	Chief Medical Officer	16 (extreme)	6	March 2025 (overdue)
9110	Paediatric Medical Staffing	Chief Medical Officer	15 (extreme)	6	October 2025
9006	Neonatal Nurse Staffing Risk	Chief Nurse Officer	16 (extreme)	6	September 2026
9346	Breast Oncology Staff Shortfall	Chief Nurse Officer	16 (extreme)	6	September 2026
9554	(ECPR) Disruption to staffing from eCare implementation		12		September 2025

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BAF 3. Failure to optimise the advantages of integrated health services for safe, high quality care

Risk cause(s)	• Lack of clear implementation plans for agreed system priorities • Under developed relationships with some system partners, including the local authorities and third sector • ICS-wide governance maturing but not yet fully developed • Insufficient modelling of demand and capacity within the ICS • Better clarity required on how ICS resources will be utilised across all sectors • Insufficient resource (budget and workforce capacity and capability) to drive integrated care transformation and lack of transition resource • Insufficient understanding and management of system-level risks • Emerging risks following national announcements on ICB restructure and cost reductions (50%) as well as for NHS England • National and geo political position meaning financial resources are increasingly constrained
Impacts if risk realised	• Ineffective join-up of care resulting in patient harm, poor flow and care quality outcomes • Negative impact on staff morale and wellbeing as a result of sustained operational pressures due to ineffective systems and processes • Missed opportunities for risk sharing • Negative impact on delivery of the Trust's financial and operational plans • Increase in health inequalities in the county • Regulatory intervention and increased scrutiny and/or restrictions resulting in reputational damage to the NHS in Cornwall • Increased operational pressures as a result of lack of alignment of system risks, priorities and plans
Strategic Objectives Affected: Year 3	**Journey of Improvement / Safer High Quality Care** • Ensure the Trust and system are financially sustainable through delivery of the System Financial Recovery Programme and improvements to productivity • Build upon our existing relationships with local Universities to support our application for University Hospital status, and to develop a Cornish medical school • Through the eCare Programme, translate the plans of the new EPR into delivery of clinical transformation and optimising our digital capabilities throughout the organisation • Make improvements in our estate, including: • Deliver the key enabling schemes for the Women and Children's build. • Establish a significant operational estates improvement programme to ensure we deliver a safe and effective environment • Through the Patient Leader Programme, strengthen patient involvement in the development and delivery of our strategic priorities. • Through provider collaboratives with Cornwall Partnership NHS Foundation Trust, the Peninsula Acute Providers Provider Collaborative and Integrated Care Areas work with system partners to improve clinical pathways of care • Realisation of annual operational and financial plan including reform transformation programme

Lead Director	Chief Performance, Partnerships and Transformation Officer	**Lead Committee**	Finance and Performance Committee	**Date of last review by Committee**	~~March~~ May 2026 (approved by Board May~~rch~~2026)

BAF risk scoring

Initial risk score	20	**Risk appetite**	Open	**Tolerable risk score**	8-10	**Target date to tolerable score**	April 2026

Risk controls or mitigations	A. RCHT Trust Strategy agreed (November 2022) and strategy being refreshed to reflect NHS 10 Year Plan B. Formal provider collaboratives governance structures established with Cornwall Partnership NHS Foundation Trust and acute providers in Devon C. System Executive Group coordinates system leadership and delivery of system transformation programmes D. Trust engagement in agreement and delivery of Joint Forward Plan (JFP) (draft agreed March 2023) and Joint Capital Plan (JCP) (agreed March 2023) E. Trust input to development of the Integrated Care Strategy F. Annual financial and operational plans aligned at system level G. Senior officer engagement in the Pathology and Imaging Networks H. Flow Programme deliverables I. Memorandums of Understanding with local universities J. System Recovery Oversight Group

Actual and prospective scores	**Actual**			**Projected**
	~~Q3~~ ~~Q1~~	~~Q4~~Q2	~~Q4~~Q3	Q1
Consequence	4 ~~4~~	4	4	4
Likelihood	3 ~~3~~	3	3	3
Current risk score (LxC)	12 ~~12~~	12	12	12

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	K. System Control Centre to inform coordinated operational response to system pressures

Assurance framework – three lines of defence (links to mitigations identified by letter reference)

	First line of defence *Care Group/operational level*	Second line of defence *Oversight/corporate*	Third line of defence *Independent/external*
Assurance	• System Executive Group fortnightly meeting monitors revenue and capital position and oversees system transformation programmes (B) • Quarterly reports on Network activities to Executive Leadership Team (F)	• Quarterly reports on delivery against Trust Strategy, including alignment to system priorities, to Trust Board (from March 2023) (A) • Scrutiny of NHS Oversight Framework metrics via Finance and Performance Committee, Trust Board and Integrated Care Board (E) • Reporting from the Integrated Care Board meetings to Trust Board (C) • Financial (revenue and capital) reporting to Finance and Performance Committee and the Trust Board (B, E) • Workforce reporting, including system-wide developments, through to People and OD Committee (A, B and C) • Reports on delivery against the university MoUs to the relevant Committee (I)	• External well-led governance reviews (RCHT and/or system-wide) (A – G) • Care Quality Commission inspections (A – G)
Gaps in assurance	1. System governance arrangements that describe effective integrated working and responds to rapidly changing context and the new ICB Cluster arrangements 2. Capacity, capability and governance arrangements to support delivery of the scale of the transformational programmes for RCHT and the system 3. Ability to respond to dynamic national and geo political context in light of 10 year NHS plan 4. Coherent system view regarding neighbourhood health (as part of the 10 year plan) and maximise the opportunities and improving health inequalities		
Overall level of assurance	Medium		

Actions to address gaps in assurance

No.	Action required	Executive Lead	Due date	Progress Report	On or off track
1a	To identify and understand the ICB governance arrangements and the development of a System Assurance Framework	Chief Performance, Transformation and Partnerships / Company Secretary	April 2026	The arrangements remain in place, noting the movement to a Cornwall and Devon ICB Cluster arrangement. Devon and Cornwall ICB cluster governance arrangements have been developed and Inaugural meeting of the South West Peninsula Board scheduled for October 2025. Planning round is now completed Transformation governance being considered in line with Neighbourhood blueprint South West Audit Forum being scheduled (with Audit Committee Chair and Co-Sec) to explore shared learning and considerations regarding a System Board Assurance Framework. Company Secretary continues engagement but progress is slow.	Off track
1b	Proactive engagement with ICB and system partners regarding the developing Cluster model.	Chief Performance, Partnership and Transformation Officer	September 2026	Ensuring every opportunity to proactively engage with ICB partners to shape effective system governance arrangements and working towards seeking clarity of functions. Devon and Cornwall Commissioning Intentions shared with providers and planning round will review and outline how they will	On track

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				be delivered and the associated impact. (Planning Framework 2026/27 and 28/29 issued in October). Understanding / seeking clarity on the future model for neighbourhood development between provider organisations. Link with gap/action 4	
2a	Overall level of risk of delivery of the scale and breadth of transformation	Chief Strategy Officer and Chief Finance Officer	Summer 2027	SRO leadership divided between Execs. New SRO for Women's and Children's Programme confirmed as Chief Finance Officer Good governance implanted across each programme. Oversight of interdependencies being explored by Executive Directors to ensure appropriate understanding and rigour in place for oversight Women's and Children's Programme governance embedded and link with BAF 2 regarding financial impacts. Alliance Agreement signed and progressing to procure provider to deliver the build but risk to deliver of Hospital 2.0. As of May 2026 provider has been allocated and announcement made – Trust continues to engage in the process and progress governance routes.	
2b	eCare oversight of programmes and enabling agile governance arrangements / infrastructure	Chief Strategy Officer	Summer 2027	E-Care now provide monthly programme updates to ELT and Finance and Performance Committee. NED check and challenge lead identified for eCare programme and Women's and Children's Hospital programme. Risks within the programme have been reviewed and are reporting to eCare Programme Board and those escalated to the Corporate Risk register are manged through Executive Risk Group. 90/60/30 day Go Live assessments in place. In the process of reviewing and providing assurance regarding Go-Live and working with NHSE regarding sign off. Programme governance has been embedded and reporting cycles strengthened through monthly reporting to Board of Go-Live risk. Heightened due diligence and the Trust continues to assess mitigations and risk tolerance ahead of Go-Live. In April 2026 the Trust Board agreed to pause the go-live and is in the process of re-evaluation the programme to determine a new timeline as well as costs impacts, training impacts etc.	Off track
2c	Develop a culture that will support the Trust deliver its strategic transformation priorities	Chief Performance, Partnership and Transformation	December 2026	Establishing a leadership and management approach that develops a culture that supports change management; through a Taskforce that identifies impacts and actions for delivery by September 2025 and by September 2026. Inaugural meeting in July Culture Taskforce presented outcomes to Trust Board in September 2025. Noted the progress and the formalisation of the Culture Group (reporting to People and Culture Committee) and engagement sessions scheduled for October 2025. Inaugural meeting took place in May 2026.	On track

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				Increased visibility and engagement with Board members regarding culture. A proposal being developed to set out the Trust approach to improve organisational culture which is a Trust strategic priority. Scheduled for early 2026. Engagement exercises are progressing i.e. staff awards Culture Task Force continues and evolving into Culture Group to have oversight of the work/programmes Align to Divisional and Corporate Structure and outcome of staff survey and the launch of a culture development programme. The Trust Board supported the proposed approach to culture transformation in April 2026 which will be underpinned by a communication and engagement approach.	
2d	Effective mechanisms for oversight of System Transformation	Chief Performance, Partnership and Transformation	April 2026	Transformation Oversight Programme (ICB led) in place to oversee the system reform agenda. RCHT actively engaging in the development of INTs with CFT and PLACE Directors. Weekly meetings with provider CEO's to focus on rapid provider improvement priorities. System transformation links with commissioning intentions and working with system on priorities. System Planning Oversight Group established with ICB which will oversee development of system priories for 2026/27. Agreement to have an iterative planning process throughout the year. Link with action 4 (INTs)	Ongoing
2e	Ability to achieve strategic objective to achieve University Hospital Status	Chief Performance, Partnership and Transformation	April 2026	MOUs with Universities are being refreshed. Continue to progress the ambitions through regular meetings and update regarding Trust progress regarding its strategic ambition to achieve University Hospital status. Discussions are ongoing and links with the strategy refresh scheduled for January 2026. New Trust strategy retains the commitment to achieve university hospital status. Developing an academic research strategy and ambition to embed research into the Divisional structure.	In Progress
2f	Ability to progress at pace the totality of the transformational priorities whilst also improving business as usual activities	Executive Team	April 2026	Given the scale of the totality of the transformation priorities in the next 1 – 5 years, the Trust has to deliver / meet all local and national requirements associated with finance, clinical, operational and statutory matters. The Trust has refreshed its Trust Strategy to focus on 4 key objectives and 6 areas of clinical focus which will provide the overarching structure and focus for the organisation. The Trust is developing its Financial, Operational and Workforce Plans for 2026/27+ as requirement by the Planning Framework. To support	Ongoing

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				this the Trust has robust governance mechanisms to report, monitor and scrutinise these plans through its Committee and Board meeting. Board assurance templates completed to support the level of assurance on the deliverability of the 2026/27+ plan. Plan submitted and further refinements ~~to plan scheduled to be~~ submitted 19 Mach 2026. Plan approved with the exception of RTT performance, noting impact of eCare go-live. RTT recovery plan being developed and presented to FPC in June 2026	
3a	Ability to respond dynamically to national and geo political context	Chief Performance, Partnership and Transformation	April 2026	Trust commenced Board engagement and clinical engagement in the development of a strategy refresh to reflect changed socio economic and political context. Draft to be issued by end of Q3 which will take into account / be aligned to the 10 year plan priorities. Regular discussion at Executive, Committee and Board level regarding national context and Board Strategy Session in October 2025 that focusses on the development of the Strategy Refresh. Recognition there has been movement globally but domestically there remains to be a lack of clarity around certain changes and potential/expected changes in legislation. Each of the BAF elements are being dynamically risk assessed against changing context and the potential for risk materialisation. Link with the above action 1d) and 3a) Significant change in the NHS Nationally and the Trust has reviewed and refreshed its Strategy in line with this. Trust Risk Manager undertaking training to support the exploration of this.	Evolving
4	Working with partners to agree the ambition for neighbourhood health for 2026/27	Chief Performance, Partnership and Transformation	April 2026	Working with partners to gain greater insight into opportunities to develop neighbourhood health as a system. Board to Board session with CFT scheduled to explore these opportunities as well as engaging with wider system colleagues regarding potential neighbourhood collaboration (which link with commissioning intentions and the refresh of the Trust Strategy). Informal provider collaborative approach being considered to support the development of a deliver model for neighbourhood, including General Practice and Voluntary Sector and Local Authority. National Association of Primary Care are leading neighbourhood health workshops with the intention to develop a blueprint for neighbourhood health in Cornwall and Isles of Scilly in February 2026. NAPC engaging with senior leadership team in January to discuss the development of the neighbourhood plan. Draft Neighbourhood blueprint developed and shared with partners. Engaging with national team regarding next steps and note that national guidance on plans for neighbourhood anticipated. Discussions continue regarding integrated services	Ongoing

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Links to Corporate Risk Register (CRR) – Integrated Health Services					
CRR reference	**Title**	**Executive lead**	**Current risk score**	**Target risk score**	**Review date**
9752	(ECPR) e Care Impact on ability to apply acute and timely Clinical Coding	Chief Performance, Partnership and Transformation	16 (extreme)	12	June 2025
9743	(ECPR) eCare impact on Trust wide Business Intelligence (RADAR) capability	Chief Performance, Partnership and Transformation	16	8	November 2025
9742	(ECPR) RCHT Capacity to Fully Engage with eCare while Delivering Operational Activity Targets	Chief Operating Officer	16	12	March 2026
9736	ECPR) Patient Safety Lesson Learnt-E Care - ACCT	Chief Operating Officer	12	6	September 20255

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BAF 4. Failure to achieve the Trust's medium-term financial recovery to positively benefit quality of care

Risk cause(s)	• Financial resources could be poorly managed and not directed to the highest priority areas. • Lack of access to external funding sources for capital and revenue developments/innovations. • Overspends within the broader Integrated Care System impacting on the Trust's financial position. • Insufficient cost improvement savings, particularly recurrent savings. • National context around financial affordability and further change in year.
Impacts if risk realised	• Breach of agreed annual financial and capital plan limits. • Regulatory action in particular mandated controls and dis-incentivisation. • Unsafe/out of date physical or digital infrastructure. • Inability to provide good quality of care and support patient safety due to poorly resourced areas. • Negative impact on staff morale if funds not managed properly and targeted to highest risk/opportunity areas. • Insufficient cash to pay the Trust's bills or staff. • Inability to address underlying deficit. • Vulnerability with contingency plans to respond to industrial action (including GP collective action). • Adverse external audit findings and report.
Strategic Objectives Affected: Year 3	**Journey of improvement** • Ensure the Trust and system are financially sustainable through delivery of the System Financial Recovery Programme and improvements to productivity • Ensure we are financially sustainable, delivering on the medium term financial plan

Lead Director	Chief Financial Officer	**Lead Committee**	Finance and Performance Committee	**Date of last review by Committee**	Mayrch 2026 (last approved by Board, ~~March~~ May 2026)

BAF risk scoring

Initial risk score	20	**Risk appetite**	Cautious	**Tolerable risk range**	6-8	**Target date to tolerable score**	March 2026

Risk controls or mitigations
A. Annual Financial and Operating Plan B. Medium Term Financial Plan (MTFP) C. Annual Capital Programme (and associated risk prioritisation) D. Budget, counter fraud, standing financial instructions and scheme of delegation training for budget managers and senior staff E. Standing Orders, Standing Financial Instructions and the Scheme of Delegation F. Finance Business Partners in place to support each Care Group G. Performance Assurance Framework H. Cost Improvement Programme (CIP) initiatives across Care Groups and corporate I. Workforce recruitment and agency controls J. Cash flow forecasting K. System financial planning through annual budgets, Joint Forward Plan and Joint Capital Plan L. Grip and Control Checklist and accompanying action plan M. Care Group financial governance letters; committing care groups to deliver N. Appointment of System Recovery Director to oversee financial recovery and medium term financial plan – overseeing enhanced governance mechanisms O. Development of financial sustainability programme for 2026/27 onwards P. P. Monthly self assessment against Risk of non delivery assessment (RONDA)

Current and prospective scores	**Actual**			**Projected**
	~~Q2~~ Q1	~~Q3~~ Q2	~~Q4~~Q3	Q1
Consequence	~~4~~ 4	~~4~~ 4	~~4~~4	4
Likelihood	~~4~~ 4	~~4~~ 4	~~4~~4	4
Current risk score (LxC)	~~16~~ 16	~~16~~ 16	~~16~~16	16

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Assurance framework – three lines of defence (links to mitigations identified by letter reference)

	First line of defence ***Care Group/operational level***	**Second line of defence** ***Oversight/corporate***	**Third line of defence** ***Independent/external***

Assurance	• Monthly monitoring of Care Group budgets at Care Group Boards (A, D, E, F, H, I) • Counter Fraud daily monitoring (D, E) • Major Capital Projects Committee (managing the strategic estates programme and budgets) (C, E) • Capital Approvals Group and subgroups to manage the Trust's capital programme (C, E) • Investment Group to manage revenue investments including elective recovery fund (A,H, I, L) • Care Group / corporate areas forecast review meetings (Q3/4) to reset forecast targets ((D, E, F, H, K) • Weekly CFO review meeting on Cash balance, previous week performance and rolling 13 week cash flow review (J)	• Monthly Performance Reviews with Care Groups/Corporate, includes financial performance (A, E, F, G, H, I) • Monthly Chief Finance Officer system meetings to review in-year revenue and capital positions (B, K) • Monthly finance (revenue, capital and cash) reports to Finance and Performance Committee and Trust Board including quarterly "deep dive" on cash (A, B, E, J) • Monthly Financial Recovery Report to FPC, QAC and PCC (A, B, E, J,I, O) • Scrutiny of Annual Capital Programme and updates by Finance and Performance Committee and approved by Trust Board (C, E) • Quarterly Counter Fraud reports to Audit and Risk Assurance Committee (D, E) • Twice yearly update on the MTFP to Finance and Performance Committee (B)	• Annual external audit including value for money review (A, B, C, H, J, K) • Internal audit of financial controls (D, E, I) • Internal audit of HFMA Financial Sustainability checklist (across core financial governance controls) • Workforce Control Internal Audit (H, I,O) • Financial Override on Segmentation (A,K) • RONDA self assessment (P)
Gaps in assurance	1. Financial risk (capital and revenue) resulting from any delays in eCare go-live (risk to delivery of the eCare programme is covered in BAF element 5) 2. Development of fully identified and costed savings schemes for 2026/27 that enable a balanced forecast financial position 3. Development of Medium-Term Financial Plan 2026/27 for submission and acceptance by NHSE 4. Management of revenue affordability of Women's and Children's Hospital Programme in line with outline business case approval conditions 5. Financial risk and funding mechanisms for any eventual change arising from workforce consultations 6. Financial risk associated with the impacts of industrial action 7. Lack of an agreed 2026/27 capital programme, limiting assurance that capital can be allocated in a timely, prioritised and risk-based way. ~~5.~~8.		
Overall level of assurance	Medium		

Actions to address gaps in assurance

No.	Action required	Executive Lead	Due date	Progress Report	On or off track
1	Monitor through finance report to eCare Board	Chief Finance Officer / Chief Information Officer	~~June 2026~~April 2027	~~Go live remains on plan for June 2026 following passing of most recent gateway. Resource plan updated and agreed and review of contingency undertaken at programme board. Continue to review up to go live in June 2026 with Go/No Go review process embedded at 90/60/30 days~~ eCare remains a critical solution to analogue to digital and the Trust and there remain risk around elective activity delivery which is being pursued through 26/27+ planning. Capital in year forecast potential risk of underspend; understanding impacts in the 2026/27 capital plan. There remain resourcing challenges which are being addressed but the programme remains on track from a revenue perspective. A sustainment plan in development (revenue consequence) to understand impacts in future years. A Board Development Session took place in February 2026. Monthly assurance report to Trust Board post go-live to provider a greater level of detail. Revenue impacts of sustainment plan as draft plan currently exceeds FBC values. In addition further review sought of benefits realisation for 2026/27 and beyond (compared to business case values).	~~In progress~~Off track

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				eCare go-live delayed following Board approval. A review of the programme taking place to determine recommendations regarding revised timeline. This includes financial impacts which remain a significant risk.	
2	Development of savings schemes for 2026/27 that enable a balanced financial position	Chief Finance Officer	April 2026	Route to breakeven presented and discussed at FPC and Trust Board. CEO and CFO escalation meetings with Care Groups in February 2026 and Trust wide communications issued. Month 11 financial position remains on plan with delivery being monitored against the route to break even. Overall risk reducing and increased confidence in year end break even delivery. For 2026/27, significant focus and work through FSP Programme Board to identify schemes against the full value required. Further actions via workstream SROs identified and being tracked monthly meetings. Percentage of high risk schemes reduced since 12 February annual plan submission. One area remains outstanding regarding RTT delivery, noting impact of eCare. The Trust is developing a trajectory to deliver 81% RTT performance; scheduled for FPC in June 2026	In progress
3~~a~~	Update and submission of MTFP by national deadline (as part of planning submission for 2026/27 +)	Chief Finance Officer	Summer 2026	First submission completed and feedback received; Executive meetings with NHSE as part of the process and further detailed work with ICB to ensure alignment and options to reduce draft deficit ahead of final submission. Board received an update on the MTFP and update on the three year planned submission in February 2026. Extraordinary Trust Board on 10 February approved the final breakeven submission of the 2026/27+ plan; updates will be provided through FPC and Board. Trust received feedback on 12 February planning submission. Work being undertaken to review this and further update to inform NHSE assurance process on 18 March 2026. Areas of focus are RTT and efficiencies development. MTFP being updated in May 2026 and scheduled for presentation to Trust Board in Private and Public in July 2026.	Ongoing
4	Through Programme Board ensure focus on revenue affordability of W&C Hospital Programme	Chief Finance Officer	March 2026	As part of the Outline Business Case refresh, ensure options consider the revenue implications of the short and longer term of the programme. Continues to be highlighted in the monthly programme board financial updates and is being developed through workshops and engagement with the new Multi-disciplinary Design Team (MDDT). Next key phase will be through the development of the OBC refresh. As part of the programme, the Trust continues to engage with NHP regarding the next phase of design and business case refresh. The New Hospital Programme (NHP) reached a milestone in the Hospital 2.0 Alliance mobilisation process. Collaborative Allocation activity has now been completed across participating Wave 1 schemes, which include RCHT, and construction partners within the Hospital 2.0 Alliance. Willmott Dixon will construct our new Women and Children's Hospital, subject to governance and contractual requirements being met over the coming weeks. Note the ongoing risk associated with the affordability of the programme and the Trust has received some assurances on a revised budget – the Trust continues to work with NHP.	Ongoing
5	Monitor financial impacts of organisational change	Chief Finance Officer	April 2026	Discussed the approach with both ICB and Region about the approach. The Trust has assessed the financial impacts and provided Board level assurance and scenario planning.	Ongoing

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				Review and report to Board as part of consultation process in November 2025 and January 2026 to approve the final structures. As of January 2026, consultation has closed and the Trust Board approved the final Divisional and Corporate Structure and the Trust is in the process of enacting this; this will be accounted for in line with accounting standards. Initial assessments of impact undertaken and lessons to be learnt.	
6	Mitigate actions to reduce the financial risk associated with Industrial Action	Chief Finance Officer	March 2027	There remains a gap in assurance in relation to the uncertainty, scale, and cumulative impact of industrial action. The impact on the current financial position is material; the Trust is proactive in its action to mitigate the financial risk. Noting the planned industrial action w/c 15 June 2026 has been stood down.	New
7	Agree the 2026/27 capital programme	Chief Finance Officer	July 2026	Review of the Trust capital programme and re-prioritisation taking place through the Capital Approvals Group. Engagement with all relevant parties and further exploration of the capital risk associated with eCare go-live, noting revised date likely to be end of winer/early Spring 2027.	New

Links to Extreme Risks on Corporate Risk Register (CRR) – Financial recovery				
CRR reference	**Title**	**Current risk score**	**Target risk score**	**Review date**
8589	Cost Improvement Plans (CIP) delivery	16	8	November 2025 (overdue)
8521	Capital programme	12	6	March 2026
9751	(ECPR) E-Care Cash releasing benefits	16	9	January 2026

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BAF 5. Failure to provide a robust digital infrastructure and capability, supported by effective cyber security, that enables the Trust to innovate healthcare provision

Risk cause(s)	• Failure to develop, maintain/replace and secure IT systems. • Cyber-attacks that breach Trust defences. • Failure of existing digital infrastructure and/or as a result of implementation of digital transformation programmes. • Ineffective use of new digital systems by staff due to a lack of capability or cultural barriers.
Impacts if risk realised	• Impact on security, connectivity, functionality and clinical care. • Breach of patient and staff data. • Failure to embed digital innovation across the workforce resulting in lost opportunities with regard clinical innovations and associated productivity, and impacts on patient safety or quality of care issues.
Strategic Objectives Affected: Year 3	**Journey of improvement** Through the eCare Programme, translate the plans of the new EPR into delivery of clinical transformation and optimising our digital capabilities throughout the organisation **Safe, high-quality care** • Through provider collaboratives with Cornwall Partnership NHS Foundation Trust, the Peninsula Acute Providers Provider Collaborative and Integrated Care Areas work with system partners to improve clinical pathways of care • Partnership Working, Digital Transformation, Making Best Use of Our Estate, Person-Centred Care

Lead Director	Chief Information Officer	**Lead Committee**	Finance and Performance Committee Shared also with Quality Assurance Committee given SIRO remit	**Date of last review by Committee**	May~~rch~~ 2026 (last approved by Board May~~rch~~ 2026)

BAF risk scoring

Initial risk score	20	**Risk appetite**	Avoid (cyber) Open (digital transformation)	**Tolerable risk range**	0 10-15	**Target date to tolerable score**	June 2027

Risk controls or mitigations	A. Trust Digital Strategy. B. System Digital Strategy. C. Programme of capital investment in digital infrastructure, prioritised by risk of vulnerability and strategic need. D. Cyber security capabilities in place and IT/Digital services monitored. Further planned cyber security enhancements. E. Cyber security training for staff and Trust Board. F. Chief Clinical Information Officer and Chief Nursing Information Officer in post. G. Training on digital systems. H. Governance structures in place for significant digital change programmes, with strong alignment to the wider integrated care system. I. Internal business continuity plans for system failure. J. Contractual requirements for third party system providers. K. Digital clinical safety arrangements.

Actual and prospective scores	**Actual**			**Projected**
	Q2 ~~Q1~~	**Q3Q ~~2~~**	**Q4~~Q3~~**	**Q1**
Consequence	5 ~~4~~	~~5~~5	~~5~~5	5
Likelihood	4 ~~4~~	~~4~~4	~~4~~4	4
Current risk score (LxC)	20 ~~6~~	20 ~~20~~	~~20~~20	20

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Assurance framework – three lines of defence (links to mitigations identified by letter reference)

	First line of defence *Care Group/operational level*	**Second line of defence** *Oversight/corporate*	**Third line of defence** *Independent/external*
Assurance	• Daily monitoring and response to cyber-attack (D, E) • Digital Transformation Project Boards (A, B, C, F, H)	• Digital Transformation Programme Board (A, B, C, F, H)	• Data Security and Protection Toolkit (D, E)

Assurance framework – three lines of defence (links to mitigations identified by letter reference)		
• Training/clinical engagement in change programmes (G) • Monthly PAF reports (A, B, C, F, H) • CITS contract monitoring arrangements (J) • Channel 3 independent assurance of the eCare programme	• Quarterly Digital Assurance Report to Finance and Performance Committee (A, B, C, F, H) • Senior Information Risk Owner (SIRO) Reports to Quality Assurance Committee (D, E) • Emergency Planning, Preparedness and Resilience assurance report to Audit and Risk Assurance Committee (I)	• Regulator scrutiny of large-scale digital transformation business cases (e.g. Electronic Patient Record) (C) • Digital Technology Assurance Questionnaire for large-scale business cases requiring national approval (J)

Gaps in assurance	1. Ability to deliver the entirety of the eCare transformation programme and the enabling programmes to deliver 2. The Corporate level risk regarding cyber reflects heightened threats in the external environment. 3. Loss of log-in credentials making the Trust more vulnerable to phishing attacks (increased AI capability internationally). 4. Risk to external vulnerability of Trust suppliers 5. Consideration of the planned implementation time for LIMS should this slip into the same timeframe as EPR 6. The ability to respond to and take action regarding the pace of change associated with Artificial Intelligence (AI)
Overall level of assurance	Medium

Actions to address gaps in assurance

No.	Action required	Executive Lead	Due date	Progress Report	On or off track
1a	Ensuring and embedding clinical engagement into the eCare Programme	Chief Strategy Officer (SRO)	June 2026	~~Clinical colleagues to produce the products to deliver Future state validation (FSV). Ensure there are mechanisms in place to escalate issues for timely resolution.~~ ~~Link with BAF 1 for quality of care provision~~ ~~Considering change control process; design principles to be developed to review existing change requests and to then inform and benchmark against future requests. Monitor through eCare Programme Board to ensure change requests are reviewed from a quality, safety and benefits perspective.~~ ~~Undertaken a review of governance arrangements and now embedding new improvements / approach. Go Live agreed to be deferred to June 2026.~~ ~~New SRO for the programme. Considerations regarding the ongoing clinical arrangements.~~ ~~Appointed Clinical Digital roles.~~ Moved to Monthly assurance reporting to Trust Board on eCare programme. Undertaking 90/60/30 day Go Live review. Training being delivered with communications programme underpinning. Board agreed in April 2026 to delay go-live. Patient care remains the top priority, a review of the programme is taking place. More time has been allocated to review Clinical workflows; ensure saff are confident on how to use the system and the right safeguards are in place to manage the change safely, particularly in our busy and high-pressure areas. This poses a risk to the Trust which is being considered.	On track
1b	Ensure the organisational is able to continue to support the solution post go-live	Chief Strategy Officer (SRO)	June 2026	Draft sustainment plan that sets out resource requirements for Care Groups and CITS in development that outlines the governance model Undertaking 90/60/30 day go live and increased level of focus and assurance on risk of delivery and	On Track

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				in light of go-live pause will be a key consideration of the revised programme timeline..	
2a.	RCHT and ICS Digital Strategy Implementation	Chief Information Officer	January 2026	RCHT Digital Strategy is still being implemented and a new Strategy is being developed which is being informed by Commissioning Intentions and links to the current ICS Digital Strategy in 2026. Interim Strategy to be developed which identifies the key strategic priorities for the Trust and a full review, aligned to the System Digital Strategy to take place in Q3/4 2025/26. Scheduled for September 2025. The Trust Strategy Refresh includes core aspects of digital priorities On track for alignment with the Trust Strategy refresh and scheduled for presentation to Board in March 2026, noting a further delay which will see the Strategy will be presented to Executive and Committee Governance in January/February (for Board in March). Noting this is an RCHT specific strategy in the context of a wider system approach. Trust Digital Strategy presented and approved by the Trust Board in Public in March 2026. Agreed to provide an annual update on progress to Trust Board of this Strategy.	On track Overall portfolio on track with ICS Digital Strategy
2b	Implementation / embedding and monitoring of the Cyber Security Strategy	Chief Information Officer	September 2025	Developed a costed implementation programme (first phase of the Cyber Strategy). The Strategy outlines the response to national requirement and outlines the delivery. Developing approach but no national funding arrangements in place; the Trust is progressing internal programme and review deliverability of the programme within resource. Invited to bid for funding in Q2 2025/26. Trust continues to ensure risks are mitigated. Bid has been submitted and was successful. The bid will enable a programme of work for 2025/26 to monitor delivery of the strategy and security of the organisation. National visit and workshop with RCHT Cyber Security Team and the approach to develop thinking in line with national requirements. Consideration of extreme risk (Corporate Risk Register) relating to ability to respond to / recover from any cyber attack. The Trust maintains systems and processes to ensure grip and control. Trust Board received Cyber Security training annually (completed December 2025). In year 2 of delivery of a Multiyear strategy which is monitored by the Cornwall Cyber Review Group (reporting to Information Governance Group). NHSE set out clear expectations for NHS Trusts regarding board and executive oversight on cyber security risks in June 2026. The Trust has dedicated Executive accountability through the CIO but will take learning from new directive cyber policies which will form part of the DPST toolkit.	On Track
3	Introduction of two-factor authentication; Trust involved in national programme.	Chief Information Officer	Plan in 2025 and implementation in 2026	There remains a national requirement for all services to protected by MFA; identified a solution using the Azure platform to ensure flexible response to requirement. As part of DSPT submission on 30 June 2024, the Trust will respond to the national requirement. Cloud business case under development and a review of the approval levels (as per Scheme of Delegation) to determine governance route. Review of the case in light of national changes and risk associated with lack of recurrent funding Business case to be developed associated with DPST toolkit compliance. The Trust will aim to address the action through consideration of application of bids for capital resource (CDEL). Link to the NHS 10 Year Plan and the expectations around two-factor authentication and as outlined in the Trust Cyber Security Strategy.	off track – delayed as business case still in development

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4	Undertake a review (prioritised) to check cyber posture	Chief Information Officer	June 2026	Programme continues regardless of delays in funding. Build a KPI into performance metrics into 2025/26. Control mechanisms in place with monitoring reporting mechanism embedded. Suggest consideration of the proposed closure of this particular action following further review of Trust policies and procedures and any further mitigating actions. Reach and effectiveness of supplier checks. Develop range of KPIs to monitor and improve compliance. Remains in progress and a review will be undertaken to determined position. As part of eCare go live the Trust would seek to obtain assurances of Oracle software	Off track
5	Further review at LIMS contract award and consideration of any contingency arrangements	Chief Information Officer	November 2025	Need to consider relationships between LIMS and eCare testing; likely to have limited impact testing remains ongoing to understand risk LIMS interfaces are being developed and are expected to be available in time for eCare testing. Agreement on the control mechanisms in place which remain ongoing but remains in progress in order to deliver the LIMs go live in September/October 2025. Resource challenges to be resolved to mitigate risk on both eCare and LIMS. Considering a contingency option to ensure the current LIMS platform is retained until post eCare go live. Cell pathology go live as first phase of LIMS (December 2025); interface build and testing underway to support main eCare testing in January 2026. Go-live phasing being developed. eCare integration testing has commenced and will identify any impacts; anticipate none Risk to delivery of LIMS noting delay to 20 April and the potential impact on eCare testing is being reviewed.~~.~~	On track
6	Organisational understanding of AI and providing assurance that existing systems and processes are compatible with AI (information sharing systems/platforms)	Chief Information Officer	November 2025	The Trust has appropriate systems and process in place as set out by NHSE guidance. The Trust is developing communications to support people's understanding of and navigating these system and processes. NHSE have issued guidance regarding appropriate usage of AI as part of national tenancy. Staff communications have been issued on the use of AI platforms and development of supporting policy documentation. Trust Board Development session to take place on 2 April 2026 ~~which will~~ focussed on understanding the global picture, what and how the Trust operates AI and opportunities for the future / risks. The Board have a greater understanding of the benefits and impacts. Communications and home screens provide information and advice on AI and application of Trust policies. The Trust is developing appropriate governed documents to support acceptable use.	New

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Links to Corporate Risk Register (CRR) – Digital Infrastructure					
CRR reference	**Title**	**Executive Lead**	**Current risk score**	**Target risk score**	**Review date**
8303	Cyber Attack - There is a risk that Trust clinical or patient data could be lost or access to clinical IT systems could be disrupted. This is caused by the potential for a cyber-attack or hack on an unpatched, out-of-date, unsupported or vulnerable networked device (managed or unmanaged), operating system or application or as a result of a successful phishing attack.	Chief Information Officer	120 (extreme)	16	March 2026
7947	End of life for pathology laboratory information system – winpath	Chief Operating Officer	16 (extreme)	8	September 2026
9551	eCare functionality (ACCT)		12	8	January 2026
9834	eCare End of IT system support and maintenance	Chief Operating Officer	12	6	December 2026
9735	(ECPR) eCare as a theatre management system		9	6	January 2026
9743	(ECPR) ecare impact on trust wide business intelligence (RADAR) capability		16	8	November 2025

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BAF 6. Failure to transform and maintain a safe and fit-for-purpose estate infrastructure for patients, staff and visitors

Risk cause(s)	• Ageing, unsafe physical estate and/or equipment • Insufficient financial resource, including delays or uncertainties in national capital funding routes • Impact of inflationary uplifts • Trust now has the 2024 6 Facet Survey data which is current for 5 years so has an overview of the condition of the estate(s) • Continuing journey of improvement regarding the lack of knowledge or understanding about the lifecycle of capital equipment • Disruption to supply chains impacting on estate maintenance or development or capital equipment renewal or sourcing • Peripheral risks arising from national NHS changes that may impact progress and or mitigations (e.g. ICB changes, NHSE changes) • Trust ability to ensure continuous engagement and support with statutory authorities • Trust ability to deliver required improvements (where prioritised/funded) within reasonable timescales and where appropriate financial year(s)
Impacts if risk realised	• Inadequate physical estate and equipment to provide good quality, safe care to patients or provide a safe working environment for staff • Breach of relevant legislation and regulation including Health and Safety Act, Fire Regulations; Radiation Regulations, resulting in regulatory intervention and/or criminal proceedings • Serious harm or death of a member of staff or patient • Delays to and/or increase in costs for backlog maintenance and/or strategic estates builds because of supply chains disruption • Delays to planned strategic builds because of delays to national authorisations or release of national funding • Staff and/or patient exposure to hazardous substances appropriate mitigations are in place through policies and procedures that are in place • Adverse impact to business continuity and operational capacity
Strategic Objectives Affected: Year 3	**Journey of improvement** • Work with our system partners to implement our local green plan and our commitment of net zero carbon Scope 2 emissions by 2040. • Make improvements in our estate, including: ○ Deliver the key enabling schemes for the Women and Children's build. ○ Establish a significant operational estates improvement programme to ensure we deliver a safe and effective environment. ○ Update estates strategy and master plan to reflect revised clinical strategy. **Safe, high-quality care** • Open the new Oncology and MRI unit, improving services for our patients.

Lead Director	Director of Estates and Facilities	**Lead Committee**	Finance and Performance Committee	**Date of last review by Committee**	Updated May~~rch~~ 2026 (last approved by May~~rch~~ 2026 Board)

BAF risk scoring

Initial risk score	20	**Risk appetite**	Cautious	**Tolerable risk range**	6 – 8	**Target date to tolerable score**	March 2026

Risk controls or mitigations	A. Backlog maintenance programme risk assessed to inform priorities as informed by the six-facet survey, statutory compliance evaluation by senior estates staff and Authorised Engineers/Authorised Persons B. Trust Annual Capital Plan and System Joint Capital Plan. Alignment with the NHS 10 Year Plan now provides ability for RCHT to plan capital on a 4 year forward looking cycle C. Strategic Estates Master Plan D. Authorised Engineers and Authorised Persons in place for all statutory functions, supported by internal governance structure and business continuity plans E. Contract management arrangements with suppliers and contractors in place and monitored by procurement team F. Standing Financial Instructions reference procurement routes and authorities and access to NHS procurement frameworks to maximise value for money G. Mandatory training on health and safety and fire safety including at Board level H. Strategic Estates Strategy (Master Plan is an output from), including Underlying Infrastructure (e.g. water, heat, power) Strategy I. Estates Governance reporting through to FPC J. Fire remediation works and planned remediation in place i.e. Cardiology K. Ensuring wider joint Trust ownership and responsibility for risks impacting fire safety (i.e. corridor fire safety)

Actual and prospective scores	**Actual**			**Projected**
	~~Q2~~Q1	~~Q3~~Q2	~~Q4~~Q3	Q1
Consequence	~~4~~4	~~4~~4	~~4~~4	4
Likelihood	~~3~~3	~~3~~3	~~3~~3	3
Current risk score (LxC)	~~12~~12	~~12~~12	~~12~~12	12

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	L. Clinical Strategy relevance to support risk controls and mitigations					

Assurance framework – three lines of defence (links to mitigations identified by letter reference)			
	First line of defence ***Care Group/operational level***	**Second line of defence** ***Oversight/corporate***	**Third line of defence** ***Independent/external***
Assurance	• Monthly monitoring of Care Group budgets at Care Group Boards (B) • Counter Fraud daily monitoring (E, F) • Major Capital Programme meeting (managing the strategic estates programme and budgets) (C) • Capital Approvals Group and subgroups to manage the Trust's capital programme (A) • Estates and health and safety governance groups (including Fire Safety, Water Safety etc) monitoring and delivery of estates improvement plan (D, G) • Established Performance & Compliance team providing and supporting the assurance processes (D, G, I)	• Monthly Performance Reviews with Care Groups, includes financial performance (B, G) • Monthly Director of Finance system meetings to review in-year revenue and capital positions (B) • Monthly finance (revenue, capital and cash) and quarterly procurement reports to Finance and Performance Committee and Trust Board (B, F) • Quarterly Estates and Facilities assurance reports to Finance and Performance Committee and quarterly health and safety reports to Quality Assurance Committee (D, G) • Scrutiny of Annual Capital Programme and updates by Finance and Performance Committee and approved by Trust Board (A, B) • Quarterly Counter Fraud reports to Audit and Risk Assurance Committee (E, F) • Estates and Facilities Senior Leadership Team	• Annual external audit including value for money review (B, E, F) • Internal audit of financial controls ((F) • National gateway process for major capital builds (C) • Six-facet survey by external company (every five years) (A) • Regular engagement with external regulatory bodies (e.g. Building Control)
Gaps in assurance	1. Robust and iterative Strategic Estates Plan (link to the Six Facet Survey) and implementation of a robust Backlog maintenance 10 year plan and limitations to appropriately mitigate (and sustain the mitigations) the risk in the challenging financial environment and the ability to respond to severe weather impacts 2. Development of an Estates Strategy (as directed by the development of a clinical strategy) and the management of long term strategic estates 3. Ability to deliver a realistic Green Plan and sustainability requirements, including capacity and resource to deliver the plan 4. Critical Electrical Infrastructure site capacity at RCH has reached its limit; there is provision within the Women's and Children's programme capacity to deliver this, but it is dependent on delivery of the early enabling phase of the W&C programme 5. Reviewing and testing the Trusts fire risk management and mitigations 6. Gap in assurance regarding the adequacy and consistency of health and safety controls, particularly in relation to statutory compliance, maintenance systems, asbestos management, and the monitoring of remedial actions. ~~5.~~7.		
Overall level of assurance	Medium		

Actions to address gaps in assurance					
No.	**Action required**	**Executive Lead**	**Due date**	**Progress Report**	**On or off track or proposed complete**
1a	Consideration and review of the existing strategic estates master plan	Director of Estates and Facilities	April 2026	Noted timing and resource/capacity to undertake the review and development of the plan. Remains work in progress. Trust Board Development session in June 2024 to review Trust Strategy and ambition which will include strategic estates master plan. Draft in development which will be further considered in light of feedback and will be informed by a Trust Clinical Strategy which is being revised as part of the Trust Strategy fresh. Procurement specification finalised for Estates Strategy. Following review of Procurement, the specification is being issued as a variation to the Women's and Children's MDDT	~~On track~~off track

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				for delivery this will ensure a quicker and more streamlined approach to delivery. Update to include 2025 changes arising from NHS 10-Year Plan and RCHT 10-Year Strategy Refresh and the Clinical Strategy.	
1b	Delivery of the 6-Facet Survey and development of a risk assessed and prioritised 10-year Backlog Capital Programme	Director of Estates and Facilities	April 2026	Completed Q4 2023/24 and due for renewal in 2028/29. Continuing to secure additional funding to support mitigate infrastructure risks. Align to national requirements around 5 year plans. Work in progress. Delivered the 6-facet survey which is completed (best practice) every 5 years. The Trust will review this but the ongoing development of the 10 year backlog maintenance plan will align with the Estates Strategy. Capital Programme moved to a 2 year plan and the Trust is aligned with the backlog maintenance programme. Capital Approval Group has oversight / reviews the programme on a frequent basis.	on track
1c	Process of Dynamic risk assessments being undertaken with a clear understanding of trigger criteria to enable decisions to take further action/escalation of cessation of mitigation	Director of Estates and Facilities	April 2026 – ongoing	Where applicable and appropriate health and safety and infection prevention and control will be involved in undertaking risk assessments. Review of infrastructure risks being reviewed to ensure they are adequately recorded on the Corporate Risk Register. These risk assessments inform responsive actions in order to re-prioritise capital (within delegation). Risks are included on the Corporate Risk Register	On track / robust mechanism
1d	Review of capital programme to mitigate risks of severe weather impacts during winter 2025/26	Director of Estates and Facilities	April 2027	The Trust experienced a range of immediate infrastructure and operational impacts associated with severe weather conditions during winter 2025/26, particularly due to Storm Goretti. These incidents, alongside power instability and lift failures, contributed to operational pressures and required activation of Business Continuity arrangements to maintain patient safety and service continuity. A review and reprioritisation of the capital programme is being undertaken.	New
24a	Having the resource and capacity to deliver a realistic sustainability plan	Chief Strategy Officer	April 2026	The Trust has a System Green Plan that outlines the targets / clearly articulates the objectives, but the Trust does not have the resource available to deliver that plan Further development of the options appraisal and assurance on resource to support programme required. Board received an update in January 2025. Note the ICB leadership role in the system green plan and the potential impacts associated	Ongoing~~Off track~~

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				with the requirement for ICB to delivery the 50% savings and the capacity to provide the leadership role in this regard. Green Plan for 2025/28 devised and approved by the Board in November 2025. . Considerations regarding improving net zero are being progressed where possible and where opportunities are identified. Resource to support the Green Plan within CPPT Officer portfolio and a sub-group to Finance and Performance Committee ~~being established.~~ in place (May 2026) Resource allocated for development of Trust wide Travel Plan; due to limited resource availability this is a 12 month project. Ongoing discussions with Cornwall Council regarding the Langarth Village heat network.	
3b	Development of a Decarbonisation plan	Chief Partnership, Performance and Transformation Officer and Director of Estates and Facilities	April 2026	NHS Pilot scheme with 9 other Trusts to consider geothermal energy opportunities and exploration of funding options to create a plan. Noted limited resource to progress. Engagement with Cornwall Council continues to pursue this opportunity. Green Plan approved by the Trust Board and reporting mechanises being established	Ongoing
4	Mitigate the risk of exceeding electrical capacity through the Women's and Children's Programme enabling works	Director of Estates and Facilities	June 2026	NHP approved the funding for the Critical Infrastructure works and the Trust Board approved the funding in October 2025. Works continue to progress.	On track
5	Undertaking a comprehensive review and testing of all fire risks across all RCHT sites in light of recent learning from other Trusts	Director of Estates and Facilities	September 2026	In light of the recent fire at Southampton NHS Trust, the Trust is reviewing all fire risk entries, risk management, training and assurance mechanisms. The Trust also will consider, in light of Risk ID 9048 (ED Crowding) associated risk. Note: link with BAF 1 around health and safety of staff and patients . Internal investigation into a fire alarm activation system fault highlighted a range of remedial actions, which were undertaken during March/May 2026; Trust engaged with the Cornwall Fire and Rescue Service and actions provided assurance	~~New~~ Ongoing
6	Ensure effective systems, processes and controls are in place and are robust and evidenced	Director of Estates and Facilities	September 2026	Assurance gaps remain in the control framework for asbestos management, contractor oversight, training compliance, record integrity, and formal accountability, with further work needed to evidence sustainable control improvement and provide board-level assurance on delivery and effectiveness. An action plan has been developed and monitored by Quality Assurance Committee.	New

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Links to Extreme Risks on Corporate Risk Register (CRR) – Physical infrastructure and supply chain				
CRR reference	**Description**	**Current risk score**	**Target risk score**	**Review date**
10024	Risk of infection due to outdated/missing ventilation systems	16	8	January 2035
9937	Insufficient electrical capacity at RCHT to meet the growing demands of the Trust	16	6	February 2028
8189	Water safety planned preventative maintenance (PPM): There is a risk that the PPM schedule is incomplete and insufficient to manage the scale of plant and assets across the Trust	16 (extreme)	4	December 2024
8040	There is a risk that there are existing unsafe conditions which could result in a significant fire spreading beyond the point of origin.	16 (extreme)	8	March 2029
7302	There is a risk that the Trust will be found to be in breach of legislative requirements regarding the safe use of radiation and control of radioactive contamination due to the poor condition and layout of premises.	16 (extreme)	8	October 2026
8858	Failure of sterile services (infrastructure)	15 (extreme)	8	August 2026
7870	Capacity and resource of the operational estates team	16 (extreme)	6	June 2026
1250	Medical gases not compliant	12	6	March 2026
7163	Sterile Services Clean Room validation	12	6	December 2025

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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 14

Title of Report: Remuneration and Appointments Committee Assurance Report to the Board – June 2026

Executive Director Lead: Isobel Down, Non-Executive Director

Author and Job Title: Lynsey Neave, Company Secretary

Email Address: lynsey.neave@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☐ **Information** ☒

This report presents to the Trust Board a summary of issues considered by Remuneration and Appointments Committee at its June 2026 meeting.

Note that given the nature of the remit of this committee in dealing with personnel matters, any items relating to individuals in post are not disclosed in this report. As a result, this report is a slightly different format to those provided for the Board's other committees.

Key agenda items and decisions/actions taken on behalf of the Board

- Update on the Chief Executive arrangements;
- Received the annual appraisal and objectives of the Chief Executive;
- Received he annual appraisal and objectives of the Executive Directors.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☐

Reputational ☐ **Legal / Regulatory** ☐

Impact:

Neave, Lynsey 30/06/2026 09:31:56

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			n/a	
Quality Impact Assessment completed?			n/a	
Data Protection Impact Assessment completed?			n/a	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	n/a
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	n/a
Sustainable and efficient use of NHS resources by RCHT	n/a

Recommendation:

The Board is recommended to:

- **Note** the items considered by Remuneration and Appointments Committee at its June 2026 meeting and any decisions taken on behalf of the Board as per the Committee's terms of reference.

Neave,Lynsey
30/06/2026 09:31:26

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 15

Title of Report: Integrated Performance Report

Executive Director Lead: Robin Jones, Chief Operating Officer

Author and Job Title: Robin Jones, Chief Operating Officer

Email Address: robin.jones2@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☒ **Assurance** ☒ **Information** ☐

To receive the Integrated Performance report reviewing the Trust Board section.

Consultation:

The report has been reviewed for assurance at the Finance and Performance Committee on 23 June 2026 and Quality Assurance Committee on 25 June 2026.

The report was due to be reviewed at the Executive Leadership Team meeting on 24 June 2026, that meeting was stood down due to the pressures from the heatwave. The report was circulated to Group members.

Note from Finance and Performance Committee

- The new reported was welcomed by the Committee and the clarity of the indicators for the committee review.
- The size of the waiting list for elective care was reviewed as a risk.
- The number of patients over 52 and 65 weeks were highlighted as an area of challenge and further work.
- The Committee noted the additional accountability meetings with Divisions targeting improvements in performance which would be reflected in the National Oversight Framework assessment.
- Discussed the challenged urgent care provision.
- Noted the finance indicators had been considered as part of earlier papers on the agenda.

Neave,Lynsey
30/06/2026 09:31:26

Note from Quality Assurance Committee

- The Committee commented on how the new layout of the report enables improved focus on areas .
- Discussed the urgent care performance challenges as part of the wider urgent care paper.
- Noted the stroke performance and discussed the need to finalise timescales for the system capacity review, also noted the internal actions to be taken to ensure no missed opportunity for admission within 4 hours to the Stroke unit.
- Reviewed and considered actions within the Trust to achieve further improvements for the direct admission within 4 hours target.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?		X		
Quality Impact Assessment completed?		X		
Data Protection Impact Assessment completed?		X		

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	N/A
Quality of services provided or arranged by RCHT, including	N/A

Please Reply 30/04/2026 at 13:16

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
inequalities in benefits from those services	
Sustainable and efficient use of NHS resources by RCHT	N/A

Recommendations:

The Board **is recommended to:**

- **Discuss** and **consider** the Trust Board Section of the Integrated Performance Report.
- **Note** that the relevant sections have been discussed at Committee, further **noting** that the People and Culture Committee meets bi monthly and that section of the report has therefore not been to Committee at the time of the Board.

Neave,Lynsey
30/06/2026 09:31:26

Integrated Performance Report

1. Approach used for the report

This is the first use of the new Integrated Performance Report. The report is written in four key sections. For the purposes of the Trust Board the first section is for consideration and the remaining three sections should be considered as stared items.

The report has sections for Finance and Performance Committee, Quality Assurance Committee and People and Culture Committee. These sections will be discussed for assurance as well as the overall summary for the Trust Board in each of those Committees.

The whole report is provided to Trust Board to enable any element of the three committee sections to be 'unstared' for discussion at the Trust Board. The report is also provided in full to the Trust Board in Public pack to enable members of the public to access the whole report.

2. Risk

The Integrated Performance Report provides for the overall performance of the Trust and is complemented by the Risk Register and Board Assurance Framework.

There is a risk that not meeting the annual plan targets for Patients, People, Performance and Pounds will cause a reduction in the Trust's National Oversight Framework segmentation score.

3. Accountability

The Chief Operating Officer is accountable for the operational performance of the Trust and overall Performance Reporting.

The Chief Finance Officer is accountable for financial performance.

The Chief Medical Officer and Acting Chief Nursing Officer are accountable for the quality performance.

The Chief People Officer is accountable for the people performance.

Each section of the integrated performance report outlines lead executive.

4. Recommendations

The Trust Board is recommended to:

Neave,Lynsey
30/06/2026 09:31:26

- **Discuss** and **consider** the Trust Board Section of the Integrated Performance Report.
- **Note** that the relevant sections have been discussed at Committee, further **noting** that the People and Culture Committee meets bi monthly and that section of the report has therefore not been to Committee at the time of the Board.

Royal Cornwall Hospitals
NHS Trust

Integrated Performance Report (IPR)



May 2026

Neave, Laura (RCH)
30/05/2026 21:26

Outstanding Care for One+All

Introduction and Methodology



The Trust has a primary strategic objective to provide Outstanding Care for one and all. This report uses the principles of the NHS Making Data Count to provide a report from floor to Board to enable the Trust to achieve and outstanding rating, deliver constitutional standards and achieve the Annual Operating Plan.

The report is designed to be used in the following ways:

- The whole report is reviewed and approved by the Executive Leadership Team meeting before submission to the Board sub-committees
- The report is submitted in full to the Board sub-committees and to the Trust Board
- The Board Sub-committees focus on the specific section of the report but have oversight of the Board level summary, triangulation section and the benchmarking
- The Trust Board will have the full report in the board paper pack so that members of the public can access the entire report for transparency and openness, however the Trust Board will focus the review on the Trust Board section only and consider the other sections as starred sections for information

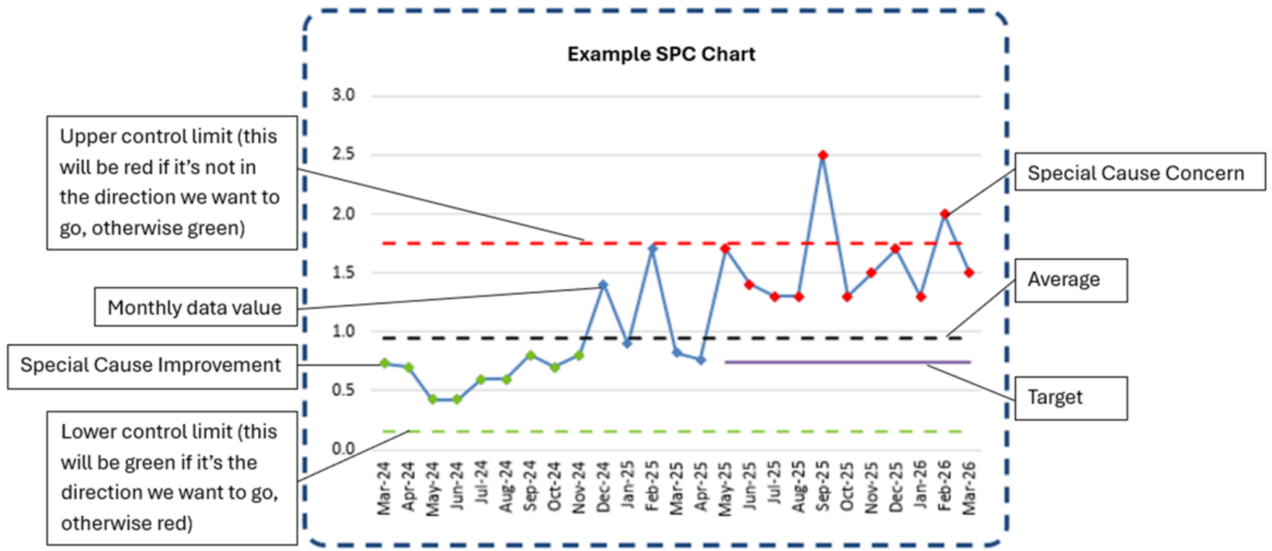
The Trust has implemented a weekly cycle of meetings with Trust Executives and Divisional Leadership teams to focus on Patients, Performance, Pounds and People. These weekly meetings are to focus on improvement and triangulation across Divisions of issues and learning. Each Division has a quarterly review chaired by the Chief Executive with all Trust Executive Directors and the Divisional Leadership. The outcome of this process is to deliver the standards as set in the Integrated Performance Report.

Neave Lunnon
30/06/2026 10:31:26

A guide to SPC charts

Within the Integrated Performance Report (IPR), statistical process control (SPC) charts are used where appropriate.
SPC is an analytical technique that plots data over time. The main aim is to understand whether what is going on is normal or different to the norm, and in doing so guides us to take the most appropriate, if any, action. This also aids against providing false reassurance often gained with trend lines, which can suggest trends which are not genuine depending on the date range and/or the amount of data points selected.
SPC is widely used in the NHS to understand whether change results in improvement from a transformation project (which is changing a process), but also in performance management. The most common SPC tool is a control chart which is a graph used to study how a process, or performance, changes over time. Data are plotted in sequential time order. A control chart always has a central line for the average, an upper line for the upper control limit and a lower line for the lower control limit. On the SPC charts within the IPR, straight lines at the top of the chart indicate the upper control limit, and the bottom line the lower control limit. The lines will be green to indicate the direction the KPI should be going in, whilst red is used for the limit which lies furthest away from the intended direction of the KPI. Straight black lines show the average. Light blue coloured lines are used for local trajectories, and purple lines are used for targets or thresholds.
SPC uses rules to help interpret the data being presented. Here are some of the rules:

- 1 point outside the warning limits (upper or lower limits) of two standard deviations – this indicates where the data is not the norm for this process or measure.
- 3 consecutive data points outside the warning limits of two standard deviations - implies a change to the normal process (red markers).
- 7 consecutive points in an upward or downward direction - implies a change in the process.



Neave Lynsey
30/09/2026 09:31:26

Abbreviation Glossary

Symbol key:

	Broken blue border around a graph indicates the metric has a local target.
	Solid blue border around a graph indicates the metric has a national target.
NHS Oversight Framework	Metric is in the NHS Oversight Framework
	Straight broken green lines within a graph indicate upper or lower control limit. The line closest to the direction the KPI should be going in will be green.
	Straight broken amber lines within a graph indicate upper or lower control limit. The line furthest away from the direction the KPI should be going in will be amber.
	Straight broken dark red lines within a graph indicate either KPI average or the KPI standard.
	Light blue lines within a graph indicate a local trajectory.
	Purple lines within a graph indicate a standard, target or threshold.

Abbreviation Glossary:

A&G	Advice and Guidance
AMU	Acute Medical Unit
ANP	Advanced Nurse Practitioner
CATU	Community Assessment and Treatment Units (typically for care of the elderly)
CDC	Community Diagnostic Centre
CEO	Chief Executive Officer
CFT / CPFT	Cornwall Partnership NHS Foundation Trust
CIP	Cost Improvement Programme
CNO	Chief Nursing Officer
COHA	Community Onset, Healthcare Associated (infection control)
DNA	Did Not Attend (missed appointments)
DOSA	Day of surgery admission
DTOC	Delayed transfer of care
ECIP	Emergency Care Improvement Programme
ECIST	Emergency Care Improvement Support Team (clinically led national NHS team)
ED	Emergency Department
ELT	Executive Leadership Team
ESR	Electronic Staff Record
FDS	Faster Diagnosis Standard (cancer 28 day standard)
FPC	Finance and Performance Committee
FSP	Financial Sustainability Plan
FTE	Full time equivalent
FUW / FUWL	Follow up waiting / Follow up waiting list
GIRFT	Getting it Right First Time

Abbreviation Glossary Continued:

GP	General Practitioner
HASU	Hyper-acute stroke unit
HAT	Hospital acquired thrombosis
HOHA	Hospital Onset, Healthcare Associated (infection control)
HSMR	Hospital Standardised Mortality Ratio
ICB	Integrated Care Board
ICC	Incident Command Centre (RCHT)
INT	Integrated Neighbourhood Team
IPAC	Infection Prevention and Control
KPI	Key performance indicator
LOS	Length of Stay
MASA	Multifactorial Assessment to optimise Safe Activity (falls)
MDT	Multidisciplinary Team
MIU	Minor Injury Unit
MNSI	Maternity and Newborn Safety Investigation
MROG	Mortality Review and Oversight Group
MRSA	Meticillin-resistant Staphylococcus aureus
NHFD	National Hip Fracture Database
NHSE	NHS England
NICE	National Institute for Health and Care Excellence
NOF	Fractured Neck of Femur
PCC	People and Culture Committee
PSII	Patient Safety Incident Investigation
PSIRF	Patient Safety Incident Response Framework
PSIROG	Patient Safety Incident Response and Oversight Group
PTL	Patient tracking list
QAC	Quality Assurance Committee
RTT	Referral to treatment
SASH	St Austell Surgical Hub
SDMA	Same Day Medical Assessment
SDSA	Same Day Surgical Assessment
SHMI	Summary Hospital Level Mortality Indicator
SMART	Specific, Measurable, Achievable/Attainable, Relevant/Realistic and Time-bound
SMH	St Michaels Hospital
SOP	Standard Operation Procedure
SPC	Statistical Process Control
SRO	Senior Responsible Officer
SSNAP	Sentinel Stroke National Audit Programme
SWASFT	South Western Ambulance Service Foundation Trust
TR	Treliske Hospital Emergency Department
UTC	Urgent Treatment Centre
WCH	West Cornwall Hospital Emergency Department / West Cornwall Hospital
YTD	Year to date

Newquay Lanes Limited 30/09/2025 08:

Executive Summary

Trust continues to operate under significant system pressure, driven by the interdependent challenges of capacity constraints, patient flow inefficiencies, and workforce fragility. While improvement actions are underway across all domains, current performance indicates a system operating at or above sustainable limits.

Performance has deteriorated slightly at a national level, with the Trust moving from Segment 1 to Segment 2 in the NHS Oversight Framework (ranked 30th of 134), reflecting variability across key domains and continued challenges in patient safety, workforce, and productivity.

Key Risks and Pressures

- Capacity - Sustained bed occupancy above 95%, with ongoing reliance on escalation areas and corridor care. Constraints across theatres and diagnostics are limiting elective recovery and contributing to long waits.
- Flow - Persistent delays in discharge and internal flow are driving ED overcrowding and ambulance handover delays (82 mins vs 29.5 target). Increasing 4-hour and 12-hour breaches, reflecting system congestion.
- Workforce - Ongoing vacancies, sickness (notably ~28% mental health-related absence), and organisational change impacts are reducing capacity and productivity. Staff experience continues to deteriorate, with only 23.1% recommending the Trust as a place to work.

Performance Highlights

- Urgent & Emergency Care performance remains below plan with sustained ED crowding and corridor care. A critical incident during May highlighted system fragility under surge conditions.
- Planned Care waiting list increased to 42,645, with rising 52-week waits (+38%).Theatre utilisation remains strong comparatively but constrained by workforce and capacity. Cancer 28-day Faster Diagnosis Standard below target at 76.3%. 62-day performance improving but remains below trajectory (78.3% vs 80% target).
- Finance Month-end deficit of £1.28m (in line with plan).The key risk remains delivery of the £42.5m Financial Sustainability Programme, currently underachieving.
- Quality and Safety - Continued focus on eradicating corridor care and improving patient flow. Increased pressure ulcers and patient safety incidents, with targeted improvement actions in place. Stroke performance and pathway capacity remain areas of concern (SSNAP rating E). Mortality indicators broadly within expected ranges, though some areas remain elevated.
- Workforce and Culture - Workforce pressures are materially impacting delivery and staff wellbeing. Cultural challenges persist, including concerns around leadership visibility, engagement, and psychological safety. Improvement programmes are in place (People Plan, Culture Transformation), but impact will take time.

Neave Lynsey
30/05/2025 11:31:26

Key Actions and Priorities

Strengthen delivery grip through enhanced divisional accountability and performance management (4Ps framework). Accelerate patient flow improvements, including discharge optimisation and GIRFT standards. Increase elective and diagnostic capacity to address backlog and long waits. Deliver the Financial Sustainability Programme with a focus on recurrent savings. Stabilise workforce through targeted recruitment, retention, and wellbeing initiatives. Continued cultural transformation to improve staff experience and engagement.

Trust Board Summary



Outstanding
Care for **One+All**

Neave, Lynsey
30/09/2026 09:31:26

Trust Board overview – summary scorecard (CQC domains)

Current performance against the 5 indicators which act as our barometer of operational grip, workforce stability; and patient flow.
These indicators are monitored through a weekly cycle of meetings with Trust Executives and Divisional Leadership teams.

- Cases per week
- Zero cancellations on the day for management reasons
- Zero agency
- Zero Escalation and Corridor Care space in use
- RTT stops

	May-26	Target	2026/27
Elective theatre cases (for the 9 specialties in the theatres plan)	1477	1478	
Cancellations on the day for management reasons	53	0	
Agency - whole time equivalent (WTE) - Nursing	Data not yet available	0	
Agency - whole time equivalent (WTE) - Medical		0	
Agency - whole time equivalent (WTE) - Allied Health Professionals		0	
Agency - whole time equivalent (WTE) - Scientists		0	
Escalation spaces in use (at 8am snapshot)	971	0	
Corridor care spaces in use (at 8am snapshot)	515	0	
RTT clock stops (working day stops) - admitted pathways	130	>2025/26 (141)	
RTT clock stops (working day stops) - non-admitted pathways	431	>2025/26 (428)	

CQC Ratings by Location (RI = Requires Improvement)

Domain	RCHT 2019	RCH 2025	WCH 2018	SMH 2018	Penrice 2022/2017	Helston 2022	SASH
Safe	RI	RI	RI	Good	RI	Good	Not Rated
Effective	Good	Good	Good	Good	RI	Not Rated	Not Rated
Caring	Good	Good	Good	Good	Good	Not Rated	Not Rated
Responsive	RI	RI	Good	Good	Good	Not Rated	Not Rated
Well Led	Good	RI	Good	Good	Good	Good	Not Rated

Site CQC Ratings by Core Service

Core Service	RCH Overall Rating	WCH Overall Rating	SMH Overall Rating
Urgent and Emergency Care	RI (2025)	Good (2018)	Not Rated
Medical Care	RI (2025)	Good (2018)	Good (2018)
Surgery	RI (2019)	RI (2018)	Good (2018)
Maternity	Good (2022)	Not Rated	Not Rated
End of Life	Good (2019)	Not Rated	Not Rated
Outpatients	Good (2019)	Good (2018)	Good (2018)
Critical Care	Good (2018)	Not Rated	Not Rated
CYP	Good (2018)	Not Rated	Not Rated
Diagnostic Imaging	Outstanding (2018)	Not Rated	Not Rated

Neave Lynsey
30/05/2026 09:31:26

Summary Performance - May 2026

Board snapshot: 12 key metrics

Improving Stable Concern

NHS Oversight Framework

Segment 2 ↓

Corridor care

47/day

New metric

ED & MIUs 4-hour performance

76% ↓

Total Aggregated Patient Delay (hours)

19,934 ↑

RTT 18-week performance

73.6% →

Waiting list size

42,645 ↑

RTT 52 week waits

408 ↑

Cancelled Operations on the day

53 ↓

Diagnostics within 6 weeks

83.4% ↓

Cancer 28-day faster diagnosis

76.3% ↓

Fractured Neck of Femur patients operated on within 36 hours

27% ↓

Monthly agency spend

£0.51m ↓

Vacancy rate

10.7% ↑

Neave Lynsey
30/06/2026 09:31:26

NHS Oversight Framework – Q4 2025/26 RCHT Overview

The NHS Oversight Framework provides a consistent and transparent way for NHS England to assess Trust performance against a focused set of evidenced based metrics. These metrics reflect national priorities in planning guidance and bring together clinical performance, financial plans and productivity goals. The framework is designed to drive improvement, provide public assurance through a published performance dashboard and league tables, and enable targeted support through a segmented, risk-based approach. As part of the methodology, a financial override is applied, meaning Trusts that are not delivering a surplus or breakeven position cannot be placed above Segment 3.

Performance is segmented as follows: Segment 1 – High Performing; Segment 2 – Above Average; Segment 3 – Below Average; Segment 4 – Low Performing

In June 2026, NHS England published segmentation scores for Q4 2025/26. RCHT dropped to Segment 2 (above average) having been in Segment 1 (high performing) for the previous 2 quarters, with an average score of 2.29 (2.01 in Q3). The Trust ranked 30th out of 134 Trusts overall. Trusts are ranked first by segment and then by average score within that segment, with rankings ranging from 1 to 134.

A likely range of rank is also published for each trust, 95% demonstrates high confidence where a Trust's ranking could fall depending on a combination of metrics applied. If a Trust is consistently performing well or consistently poorly across lots of different metrics, its range will be narrow. RCHT's likely range of rank remains broad between 18 – 107 in Q4 demonstrating that we perform well in some areas but poorly comparatively in others.

The list of metrics that Trust's will be assessed against in 2026/27 was published on 11th June 2026, and it is expected that the technical guidance will be published by the end of Q1. Further details on the 2026/27 NHS Oversight Framework will be included in future reports.

Description	Quarter Units	Q4 2025/26 Metric score	Rank	Q3 2025/26 Metric score	Rank	Q2 2025/26 Metric score	Rank	Q1 2025/26 Metric score	Rank
Average metric score	score	2.29	64 out of 134	2.01	26 out of 134	2.03	28 out of 134	2.13	38 out of 134
Unadjusted segment	segment	2.00		1.00		1.00		2.00	
Adjusted segment	segment	2.00	30 out of 134	1.00	18 out of 134	1.00	19 out of 134	2.00	18 out of 134
Access to services domain score	score	1.98	47 out of 131	1.49	10 out of 131	1.61	15 out of 131	1.79	20 out of 131
Finance and productivity domain score	score	2.18	59 out of 134	1.99	42 out of 134	1.65	21 out of 134	1.85	30 out of 134
Effectiveness and experience domain score	score	2.23	71 out of 134	2.04	49 out of 134	2.04	55 out of 134	2.11	58 out of 134
Patient safety domain score	score	3.04	113 out of 134	3.18	123 out of 134	3.23	123 out of 134	3.10	109 out of 134
People and workforce domain score	score	3.03	107 out of 134	2.91	97 out of 134	2.90	96 out of 134	2.79	84 out of 134
Access to services domain segment	segment	2.00		1.00		1.00		1.00	
Finance and productivity domain segment	segment	3.00		2.00		1.00		2.00	
Effectiveness and experience domain segment	segment	3.00		2.00		2.00		2.00	
Patient safety domain segment	segment	4.00		4.00		4.00		4.00	
People and workforce domain segment	segment	3.00		3.00		3.00		3.00	

This table details the Trust's overall average metric score and segment, along with a breakdown of the scores and segments for each of the 5 domains, with comparison to previous quarters.

Quarter 4 2025/26

For the fourth consecutive quarter since the dashboard was introduced, RCHT remained in:

- Segment 3 for people and workforce
- Segment 4 for patient safety

The Trust has deteriorated one segment position in the remaining three domains this quarter:

- Moved from segment 1 to segment 2 for access to services
- Moved from segment 2 to segment 3 for finance and productivity
- Moved from segment 2 to segment 3 for effectiveness and experience

Neeley Young 30/06/2026 09:21:26

NHS Oversight Framework – Q4 2025/26

Domain	Sub-domain	Description	Reporting date	Metric value	Units	Metric value change	Metric score	Rank	Median	Standard
Access to services	Cancer care	Percentage of patients with cancer diagnosed or ruled out within 28 days of an urgent referral	Q4 2025/26	77.08	%	-1.74 ↓	2.83	79 out of 117	79.34	80
Access to services	Cancer care	Percentage of patients treated for cancer within 62 days of referral	Q4 2025/26	73.25	%	-7.47 ↓	2.22	45 out of 118	70.24	75
Access to services	Elective care	Percentage of patients waiting over 52 weeks for elective treatment	Mar-26	0.59	%	-0.02 ↑	1.00	37 out of 130	0.96	1
Access to services	Elective care	Percentage of patients waiting over 52 weeks for community services	Mar-26	0.05	%	-1.03 ↑	2.11	29 out of 78	0.46	
Access to services	Elective care	Percentage of cases where a patient is waiting 18 weeks or less for elective treatment	Mar-26	73.65	%	0.55 ↑	1.33	15 out of 130	64.83	
Access to services	Elective care	Difference between planned and actual 18 week performance	Mar-26	-0.36	percentage points	-1.90 ↓	2.13	88 out of 130	0.99	0
Access to services	Urgent and emergency care	Percentage of emergency department attendances admitted, transferred or discharged within four hours	Q4 2025/26	76.48	%	-3.02 ↓	2.25	46 out of 123	74.01	78
Access to services	Urgent and emergency care	Percentage of emergency department attendances spending over 12 hours in the department	Q4 2025/26	6.61	%	0.54 ↓	1.97	40 out of 122	8.71	
Effectiveness and experience	Effective flow and discharge	Average number of days from discharge ready date to actual discharge date (including zero days)	Mar-26	0.84	days	0.13 ↓	2.68	72 out of 128	0.80	
Effectiveness and experience	Patient experience	Summary Hospital-level Mortality Indicator	Jan 24 - Dec 25		score		2.00			
Effectiveness and experience	Patient experience	CQC inpatient survey satisfaction rate	2024		score		2.00			
Finance and productivity	Finance	Planned surplus/deficit	2025/26 plan	0.00	%	0.00 →	1.00	12 out of 134	-1.54	0
Finance and productivity	Finance	Variance year-to-date to financial plan	Month 12 2025/26	0.66	%	0.66 ↑	1.00	15 out of 134	0.03	
Finance and productivity	Finance	Combined finance	Q4 2025/26				1.00			
Finance and productivity	Productivity	Implied productivity level	Q3 2025/26 vs Q3 2024/25	0.62	%	-0.78 ↓	3.37	106 out of 134	2.57	
Patient safety	Patient safety	Number of MRSA bacteraemia cases (12 months)	Mar-26	4.00	count	0.00 →	2.81		3.50	0
Patient safety	Patient safety	Proportion of E. coli bacteraemia	Mar-26	1.18	rate	-0.04 ↑	2.88		1.17	1
Patient safety	Patient safety	NHS Staff survey - raising concerns sub-score	2025	5.86	out of 10	-0.32 ↓	3.84	127 out of 134	6.32	
Patient safety	Patient safety	Proportion of C. difficile infections	Mar-26	0.98	rate	-0.12 ↑	1.00		1.09	1
People and workforce	Retention and culture	Sickness absence rate	Q3 2025/26	5.53	%	0.53 ↓	2.15	65 out of 134	5.59	
People and workforce	Retention and culture	NHS staff survey engagement theme sub-score	2025	6.27	out of 10	-0.30 ↓	3.91	130 out of 134	6.80	

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Model Hospital Benchmarking

The Model Health System is a data-driven improvement tool that enables NHS health systems and trusts to benchmark quality and productivity. By identifying opportunities for improvement, the Model Health System empowers NHS teams to continuously improve care for patients. The Model Health System incorporates the Model Hospital, which provides hospital provider-level benchmarking. Insights from the Model Health System can be used to support productivity and efficiency; transformation of services; clinical improvement; better quality and safety. Model Hospital benchmarking uses quartiles to summarise hospital performance, with quartiles based on statistical data distribution for each metric. Model Health System is only one of a range of benchmarking sources in regular use.

The tables below detail RCHT's most recent benchmarked position across a range of key operational metrics. This represents a small subsection of the total metrics available on Model Hospital benchmarking.

Metrics in the best quartile

Metric	Trust Performance	National Average	Best decile performance	What does good look like?	Month	RCHT consistently in best quartile since:
Percentage of incomplete RTT pathways <18 weeks	73.65%	65.54%	83.99%	Higher value is better	Mar-26	Last 2 years
Capped elective theatre utilisation % (monthly)	86.8%	81.6%	85.7%	Higher value is better	Apr-26	March 2025 - best decile / quartile. Prior to this Trust fluctuates between upper interquartiles range and best quartile.

Metrics in the interquartiles range

Metric	Trust Performance	National Average	Best decile performance	What does good look like?	Month	RCHT consistently in interquartiles range since:
ED ≤4 hour wait %, all type	78.7%	76.7% (Benchmark 78.0%)	83.3%	Higher value is better	Apr-26	January 2026. Prior to this Trust fluctuates between upper interquartiles range or best quartile over the last 2 years.
Percentage of incomplete RTT pathways >52 weeks	0.59%	0.86%	0.00%	Lower value is better	Mar-26	January 2026. Prior to this Trust fluctuates between interquartiles range or best quartile over the last 2 years.
Suspected all cancers: diagnosed or ruled out within 28 days %	79.1%	81.2% (Benchmark 80.0%)	86.4%	Higher value is better	Mar-26	June 2025. Prior to this Trust fluctuates between interquartiles range or best quartile over the last 2 years.
All cancers: treated within 62 days %	74.5%	74.3% (Benchmark 75.0%)	86.5%	Higher value is better	Mar-26	January 2026. Prior to this Trust predominantly in best quartile (with occasional upper interquartiles range) over the last 2 years
Total (all 15 diagnostic tests/procedures): % waiting >6 weeks	11.6%	14.0%	2.7%	Lower value is better	Mar-26	> 2 years (with the exception of April 2025 when the Trust achieved best quartile for one month)

Metrics in the worst quartile

Metric	Trust Performance	National Average	Best decile performance	What does good look like?	Month	RCHT consistently in worst quartile since:
ED ≤4 hour wait %, type 1&2	48.2%	64.3%	77.9%	Higher value is better	Apr-26	December 2025. Prior to this Trust fluctuates between lower interquartiles range or worst quartile over the last 2 years. 3rd worst performing Trust nationally in April 2026, behind University Hospitals Plymouth and Torbay and South Devon.
ED ≥12 hour wait % type 1&2 (ecds)	17.5%	9.7%	1.4%	Lower value is better	Apr-26	September 2025. Prior to this Trust fluctuates between interquartiles range or worst quartile over the last 2 years.

Neary Upon
30/06/2026 11:26

Divisional Update – Clinical Support and Cancer

Strategic Intent of the Division:
To develop a clinical diagnostic, cancer and delivery support services model that improves demand and capacity planning, reduces waste and increases productivity and efficiency to enable clinical services to deliver a high clinical quality, cost effective service that can meet customer demand both within and outside the organisation.

Cross Cutting Intent
To have Customer Focus at the core of the service to deliver patient outcomes, quality, safety and performance across the Trust.

Summary from Hannah Falvey, Clinical Chair

Partnership working
- Initial conversations commenced with regards to neighbourhood working and opportunities to move care activities into the community
- PET CT – The trust remains committed to securing static PET CT on the Treliske site through a collaboration with the independent sector – national procurement underway
- The Division is working in partnership with the peninsula networks, specifically PenRad (Radiology) and PenPath (Pathology)

Strategic plans:
- Establishing Divisional Community
- Development of a Strategic Cancer Plan to move cancer provision onto a sustainable footing.
- Delivery of new Clinical Administration Model for the Trust.
- Optimise flow across Diagnostics which includes full use of Community Diagnostic Centres (CDCs) and all opportunities that the CDCs present

Success:
Initial feedback from teams in the Division is that the new Divisional structure promotes understanding and communication across interconnected teams. The integration of Haematology, Oncology and Cancer Services has been well received.
The Division has started the year with strong performance across all domains and against its operating and financial plan.
Smaller services such as medical Physics recognised for their contribution in the management of the recent critical incident – their flexibility and reactivity to issues underpinned the success of the actions taken to keep patients safe.
LIMS (Laboratory Information Management System) implementation – successful go live following a significant effort by the whole Pathology team. This was against a backdrop of ongoing operational pressures and the requirement for highly skilled expertise that were not easily backfilled. Our thanks go to the team and for their ongoing efforts to minimise disruption to other clinical services.

Neave Lynsey
30/05/2026 06:42:36

Concerns:
Ongoing workforce challenges amid sustained operational pressures leading to concerns regarding service sustainability and staff wellbeing across Cancer Services.
Divisional Leadership bandwidth during significant organisational change process (Clinical Admin Review) whilst maintaining pace on Divisional delivery plans.
Achieving financial balance against the backdrop of growing workforce pressures and maintaining traction with key specific targets, particularly cancer given the national focus.

Divisional Update - Medicine

Strategic Intent of the Division:
To deliver equitable, high-quality emergency and medical care for our patients by managing demand reducing attendances and avoidable admissions to protect and allow us to grow our core elective business. Working to use resources well so that our emergency care for Cornwall is top decile against productivity indicators.

Cross Cutting Intent
To have Customer Focus at the core of the service to deliver patient outcomes, quality, safety and performance across the Trust.

Summary from Roz Davies, Divisional Director

Key updates regarding the Division of Medicine's ongoing initiatives for evolving culture. The team continues to focus intensely on eliminating corridor care, with daily efforts centred on next steps and discharge planning for patients. This approach is intended to foster a culture of empowerment, encouraging speciality teams to take ownership of their wards to drive positive change among ward leaders and specialty leads. Development away days have been scheduled for June to engage the specialties with the importance of adopting the GIRFT (Getting It Right First Time) Clinical Operational Standards.

The Division is currently developing plans to establish a Discharge Ready Unit, designed to cohort medically optimised patients. This will allow new admissions to be placed directly onto specialist base wards, streamlining patient flow and improving overall care. The whole division is preparing for the upcoming introduction of GIRFT standards for eliminating corridor care, which will launch in June. The division is finalising plan tackle areas of non-compliance, to meet and exceed these new benchmarks.

For elective care, the team has been dedicated to raising our incomplete target for Respiratory Physiology and Sleep Studies. Notably, Sleep Studies have been revising their pathways to serve more patients, and these changes are already resulting in improved performance week by week. The Division is applying a similar strategy to echocardiograms, aiming to increase patient numbers there as well.

Importantly, the culture within the Division is undergoing a positive transformation. The Division has made space to bring ward leaders and specialty leads together outside of their usual environments to empower them and inspire positive thinking. The Division's recently launched Facebook page has become a vibrant platform, featuring a mid-week good news story from within the division and closing the week with awards and heartfelt thanks to staff, currently medical wards managing their capacity and demand.

Further work continues with our Integrated Neighbour Teams including digital solutions for our patients on the Isles of Scilly. Work continues on the divisions plans with help from the Cancer Alliance on the plans to deliver preventative care to patients working in agriculture as we prepare our "mole patrol" van which will include dermatology skin cancer checks, liver screening, blood pressure and oral screening.

The exciting transformation of the Medical Division continues.

Neave Lynsey
30/05/2026 09:31:26

Divisional Update – Surgery and Peri-Operative Medicine

Strategic Intent of the Division 1:
To deliver equitable, high-quality care for our patients in a timely way resulting in excellent elective and emergency services as the Acute care provider for Cornwall using resources well so that our service is top decile against productivity indicators.

Strategic Intent of the Division 2:
To further develop our regional and national reputation, developing supporting strategic partnerships where required, whilst at the same time improving our margin to grow profitable revenue and market share.

Cross Cutting Intent
To have Customer Focus at the core of the service to deliver patient outcomes, quality, safety and performance across the Trust.

Summary from James Clark, Clinical Chair

The Division continues to focus on embedding the new operating model and developing a cohesive leadership structure across Surgery, Anaesthetics, Critical Care and Perioperative Care. During this period significant progress has been made in establishing regular clinical leadership forums, strengthening governance arrangements and developing a shared divisional identity and culture to support delivery of the Trust's strategic objectives.

Alongside this organisational development, considerable focus has been placed on improving operational performance and patient flow. The launch of the START WELL Theatre Programme represents a major divisional initiative aimed at improving theatre utilisation, teamwork and operational effectiveness. Early engagement with clinical, operational and administrative teams has been positive, identifying a range of opportunities to reduce avoidable cancellations, improve utilisation and maximise the value of existing theatre capacity. Similar work is underway across a number of cancer pathways, particularly within Breast Surgery and Oral & Maxillofacial Surgery, where increasing demand and pathway complexity continue to present challenges to timely access. Reviews of referral pathways, diagnostic processes, clinic capacity and workforce models are being undertaken to support sustainable improvement and delivery of cancer standards.

The Division has also strengthened its governance infrastructure through the establishment of a Divisional Governance Leads Forum, bringing together governance leads from across specialties to improve consistency, organisational learning and dissemination of best practice. This work supports a more standardised approach to governance, quality improvement and patient safety across the Division.
Supporting the Trust's prevention and neighbourhood health ambitions, work has commenced on the development of a Community Optimisation Hub in partnership with Anaesthetics and Perioperative Medicine. The model seeks to identify patients who would benefit from targeted optimisation prior to surgery, including support around fitness, nutrition, frailty, smoking cessation and management of long-term conditions. By ensuring patients enter surgical pathways when clinically ready to benefit from intervention, the programme aims to improve outcomes whilst supporting wider population health objectives and reducing avoidable perioperative risk. This work complements ongoing development of community-based emergency and perioperative care pathways, helping to improve access, reduce unnecessary hospital attendance and deliver more care closer to home.

Neave Lyddon
30/09/2025 09:31:26

Divisional Update – Surgery and Peri-Operative Medicine

Progress also continues across a number of strategic programmes aligned to the Trust's ambition to develop as a University Hospital. The robotic surgery programme is advancing across multiple specialties and is being supported by growing academic and research activity across the Division. Current areas of focus include clinical research, service innovation, digital surgery, human factors and evaluation of new models of care, strengthening both the Division's regional reputation and its contribution to the wider academic agenda.

Challenges remain around workforce, capacity and balancing elective recovery with increasing emergency demand. However, the Division continues to work collaboratively across clinical, operational and executive teams to develop sustainable solutions whilst maintaining high standards of patient care, safety and experience.

Key outputs from the latest quarterly review
Leadership & Governance
Establishment of regular Group Clinical Director leadership forums.
Creation of the Divisional Governance Leads Forum.
Operational Improvement
Launch of the START WELL Theatre Programme.
Progression of cancer pathway improvement work within Breast and Oral & Maxillofacial services.
Prevention & Community Care
Commencement of the Community Optimisation Hub programme with Anaesthetic and Perioperative teams.
Development of community-based emergency and perioperative care models.
Innovation & Academic Development
Continued progression of the robotic surgery implementation programme.
Ongoing growth in research, innovation and academic partnerships supporting University Hospital ambitions.

During the next quarter the Division will focus on:
Operational Excellence
Embedding the START WELL Theatre Programme.
Improving cancer pathway resilience within Breast and Oral & Maxillofacial services.
Prevention & Community Care
Further development of the Community Optimisation Hub.
Progression of community-based emergency and perioperative care pathways.
Governance & Culture
Strengthening governance standardisation across specialties.
Undertaking a divisional culture and engagement survey.
Innovation & University Hospital Ambitions
Progressing robotic surgery implementation.
Expanding research, innovation and academic collaboration across the Division.

Neave Lyon 30/09/2025 09:12:28

Divisional Update – Women and Children

Strategic Intent of the Division 1:
To deliver equitable, high-quality, and family-centred care that supports lifelong health and well-being of our population. We will empower families through accessible services, timely interventions, and seamless care pathways—ensuring safety, autonomy, and positive outcomes across the continuum of care.

Strategic Intent of the Division 2:

Effective development and delivery of new hospital Programme. The Division is navigating the requirements of Hospital 2.0 with the New Hospital Programme whilst ensuring that the clinical priorities are not compromised.

Cross Cutting Intent

To have Customer Focus at the core of the service to deliver patient outcomes, quality, safety and performance across the Trust.

Summary from Caroline Chappell, Divisional Director

Partnership working
The Division has secured funding from the ICB to launch the Paediatric Neighbourhood MDT Test and Learn programme and so far, have 8 GP practices signed up to be involved with the deadline for applications is the 30th June.
Starting system working to incorporate our Gynaecology services into Women's hubs across and work with primary care to establish community Gynaecology services in line with the National Women's Health Strategy.

Strategic plans:
Workforce Sustainability – targeted recruitment, retention and planning for predictable gaps. Promoting career development, especially for non- medical clinical workforce.
Culture and staff experience focusing on compassionate leadership, team empowerment to prevent burnout, fatigue and improve well being.
Transition of young people to adult services: With a newly formed clinical team and key stakeholders in place the Transition working group is being established, the priority will be the transition for young people with complex needs and establishing an area in the hospital for young people aged 16-17 who require admission. This group will also focus on the CQC Mental Health Assessment action plan.
Elective productivity and capacity optimisation to reduce overall waiting times across the Division.

Success:
We are committed to creating a culture where everyone feels heard, valued and respected and where our staff voices help shape how we improve our services and support one another, We have launched our Neonatal culture review and there is ongoing work within maternity, this will be rolled out across the Division and successes shared across Divisions.

Neave Livesey
30/09/2026 09:31:2

Concerns:
The Division has significant workforce shortages across several specialities, notable in Neonates and Obstetrics with Extreme risk scores of 20. The Obstetrics risk is mitigated to an extent at the risk of elective Gynaecology capacity which has seen our RTT performance deteriorate in recent months. Recruitment in both Obstetrics and Neonates has been successful and the risks will reduce in the autumn of 2026 with the new recruits.

Trust Board Overview – Triangulation of Issues

The Trust continues to experience system-wide pressure driven by the interdependency between capacity, flow and workforce, with each acting as both a cause and consequence of performance variation. While improvement activity is in place across all three domains, the current position reflects a system operating at or above sustainable limits.

1. **Capacity: Constrained across beds, theatres and diagnostics**
    I. Capacity constraints remain a central limiting factor across both urgent and elective pathways. Bed occupancy continues to operate above the sustainable level (circa >95%), with the routine use of escalation areas and corridor care reflecting a system that is persistently full.
    II. In elective care, theatre capacity and diagnostic bottlenecks (notably endoscopy, echocardiography and sleep studies) are constraining throughput and contributing to growing waiting lists and long waits (including 52+ week breaches). These constraints are compounded by competing demand between emergency and elective pathways Infrastructure and estate limitations (e.g. UTC footprint, endoscopy disruption). Delays in capital programme progression impacting service optimisation as a result, the Trust is unable to consistently match demand with available capacity, creating sustained operational imbalance.

2. **Flow: Inefficient patient movement driving system congestion**
    I. Flow remains the most critical operational pressure point and is the primary mechanism through which capacity constraints manifest as performance deterioration.
    II. Delayed discharges and reduced early-day flow from inpatient wards are leading to prolonged ambulance handover delays (mean 82 minutes vs 29.5 target).
    III. ED crowding and increasing 4-hour and 12-hour breaches. High levels of aggregated patient delay This reflects insufficient discharge throughput and reliance on late-day discharges.
    IV. Constraints in community and onward care capacity. Fragmentation across pathways (e.g. stroke, medical admissions) flow inefficiencies are also evident internally, with patients held in non-specialist areas (impacting outcomes and productivity) with limited ability to decant medically optimised patients promptly variability in adherence to clinical operational standards (GIRFT). While initiatives such as Discharge Ready Units, Whole Hospital Reviews, and the Clinical Vision of Flow are being deployed, improvement is not yet at scale to offset demand pressures.

3. **Workforce: Impact of organisational change Clinical admin review and structural changes - Affecting morale - Creating temporary gaps during transition, change is necessary, but short-term instability increases fragility, impacting both capacity and flow**
    I. Workforce pressures underpin both capacity and flow challenges and remain a key limiting factor to drive recovery.
    II. Across divisions, there are persistent vacancies and reliance on temporary workforce in key areas (ED, diagnostics, theatres)
    III. High sickness absence, particularly driven by mental health and musculoskeletal conditions (~28% mental health)
    IV. Deteriorating staff experience, with only 23.1% recommending the Trust as a place to work
    V. In addition, workforce shortages are directly reducing service capacity (e.g. UTC closures, obstetrics impact on gynaecology elective work)
    VI. Staffing gaps are slowing patient flow (e.g. discharge delays, reduced overnight ED cover) Organisational change and cultural factors are affecting morale, retention and productivity these pressures contribute to a cycle of reduced productivity, increased operational risk, and further workforce strain.

Neave Lynsey
30/06/2026 09:31:26

Finance and Performance Committee Section



Outstanding Care for **One+All**

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Finance and Performance Committee Specific – Executive Review

Executive Director Summary, key issues to highlight

Finance – Graeme Booth, Deputy Chief Finance Officer

- Agreeing a balanced capital programme which mitigates extreme scheme risks is a priority. At this stage, capital spend being under plan should not be focused upon.
- Focus on risk of delivering 2026/27 revenue breakeven plan rather than current actual position. Note that run-rate of spend, particularly pay, remains flat.
- Developing and delivering Financial Sustainability Programme (FSP) schemes, particularly recurrent schemes.
- Further work will be required to provide assurance that the new RTT / Activity plan can be delivered from RCHT and System available finances.
- Sustained productivity requirements will be required.

Performance – Robin Jones, Chief Operating Officer

The Trust has received the latest publication of the National Oversight Framework for Quarter 4 of 2025/27 which has seen a reduction from segment 1 to segment 2. This is the lower end (close to segment 3) of segment 2. In response to that and coupled with months 1 and 2 of this year being off plan for Elective Care (RTT) and Urgent and Emergency Care (UEC) the Chief Operating Officer has initiated an additional delivery assurance process with the Divisional Directors meeting on a Tuesday to set actions and a follow up on a Friday to supplement and support divisional directors. This is being done in the spirit of balance with the commitments to empower the Divisions to own their delivery and the Executive not wanting to over-react to some initial challenges.

Performance is being impacted because of some gaps in the new structure which are being recruited to which whilst the Divisions are forming their new ways of working those gaps are having an impact. The Clinical Administration review changes are essential as that will right shape the critical function of clinical administration to support elective performance.

Immediate areas of attention through the new accountability meetings are intended to compliment the clinical vision for planned care and the clinical vision for flow. With that in mind they will be immediate actions to significantly reduce speciality patients who are 'expected' arriving in ED with specialities asking those patients to attend speciality admissions/assessment areas and a dedicated focus on reducing patients who have an ED stay of between 4 and 5 hours. This does not detract from the work across the Trust for the Clinical Operational standards to reduce ED crowding.

During the month of May we experienced significant urgent and emergency pressure, Southwest ambulance service peaked at the highest number of calls received across the Southwest since post-covid, in Cornwall 486 calls on Tuesday 26th May compared to the predicted 330, resulting in unprecedented demand at the Emergency Département. The trust declared a critical incident on the 27th May, emergency planning and resilience surge plans worked well, and clinical leads supported operational teams in the incident command centre, resulting in us de-escalating rapidly on the 28th May. A full internal de-brief has been completed and recommendations taken forward for future planning and training sessions.

From a Planned Care perspective, the immediate focus is to increase the number of patients through theatres and outpatients, we need to increase our completed treatments for patients over 18 weeks to reduce our waiting list size. In addition, a detailed review of patients over 52 weeks and the list orders to reverse the trend of the over 52 week wait number increasing. In support of the overall 18-week delivery reviews of outpatient capacity and use of all diagnostics, including the Community Diagnostic Centres, is underway. The route to 81% paper being presented to Finance and Performance Committee will provide more detail of actions.

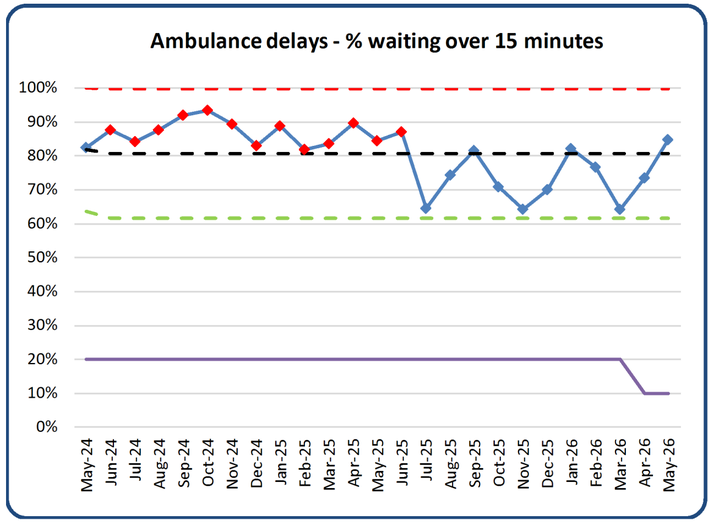
The Cancer Action Delivery Board has been re-energised with the new Divisional Structure with the intention of returning the Trust to delivery of the aggregated performance and then tackling the specific specialties with the higher numbers of patients over 62 days.

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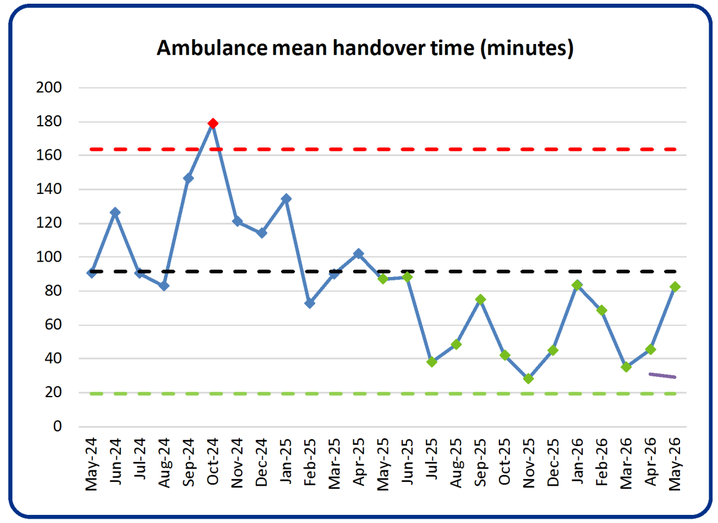
Finance and Performance – Urgent and Emergency Care

Lead Division – Medicine

Lead Executive – Robin Jones, Chief Operating Officer



May-26
84.59%



May-26
82

Background, what the data is telling us, and underlying issues

Ambulance performance deteriorated for a second month, and at 82 minutes, mean handover time exceeded the operational plan target of 29.5 minutes in May by 52.5 minutes. Maximum handover time also increased to 749 minutes from 412 in April.

Ambulance hand over delays have been attributed to a lack of discharges from the wards and a reduction in ED doctors' hours overnight which have had an impact. Delayed discharges from the wards have pushed the flow to later in the day which causes bottle necks which are challenging to recover from.

Improvement actions planned, timescales, and when improvements will be seen

The Clinical Vision of Flow meeting continues with a focus on increasing appropriate discharge.

This will be aided by the actions for Getting It Right First Time (GIRFT), using Internal Professional Standards across the Divisions to collectively eradicate corridor care and improve ambulance handover delays. These include 10 key areas of focus raging from full clinical assessment for new patients within 1 hour to a reduction in deconditioning with patients sitting out of bed every day. Twice weekly meetings are taking place within the Division to deep dive into how to deliver these targets as all will have an impact on flow and therefore meeting ambulance handovers.

Risks to delivery and mitigations

Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

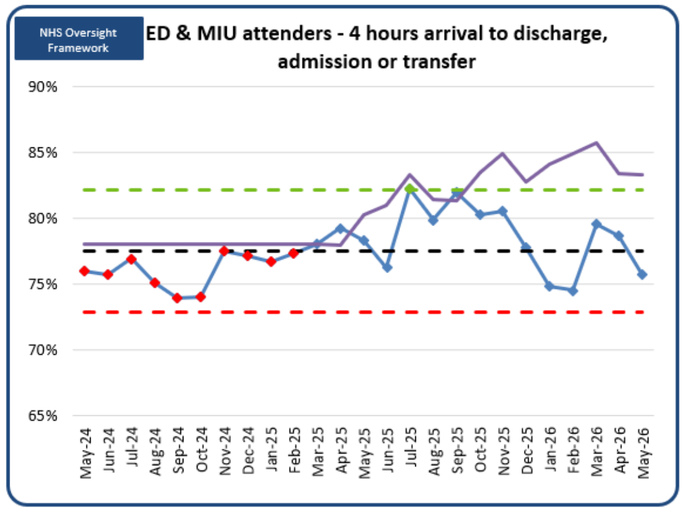
Risk description - The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

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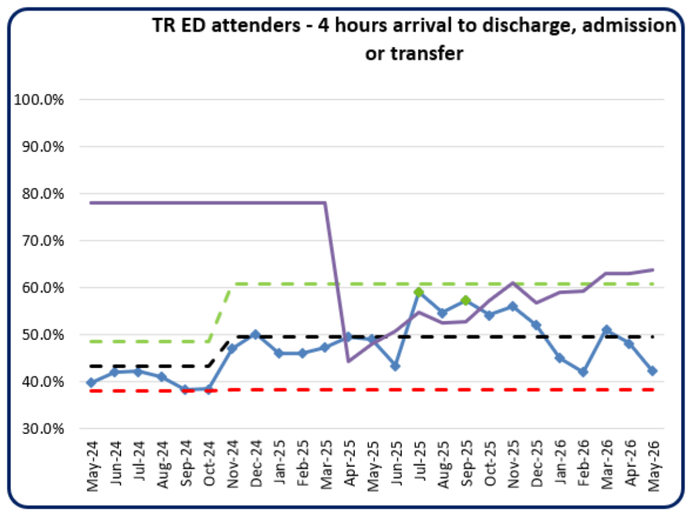
Finance and Performance – Urgent and Emergency Care

Lead Division – Medicine

Lead Executive – Robin Jones, Chief Operating Officer



May-26
75.70%



May-26
42.41%

Background, what the data is telling us, and underlying issues

All type and Treliske ED 4-hour performance has remained below operational plan consistently since October 2025, with direction of travel over the last 2 months moving away from the intended position submitted in the plan (83.3% for ED and MIU attenders, 63.7% for Treliske ED in May). Performance is also lower than the same month last year.

The national target for 4-hour performance is for all Trusts to maintain or improve to 82% by March 2027.

In the most recent Model Hospital benchmarking, the Trust benchmarks in the lower quartile for Type 1 and 2 4-hour performance (Treliske ED) and in the interquartiles range for All Type 4-hour performance (ED & MIU).

Neave Lynes 30/06/2026 Public Trust Board

Improvement actions planned, timescales, and when improvements will be seen

The team have instigated a weekly meeting to address and target the 4-hour standard with a particular focus on the non-admitted patients. A third senior doctor has been implemented to bolster the night shifts.

The actions the Division are working towards for ending Corridor Care (GIRFT) will also assist with the 4 hours target. These include:

- Enhanced Nurse Practitioner streaming
- ED capital works to increase productivity
- Flow Coordinator for twilight shifts
- 4-hour breach report validation

Work continues to support the West Cornwall UTC 4 hour processes which benefits from the new structure aligning ED and UTC teams (see next page for UTC detail)

Risks to delivery and mitigations

Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

Risk description - The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

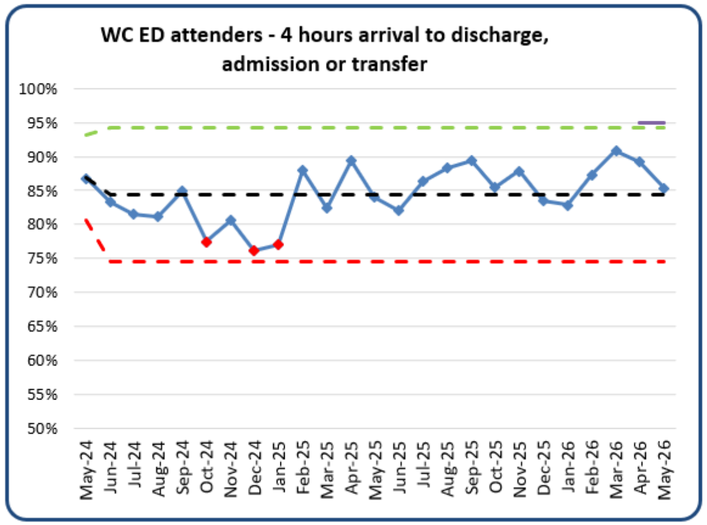
Risk that the third senior doctor shift overnight is not filled consistently.

Mitigations – reviewing locum options and seeking approval for substantive recruitment.

Finance and Performance – Urgent and Emergency Care

Lead Division – Medicine

Lead Executive – Robin Jones, Chief Operating Officer



May-26
85.37%

Background, what the data is telling us, and underlying issues

Following the improved position seen in March, performance has deteriorated for a second month and is now c.10% below the Trust target of 95%.

The West Cornwall position has deteriorated due to a lack of staffing and therefore early closures. This not only causes an issue for those in the west of the county but also adds additional pressure to the Emergency Department.

Neave Lydsey
30/06/2026 09:31:26

Improvement actions planned, timescales, and when improvements will be seen

Further enhancement to staffing is planned for the summer/early autumn with the regular attendance of an ED consultant, Monday to Friday. This senior post will bring training and continuity to the existing GPs and Specialty doctors working at the Urgent Treatment Centre (UTC) and in turn further increase the position. A daily validation review has been introduced to investigate potential breaches of the target.

The Division have allocated a senior Band 7 nurse within the UTC and have had regular on-site support from the Emergency Departments consultant body. Interviews are being arranged for July to appoint a permanent Band 7 UTC leader shortly.

Risks to delivery and mitigations

Staff sickness is currently the biggest risk to delivery.

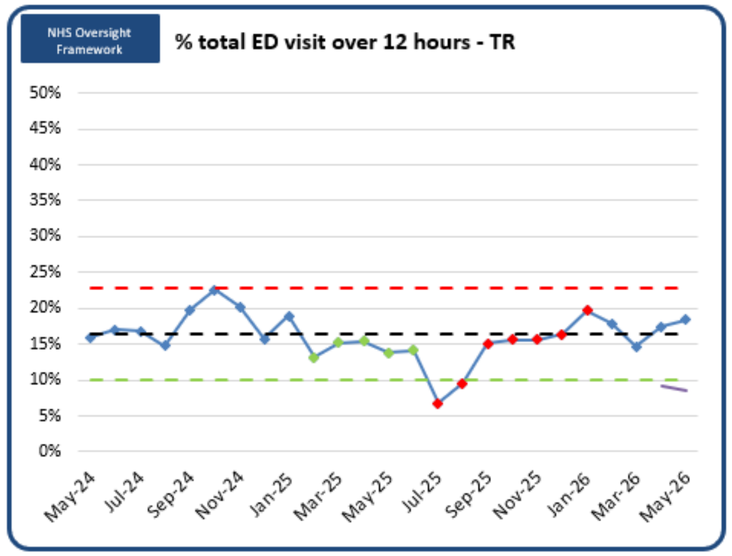
There are currently 2 medical vacancies, 0.6 Emergency Nurse Practitioner (ENP). 1 nursing vacancy and 1 admin vacancy. Plans for recruitment are all in place.

The UTC unit sits within a small template of 4 cubicles and 1 side room. This can be challenging to manage at times of surge. The Division are currently working with the Estates team on designs to relocate and enhance the UTC so that it has space to facilitate flow which can inhibit the 4 hours standard.

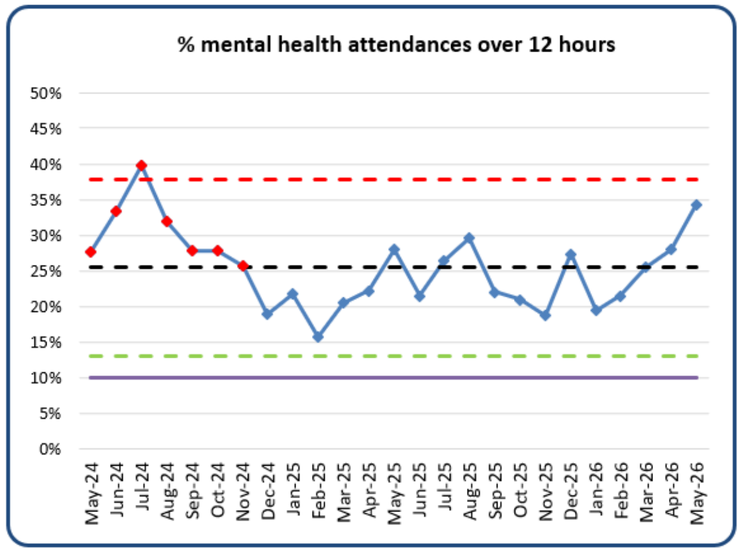
Finance and Performance – Urgent and Emergency Care

Lead Division – Medicine

Lead Executive – Robin Jones, Chief Operating Officer



May-26
18.43%



May-26
34%

Background, what the data is telling us, and underlying issues

The service holds the challenging position of patients within the unit exceeding the 12-hour target. A contributor has been the flow through to our Medical Rapid Assessment Triage unit taking priority over ED admitted patients. This has now ceased to allow balance however our Medical admissions are split over 3 areas which is challenging to manage.

The national target is for all Trusts to achieve a higher percentage of patients admitted, discharged and transferred from ED within 12 hours across 2026/27 compared to 2025/26. Therefore, in the context of the metric reported above, a lower value is better. For the first 2 months of 2026/27 the Trust has adversely exceeded the Trust's trajectory with performance moving in the opposite direction to the intended plan. Performance is also higher than the same months last year.

In the most recent Model Hospital benchmarking, the Trust benchmarks in the lower quartile for ED waits over 12 hours (Type 1&2). All type 12-hour waits are used in the NHS Oversight Framework (since Q3 2025/26) and in the most recent quarterly publication of the framework (Q4 2025/26), the Trust benchmarked in the interquartile range.

Improvement actions planned, timescales, and when improvements will be seen

The GIRFT standards to end corridor care will help us to create flow and eliminate the issue of 12-hour breaches in the Emergency Department. These standards have been set as tried and tested methods to increase flow and optimise decision making.

To begin this, the wards within the Medical Division have been issued with discharge targets per day, baseline, Opel 3 and Opel 4. These are to be achieved each day. The Acute Medical Unit has the greatest variance to target however supporting the unit will be key. Actions being taken will be include the appointment of a Specialty Lead to aid the team with the change.

Other areas of work are underway to reduce admissions such as:

ED Consultant Led Single Point Of Access (SPOA) commencing in October

Primary Care Respiratory winter MOTs (Penwith Integrated Neighborhood Team (INT) and providing Monofer infusions for Heart Failure preventing admissions

Risks to delivery and mitigations

Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

Risk description - The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

Delays in Mental Act Assessments being undertaken for ED patients.

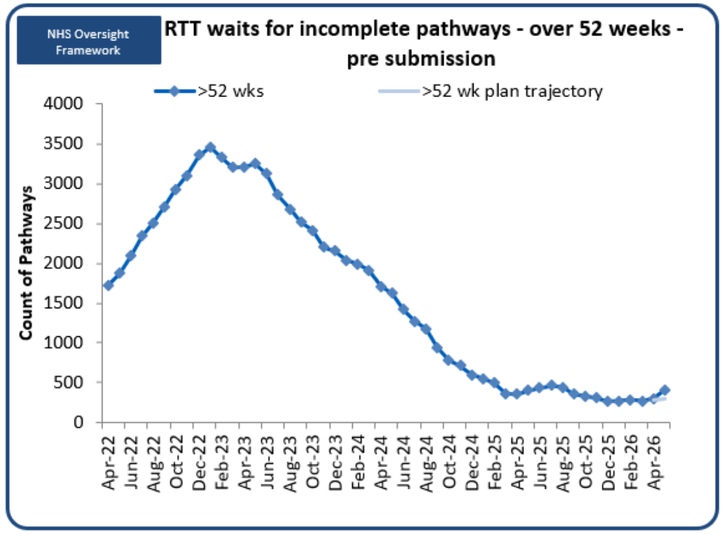
Increased number of patients awaiting MHA assessments due to lack of Adults Social Care and CFT doctors out of hours and at times of peak surge plus lack of specialist mental health inpatient beds are escalated at time of delay through daily system calls and to CFT Chief Operating Officer. Lack of suitable timely transport from the emergency department is also attributable to the delays, this has been escalated to the ICB who commission the transport services.

Next Trust Board 30/09/2026 Page 23

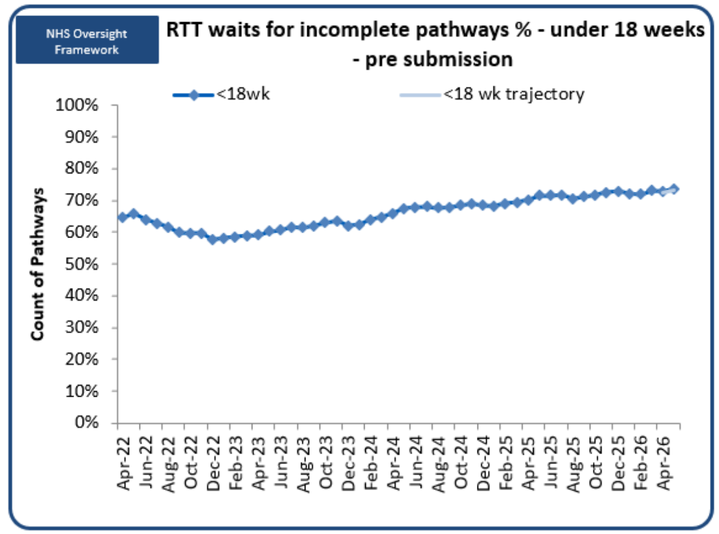
Finance and Performance – Planned Care

Lead Division – Surgery and Peri-Operative Care

Lead Executive – Robin Jones, Chief Operating Officer



May-26	
Over 52 wks	408



May-26	
Under 18 wks	73.61%

Background, what the data is telling us, and underlying issues

Whilst incomplete pathway performance was above the plan of 73.0%, this was because of further increases in the waiting list rather than an improvement in the percentage of pathways over 18 weeks. The waiting list grew to 42,645, the largest since October 2024.

Long waits also rose, with 52-week waits increased by 38% to 408. 18 treatment functions reported breaches including Trauma & Orthopaedics (282), Gynaecology (42), ENT, Ophthalmology and Cardiology (all 13).

There were 38 65-week waits compared with 24 in April, and 78 week waits increased to 3.

Improvement actions planned, timescales, and when improvements will be seen

The Divisions are managing a range of improvement actions in order to deliver recovery. For outpatients this includes increasing first outpatient capacity through:

- Clinic template and follow-up to new ratio reviews, enabled by GIRFT (Getting It Right First Time) clinical pathway implementation.
- Workforce adjustments including job plan reviews, consultant recruitment and registrar clinics.
- Further development and use of super clinics and community-based models.
- Twice weekly additional assurance meeting implemented with the COO which includes review of booking sequence to ensure booking in time order (taking into consideration clinical priority) with the intention of reducing over 52 week waits
- Re-affirmed the process of not booking patients past 52 weeks without escalation to senior leader in the Division to ensure no alternative to avoid the breach

Risks to delivery and mitigations

The most significant pressures relate to:

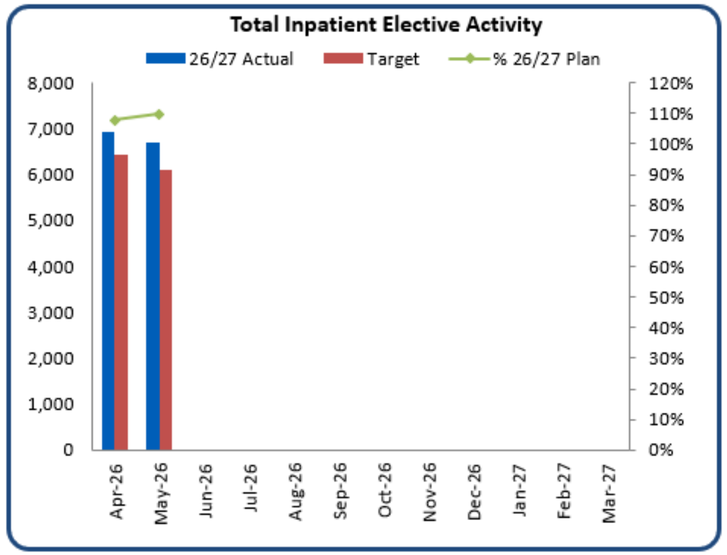
- Theatre capacity and specialist workforce (Surgery, Gynaecology, T&O)
- Outpatient access delays constraining pathway flow (Cardiology, MSK)
- Diagnostics bottlenecks (Endoscopy, Echocardiography, Sleep studies, Neurophysiology)
- Plans are being developed to review insourcing/outsourcing options
- Detail needed to make the changes to clinical practice for new to follow up ratio changes to enable overall outpatient improvements

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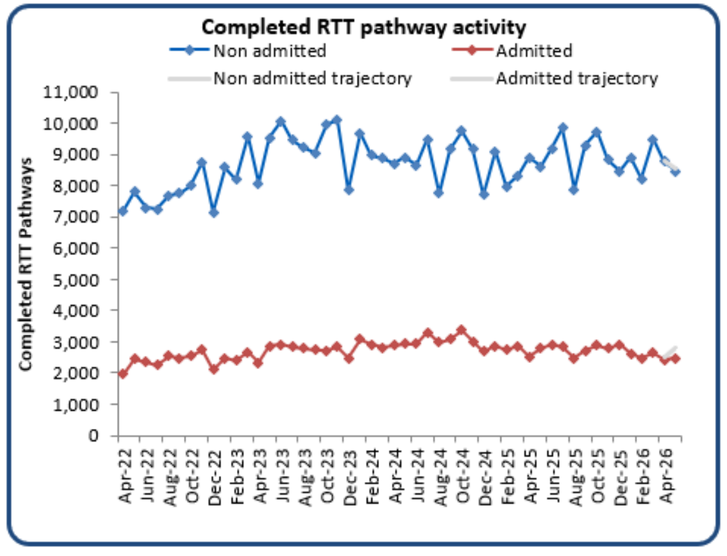
Finance and Performance – Planned Care

Lead Division – Surgery and Peri-Operative Care

Lead Executive – Robin Jones, Chief Operating Officer



May-26	
Target	6111
26/27 Actual	6,702
26/27 Plan %	109.67%



May-26	
Admitted	2485
Non admitted	8464

Background, what the data is telling us, and underlying issues

Trauma & Orthopaedics (T&O) continue to have capacity issues across all the subspecialties, whereas the other specialities i.e. Ear Nose and Throat (ENT) have surgeon specific issues.

Trauma and Orthopaedic completed pathways remain low compared to pre-pandemic levels, at 66% compared with the same period in 2019/20 (non-admitted 58% and admitted 78%).

Gynaecology's position continues to decline driven by both staffing constraints linked to the extreme obstetric risk and limited access to RCHT theatre capacity. The longest waits are for our Endometriosis and Uro-Gynae sub-specialities.

Neave Lynsey
30/06/2026 09:31:26

Improvement actions planned, timescales, and when improvement will be seen

Theatres and electives recovery actions include:

- Expansion of theatre lists to increase the number of cases per session and additional weekend operating.
- Full use of St Austell Surgical Hub capacity.
- Review of use of the WCH theatres along side using the Penlee Unit for local anesthetic work.
- Peri-operative optimisation plan being developed to help avoid cancellations before day of operation.
- Exploring developing pools of patients that could sit on a short notice list to backfill any cancellation on the day.
- There have been 3 successful appointments of Obstetric and Gynecology Consultants who will commence in September 2026 which will bolster the elective provision within job plans.

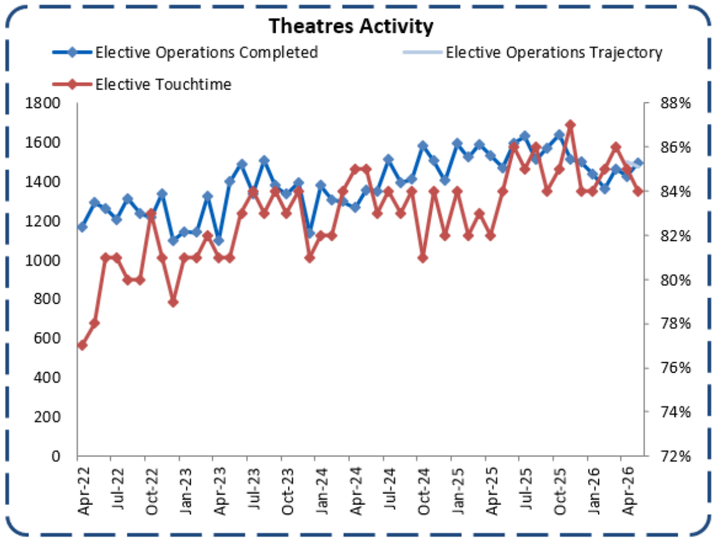
Risks to delivery and mitigations

- Demand exceeding capacity, particularly in T&O and Gynaecology.
- Balancing cancer/clinically urgent demand.
- Theatre capacity limitations.
- Workforce fragility and delays to recruitment start dates.
- Reliance on additional/premium sessions (weekends, extra lists) not fully sustainable.

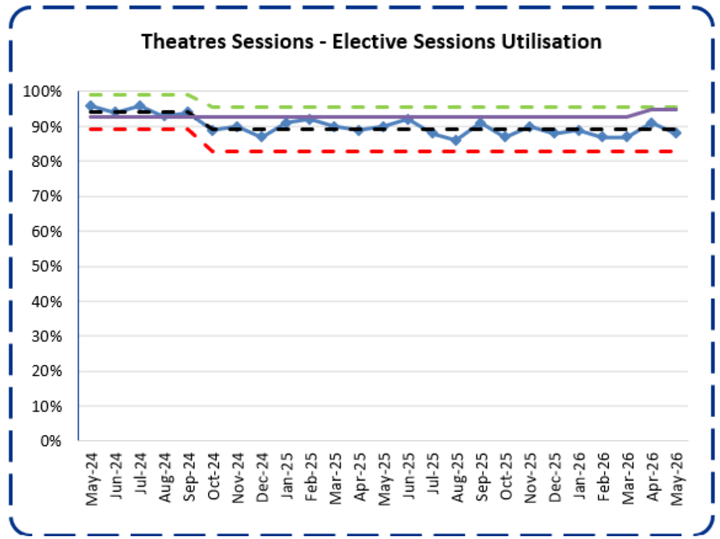
Finance and Performance – Planned Care

Lead Division – Surgery and Peri-Operative Care

Lead Executive – Robin Jones, Chief Operating Officer



May-26	
Elective Operations Completed	1495
Elective Touchtime	84.00%



May-26	
Elective Session Utilisation	88.00%

Background, what the data is telling us, and underlying issues

Sessional utilisation was impacted during May due to a high volume of theatre staff off sick coupled with annual leave over the half – term period. Planning will be reviewed for the August bank Holiday and over the school holiday period.

The graph above shows all elective operations completed. The weekly 4 P's meetings (patients, people, pounds and performance), tracks the recovery critical 9 specialities included in the elective theatres plan: General Surgery, Urology, Breast Surgery, Vascular Surgery, Trauma and Orthopaedics, Ear Nose and Throat (ENT), Ophthalmology, Oral and Maxillofacial Service, and Gynaecology.

Elective operations for these 9 specialties in May fell 1 below plan at 1477 vs plan 1478. The additional elective activity in the graph above for May was in Pain Management and Cardiology.

Despite not meeting the Trust's target of 95% for elective session utilisation, the Trust continues to benchmark in the best decile in the most recent Model Hospital benchmarking for capped elective theatre utilisation.

Improvement actions planned, timescales, and when improvements will be seen

Work continues to improve sessional utilisation – review of how surgical and anaesthetic colleagues engage to pick up the available sessions.

In addition, there is work ongoing to a) identify patients booked on the acute site that can be done elsewhere, and b) Engage with specialties in booking and identifying efficiencies within sessions.

"Start Well " project for improving theatre productivity has been launched aiming to empower the band 7's in theatres to lead and challenge as required.

A listening event with the booking team planned in June to understand their issues so the leadership team can help unblock and support resolution.

A review of annual leave planning to ensure staff take their leave and service capacity is maintained

Risks to delivery and mitigations

Weekend working relies on both surgical and anaesthetic uptake.

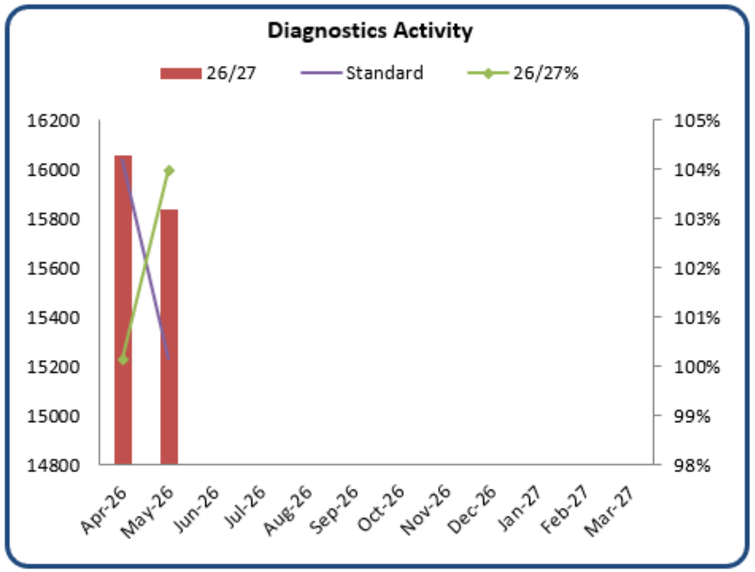
Sickness rate within the theatre team is rising and is being monitored closely. There is a focus on supporting long term sick members of the team and individual return to work meetings, to ensure any support required is provided.

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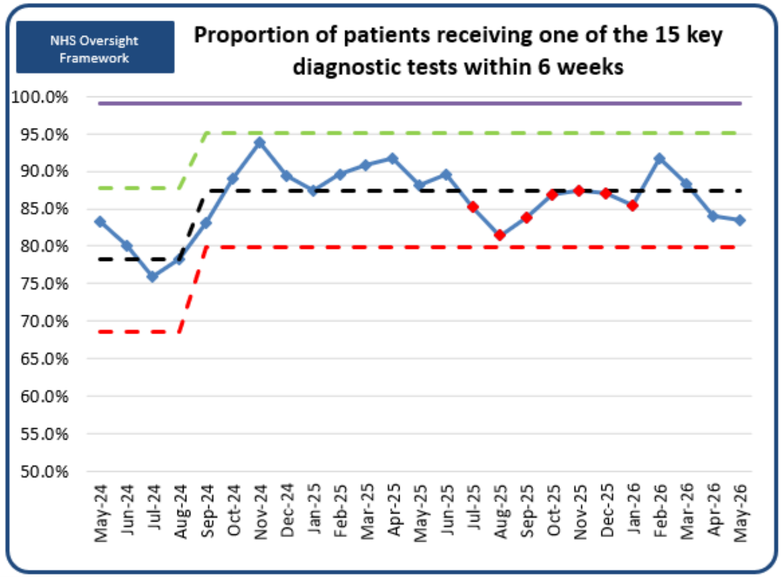
Finance and Performance – Planned Care

Lead Division – Clinical Support and Cancer Services

Lead Executive – Robin Jones, Chief Operating Officer



May-26	
26/27	15,838
26/27%	103.97%



May-26
83.43%

Background, what the data is telling us, and underlying issues

Diagnostics 6 week wait standard was a contextual metric for the 25/26 NHS Oversight Framework – for 26/27 it becomes a scoring metric.

Overall diagnostic performance remains variable and off trajectory, with improvement in some modalities offset by pressure in others

Strong performance: Cystoscopy, Urodynamics and Imaging reporting improvements

Key challenged areas: Endoscopy (workforce + infrastructure disruption), Echocardiography capacity and pathway consistency Sleep studies and Neurophysiology backlog. Longest wait was 57 weeks (Cardiology, under investigation) with a further 104 at 20-30 weeks (various tests).

Improvement actions planned, timescales, and when improvements will be seen

- Continue to drive use of Community Diagnostic Centres (delivering to RCHT plan and accessing ICB funded capacity). Transfer of Endoscopy waiters to InHealth CDC. The full CDC capacity needs to be utilized to enable improvement in endoscopy performance
- Developing nurse-led models (Urodynamics).
- Weekend working for recovery for Endoscopy.
- Admin Pathway redesign for echocardiography to ensure equitable access to system-wide capacity.
- Ongoing validation and pathway management to improve utilisation.
- Pathway redesign to increase C-PAP and Sleep Studies

Risks to delivery and mitigations

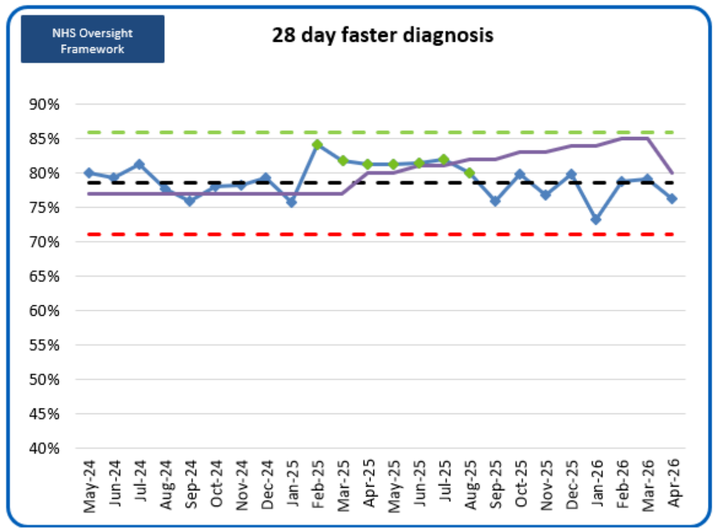
- Persistent workforce shortages and recruitment challenges.
- Operational constraints (e.g. decontamination, infrastructure disruption in Endoscopy, nursing sickness).
- Risk of inconsistent system flow across sites - echo capacity variation, limited access to In Health endoscopy services remain an issue, this has been escalated to the ICB.
- Administration gaps and the continued impact this is having on the booked ahead position and ability to hold and focus on the 6-week target.

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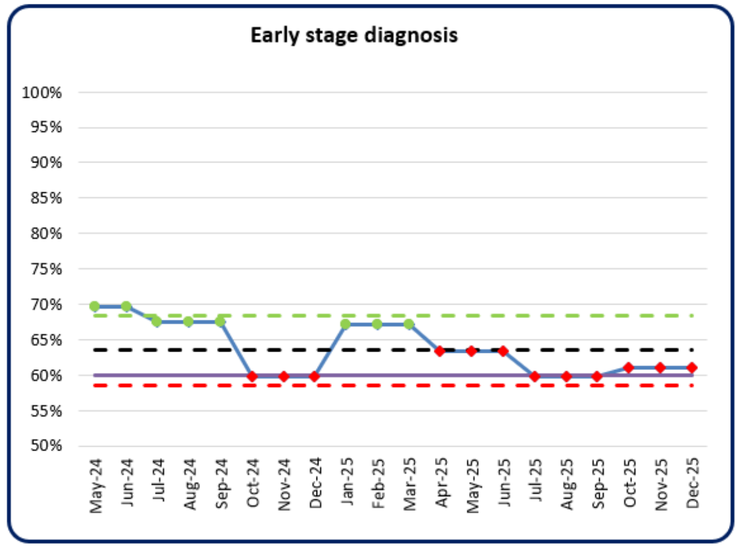
Finance and Performance – Cancer

Lead Division – Clinical Support and Cancer Services

Lead Executive – Robin Jones, Chief Operating Officer



Apr-26	
Faster Diagnosis	76.34%



Dec-25
61.05%

Background, what the data is telling us, and underlying issues

The Trust's 28-day FDS (faster diagnosis standard) position deteriorated between March and April with performance dropping from 79% to 76.3%. This tracked against England average which also reported a similar decline from 79.3% to 75.8%. The national target from April is 80% and the expectation is that the year end position shows an average performance on or above this.

We anticipated a performance drop due to capacity within the breast service and backlog clearance by histology. The backlog clearance impacted April performance but will result in a stronger performance in May as the number of patients waiting over 10 days for a histology report will be significantly lower and breast made improvements in their booking window.

Improvement actions planned, timescales, and when improvements will be seen

To achieve an 80% average, the Trust must exceed expectations on FDS from now on until year end. Support services such as histology and imaging should avoid backlog, and front-line specialties need to quickly expand capacity as needed. High-volume areas—breast, colorectal, head and neck, and skin—must keep booking windows under 10 days when diagnostics are required for cancer confirmation or exclusion.

Pathway opportunities to be identified to offer direct access to CDCs

Further review of historic annual leave booking practices to ensure staff supported to take leave across the year whilst maintaining service provision

Deep dive on any capacity changes that may have had an unintended consequence on the FDS delivery (for example changes to insourcing/outsourcing)

Review of capacity and demand to reduce reliance on staff undertaking additional activities

Risks to delivery and mitigations

To sustain ongoing improvement, it is essential for specialties to improve the 28-day FDS as soon as possible, thereby facilitating increased opportunities for treatment scheduling within 62 days. This process relies on maintaining current turnaround times in imaging and histology, as well as efficient outpatient bookings and adequate theatre capacity.

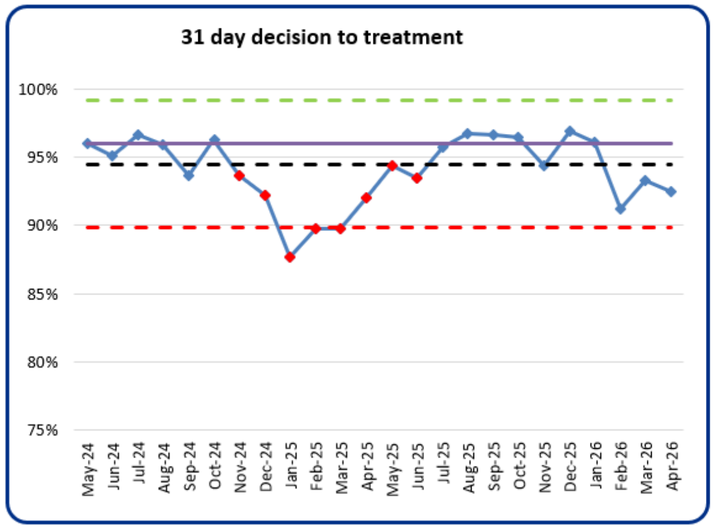
Varying levels of willingness to undertake additional activities

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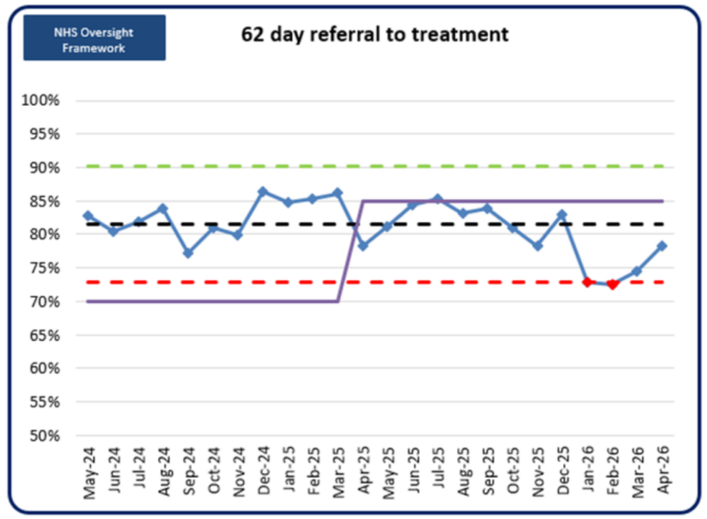
Finance and Performance – Cancer

Lead Division – Clinical Support and Cancer Services

Lead Executive – Robin Jones, Chief Operating Officer



Apr-26
92.44%



Apr-26
78.28%

Background, what the data is telling us, and underlying issues

Cancer 62-day performance rose between March and April for the Trust from 74.5% to 78.3%. This was opposite to the national average which dropped from 72.8% to 69.9%. This is the third month in a row the Trust has shown an improvement but is still short of expected performance (80%) and stretching to the national target of 85%. Head and Neck performance dropped to 40% due to a combination of complex pathways and capacity across both ENT and MaxFax. The other 2 challenged pathways are Lung which remained under 60% at 53% against the England average of 61.6% and Breast at 57.8% against the national average of 68.8%. Lung typically spans providers and breaches can be shared where diagnosis and work up happens locally, with surgery at the tertiary centre (UHP). The Breast pathway is wholly managed by RCHT and capacity throughout the pathway is impacting performance. Work to reduce the wait to first appointment will show an impact but not likely to be visible until July as patients move through the pathway.

The Trust has closely mapped to national performance for 31-day performance with April at 92.4% for RCHT against national performance of 91.5%. The target is 96% and the Trust met this 5 times in the last 12 months. The target is a combination of modalities (surgery, radiotherapy and SACT (systemic anti-cancer therapy) for both first and subsequent treatment. Locally, radiotherapy is the most significant contributor to the performance position with 80.8% of patients starting a treatment within 31 days of a decision. The backlog within Breast and fragility in other cancer pathways as a result of workforce shortfall to deliver the capacity needed for a sustainable pathway e.g. medics, radiotherapy, support areas such as tech services. Surgery performance has improved and is stronger than the England average with 91.1% against 85.9%. However, underlying this the majority of breaches sit within Breast for both surgery and onco-plastics which between them account for at least 2/3 of the breach numbers.

Improvement actions planned, timescales, and when improvements will be seen

The Cancer Delivery Board is being re-based by the Cancer Manager to support more detailed analysis of opportunities for improvement

Breast pathway plan remains in place

The new additional assurance weekly review meetings implemented by the COO will review the plans for the most challenged specialities and timescales

Risks to delivery and mitigations

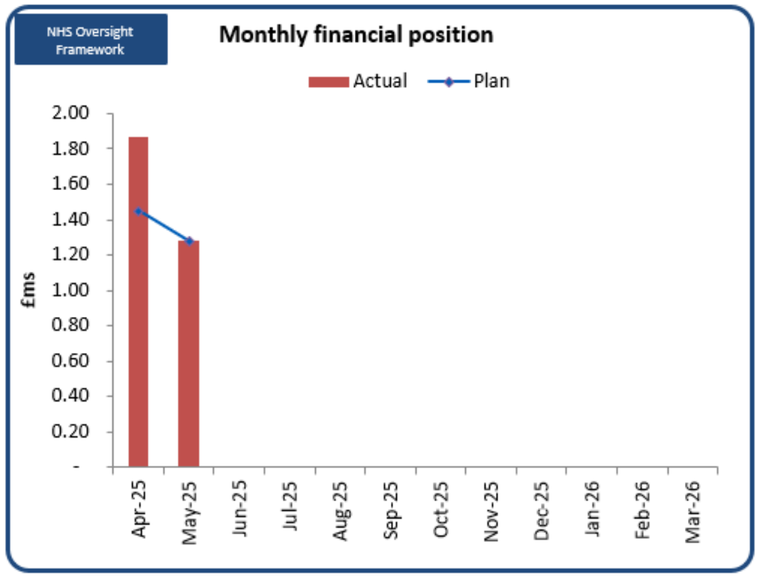
There is a risk that the workforce required is a national shortage and recruitment will be difficult or time-consuming if training up staff is the preferred option. Breast surgery and radiology are working together on this review.

Administration gaps which demonstrates the importance of how these teams underpin management of patients through the Patient Tracking List (PTL). This has been flagged as a national issue.

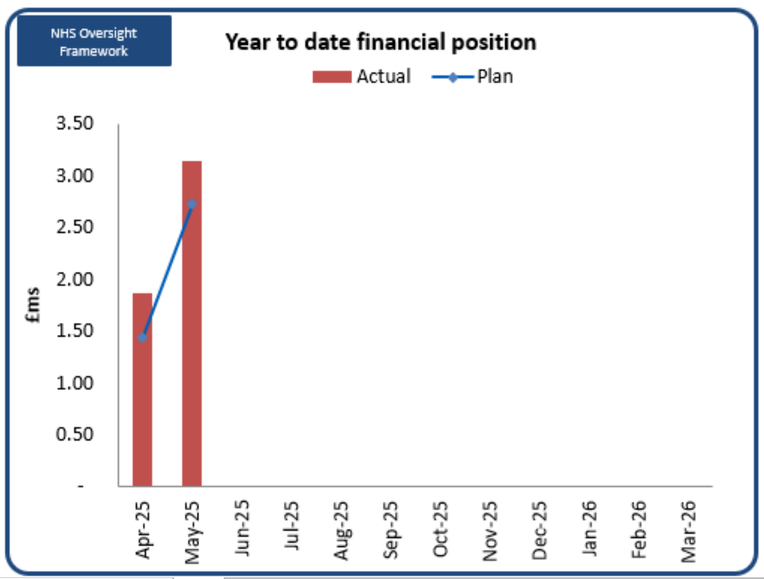
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Finance and Performance

Lead Executive – Ian Dean, Chief Finance Officer



	May-26
	1.28



	May-26
Actual	3.14
Variance	0.41

Background, what the data is telling us, and underlying issues

The Trust reported a deficit of £1.28m in May, in line with plan and delivering a marginal positive variance. Year to date (months 1–2), there is an adverse variance of £0.42m, driven by the cost of April industrial action.

Improvement actions planned, timescales, and when improvements will be seen

While a formal forecast has not yet been completed, current assessment indicates that delivery of the breakeven plan remains achievable.

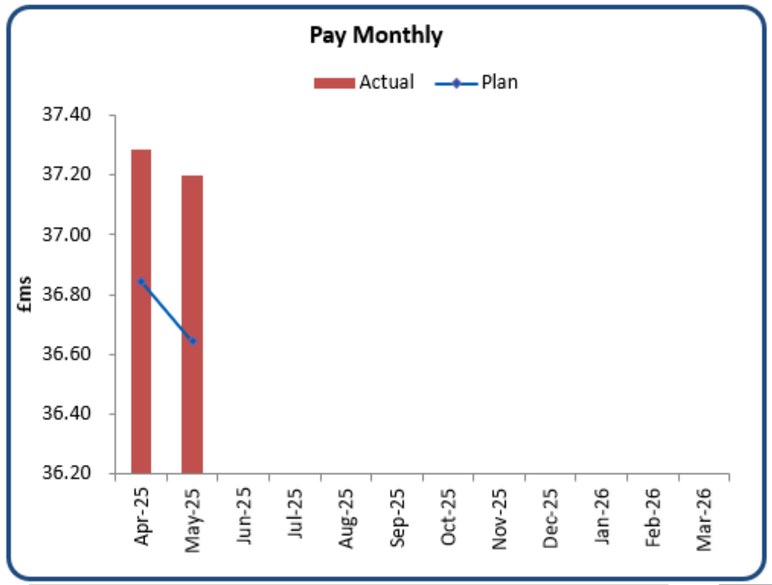
Risks to delivery and mitigations

The main risk to achieving a breakeven position in 2026/27 is delivering the Financial Sustainability plan both in totality and meeting the 75% recurrent requirement to close the underlying deficit.

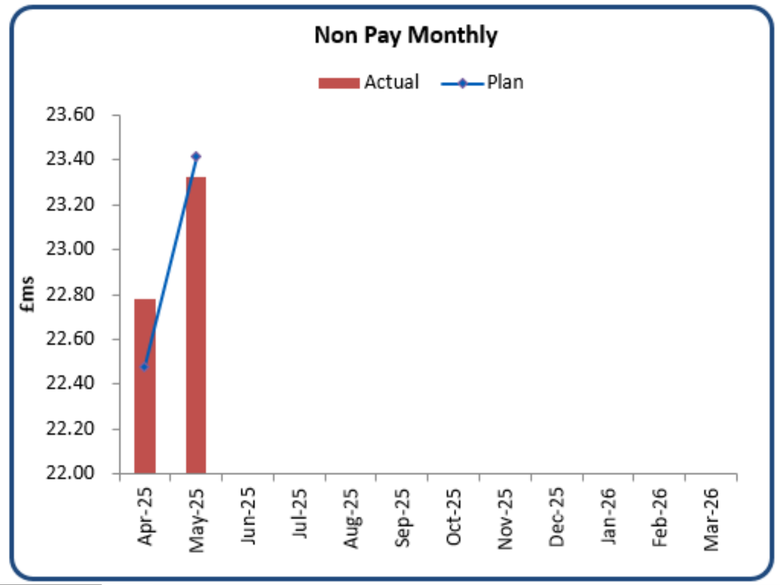
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Finance and Performance

Lead Executive – Ian Dean, Chief Finance Officer



May-26
37.20



May-26
23.33

Background, what the data is telling us, and underlying issues

Pay was £0.56m over budget in May and £1.00m cumulatively. On a run rate basis pay has remained consistent at £38m per month. Due to increased escalation costs and the April industrial action.

Non-Pay was £0.09m under budget in May reducing the cumulative adverse position to £0.22m. On a run rate basis expenditure increased primarily attributable to eCare related costs and higher drug spend.

Improvement actions planned, timescales, and when improvements will be seen

Improvement in expenditure rates dependent on delivery of Financial Sustainability plans and conclusion of existing consultations.

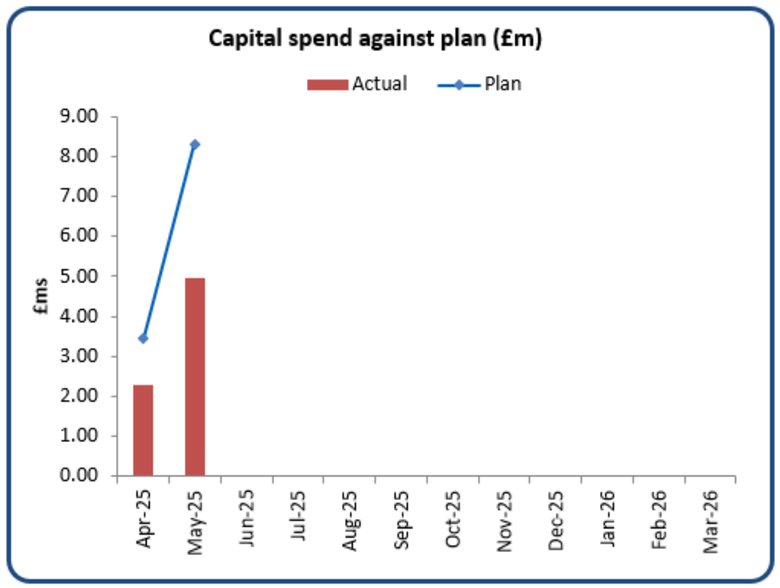
Risks to delivery and mitigations

Risk of continued high pay costs in connection to escalation areas being open, non-delivery of FSP and further industrial action.

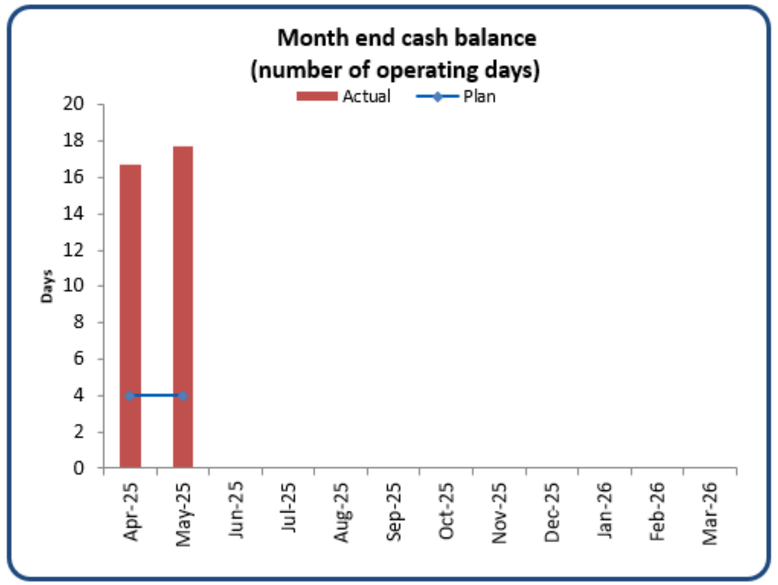
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Finance and Performance

Lead Executive – Ian Dean, Chief Finance Officer



May-26
4.98



May-26
18

Background, what the data is telling us, and underlying issues

Capital Spend: The capital plan for M2 was £8.313m, actual spend at M2 is £4.979m.

Of this, £1.821m relates to CDEL. The majority of this variance is due to the fact that the Trust has not yet been able to approve a balanced capital plan and has had to place projects on-pause until an affordable plan can be agreed. Once a plan has been approved, the budgets and profiling of these across the year will be amended to reflect the delay to the start of these projects.

The remaining £1.513m variance is linked to externally funded projects; the majority of which is caused by the current delays to the eCare project. These delays are going to result in increased costs, and this budget is expected to be revised and reprofiled in the same way as the CDEL budgets, and to be fully spent by the end of 2026/27.

Cash Balance: The Trust ended May 2026 with a cash balance of c.£39m (31 March 2026 c.£44.3m) compared with a planned balance of c.£20.3m, resulting in a c.£18.7m / 10.9 day favourable variance.

Improvement actions planned, timescales, and when improvements will be seen

Capital Spend: A revised capital plan has been developed by the Trust's Capital Approvals Group which aims to seek approval from the Trust Board at it's July meeting. Should it be approved, the capital programme will be reset and re-profiled to reflect the shorter delivery period.

Cash Balance: No improvement plans required.

Risks to delivery and mitigations

Capital Spend: Project teams have reviewed this year's project budgets to ensure that all of the work would still be deliverable despite the pause, at this stage they are confident that the programme remains deliverable.

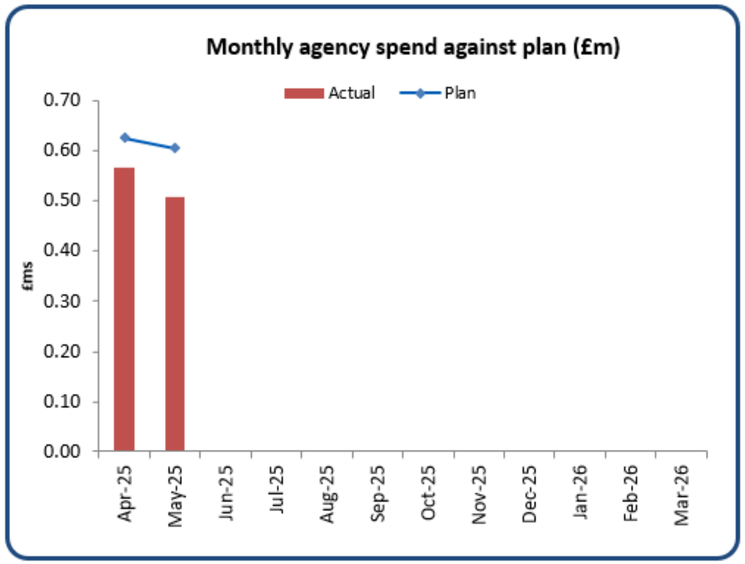
Capital Approvals Group will continue to monitor the programme to ensure deliverability of projects once the plan is approved and project implementation is underway.

Cash Balance: Key risk is delivery of the financial plan.

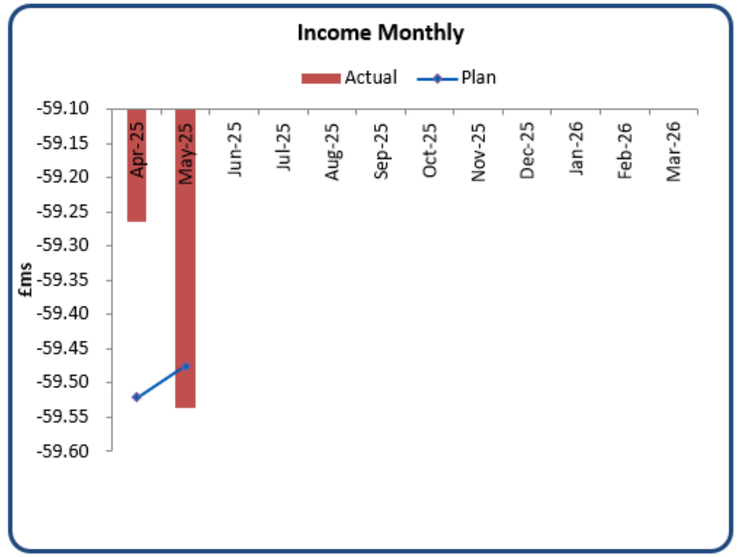
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Finance and Performance

Lead Executive – Ian Dean, Chief Finance Officer



May-26
0.51



May-26
-59.54

Background, what the data is telling us, and underlying issues

Income was £0.06m above plan in month, reducing the adverse variance from April to £0.20m.

Agency expenditure remains below plan in May across all staff groups.

Improvement actions planned, timescales, and when improvements will be seen

At this stage no improvement plans required, however important to note that the agency plan is challenging as it reduces throughout the year.

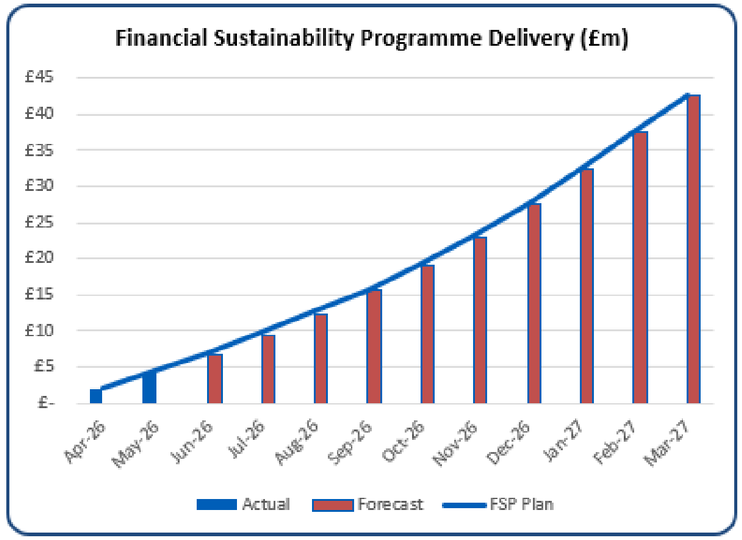
Risks to delivery and mitigations

Continued escalation and industrial action may lead to increased agency expenditure.

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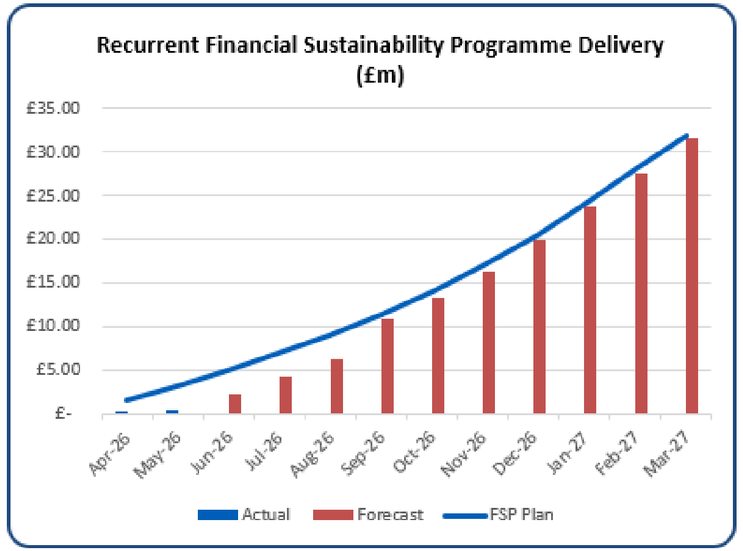
Finance and Performance – Financial Sustainability Programme

Lead Executive – Ian Dean, Chief Finance Officer



	May-26
Delivery %	90%
Delivery £	4.08

	Forecast Full Year
Delivery %	100%
Delivery £	42.50



	May-26
Delivery %	14%
Delivery £	0.45

	Forecast Full Year
Delivery %	99%
Delivery £	31.59

Background, what the data is telling us, and underlying issues

The 2026/27 financial plan set a total savings requirement of £42.5m. In May, the FSP programme delivered £2.07m against a target of £2.31m, resulting in a £0.24m shortfall and increasing the year-to-date variance to £0.41m against the £4.51m plan.

Improvement actions planned, timescales, and when improvements will be seen

The Financial Sustainability Programme has reviewed the early programme position, with the current focus on strengthening delivery assurance, governance and scheme mobilisation.

Risks to delivery and mitigations

Risk of increased escalation and delivery of restructuring consultations, which could be mitigated by identification of additional non-recurrent FSP.

Neave Lynsey
30/06/2026 09:31:26

Quality Assurance Committee Section



Outstanding Care for **One+All**

Neave, Lynsey
30/09/2026 09:31:26

Quality Assurance Committee Specific – Executive Review

Executive Director Summary, key issues to highlight

Quality – Bernadette George, Acting Chief Nursing Officer

The focus continues on eradicating Corridor Care. Electronic breech reporting is now in place across the Trust with a focused weekly breech report now in place to support learning and improvement actions.

A deep dive into May's pressure ulcers showed no direct link to Corridor Care and this has reported through to Junes Quality Assurance Committee meeting. Focus remains on the driving down our rate of hospital acquired pressure ulceration with a quality summit having taken place with focused actions coming out of it.

The focus of the recent Patients Performance meeting has been patient experience and complaints. The Divisions are reviewing outside of the meeting and presenting back to the July meeting.

Performance indicators, impact on quality – Robin Jones, Chief Operating Officer

There are a wide range of indicators for Urgent and Emergency Care (UEC), the one in particular focus is the aggregated patient delay (APD) in the Emergency Department which is reported at 19,934 hours in May. To reduce risk 9048 (ED Crowding) from a score of 25 to 20 (which would remain an extreme risk) the rolling 30 days APD would need to be 9,000 hours or less. The Clinical Vision of Flow focuses on the Getting It Right First Time (GIRFT) clinical operational standards, this covers standards in the ED (such as wait to be seen) and the standards outside of the ED to support discharge and general flow. These standards have been launched across the Trust with further engagement commencing week of 15th June to directly engage every consultant in the Trust in the standards and how they can impact flow. This is being combined with work with our system partners to work through identifying underused capacity and engaging the relevant clinicians to help identify the patients to use that capacity. The Trust is also leading work on Exit Timely Handover Protocol (THP) which works in the same way as the ambulance handover as a set of targets to help flow out of the hospital. These standards will support trauma patients being admitted to the unit on time which drives time to theatre for fracture neck of femur and the stroke access standards, stroke is noted in a number of places in the report, a critical action is the system wide capacity and demand.

There is a whole hospital review process now in place and an emerging route cause analysis mechanism to embed learning from any patient who has a corridor care stay over 12 hours with an aspiration to reduce that to the 45 minutes as set out in the GIRFT improvement guide. This is providing detailed areas of focus for improvement work as well as reducing longer waiters in our hospital.

Overall, for the UEC indicators the Trust is committed to the clinical vision of flow, new medical model and the GIRFT Clinical Operational Standards as the internal actions to reduce the crowding risk in ED, reduce corridor care use, improve patient and staff experience.

The additional assurance process combined with the new Performance meeting '4Ps' is beginning to show improvements reducing the number of cancellations on the day for surgery which is better for patients and also reduces the number of patients to re-book to achieve the 28-day rebooking target. The work led by the Surgery and Perioperative Medicine Division on 'start well' will target this too. For reference the 4P meetings are Patients, People, Performance and Pounds with a weekly meeting engaging all Divisions and executives cycling the focus each week through the 4 P topic areas.

Neave Hyde
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Quality Assurance Committee Specific – Executive Review

Executive Director Summary, key issues to highlight

Quality – Meridith Kane, Chief Medical Officer

#NOF - Since January 2025 NHFD data demonstrates a sustained improvement in 30-day mortality, average time to theatre and % receiving surgery in less than 36 hours for patients with fractured neck of femur, though there remains ongoing need for further progress. RCHT is recognised as a disproportionately busy trust for #NOF admissions for overall bed base and orthopaedic workforce, likely due to population demographics. Further planning is underway to address theatre / surgeon capacity and therapies input challenges.

Stroke - RCHT have been selected as one of the 12 sites working with the Thrombolysis and Thrombectomy in Acute Stroke Collaborative (TTASC) over the coming 12 months to implement a quality improvement project to improve thrombolysis and mechanical thrombectomy rates. The TTASC is a national programme with the clear ambition that at least 20% of eligible stroke patients should receive thrombolysis. RCHT thrombolysis rates are consistently low currently averaging 5.4% with the national thrombolysis rate at 13.2%.

4-hour performance declined in May to 25.71%. This remains below the standard of 90% which is reflective of the high number of Stroke outliers on other wards and in response, the escalated ICB action for urgent bed modelling is underway at pace. 78.26% stay on the Stroke unit in May dropped slightly from 81% in April, and does not meet the national standard of 90%.

Capacity and demand modelling for stroke services formed part of recommended actions from the Royal College of Physicians (RCP) external review, and in feedback from the National Clinical Lead for Stroke. Current stroke pathway arrangements across RCHT and CFT are fragmented, with significant workforce challenges. A unified, system-wide Integrated Stroke Pathway Capacity and Demand Model across Royal Cornwall Hospitals NHS Trust (RCHT), Cornwall Foundation Trust (CFT), and NHS Cornwall & Isles of Scilly ICB is underway. A task and finish group has been established and work is moving at pace with a target timeline of three months for completion. The aim is to establish a consistent, efficient, and clinically robust stroke pathway supported by accurate modelling, sustainable workforce planning, and strengthened governance.

Harm - Work is underway to build a robust and sustainable Harm review process to enable outstanding harm reviews to be cleared. Progress will be reported through the monthly PPPP – Patients meetings.

Mortuary Report – update on security recommendations

WCH mortuary: CCTV is operational, all of the access control kit and alarm are installed, commenced issuing proxy cards to staff, awaiting CITS authorisation to upload the software

RCH Mortuary: Capital funding allocation has been confirmed as having been carried forward into this year, awaiting review for asbestos.

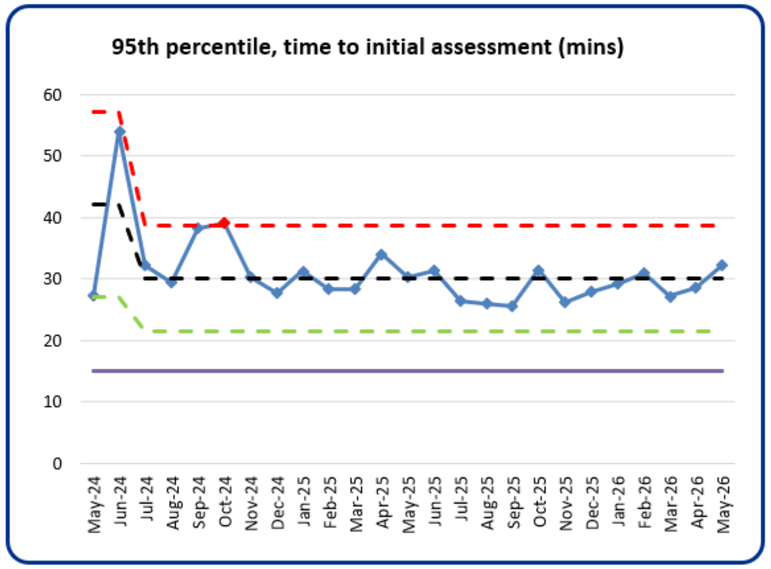
Neave Review
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Symptomatic Breast Pathway - The breast symptomatic pathway is one of three main routes into the breast cancer pathway, the other two being an Urgent Suspected Cancer referral and breast screening. The symptomatic pathway is the lowest risk type with the conversion rate being under 1%. Patients are seen in clinic and return only if a further diagnostic investigation is required, compared to a one-stop triple assessment clinic for urgent suspected cancer patients. These patients are monitored as part of the cancer waiting times targets with the aim of confirming or excluding a cancer within 4 weeks of referral. Since 16 April all urgent referrals have been booked to a red symptomatic clinic for surgical review and the required radiology, achieved by adding in additional evening and weekend. Work is underway to develop a sustainable solution.

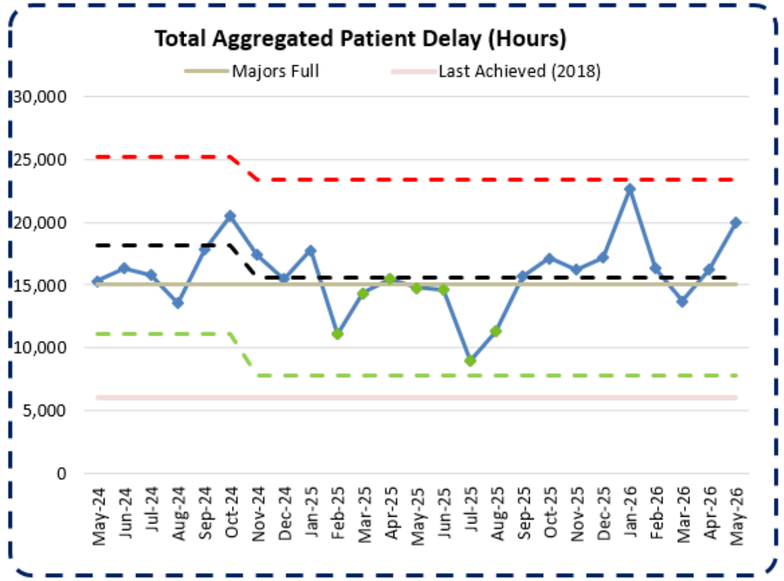
Quality Assurance – Urgent and Emergency Care

Lead Division – Medicine

Lead Executive – Meridith Kane, Chief Medical Officer



May-26
32



May-26
19,934

Background, what the data is telling us, and underlying issues

95th percentile, time to initial assessment, was the highest in May at 32 minutes since April 2025, over double the 15-minute target.

Total aggregated patient delay also deteriorated further, with c.5000 hours more delay in May 2026 than in May 2025.

Improvement actions planned, timescales, and when improvements will be seen

The team are reviewing processes to address time to initial assessment delays within Minors at peak times such as basing an Enhanced Nurse Practitioner within the area to stream and triage patients and ensuring double triage with the support of a resident doctor. Between 13.00 and 19.00 the Senior Consultant overseeing Rapid Treatment and assessments in Majors will also support when possible. This will encourage patients to be re-directed to the most appropriate alternative health care provider.

The "wait to be seen" will begin to reduce with the third middle grade coming into post in August. Other actions are scrutiny on the productivity within ED, focus on the 4 hours standard for non admitted and an increase in staffing as new starters begin.

Risks to delivery and mitigations

Risk 9048 – ED Crowding. Managed through Executive Risk Group (ERG).

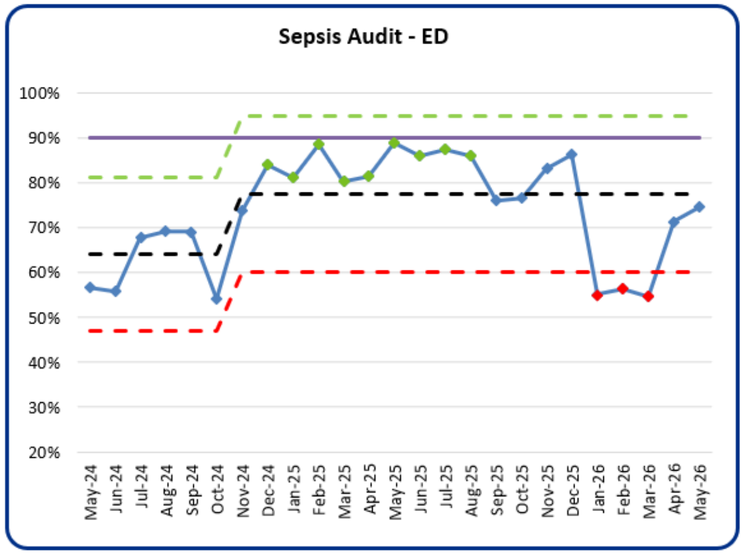
Risk description - The emergency department (ED) team will be unable to provide optimum medical and nursing care to patients accessing their services within the agreed Emergency Care Standard timescales.

Neave Lynsey
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Quality Assurance – Urgent and Emergency Care

Lead Division – Medicine

Lead Executive – Meridith Kane, Chief Medical Officer



May-26	
Antibiotics within 1 hr	74.60%

Background, what the data is telling us, and underlying issues

We are at 75% against a target of 90% but is an improving trajectory from 55% in January.

In January 2026 the audit was not fully validated leading to some discrepancies which are being investigated.

Improvement actions planned, timescales, and when improvements will be seen

The department have undergone a series of educational opportunities and safety briefs in the delivery of the Sepsis 6 and the documentation that supports our decision making.

The team have reinvigorated the Sepsis 6 management and education of all staff within the Emergency Department both at RCH and West Cornwall, this will be continuous piece of training.

Risks to delivery and mitigations

Patients may not be treated in a timely manner leading to delay in medication or recognition of sepsis.

Risk of the metric looking worse than it is due to documentation completion inaccurate.

Focus has been on timely completion of paperwork; we believe the performance has improved further that what the audit suggests, as we are not robust in documenting when sepsis treatment is not required, despite clinical triggers

The team have also been focusing on NEWS Score 3 for new confusion as this may also be underrepresented.

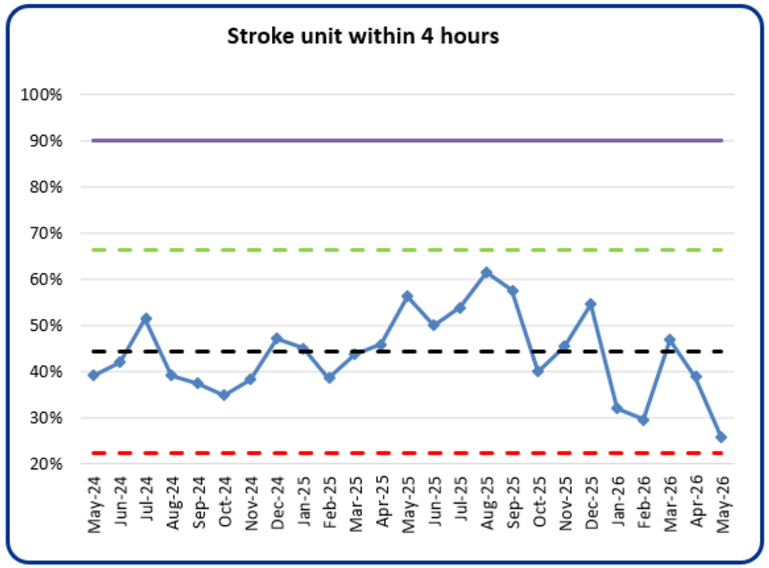
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Quality Assurance – Stroke

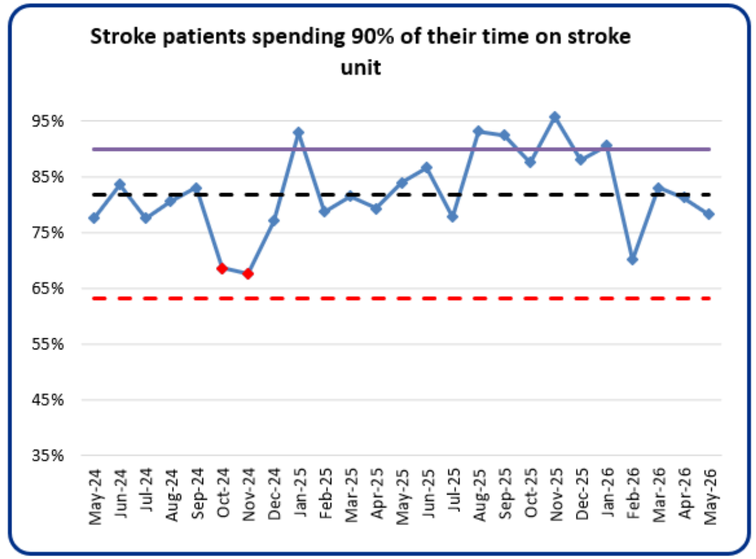
Current SSNAP rating = E
(Jan – March 2026)

Lead Division – Medicine

Lead Executive – Meridith Kane, Chief Medical Officer



May-26
25.71%



May-26
78.26%

Background, what the data is telling us, and underlying issues

Admission to the stroke unit deteriorated to the lowest level in over 2 years at 25.7% in May, close to the lower control limit on the statistical process chart (SPC).

For the 4th consecutive month, stroke patients spending 90% of their time on the stroke unit remained below the 90% target. This follows a sustained period of improvement between August 2025 – January 2026 when performance consistently either met or was very close to the meeting target each month.

Whilst performance since February 2026 when compared with performance over the last 2 years does not demonstrate any special cause variation from a statistical perspective, the graph demonstrates a deteriorated position following the 6-month period of improvement last year.

Improvement actions planned, timescales, and when improvements will be seen

Recruitment has been successful with 3 specialist nurses starting in June. We prepare for the August delivery of the thrombolysis 24/7 rota whereby patients will be treated within 60 minutes within ED. The challenge is relocating these patients to the unit in a timely manner. Work continues on this element. The system wide bed modelling is being undertaken by the ICB due to the capacity and demand issues along the whole stroke pathway.

There is a lack of flow to reallocate Mimic Strokes to general medical wards to create stroke capacity. The team have begun work on stroke flow to remove mimic strokes out of the phoenix template to create capacity in the unit.

Risks to delivery and mitigations

Risk 2864 – Stroke patients not admitted direct to stroke unit (within 4 hours).

Risk 6487 – Reducing Stroke mortality rate.

Risk 7656 – Stroke Post Admission Review.

Current SSNAP rating has dropped to E.

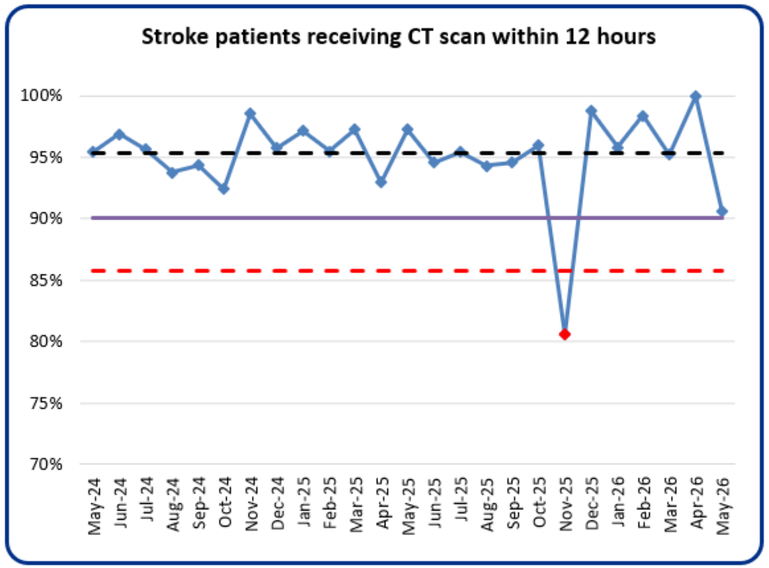
RCHT have been selected as one of the 12 sites working with the Thrombolysis and Thrombectomy in Acute Stroke Collaborative (TTASC) over the coming 12 months to implement a quality improvement project to improve thrombolysis and mechanical thrombectomy rates.

Neave Lynsey
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Quality Assurance – Stroke

Lead Division – Medicine

Lead Executive – Meridith Kane, Chief Medical Officer



May-26
90.54%

Background, what the data is telling us, and underlying issues

This element is delivered consistently at 90% and above (with the exception of November 2025). This is line with SSNAP targets.

Access to CT inline with these targets is a key priority for Radiology as part of its internal standards.

November was a particularly pressured month which saw this standard slip. On going, this target is balanced with overall demand from ED and urgent inpatient activity.

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Improvement actions planned, timescales, and when improvements will be seen

This is at or above target and is regularly monitored by the Clinical Support and Cancer Division.

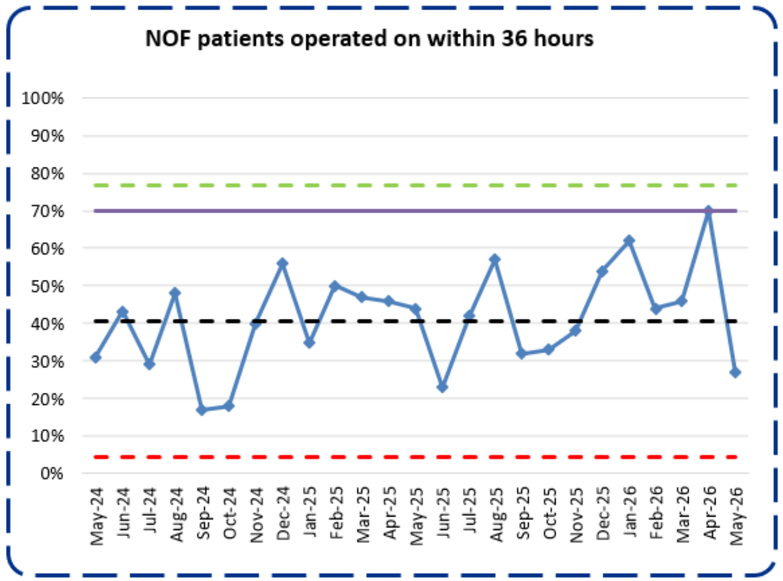
Risks to delivery and mitigations

Risk to this target is always related to demand pressures and the ability to manage this capacity. Stroke and Trauma access to CT remain the highest priority.

Quality Assurance – Fractured Neck of Femur (NOF)

Lead Division – Surgery

Lead Executive – Meridith Kane, Chief Medical Officer



May-26
27.00%

Background, what the data is telling us, and underlying issues

There were 76 fractured neck of femur (NOF) & 5 Peri-prosthetic fractures treated. The month of May we were in Trauma surge with 135 patients listed for surgery on the trauma whiteboard and ending the month with 98 patients. A total of 15 to 23 patients were scheduled for surgery each day. The 36 hours to theatre was only met for 14 patients in the month, with the average time to theatre at 56 minutes.

Elective theatres were cancelled to release additional hip surgeons to support NOF and Peri-prosthetic surgery. Elective patients were cancelled to accommodate suitable trauma cases at St Michaels Hospital.

Improvement actions planned, timescales, and when improvements will be seen

Trauma surge Standard Operating Procedure (SOP) to support high volume of trauma was discussed at the Directorate in May, still needs to be finalised and then ratified at the June Directorate meeting.

The Trauma Multi-Disciplinary Team (MDT) have formalised the day one mobilisation improvement approach and a standardise hip fracture pathway to launch in June.

The Trust is undertaking a further review of exit pathways for the Trauma Unit. The proportion of patients expected to need a pathway 2 has increased, previous dedicated work on pathway 2 challenge to other pathways (P1 and P0) improved length of stay and therefore time to theatre

Risks to delivery and mitigations

Continuing whiteboard position will continue to remain high with seasonal impact of visitors to Cornwall.

The whiteboard is reviewed daily with Lead Trauma Consultant and Trauma co-ordinator and escalations to Service Manager for capacity and demand requirements.

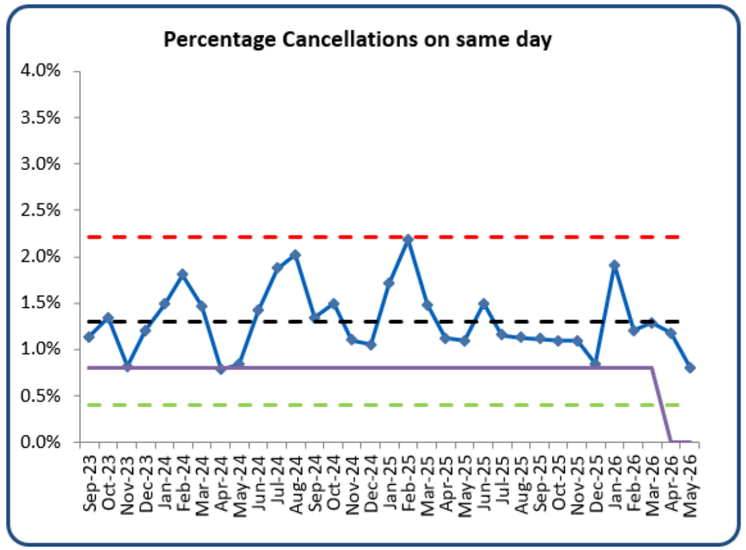
Trauma Improvement plan is in place with key actions being led by the Divisional clinical leadership team.

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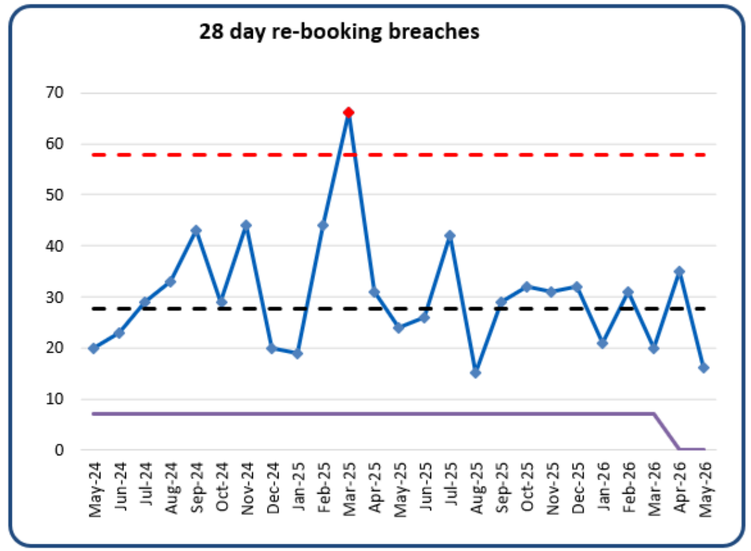
Quality Assurance – Elective cancellations

Lead Division – Surgery and Peri-Operative Care

Lead Executive – Robin Jones, Chief Operating Officer



May-26
0.80%



May-26
16

Background, what the data is telling us, and underlying issues

Operational performance improved slightly (hospital causes reduced).

However, this was offset by deterioration in patient factors in attendance issues (DNA), late withdrawals (patient decision) and clinical optimisation (unfit).

During the Month of May 53 cancellations on the day for procedures, 47 in Surgery, the majority was due to theatre staff sickness.

During Critical Incident only one patient lost their procedure due to lack of higher-level care bed.

During the planning for Industrial action in June, no inpatient or outpatient cancellations occurred, which is a testament to our rota c-ordination team.

Improvement actions planned, timescales, and when improvements will be seen

Ringing of patients prior to day of surgery has commenced, revisit scheduling conversations and ask Clinical Directors to help with specialty conversations regarding late patient decisions.

Development of the perioperative optimisation hub which will be looking to improve the health of those waiting on the waiting list.

Monitoring of this data with the Clinical Directors and group managers regularly to ensure we have clinical engagement.

Risks to delivery and mitigations

Theatre annual leave planning and ongoing sickness management.

Patients not engaging with pre-assessment instructions before surgery ie stopping certain medication.

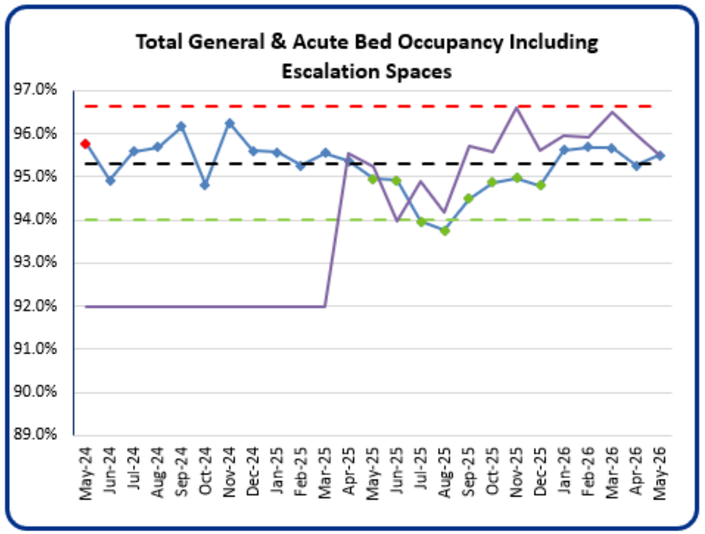
Surgical division monitor annual leave and have sickness management plans in place.

Surge plans for Opel 4 have been reviewed, and plans have been adjusted accordingly.

Neave Lynsey
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Quality Assurance – Corridor Care

Lead Executives – Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer and Bernadette George, Acting Chief Nursing Officer



May-26
95.49%

Corridor Care

Daily highlights	Value
ED peak day	43 instances (27 May)
ED lowest day	14 instances (17 May)
Hospital peak snapshot	20 patients
Hospital lowest snapshot	9 patients

Background, what the data is telling us, and underlying issues

NHS England have published the first set of corridor care reporting using May data. Nationally the Trust ranked 25th for ED and 14th for in-hospital corridor care. Combining both, so all corridor care, we come out 19th overall, averaging 47 per day.

Corridor care is an NHS Oversight Framework contextual metric for 26/27.

Total General and Acute bed occupancy including escalation spaces only marginally came in under the operational plan by 0.01%, with the plan for May at 95.50%, although remains consistently higher than the sustainable occupancy rate of 92%.

Improvement actions planned, timescales, and when improvements will be seen

The Medical Division continue to work towards ending corridor care. Weekly meetings take place to implement the GIRFT standards (Getting it Right First Time) which include compliance with 10 key drivers for reducing length of stay and therefore creating flow. To aid this, the Division have held two "empowerment" events for our clinical ward leaders and specialty leads.

The Patient safety and Head of Nursing teams have implemented a process of capturing detail of patient who experience corridor care, using that to undertake themed analysis to drive targeted improvements. This triangulates to the clinical vision of flow programme with significant priorities in the GIRFT standards, acute medical model opportunities and collaborative working with system partners.

This work is complemented by the work lead by the Chief Nursing Officer's office on the whole hospital review to reduce length of stay (see next page)

Risks to delivery and mitigations

8472 Corridor Care Risk (12 high) this risk isn't currently managed through ERG (Executive Risk Group) because it closely linked to a well managed ERG Risk (ID 9048) this risk is also underpinned by a dynamic risk assessment.

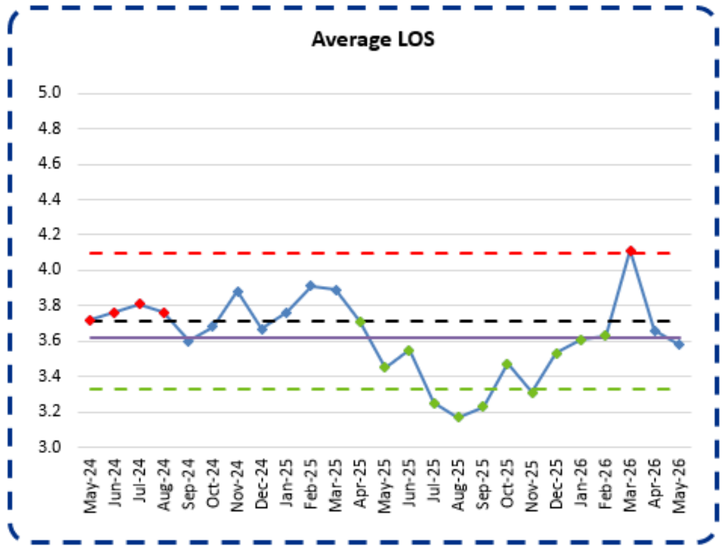
The Executive Risk Group are considering risks in more detail during the monthly committee, and the executives are interceding at an earlier stage in risk development to ensure that risks are mitigated and managed appropriately prior to escalation.

The ERG is using the quality indicators for risk to hold the Divisions to account for progress against actions and to ensure that significant risk for the trust is effectively managed. Risks that do not meet expectations or where progress in-month has not been sufficient are being tracked month on month to ensure oversight.

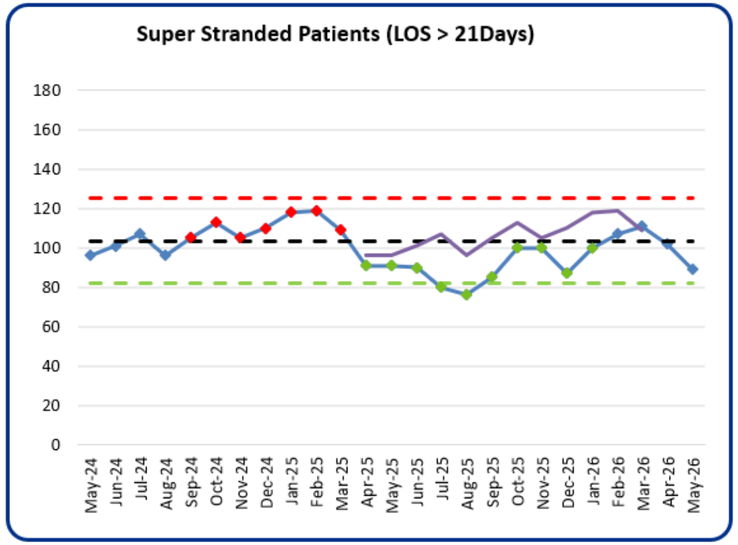
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Quality Assurance – Length of Stay

Lead Executives – Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer and Bernadette George, Acting Chief Nursing Officer



May-26
3.58



May-26
89

Background, what the data is telling us, and underlying issues

Length of Stay (LOS) Pathway is divided into Medically Optimised and Non-Medically Optimised.

Nursing colleagues lead the LoS review process as part of the Whole Hospital Review process which is at medically optimised day 7, 10, 21 and 30

Medical colleagues lead the LoS review of non-medically optimised and are working up a process with the Deputy Chief Medical Officer and Divisional Representatives.

Our data is showing that we are returning to the organisational standard of average LOS

Super stranded patients with a length of stay over 21 days also improved to the lowest number since December 2025.

Improvement actions planned, timescales, and when improvements will be seen

Whole Hospital Review continues daily Monday to Friday within nursing to have a documented review of all patients who are Medically Optimised. These reviews commenced at the end of March and both graphs are showing positive imrpvement

The purpose to "own" their wards and stand together as a team. Daily meetings continue with the ward leaders to discuss each patient's journey and discharge home with particular focus on those with extended length of stay. The process is now embedded as business as usual. Extended Length of stay continues to be challenging due to onward care. Those with "active pathways" over 30 days within Medicine are discussed with the clinical team to ensure options for home care have been explored. This is with the knowledge that deconditioning from extended length of stay can cause harm.

Risks to delivery and mitigations

Medically Optimised Patients: There is a risk of increased LOS because of capacity outside of the acute sector for the patient to be discharged from RCHT.

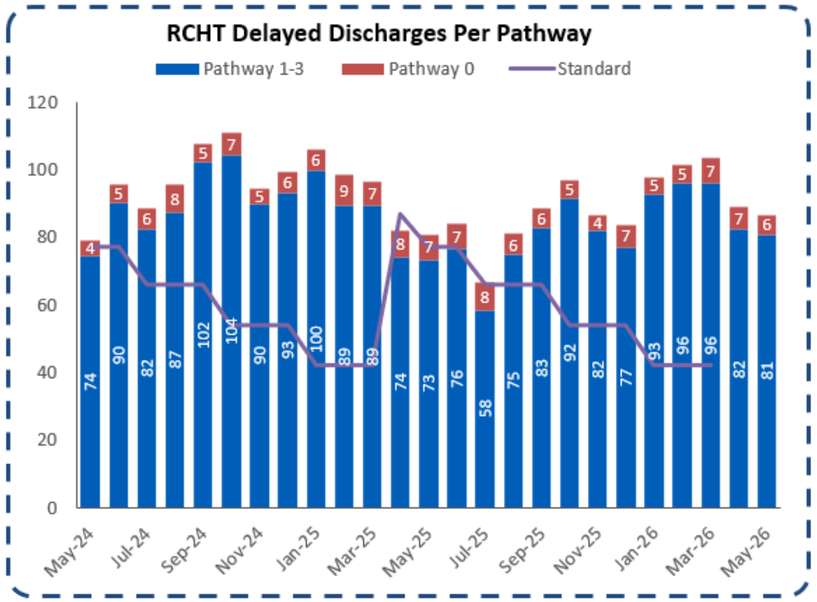
Non-Medically Optimised Patients. There is an unknown risk until an agreed process is worked up for review these patients systematically.

The patient flow hub team support the wards with all RCHT internal actions and are the conduit between the inpatient wards and system service leads to escalate any delays with external actions.

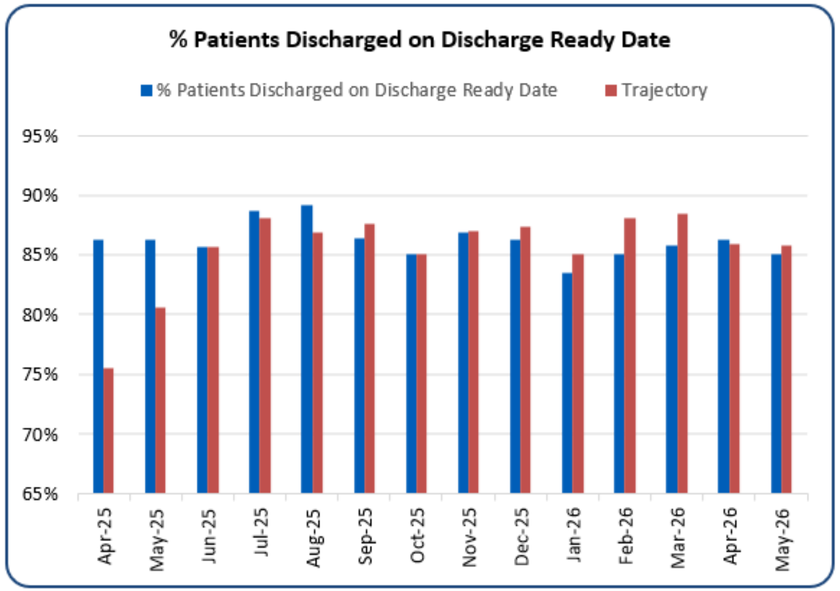
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Quality Assurance – Length of Stay

Lead Executives – Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer and Bernadette George, Acting Chief Nursing Officer



May-26	
Pathway 0	6
Pathway 1-3	81
Total	87



May-26
85.04%

Background, what the data is telling us, and underlying issues

Delayed discharges for patients on discharge pathways 1-3 were higher in May 2026 than the same month in the previous 2 years. Delays for pathway 0 patients remains in line with previous months.

The percentage of patients discharged on their discharge ready date missed the target set out in the operational plan by just 0.7% in May.

Improvement actions planned, timescales, and when improvements will be seen

The Medical Division are now in the planning stages of creating two Discharge Ready Units (DRU) for our medically optimised patients with a focus on pathway 1.

By cohorting our delayed patients, we will create flow on our base wards to take new admissions ensuring we are following the ethos of Right Patient, Right Ward allowing our specialists to focus on patients needs.

These areas will be ready mid July. Focus from our Flow Team along with therapy input will be in place. These areas will also be where patients ready for our Integrated Neighborhood Teams (GPs) will congregate.

This primary care pathway is still within its infancy but progressing with its purpose of taking their local practice patients' home to care for them in the community.

Risks to delivery and mitigations

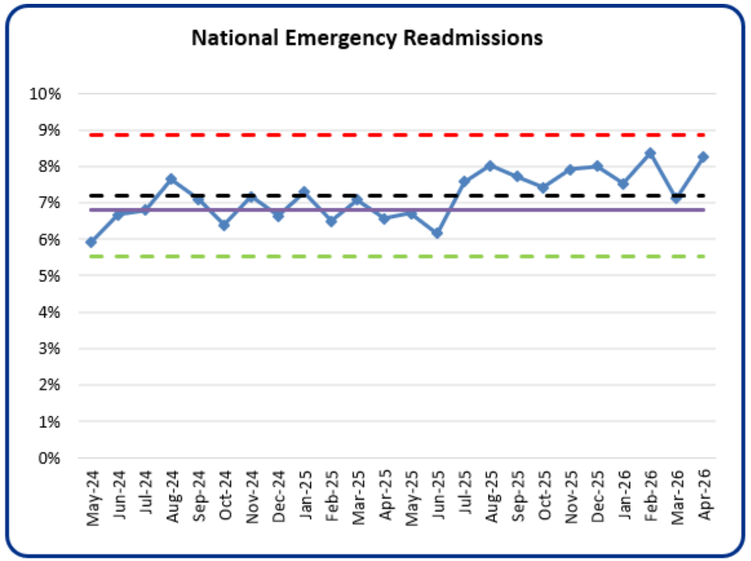
The Medical Division is working with their clinical teams to educate this element to ensure correct and timely data is available.

This has been highlighted at the two away days as a key topic.

Neave Lynsey
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Quality Assurance – Readmissions

Lead Executives – Meridith Kane, Chief Medical Officer, Robin Jones, Chief Operating Officer and Bernadette George, Acting Chief Nursing Officer



Apr-26
8.24%

Background, what the data is telling us, and underlying issues

The Trust's emergency readmissions reporting has been updated in June to reflect the national guidance from NHS England. One of the key changes is that reporting has moved to being one month in arrears, so for this month's IPR the most recent month's data available is April 2026. The data in the graph above has been updated to reflect the national logic.

The biggest spike in April when compared to usual average performance for this metric with the new logic applied was in the division of Medicine at 8.61%, higher than the usual monthly average in 2025/26 of 7.01%. In particular for patients discharged from the Endoscopy Unit, Grenville Ward and Tintagel Ward. In addition, a continued higher percentage of readmissions for patients discharged from the Medical Day Unit since December 2025.

Improvement actions planned, timescales, and when improvements will be seen

The team is strengthening discharge planning on admission to identify high risk patients early.

Learning from incidents to reduce readmission rates through the specialties governance huddles and ward leader's meetings.

Risks to delivery and mitigations

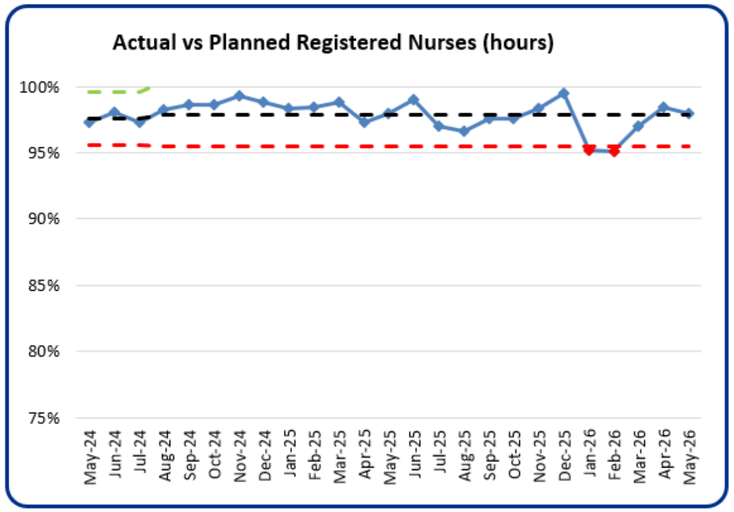
The spike in April is being investigated due to the areas highlighted. The results of this will be discussed in the Divisions Governance forums.

Further risks include workforce pressures, delayed discharged planning, poor MDT communication and limited community capacity. These will contribute to unsafe or delayed discharges which increase length of stay and admissions rates.

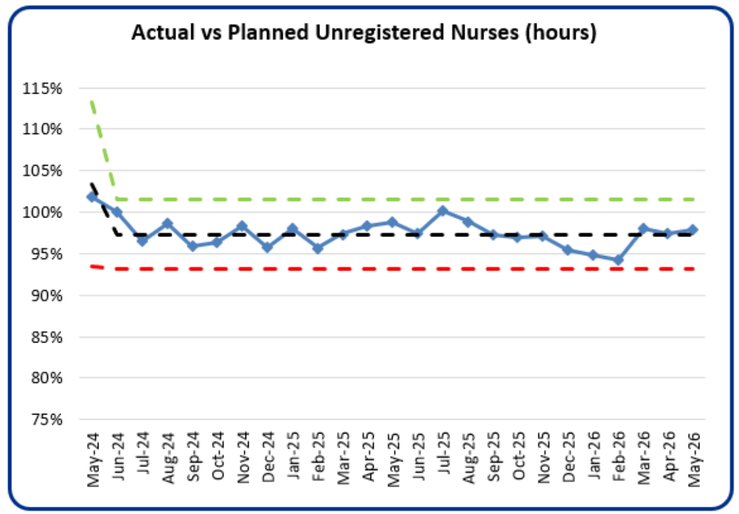
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Quality Assurance – Nurse staffing

Lead Executive –Bernadette George, Acting Chief Nursing Officer



May-26	
Actual vs Planned	97.95%



May-26	
Actual vs Planned	97.91%

Background, what the data is telling us, and underlying issues

The organisation is remaining at a safe level of shift coverage with both registered and unregistered nurse staffing. This is monitored through the Safecare Nursing Staffing Meetings chaired by a Clinical Matron and overseen by a Head of Nursing each day. Fill rates is impacted by vacancies and sickness and demand for additional staffing of escalation areas.

Improvement actions planned, timescales, and when improvements will be seen

Linked improvement actions are all Patient Flow actions which will result in closure of escalation areas, management and supporting colleagues' attendance which is ongoing and the monthly recruitment events which have seen success where we are awaiting 114.18 WTE HCA which are going through pre-employment checks which will improve coverage.

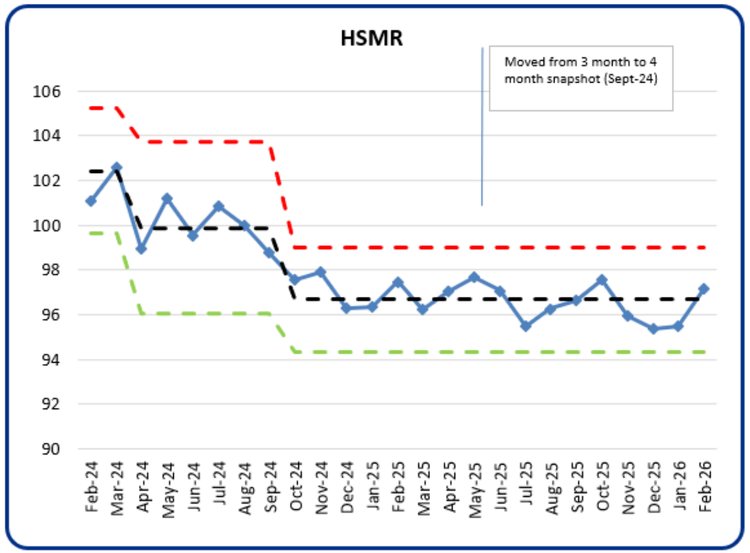
Risks to delivery and mitigations

Sub-optimal staffing has an impact on care delivery and safety but this is managed through the Safe care deployment system to mitigate risk and deploy resource.

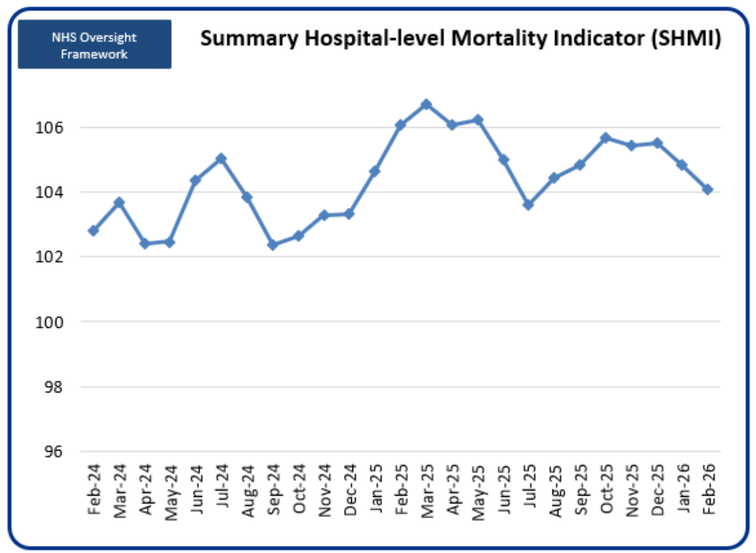
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Quality Assurance – Mortality

Lead Executive –Meridith Kane, Acting Chief Medical Officer



Feb-26	
HSMR	97.14



Feb-26
104.07
(Expected range)

Background, what the data is telling us, and underlying issues

HSMR for the rolling 12-month period March 25 – February 2026 is 97.14 (was 95.4). HSMR remains well with confidence limits

SHMI for the rolling 12-month period March 25 to February 2026 is 104.07 (was 104.8). SHMI remains elevated. Elective SHMI remains elevated at 121 but has improved from 130.

Fractured Neck of Femur 95% Lower Confidence level remains elevated at 128.86 but has reduced from 130.80.

No other alerts identified.

Improvement actions planned, timescales, and when improvements will be seen

Elective SHMI actions:- Emails sent to Matrons for Same Day Medical Assessment (SDMA) and Medical Rapid Assessment Triage (MRATS) with guidance for Ward clerks of the correct codes for the method of admission. Clinical Effectiveness team have offered support to the team if required. Confirmation received from the matron for Acute Medical Unit (AMU) and SDMA that this has been shared with the teams. Will be unable to measure a change improvement in the Elective SHMI for approximately 6 months.

Risks to delivery and mitigations

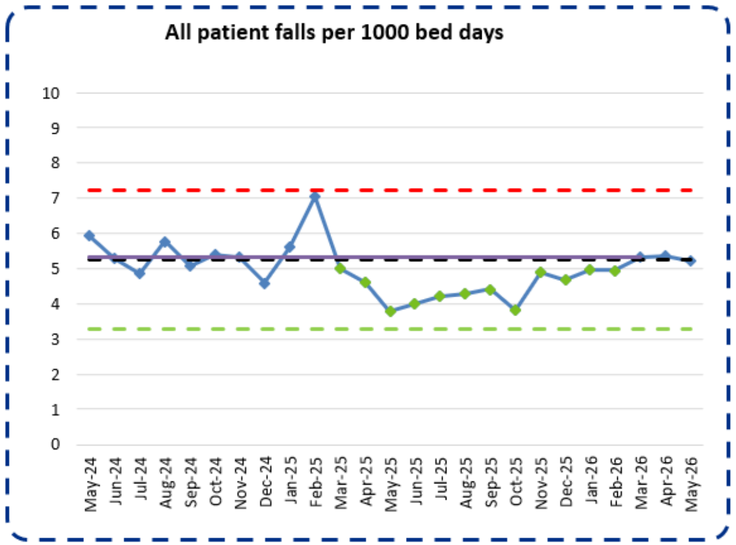
Risk 9081 - Clinical Coding Resource - this due to be presented at the next Exec Risk Group. Current risk rating is 15.

9081 - Risk description: There is a risk that the mortality information will not be accurate due to the current issues with the clinical coding capacity. The trust are currently reporting data 1 month in arrears in order to mitigate this.

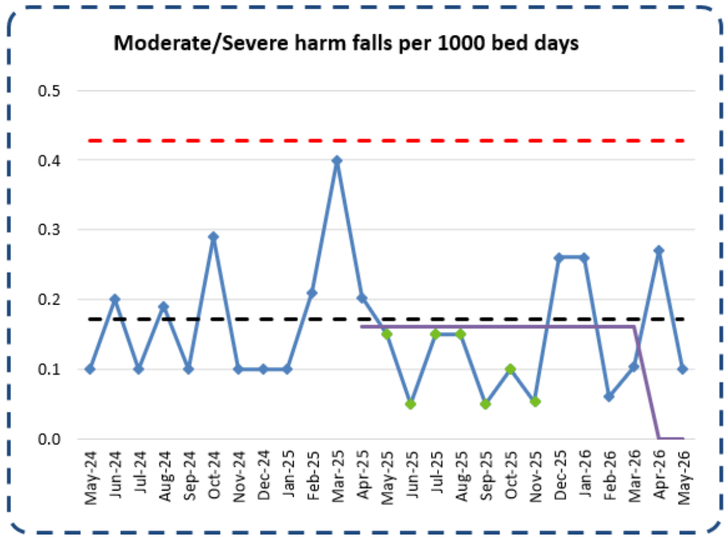
Neave Lynsey
30/09/2026 09:31:24

Quality Assurance – Patient falls

Lead Executive – Bernadette George, Acting Chief Nursing Officer



May-26
5.21



May-26
0.10

Background, what the data is telling us, and underlying issues

In May, 101 inpatient falls were reported, a slight increase from April, but the Trust met its overall falls rate target (5.21 vs target 5.32 per 1,000 bed days).

Harm-related performance was also within target, with two moderate-or-above harm incidents (including significant fractures) and a harm rate of 0.10 against a target of 0.00.

Additional falls (12) occurred in non-bedded areas and are reported separately. A retrospective April fall was also identified, indicating some reporting delays.

A key concern is the rise in multiple fallers: increasing from 6 patients (14 falls) in April to 14 patients (38 falls) in May, highlighting a concentration of risk in a smaller cohort.

Improvement actions planned, timescales, and when improvements will be seen

Immediate action in relation to the increase in multiple fallers has been taken through communication with Clinical Matrons requesting assurance on:

Consistent handover of falls risk during patient transfers

Targeted prevention strategies for multiple fallers

Local learning and immediate changes following incidents

Multi-factorial assessment to optimise safe activity (MASA) remains the core prevention strategy.

During May, MASA-specific training was delivered to ward leaders across all divisions. Ward leaders are expected to cascade training to nursing teams, monitor compliance, and provide assurance via the Clinical Matrons' Community of Practice.

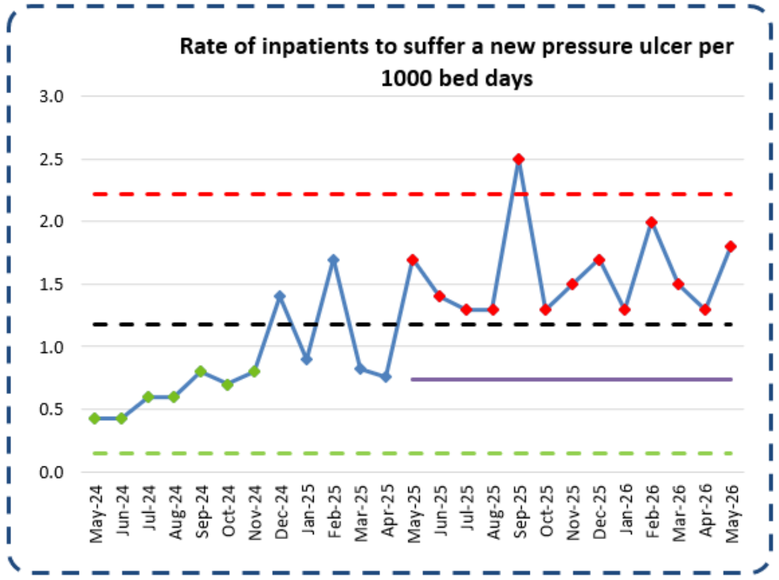
Risks to delivery and mitigations

The Trust's preferred prevention approach (MASA) is evidence-based and aligned to national standards but is not fully supported within the eCare system, limiting full compliance and reporting alignment. The Chief Nursing Informatics Officer is working with the internal build team to clarify the optimal approach and develop a plan for progressing the change request following go-live.

Neave Lynsey
30/09/2026 09:31:28

Quality Assurance Committee - Incidents

Lead Executive –Bernadette George, Acting Chief Nursing Officer



May-26
1.80

Background, what the data is telling us, and underlying issues

In May 2026, there was a significant increase in hospital acquired pressure ulcers, with 57 category 2 and above in total. Of these incidents, 16 were reported in ED, with a total of 40 in the Medical Division and 17 in the Surgical Division. 6 moderate harm incidents were reported this month, with investigations ongoing. Initial themes from incidents remain the same as previous incidents and investigations.

Overall incidence rate for May was 1.8 per 1000 bed days, however, 21 incidents were not included in this calculation, and they were in areas classed as outpatient (eg. Emergency Department, Fracture Clinic, MRAT etc).

Improvement actions planned, timescales, and when improvements will be seen

A clinical summit is being held on the 11th of June 2026 with a focus on hospital acquired pressure ulcer incidents. It is hoped that through collaborative working and open discussion, achievable actions will be produced and implemented, ultimately leading to a reduction in hospital acquired pressure ulcer harm.

There is ongoing work within admitting areas, particularly ED and AMU, with regular meetings being held between senior leadership, Tissue Viability and governance. Actions from the Tissue Viability thematic review have been implemented, however there has been no significant improvement in these areas to date. Independent audits remain ongoing.

The revised pressure ulcer policy has been approved. The new policy contains updated guidance from the European Pressure Ulcer Advisory Panel (EPUAP), with pathways that have been developed for areas with patients at higher risk (critical care, theatres and admitting areas). It is hoped that the introduction of these pathways will increase staff knowledge and boost completion of initial SSKIN bundle and pressure ulcer risk assessments.

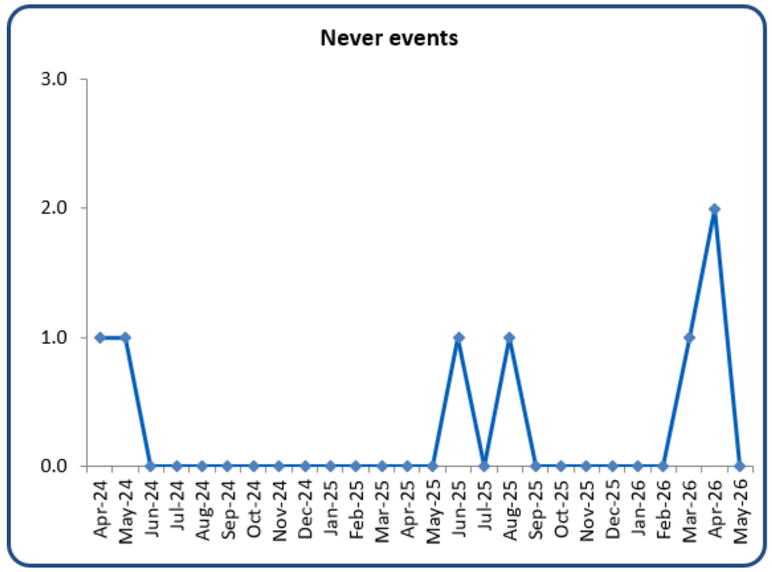
Risks to delivery and mitigations

There is a risk that due to lack of formal education for pressure ulcer prevention, patients are at higher risk of pressure ulcer development. Toolbox education has been sent to clinical practice educators and to ward managers where issues have been identified with documentation on the SSKIN and pressure ulcer risk assessment.

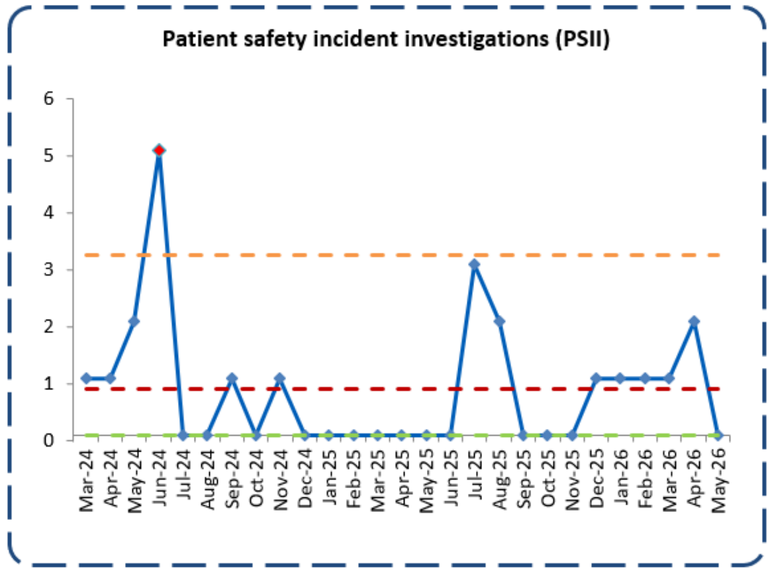
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30/06/2026 09:

Quality Assurance Committee - Incidents

Lead Executive –Bernadette George, Acting Chief Nursing Officer



May-26
0



May-26
0

Background, what the data is telling us, and underlying issues

No Patient Safety Incident Investigations and no Never Events declared in May 2026.

There are currently 4 internal Patient Safety Incident Investigations in progress, which include 2x Never Events – 1 relating to a retained swab and the other to a retained guidewire in a Naso-gastric tube. These investigations are within time for delivery.

Improvement actions planned, timescales, and when improvements will be seen

The two internal Never Event investigations are due for completion in July; recommendations will be identified following completion of the reviews and actions identified from the recommendations.

Risks to delivery and mitigations

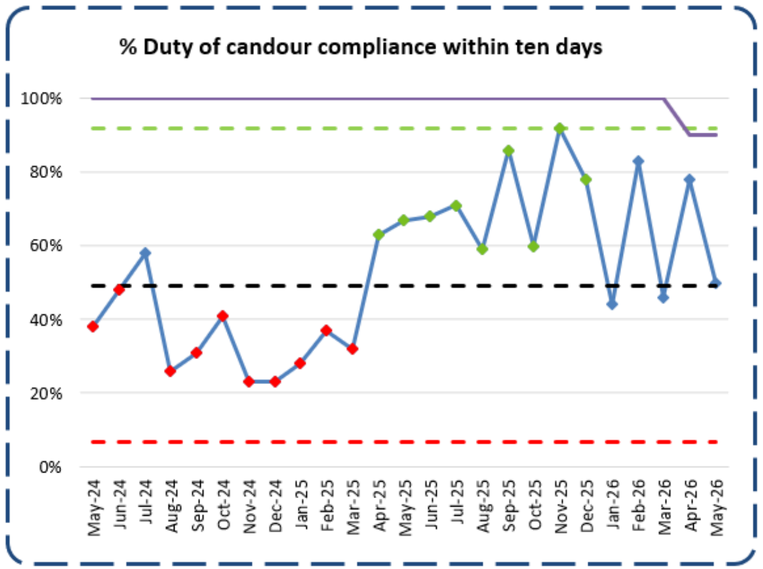
No risks to delivery identified at this time.

The Patient Safety Incident Response and Oversight Group (PSIROG) process provides a monthly report for assurance and oversight of patient safety intelligence, incident management, and improvement activity in line with the Trust's Patient Safety Incident Response Framework (PSIRF), Patient Safety Incident Response Policy, and national patient safety requirements.

Neave Lynsey
30/06/2026 09:31:26

Quality Assurance Committee - Incidents

Lead Executive –Bernadette George, Acting Chief Nursing Officer



May-26
50.00%

Duty of Candour (All Incidents)	Dec-25	Jan-26	Feb-26	Mar-26	Apr-26	May-26
Incident Graded Moderate or Above	18	18	18	13	18	18
Duty of Candour Complete	14	8	15	6	14	9
% Compliance with Duty of Candour	**78%**	**44%**	**83%**	**46%**	**78%**	**50%**

Background, what the data is telling us, and underlying issues

The duty of candour performance remains volatile and dependent upon the availability of staff to review the level of harm. There are escalation processes in place with twice weekly tracking and divisional level escalations, but operational pressures remain consistent.

Improvement actions planned, timescales, and when improvements will be seen

The Duty of Candour sprint task and finish group has continued with developing training but there is a need to revitalise this forum. There is a meeting with Divisional Governance Managers on 16th June 2026 which is an opportunity to re-apply Quality Improvement (QI) methodology.

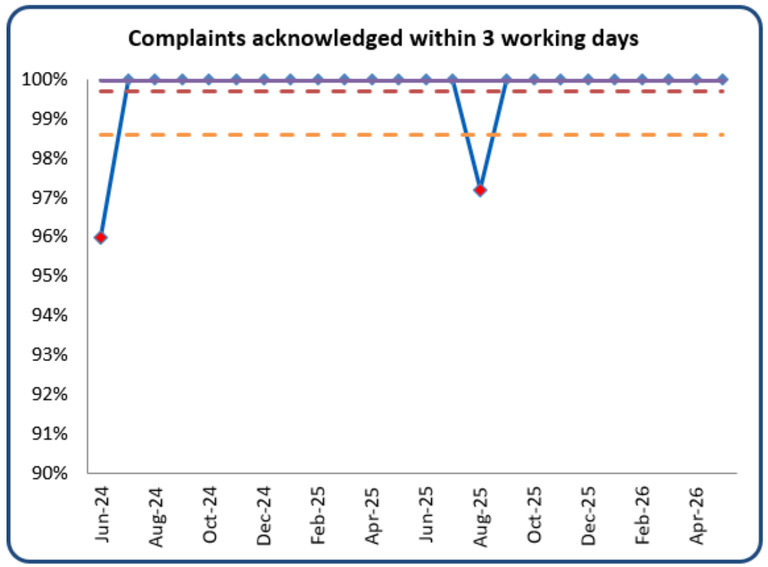
Risks to delivery and mitigations

The Patient Safety Specialist is conducting a data deep dive to pinpoint any thematic issues. The Associate Director of Governance continues to work with the divisional senior leadership teams around prompt incident review.

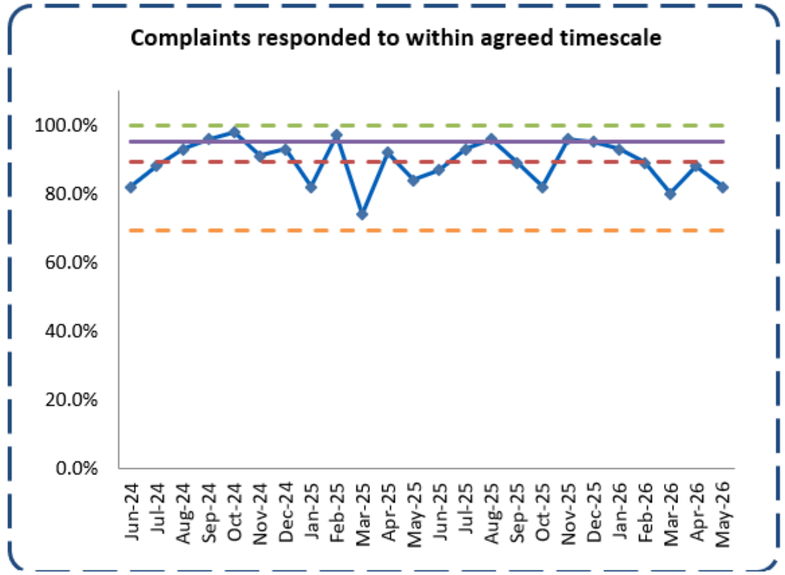
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Quality Assurance – Patient Feedback

Lead Executive –Bernadette George, Acting Chief Nursing Officer



May-26
100.00%



May-26
82.00%

Background, what the data is telling us, and underlying issues

All complaints were acknowledged within three working days, maintaining 100% compliance and demonstrating strong performance in initial communication.

Performance against response times has declined, with formal complaints at 82% (below the 95% KPI and down from 88%) and informal complaints at 70% (below the 75% KPI, though improved from 66%). These actions are already in place and are expected to deliver improvements in informal complaint compliance within next 3 months.

Improvement actions planned, timescales, and when improvements will be seen

This suggests underlying pressures of increased workload, delays in responding from clinical teams, and variability in service-level performance. To address this, a weekly Complaint Scrutiny Group has been implemented within the Medicine Division, involving Heads of Nursing, Service Managers, and Governance Leads, with a focus on early escalation and improving the timeliness and quality of responses. Divisions have also been asked to present at the next Patients Performance meeting in July key actions to be taken.

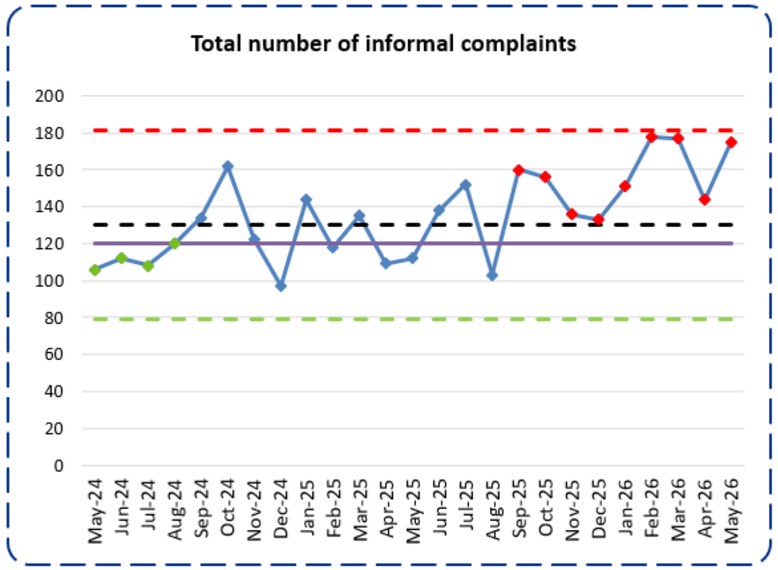
Risks to delivery and mitigations

Key risks to delivery include sustained high complaint volumes, delays in responses, and variable engagement across teams; these are being mitigated through strengthened oversight, increased senior accountability, and continued emphasis on balancing response quality with timeliness.

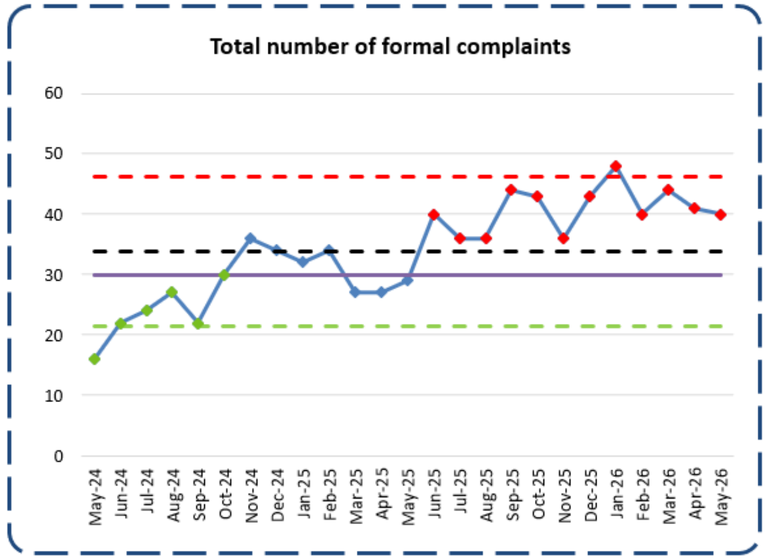
Neave Lyons
30/06/2026 09:17:26

Quality Assurance – Patient Feedback

Lead Executive –Bernadette George, Acting Chief Nursing Officer



May-26
175



May-26
40

Background, what the data is telling us, and underlying issues

There was a slight decrease in formal complaints in May (40 compared to 41 in April); however, informal complaints increased significantly to 175 from 144, indicating rising concerns at an earlier stage.

Improvement actions planned, timescales, and when improvements will be seen

Please see previous page which also applies to these metrics.

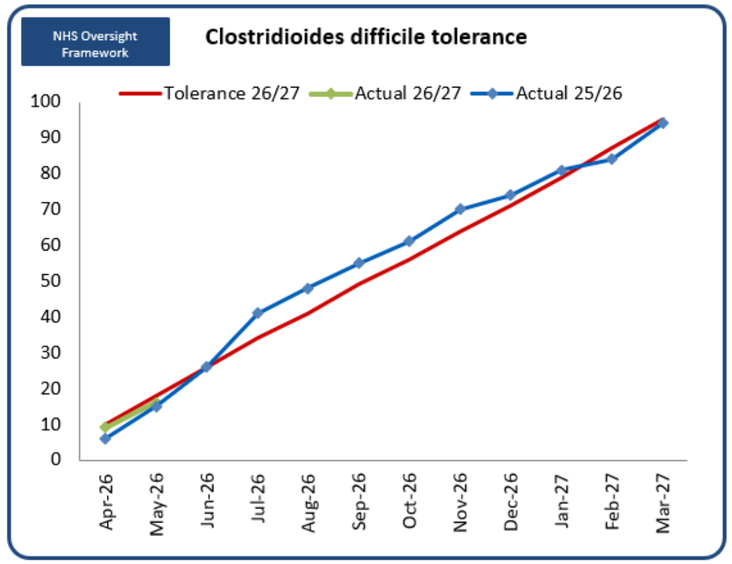
Risks to delivery and mitigations

Please see previous page which also applies to these metrics.

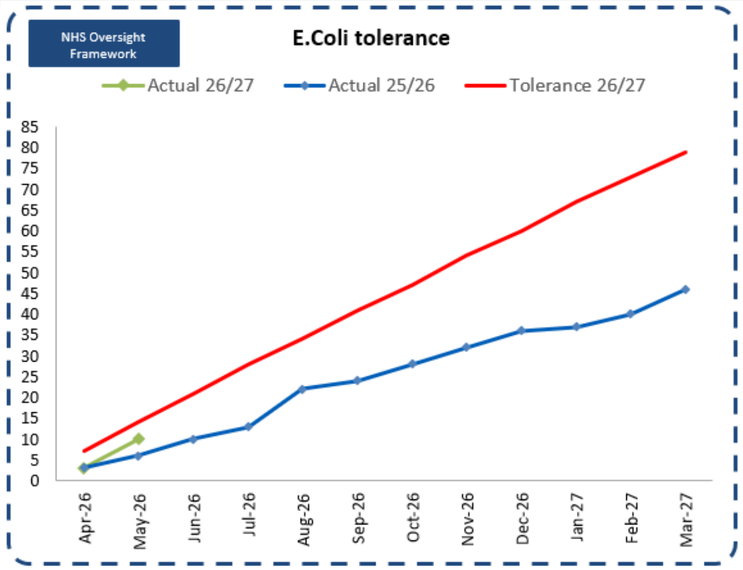
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Quality Assurance – Infection Prevention and Control (IPAC)

Lead Executive – Bernadette George, Acting Chief Nursing Officer



May-26	
Cdiff cumulative	16
Tolerance	18



May-26	
E. Coli cumulative	10
Tolerance	14

Background, what the data is telling us, and underlying issues

Clostridioides difficile (C.diff), previously Clostridium difficile is a spore forming, gram-positive bacterium that can grow in the gastrointestinal tract of a person and cause infection, particularly if a person has received antimicrobials.

The infection can cause diarrhoea and lead to life threatening illness. Historically Cornwall exceeds its tolerance for the number of C.diff cases per year, however in 2025/26 the Trust was one case below which is a significant achievement. The above data highlights the number of cases per month and the cumulative number of cases per month vs the previous year and the current years tolerance.

Improvement actions planned, timescales, and when improvements will be seen

The pharmacy team continue to de-label penicillin allergy and are expanding this service, there is monthly monitoring of national antimicrobial stewardship targets (reducing broad-spectrum usage) these are ongoing actions with no end date. The antimicrobial pharmacist is reviewing the number of C.diff relapses and reviewing the evidence regarding an alternative first line treatment for high-risk groups, a decision will be made for 2026/27 year.

The infection control team continue to review all C.diff cases on a weekly basis with the MDT. A hospital associated infection (HAI) point prevalence survey has been completed in May 2026, the data will be used to target the most common infections, with the aim of reducing (HAI's) and therefore reducing antimicrobial usage, projects outlined for completion by March 2027. Ongoing work with Estates to improve clinical environments targeting high incidence wards.

Risks to delivery and mitigations

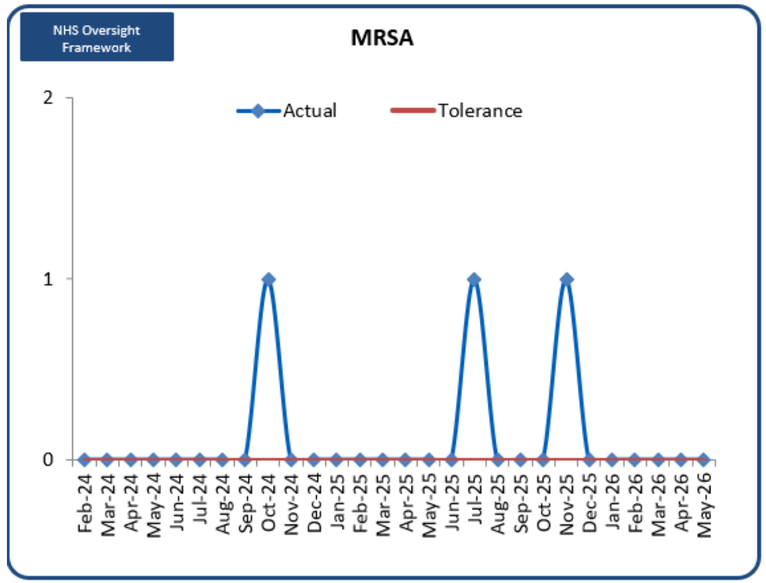
Deteriorating estate with limited budget available to maintain, repair, or improve clinical environments. Mitigated by prioritisation based on infection data and use of automated disinfection devices.

Prescribing of antimicrobials outside of Trust guidelines, using 'watch' and 'reserve' antimicrobials which are held back due to growing resistances. Mitigated by an extensive Trust guideline and routine monitoring with feedback provided to medical leads regularly.

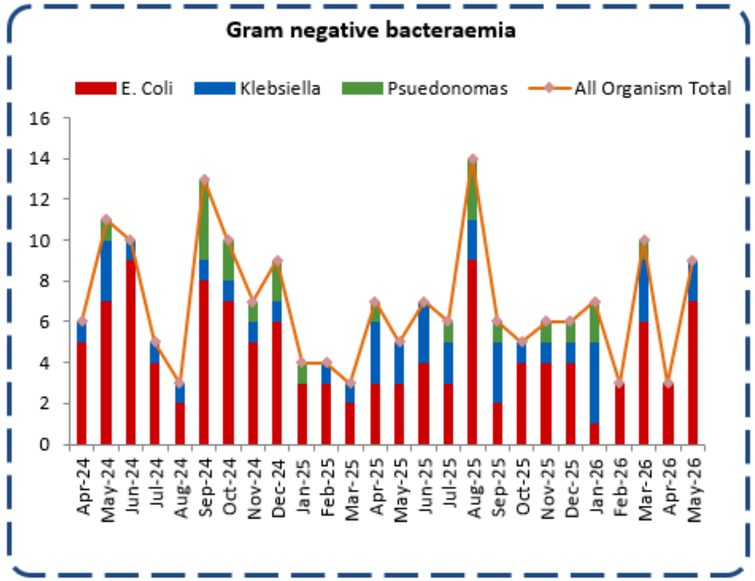
Neave Lynsey
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Quality Assurance – Infection Prevention and Control (IPAC)

Lead Executive – Bernadette George, Acting Chief Nursing Officer



May-26
0



May-26	
E.coli	7
Klebsiella	2
Pseudomonas	0
All Organism Total	9

Background, what the data is telling us, and underlying issues

Blood stream infections are caused by a bacteria entering the blood stream and evading the persons immune defence, leading to infection and life-threatening illness. The above charts show MRSA cases month on month, historically the Trust has a low rate of MRSA infections, <2 per year this compares well with National rates. The E.coli chart shows a cumulative total month on month for the year vs last year and this year's tolerance. The gram-negative total chart shows number of cases per month. Delayed sampling early in admission has been identified as a theme in patient safety incidents, improving compliance here could reduce the number of Trust apportioned blood stream infections.

Improvement actions planned, timescales, and when improvements will be seen

Justification of urinary catheter audit completed in March and results shared with IPC link practitioners and at IPC steering group. Ward areas to complete IPC educational boards with the 'getting it right first time – urinary catheters' guidance by end of June 2026.

Audit of blood culture collection compliance in emergency care to identify a baseline, then a targeted educational programme with a review audit. Completion due by March 2027.

Risks to delivery and mitigations

There is potential for seasonal infection trends to compromise planned activity within the IPC team. The team is prioritising planned activity during the summer months to position themselves favourably by October.

There is no standard sepsis audit framework within the Trust, this will make data collection difficult and time-consuming. Liaising with ED leads to identify a solution.

Improper use of invasive devices. Education and monitoring use is a key part of the infection control annual programme of work.

Neave Lynsey
30/06/2026 09:31:28

People and Culture Committee Section



Outstanding Care for **One+All**

Neave, Lynsey
30/09/2026 09:31:26

People and Culture Committee Specific – Executive Review

Executive Director Summary, key issues to highlight

Alison Thorne-Henderson, Dual Chief People Officer

The Trust's workforce position continues to reflect sustained operational pressure, organisational change, and underlying cultural challenges, which are now materially impacting staff experience, wellbeing, and key workforce metrics. This is consistent with the Trust's current Segmentation Level 3 rating for People and Workforce within the NHS Oversight Framework. Staff experience has deteriorated, with a notable decline in staff recommending the Trust as a place to work down to 23.1%. Feedback highlights persistent concerns including negative workplace culture (notably bullying and blame behaviours), perceived disconnect and limited visibility of leadership, high workload and burnout linked to staffing gaps, and staff feeling undervalued and unheard. Organisational change, particularly the clinical administration review, has further contributed to reduced morale.

There is also growing reliance on Freedom to Speak Up (FTSU) processes, suggesting reduced confidence in local resolution mechanisms, alongside inconsistent psychological safety and fear of detriment when raising concerns. Health and wellbeing indicators remain a concern, with sickness absence continuing to be driven primarily by mental health (circa 28%) and musculoskeletal conditions, reflecting ongoing workforce fatigue and pressure.

Performance in training and development has plateaued, with mandatory training compliance at approximately 78% since January 2026. This is attributed to reduced training capacity due to the eCare rollout, operational pressures limiting staff release, and inefficiencies in rostering leading to underutilised training opportunities. Workforce supply shows some positive progress, particularly the elimination of the Healthcare Assistant vacancy gap. However, disparities remain in workforce equality, with 13.6% of staff from BAME backgrounds compared to only 2.06% representation at senior leadership level.

A number of improvement programmes are underway. A new People Plan, Integrated Workforce Plan, and Health and Wellbeing Strategy are in development and progressing to Executive Leadership Team (ELT) approval.

Recovery actions are also focused on increasing training capacity, with anticipated improvements from June, alongside targeted recruitment campaigns and strengthened workforce data analysis to support more effective workforce planning and intervention targeting. Overall, while there are clear and structured improvement initiatives in place, workforce pressures, cultural challenges, and staff experience require sustained and consistent focus to deliver meaningful improvement.

Ella Stracey, Chief Strategy Officer

Culture update

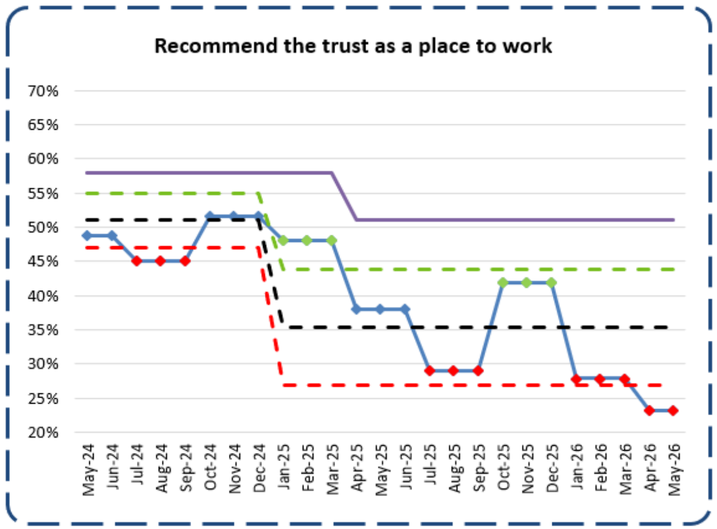
The responses to the Staff Pulse survey in May show that the culture approach is not yet having measurable impact. However, there has been significant activity from the culture approach in the last month including launching of the 6 workstreams and the establishment of both the culture working group and the steering group with accountability to People and Culture Committee.

The Chief Strategy Officer (CSO) and Deputy CSO have held culture review meetings with all Divisional Leadership Teams to develop targeted culture improvement plans at Divisional level. The new leadership network has met and is open to all leaders at band 8b and above. The first session was opened by the CSO and closed by the CEO and the session was facilitated by the newly recruited Culture Improvement Practitioner focusing on how we move forward as a leadership team from the last year of change. The communications team have developed a new video with broad staff involvement to share the Trust strategy in a more relevant and accessible way. They have also delivered a communications workshop with Executive colleagues alongside launching new comms approach for emails and staff cascades. The Trust Values awards have been relaunched with winners in April and May being presented with certificates by Executive colleagues. The Chief Executive and Executive team have been on walk arounds and have shared their learnings at the first "One and All" all staff engagement event which will be a monthly event going forward.

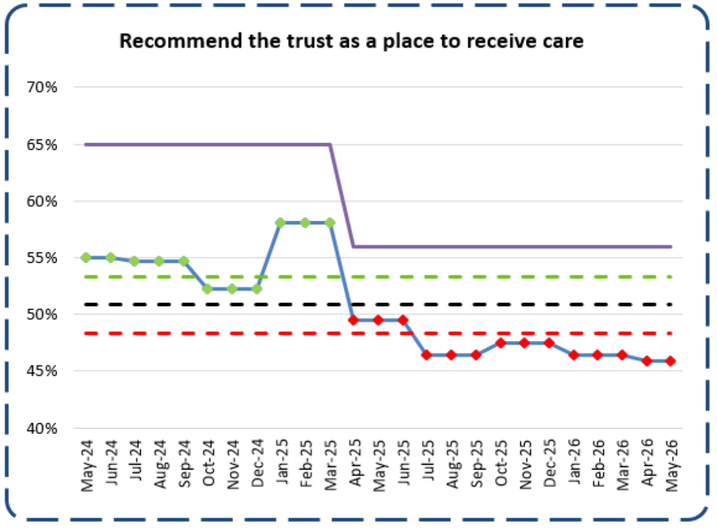
Neave Lloyd
30/06/2026 09:57:36

People and Culture – Staff feedback

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26
23.13%



May-26
45.91%

Background, what the data is telling us, and underlying issues

Recommend the Trust as a place to work – 23.1% for Q1 (down nearly 5% on Q4 25/26)

Recommend the Trust as a place to receive care – 45.9% for Q1 (down 0.51% from Q4 25/26)

Our people are reporting a further decline in their experience of working for RCHT, whereas people are reporting a more stable picture for recommending the organisation as a place to receive care.

This indicates the primary dissatisfaction continues to be around the workplace environment. Drivers for this as derived from comments in the pulse survey are:

1. Culture – bullying, blame and poor behaviours
2. Leadership and management disconnect. Perception that senior leaders are not visible, do not understand frontline realities, do not listen to staff input. Concerns also raised about:
3. Workforce pressures and burnout - Chronic short staffing and vacancies, increasing workload expectations, Staff reporting exhaustion and stress which staff frequently linked directly to patient safety concerns.
4. Feeling undervalued and unheard. Staff report a lack of recognition, not being listened to, not feeling valued as individuals, Strong mismatch with stated organisational values
5. Impact of change and consultation (particularly admin review) Perceived as: Poorly communicated, Unfair, damaging to morale and trust. This has had a significant negative impact on confidence in the organisation.

Neave, Lynsey
30/06/2026 09:31:26

Improvement actions planned, timescales, and when improvements will be seen

In April, Trust Board endorsed the 'We Are RCHT' Culture Transformation programme, which sets out how we will make RCHT a better place to work. Due to the ongoing context of organisational change with the admin review, improvements in these metrics should not be expected for 18 –24 months (Ipsos, Karian and Box - Organisational Change: managing the impact on employee engagement and culture).**Actions so far include** Enhanced communication and engagement approach (tone review, humanising and senior leadership visibility, branding) ; Relaunch of the Values Champions awards with enhanced communications programme; Establishment of a senior leadership forum leadership forum; Establishment of oversight and working group for the culture programme including workstream leads; Establishment of a small OD resource to support ad hoc team culture sessions. **Actions coming in the shorter term (weeks months):** Launch of a monthly RCHT all hands meeting (One + All) June 16th ; Launch of a more junior leadership forum by August; Long service awards; Redesign and re-establishment of onboarding and exit questionnaires June.

Risks to delivery and mitigations

Funding approval for culture programme.

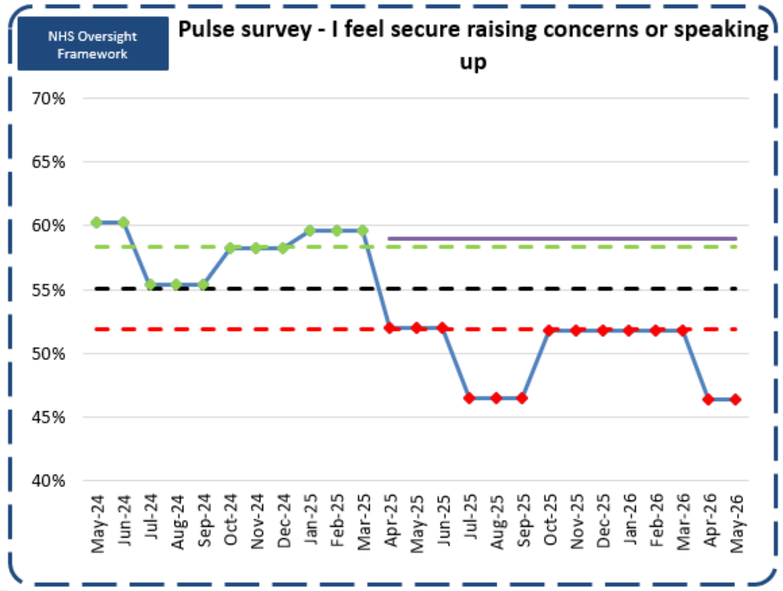
Operational release of staff to training leadership programmes.

Clinical admin review.

60

People and Culture – Staff feedback

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26
46.43%

Background, what the data is telling us, and underlying issues

The Freedom to Speak Up (FTSU) Guardian continues to be a popular route for staff to raise concerns, but some staff state they come to the Guardian with concerns as they do not feel safe and or confident that concerns will be addressed at a more local level. Psychological safety is mixed across the organisation , often staff feel unsafe raising concerns and fear detriment following or during their raising concerns. As an organisation we respond to a number of anonymous concerns which are above the national average.

Improvement actions planned, timescales, and when improvements will be seen

The lead Guardian is working with each division to support FTSU work going forward, this will include telling speak up stories, supporting cultural improvement work, with the aim of increased promotion of speak up routes, and a deeper understanding of themes across the organisation. The FTSU champion network now has over 100 members, including 5 medical staff. The champions meet monthly and promote FTSU work across the organization, providing a diverse range of colleagues to raise concerns with.

Risks to delivery and mitigations

Low confidence in speaking up at a local level may lead to increased escalation to the Guardian and executives. Continuing high levels of anonymous reporting limits our ability to fully investigate and give feedback about concerns. If staff do not trust concerns that will be addressed appropriately, we may not see improvement in cultural change.

Mitigations include:

Divisional support (Guardian and OD practitioner)

Management support – new leadership programme

Enhanced communication (CEO leading new communication sessions)

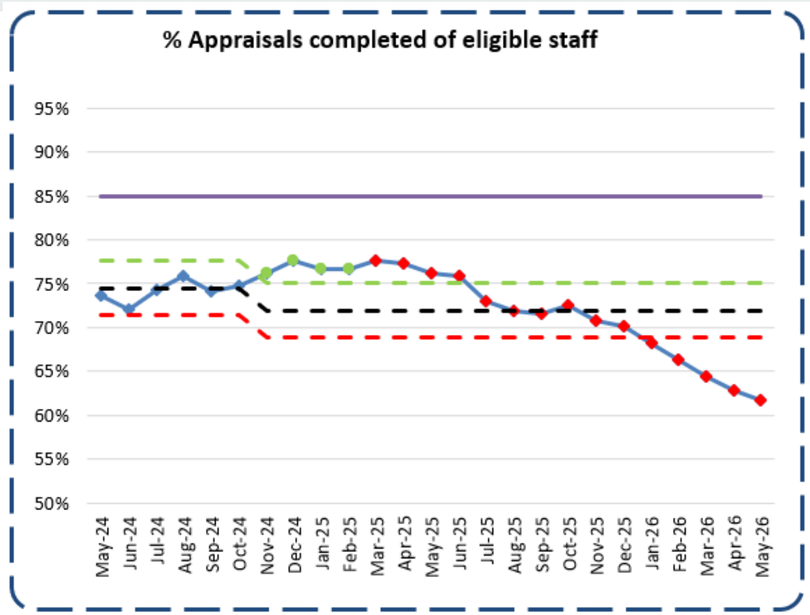
Continue to triangulate data

Ongoing development of the FTSU champion network.

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People and Culture – Staff development

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26
61.7%

Background, what the data is telling us, and underlying issues

The impact of operational pressures, coupled with organisational change and high levels of vacancies in some areas, has impacted on the completion of appraisals.

We have identified a potential issue that medics may not be recorded on the electronic staff record (ESR).

Managers recognise the importance of appraisal, but we have inconsistent ways of conducting appraisals.

Improvement actions planned, timescales, and when improvements will be seen

June 26 - focus groups set up to understand what is working well and how we can improve appraisals and ensuring our appraisal process is inclusive– 4 focus groups will be set up by end of June 2026.

Linking in with national and regional colleagues to keep up-dated on any progress with a national appraisal scheme which may be linked to the overall digital transformation programme.

Risks to delivery and mitigations

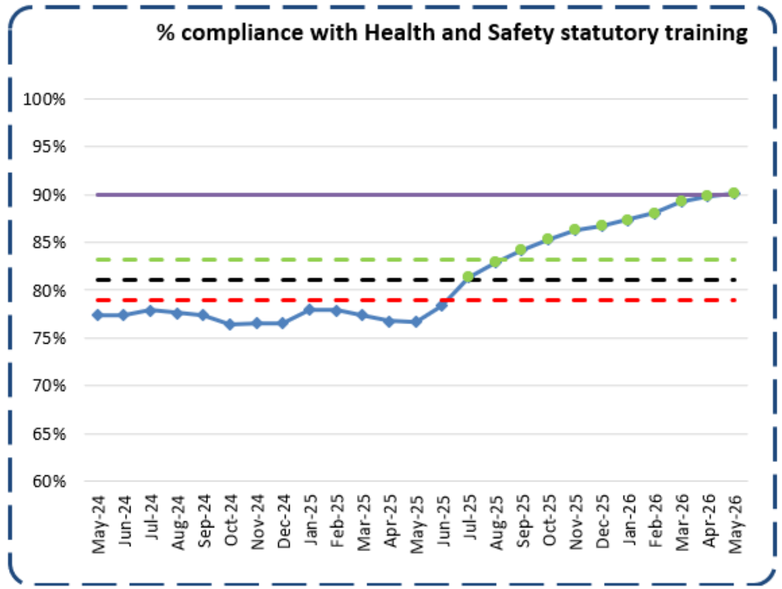
Continuing operational pressures may impact on capacity.

Resources to deliver any additional training on conducting appraisals.

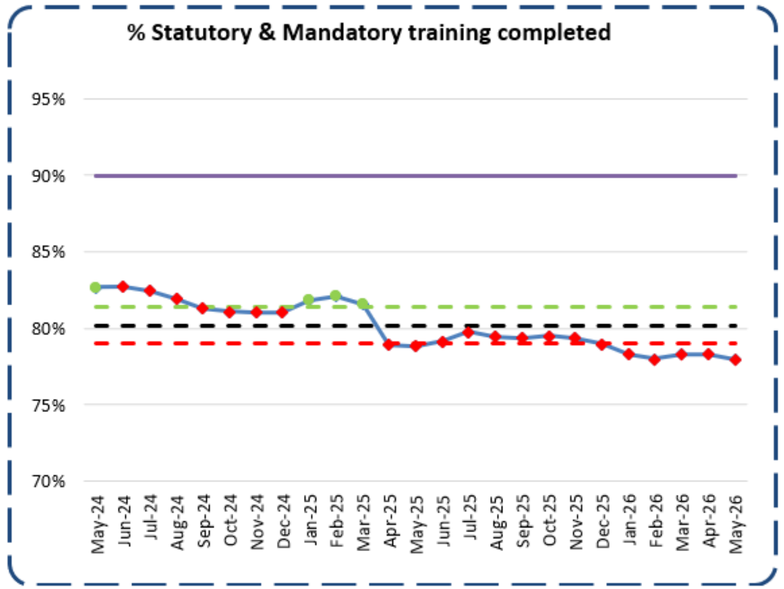
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People and Culture – Staff development

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26
90.1%



May-26
78.0%

Background, what the data is telling us, and underlying issues

Statutory and mandatory training compliance has remained at approximately 78% since January 2026, indicating a persistent plateau rather than short-term fluctuation.

The data suggests the following underlying issues:

Reduced face-to-face delivery capacity in April and May due to the planned E-Care rollout, which required classroom space and staff time.

Classroom availability constraints limited the number of sessions that could be delivered.

Operational pressures staff availability to attend training.

Backlog accumulation occurred during the reduced delivery window.

In May there was a total of 136 unused spaces available on face-to-face mandatory training.

Improvement actions planned, timescales, and when improvements will be seen

Learning & Development have implemented several actions to increase throughput: Increased classroom availability and expanded scheduling of statutory and mandatory sessions; Higher attendance levels already visible in early June 2026; Active promotion of available spaces, including regular updates on the staff Facebook page; Collaboration with Trust educators to support attendance and improve compliance.

Expected improvements:

Late June 2026: Early uplift as increased attendance is recorded.

July 2026: More significant improvement as staff complete training.

August 2026: Stabilisation if capacity remains consistent and staff release improves.

Risks to delivery and mitigations

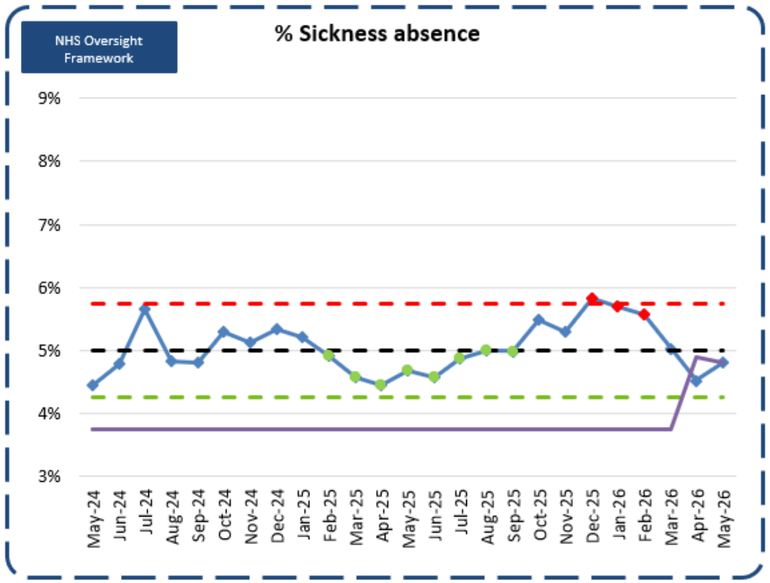
Key Risks: Future E-Care rollout phases will again pause face-to-face mandatory training, reducing delivery capacity; Staff release challenges continue to limit attendance, particularly in high-pressure clinical areas; Unfilled training spaces persist despite availability, indicating local release and rostering issues; Operational pressures may divert staff away from scheduled sessions, prolonging the backlog.

Mitigations: Continued expansion of classroom availability to maximise delivery before future E-Care phases; Proactive advertising of unfilled spaces, including regular posts on the staff Facebook page; Close working with Trust educators to encourage attendance and support local compliance improvement; Encouragement of protected learning time to support staff release for mandatory training.

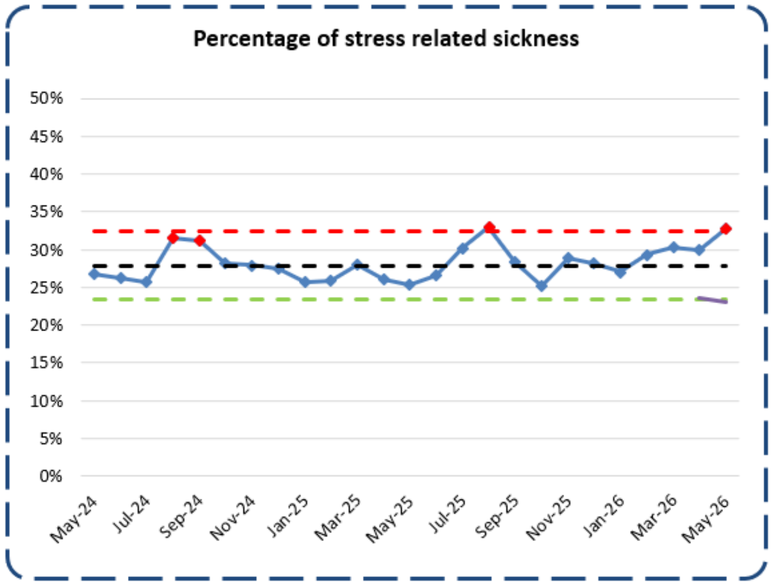
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People and Culture - Absence

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26
4.80%



May-26
32.80%

Background, what the data is telling us, and underlying issues

Fatigued staff, operational pressures, impact of organisational change, high levels of vacancies are impacting levels of absence.

Mental health and musculoskeletal (MSK) continue to be top reasons for absence

Mental health absence still tracking at c28%.

Improvement actions planned, timescales, and when improvements will be seen

Developing a health and wellbeing strategy and delivery plan, linked to RCHT People Strategy and Culture programme

Reviewing current programme to ensure that it is inclusive

Investment Bid being prepared for the rebasing of occupational health budgets following CFT decision to go to external provider for Occupational Health services.

Risks to delivery and mitigations

Risks

Investment bid is not supported for Occupational Health

Resources are not available for the delivery of the programme ie Strategic Workforce Partners.

Engagement from Divisions due to conflicting demands

Mitigations

Exploring income generation options for OH

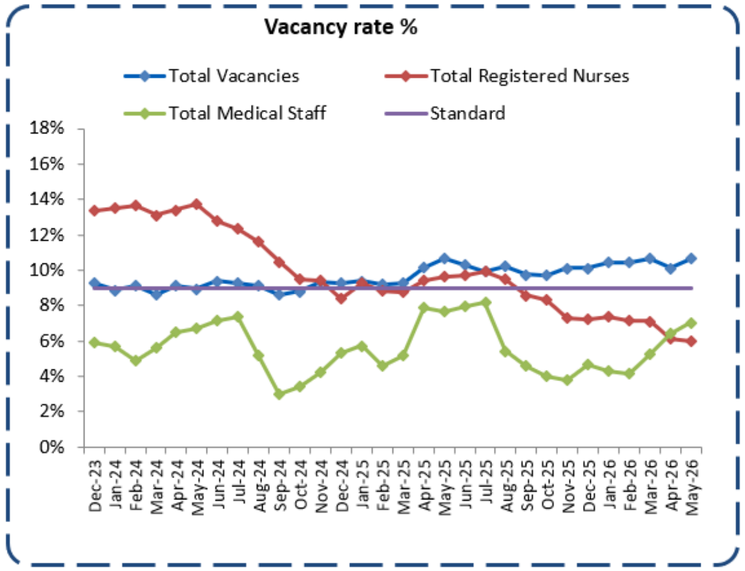
Recruitment Campaign underway for recruitment into key roles

Engaging with Divisions through PPPP meetings and other committees.

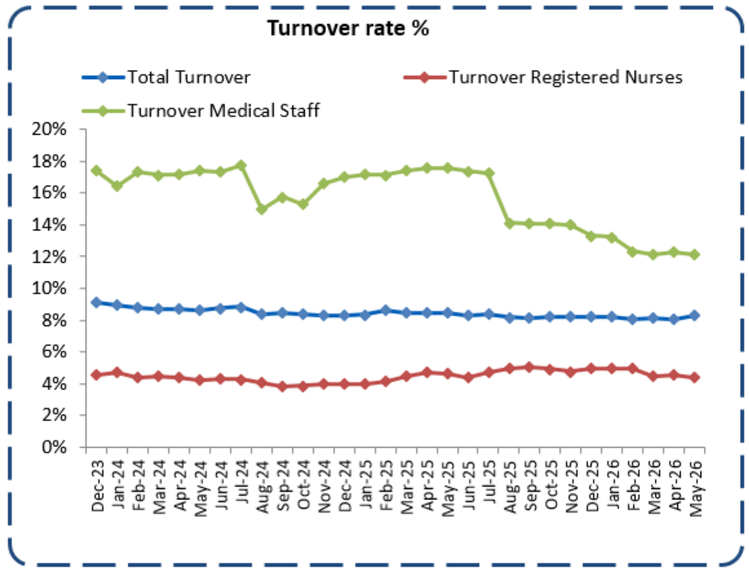
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People and Culture - Vacancy

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26	
Total vacancies	10.7%
Total registered nurses	6.0%
Total medical staff	7.0%



May-26	
Total turnover	8.3%
Total registered nurses	4.4%
Total medical staff	12.1%

Background, what the data is telling us, and underlying issues

There has been a focus on closing the vacancy gap for Health Care Assistants with targeted recruitment events in March, April and May and the current reported vacancy gap (pending offers and pre-employment checks) is at 0%.

Turnover remains fairly stable. We may see an increase in our turnover rate is likely to increase with those leaving due to organisational change in the coming months.

Improvement actions planned, timescales, and when improvements will be seen

A further recruitment event is being held in June, focussed on closing the recruitment gap for registered nurses.

With support from the Divisional Director where we identify areas of increased turnover we will triangulate data to understand if there is a need for intervention.

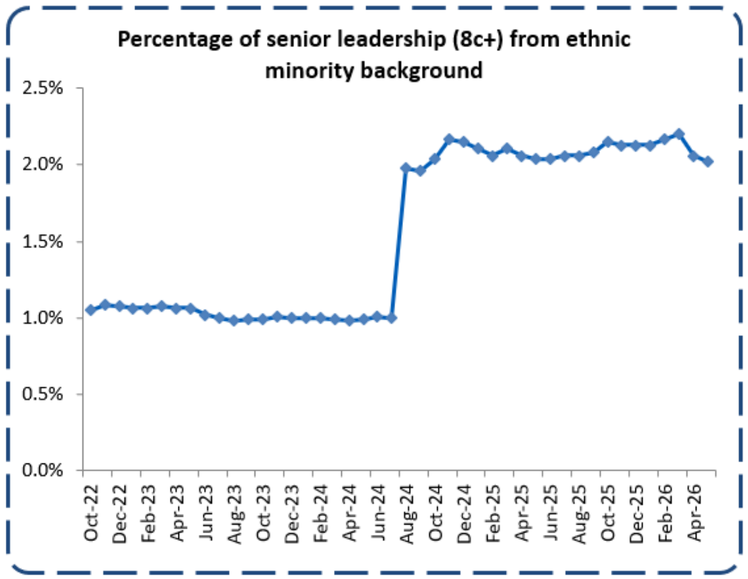
Risks to delivery and mitigations

Mitigations for the vacancy rate will be further recruitment campaigns. For Turnover rate we will continue to monitor turnover and the impact.

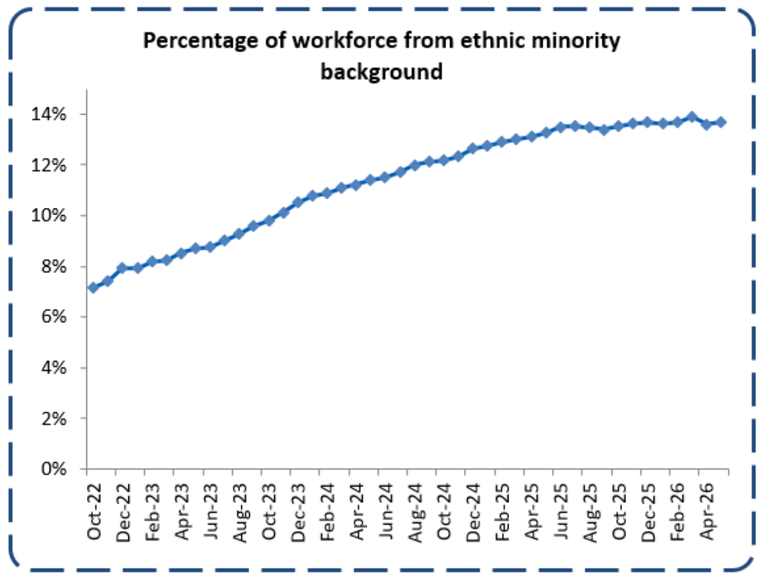
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People and Culture - Diversity

Lead Executive –Alison Thorne-Henderson, Dual Chief People Officer



May-26
2.02%



May-26
13.7%

Background, what the data is telling us, and underlying issues

13.6% of staff are from a BAME background, which is higher than the local population. However, only 2.06% are in senior leadership roles. Most of this workforce are linked to the medical workforce there is clear under representation at senior levels within Agenda for change workforce.

Improvement actions planned, timescales, and when improvements will be seen

Through the Workforce Race Equality Standard (WRES) and Ethnicity Pay Gap work, focus on identifying and developing BAME talent, strengthening leadership development, and building a sustainable talent pipeline. Improvements are expected over the medium to long term as these interventions begin to take effect.

Inclusive recruitment training programme being developed for all appointing managers which will ensure that we are being equitable at all times throughout the appointment process.

Review turnover rates with a view to understanding if there is a higher turnover from globally educated workforce to understand the reasons for leaving.

Timescales for delivery will be for the latter quarter of 26/27 financial year.

Risks to delivery and mitigations

A significant proportion of BAME staff are internationally recruited nurses entering at Band 5, which limits short-term progression to Band 8c within a clinical environment. This could be mitigated through targeted talent pipelines and structured development pathways to support progression and increase readiness for senior roles over time.

If retention could be improved from globally educated workforce this could give the opportunity to ensure development and progression opportunities are taken up by our globally educated workforce.

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Our values

Respect

Compassion

Honesty

Teamwork

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Outstanding
Care for **One+All**

Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 16

Title of Report: Charitable Funds Committee Assurance Report to the Board – June 2026 meeting

Committee Chair: Richard Kramer, Non-Executive Director

Author and Job Title: Company Secretary

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

The purpose of this report is to present a summary of decisions made and assurance sought by Charitable Funds Committee on behalf of the Board of Directors at its recent meetings.

Key agenda items and decisions/actions taken on behalf of the Board

There were no decisions taken on behalf of the Board.

Issues for escalation or notification to the Trust Board

The Committee remains assured that charitable funds are being managed appropriately, with strong oversight of investments, fundraising and expenditure. Clear actions are in place to address income sustainability, delivery risk and performance monitoring. No matters were identified that required escalation to the Board.

Summary of assurance and risk

The Committee received **a beneficiary story** regarding the Kitten Scanner which supports children and young children understand how an MRI or CT is undertaken. The equipment is an essential learning and visual tool for children and young people and supports Children Play specialists to encourage and put patients at ease to avoid a general anaesthetics. Members suggested raising awareness across the Trust and with key stakeholders i.e. shared with General Practice noting this was

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available for all patients.

The Committee debated the Charity Team structure in line with Charity Governance arrangements and agreed the future model. Members noted the **Fundraising Manager's report** focussing information and assurance on the launch of the Charity Lottery which was an excellent opportunity and would be actively promoted. Members sought clarity on the development of a pilot to improve workforce wellbeing using NHS Charities Together Workforce Wellbeing Fund; set out the case for the monitoring and evaluation with outcome/expected change. Members were highlighted to delays in projects associated with estates challenges and agreement was made to progress this.

Family Accommodation and Appeal Update set out further delays to the project, noting the Trust was awaiting confirmation of building costs. Members agreed to ensure agile governance to support timely consideration and actions and spoke positively of the exciting opportunities afforded through this accommodation.

Charity Strategy Review (Year 3) set out correlation of fundraising costs and return on investment and recognised the culture around fundraising could impact this. Discussed the leadership / stewardship of fundraising and embedding fundraising as a strategic objective for the organisation. With regard to monitoring; clear metrics would support understanding on return of investment and requested future reports provide impact on patients and staff as well as how the charity is promoted. Members explored, creatively, potential opportunities and made suggestions.

Welcomed the centralised and structured approach to developing **Charitable Projects** Group which would look at prioritising projects**.** Members highlighted the generational opportunities associated with the Women's and Children's Programme and made suggestions regarding fundraising appeals to support the programme, including engagement on Social value projects. W&C Programme SRO to engage with Fundraising team.

Financial and Investment Performance Reports set out a £916k down from previous year, noting previous year had significant legacies therefore overall there was broadly similar year on year performance.

The Committee reviewed the year-end position for 2025/26 alongside the early financial position for 2026/27 and noted that headline movements were largely attributable to one-off factors rather than underlying changes in performance. Income for the year was lower than the previous year due to the absence of significant legacy receipts; however, when adjusted for legacy income, overall income levels were consistent year on year.. Expenditure was ahead of the same period in the previous year, particularly in terms of direct charitable spend, which was considered positive and reflective of ongoing efforts to deploy funds. It was acknowledged that some variation in both income and expenditure is expected at this stage of the year

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due to timing differences in the recognition of income and commitment of spend. Members requested future reports map against the income projections over the next years.

There were no **Charitable Investment Requests over £25k.**

The Committee received a **Spending Plan Report over £50k** for the Cancer Research Fund. The Committee considered whether the forecast underspend against the allocated balance would be fully utilised and sought assurance that there were clear plans in place to deploy the remaining funds. It was noted that, while only confirmed expenditure has been included within the current spending plan, there are a number of emerging proposals.

Review of Charity Risk Register set out changes associated with review of investments, the updated Investment Policy (and restrictions) and noted the volatility around investments and how they are monitored.

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Meeting: Trust Board In Public

Date of Meeting: 02 July 2026

Item Number: 17.1

Title of Report: Corporate Risk Register Report Update

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Samantha Chalmers, Risk Manager

Email Address: Samantha.chalmers@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☐

This paper provides a position statement on the significant and extreme risks to the Trust as they stand on the Corporate Risk Register.

Consultation:

The corporate risks were reviewed individually by the responsible Executive Directors in April and May 2026 with changes agreed by the Executive Lead as well as reviewed in the Executive Risk Group on 1st June 2026 and by the Audit and Risk Assurance Committee on 16th June. Relevant risks have also been reviewed by safety subgroups such as ventilation, water safety and fire.

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☒ **People** ☒

Reputational ☒ **Legal / Regulatory** ☒

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			X	
Quality Impact			X	

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Assessment completed?				
Data Protection Impact Assessment completed?			X	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	None Identified
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	None Identified
Sustainable and efficient use of NHS resources by RCHT	None Identified

Recommendation(s):

The Board is recommended to:

- **Note** the risk profile for RCHT that underpins the Corporate Risk Register and information included at the request of the Audit and Risk Assurance Committee
- **Note** the risks approved onto the Corporate Risk Register
- **Note** the presented updates including changes to scoring

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Corporate Risk Register Update

1. Situation / Executive Summary

1.1 Updates to the corporate risks were made in April, May and June 2026 with progress against actions included where available.

1.2 A summary of the top-rated risks and progress against them is listed in section 3 below.

1.3 Analysis of risks levels to determine if broadly in line with expectations for the year, as well as at what point the volume or severity of risks might signal increasing organisational exposure or capacity pressure has been included at the request of the Audit and Risk Assurance Committee.

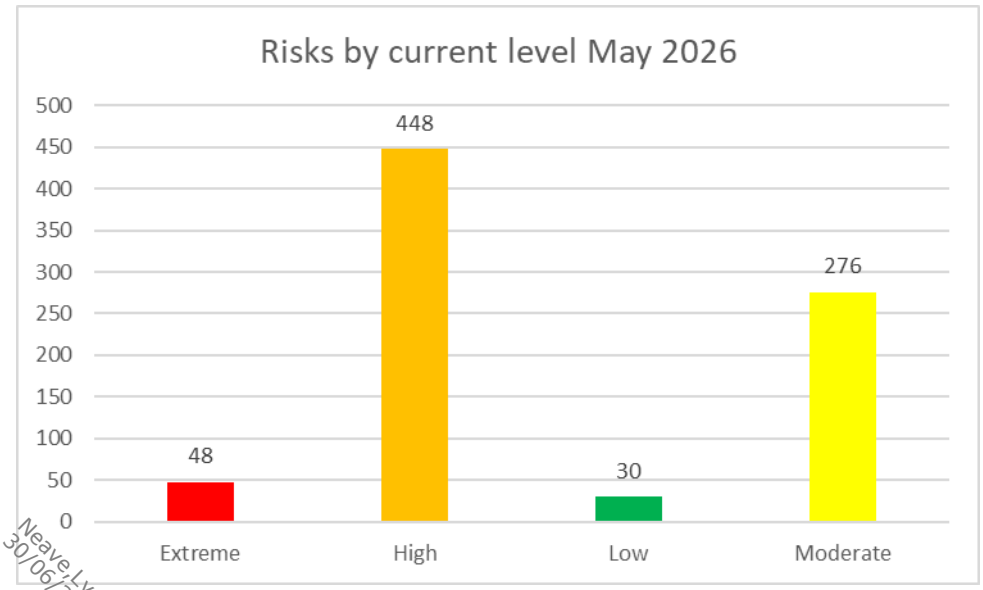
2. Background

The Executive Team retains operational oversight of all extreme and high-level Trust-wide risks through the Corporate Risk Register. These risks are reviewed at least monthly through the Executive Risk Group or other forums, with ERG agenda activity reviewed weekly by the Executive Team. Board sub-committees provide additional assurance on key risks.

3. Assessment

3.1 Trust Risk Profile

The Corporate Risk Register reflects the significant and extreme risks across the Trust and is underpinned by a dynamic and rich risk register managed using Datix. At time of reporting there were 802 open and finally approved risks on Datix. There were 48 extreme rated risks (of which 28 have been accepted onto the Corporate Risk Register).



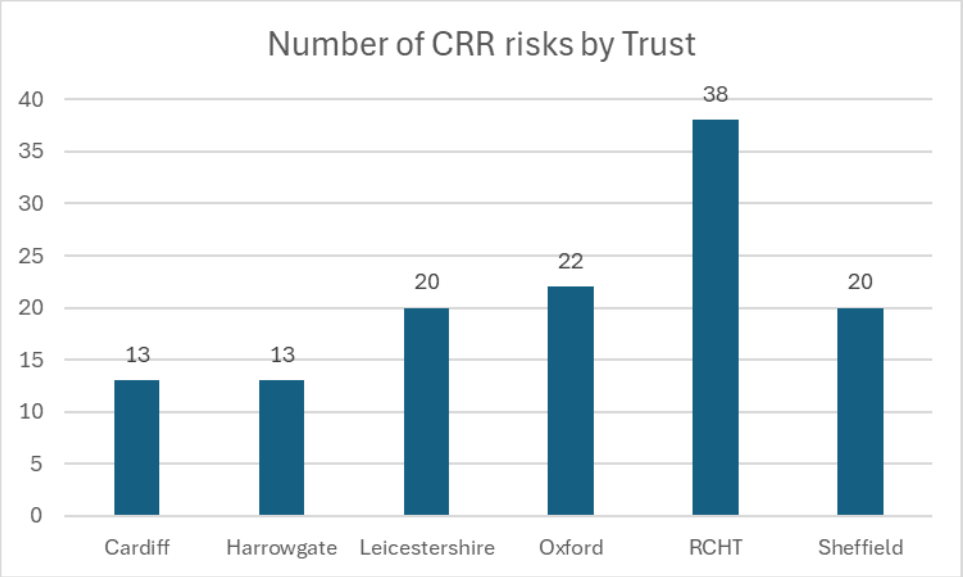
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Extreme risks not yet accepted onto the CRR were reviewed by the Executive at the June ERG. This will become a standing agenda item to maintain visibility of emerging risks. ARAC identified this as a significant action and will retain oversight, with further assurance expected in July.

ARAC requested that future reports confirm whether risk levels meet annual expectations and highlight when volume or severity may indicate rising organisational exposure or capacity pressure. A three-stage process is planned:

- Stage 1: Benchmarking RCHT against other Trusts (June 2026)
- Stage 2: Creating heat maps to review risk trends versus incident rates (August 2026)
- Stage 3: Calibrating controls to evaluate their quality and effectiveness (October 2026)

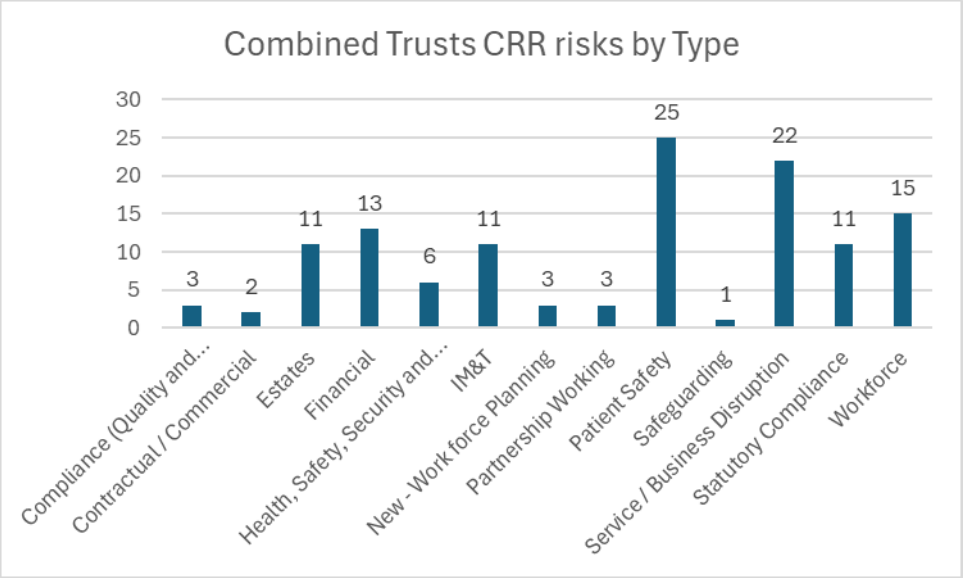
The Audit and Risk Assurance Committee also asked that risk trends over time be included, and this will be added to the August data.

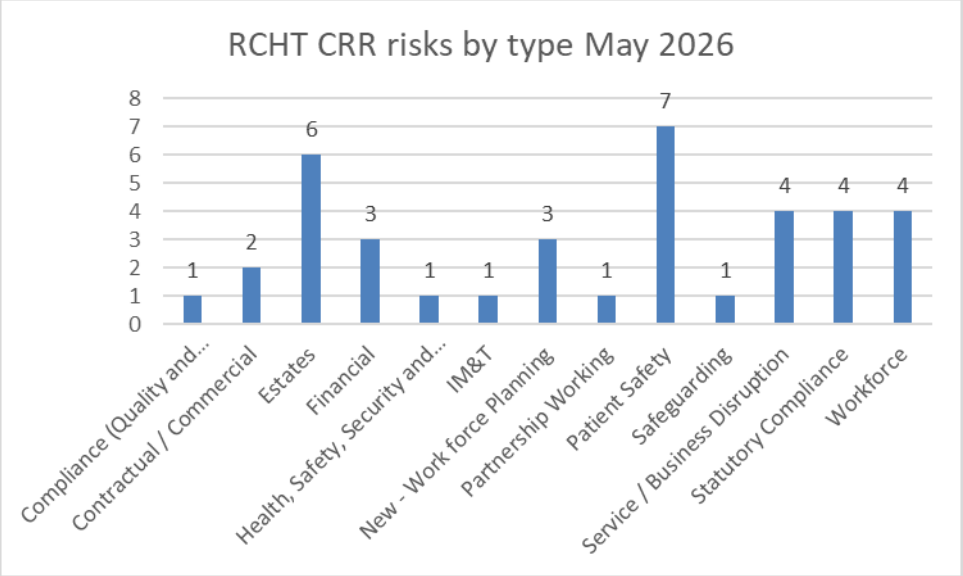


Analysis of six NHS Trusts' CRRs shows RCHT has a more complex, higher-rated profile than peers, with a CRR threshold of 12 and priority risks in infrastructure and digital transformation. Workforce pressures remain, while waiting list backlogs are less prominent. Patient safety risks relate to overcrowding, estate condition and system demand; financial risks are moderate and linked to delivery and funding.

At the May 2026 meeting, the Executive Risk Group confirmed that the Corporate Risk Register's inclusion criteria were optimal. The ERG also noted that the estate's risks significantly affect safety, operational capacity, and fitness for purpose within financial constraints, accurately representing major risks for the Trust.

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RCHT faces significant operational pressures while delivering infrastructure and digital upgrades. Interconnected risks require robust review, clinical input and clear ownership to maintain safety and quality.

Monthly reports track overdue reviews, risks without actions and overdue actions across Care Groups. Since April 2026, overdue reviews reduced from 240 to 202 and overdue actions from 129 to 124, while risks without action plans rose from 274 to 294. Compliance against review cycles is detailed in **Appendix 1.**

3.2 Corporate Risk Register

No risks were approved onto the Corporate Risk Register in April 2026.

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Three risks were approved onto to the Corporate Risk Register in May 2026:

Risk ID	Risk title	Update	Score/ Movement
9573	Subject Access Requests (SARs) Non-Compliance	This risk remains at 20 (extreme) while the Trust continues to hold a backlog of Subject Access Requests. The backlog had reduced by 6.7% (down from 778) in the first two weeks of May, however level of compliance remains sub-optimal, and it has the potential for regulatory action by the ICO. Risk reduction is dependent on sustained workforce stabilisation and implementation of longer-term solutions. The ERG agreed to monitor for an additional month to confirm the risk has reduced before releasing it to the Quality Assurance Committee to oversee.	20 ↔
9719	BC002 Security Services - Training (Security Officers)	The risk has been escalated due to a clear training gap between internal security officers and externally contracted staff, alongside rising incidents of violence, aggression, and clinically related behaviours that increase operational and safety concerns. Emerging regulatory requirements, including Martyn's Law and upcoming SIA changes, further heighten legal and compliance risks. Outstanding actions include securing funding approval for an accredited security officer training programme, finalising the selection of an external provider to deliver a tailored train-the-trainer model, and implementing structured development pathways to support long-term professionalisation. Work is also required to establish a consistent training standard aligned with updated requirements and to address training capacity constraints ahead, ensuring officers can be brought up to the required competency level. The ERG agreed to review delegated authority for funding to see if this risk can be reduced.	15 ↔
9469	SECSY Access Control & ID Badge System - End of Life August	The risk has been escalated because the Trust's access control and CCTV systems have reached end-of-life, with obsolete components, limited software support, and rapidly diminishing spare parts, creating a high	20 ↔

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	2025	likelihood of system failure. This exposes the organisation to significant operational, clinical, safeguarding, cyber-security and regulatory risks, including potential loss of access control to critical areas and reduced CCTV coverage. With no funded replacement programme in place and failure rates expected to rise, executive acceptance and support are required to progress urgent stabilisation and replacement actions.	

No risks were removed from the Corporate Risk Register in May 2026.

Three risks were removed from the Corporate Risk Register in May 2026:

- **9554** (ECPR) Disruption to staffing from eCare implementation – ACCT has been closed following the commencement of training.
- **7947** End of Life for Pathology Laboratory Information System – WinPath has been closed following the move onto the new system in April 26.
- **8711** Compliance with NHSEI National Standards for Healthcare Cleanliness 2025 guidance has decreased from 12 (high) to 8 (high) and this risk will now be monitored via the estates governance process.

One risk decreased in score in April 2026:

- **8589** The Financial Sustainability Programme (Previously named Cost Improvement Plans (CIP) delivery) – As detailed in the below updates.

One risk decreased in score in May 2026:

- **8769** Microbiology medical workforce risk had decreased from 16 (extreme) to 12 (high) following approved funding for 4 WTE consultant microbiologists.

No risks increased in April 2026.

Three risks have increased in score following the delay in implementation of eCare in May 2026.

- **9743** (ECPR) (DGR053, DGR054, DGR071) - eCare impact on Trust wide Business Intelligence (RADAR) capability has increased from 16 (extreme) to 20 (extreme)
- **9384** (ECPR) End of IT System support an maintenance – eCare has increased from 12 (high) to 16 (extreme)
- **8521** Capital Programme - funding and delivery has increased from 12 (high) to 16 (extreme)

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The Executive Risk Group received updates relating to the following critical risks to the

Trust.

Risk ID	Risk title	Update	Score/ Movement
9048	ED Overcrowding	ED Crowding Risk remains the highest rated risk in the Trust at 25 (extreme). This is due to rising Aggregated Patient Delay (a measure of ED crowding) Risk continues to rise in 'minors' area where patients needing trollies and cardiac monitoring are spending prolonged periods in the waiting room or corridor chairs every night. This has worsened since THP45. April / May 26 has seen a return to regular prolonged ambulance holds causing risk in ED and the community.	25 ↔
9663	Risk to patient safety due to T1 recovery water ingress	T1 Recovery continues to operate with reduced capacity, with four bays closed including paediatric space, due to ongoing water ingress issues. Leaks are being monitored and managed depending on weather conditions. The risk remains at the pre-tender stage, with Estates close to awarding the tender and confirming dates for commencement of works. The risk score remains unchanged, with deterioration noted since December 2024, pending progress through the tender and delivery phase.	20↔
10027	T6 Water Ingress	Water ingress affecting Theatre 6 and adjacent areas continues, with variable impact linked to rainfall. As with T1 Recovery, the issue remains at pre-tender stage, with Estates preparing to award the tender and establish delivery timescales. The issue has been ongoing and deteriorating since December 2024. The risk score remains unchanged, awaiting confirmation of works and implementation of the permanent mitigation.	16↔
8711	Compliance with NHSEI National	The risk has reduced from 12 (high) to 8 (high) and stabilised, supported by full	8 ↓

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Risk ID	Risk title	Update	Score/ Movement
	Standards for Healthcare Cleanliness 2025 guidance	recruitment, a dedicated Deep Clean Team, improved audit performance, and sustained compliance. Continued monitoring will ensure early identification of any emerging risks.	
9754	BC014 Security Services - Compliance with NHSE Violence Prevention and Reduction Standard	This risk remains at 16 (extreme) with the VPR Strategy (2023) due for full review in 2026. The strategy and self-assessment tool is not currently aligned with NHSE V2. The six-monthly self-assessment/action plan is overdue (Feb 2026). There is ongoing discussions between Chief Operating Officer and Dual Chief People on remit and ownership. The expanded national scope (Civility; VPR; Sexual Safety) now requires involvement of Deputy Chief Executive and Chief Nursing Officer.	16 ↔
7870	Capability and Resource of the Operational Estates Team	The continued pressures on the operational teams are further restricted due to the ability to recruit into certain roles. There are several vacancies as a result of retirement or resignation that cannot be recruited to. Long term absence in some roles is also challenging with additional pressure on remaining resources and limited ability to backfill positions. Authorised Person cover continues to improve. There are difficulties in recruiting trade roles where it has not been possible to recruit a plumber or electrician due to market conditions where the Trust cannot compete on pay. The challenging recruitment is leading to the use of more contracted services at increased cost.	16 ↔
10024	Risk of infection due to outdated/missing Ventilation	The delivery of the operational plan for elective surgery is impacting on the ability to undertake some of the planned maintenance where a Theatre would be	16 ↔

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Risk ID	Risk title	Update	Score/ Movement
	Systems	shutdown to complete works. This excludes some of the capital works that may be undertaken as part of wider scheme as these may not be known at this time - dependent on the development of services to meet the clinical strategy. It is unlikely that a decrease in score will be seen until at least 2029 if sufficient progress has been made and subject to funding.	
8922	Lack of Security at the RCH to Support the Trust	The operational team reorganisation is now complete. The new rota, introduced in March, is already delivering improved coverage, greater resilience, and more consistent operational performance. External contractors have now been fully removed from the Emergency Department, with duties successfully absorbed by the in-house team. Once the in-house team is fully recruited to establishment, we anticipate being able to reduce the overall risk level.	16 ↔
9972	Lack of Immutable Backups	The risk is currently rated 20 on the basis that in the event the backup is comprised it would significantly impact the ability to restore clinical applications and data in effective manner, instead of hours to recover it could be measured in weeks or months. This could result in data loss or being almost impossible to effectively recover using existing BCPs. A business case is currently being circulated for approval within RCHT (approved at CAG and ELT) and has been approved by CFT to replace present secondary backup platform that is due for tech refresh and goes EOL (end of life) in Dec 2026. The proposed solution is planned to be operational by August 1st 2026 to avoid licence renewals of present solution.	20 ↔

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Risk ID	Risk title	Update	Score/ Movement
9969	VOIP Licence renewal	Funding has not been identified for this in the current RCHT capital plan. Telephony services at RCHT and CFT are provided by a Voice over Internet Protocol (VOIP) solution which is contracted through BT and utilises a licensed product from CISCO. The current license was purchased in February 2024 for a 3-year term on capital and expires in February 2027. Renewal of these licenses have been built into future capital projections, however the Trust has limited capital to dedicate to all the high priority schemes.	16 ↔
8462	Use of ICE for blood rests in Rheumatology	The number of requests being placed in ICE is increasingly significantly over time. ICE does not include native scheduling functionality so all requests have to be generated manually and has created significant workload for Rheumatology. Infoflex is live and producing required outputs for RPA to use with patients being set up on Infoflex as prescriptions renewed or new treatments started.	12 ↔
10080	Obstetrics Medical Staffing	Owing to recent sickness in the gynaecology team there has been reduced capacity to provide support and a continued fragility of the Obstetric team and lack of on-call resilience. The trigger for risk reduction will be based on new consultants starting in service to impact the on-call rota and reduce the need for the step down of consultants to cover middle grade gaps. There are planned interview dates for a new Gynaecology and Obstetrics Group Manager to provide needed day to day support regarding recruitment.	20 ↔
10034	Nurse Call	The Nurse Call replacement programme is established and progressing, with two	16↔

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Risk ID	Risk title	Update	Score/ Movement
	System	obsolete systems removed during 2025/26 and Phase 1 schemes confirmed for delivery in 2026/27. Contracts have been awarded and preparatory works are underway, with further resilience measures implemented through temporary systems to mitigate ward-wide failures. While delivery challenges continue due to programme delays, funding is in place and additional phases are planned as capacity allows. The risk score remains unchanged at 16 (Extreme), with reductions anticipated once Phase 2 is completed.	
7302	Environment Agency/CQC/HSE Compliance re Radioactive Materials - Condition of Premises	Progress has been made in resolving the complex drainage design required to address compliance issues within Nuclear Medicine, including approval of a revised route with appropriate radiation shielding. The design has been supported by the Project Group and senior physics leads, with final sign-off pending. Delivery of the capital works is now planned to commence at the end of August 2026, with completion expected in Q3 2026/27. The risk score remains stable at 16, however completion of the drainage works is expected to reduce the score to 12.	16↔
8521	Capital Programme - funding and delivery	The Trust's capital programme for 2025/26 is forecast to be close to plan, with a balanced but risk-based programme set for 2026/27 following significant review and challenge. Core funding levels are now confirmed through to 2028/29; however, capital investment requirements continue to significantly exceed available funding, creating a persistent risk. The programme will be reprioritised in May 2026 to reflect emerging pressures and funding constraints. The risk score remains unchanged at 12, reflecting the ongoing nature of this risk.	12↔

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Risk ID	Risk title	Update	Score/ Movement
8589	The Financial Sustainability Programme (Previously named Cost Improvement Plans (CIP) delivery)	The Financial Sustainability Programme has a £42.5m savings requirement for 2026/27, with schemes identified and agreed by Executive SROs. Active programme management arrangements are in place, including FSP Board oversight and regular reporting; however, there remains a risk of delayed implementation due to limited delivery detail for some schemes and competing organisational priorities, including the divisional restructure and eCare programme. The risk score has reduced from 16 to 12, reflecting improved governance and control, and the risk is now subject to monthly review.	12↓

4. Risk

All new areas of risk are described in section 3 above.

5. Accountability

Bernadette George, Acting Chief Nursing Officer is the Executive Director for the Corporate Risk Register

6. Recommendations

- **Note** the risk profile for RCHT that underpins the Corporate Risk Register and information included at the request of the Audit and Risk Assurance Committee
- **Note** the risks approved onto the Corporate Risk Register
- **Note** the presented updates including changes to scoring

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Appendix 1

Open Risks Overdue for Review May 2026					
Division	Extreme	High	Moderate	Low	Total
Acute and Emergency Medicine	1	23	5		29
Anaesthetics, Critical Care and Theatres	1	9	7		17
Clinical Support and Cancer Services		11	3		14
Corporate	7	27	14		48
Estates & Facilities	1	2	3		6
Medicine Division		1	1		2
Security Services	2		1		3
Specialist Surgery		13	10	2	25
Surgery Division		27	14	1	42
West Cornwall Hospital (WCH)		2	3		5
Women and Children Division		2	1		3
Women, Children & HIV		5			5
(blank)	1	2			3
Grand Total	13	124	62	3	202

Open Risks Without Action Plans May 2026					
Division	Extreme	High	Moderate	Low	Total
Acute and Emergency Medicine	1	10	5		16
Anaesthetics, Critical Care and Theatres	2	22	18		42
Clinical Support and Cancer Services	2	33	21		56
Corporate		22	18	2	42
Estates & Facilities		7	10		17
Medicine Division		4	4		8
Specialist Surgery		3	6	4	13
Surgery Division		38	39	1	78
West Cornwall Hospital (WCH)		4	3		7
Women, Children & HIV	1	9	4		14
(blank)	1				1
Grand Total	7	152	128	7	294

Risks With Overdue Actions May 2026					
Division	Extreme	High	Moderate	Low	Total
Acute and Emergency Medicine	1	16	2		19
Anaesthetics, Critical Care and Theatres	2	8	2		12
Chief Operating Officer	1	1			2
Clinical Support and Cancer Services			1		1
Corporate	3	20	10		33
Estates & Facilities		3	1		4
Medicine Division			6	1	7
Security Services	3		1		4
Specialist Surgery		15	10	3	28
Surgery Division		8			8
West Cornwall Hospital (WCH)			1		1
Women and Children Division		1			1
Women, Children & HIV		4			4
Grand Total	10	76	34	4	124

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Key
→ Indicates movement in the month;
♦ Diamond indicates current score;
❍ Circle indicates target risk score
\# Hash symbol column indicates number of overdue actions
★ Indicates no open actions.
Indicates closed risk or reduced score and removed from CRR

Corporate Risks Register and Risk Oversight Dash Board

Corporate Risk Register			Risk Lead	Current	Date escalated to CRR	Date risk changed		Score when identified	Date risk Identified	≤6	8	9	10	12	15	16	≥20	BAF ref	Progression in month	Dates to achieve target risk score
Acute and Emergency Medicine	9048	ED Overcrowding	Dr Owen McCormack	25	Feb-24	Feb-23	↑	12	Aug-23		❍						♦	1	↔	Apr-26
Anaesthetics, Critical Care and Theatres	9663	Risk to patient safety due to T1 recovery water ingress	Mrs Tanya Allan	20	Feb-23	Feb-24	↔	15	Dec-24	❍							♦	6	↔	Mar-27
Anaesthetics, Critical Care and Theatres	10027	T6 water Ingress	Mrs Anneka Southworth	16	Jun-25	Feb-26	↓	8	Oct-25	❍						♦		6	↔	Mar-27
Anaesthetics, Critical Care and Theatres	9736	(ECPR) (DGR030) Patient Safety Lesson Learnt-E Care - ACCT	Mrs Anneka Southworth	12	Sep-23	Dec-25	↑	12	Jul-24	❍				♦				1 and 3	↔	Mar-26
Anaesthetics, Critical Care and Theatres	9551	(ECPR) E Care functionality (ACCT)	Mrs Anneka Southworth	12	Feb-23	Dec-23	↑	25	Jun-24		❍			♦				5	↔	Mar-26
Chief Operating Officer	9742	(ECPR) (DGR002, DGR049) RCHT Capacity to Fully Engage with eCare while Delivering Operational Activity Targets	zMr zSteve zVann***LEAVER 16/12/2025	16	Sep-24	Nov-25	↔	16	Feb-25		❍					♦		3	↔	Mar-26
Clinical Support and Cancer Services	8693	Blood Sciences Workforce and Training Capacity	Lisa Vipond	16	Mar-25	Dec-21	↑	12	Oct-22	❍						♦		2	↔	Sep-26
Clinical Support and Cancer Services	8769	Microbiology medical workforce risk	Lisa Vipond	12	Mar-25	Sep-24	↑	10	Jan-23	❍				♦				2	↓	Jun-26
Clinical Support and Cancer Services	2382	Insufficient workforce and loss of key skills due to staff vacancies and recruitment.	Mr Iain Davidson	12	Mar-23	Jun-25	↑	6	Oct-09	❍				♦				2	↔	Mar-26
Corporate	9972	Lack of Immutable Backups	Director of Estates and Facilities	20	Jul-22	Feb-25	↔	16	Sep-25	❍							♦	5	↔	Jun-26
Corporate	9743	(ECPR) (DGR053, DGR054, DGR071) - eCare impact on Trust wide Business Intelligence (RADAR) capability	Linzi Lancaster	20	Sep-24	Mar-25	↔	12	Jan-25		❍						♦	3 and 5	↑	Jun-26
Corporate	8303	Cyber-Attack EPRR	Mr Martin Price	20	Jan-26	May-22	↓	30	Jul-21								♦	5	↔	Mar-26
Corporate	9969	VoIP licence renewal	Robert Phillips	16	Mar-23	Feb-25	↓	20	Sep-25	❍						♦		5	↔	Mar-26
Corporate	9752	(ECPR) (DGR058, DGR059, DGR060, DGR062, DGR063) - eCare impact on ability to apply accurate and timely Clinical Coding	Linzi Lancaster	16	Dec-21	Mar-25	↔	12	Nov-24					❍		♦		3	↔	Mar-26
Corporate	9751	(ECPR) (DGR015, DGR052) eCare Cash Releasing Benefits	Mrs Emily Cudmore	16	Jun-23	Mar-25	↔	12	Feb-25			❍				♦		4	↔	Jun-26
Corporate	9384	(ECPR) End of IT System support an maintenance - eCare	Miss Liz Evans	16	Oct-24	Jul-23	↔	15	Jul-24	❍						♦		5	↑	Dec-26
Corporate	8521	Capital Programme - funding and delivery	Adam Wheeldon	16	Jan-26	Feb-22	↑	27	Apr-22					❍		♦		4	↔	Jun-26
Corporate	8339	Increase activity in Safeguarding referrals	Zoe Cooper	16	Jan-26	Apr-22	↓	29	Sep-21	❍						♦		1	↔	May-26
Corporate	9664	Safeguarding Maternity Provision	Suzie Williams	15	Mar-23	Jul-25	↔	12	Dec-24			❍			♦			1	↔	Mar-27
Corporate	9081	Clinical Coding Resource	Linzi Lancaster	15	Jun-25	Jan-23	↑	15	Sep-23						♦			3	↔	Aug-26
Corporate	8589	Financial Sustainability Programme (FSP) Delivery	Mr Doug Riley	12	Feb-25	Dec-21	↓	25	Jun-22		❍			♦				4	↔	Jun-26
Estates & Facilities	10034	Nurse Call System - Age	Robert Davies	16	Mar-21	Mar-25	↑	12	Oct-25	❍						♦		1 and 6	↔	Apr-29
Estates & Facilities	10024	Risk of infection due to outdated/missing Ventilation Systems	Ryan Hill	16	Aug-22	Feb-25	↓	20	Oct-25		❍					♦		6	↔	Jan-35
Estates & Facilities	9937	Insufficient electrical capacity at RCH to meet the growing demands of the Trust (NBPR)	Mr Richard Parris	16	Dec-21	Feb-25	↔	16	Dec-24	❍						♦		6	↔	Feb-28
Estates & Facilities	8040	There are underlying unsafe conditions to the building infrastructure that have an impact on Fire Safety EPRR	Mr Brian Johnson	16	Feb-25	Mar-23	↑	15	Oct-20		❍					♦		6	↔	Mar-29
Estates & Facilities	7870	Capability and Resource of the Operational Estates Team	Mr Richard Parris	16	Feb-25	Aug-22	↓	16	Jun-20	❍						♦		2 and 6	↔	Jun-26
Estates & Facilities	7302	Environment Agency/CQC/HSE Compliance re Radioactive Materials - Condition of Premises	Philip Bond	16	Oct-25	Feb-24	↑	12	Apr-19		❍					♦		6	↔	Mar-27
Estates & Facilities	8858	Failure of Sterile Services Department (Engineering Support & Infrastructure)	Mr Richard Parris	15	Nov-25	Sep-24	↔	12	Apr-22	❍					♦			6	↔	Apr-27
Estates & Facilities	1250	Medical Gases not compliant with HTM02	Mr Richard Parris	12	Mar-25	Mar-21	↑	12	Apr-08	❍				♦				6	↔	Jul-26
Security Services	8922	Lack of Security at the RCH to Support the Trust	Miss Natasha Quick	16	Dec-25	Feb-26	↓	12	Jun-23					❍		♦		1	↓	Mar-26
Specialist Surgery	8462	Use of ICE for blood tests in Rheumatology	Mr Andrew Pothecary	12	Jan-26	Mar-22	↓	28	Jan-22	❍				♦				3	↑	Apr-26
Surgery Division	9397	SDSA corridor waiting area accommodating acutely unwell patients	Zoe Ainsworth	12	Jul-23	Jul-23	↔	16	Jul-24			❍		♦				1	↔	Apr-26
Surgery Division	8585	NOF mortality increases	Charlotte Chapman	12	Jan-26	Dec-25	↑	26	Jun-22			❍		♦				1	↔	Feb-26
Women, Children & HIV	10080	Obstetric Medical Staffing	Miss Sophie Haynes	20	Mar-26	Mar-26	↑	16	Nov-25	❍							♦	2	↔	Jun-26

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Key

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Corporate Risks Register and Risk Oversight Dash Board

Corporate Risk Register			Risk Lead	Current	Date escalated to CRR	Date risk changed		Score when identified	Date risk Identified	≤6	8	9	10	12	15	16	≥20	BAF ref	Progression in month	Dates to achieve target risk score
Women, Children & HIV	9006	Neonatal Nurse Staffing Risk	Chief Information Officer	20	Jul-25	Mar-23	↑	20	Jul-23	❍							♦	2	↔	Sep-26
Women, Children & HIV	9524	Maternity Triage	Mrs Sarah Harvey-Hurst	16	Jul-23	Oct-24	↔	16	Sep-24	❍						♦		1 and 2	↔	Aug-26
Women, Children & HIV	9106	Delivery of the Children in Care service and related statutory duties	Alison Birch	16	Dec-23	Feb-23	↑	12	Oct-23	❍						♦		1	↔	Oct-26

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Meeting: Trust Board In Public

Date of Meeting: 02 July 2026

Item Number: 18

Title of Report: Risk Management Strategy and Policy Update

Executive Director Lead: Bernadette George, Acting Chief Nursing Officer

Author and Job Title: Samantha Chalmers, Risk Manager, Kate Locke, Deputy Risk Manager

Email Address: Samantha.chalmers@NHS.net, Kate.locke@NHS.net

Purpose of the Report:

Decision ☒ **Discussion** ☐ **Assurance** ☒ **Information** ☐

To advise on current changes and updates made to the Risk Management Strategy and Policy

Consultation:

This policy has been circulated to the Divisional and Specialist Governance leads to ensure accuracy and that the policy conforms to best practice. It has been reviewed at the Executive Leadership Team meeting in May 2026 and Executive Risk Group the Audit and Risk Assurance Committee in June 2026.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☐

Reputational ☐ **Legal / Regulatory** ☒

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?	/			None Identified
Quality Impact	/			None Identified

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Assessment completed?				
Data Protection Impact Assessment completed?	/			None identified

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Not applicable
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Not applicable
Sustainable and efficient use of NHS resources by RCHT	Not applicable

Recommendation(s):

The Board is recommended to:

- **Note** the changes made to the policy in line with best practice and Internal Audit recommendations
- **Note** the updates made following organisational changes
- **Note** the requirement for further updates pending go-live of the new Risk Management System
- **Approve the amended** policy with a further update coming to the August meeting with the revised risk appetite sections

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1. Situation / Executive Summary

The Risk Management Strategy and Policy is scheduled for review to ensure that the Trust continues to provide good quality advice and support to staff and that the policy reflects best practice.

The policy has been reviewed in conjunction with:

- The Orange Book
- ISO 31000
- HSG65
- GGi Risk Maturity Matrix
- Internal Audit Recommendations
- Staff and specialist expert feedback

Updates have been made to the following sections:

- Changes to titles and divisional names
- A new section related to project risk management
- Correction of the risk scoring matrix

To improve clarity and ensure that the policy is in alignment with best practice, further revision is proposed.

This will include:

- Changes to the structure and content
- Updated terminology
- Process changes arising from the new Risk Management System (RMS)
- New risk assessment types (including dynamic risks, global and futures risks)
- Updated responsibilities
- Updated risk appetite

The Trust's plan to modernise the Risk Management System (currently Datix) will also mean that further changes will be required. To reduce disruption and confusion for staff, it is proposed that only minor amendments are made at this stage. This will present the opportunity to revise the policy to include updated sections relating to the Board Assurance Framework (BAF) and Risk Appetite.

2. Background

Following an Internal Audit undertaken by ASW looking at the strategic project management process, the auditors identified areas for improvement/inclusion into the risk policy. A new section (section 7) has been added to the policy relating to project management.

3. Assessment

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The policy was updated to reflect the Trust structure as at April 2026, including changing 'Care Group' to 'Division'.

Following ASW Internal Audit recommendations, a new section on project risk management has been added.

Approval to replace DATIX with a new Risk Management System means the policy and strategy will need further revision once implemented.

Further planned revisions will reflect staff consultation and expert review. The 2025 survey asked regular users about:

- Frequency of use
- Usefulness of content
- Most used content
- Suggested inclusions

The consultation indicated the policy was underused and only limited sections were considered useful. Feedback will inform a content refresh later in the year.

The Risk Manager and Deputy Risk Manager reviewed the policy against the Orange Book and ISO 31000 using AI comparison tools. This identified no clearly defined strategy and 22 improvement areas, listed in Appendix B.

The BAF and Risk Appetite will be updated following Board work in June 2026. A new Risk Strategy section is recommended to reflect Good Governance Institute best practice and the Trust and Clinical Strategies.

4. Risk

Failure to provide a coherent and user-friendly policy for the management of risk may result in inconsistent or poor practice and mean that the Trust will not meet its statutory obligations to undertake suitable and sufficient risk assessments.

5. Accountability

Accountability for the Risk Management Policy and Strategy sits with the Chief Executive and responsibility for oversight and development has been delegated to the Director of Nursing Midwifery and Allied Healthcare Professionals.

6. Recommendations

- **Note** the changes made to the policy in line with best practice and Internal Audit recommendations
- **Note** the updates made following organisational changes
- **Note** the requirement for further updates pending go-live of the new Risk Management System
- **Approve the amended** policy with a further update coming to the August meeting with the revised risk appetite sections

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Appendix B

Ref	Area	What changed	Impact	Action needed before approval
1	Document purpose & structure	Policy reframed from a combined Strategy & Policy document to a more practical, operational risk management policy, organised around the end-to-end risk lifecycle	Makes the policy clearer and easier for operational teams to follow; improves usability and consistency Enhances the clarity of the policy, making it simpler for operational teams to implement while boosting usability and consistency.	Confirm Board is content with the strategy being embedded rather than held as a separate document
2	Overall approach	Introduced a clear 4-step risk management lifecycle (Identify → Assess → Manage → Review/Escalate)	The policy aligns closely with NHS England standards and ISO principles, ensuring that its structure and content meet recognised benchmarks for quality and consistency. This alignment reinforces best practice and provides a robust foundation for operational teams. In addition, the policy actively supports both training and the consistent application of procedures across staff	No action required – note alignment for assurance

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Ref	Area	What changed	Impact	Action needed before approval
			groups. By adhering to these standards, it fosters a practical environment where guidance is clear and implementation is straightforward, further strengthening staff confidence and operational reliability.	
3	Principles section	New explicit Principles of Risk Management section added	The policy establishes explicit expectations regarding ownership and consistency. Everyone is made aware of their responsibilities, ensuring that processes are conducted reliably and in line with established standards. This clarity promotes accountability and uniformity across all areas. Actions are guided by the principle of proportionality, meaning that responses and measures are appropriate to the situation at hand. This careful approach helps maintain fairness and balance when addressing issues. Clear escalation routes are defined within the policy. When situations require further attention or additional support, staff are provided with structured guidance on how to escalate concerns.	N/A

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Ref	Area	What changed	Impact	Action needed before approval
			This ensures that problems are addressed efficiently and effectively. The policy supports a just culture	
4	Single system rule	Stronger wording that Datix is the single source of truth for organisational risks; local spreadsheets/registers cannot act as master records	Ensuring robust data quality is fundamental to the effective management and utilisation of organisational information. High standards of data quality contribute to improved governance oversight, enabling accurate monitoring, reporting, and compliance with relevant policies and regulations. These measures collectively support a seamless transition during future system migrations, reducing risk and ensuring continuity of operations.	Confirm organisational readiness and alignment with Divisions
5	Terminology & organisational model	References updated from Care Groups to Divisions / Corporate areas	The policy has been reviewed and updated to ensure alignment with the current organisational and governance structure. This ensures that the policy reflects the latest hierarchy, reporting lines, and decision-making processes within the organisation. By doing so, it provides clarity regarding roles and responsibilities, facilitating effective implementation and oversight. The updated structure supports consistent	N/A

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Ref	Area	What changed	Impact	Action needed before approval
			application of the policy across all departments, enhancing accountability and supporting robust governance practices.	
6	Roles & responsibilities – overall	Responsibilities section simplified; clearer distinction between risk owners and action owners	Accountability and understanding at the operational level are crucial for ensuring that policies and procedures are properly implemented throughout the organisation. By clarifying roles and responsibilities, staff are empowered to take ownership of their actions and decisions. This, in turn, leads to more effective communication, clearer expectations, and greater transparency within teams. Improved operational accountability facilitates the identification and resolution of issues as they arise, thereby supporting compliance and continuous improvement. When staff have a thorough understanding of their responsibilities, it strengthens their engagement and contributes positively to overall organisational performance.	N/A

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Ref	Area	What changed	Impact	Action needed before approval
7	Risk Manager role	Detailed standalone “Risk Manager” role description removed; responsibilities absorbed into Risk Team / Head of Patient Safety & Risk	The current approach is structured around a team-based delivery model, ensuring that responsibilities and tasks are allocated within existing teams. This method not only aligns with contemporary organisational practices but also helps to eliminate unnecessary duplication of effort. By concentrating on cohesive team structures, processes become more streamlined and efficient, fostering improved collaboration and clarity.	Confirm senior leaders are content with revised accountability model
8	Risk identification & description	Clearer expectations on risk titles and descriptions (concise, evidence-based, max three sentences)	Ensuring consistency in governance oversight is essential for maintaining reliable and uniform standards across all organisational processes. By establishing clear frameworks and procedures, governance teams can more effectively monitor compliance, identify areas for improvement, and uphold best practices throughout the organisation. Improved report quality contributes significantly to effective governance oversight. High-quality reports enable informed decision-making, provide transparency, and facilitate accurate	N/A

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Ref	Area	What changed	Impact	Action needed before approval
			assessments of organisational performance. Consistent and well-structured reporting ensures that oversight bodies receive relevant, precise, and actionable information, thereby supporting robust governance.	
9	Risk scoring rules	Explicit rule introduced: open risks cannot be scored as low	This mitigates the risk of under-scoring and enhances assurance.	Highlight to Divisions via training/communications post-approval
10	Datix field requirements	Clearer specification of mandatory Datix fields (owner, exec sponsor, controls, actions, review date, scores)	The implementation of improvements directly contributes to higher data quality, ensuring that information collected and processed is accurate, reliable and consistent. As a result, these enhancements enable more effective and informed decision-making across the organisation. By prioritising the integrity of data, stakeholders are better equipped to analyse trends, respond to challenges, and support strategic objectives, ultimately strengthening overall performance and outcomes.	N/A
11	Risk review frequencies	Review cycles refined: Extreme – monthly; High – 3-monthly;	The approach to oversight has been refined to ensure it is proportionate to the requirements, thereby minimising	Confirm Divisional governance capacity supports revised frequencies

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Ref	Area	What changed	Impact	Action needed before approval
		Moderate – 6-monthly; Low – annual (as closed risks)	unnecessary administrative workload. By focusing only on essential monitoring and reporting, the process avoids excessive bureaucracy and streamlines compliance. This reduction in administrative burden allows staff to devote more time and attention to core responsibilities, enhancing overall efficiency and effectiveness.	
12	Low risks handling	Low risks managed as closed risks with annual review, rather than remaining open	Providing clear guidance helps staff understand exactly what is required of them. This ensures that everyone is on the same page and minimises uncertainty within the team. By setting out precise expectations, the likelihood of unnecessary or excessive entries in registers is significantly diminished. This streamlines processes and prevents registers from becoming overloaded with redundant information, allowing for more efficient management and oversight.	N/A
13	Closed risk archiving	New instruction to archive closed risks after 12 months using a defined Datix status/reason	Ensuring that the risk register remains current and manageable is crucial for effective risk management within the	Confirm Datix configuration supports the archive method described

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Ref	Area	What changed	Impact	Action needed before approval
			organisation. Regular review and updates help to identify emerging risks, address existing issues, and maintain oversight of mitigation strategies. Regular monitoring, clear responsibilities, and consistent processes support the ongoing maintenance of the risk register. This approach fosters accountability and transparency, contributing to a robust risk management framework.	
14	Datix approval status	Requirement to set risks as “Final Approved” once agreed at the appropriate level	The introduction of improved governance practices ensures that oversight is more transparent within the organisation. Clearer visibility enables stakeholders to monitor processes effectively, facilitating timely interventions and informed decision-making. This clarity supports both internal and external assurance requirements. By refining reporting mechanisms, the accuracy of organisational data and information is strengthened. Precise reporting allows for more reliable records, aiding compliance and supporting performance evaluations.	N/A

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Ref	Area	What changed	Impact	Action needed before approval
			Enhanced accuracy ensures that management and regulatory bodies have greater confidence in the data presented.	
14	Escalation principles	Clearer description of when risks should be escalated (authority, capability, resources, or Trust-wide impact)	The approach outlined ensures that escalation decisions are made in a consistent manner. By providing clear guidance and structured criteria, staff can confidently follow established procedures when determining whether escalation is necessary. This consistency minimises the risk of miscommunication and ensures that all cases are handled according to agreed standards. As a result, the process supports both organisational assurance and the effective implementation of policies.	N/A
16	Corporate Risk Register (CRR) criteria	Clarified criteria for CRR consideration (score ≥15, or score 12 with Trust-wide / cross-Divisional impact)	The escalation process to Trust level has been enhanced to promote greater transparency and ensure consistent application across all cases. By establishing clear procedures and guidelines, staff can confidently escalate issues knowing that the process will be fair and uniform. This approach not only clarifies expectations for all parties involved but also supports accountability	N/A

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Ref	Area	What changed	Impact	Action needed before approval
			and strengthens organisational assurance.	
17	Parent / global risks	Language modernised but principle retained (local risks may link to Trust-wide parent risks)	Effective strategic oversight is essential for ensuring that organisational processes are streamlined and well-coordinated. By maintaining a clear overview of activities, potential redundancies are identified and eliminated, allowing resources to be utilised efficiently. This approach not only enhances operational effectiveness but also ensures that all initiatives align with the wider organisational strategy. As a result, the risk of duplicated efforts is minimised, supporting a more cohesive and productive working environment.	N/A
18	Board Assurance Framework (BAF)	BAF section flagged for update / completion in draft version	Clear communication of Board-level risk assurance is vital to the organisation's governance. By providing unambiguous information regarding risk management, the Board is better positioned to oversee and ensure that all significant risks are identified, assessed, and managed effectively. This clarity not only supports robust decision-making but also strengthens accountability and	Complete and finalise BAF section before approval

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Ref	Area	What changed	Impact	Action needed before approval
			transparency throughout the organisation.	
19	Risk appetite content	Risk appetite section simplified; detailed appetite tables reduced or pending inclusion	The approach taken ensures that the fundamental principle of appetite is preserved throughout the policy. At the same time, efforts have been made to streamline and simplify the document, making it more accessible and easier to understand for all users. This balance allows the policy to remain robust and clear in its intent while reducing unnecessary complexity.	Confirm final appetite statement and tables are included or cross-referenced
20	Appendices & practical guides	Increased emphasis on quick guides (Datix entries, reviews, scoring) rather than workflow diagrams	The introduction of a dedicated training and support section, complete with a clear contact route, serves to significantly improve staff accessibility. By streamlining the process for staff to seek guidance and support, it ensures that team members can efficiently access the resources they need for their roles. These measures not only make training more accessible but also enhance its overall value. With strengthened implementation and assurance, staff are better equipped to engage with training	Confirm appendices are final and consistent with system configuration

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Ref	Area	What changed	Impact	Action needed before approval
			materials, leading to improved understanding and compliance. The focused approach fosters greater engagement, ensuring that training is both relevant and beneficial to all employees.	
21	Training & support	Dedicated training and support section added with clear contact route	Enhances the effectiveness of implementation and ensures robust assurance.	N/A
22	Tone & accessibility	Language simplified; policy is shorter and more user-focused	By simplifying the language and making the policy shorter and more user-focused, the document has become easier for staff to understand and apply. This improvement not only supports compliance with organisational requirements but also encourages greater engagement among employees. Clearer communication helps ensure staff are informed and confident in following the policy, thereby fostering a positive and proactive working environment.	N/A

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Royal Cornwall Hospitals NHS Trust

Risk Assessment and Management Strategy and Policy

V10.20

June 20263

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Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

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1. Introduction

1.1 This document sets out the key aims and objectives for the management of risk at the Royal Cornwall Hospitals NHS Trust (RCHT).

1.2 The Trust is committed to having a risk management culture that underpins and supports the business of the Trust and demonstrates an on-going commitment to improving the management of risk throughout the organisation.

1.3 Risk management is the systematic method of identifying, analysing, managing, monitoring, and reviewing of risks in order to ensure achievement of the Trusts objectives. It is also clear that managed risk taking is sometimes critical to taking developments forward and improving care for patients. A list of definitions can be found in section 4.

1.4 This version supersedes any previous versions of this document.

2. Purpose of this Policy/Procedure

The purpose of the Risk Assessment and Management Strategy and Policy is to:

- Provide a framework which supports the development of an organisational culture whereby risk management is an integral part of providing healthcare and day to day decision-making.
- Support the delivery of safe, caring, effective and sustainable health care provision for patients, visitors, and staff.
- Comply with legal statutory requirements and comply with the requirements of external regulators and other relevant bodies.
- Identify risk escalation arrangements throughout all levels of the organisation.
- Provide a common risk identification and management process which sets out a consistent and integrated approach to risk management and allows for meaningful comparison of risk, thus establishing priorities for action.
- Provide a framework of assurance for the management of risk.
- Promote an open, honest, and just culture where staff can report any risks, free from fear and which will support them and enable positive action to take place to reduce risk.
- Describe the resources available for risk management in the organisation.

3. Scope

This document applies to all employees working within the Trust including bank, agency, and locum staff. It also applies to all honorary contract holders. Contractors must be advised upon commencement of contract of how to raise a risk and will be made aware of their own responsibilities.

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4. Definitions

- **Risk Management**

  The systematic method of identifying, analysing, managing, monitoring, and reviewing of risks.

- **Risk Register**

  A register of all identified risks within the Trust.

- **Risk Assessment**

  The process used to evaluate the risk and to determine whether controls are adequate or more should be done to mitigate the risk.

- **Board Assurance Framework**

  Sets out the principal risks to achievement of the Trust's strategic objectives.

- **Principal Risks**

  Risks that threaten the achievement of the principal objectives of the Trust. These are managed through the Board Assurance Framework.

- **Risk**

  The likelihood of something happening that will have an impact upon objectives or an adverse outcome. It is measured in terms of likelihood and consequence.

- **Consequence**

  The potential adverse outcome(s) should the risk materialise.

- **Control Measure**

  Steps taken to minimise the risks associated with the area, activity or process being undertaken.

- **Corporate Risk Register**

  All risks which score above 15 or which are considered to have a Trust wide impact.

- **Escalation**

  The act of advancing an issue to a higher management level for resolution, action, or attention.

- **Likelihood**

  The degree of potential for the risk to materialise.

- **Residual Risk Score**

  The estimated achievable risk score when all actions are completed.

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- **Risk Appetite**

  The amount of risk that the Trust Board is prepared to tolerate or accept. This reflects the Trust values, policies, and objectives.

- **Risk Domain**

  Risk domains help classify risks based on potential consequences.

- **Live Risk**

  An identified risk that has been approved and is currently managed with further planned mitigating actions. Live risks will tend to have active impacts.

- **Accepted Risk**

  Risks which are below the residual (target) score where all reasonable actions have been carried out and the risk cannot be practically reduced any further or there are no further actions possible.

- **Closed Risk**

  A risk which is no longer relevant or covered by another risk can be defined as closed on the Datix Risk Management System. There may be risks that can be closed which have reoccurring theme (e.g. New intake of junior doctors). These risks should be given an annual review date to check on current status.

5. Ownership and Responsibilities

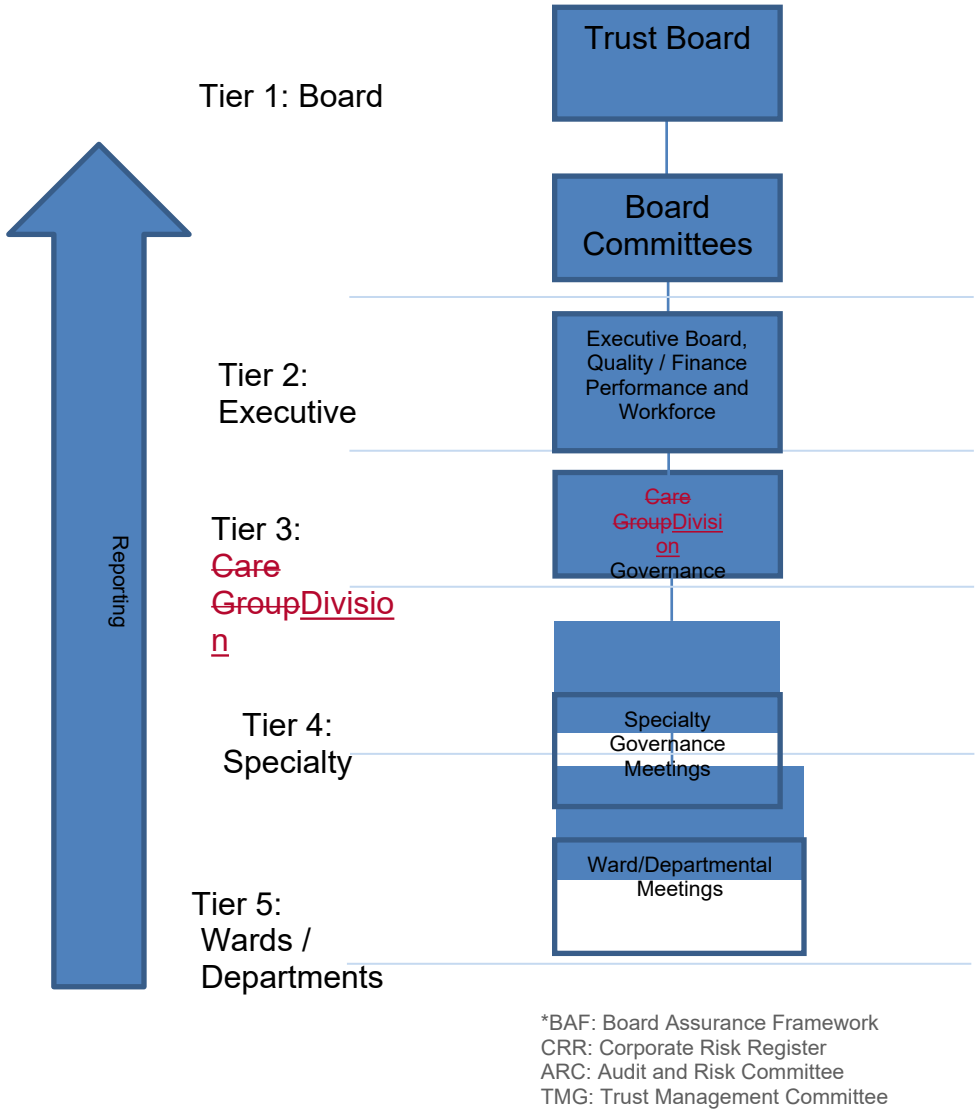
5.1. Governing levels of risk and responsibilities:

5.1.1. There are different levels (or 'tiers') of governing risk within the Trust: The document outlines these tiers and scores and how these factors dictate the process of risk review within the Trust.

Please see flow chart on next page

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Figure 1 Governing Levels and Reporting



* Some specialties may not hold Specialty Governance meetings as these take place at ~~Care Group~~Division level, it is important that all Specialty risks are reviewed ~~Care Group~~Division Governance meeting.

5.1.2. Within these tiers, there are various Committees responsible for the review and scrutiny of risk. The table below describes each of these Committees and their responsibilities as regard to risk:

Continued on next page

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Figure 2: Committees responsible for risk review and management.

Committee / Group	Tier	Frequency	Report Remit	Function	Purpose / Responsibility
Trust Board	1	Quarterly	Corporate risk register (all risks that are 15 and above).	Overall accountability for effective risk management.	To understand the nature and extent of risks facing the Trust. To establish principal strategic and corporate objectives and drive the organisation forward to achieve these. Monitor risks identified in the Board Assurance Framework that may prevent the Trust from achieving its objectives. To consider the extent and categories of risk which it regards as acceptable for the Trust to bear i.e. risk appetite. To weigh the likelihood of specific risks materialising. To identify the Trust's ability to reduce incidences occurring and reduce/eliminate the impact on the business. To direct the executive to act on risks that do materialise. To weigh the costs of operating particular controls relative to the benefits obtained in managing related risks i.e. cost/risk balance.
		Quarterly	Board Assurance Framework (all associated risks).	Agreeing strategic objectives and associated risks for inclusion in the Board Assurance Framework and reviewing the achievement against these objectives.	

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Committee/ Group	Tier	Frequency	Report Remit	Function	Purpose / Responsibility
Audit and Risk Assurance Committee	1	Quarterly	Corporate risk register (all risks that are 15 and above).	To seek assurance and review risks to ensure effective management of the Corporate risk register; Consider deep dives into the effectiveness of the risks management structure.	Maintain an overview of the Trust's risk management processes and responsibilities. Receive the Corporate risk register and undertake periodic deep dives on individual risks.
			Board Assurance Framework (All associated risks).	To seek assurance and review risks associated with the achievement of the strategic objectives.	Monitor and review the Board Assurance Framework.
					Review progress on assessing and managing major risks.
Executive Risk Group	1	Monthly	Candidate risks for Corporate Risk Register approval/removal. Corporate Risk Register (all risks that are 15 and above).	Approval of New Risks onto the Corporate Risk Register. Review recommendations made by ~~Care Group~~Divisions for inclusion onto the Corporate risk register. Approval of removal of risks from Corporate Risk Register.	To provide the operational management and monitoring of risk through the Corporate Risk Register. To agree new and closed risks onto the Corporate risk register. Scrutinise the accuracy / validity of risks that have been escalated. To agree action mitigation plans, ensuring their delivery. The group will review recommendations made by Board Committees for inclusion of additional risks to the Corporate Risk Register.

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Committee/ Group	Tier	Frequency	Report Remit	Function	Purpose / Responsibility
					Provide information and making recommendations to the Board on risk issues. Provide assurance that risks are being managed appropriately. Make recommendations where it considers any identified risk should be escalated to the Corporate Risk Register. Report any areas of significant concern to the Trust Board as appropriate.
~~Care Group~~Division Performance Review Meetings. **Relevant groups reporting into this group:** ~~Care Group~~Division Business and Governance Meetings	3	Monthly	High level risk (risk scores above 12).	Operational. To agree risks for escalation onto the CRR.	Challenge the validity of risk scores, action plans to mitigate risks. Ensure that risks are proportionate.

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Committee/ Group	Tier	Frequency	Report Remit	Function	Purpose / Responsibility
~~Care Group~~Division Boards **Relevant groups reporting into this group:** Specialty	3	Monthly*	All risks held in ~~Care Group~~Division via dashboard review (e.g. risks overdue for review/high level risks).	Operational. To agree de/escalation of risks from ward level to ~~Care Group~~Division. Provide exception report to Executive Board bi- monthly.	To ensure the appropriate governance arrangements are in place for safety, quality, and risk management. To ensure the identification and management of risk.

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Committee/ Group	Tier	Frequency	Report Remit	Function	Purpose / Responsibility
Governance meetings.					To agree accepted and closed risks. To identify risks for escalation and de- escalation.
Corporate services groups / forums / Speciality governance groups. **Relevant groups reporting into this group:** Corporate team/ departmental / Ward meetings.	4	Monthly*	All risks within the service domains (e.g. risk type) or Logged to the speciality area (e.g. risks that are logged below ~~Care Group~~Division Governing level).	Operational. To agree escalation risks from services to ~~Care Group~~Division Governance Board monthly.	To ensure the appropriate governance arrangements are in place for safety, quality, and risk management. To ensure the identification and management of risk. To agree accepted and closed risks. To identify risks for escalation and de- escalation.

*Frequency of meetings will vary by ~~Care Group~~Division

5.1.3. Each ~~Care Group~~Division and Corporate service is responsible for ensuring that adequate governance processes are in place. All risks on either the ~~care group~~Division risk register, corporate service groups or risks logged within the relevant service domain (such as medical device risks) must be reviewed as per the risk review frequency guidance. It is at these meetings that risks for appropriate escalation via the risk reporting tiers are agreed. Guidance on completing the risk register can be found in appendix 3.

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5.2. All staff

Risk management is the responsibility of all staff, irrespective of their level or job title, all staff must:

- Identify actual or potential hazards, issues or risks and escalating them to the appropriate manager.
- Raise concerns about any activity, practice or location that does not appear to have a satisfactory risk assessment.
- Attend, participate in, and comply with mandatory training as required by the Trust.
- Implement and adhere to the identified control measures to minimise the risks identified within risk assessments.

5.3. Board Members

All members of the Trust Board have a collective responsibility to ensure that systems and processes to ensure that risks are appropriately identified, robustly managed, and monitored through regularly regular assurance; summarised annually through the Annual Governance Statement.

Provide leadership on risk management and in particular:

- Determine the risk appetite for the Trust.
- Ensure the approach to risk management is consistently applied.
- Seek assurances that risks have been identified, assessed and all reasonable steps taken to manage them effectively and at sufficient pace.
- Endorse the Annual Governance Statement which assures the organisation has the necessary controls in place to manage its exposure to risk.
- Approve annually the Risk Management Strategy.
- Oversight on Principal Risks specific to their portfolio.
- Leading specific Committees responsible for the assurance of risk.

5.4. Chief Executive

On behalf of the Trust Board, the Chief Executive is the accountable officer with overall responsibility for risk management.

5.5. Chief Nursing Officer and ~~Director of Integrated Governance~~Director of Nursing, Midwifery and Allied Healthcare Professionals

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The Deputy Chief Executive / Chief Nursing Officer is ~~responsible~~accountable, via delegated authority from the Chief Executive via this policy, for the Trust's

overall approach to risk management and, in turn, delegates day-to-day responsibility to the ~~Director of Integrated Governance~~Director of Nursing, Midwifery and Allied Healthcare Professionals for:

- Risk management and is responsible for reporting to the Trust Board on the development and progress of Risk Management on behalf of the Deputy Chief Executive / Chief Nursing Officer and Chief Executive.
- Ensuring the Risk Management Strategy and Policy is implemented and evaluated effectively.
- Providing the Board with specialist advice and support regarding the risk management policy and processes.
- Ensuring relevant and focused training is provided to board members in risk management.
- Ensuring the Trust operates in accordance with statutory regulations, Trust Standing Orders and Standing Financial Instructions in relation to risk management.
- Ensuring the Risk Management Strategy and Policy is reviewed on an annual basis, and revised as appropriate.

5.6. Company Secretary

The Company Secretary is responsible for working with the ~~Director of Integrated Governance~~Director of Nursing, Midwifery and Allied Healthcare Professionals on implementation of the Trust's Risk Management Policy and processes and specifically for:

- Recording and maintaining the Board Assurance Framework including updating the risks, controls, sources of assurance and any gaps in control or assurance identified and reporting to the Trust Board and its Committees.
- Ensuring the Trust's risk appetite is reviewed at least annually, liaising with the ~~Director of Integrated Governance~~Director of Nursing, Midwifery and Allied Healthcare Professionals to combine this with annual risk training for the Trust Board

5.7. ~~Head of Patient Safety, Risk and Patient Experience~~Associate Director of Quality Governance

The Associate Director of Quality Governance~~Head of Patient Safety, Risk and Patient Experience~~ has responsibility for:

- Delivery of the Trust's Risk Management Strategy's Implementation Plan, providing expert advice as appropriate.
- Ensuring continuous development of a proactive risk management culture and practice throughout the organisation.
- Promoting and ensuring good risk and governance practices.

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- Developing and maintaining the Trust Risk Register.
- Providing practical risk advice, challenge, support, and training to staff across the Trust to ensure adoption of good risk management practice.
- Ensuring the effective operation of the Trust's electronic risk management system (Datix).
- Undertaking periodic risk analysis to identify trends in risk themes.
- Providing an annual programme of Risk Management training.
- Producing cyclical and ad hoc reports for the Trust Board, Committees, services, and corporate areas.

5.8. Risk Manager

The Risk Manager has responsibility for:

- Leading the development and operational delivery of the Trust's Risk Management Strategy.
- Providing expert advice and support in risk management in order to ensure the Trust:
  - Develops and coordinates a risk management structure
  - Utilises risk management processes in the clinical environment
- Providing expert advice / guidance on risk management issues to the Executive Team and all staff upon request at all levels of the organisation on existing and new legislation and directives of all risk management requirements showing negotiating skills as necessary.
- Providing expert advice for risk identification and assessment.
- Leading monthly ~~Care Group~~Division Risk Surgeries, providing advice and guidance as required and monitoring the completion of reviews and risk assessments in a timely manner.
- Leading and take full accountability for the development, implementation and monitoring of the Trusts Risk Policy and trust policies and procedures to ensure effective and efficient incident investigation and patient experience
- Including complaints management, ensuring these comply with national and local requirements and the corporate agenda.
- Leading the development of an environment and culture that improves the monitoring and management of clinical risk management.
- Planning and organisation of a broad range of complex risk management activities including the development of action plans which impact across departments.

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- Leading the implementation of Risk Management Strategies, monitoring, and facilitating the risk management work programme.
- Ensuring the Trust is able to meet current standards for risk management.
- Developing bespoke Risk Management Training for clinicians, managers, and employees, where appropriate identify and source key training providers.
- Acting as the module leader for risk management training courses. Plan and organise training courses in line with the strategic objectives of the organisation.

5.9. ~~Care Group~~Division / Corporate Governance Leads – In conjunction with Clinical Directors, General Managers and Heads Of Nursing

Have responsibility for:

- Providing specialist clinical safety and risk managements advice and support to managers within their ~~Care Group~~Divisions as required.
- Provide Guidance for those undertaking risk assessments and other local risk management functions.
- Acting as the link between their ~~Care Group~~Division and the corporate functions on risk management issues.
- Coordinating the generation of ~~Care Group~~Division risk registers and assist in the development of risk mitigation plans.
- Adding Identified risks to the Trust's Datix system completing the risk assessment, identification of the risk owner and securing ~~care group~~Division approval of the risk.
- Ensure that risks on service and ~~Care Group~~Division risk registers are appropriately articulated, scored and relevant
- Ensure that following risk review, risks are logged to the appropriate governing level and sits within the correct risk workflow (e.g. live risk, accepted risk, closed risk).
- Using the Trust's risk register system (Datix), ensuring risks are reviewed in a timely manner as per the risk workflow.
- Provide advice and guidance on which risks required escalation and de-escalation
- Promoting a culture where staff feel confident and supported in reporting risks, incidents, and issues.
- Agree / sign off individuals for access to Datix to add new risks

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5.10. Corporate/Specialty/Service/Ward/Department Management

Teams

These teams have responsibility for:

- Ensuring compliance with the overall risk management system and processes.
- Ensuring that all risks within their areas are managed appropriately with adequate controls.
- Ensuring the Risk Register is maintained and updated regularly through review at monthly Corporate services groups / forums.
- Ensuring that all relevant risks are reviewed and managed at Service governance meetings and discussed with the appropriate risk owner for review of risk scoring and management.
- Ensuring that risks which are proposed for closure or acceptance are reviewed and agreed at the appropriate committee / group and/or with the appropriate risk owner.
- Ensuring that staff have a clear understanding of the risks to their Service and at all times ensure compliance with policies/procedures and all relevant legislation.
- Ensuring that appropriate action mitigation plans are in place with clear predefined action plans that would be initiated should the risk materialise.
- Working in partnership with other Services and specialties to provide cross challenge of risk descriptions and scores.
- Making decisions on which risks required escalation and de-escalation.
- Fostering an environment where staff feel confident and supported in reporting risks, incidents, and issues.

5.11. Risk Owners

Risk owners should be the individuals best placed to take responsibility for mitigation of the risk. The risk owner will be agreed by the relevant manager. The identified risk owner is responsible for:

- Ensuring the risk is managed appropriately, controls are in place to mitigate the risk and an action plan is identified to address gaps in control measures.
- Reviewing the risk register on Datix at appropriate intervals to ensure the descriptor, controls and risk score accurately reflect the level of risk and that progress is being made at sufficient pace to reduce the risk score to the residual level.
- Liaising with action owners to ensure they are aware of their responsibilities for delivering actions.

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- Reporting on the overall status of the risk, escalating where appropriate in line with local risk procedure and the risk escalation process detailed in this policy.

5.12. Action Owners

Action owners have responsibility for:

- Ensuring the delivery of a task or activity by the appointed deadline that will address gaps in control measures.
- Providing regular reporting on progress.

6. Standards and Practice

6.1. Risk Identification

The identification of risks broadly falls into two categories: proactive and reactive identification. Risks may be identified proactively through local risk assessment, compliance with national standards or regulatory frameworks whereas the reactive process identifies risks from events that have already occurred such as incidents.

Figure 3: Risk Identification Methods.

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

6.2. Risk Assessment

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

6.2.2. In order to assess the risk, it is important to understand not only what is likely to go wrong but also how and why it may go wrong. Consider the activity within the context of the physical and emotional environment, and the culture of the organisation and the staff who perform the activity. Take into account things that have gone wrong in the past and near-miss incidents. Further guidance on risk assessment can be seen in appendix 3.

6.2.3. The risk matrix in appendix 3 must be used to score risks. Your risk should be scored on the potential consequences of the risk developing along with the likelihood of the risk materialising.

6.3. Risk Response and Management

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

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

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

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

- Target Implementation date
- Person responsible for implementing action
- How the action will be evidenced

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- Progress on completion of action

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

6.4. Risk Register

6.4.1. The Trust risk register is populated from risk assessments carried out proactively and reactively as a result of incidents, these are undertaken both at strategic and operational levels, which are recorded on the Trust's electronic risk management system (Datix). Where risks cannot be immediately resolved they will be added to this register.

6.4.2. A risk register is a living document, constantly being updated to demonstrate progress of risk reduction. It is a way of assisting with the prioritisation of actions in relation to the risks identified. It is also a tool to operationally manage the reduction and mitigation of risk and actively demonstrate that risks are being managed.

6.4.3. The aim of a risk register is to help the Trust:

- Identify all actual and potential hazards and their associated risks.
- Evaluate the level of existing controls in place to address the risk and track their progress.
- Quantify the risk according to its relative importance in terms of consequence of the risk and the likelihood of occurrence.
- The risk score will inform the escalation of risks.
- Decide the appropriate additional methods of control and risk treatment.
- Prioritise annual business plan objectives and associated planning.

6.4.4. Each level of the organisation (service, specialty, ward/department) must include all identified risks on the Trust Risk Register held on Datix to enable the Board to be assured that its system of internal control is effective in managing risk at all levels. Risks should not be held in other formats or on local risk registers. All risks should be held on Datix.

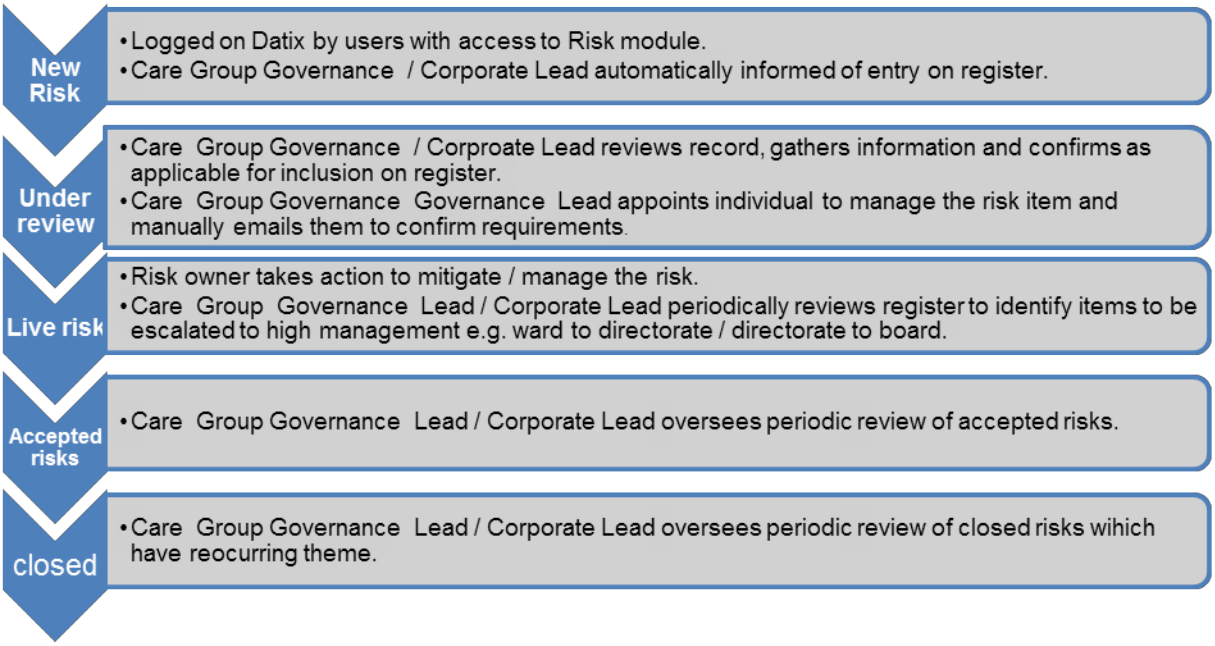
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6.4.5. Access to the Risk Register on Datix will be provided according to remit and role and will be agreed by ~~Care Group~~Division Governance Leads for clinical ~~Care Group~~Divisions/ Corporate Governance team for Corporate Services.

6.5. Datix Risk Register work flow

6.5.1. The Datix work flow from initial risk logging, management / mitigation and ultimately the closure or acceptance of the risk is summarised below:

Figure 4: Datix Risk work flow



6.5.2. There may be risks that impact on the organisation or are cross ~~care Group~~Divisions. It is recommended that a parent risk (or global) is identified and owned by the accountable service, however each impacted service should be informed of the risk so they can, in turn assess the applicability to their area (hotspots).

6.6. Approval Process for Candidate Risks for the Corporate Risk Register (CRR) see figure 5 below.

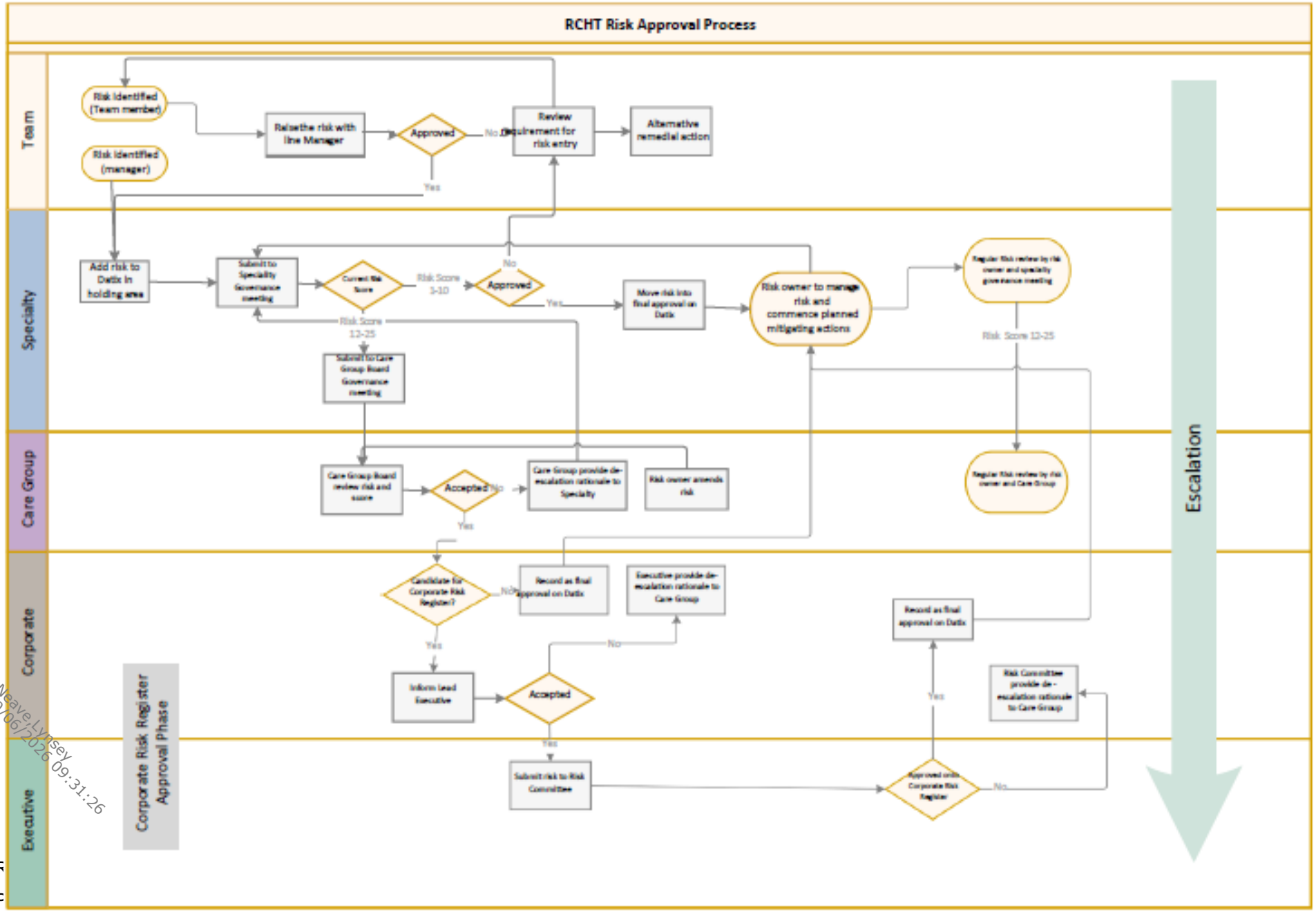
6.6.1. New Risks that would trigger onto the CRR (i.e. a risk rating of 15 or 12 with Trust - wide implications):

- The new risk should be accepted by the ~~Care Group~~Division through their Governance Board.
- The risk should then be discussed with the Executive Lead and accepted by them.
- The risk will then be presented to the Audit and Executive Risk Group for approval onto the CRR.

Please see flowchart on next page.

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Figure 5: CRR Approval Process



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6.7. Review and Escalation

6.7.1. Risk review

The Trust recognises that risk management should be embedded within all that the Trust does. The review of risk should be an on-going iterative process which is part of day-to-day work. As part of the assurance process the Trust requires that risks should be reviewed in accordance with the required review date by the risk owner in order to:

- Enable key controls to be reviewed for effectiveness.
- Identify at an early stage that the current risk score is increasing by monitoring key indicators within impacts/ effects.
- Implement action mitigation plans and additional action plans to be put in place if appropriate.
- Enable opportunity for escalation so that the Trust is aware of its risk profile and its total exposure to risk.
- Monitor implementation dates on action plans to assess if work planned is on target.
- Review risk score to determine whether a risk has been successfully reduced or requires a change in scoring.
- Monitor the overall ongoing progress towards risk reduction.

6.7.2. Frequency of risk reviews

Risks should be reviewed on a basis proportionate to the current risk rating. All risks should be reviewed by the risk owner and discussed at the appropriate governance meetings. The review should encompass the risk descriptor, scoring, action plan progress and updates.

Figure 5: Risk review frequency guide.

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

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Red/ extreme risks (risks that score 15 or above).	Monthly.

In addition, Risks should be further reviewed when there is a planned change; when there has been significant change to statutory duty, policy, procedure, or national/local guidance or when there has been a significant change in conditions for example (staffing, layout etc.).

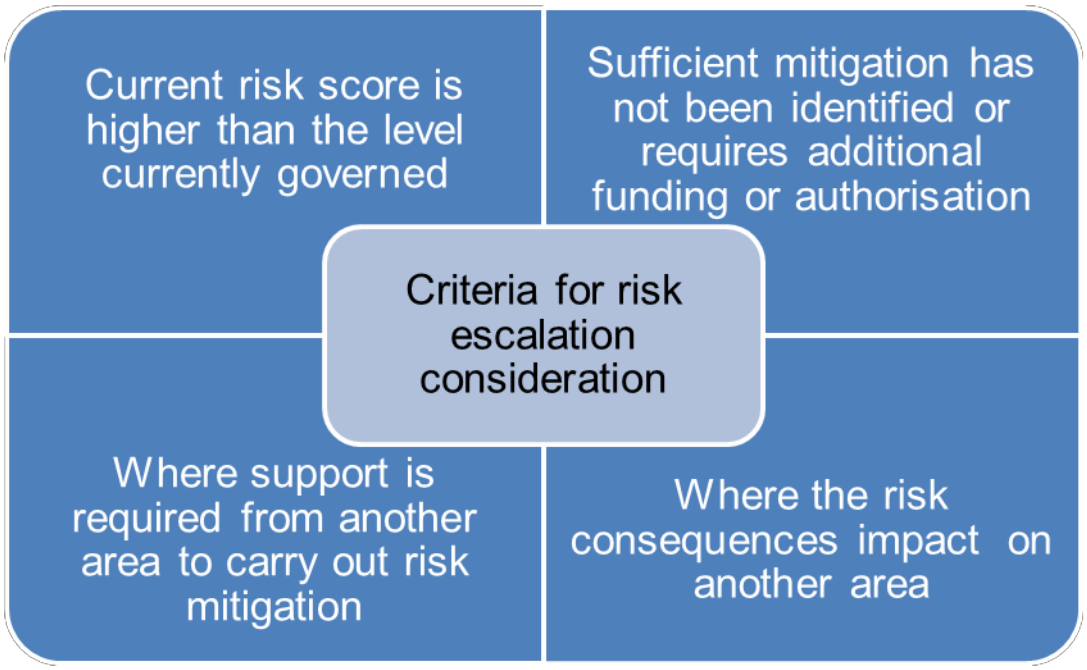
6.7.3. Risk Escalation and de-escalation of risks

The consequences of some risks, or the action needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from a Ward Risk Register to a ~~Care Group~~Division Risk Register. Risks will be escalated or de-escalated via the risk reporting tiers (figure 1) and risks will be reviewed at the appropriate committee with the authority to act for each level (as set out in figure 2). The diagram below sets out the flow of escalation:

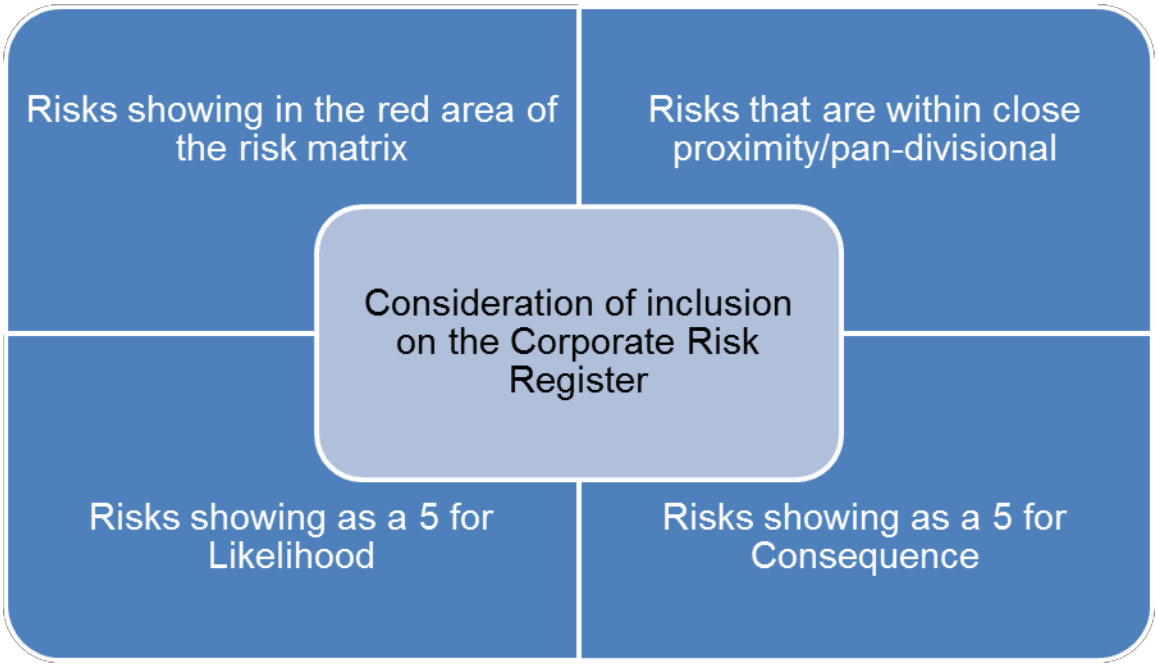


Following the implementation of all actions that are possible and practical, there may also be on occasion, the need to report a risk by escalating it to the next level of management as outlined in the risk reporting tiers (figure 1):

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Risks that fall into the areas outlined in the diagram below, need to be considered at the appropriate risk forum for escalation up the risk reporting tiers (figure 1) and via the appropriate committee (figure 2) for potential inclusion onto the corporate risk register:



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6.8. Risk Acceptance or Closure

6.8.1. Risks are accepted if the risk is below the residual score, where all reasonable actions have been carried out and the risk cannot be practically reduced any further. A clear rationale for accepting the risk should be added to the risk register entry on Datix. Risks which have been accepted should be reviewed by the relevant team on an annual basis (Figure 5: Risk review frequency guide).

6.8.2. Where risks have been agreed for removal from the Risk Register or are covered by an existing risk, the risk can be closed on Datix. All actions should be completed, and a date of closure should be included along with the rationale for closure of the risk. It is good practice to log on Datix the risk forum that agreed for the risk to be closed. Risks should not be closed if the score does not meet the residual score.

6.8.3. Risks which are closed but have a reoccurring theme, should be given a review date of one year later.

6.9. Board Assurance Framework (BAF)

6.9.1. The Board Assurance Framework identifies:

- The principal risks to achievement of the Trust's strategic objectives.
- The components of the system of internal control in place to manage the risk.
- The assurance sources on which the Trust Board rely on relating to the effectiveness of such controls.
- The RAG (red, amber, green) rating relating to the level of assurance available from the assurance sources.
- Records the actions taken to address identified gaps in control and assurance.
- Assurance about the effectiveness of those controls.

6.9.2. The Board assurance framework will be reviewed by the Board, with further scrutiny around risks controls and assurance being provided by the appropriate committee outlined in figure 2.

6.10. Risk Appetite

6.10.1. Risk appetite is 'the amount and type of risk that an organisation is willing to take in order to meet its strategic objectives.' No organisation can achieve its objectives without taking and accepting some risk. The level of risk the Trust is prepared to accept or be exposed to will vary according to the nature of the risk, the context within which the Trust is operating and regulatory or legislative constraints. The Board therefore needs to be prepared to take comparatively large risks in some areas and tolerate very little risk in other areas.

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6.10.2. The Trust's risk appetite statements have been written to cover several scenarios, setting out where the organisation may accept a greater tolerance of risk in certain situations. It is though not possible to set out all possible scenarios that might impact on risk appetite; as such it is expected that the Board, its committees, the executive team, and managers will actively consider the stated risk appetite e.g. for safe, high-quality care, and identify if or how a flexible risk tolerance needs to be applied in a unique circumstance. Any such deviation from the risk appetite as a result of situation not already covered below, should be formally recorded for transparency.

6.10.3. The Trust's risk appetite is mapped to the elements of its Board Assurance Framework, plus an additional, specific risk appetite statement on reputation. The current statement of risk appetite by risk type, including a guide to the level of risk that may be considered as tolerable, is summarised by the below table:

Category Number	Risk Type and Guide	Risk Appetite
1	**Safe and high-quality care** The Trust has a low tolerance for risk which compromises patient safety and jeopardises compliance with our statutory duties for quality and safety. In order to achieve safe, high-quality care, the Trust accepts that there may be times when a higher level of tolerance for patient safety must be accepted, particularly when under prolonged, significant operational pressure or staffing challenges over the short term. A higher tolerance for risk may also be accepted when supporting patients through clinical trials. When such occasions arise, management will support staff to work develop appropriate and safe care plans and/or dynamic risk assessments. The Trust has a medium appetite for risk related to innovations in new models of care designed to improve quality of care, subject to appropriate and managed risk assessments to protect patient safety. The Trust is prepared to accept managed risks to our compliance with performance standards where they relate to patient safety and quality improvements as long as patient safety, quality of care and effective outcomes are prioritised. However, we recognise there may be unprecedented operational challenges which may result in lower performance levels and unsustainable service delivery for periods of time; these would need to be reported to the Board or the relevant Committee via the Integrated Performance Report or other appropriate mechanism.	1 – Minimal 3 - Open

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Category Number	Risk Type and Guide	Risk Appetite
2	**Sustainable workforce** The Trust is committed to ensuring our staff feel valued and supported to do their jobs well as reflected in one of our core strategic objectives. The Trust has a low tolerance for risks related to workforce decisions where they would negatively impact staff wellbeing or staff safety but, given recognised workforce shortages, may accept a higher tolerance at times of significant, short-term operational pressure, subject to appropriate risk assessments of staff wellbeing/safety. The Trust has a medium tolerance for risks associated with the implementation of innovative new models of working / changes transformation in patient pathways and in the working arrangements of staff where these are expected to enhance or improve patient safety, quality of care, staff experience and wellbeing, workforce sustainability or service delivery.	1 to 2 – Minimal to cautious 3 - Open
3	**Integrated health services** The Trust is open to developing and maintaining partnerships with organisations that have an aligned set of values, enable us to promote and support safe, high-quality care, enhance the reputation and effectiveness of the NHS in the county, and maintain the required level of compliance with our statutory duties. The Trust values its partnerships within the county, wider region and nationally and is committed to pursuing the objectives of the Integrated Care System to improve the quality of care for patients. The Trust has a high tolerance for risks associated with research and innovation and partnership with academia in order to realise the provision of new models of care, new service delivery options, new technologies, efficiency gains and improvements in clinical practice. The Trust will only take such risks where it has the capacity to manage them and is confident there will be no adverse impact on the safety and quality of the services provided.	3 – Open (ICS partnerships) 4 – Seek (academic partnerships and research)
4	**Financial recovery** The Trust has a medium tolerance to risks to financial sustainability, acknowledging however the balance required to meet statutory financial duties, including the Trust's financial duties as part of the Cornwall and Isles of Scilly health system, and to mitigate risks to patient and staff safety, where such related investments are required. The Trust strives to deliver its services within the revenue	2 – Cautious

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Category Number	Risk Type and Guide	Risk Appetite
	budgets set out in our financial plans and will only consider accepting or taking financial risks where this is required to mitigate significant risks to workforce, patient safety or quality of care. The Trust will ensure that all such financial responses deliver optimal value for money. The Trust will prioritise on the basis of risk assessments its finite capital resources and have a low tolerance to breaching its duties in relation to meeting its capital resource limit. On that basis, the Trust will prioritise capital investments, on a risk assessed basis, that are required to meet or address statutory compliance/safety requirements, with business cases for quality-of-care improvements as the second tier of priority. Where the Trust can apply for external funding to pump prime or drive improvement and innovation opportunities, the Board will accept a medium tolerance, subject to any resultant oncosts to the Trust being sustainable from resultant savings or resource reallocation. The Trust has no tolerance for accepting or pursuing risks that would leave the organisation open to fraud or breaches of Standing Financial Instructions/Scheme of Delegation.	
5	**Digital infrastructure** The Trust has no tolerance to actions or decisions that may weaken the Trust's cyber security or that may threaten its critical digital infrastructure. The Trust has a medium tolerance for innovation risks relating to pursuing new technologies to enhance the quality of care and safety, accepting the possibility of failure in pursuing such innovations.	0 – Avoid (cyber security) 3 – Open (digital innovation)
6	**Physical infrastructure and supply chain** The Trust has a low tolerance for risks which may compromise health and safety of our staff, patients, and visitors to our sites. The Trust is committed to ensuring that our services are provided in buildings that are fit for purpose, are compliant with legislation and regulator expectations and do not represent a health and safety risk	2 - Cautious
7	**Reputation** The Trust aims to demonstrate its values by maintaining high standards of transparency, accountability, and professionalism at all times; in doing so, the Trust aims to protect the reputation of the organisation and the NHS. However, the Trust has a medium tolerance for risks related to reputation as sometimes, particularly when under	3 - Open

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Category Number	Risk Type and Guide	Risk Appetite
	significant operational pressure, decisions may need to be taken which might have a negative impact, such as restricted visiting or cancellation of elective activity. In such instances, the Trust will take a proactive approach to management of the Trust's reputation through clear communication and engagement with stakeholders/regulators.	

6.10.4. The Trust's risk appetite is reviewed at least annually by the Board via its Board Strategy and development sessions; any recommended amendments are taken through the Trust's formal governance structure for approval and enacted by a change to this policy.

6.10.5. Definitions:

- **Risk appetite:** The amount of risk that the Trust Board is prepared to tolerate or accept. This reflects the Trust values, policies, and objectives. Risk appetite is the aggregate level and types of risk that the Trust's executive management and Board is willing to assume within its risk capacity to achieve business objectives.

- **Risk tolerance:** Risk tolerance determines the maximum risk the Trust is willing to take for a particular activity / objective, or category of risk. It is subtly different to risk appetite in that it reflects the boundaries within which the executive management are willing to allow the true day-to-day risk profile of the organisation to fluctuate while they are executing strategic objectives in accordance with the board's strategy and risk appetite. It is the level of residual risk within which the board expects committees to operate and management to manage. Breaching the tolerance requires escalation to the board for consideration of the impact on other objectives, competing resources, and timescales.

6.10.6. Definitions for levels of risk appetite are set out in the below. These have been adopted from the Good Governance Institute's Risk Appetite for NHS Organisations Matrix

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Risk Levels (consequence)	
AVOID	Avoidance of risk and uncertainty is a key organisational objective ALARP (As little as reasonably possible)
MINIMAL	Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential
CAUTIOUS	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward
OPEN	Willing to consider all potential delivery options and choose while also providing an acceptable level of reward and Value for Money (VfM)
SEEK	Eager to be innovative and choose options offering potentially higher business rewards despite greater inherent risk
MATURE	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust

6.10.7. Definitions for risk tolerance. The Trust uses the National Patient Safety Agency (NPSA) risk matrix (likelihood by consequence) which is set out at Appendix 3 [of the policy]. In summary, they are:

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

The articulated risk tolerance within the risk appetite statements can therefore be used to determine whether the actual risk scores are higher or lower than the tolerance; this would inform any escalations to other governance bodies in the Trust as required.

7. Project risks

7.1 Project risks are risks that are related to the completion or success of a project and are identified prior to or during a project. They are usually transient (short lived) and the impact is confined to the project. They are not normally considered for inclusion onto Datix as they do not meet the significance threshold.

7.2 Responsibility for risks relating to a particular project are held by the project team and accountability is held by the Senior Responsible Officer (SRO) with oversight provided by the project or programme board on behalf of the executive and the Trust Board.

7.3 Project teams and managers will record, review and update the risk register on behalf of the SRO and project or programme board.

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7.4 Third party project registers may be recorded using any pre-approved system (smartsheets etc.) and must still meet the minimum standards for quality and consistently as set out by industry approved standards, or the required NHS guidance.

7.5 Risks arising from the project which have an impact on the wider Trust or which may outlive the project term may be escalated via the project or programme board onto the Trusts risk register and must be recorded and scored according to the standards set in this policy. Further guidance provided in Appendix 3.

7.6 Where risks meet the criteria for inclusion onto the Corporate Risk Register, the SRO must ensure that the correct process is followed for escalation.

~~7.~~8. Dissemination and Implementation

7.1. Following Board approval, this document is disseminated to staff via the management structure. Staff will be notified via the Daily Bulletin when the policy is made available on the Document Library: They will be made aware of its contents during relevant risk management training during Induction and in line with the Training Needs Analysis as outlined in the RCHT Core Training Policy.

7.2. General “risk management” awareness training will be included in the Trust Induction package. Risk management and assessment refresher training will be available in the Trust’s training programme.

7.3. Specific risk management training will be delivered for senior managers according to need. The provision and arrangements for training will be reviewed and revised as necessary.

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~~8.~~9. Monitoring compliance and effectiveness

The Trust's risk management arrangements will be subject to an annual audit on their effectiveness, which will be reported to the Audit and Risk Assurance Committee.

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Risk Management Strategy.
Lead	~~Director of Integrated Governance~~Director of Nursing, Midwifery and Allied Healthcare Professionals.
Tool	Annual Internal audit of risk management arrangements monitored as part of the ongoing audit process on a Word or Excel template specific to the topic.
Frequency	Annual.
Reporting arrangements	Audit and Risk Committee will receive the results of the internal audit.
Acting on recommendations and Lead(s)	Integrated Governance / Risk and Compliance Team.
Change in practice and lessons to be shared	Audit and Risk Committee will receive the results of the internal audit.

~~9.~~10. Updating and Review

The Risk Management Strategy will be reviewed on an annual basis and updated.

~~10.~~11. Equality and Diversity

~~10.1~~11.1 This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

~~10.2~~11.2 Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

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Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Risk Assessment and Management Strategy and Policy V10.10
This document replaces (exact title of previous version):	Risk Assessment and Management Strategy and Policy V10.09.3
Date Issued/Approved:	6 April(TBC) 20263
Date Valid From:	June 20263
Date Valid To:	June 20276
Directorate / Department responsible (author/owner):	Bernadette George, Director of Integrated GovernanceDirector of Nursing, Midwifery and Allied Healthcare Professionals Liz Trew, Head of Safety, Risk and Patient ExperienceJill Tozer, Associate Director of Quality and Governance
Contact details:	01872 258578
Brief summary of contents:	Policy outlines the Risk Management Strategy for the organisation
Suggested Keywords:	Working environment - Occupational health and safety - Preventive measures - Accident prevention - Safety measures - Hazards - Risks - Assessment - Management - Risk management - Risk assessment
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Nursing Officer
Approval route for consultation and ratification:	Audit and Risk Assurance Committee Care Trust Board of Directors
General Manager confirming approval processes:	Not applicable

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Information Category	Detailed Information
Name of Governance Lead confirming approval by specialty and ~~care group~~Division management meetings:	Samantha Chalmers, Risk Manager
Links to key external standards:	Care Quality Commission
Related Documents:	• Incident and Serious Incident Reporting policy • Health and Safety General policy • Complaints and Compliments policy • Fire Safety Policy • Statutory and Mandatory Training Policy • ISO 31000:2015 Risk Management Principles and Guidelines • NPSA (2004) Seven Steps to Patient Safety. NPSA Risk Assessment Programme Overview (2006)
Training Need Identified?	Yes
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Chief Executive / Corporate Governance

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
26.08.04	V1	Final amendments approved; EIA Completed; document published	Chris Iremonger Governance Manager
15.02.07	V1.1	Full review required; updates on coversheet and in body of policy regarding processes	Debby Blease Deputy Director of Nursing
4.10.08	V2	Annual review required, updates on coversheet and in body of policy regarding processes	Debby Blease Deputy Director of Nursing

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Date	Version Number	Summary of Changes	Changes Made by
01.07.09	V3	Annual review required; updates on coversheet and in body of policy regarding processes	Debby Blease Deputy Director of Nursing
06.09.10	V4	Full annual review and consultation	Teresa Anderson Risk and Complaints
07.03.12	V5	Full annual review and consultation	Teresa Anderson Risk and Complaints
09.11.12	V5.2	Training and Education section added.	Joan Shirley Risk Co-ordinator
30.05.14	V6.1	Full annual review and consultation	Joan Shirley Risk Management Specialist
14.11.16	V7	Combined Risk Assessment Policy with Risk Management Strategy	Ceri Evans Risk Manager
07.06.18	V8	Full review and consultation. Update of risk governing levels, escalation processes and review frequencies	Thomas Lafferty Director of Corporate Affairs
26.11.19	V9	Full review and consultation aligned to new ~~care group~~Division structure and committee infrastructure	Bernadette George, Director of Integrated Governance
02.07.20	V9.1	Review of risk appetite and strategic pledges due to Covid-19	Samantha Chalmers Risk Manager
03.11.22	V9.2	Update to responsible officer for the Board Assurance Framework	Sian Millard, Company Secretary
11.04.23	V9.3	Updated section 6.10 to reflect new risk appetite statements.	Sian Millard, Company Secretary
25.04.23	V10.0	Minor amendments to correct spellings, update service line to care group and for clarity.	Samantha Chalmers, Risk Manager
11.05.2026	V10.1	Updates to represent organisational changes to Divisional structure Addition of project risk element following Internal Audit recommendations Correction of scoring matrix and consequence guidance	Samantha Chalmers, Risk Manager

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Date	Version Number	Summary of Changes	Changes Made by
17.06.2026	V10.2	Corrections ncluding typographical erros identified at Audit and Risk Assurance Committee	Samantha Chalmers, Risk Manager

All or part of this document can be released under the Freedom of Information Act 2000

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

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Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Risk Assessment and Management Strategy and Policy V10.0
Directorate and service area:	Corporate, Integrated Governance
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Samantha Chalmers
Contact details:	01872 253033

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	The Strategy sets out the key aims and objectives for the identification, assessment, management assurance of risks in the Royal Cornwall Hospitals NHS Trust.
2. Policy Objectives	To set out the Risk Management Strategy of the Trust in order to achieve the Trust's strategic aims and objectives.
3. Policy Intended Outcomes	To provide a consistent approach to risk management and mitigation within the Trust.
4. How will you measure each outcome?	Risks managed effectively.
5. Who is intended to benefit from the policy?	All patients, staff, and visitors to the Trust

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Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Chief Executive Chief Nursing Officer ~~Director of Integrated Governance~~Director of Nursing, Midwifery and Allied Healthcare Professionals Audit and Risk Assurance Committee Trust Board of Directors
6c. What was the outcome of the consultation?	Approval of the amendments to the Policy
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact
Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Sex (male or female)	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff

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Protected Characteristic	(Yes or No)	Rationale
Race	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Religion or belief	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Marriage and civil partnership	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Pregnancy and maternity	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	There is an equity risk domain which ensures that risks pertaining to equality are identified and reviewed by the appropriate staff

A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Samantha Chalmers, Risk Manager.

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

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Appendix 3. Instructions for Scoring Risks

To calculate the risk placement on the matrix, it is necessary to consider both the consequence of it is happening and the likelihood of the risk happening.

The Trust uses the National Patient Safety Agency (NPSA) risk matrix which is set out below:

Table 1 – Risk Matrix for Risk Managers

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

	Likelihood				
Consequence	1	2	3	4	5
	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

NPSA. 2008.Risk Matrix for Risk Managers.

For example, if you assess a risk as moderate consequence with a possible likelihood, the overall risk would sit at X on the above table, i.e. moderate consequence (3) and possible likelihood (3):

Consequence and Likelihood

The consequence of a risk and the likelihood of that consequence occurring is always a question of judgement.

Table 2 – Likelihood guide

Consequence is the term given to the resulting loss, injury, disadvantage or gain if a risk

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

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materialises. When considering how severe the consequence would be of the risk, consider the likely of this consequence to occur.

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http://webarchive.nationalarchives.gov.uk/20171030130225/http://www.nrls.npsa.nhs.uk/resources/?entryid45=59833andq=0%c2%acrisk%c2%acandp=1

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Table 3 - Consequence Guidance

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	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training/key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage	Incident leading >25 per cent over project budget Schedule slippage

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Descriptor
Staff/ Patient/ Visitor Injury (Physical/ Psychological)
Equipment

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~~**Patient Experience**~~
~~**Environmental Impact**~~

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	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment No time off work required	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	Moderate injury requiring professional intervention Requiring time off work for 4–14 days Increase in length of hospital stay by 4–15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/ disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service sub-optimal Informal complaint/inquiry	Overall treatment or service sub-optimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Incident leading to totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/ staffing/competence	Short-term low staffing level that temporarily reduces service quality (<1 day)	Low staffing level that reduces service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attendance for mandatory/key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training/key training on an ongoing basis
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Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage	Incident leading >25 per cent over project budget Schedule slippage

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~~Competence~~
~~Complaints/Claims~~

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~~Financial~~
~~Objectives/Projects~~

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~~**Business/ Service Interruption**~~
~~**Inspection/ Statutory Duty**~~

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~~Adverse Publicity / Reputation~~
~~Fire Safety~~ ~~/ General Security~~

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~~Information Governance/ IT Security/ Cyber~~

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w = minor treatment is defined as first aid, additional therapy, and additional medication. It does not include any re admission into hospital, any extra time as an outpatient or continued treatment over and above the treatment already planned.

x = moderate increase in treatment is defined as a return to surgery, an un-planned re-admission, a prolonged episode of care, extra time as an outpatient, cancelling of treatment or transfer into hospital as a result of the incident

y = Permanent harm directly related to the incident and not the natural course of the patients illness or underlying condition is defined as permanent lessening or bodily functions, sensory, motor, physiologic or intellectual

z = The death must relate to the incident rather than to the natural course of that patients illness or underlying condition

Risk scoring = Likelihood x consequence (L x C)

	Likelihood				
Consequence score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

Score	**Risk**
1 - 3	Low risk
4 - 6	Moderate risk
8 - 12	High risk
15 - 25	Extreme risk

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http://webarchive.nationalarchives.gov.uk/20171030130225/http://www.nrls.npsa.nhs.uk/resources/?entr yid45=59833andq=0%c2%acrisk%c2%acandp=1

Alex Lynsey
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Meeting: Trust Board In Public

Date of Meeting: 02 July 2026

Item Number: 19

Title of Report: Patient Property Policy

Executive Director Lead: Bernadette George, Acting Chief Nurse

Author and Job Title: Jayne Martin, Head of Patient Services

Email Address: jayne.martin4@nhs.net

Purpose of the Report:

Decision ☒ **Discussion** ☐ **Assurance** ☐ **Information** ☐

The purpose of this report is to agree the Trust's Patient Property Policy and note the Policy's role in meeting the Trust's legal duty under regulations to provide a safe and secure environment for care and safe custody of patient's property.

Consultation:

This review invited feedback from Executive Leadership Team, Head of Patient Experience, Patient Information, General Office and Mortuary Services. The updated policy was endorsed for approval at the June Quality Assurance Committee meeting.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☒ **People** ☐

Reputational ☒ **Legal / Regulatory** ☒

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?	x			
Quality Impact		x		

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Assessment completed?				
Data Protection Impact Assessment completed?		x		

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	This policy includes provisions for patients who may lack the capacity to make decisions regarding the safekeeping of their property. It also recognises and respects the needs of patients who wish to retain items of personal or religious significance; such items will be managed in accordance with the same procedures applied to all patient property. In addition, the policy outlines the processes for managing lost property and sets out the procedures for handling the property of deceased patients.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The purpose of this policy is to ensure that a safe and secure care environment is maintained, where the risk of loss or damage to patient property is minimised. It also ensures that risks associated with the handling of patient property, including cash and valuables, are appropriately managed through robust procedures and controls.
Sustainable and efficient use of NHS resources by RCHT	The policy aims to minimise the risk of loss of patient property, including cash and valuables, by ensuring appropriate arrangements are in place for the safe custody of such items. This approach supports a reduction in the incidence of claims made under the Trust's Losses and Special Payments Policy.

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Recommendations:

The Board **is recommended to:**

- **Approve** the Patient Property Policy.

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1. Situation / Executive Summary

NHS organisations have a legal duty under regulations to provide a safe and secure environment for care as set out in the NHS Constitution. The Health and Social Care Act 2008 (Regulated Activities) Regulation 2010 make specific references to the protection of patient property. Regulation 11 says that providers “must make suitable arrangements to ensure that service users are safeguarded against the risk of abuse” and includes “theft, misuse or misappropriation of money or property” within the relevant meaning of “abuse”.

This paper invites the Committee to recommend a re-approval of the Patient Property policy noting the purpose of the policy.

2. Background

The Royal Cornwall Hospitals Trust has an obligation to provide secure facilities for patients’ property and valuables which are handed to the Trust for safekeeping along with the safekeeping of property of unconscious, confused or deceased patients.

The policy has been developed to ensure that there is a framework in place which provides guidance on the collection, custody, recording, safekeeping, return and disposal of patients’ property.

The safe custody of patients’ personal property and valuables is an important part of patient care, and every effort must be made, at all times, to protect the interests of the patient and the Trust.

The policy has been revised following Executive Leadership Team feedback to strengthen section 6.12 relating to illegal items and care groups amended to divisions.

3. Assessment

Following a comprehensive revision undertaken three years ago, it is confirmed that the policy remains current and compliant with relevant national guidance, including Department of Health guidance on the secure management of patients’ property and the requirements of the Health and Social Care Act 2008 (Regulated Activities) Regulations. The arrangements for the management of NHS patient property continue to be robust and fit for purpose, and no amendments are required at this time.

Trust-wide safety briefings were delivered in June 2024 to reinforce and embed the requirements of the Patient Property Policy. These briefings aimed to raise staff awareness of their responsibilities in relation to the safe handling, recording, and storage of patient property, including cash and valuables, and to support consistent application of the policy across all services.

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4. Risk

The risks associated with the management of NHS patient property, primarily loss, damage, or misappropriation of patient belongings remain unchanged and are

adequately mitigated through existing controls. These include established procedures for the secure handling, recording, storage, and return of patient property, in line with Department of Health guidance and statutory requirements under the Health and Social Care Act 2008. Ongoing adherence to this policy continues to minimise the risk of financial loss, distress to patients and relatives, and reputational impact to the organisation, while ensuring compliance with Care Quality Commission standards regarding the safeguarding of patient property.

Such losses and/or damage may be subject to ex-gratia claim via the Trust's Losses and Special Payments policy, with the Trust liable for losses and associated financial risk.

5. Accountability

Operational responsibility sits with service leads, clinical matrons, and ward/department managers, who must ensure that staff adhere to the procedures for the safe handling, recording, storage, and return of patient belongings. All staff involved in the management of patient property are individually accountable for complying with this policy and associated procedures. Failure to do so may result in investigation in line with Trust policies and could lead to disciplinary action.

Directors, senior managers, and clinical leaders are responsible for implementation within their areas and for ensuring that staff are appropriately trained and supported. All staff have a responsibility to act in accordance with this policy and relevant procedures. Compliance will be monitored through established governance and assurance mechanisms, including audit and incident reporting processes.

6. Recommendations

The Board is recommended to:

- **Approve** the Patient Property.

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Royal Cornwall Hospitals
NHS Trust

Patient Property Policy

V11.0

June 2026

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Summary

NHS organisations have a legal duty under regulations to provide a safe and secure environment for care. This is set out in Quality Standards for healthcare providers that are overseen by the Care Quality Commission. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 makes specific references to the protection of patient's property.

The safe custody of patient's property, valuables and cash is a service the Trust must provide to protect the interests of patients, staff, and the Trust.

This document sets out the Royal Cornwall Hospitals NHS Trust's policy for the safe keeping of patient property. It provides a robust framework to ensure a consistent approach across the whole organisation and supports statutory duties as set out in the NHS constitution.

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Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

Steve Lukey
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1. Introduction

1.1. This document sets out the Royal Cornwall Hospitals NHS Trust policy and procedures for the management and safekeeping of patient property. It provides a robust framework to ensure a consistent approach across the whole organisation, supporting statutory duties.

1.2. The safe custody of patients' personal property and valuables is an important part of patient care, and every effort must be made, at all times, to protect the interests of the patient and the Trust.

1.3. The Royal Cornwall Hospitals Trust has an obligation to provide secure facilities for patients' property and cash and valuables which are handed to the Trust for safekeeping, together with the safekeeping of property for unconscious, confused or deceased patients.

1.4. The Trust does not accept liability for any property brought onto the Trust's premises unless it is handed in for safekeeping. Disclaimers must be displayed prominently in all patient areas, but this does not remove the Trust's duty of care to take reasonable steps to ensure the safety of patients' property.

1.5. This version supersedes any previous versions of this document and supersedes the "Secure Management of Deceased Patient Property during the Covid-19 pandemic" policy.

2. Purpose of this Policy/Procedure

2.1. Providing a safe and secure environment for care is a legal duty under the regulations which underpin the quality standards for healthcare providers overseen by the Care Quality Commission (CQC). The Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 make specific references to the protection of patient's property. Regulation 11 says that providers "must make suitable arrangements to ensure that service users are safeguarded against the risk of "abuse" and includes "theft, misuse or misappropriation of money or property" within the relevant meaning of "abuse".

2.2. The purpose of this policy is to ensure adherence to best practice and to effectively manage patient property taken by the Trust into safekeeping. The Trust has a responsibility to provide safe custody for any items handed in by patients for safe keeping, or where items are found to be in the possession of patients admitted to hospital, who are unconscious, confused, lack capacity or who subsequently die whilst in hospital.

2.3. The Trust attaches high importance to the safekeeping of patients' cash, valuables, and personal property. The intention of this policy is to ensure that:

2.3.1. The risks associated with the handling of cash, valuables and property are managed appropriately.

2.3.2. A care environment is provided where the risk of loss or damage to patients' property is minimised.

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2.3.3. Staff have a procedure that ensures transparency in dealing with valuables, that ensures both patients and staff are safeguarded.

2.3.4. Handling practices are described, and incidents are reported.

3. Scope

3.1. This policy applies to all individuals employed by the Trust including students, locum and bank/agency staff, contractors, volunteers, and staff employed on honorary contracts who are involved in Trust business on Trust premises.

3.2. This policy applies to all areas of the Royal Cornwall Hospitals NHS Trust in which NHS care is provided and to all clinical settings managed by the Trust.

4. Definitions / Glossary

4.1. Valuables. The term ‘valuables’ refers to any item of value and may include but is not limited to the following: cash, cheques, foreign currency, jewellery, rings, watches, keys, mobile phones, computer equipment, iPads, laptops, formal documents including driving licence, passport, financial documents including bank books, saving certificates, certificates of any kind, credit/debit cards etc.

4.2. “Cash” refers to any coins and or notes of any currency irrespective of their country of origin belonging to a patient.

4.3. “Patient Property” refers to general items such as clothing or toiletries other than cash and valuables but may also include items such as ‘personal aids’ e.g., dentures, hearing aids, spectacles, and walking aids which if lost can cause considerable inconvenience and distress to patients.

4.4. “Deposited Property” refers to property which the Trust takes into its care for safekeeping, e.g. cash and valuables either following an explicit agreement with the patient or because the patient is incapacitated or otherwise unable to look after it.

4.5. “Undeposited Property” refers to property which patients retain with them on the Trust’s premises.

4.6. “Handling” of cash, valuables and/or patient property means accepting, transferring, and disposing of such items.

4.7. Cash and Valuable Bags. Cash and Valuables Bags are issued by the General Office to secure cash and valuables handed in for safe keeping. Each bag has a unique tracking system.

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5. Ownership and Responsibilities

5.1. Role of Chief Executive

The Chief Executive has overall responsibility for the provision of a safe and secure environment for patients and their property whilst on Trust premises.

5.2. Role of Chief Nursing Officer

The Chief Nursing Officer is responsible for ensuring that the Patient Property Policy is appropriately disseminated and will ensure that systems are in place to monitor compliance with the policy.

5.3. Role of Director Of Nursing , Midwifery and Allied Health Care Professionals

The Director of Nursing, Midwifery and Allied Health Care Professionals has responsibility for ensuring that the Trust has a robust written process regarding the management of patients' property and for ensuring that all staff in clinical areas are aware of and follow the correct process.

5.4. Role of Chief Finance Officer

The Chief Finance Officer has responsibility for implementing the Trust's financial policies including those relating to patients' monies and other property.

5.5. Role of Head of Security

The Head of Security has responsibility for security management within the Trust and to support the security team in their role so they can fulfill their duties and meet statutory requirements The Head of Security will work with key colleagues to promote the secure management of patients' property and effectively respond to incidents and security breaches relating to patient property.

5.6. Role of Divisions/Service Managers

Divisions/Service Managers are responsible for ensuring that all wards/departments and staff within the Division are aware of and implement this policy; to monitor overall compliance and where there are deficiencies of concern in delivery, these are investigated and reported via Divisional Governance Boards.

5.7. Role of Local Counter Fraud Specialist

The Local Counter Fraud Specialist can investigate suspected fraud where there is reason to think that a patient has falsely claimed compensation for lost property. The Local Counter Fraud Specialist will not normally investigate complaints of theft where fraud is not suspected.

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5.8. Role Of Clinical Matrons/Ward Leaders/Nurse/Midwife In Charge of the Ward

Matrons have responsibility for investigating and reporting any instances of loss. Ward Leaders are responsible for informing staff, on appointment, of their responsibilities and duties for the administration of patients' property. They are also responsible for ensuring this policy, and all other relevant policies and procedures are implemented in the Department, Ward, or Unit. Deceased patient belongings should be handed back to the family if present. If the family is not present, then the belongings should be safely stored on the ward for later collection by the family.

5.9. Role of Nursing staff

Nursing staff are responsible for ensuring that patients are aware that the Trust does not accept liability for lost property, that valuables should be handed in for safekeeping and all other non-essential property sent home and adhering to the procedures within this policy for managing patients' property and valuables.

5.10. Role of Security Personnel

Security Personnel should be adequately trained and made aware of security practices and procedures in relation to patient property, including cash and valuables and care and custody of lost property**.**

5.11. Role of Anyone Who Has Responsibility for Staff

Anyone who has responsibility for staff has responsibility for ensuring that:

5.11.1. All staff have access to this policy and associated procedural documents.

5.11.2. All staff adhere to and implement this policy and associated procedural documents.

5.11.3. The appropriate staff, equipment and stationery are available to enable this policy to be followed.

5.11.4. Staff have the necessary training to enable them to implement this policy.

5.12. Role of All Other Staff Involved in the Handling of Patient Cash, Valuables, and Property

All other staff involved in the handling of patient cash, valuables and property are required to:

5.12.1. Familiarise themselves with all relevant Trust policies and procedures referred to within this document. Adherence to the procedures within this policy.

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5.12.2. Uphold security arrangements, thus enabling the Trust to meet its obligations around maintaining a safe and secure environment for patient care.

5.12.3. Comply with financial procedures and ensure propriety in all their activities.

5.13. Role of General Office/Patient Services Assistants

General Office and Patient Services Assistants are responsible for ensuring the safekeeping of “Deposited Property”, its correct documentation upon receipt and the administration of the cash and valuables system, as well as the administration functions in respect of ex gratia claims for lost patient property in line with the Trust’s Losses and Special Payments Policy.

5.14. Role of General Office Supervisor

The General Office Supervisor will ensure that the Patient Services Assistants are fully trained in their specific duties associated with the Patient Property Policy. The General Office Supervisor will co-ordinate and administer requests for ex-gratia payments in respect of lost and damaged property and maintain appropriate records of ex-gratia claims authorised to the Finance department for payment in line with the Trust’s Losses and Special Payments Policy.

5.15. Role of Head of Patient Services

The Head of Patient Services is responsible for ensuring that appropriate central storage is provided for the safekeeping of “Deposited Property” into the care of the Trust and for ensuring that the Patient Services Assistants based in the General Office are complying with the Patient Property Policy.

5.16. Role of Bereavement Office

The Bereavement Office is responsible for adherence with the procedures as set out in the Care After Death Policy (V3), including arrangements for Public Health funerals. The Mortuary and Bereavement Deceased Care Record is attached at Appendix 8 which is completed at a ward level and accompanies the deceased to the mortuary.

5.17. Role of Linen Room

The Linen Room is responsible for receiving and holding items of found clothing until they are claimed by the patient or their representative or disposed of in accordance with national and local guidelines for the disposal of such items.

5.18. Role of Patient Experience Team

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Patient Experience will support patients who may have cause to raise a concern in relation to the safekeeping of their property and will work together with all areas to improve patient experience when concerns are shared. The team will process complaints regarding lost property, where complainants are not satisfied that the appropriate investigations have taken place.

6. Standards and Practice

6.1. All pre-admission information given to patients must include information on the Trust's property disclaimer (Appendix 3) and advise them not to bring valuables and non-essential items into hospital. All patients should be advised that the Trust does not accept liability for loss or damage to patients' property unless it is handed in for safe keeping.

6.1.1 Every patient admitted must be informed of the Trust property disclaimer and advised to send home with a relative or friend any cash and valuables or other property which is not needed whilst in hospital or, if not sent home, to hand in valuables for safe keeping. On admission to hospital the Patient Property Disclaimer Form (CHA4461) (Appendix 4) must be completed. Any cash and valuables must follow the cash and valuables process and be deposited with the General Office for safe keeping in line with section 6.6. In respect of Elective Day Case Admissions, Form (CHA3609) must be completed. Specialty specific Perioperative Documentation Packs must also be completed where appropriate. If a patient declines to hand any valuables in for safekeeping this must be documented.

6.2. The Trust Property Disclaimer for display (Appendix 3) will be displayed in prominent areas in wards/departments. This disclaimer also applies to belongings required in daily life, such as dentures, spectacles, and hearing aids.

6.3. Upon admission, all patients must be strongly advised to send home with a relative or friend all property and/or cash and valuables that are not required whilst in hospital. If this is not possible the cash and valuables procedure must be followed.

6.4. The Trust will not accept liability in respect of any loss or damage to patients' property and belongings unless they have been handed over to a member of staff for safekeeping. When property is handed over for safe keeping this should be recorded in the patient record, with cash and valuables deposited into General Office in accordance with the cash and valuables procedure.

6.5. Patients Who Lack Capacity

The Trust has a responsibility to provide safe custody for any items handed in by patients for safekeeping, or where items are found to be in the possession of patients admitted to hospital, who are unconscious, confused, lack capacity, or who subsequently die whilst in hospital.

6.5.1. Where a patient lacks capacity (confused, lacks capacity or severely incapacitated for any other reason*)* to make a decision about their property, staff may have to make *a* decision in their best interests. Where a patient is unable to take responsibility for their own property but has not given it up for safekeeping, the Trust becomes an "involuntary bailee" and is obliged to take care that items are not lost. This may apply in the case of emergency admission of unconscious patients or the transfer of patients to theatre for example.

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6.5.2. The most common action staff should consider taking in relation to a patient's property when the patient lacks capacity, is to take the property and place it into safekeeping, thus meeting the Trust's obligations and duty of care. Before doing so, staff should consider whether there is anyone with authority to make decisions on behalf of the patient, either Lasting Power of Attorney (POA) or a deputy associated by the Court of Protection who manages the affairs of someone who does not have the capacity to make decisions about their own affairs.

6.5.3. Staff should bear in mind that even where a patient is assessed as lacking capacity to make a decision, they should be involved as fully as possible in the decision. For example, when deciding which of a patient's belongings to remove from their bedside, every effort should be made to consider their wishes and feelings in this regard.

6.5.4. In situations where a patient lacks capacity to make decisions about their affairs and who have been admitted with valuable items and/or cash, these items must be deposited into central storage using the cash and valuables system, with two members of staff assuming responsibility for depositing the items on behalf of the patient.

6.6. Cash and Valuables System – Deposited Property

The Trust provides a secure central storage facility for the safe keeping of patients' cash and valuables. This is provided by the General Office. The Patient Services Assistants based in the General Office can provide advice and guidance to ward and departments on the process associated with depositing patient property for safe keeping. The General Office has a cash and valuables safe used solely for this purpose.

6.7. Cash and Valuable Bags

6.7.1. In circumstances where a patient is unable to send valuable items and cash home with family members or it is decided that it is in the best interests of the patient for these items to be deposited for safe keeping, a "cash and valuables" bag must be obtained from the General Office for depositing the patient property into central storage. Cash and valuables bags are issued by General Office to all wards upon request. Patient property is placed into the bags by ward staff and returned to the general office for safe keeping until the patient is discharged. Two members of staff must record the valuables, ideally in the presence of the patient.

6.7.2. Each cash and valuables bag has a uniquely numbered seal, together with uniquely matching documentation. A white card to which a patient label is affixed and inserted into the address window of the bag, an orange receipt card, which is retained by the patient for the items deposited into central storage, and an orange numbered label corresponding to the bag that must be inserted into the patient's hospital notes/episodic folder/temporary folder indicating that items have been placed into central storage.

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6.7.3. Terms such as “gold” and “silver” must not be used when describing items of jewellery. Descriptions such as “yellow material” or “white metal” must be used instead. Stones in rings or other jewellery must not be described as “diamond” or “ruby” etc. instead the term “white stone” or “red stone” must be used. For example: yellow metal ring with 3 white stones.

6.7.4. Patients must be advised that any cash over £1,000 will be banked and returned to them via BACS.

6.7.5. In circumstances where the patient does not have the capacity to make a decision about looking after their valuables, and it is decided that it is in their best interests to use the cash and valuables system, two members of staff must witness the items placed inside the bag, and sign the white card, which is placed in the window of the bag.

6.7.6. The Patient Services Assistants will not accept cash and/or valuable bags where the seal on the bag has been damaged, removed, or lost. It is the responsibility of the ward staff depositing the property with General Office to ensure the seals on the bags are intact.

6.7.7. During office hours (Monday to Friday 0830-1630) cash and valuable bags must be taken to the General Office and deposited with the Patient Services Assistants. The uniquely numbered seal will be entered on the Patient Property Database, (CAVE) with the bags stored in the patient valuables safe in the General Office.

6.7.8. It is the responsibility of the ward staff to co-ordinate the return of cash and valuables held in central storage in the General Office to the patient or the patient’s representative.

6.7.9. On discharge or at the patients’ request the cash and valuables bag will be returned upon presentation of the signed orange card and a check by two Patient Services Assistants that all seal numbers correspond. Two members of General Office staff must be always present, and both verify the seal numbers correspond. The seal number and details are entered onto the CAVE database and a receipt printed. If a member of staff is collecting the bag on behalf of a patient the receipt must be dated and signed. Upon receipt of the bag the patient will break the seal and unzip the bag. Once the patient has removed their valuables from the cash and valuables bag, the white card must be signed to confirm receipt.

6.7.10. If the patient is incapacitated, property will be returned to their representative, or an appropriate member of staff should collect it on behalf of the patient. The Patient Services Assistants will retrieve the property from the safe and check that all seal numbers correspond. This must be completed in the presence of the patients’ representative or staff member. The representative or staff member will sign for receipt of the property and be issued with a receipt. If they refuse to sign, then two members of staff must document who has been given what property and why. Other than when a patient is incapacitated, staff should not hand over property to anyone other than the patient without the patient’s written consent. The return of cash will require a separate signature for its return. All information will be recorded on CAVE.

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6.7.11. Once the property is returned to the ward, staff must ask the patient or their representative to check the contents and documents and confirm that the property has been returned to them in good order.

6.7.12. Patients should be advised that there is no facility for withdrawing cash and/or valuables from the General Office out of hours.

6.7.13. Depositing cash and valuables out of hours must be undertaken by two members of staff, one of which must be from the Trust's Security team. The two members of staff will assume responsibility for depositing the items on behalf of the patient, signing, and printing their names on the deposit form held in General Office.

6.7.14. The contents of the cash and valuables safe will be checked routinely each month (as a minimum) by the Patient Services Assistants in General Office. It is the ward's responsibility to check if any property is held in the cash and valuables safe before a patient is discharged.

6.8. Elective Admissions

6.8.1. On admission to hospital every patient must be informed of the Trust property disclaimer and advised to send home with a relative or friend any cash and valuables or other property which is not needed whilst in hospital or, if not sent home, to hand in valuables for safe keeping. On admission to hospital the Patient Property Disclaimer CHA4461 (Appendix 4) must be completed for all patients. Any cash and valuables must follow the cash and valuables process and be deposited with the General Office for safekeeping in line with section 6.6. In respect of Elective Day Case admissions Form (CHA3609) must be completed. Specialty specific Perioperative Documentation Packs must also be completed where appropriate. If a patient declines to hand any valuables in for safekeeping this must be documented.

6.8.2. Patients must be advised that any cash over £1,000 will be banked and returned to them via BACS. Should a patient not have a bank account then this must be escalated to the Head of Patient Services.

6.8.3. Terms such as "gold" and "silver" must not be used when describing items of jewellery. Descriptions such as "yellow material" or "white metal" must be used instead. Stones in rings or other jewellery must not be described as "diamond" or "ruby" etc. instead the term "white stone" or "red stone" must be used. For example: yellow metal ring with 3 white stones.

6.8.4. When a patient is wearing rings which are loose and they wish to keep them on their hand, tape should be applied to reduce the risk of rings falling off and being lost.

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6.8.6. Pink Property Trays. All admitting areas have pink property trays available to hand out to patients for keeping small personal items such as glasses, teeth etc. These trays must be labelled with the correct patient sticker and move through the hospital with the patient. Once the patient has been discharged trays must be cleaned and returned to the admitting areas to ensure stock is being refreshed for new patients coming into hospital.

6.9. Outpatient Attendances

Patients attending outpatient appointments should be advised that they should not bring valuable items or large amounts of cash with them when attending hospital.

6.10. Emergency Admissions

Where a patient is admitted as an emergency admission, all personal items of property must be recorded. Special attention must be given to personal items that a patient needs to keep with them e.g., spectacles, hearing aids and dentures. The items retained by the patient should be recorded on the Patient Property Disclaimer CHA4461(Appendix 4) and detailed records kept and maintained of actions taken in respect of patient property to enable a full audit trail to be maintained during a patients stay.

6.11. Police Requests for Property

In cases where the police request to seize property recorded as a valuable item, property must not be automatically handed over. The requested property must be secured and held at General Office. Staff should provide assurances that the item(s) will be held securely in the General Office until the Police formally approach the Trust to request the release. This process is managed by the Trust's Head of Information Governance and all enquiries must be directed through them.

6.12. Illegal Items

Patients must not bring illegal or prohibited items onto Trust premises. Such items include, but are not limited to, firearms, offensive weapons (including locking knives, or knives with blades exceeding 3.5 inches, as defined under the Criminal Justice Act 1988 and Offensive Weapons Act 2019), and suspected illicit substances as controlled under the Misuse of Drugs Act 1971 and associated regulations.

Where any such items are identified, patients will be required to surrender them to Trust staff for secure storage in accordance with Trust procedures, pending appropriate disposal or transfer to the relevant authorities. The Trust will manage such items in line with its Controlled Drugs Standard Operating Procedure, local security policies, and statutory obligations.

Any refusal to comply with this request will be treated as a serious matter and may result in the immediate involvement of the police. The Trust reserves the right to take all necessary action and proportionate actions, in line with the Health and Safety at Work Act 1974 and NHS security management requirements, to ensure the safety and security of patients, staff and visitors.

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6.13. Movement of Patient Property

Ward/clinical staff are responsible for ensuring that all patients' valuables and/or property taken for safekeeping by the Trust is returned to the patient on their transfer between the hospital sites, out of the Trust or on discharge. When a patient is transferred to a different ward or area within the hospital, the patient's property must be discussed and documented in the handover between the transferring unit and the receiving unit as a matter of routine and documented accordingly.

6.14. Inter Hospital and Care Home Transfers.

6.14.1. An Inter Healthcare Transfer of Care form (CHA4158) (Appendix 5) should be completed for every patient. The healthcare professional must record items of property bought in at the time of admission and ensure these are recorded on the Patient Property Disclaimer (Appendix 4).

6.14.2. In circumstances where an inter hospital and care home transfer is made, staff on the transferring ward must ensure that all items documented are transferred to the new location in an appropriate manner. The staff at the receiving hospital/care home must verify that all items transferred with the patient match the items recorded on the form.

6.14.3. If items of patient property are missing, the receiving area must notify the transferring ward immediately, so that a search for these items may be conducted. Details of the missing items must be recorded.

6.14.4. Where items of patient property have been lost or damaged, the General Office must be informed of the date and time of the loss, the ward reporting the loss and patient level details. The loss must be recorded on datix by the ward. This will ensure the prompt handling of a claim for loss or damage should the need arise.

6.14.5. If the patient has deposited cash and valuables into central storage, and the patient is transferred to a different NHS organisation, their deposited property must be withdrawn from the General Office. It is important to ensure that the transferring ward makes arrangements for this with the General Office in good time, so that the property can be handed over to staff in the receiving organisation (which may be via a patient transport service) at the time of transfer.

6.14.6. Patient Transport Transfers**.** In circumstances where a patient is fit for discharge and the Trust's contracted transport provider is used to take the patient to another hospital or care home, the discharging ward will ensure that all patient property is placed in an appropriate container and sent with the patient on discharge. Arrangements must be made, prior to the discharge from hospital, for any cash and/or valuables that are placed into central storage are collected from the General Office in *a*ccordance with the cash and valuables procedure as set out in section 6.6.

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6.15. **Deceased Patients.**

6.15.1. The patient and their Next Of Kin (NOK) should be afforded the greatest respect, maintaining privacy, dignity, and confidentiality at all times. This policy sits alongside the Trust's Care After Death Policy (V3).

6.15.2. When a patient dies the Trust has a duty to look after their property until such time as it can be handed over to the appropriate person(s).

6.15.3. The Trust owes a duty of care to the deceased patient that any money or property (e.g. house keys) is handed to the correct relatives. If the Trust were to release cash, valuables, or property to the incorrect representative, the Trust may have to make good anything made over to the incorrect person.

6.15.4. The nurse in charge of the patient's care will inform the family as soon as possible after death. In instances of sudden unexpected death, the NOK details should be identified via the patient notes. Deceased patient clothing, aids/belongings remain the responsibility of the ward for safekeeping and for their safe return to the deceased patient's NOK or representatives by the nursing staff on the ward at the time of death. If the family is not present, then the belongings should be stored on the ward for later collection by the NOK/family. It is the responsibility of the ward to return all non-cash and valuables to the deceased's relatives/representatives.

6.15.5. Soiled clothing should ideally be disposed of with the families' consent by the ward/clinical area as they can become an infection risk if stored for many days before collection by relatives. Any clothing disposed of must be documented in the patient's records/nursing notes.

6.15.6. All cash and valuables, which have not already been handed over to the Trust for safekeeping, must be deposited with the General Office following the cash and valuables procedure at section 6.7 and in line with infection prevention and control measures. Any valuables such as bank cards and mobile phones, must be wiped down with disinfectant wipes, allowed to dry, prior to returning to the family, or placing in an RCHT cash and valuables bag. Two members of staff must record the items and write their names and sign for the items being deposited. Out of hours please refer to section 6.7.13.

6.15.7. All items must be individually itemised. The blanket term "valuables" must not be used.

6.15.8. All jewellery should be removed, in the presence of another member of staff and handed back to the family if present and documented in the nursing notes together with details of who received the property. If the family is not present all jewellery should be dealt with in accordance with the cash and valuables section of this policy at 6.6 and deposited with the General Office. Jewellery must not be described as 'gold', 'silver', or 'diamond' etc with the terms, yellow metal', 'white metal' or 'white stones' being used instead.

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6.15.9. If it is not clear that appropriate relatives are present (for example where there is a dispute between relatives as to who should take the property) then the property must be taken into the hospital's safekeeping as described in section 6.7.

6.15.10. If it is not possible to remove all jewellery, or the family insist on the jewellery remaining on the deceased, it should be taped in place and recorded on the deceased care record (Appendix 8) and signed by two members of staff.

6.15.11. If any hazardous items are discovered, they must be made safe (e.g. with the use of a sharps container) and bagged as usual.

6.15.12. If in taking into custody patients' property, any offensive weapons or other items are found that are reasonably believed could cause serious harm to others, the Head of Security and the Police must be informed.

6.15.13. It is the responsibility of the ward staff to notify the General Office as soon as possible upon the death of a patient for whom cash and valuables are being held in safekeeping. Details must include the deceased patient's name, date of birth, and their address, together with the full name, contact number of the NOK and their relation to the patient and what they believe the possessions to be. The NOK should be advised to email the General Office with the above details to arrange a mutually convenient collection time.

6.15.14. The Patient Services Assistants will make every effort to ensure that retained cash and valuables are returned to the NOK. This will include a NOK check on PAS together with liaison with the Trust's Bereavement Service to confirm NOK details, funeral directors, details of property held on the mortuary form, securing the orange card and make the necessary arrangements for the collection of cash and valuables via the completion of a claim and indemnity form together with proof of responsibility as detailed below at 6.15.15. The claim and indemnity form must be signed and witnessed by two Patient Service Assistants. Banked monies are returned to the NOK by BACS payable to the estate of the deceased.

6.15.15. Where cash and valuables are held by the Trust, the patient's representative must supply evidence that they have a responsibility for the deceased patient's affairs. This may include a sealed Grant of Probate, or in the case of a person leaving no will, a Letter of Administration. The representative will also be asked to bring proof of identification e.g. driving licence or passport.

6.15.16. In the event that staff are unsure whether the person requesting the return of the patient's property is entitled to do so, the items must be retained by the Trust in safekeeping pending further enquiries. They will be held until the necessary evidence is received or a legal third-party decision, for example a Court Order, is produced to allow safe release of high value items. This must be fully documented in the patient notes with a full list of the items held documented.

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6.15.17. Upon presentation to the General Office, the cash and valuables bag will be removed from the safe and the seal number entered on the CAVE database together with the returned to details and a receipt printed.

6.15.18. The patient representative will be taken to a private space to open to the bag with two members of General Office staff. Once the possessions have been removed from the cash and valuables bag the white card will be signed and the claim and indemnity form to confirm receipt. The white card and receipt will then be stored within General Office.

6.15.19. In some cases, funeral directors will be instructed to collect the cash and valuables on the family's behalf.

6.15.20. In rare circumstances where this is not possible, and every effort has been made to identify the patient's legal representative, the property will be treated as unclaimed and processed in accordance with paragraph 6.20.3 of this policy.

6.15.21. Patient's medication will be labelled as deceased and returned to Pharmacy.

6.15.22. The Bereavement staff will refer all requests for a Public Health Funeral to Cornwall Council who will be the point of contact for Public Health funded funerals and liaise with the General Office where there is no NOK, or the NOK hand over responsibility for funeral arrangements to the Trust to ensure any cash and valuables held by the Trust are identified.

6.16. **Lost Property**

Lost property is defined as property which cannot immediately be identified as belonging to a particular individual.

6.16.1. If items of property are found Clinical Staff must make reasonable effort to reunite the lost property with the patient.

6.16.2. If the property is identified as belonging to a patient, then the ward/clinical area staff are responsible for making sure that the property is taken to the patient (if they are still an inpatient at the Trust) or that patient is contacted to arrange collection).

6.16.3. If the owner of the property cannot be identified: Cash and Valuables should be sent to the General Office for processing as lost property. Non-valuable property should be retained on the ward/clinical area for one month and then if uncollected disposed of.

6.16.4. If a patient informs a member of staff that they have lost something, the staff must make reasonable effort to find the lost property and immediately inform the ward leader/head of department. If the property is not located, the staff must give the patient the details of General Office/Patient Experience and complete an incident report on Datix. Staff must be aware and are responsible for ensuring that the patient is aware, that the recording of a loss of a patient's belongings on Datix, does not constitute a claim for reimbursement.

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6.16.5. All lost property handed to the General Office is logged on the lost property database and given a reference number. A check is also made to see if an enquiry has already been made regarding the loss.

6.16.6. Any member of staff or the public finding an item of lost property on Trust premises is encouraged to hand it into the General Office.

6.16.7. When an enquiry is made to the General Office for lost property that has not been handed in, the enquiry (with name and contact details) will be logged on the database. The enquirer will be contacted if the property is subsequently handed in, to arrange collection.

6.16.8. Valuable lost property is stored in the General Office for six months. Non valuable lost property is stored for three months and then disposed of.

6.16.9. After six months valuable items are collected and sold at auction. Monies raised are paid into Trust Charitable Funds. Any valuable items that may contain data must be securely disposed of via CITS.

6.16.10. Property left behind on a ward after a patient's discharge does not fall into the category of lost property. Ward staff should contact the patient concerned and ask them to arrange for the property to be collected from the ward. If the patient declines or fails to remove the property within the agreed timescale, then any items of possible value e.g. spectacles should be taken to the General Office and clothing to the Linen Room.

6.16.11. **Loss of Property in circumstances considered suspicious.**

6.16.11.1. All staff have a responsibility to report any loss of property in suspicious circumstances to the Trust's Head of Security.

6.16.11.2. All such reports to the Trust's Head of Security must be followed via an incident report logged on Datix.

6.17. Claims for Lost Property.

6.17.1. The Trust does not accept liability for property not handed in for safekeeping. However, in certain circumstances the Trust has a duty of care and may feel it appropriate to reimburse a patient for lost property. For example, a patient going from a ward to a theatre would reasonably expect to be reimbursed if their hearing aids were removed and lost. The Trust's Losses and Special Payments policy sets out the procedure for ex-gratia payments. All claims are managed by the General Office in line with the Losses and Special Payments policy. If the Trust has accepted property into safekeeping, and loses that property, the patient will be entitled to make a claim for reimbursement.

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6.17.2. Where monetary reimbursement is offered and accepted, the Trust will arrange payment of the reimbursement amount only on the production of

a valid receipt by the patient or someone acting on their behalf confirming the purchase of replacement item(s). Payments will be made via BACS. Quotations, invoices, or receipts should be attached to all claims and the Trust will consider each case on its merits. Where a patient chooses not to replace the lost items or is unable to produce a receipt the claim will be declined.

6.17.3. Dentures will normally be reimbursed only at NHS rates, unless it can be shown that there is an acceptable reason for the use of a private dentist.

6.17.4. There is no emergency inpatient dental service provided at the Trust. In circumstances where a patient is exempt from NHS Treatment Charges, ward staff should complete a Special Care Dentistry Referral Proforma, (Appendix 6) and email this to the Referral Management Service. The Referral Management Service will send the referral to the Community Dental Service where the referral will be triaged by a Special Care Dentist. This referral route can also be used for those patients without an NHS or private dentist.

6.17.5. The Special Care Dentist will contact the patient or their family and advise on the most appropriate treatment route for the replacement of their dentures, this may include onward referral to a dentist or the arrangement of a domiciliary visit to the patient.

6.17.6. Where a patient would normally pay for dental treatment, they should be encouraged to contact their NHS or private dental practice to arrange treatment. The patient must obtain a receipt for their treatment so that if the Trust after investigation, accepts the loss, reimbursement can be made to the patient in line with the receipt presented for treatment.

6.18. Lost Property following the death of a patient.

6.18.1. The Trust recognises the distress caused to patients' relatives when valuable or sentimental items of patient property go missing following bereavement. In circumstances where a relative reports cash and/or valuables as missing the loss will be reported in line with the Losses and Special Payments policy.

6.18.2. The relative or patient representative making the claim must supply evidence that they have a responsibility for the deceased patient's affairs. This may include a sealed Grant of Probate, or in the case of a person leaving no will, a Letter of Administration.

6.18.3. If following investigation, the loss of the reported item is upheld, an ex-gratia payment will be made to the estate of the deceased via BACS transfer.

6.18.4. Where items belonging to a deceased patient are not required to be replaced e.g., spectacles, dentures, hearing aids, clothing, no payment will be made to the estate of the deceased.

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6.19. Exceptional cases e.g. Hardship

In exceptional cases, if the patient, or anyone acting on their behalf, is financially unable to purchase a replacement item, to the offered upper limit without prospective (as opposed to retrospective) monetary reimbursement from the Trust, the Trust will use its discretion and consider if it is just, equitable, and practical to provide the offered reimbursement by alternative means, such as paying the vendor directly. In the event that such an alternative method of reimbursement is offered, the alternative must meet the standards set out the in the Trust's Losses and Special Payments Policy. However, no reliance is to be placed by the patient or anyone acting on their behalf that the Trust will be able to offer an alternative means of prospective reimbursement.

6.20. Disposal of lost and unclaimed property

6.20.1. All attempts will be made to reunite property with the rightful owner. Additional checks of the Patient Administration System will be made, together with supplementary checks against the Summary Care Record to identify if a patient has moved address. Where a new address is identified a recorded delivery letter will be sent to the patient detailing the items held, requesting collection in person with a copy of said recorded delivery letter and photographic proof of identify and proof of address e.g. council tax bill. If there is no response a further recorded delivery letter will be sent within 4 weeks from the date of the first letter.

6.20.2. If the patient is deceased every effort will be made to contact the NOK and identify the executors of the estate, liaising with the Bereavement Service as appropriate.

6.20.3. If there is no response to a second letter, a third and final letter will be sent via recorded delivery making it clear that the item will be disposed of if no response is received. Once the item has exceeded six months in storage, without response to three letters, the appropriate arrangements will be made for its disposal.

6.20.4. Lost debit/credit cards will be destroyed within three working days. Numbers must not be documented in full. General Office staff will record the type of card (Visa, Credit, Access, etc) and the last four numbers only, expiry date and the name on card. (Staff ID badges will be returned immediately to the Staff ID badge office).

6.20.5. Any cash handed in to the General Office as lost property is retained in the cash and valuables safe for one month. If unclaimed after one month, the monies are banked to Lost Property/Surplus Monies 10080/Income Miscellaneous Trustwide. If claimed after the monies have been banked, the monies can be paid from petty cash and a reversal actioned accordingly. If the monies are not claimed after six months, they must be transferred across to Charitable Funds requiring a journal entry liaising with the finance department.

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6.20.6. If the unclaimed property is already held in a cash and valuables bag and remains uncollected after the three reminder letters have been sent the deposited property bag will be opened by two members of staff from the General Office Team and witnessed by the General Office Supervisor or another senior manager.

6.20.7. All items will be documented on the Trust's Cash and Valuables system (CAVE) against the bag number originally deposited with the General Office.

6.20.8. Where a bag contains jewellery, watches, or other such items as detailed description as possible will be made on CAVE using descriptions such as "yellow metal ring with blue stone" or "white metal bracelet with three white stones". No valuation of jewellery will be made by the General Office staff. As soon as the items are documented the valuables will be placed back in the safe awaiting disposal by means of sale/auction.

6.20.9. Where a bag contains cash, the cash will be recorded on CAVE and banked to Charitable Funds. The sum of money will be entered onto the General Office System of Transactions (GOST).

6.20.10. If property is not claimed within six months, after date of discharge or death and three letters have seen sent, it will be disposed of as follows:

- Items of jewellery and other possible valuables will be examined and valued by a local auction house, identified by Procurement. Anything identified as having a resale value of more than £100 will be kept for a further year and every effort make to find the owner. Anything with a resale value of less than £100, or valuables that have not been claimed after the eighteen-month period will be sold by the auction house as appropriate with the financial proceeds returned to the Trust's charitable funds.

- Spectacles will be donated to an appropriate charity.

- Mobile phones, laptops, tablets, ipads etc. will be referred to Cornwall IT Services (CITS) so that wherever possible the item can be returned to the rightful owner, but where this is unsuccessful the item will be disposed of by CITS through their operational process for the disposal of such equipment.

- Keys will be returned to Estates for safe disposal.

- Dentures will be placed in normal waste for disposal.

- Hearing Aids return to Audiology.

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7. Dissemination and Implementation

7.1. A copy of this policy will be stored electronically in the Clinical Policy Section of the Trust's Document Library on the intranet/internet site.

7.2. A copy of this policy will be circulated to all staff to enable them to participate in and support the implementation of this policy.

7.3. A clear communication will be sent to Senior Managers and Senior Nursing staff and Midwifery Staff to make them aware that a revised policy has been issued and that they are responsible for cascading the information to staff members they are responsible for including those who do not have regular access to email.

7.4. Information to promote awareness of the new policy will also be included in the Trust's One and All user communication which is circulated to all staff.

8. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	A six-monthly report of losses and special payments presented to Audit Committee. Breaches of the policy will be monitored through incident reporting and complaints at a Divisional level. Safe contents will be checked and reconciled on a weekly basis by the General Office Supervisor. A six-monthly review of compliance with the weekly safe checking will be undertaken by the Trust's Security Officer.
Lead	Head of Patient Services
Tool	Ex gratia spreadsheet held by General Office. Payment audit reports held by Finance. Incident reporting via Datix. Cash and valuables checklist.
Frequency	Bi-annual report of losses and special payments to Audit Committee. Quarterly Divisional Governance Monitoring. Weekly cash and valuables safe reconciliation.
Reporting arrangements	Audit Committee. To receive the biannual ex-gratia report, identify deficiencies in the system and act upon them. Divisional Governance Boards to receive reports related to losses recorded on Datix, identify deficiencies in the system and act upon them.

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Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Head of Patient Services and General Office Supervisor to undertake bi-annual audits and feedback to Divisional Governance Boards together with identified themes and recommendations for action where appropriate.
Change in practice and lessons to be shared	Head of Patient Services via Divisional Governance Boards and Patient Experience Group.

9. Updating and Review

This policy will be reviewed three years from the date of issue. It may be required to review prior to that date if patient safety reports/patient experience identify areas for concern or if relevant additional national statutory guidance is published.

10. Equality and Diversity

10.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

10.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

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Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Patient Property Policy V11.0
This document replaces (exact title of previous version):	Patient Property Policy V10.1
Date Issued/Approved:	25 June 2026
Date Valid From:	July 2026
Date Valid To:	July 2029
Directorate / Department responsible (author/owner):	Jayne Martin, Head of Patient Services
Contact details:	01872 252515
Brief summary of contents:	This policy aims to effectively manage patients' property by providing clear procedures and guidance for recording patient property and taking patient property into safe keeping.
Suggested Keywords:	Property, cash, valuables, lost property, bereavement.
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Nursing Officer
Approval route for consultation and ratification:	Divisional Governance Board Executive Leadership Team Quality Assurance Committee. Trust Board.
General Manager confirming approval processes:	Richard Andrzejuk, Clinical Support Division
Name of Governance Lead confirming approval by specialty and divisional management meetings:	Michelle Reed, Divisional Governance Manager, Clinical Support Division

Not to be used after 30/06/2029 09:31:26

Information Category	Detailed Information
Links to key external standards:	Care Quality Commission. Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 (Regulation 11).
Related Documents:	Losses and Special Payments Policy. Care After Death Policy. Policy on Principles for Remedy. Security Policy. Medicines Management Policy.
Training Need Identified?	Yes, refresher training via Matrons, Ward Leaders to disseminate to all ward staff. Learning and Development department to be informed.
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Patient Administration

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
Not known	V1.0 to V8.0	Previous details not known	Not known
July 2013	V8.1	Patient's Property Policy	Judy Rowe, Site Services Manager
July 2016	V8.2	Complete re-write in draft form to reflect Trust responsibilities under the Health and Social Care Act 2008 and NHS Protect Guidance	Kevin Bolt, Payments, and Contracts Manager
December 2016	V8.3	Version 8.2 amended following discussions with Jayne Martin, Head of Patient Services, and input from representatives of the Nursing and Governance Collaborative	Kevin Bolt, Payments, and Contracts Manager
December 2016	V8.4	Inclusion of paragraph 10.4. Inclusion of new Appendices 3, 4, 7 and 8. Minor typographical changes	Kevin Bolt, Payments, and Contracts Manager

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Date	Version Number	Summary of Changes	Changes Made by
February 2017	V8.5	Incorporating advice from Paul Dixon, Security Management Specialist additional wording in section 7.3.	Kevin Bolt, Payments, and Contracts Manager
15 February 2017	V8.6	Incorporating comments from Lorna Watt, Legal Services additional paragraph in section 7.3 regarding patients wishing to retain items against hospital advice	Kevin Bolt, Payments, and contracts Manager
21 October 2019	V9.0	Review and update of current policy to reflect regulatory body changes – e.g. NHS Protect now NHS Counter fraud Authority. NHS Litigation Authority now NHS Resolution. Additional new Section 6.6 – Procedure for Disposal of unclaimed patient valuable items.	Kevin Bolt, Payments, and Contracts Manager
August 2023	V10.0	Updated role of Counter Fraud Specialist and General Office Supervisor Role. Removal of references to MITIE. Updated role of Bereavement Office. Nursing documentation and associated forms updated. Introduction of sections in relation to police requests and illegal items. Introduction of arrangements for cash over £1,000 bought onto hospital premises. Disclaimer notice reviewed and updated.	Jayne Martin, Head of Patient Services
May 2024	V10.1	Removal of reference to CHA3831 – Initial Care Nursing Record Update to Trust Disclaimer poster (Appendix 3) Addition at paragraph 6.15.16. If at any stage there is doubt as to the patient representative's entitlement to the property, items must be retained in safe custody pending further enquiries. CHA4461 – Patient Property Disclaimer Form (Appendix 4) proof copy updated to	Jayne Martin, Head of Patient Services

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Date	Version Number	Summary of Changes	Changes Made by
		final version. Inclusion of reference to CHA3609 Day Case Admission Form at section 6.1.1 and 6.8.1. Section 6.1.1. addition of text advising “If a patient declines to hand any valuables in for safekeeping this must be documented”. Addition to paragraph 6.15.13 to help inform the deceased patient process. Addition to paragraph 6.7.1 “Two members of staff must record the valuables, ideally in the presence of the patient”. Addition to paragraph 6.13 “Ward/clinical staff are responsible for ensuring that all patients’ valuables and/or property taken for safekeeping by the Trust is returned to the patient on their transfer between the hospital sites, out of the Trust or on discharge”. Addition to paragraph 6.7.10 “If they refuse to sign, then two members of staff must document who has been given what property and why”. Deletion of text “If at any stage there is doubt as to the patient representative’s entitlement to the property, items must be retained in safe custody pending further enquiries” at paragraph 6.15.16 and replaced with “In the event that staff are unsure whether the person requesting the return of the patient’s property is entitled to do so, the items must be retained by the Trust in safekeeping pending further enquiries. They will be held until the necessary evidence is produced or a legal third-party decision, for example a Court Order, is produced to allow safe release of high value items. This must be fully documented in the patient notes with a full list of the items held documented. Addition to paragraph 6.15.14 “Banked	

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Date	Version Number	Summary of Changes	Changes Made by
		monies are returned to the NOK by BACS payable to the estate of the deceased". Updated to reference the Care after Death policy at section 6.15.1	
June 2026	V11.0	Section 6.12 (Illegal items) updated to strengthen policy language, clarify Trust procedures for the identification, management, and disposal of prohibited items, and in incorporate relevant statutory and regulatory frameworks. Additional detail included regarding escalation and police involvement in cases of non-compliance. Updated Appendix 8 Mortuary and Bereavement Deceased Care Record Change from Care Groups to Divisions.	Head of Patient Services

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing.

Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

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Appendix 2. Quality and Equality Impact Assessment (QEIA) Form

The QEIA process allows RCHT to monitor the impact of changes to its policies and services, ensuring that nobody is unduly disadvantaged.

Please ensure you have completed a Quality and Equality Impact Assessment (QEIA) using this link to complete the form:

E11 QEIA Policy.

For guidance, please see the QEIA Essentials – Quick Reference Guide or contact as required below:

Equality, Diversity and Inclusion guidance, please contact: rcht.inclusion@nhs.net

Quality Governance guidance, please contact Jillian Tozer: jillian.tozer3@nhs.net

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Appendix 3. Trust Property Disclaimer for Display



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Appendix 4. Patient Property Disclaimer Form (CHA4461)

Please note this form is available on Unit 4 and will be provided in paper format.

NHS Number: _____
Name: _____
Address: _____
_____
Date of Birth: _____
CR Number: _____

Affix patient label

NHS
Royal Cornwall Hospitals
NHS Trust

Patient Property Disclaimer Form

Ward:	Date:	Time:

Does the patient have any of the following property with them?

Glasses	☐	Wedding ring / Other	☐	Mobility aids	☐
Number of pairs	☐	Denture - bottom set	☐	Specify	
Denture - top set	☐	House keys	☐		
Hearing aid	☐	Lifeline item	☐		
Mobile phone	☐	Necklace / Other	☐	Money	£

Other please specify (all other property of significant value that the patient has elected to keep with them should be recorded here e.g. mobile phone, tablet, laptop, ipad):

Patient Disclaimer:

I have been advised to restrict to a minimum the amount of property, including cash, brought into the hospital and to hand in as soon as possible any articles I wish to be kept in safe custody for which a sticker will be placed in my records and I will be given a redemption card with the seal number which relates to my specific property bag. The bag will be held in the safe in the General Office. I acknowledge that I am responsible for property (including cash) not handed over for safe custody and Royal Cornwall Hospitals NHS Trust accepts no responsibility for the loss of, or damage to, personal property of any kind, in whatever way the loss or damage may occur, unless deposited for safe custody. If I decide to send home any items identified on this disclaimer, or have not informed staff that I have an item in my possession I understand that the Trust cannot be held responsible for them.

Signed: **Print:** **Date:**

Patient unable to sign Disclaimer Form

Reason:

Relative/Carer Disclaimer: **Print:** **Date:**

Signed: **Relationship:**

Patient refuses to sign disclaimer form ☐ **Date:**

Have any monies and / or valuables been handed in for safekeeping? YES ☐ NO ☐

Patient's Property Sheet Number:

Property stored in General Office* ☐ *During Out of Hours, Security will take property to General Office

I have informed the patient and / or relative of the Trusts policy regarding patient's personal property and have made all reasonable efforts to ensure that the and in my opinion the patient/relative understands that the Trust accepts no responsibility for any items not handed over to the Trust for safe keeping.

Signature: **Print:** **Designation:** **Date:**

On Discharge/Transfer to other NHS Provider The listed property has been returned to me in full.

Signature: **Print:** **Date:**

I am patient/patients representative (please specify):

Signature: **Print:** **Witnessed:** **Date:**

Sample Only

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CHA4461 V2 Printed 01/2024 **Review due 2027**

Appendix 5. CHA4158: Inter hospital and care home transfer form

This form is to access and printed from the hyperlink above.

File within 3rd spine

Place patient sticker **within** this box

NHS

Inter hospital and care home transfer form

S

Transferring from: Hospital ..... Ward/Department.....

Name and designation of staff handing over .....

Diagnosis .....

NEWS2..... Reason for raised NEWS .....

On Oxygen? YES ☐ / NO ☐

Medically reviewed in the last 24 hrs and fit for transfer YES ☐ NO ☐

Stable/improving bloods and diagnostics YES ☐ NO ☐

If End of Life or 'NO' to the above questions, please discuss with medical team to ensure the patient is safe to transfer

B

Past Medical History .....

.....

Social History .....

.....

A

Infection Risk .....

(C. Diff, recent loose stools)..... Sample sent..... Date .....

COVID-19 status .....

Mobility status .....

Transfers status .....

Activities of daily living		Washing	Dressing	Toileting	Eating	Drinking
	Independent with:	☐	☐	☐	☐	☐
	Needs assistance with:	☐	☐	☐	☐	☐

At risk of falls? YES ☐ NO ☐ if **YES**, indicate why:

History of falls last 12 months	Delirium	Poor balance mobility	Pain	Postural hypotension	Poor eyesight	Can't use bell	Won't ask for help
☐	☐	☐	☐	☐	☐	☐	☐

At risk of falls from bed? YES ☐ NO ☐ if **YES**, indicate what interventions used (falls alarm, ultra-low bed):

Bed rails status: Bedrails up ☐ Bedrails down ☐

Increased supervision required? YES ☐ NO ☐ if **YES**, indicate intervention used:

Level 4 / Within arm's reach ☐ Level 3 / Within Line of sight ☐ Alarm mat ☐

Care / Intentional rounding ☐ Frequency of rounding: ..... End of life observations ☐

Sample Only

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Place patient sticker **within** this box

A

Any **behavioural concerns?** YES ☐ NO ☐ if **YES**, describe:
Wandering ☐ Aggressive ☐ Sundowning ☐ Low Mood ☐ Risk of absconding ☐

Is Deprivation of Liberty Safeguard **(DoLS)** in place? YES ☐ NO ☐ if **YES**, provide date:

Any **communication concerns?** YES ☐ NO ☐ if **YES**, indicate below:

Poor vision ☐ Poor hearing ☐ Additional communication needs:
Wears glasses ☐ Wears hearing aids ☐

Any **food intake concerns?** YES ☐ NO ☐ if **YES**, describe:

MUST Score: Low ☐ Medium ☐ High ☐	Significant weight loss Yes ☐ No ☐	Special/Modified Diet:

Any **fluid intake concerns?** YES ☐ NO ☐ if **YES**, describe:

if **YES**, indicate strategy used:
24hrs Fluid chart ☐ Modified fluids ☐ Other:

Any **continence concerns?** YES ☐ NO ☐ if **YES**, describe:

if **YES**, indicate strategy used:
Pads & pants ☐ Urine bottle ☐ Conveen ☐ Stoma ☐ Catheter ☐ Toileting routine ☐
Date catheter inserted: Reason: Date trialled without catheter:

Any **skin integrity concerns / wound / pressure ulcers?** YES ☐ NO ☐

if **YES**, describe what / where:	if **YES**, describe strategies/equipment used:

Any **critical medicines?** YES ☐ NO ☐ if **YES**, indicate which:
Diabetic ☐ Antibiotics ☐ Warfarin ☐ Parkinson's meds ☐ Cardiac ☐

Syringe driver? YES ☐ NO ☐ start time:

Allergies? YES ☐ NO ☐ if **YES**, describe:

Has patient got?	To Take Out (TTO') ☐	Medicine Administration Prescription (MAPP) ☐	Medicine Administration Charts (MACS) ☐	Controlled Drugs (CDs) ☐

Is Treatment Escalation Plan in place **(TEP)?** YES ☐ NO ☐

What is patient's current resus status? **NOT** for Resuscitation ☐ For Resuscitation ☐

Is Pre-Notified Death Form in place YES ☐ NO ☐ Not applicable ☐

R

Reason for admission:
Rehabilitation ☐ Discharge planning ☐ End of life care ☐ Symptom management ☐

Discharge goals:

Other relevant info (ie: appointments, tests etc):

*PLEASE MAKE SURE A **DISCHARGE SUMMARY** and **TTO's** COME WITH PATIENT* ☐

D

Time transfer booked for:
Next of kin informed? YES ☐ NO ☐ Contact name:

By signing I confirm that the patient is **CLEAN** and **COMFORTABLE** with **SYMPTOMS CONTROLLED** at time of Transfer:
Print Name: **Signature:** **Designation:**
Date: Time: Receiving ward/hospital:

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Appendix 6. Special Care Dentistry Referral Proforma

Primary Care Dental Service – NHS England South West Referral Form
Request for Assessment of Patients with Additional Needs

Please note that if your referral does not meet the Primary Care Dental Service criteria or if this form is not legible or completed fully, we reserve the right to return it to you.

SECTION 1 REFERRAL INFORMATION			
Do you consider this to be an urgent referral?	Yes ☐ No ☐	If yes, please state why	
Type of Referral	Specialist Opinion only ☐		Specialist Opinion and Treatment ☐

SECTION 2 PATIENT DETAIL		**SECTION 3 PARENT/CARER/GUARDIAN INFORMATION**	
First Name		First Name	
Surname		Surname	
Address		Address	
Postcode		Postcode	
Home Tel. No.		Home Tel. No.	
Mobile Number		Mobile Number	
Email address		Email address	
Date of Birth		Relationship to patient	
Name of School/Nursery (if patient under 16)		Is there a social worker or learning disability team involved? Yes ☐ If yes, please give details	
Gender	Male ☐ Female ☐ Other ☐		
NHS Number			

SECTION 4 REFERRER DETAILS		**SECTION 5 PATIENT GP DETAILS (if not the referrer)**	
First Name		First Name	
Surname		Surname	
Registration number		Practice Address	
Address			
Postcode		Practice Postcode	
Tel. No.		Practice Tel. No.	
Email Address		Email Address	

SECTION 6 COMMUNICATION AND SPECIAL REQUIREMENTS			
First language if not English		Interpreter required	Yes ☐
Sensory impairment	Hearing ☐	Vision ☐	Communication ☐
Mobility	Can manage stairs ☐	Can walk with frame ☐	Can weight bear ☐
Wheelchair user ☐	Can transfer by self ☐	Wheelchair tipper ☐	Hoisting required ☐
	Learning disability		Yes ☐

Sample Only

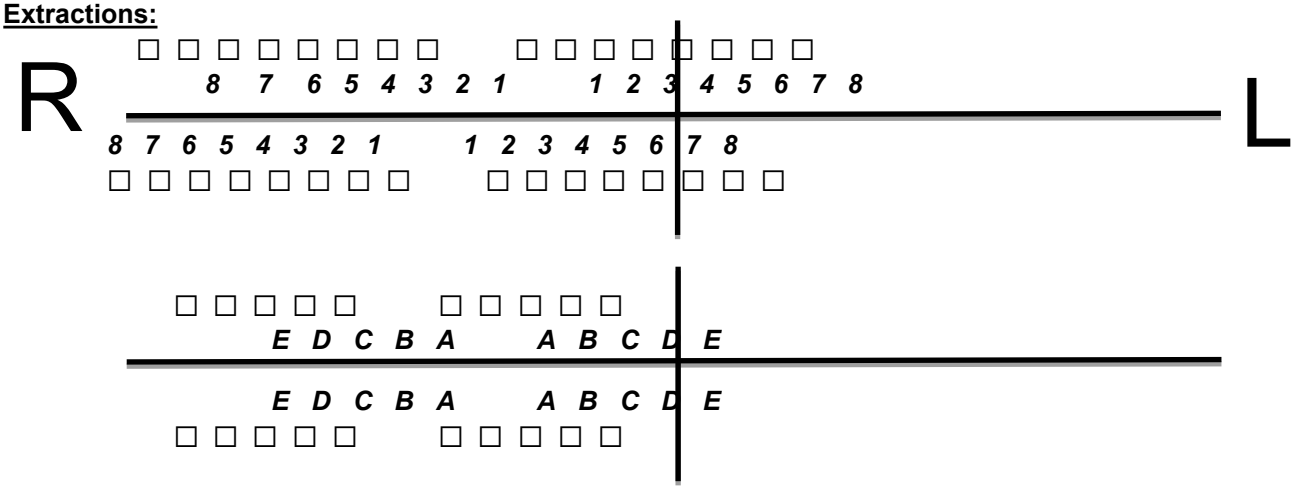
Neave Synsey 30/07/2026 08:31:26

Does the patient have any additional needs? *please tick all that apply*	Acquired brain injuries	Yes ☐
	Diagnosed mental health illness	Yes ☐
	Autistic spectrum disorders	Yes ☐
	Current significant misuse of substances	Yes ☐
	Child with cleft lip or palate	Yes ☐
	Dental treatment complicated by medical condition	Yes ☐
	Medical condition significantly affected by poor oral health	Yes ☐
	Sensory disability making access to general dental service difficult	Yes ☐
	Physical disability making access to general dental service difficult	Yes ☐
	Access to bariatric chair needed (patient is over 21 stone / 133 kg)	Yes ☐
	If yes, please specify the weight of the patient	
	Children with a high level of anxiety or children with a phobia of dental treatment and/or children with behavioural difficulties (treatment must have been attempted in GDP first)	Yes ☐

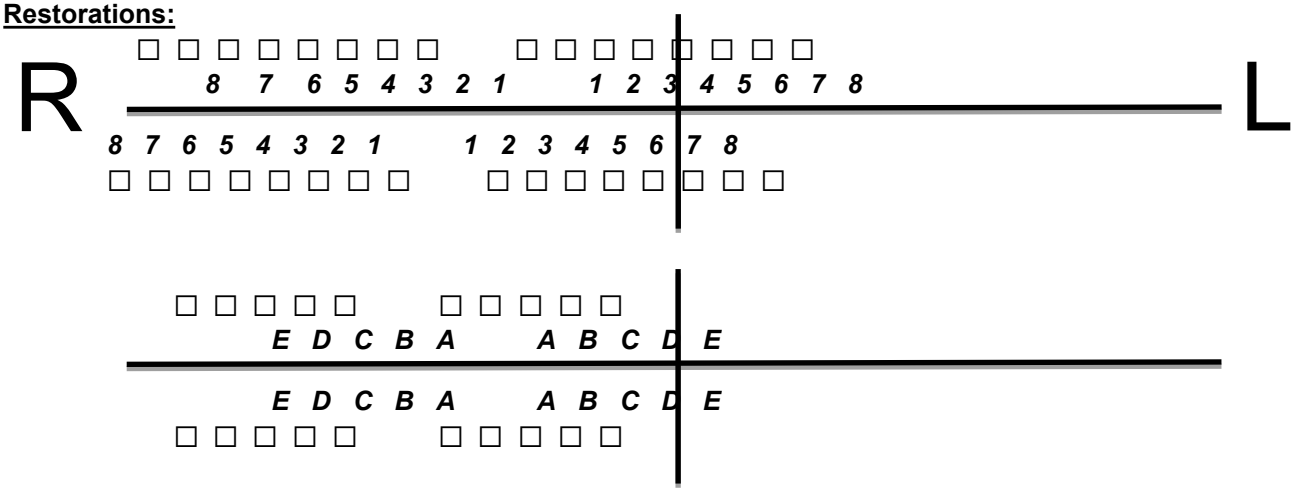
SECTION 7 REASON FOR REFERRAL AND TREATMENT REQUESTED

Please explain why you are referring the patient and what treatment is required

Extractions:



Restorations:



Other:

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SECTION 8 DESCRIBE PREVIOUS ATTEMPTS AT TREATMENT
Please explain what treatment attempted and why the patient cannot be treated within General Dental Practice

SECTION 9 RADIOGRAPHS			
Radiographs are required for patient assessment **Please ensure all relevant and recent radiographs are enclosed**			
Radiographs enclosed:	DPT ☐	Intra Orals ☐	None (give reason) ☐

SECTION 10 CHECKLIST	
The above referral has been discussed and agreed with the patient and/or Parent/Guardian	Yes ☐
I understand that the final decision for treatment offered rests with the PCDS Dental Officer following discussions with the patient/parent/carer. When appropriate, consultation with the General Dental Practitioner will be undertaken	Yes ☐
I understand that NHS charges are payable to PCDS unless the patient is exempt and that NHS charges have only been raised for treatment already carried out.	Yes ☐
I have enclosed a Personal Treatment Plan form FP17RN. Charges will be payable for work carried out by PCDS.	Yes ☐
Recent relevant X-ray enclosed	Yes ☐
Signed Primary Care Dental Service medical history form/appropriate practice medical history form enclosed	Yes ☐
I confirm that this patient referral meets the current referral guidelines. I understand that incomplete and/or inappropriate referrals will be returned for revision and may delay patient treatment.	Yes ☐

SECTION 11 SIGNATURE			
Print Name		**Signature**	
Registration Number		**Date**	

SECTION 12 TRIAGE OUTCOME			
Date Triaged		**Triaged by (print name and position)**	
Referral Accepted	Yes ☐ No ☐	**If rejected, please state reason for rejection**	
Patient Complexity	Level 1 ☐	Level 2 ☐	Level 3 ☐

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Primary Care Dental Service – NHS England South West Medical History Form

Medical history form or copy of dental practice medical history form must accompany the PCDS referral form

SECTION 13 PATIENT'S DETAILS			
Patient's Name		**Date of Birth**	

SECTION 14 PATIENT MEDICATIONS
Please list all current medications

SECTION 15 CONFIDENTIAL MEDICAL HISTORY FORM			
PLEASE ANSWER *ALL* QUESTIONS	**YES**	**NO**	**DETAILS – PLEASE STATE**
Has the patient ever been admitted to hospital?	☐	☐	
Has the patient had any operations?	☐	☐	
Is this patient attending or receiving treatment from a doctor, hospital, clinic, or specialist?	☐	☐	
Has the patient ever had a general anaesthetic? If YES, where, when and what for?	☐	☐	
Has the patient had a bad reaction to a general or local anaesthetic?	☐	☐	
Is the patient taking any medicines (tablets, creams, ointments, injections, other – including Warfarin, aspirin, contraceptives, and HRT) or alternative remedies? *Please specify* Please bring repeat prescription/MARS sheet (if applicable)	☐	☐	
Is the patient taking or has taken steroids in the last two years?	☐	☐	
Is the patient using or has ever used recreational drugs?	☐	☐	
Is patient allergic to any medicines or food substances?	☐	☐	
Does the patient suffer from Parkinson's disease, motor neurone disease, or other neurological condition?	☐	☐	
Has the patient ever been told they have a heart murmur, heart disease, high blood pressure, angina, heart attack, stroke, or heart surgery?	☐	☐	
Does the patient have a pacemaker, VNS implant, stent, artificial valve, shunt, or other form of implant?	☐	☐	
Has the patient ever had jaundice, liver, kidney disease or hepatitis?	☐	☐	
Does the patient suffer from allergies e.g. hay fever or eczema?	☐	☐	
Does the patient suffer from bronchitis, asthma, or other chest conditions/snoring/sleep apnoea?	☐	☐	

Name: Lucy [illegible]
30/06/1925 [illegible]

PLEASE ANSWER *ALL* QUESTIONS	YES	NO	DETAILS – PLEASE STATE
Does the patient have fainting attacks, giddiness, blackouts, or epilepsy?	☐	☐	
Does the patient have diabetes?	☐	☐	
Does the patient have anaemia?	☐	☐	
Has the patient ever bled excessively?	☐	☐	
Does the patient suffer from any infectious diseases (including HIV, Hepatitis B or C)?	☐	☐	
Has the patient ever been notified for public health purposes that they are at risk of CJD or vCJD?	☐	☐	
Does the patient carry a warning card or a medi alert?	☐	☐	
Does the patient have a TEP (Treatment Escalation Plan) – sometimes known as DNAR (Do Not Attempt Resuscitation)?	☐	☐	
Does the patient drink alcohol – if so, how many units per week?	☐	☐	
Does the patient smoke or chew tobacco products – if so, how many per week?	☐	☐	
Does the patient wish to receive advice about stopping smoking?	☐	☐	
Does the patient have any physical, visual, or hearing problems?	☐	☐	
Does the patient have any behavioural or learning disabilities?	☐	☐	
Does the patient have an Autism Spectrum Condition, or ADHD?	☐	☐	
Has the patient ever had any mental health problems, including anxiety and panic attacks?	☐	☐	
Is the patient pregnant or breastfeeding?	☐	☐	
Is there anything else the dentist should know?	☐	☐	

SECTION 15 PATIENT/PARENT/CARER SIGNATURE			
Print Name		**Signature**	
Date			

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Appendix 7. Cash and Valuables Leaflet

Royal Cornwall Hospitals NHS Trust

Cash and valuables



If you have brought cash and valuable items into hospital, we suggest that you give them to your family or a friend to take home.

If you are unable to do this, the Trust has a cash and valuables system that can look after your cash and items of value. This leaflet explains the steps to follow.

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30/06/2026 09:31:26

Depositing cash and valuables for safekeeping

Cash and valuables bag

The cash and valuables bag contains the following:

- White address card.
- Orange receipt card.
- Sticky label.
- Security numbered seal.

1. Remove the contents of the bag and check that the security numbered seal matches the number on both cards and the sticky label.
2. Complete the information on the white address card and orange receipt card as follows:

White address card

Name:

Hospital number:

Your signature:

Ward name:

Date:

Staff signature:

Orange receipt card

Name:

Hospital number:

Ward name:

Date:

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30/09/2026 09:31:26

1. To save completing the details by hand an adhesive label with your name and hospital number may be available from a member of staff, please ask.

2. Place white address card in the window of the bag facing outward. This will show your details clearly on the outside of the bag.

3. Place the items you wish to deposit for safekeeping in the bag. Remember to keep a small amount of money on the ward during your hospital stay to buy newspapers, magazines, and other small items.

4. When all of your items are in the bag and your details are clearly shown in the address window, you can seal the bag.

5. Close the zip on the bag.

6. Check that the number printed on the seal matches the number printed on the address card, the orange receipt card, and the sticky label.

7. After checking that all the details match, place the seal in the slot with the number facing outward. This seal will click into place and will not be broken until your items of value have been returned to you.

8. A member of staff will **place the sticky label in your hospital records.** You will need to keep the orange receipt card along with this information leaflet in a safe place.

9. The card must be shown to a member of staff when you wish to collect your items of value.

Neave,Lynsey
30/06/2026 09:31:26

Collecting your cash and valuables

1. Valuables can only be collected on: Monday to Friday from 9am to 4.15pm.

2. If you are due to be discharged during the hours mentioned above, please give the member of staff at least one hour's notice of your wish to collect the cash or valuables. If however, you are due to be discharged outside of these hours please inform the member of staff that you have cash and valuables that you wish to collect **as soon as possible.**

3. When a member of staff offers to collect your bag, sign the section marked 'Authorisation for collection' on the orange receipt card and give it to the member of staff.

4. They will then collect your bag and return it to you with the seal in place.

5. When the bag is returned to you, check your name and that the number printed on the seal matches the number printed on the address card in the window. If they don't match, return the bag to the member of staff.

   Do not attempt to open the bag.

6. If your name appears on the address card in the window and the seal numbers match, break open the zip and remove your items of value. By doing this you will break the security seal.

7. When you have removed your items, take the white address card, and sign the section marked 'Confirmation of receipt'.

8. The card must then be placed inside the bag and handed back to the member of staff.

9. Once returned the bags are prepared for another patient to use.

Neave,Lynsey
30/06/2026 09:31:26

Your questions answered

What if I need something from my bag or would like someone to take my valuable items home?

You will need to tell a member of staff and follow the instructions above ‘Collecting your cash and valuables’. If you wish to deposit your items again, you will need to start a new bag and follow the system as shown overleaf.

What if I break the seal (having forgotten to place an item in the bag) or spoil the cards inside?

Explain to a member of staff who will take the cards and the bag away and bring you a new one.

What if I am moved to another ward?

Your cash and valuables bag has been noted in our hospital records and these will follow you throughout your stay in hospital. When you wish to have your bag returned, follow the instructions for ‘Collecting your cash and valuables’. If however, you are unwell and unable to take care of your belongings they will be held securely until you are able to arrange collection.

What will happen if I lose my orange receipt card?

A record of your cash and valuables being deposited will have been made in your hospital records. When you wish to collect your cash and valuables, inform a member of staff who will make the necessary arrangements for collection.

Disclaimer

Please be reminded that Royal Cornwall Hospitals NHS Trust does not accept responsibility for the loss of, or damage to any:

- Valuables.
- Cash.
- Personal property.

Which is not deposited for safekeeping.

If you would like this leaflet in large print, braille, audio version or in another language, please contact the General Office on 01872 252690.

Weare, Lynsey
30/06/2026 09:31:26

RCHT 1286.

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Reviewed 08/2021 V4 **Review due 08/2024.**

Appendix 8. Mortuary And Bereavement Deceased Care Record

Bereavement Care Services (RCHT1620)

Please note this form is held electronically within the Q Pulse document library and are printed and distributed to individual wards on request by Mortuary staff.

MORTUARY AND BEREAVEMENT DECEASED CARE RECORD

SURNAME:		FIRST NAMES:		
CR NO:	WARD:		DATE OF BIRTH:	
DATE OF DEATH:	TIME OF DEATH:		END OF LIFE PATHWAY: Y / N	
RISK OF INFECTION: Y / N	PLEASE SPECIFY:			
TICK TRANSMISSION ROUTE:	BLOOD BOURNE ☐	AIRBOURNE ☐	INGESTION ☐	CONTACT ☐
IMPLANTABLE DEVICE: Y / N (I.E PACEMAKER)	PLEASE SPECIFY:			
NEXT OF KIN NAME:				
RELATIONSHIP TO DECEASED:	CONTACT NO:			

PATIENT PROPERTY (please tick)			
NO PROPERTY ☐	ON DECEASED ☐	ON WARD ☐	GENERAL OFFICE ☐
Please log all personal property left on patient in this box.			
TO BE SIGNED BY A MEMBER OF WARD STAFF, PRESENT AT TIME OF DEATH			
NAME:		SIGNATURE:	
DATE:		OCCUPATION:	
PORTERS			
PORTERS NAMES:			
TRANSFER DATE AND TIME:		FRIDGE NO:	

Release check list

(To be completed by the releasing APT in conjunction with the appointed Funeral Director)

☐ Deceased Identification confirmed three points of ID confirmed against funeral director release authority
☐ Awareness of the presence of medical devices/cannulas/ catheters communicated and understood by funeral director
☐ Universal PPE precautions advised and understood by funeral director
☐ Risk of Infection status communicated and understood by funeral director
☐ Condition of the deceased - Satisfactory ☐ Body fluids ☐ Trauma ☐ Decomposed ☐ Infested ☐ other ☐
Corrective action agreed.....
☐ No leakage ☐ Managed / contained (pads/ dressings) ☐ Ongoing management required, funeral director aware
☐ Viewing restrictions advised ☐ YES ☐ NO
☐ funeral director aware that further restorative works may be required/ongoing to maintain deceased respect & dignity

Sample Only

Declaration

By signing this document, all parties confirm that the deceased has been correctly identified, risks and condition have been communicated and the responsibility for the deceased has been transferred.

Not all patients with known or potential infections display typical symptoms, therefore some infections may not have been identified at the time of death. The mortuary staff may also not have been informed of the patient infection, and the information passed on is to the best of our knowledge. This form does not stop or imply that the deceased cannot be viewed, it is to highlight the hygiene precautions required to prevent the risk of cross infection. It is the sole responsibility of the funeral operative/authorised person collecting the deceased to pass on any relevant information. Royal Cornwall Hospital Trust accepts no responsibility for any error or other relevant information not provided or found at, and after the point of collection.

Neavey, Kate (RCHT)
30/06/2021 09:29

PROPERTY CHECKED BY:	COLLECTED BY:
COMPANY:	SIGNATURE:
DATE OF COLLECTION:	TIME OF COLLECTION:
APT NAME:	APT SIGNATURE:

Meeting: Trust Board In Public

Date of Meeting: 02 July 2026

Item Number: 20

Title of Report: Integrated Safeguarding Services Annual Report 2025/2026

Executive Director Lead: Bernadette George Acting Chief Nursing Officer

Author and Job Title: Kathryn Clements, Deputy Head of Safeguarding

Email Address: kate.clements2@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

This report provides the group with assurance on the effectiveness, governance and statutory compliance of safeguarding services delivered during 2025/02 across Royal Cornwall Hospitals NHS Trust (RCHT) and Cornwall Foundation Trust (CFT). It summarises safeguarding activity, key risks, learning and priorities, including assurance relating to organisational abuse, professional allegations, and specialist services

Consultation:

Quarterly reports have been presented at the Quality Assurance Committee part 2 throughout the year. The annual report was presented and approved at the Quality Assurance Committee part 2 on 13 May 2026

Key Risks (please tick one or more):

Clinical ☒ **Financial** ☐ **People** ☒

Reputational ☐ **Legal / Regulatory** ☒

Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	

Mandy Lynsey 30/06/2026 09:31:26

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Quality Impact Assessment completed?			x	
Data Protection Impact Assessment completed?			x	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Safeguarding includes inequality and wellbeing
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	
Sustainable and efficient use of NHS resources by RCHT	

Recommendation(s):

The Board **is recommended to:**

- **Note** the Safeguarding Annual Report

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Annual Safeguarding Report

1. Executive Summary

Safeguarding services across Royal Cornwall Hospital Trust (RCHT) and Cornwall Partnership NHS Foundation Trust (CFT) continue to deliver a clear vision to protect people of all ages from abuse, neglect and avoidable harm. Safeguarding is embedded as everyone's responsibility and delivered through trauma informed, person centred and proportionate practice that recognises inequality, cumulative harm and the importance of early identification, professional curiosity and partnership working. A culture of openness, accountability and learning underpins safeguarding practice across the Trusts.

A robust, integrated safeguarding governance framework provides clear accountability, effective escalation and strong Board level oversight. Safeguarding activity and risks are routinely reported through quality and safety structures, enabling triangulation with workforce and patient safety intelligence. Executive oversight supports early identification and proportionate management of emerging risks, providing assurance that safeguarding concerns are addressed promptly.

Safeguarding activity increased significantly during 2025/2026. Adult safeguarding services received over 10,000 contacts, with rising Section 42 enquiries and increased concerns relating to self-neglect, domestic abuse and organisational abuse. Organisational abuse themes included unsafe discharge processes, care quality issues and provider oversight challenges, reinforcing the importance of multi-agency working. Oversight and audit activity demonstrated improving referral quality and increased professional confidence.

Children's safeguarding services maintained a strong and visible health presence within multi agency arrangements. Neglect, domestic abuse, parental mental ill health and exploitation remained prominent, often presenting as cumulative harm. Learning from audit, supervision and safeguarding practice reviews was embedded to support continuous improvement.

Maternity safeguarding remained a high risk and high-pressure area, with over 1,300 safeguarding referrals, predominantly linked to domestic abuse, parental vulnerability and concerns for unborn babies. Despite sustained workforce pressures, statutory responsibilities and multi-agency planning were maintained. Workforce sustainability remains the principal ongoing risk, with mitigations prioritised for 2026/2027.

Specialist safeguarding services made a significant contribution to protecting highly vulnerable populations. The admiral nursing service supported 746 carers. The acute learning disabilities service supported 5,544 patients, a 6% increase on the previous year, focusing on preventing organisational abuse and ensuring Mental Capacity Act compliance. High intensity user and homeless hospital discharge services supported people with complex needs, contributing to safer care planning and an estimated 70% reduction in delayed discharge bed days for people experiencing homelessness.

Domestic abuse remained a pervasive safeguarding issue across all services, with high volume and increasingly complex multi-agency risk assessment conference (MARAC) activity. Implementation of the NHS sexual safety charter strengthened safeguarding protections for patients, families and staff. The Trust also met its statutory Prevent duties, with activity overseen through safeguarding governance arrangements.

Not to be copied or distributed

At RCHT, deprivation of liberty safeguards activity continued to be impacted by system pressures, particularly workforce shortages within local authorities. The administration of the Mental Health Act has historically relied on non-specialist staff at RCHT. A proposed extension of CFT's specialist Mental Health Act administration support to RCHT has been identified as a key mitigation to strengthen compliance, governance and patient safeguards.

The safeguarding workforce remains skilled and committed, working under sustained demand and capacity pressure. Training compliance remains below target, particularly at Level 3; however, revised training models and strengthened assurance processes are in place to improve compliance during 2026/2027.

2. Risk

Key risks relating to workforce capacity, sustainability of specialist services and maternity safeguarding remain and are actively managed. Clear priorities are in place for 2026/2027, providing the Board with assurance that safeguarding remains embedded as core business and is subject to continuous oversight and improvement.

3. Accountability

Executive Oversight is via Bernadette George, Acting Chief Nursing Officer

Operational Delivery is via Alison Bartlett, Acting Director Of Nursing and Allied Healthcare Professionals CFT and the Integrated Safeguarding Team

4. Recommendations

The Board is recommended to:

- **Note** the Safeguarding Annual Report

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Safeguarding Services

Annual Report 2025/2026





Neave,Lynsey
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Safeguarding Annual Report April 2025 – March 2026

This annual report outlines the activity, performance and impact of the integrated CFT and RCHT safeguarding services for the financial year April 2025 to March 2026.

Safeguarding activity is routinely monitored through robust and well-established governance arrangements. These include quarterly reporting to the joint quality assurance committee (QAC), bi-monthly safeguarding operational groups (SOGs), and strategic oversight via the safeguarding oversight sub-committee (SOC) at CFT. These structures provide assurance, promote shared accountability, and support continuous improvement across both organisations.

Since April 2020, safeguarding services across RCHT and CFT have operated as a fully integrated service. This model, underpinned by strong system-wide partnerships, has enabled new and innovative ways of working across organisational boundaries and supported a place-based approach to care. Following integration, governance arrangements were reviewed and strengthened to ensure clear lines of accountability, effective assurance, and strong professional and executive leadership across both Trusts.

Throughout 2025/2026, safeguarding services continued to operate within a context of sustained system pressure, characterised by increasing demand, complexity and risk. This was evident across adult safeguarding, children's and maternity safeguarding, domestic abuse and sexual violence, Prevent, and specialist safeguarding services. Despite these pressures, both Trusts maintained statutory compliance, strengthened multi-agency collaboration, and made demonstrable progress against the safeguarding services vision.

The vision, purpose and values for safeguarding services are clearly articulated and informed by local and national learning, reviews and best practice. These have shaped shared priorities over 3 years (2024 – 2027) and provide a consistent framework for service development. Key achievements during the year include enhanced early intervention and prevention, improvements to governance and learning from reviews, strengthened organisational responses to sexual safety and domestic abuse, and continued embedding of trauma-informed and Think Family approaches.

Safeguarding remains firmly embedded as core business across both Trusts. Clear priorities have been identified to further strengthen sustainability, workforce capacity and resilience, and the quality of assurance arrangements during 2026/2027. These priorities will support the ongoing delivery of safe, effective and compassionate care, ensuring safeguarding remains central to organisational strategy and practice.

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1.Adult safeguarding team

Section 42 Care Act 2014 – safeguarding duty

Under Section 42 of the Care Act 2014, the local authority (LA) has a duty to make, or cause to be made, safeguarding enquiries where there are reasonable grounds to suspect that all three statutory criteria are met:

- The adult has needs for care and support, whether or not these needs are currently being met by services.
- The adult is experiencing, or is at risk of, abuse or neglect, which may include physical, sexual, emotional or psychological abuse; domestic abuse; financial abuse; modern slavery; neglect; organisational abuse; or self-neglect.
- As a result of those care and support needs, the adult is unable to protect themselves from abuse or neglect. This is not an absolute test and may reflect functional or contextual factors such as fluctuating mental capacity, coercion, control, fear or dependency. This criterion links closely to the Mental Capacity Act 2005 and the Human Rights Act 1998.

The Care Act does not require proof that abuse or neglect has occurred. The safeguarding duty is triggered where there are reasonable suspicions based on the information available at the time.

Safeguarding responses should be person-centred and aligned with making safeguarding personal principles. Consent should be sought where this does not increase risk; however, a lack of consent does not remove the safeguarding duty where risks remain.

1.1 Safeguarding activity

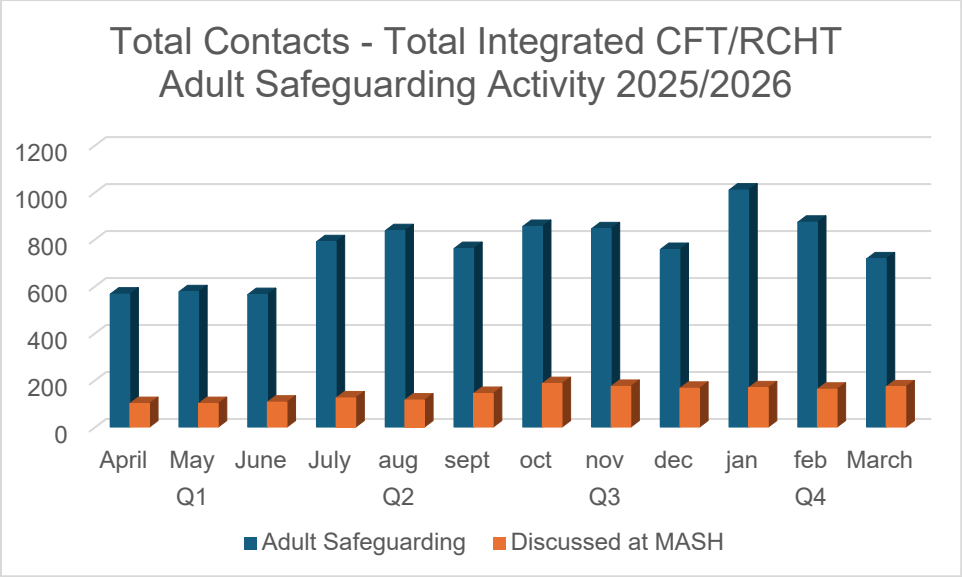
The adult safeguarding team has continued to experience a high and sustained level of activity during 2025/2026. During this period, a total of 10,852 contacts were received across both Trusts (figure 1).

This represents a 105.14% increase compared to 2023/25 figures and demonstrates a continuing upward trajectory in safeguarding activity.

This increase is likely to be influenced by a range of factors. However, it is considered that rising levels of deprivation within local communities, alongside economic hardship and increasing social isolation, are key contributors. These factors have continued to intensify and are having a significant negative impact both locally and nationally.

Neave,Lynsey
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Figure 1



Statistically, early intervention can reduce the need for longer-term and more complex interventions. However, this can be difficult to sustain as service pressures continue to increase. Despite this, the adult safeguarding team has proactively sought to engage with individuals as early as possible, with the aim of reducing risk and achieving positive outcomes.

Of the 10,852 total contacts received, 23% (2,507) related to information, advice, and support. This is a key function of the service, supporting colleagues across both Trusts. The team provides specialist information, advice, and guidance, including appropriate signposting. This approach represents early intervention in practice, ensuring professionals have the information required to support individuals effectively. This includes safety planning at the earliest opportunity, helping to reduce potential impact on patients and their relatives.

The safeguarding team participates in a daily multi-agency safeguarding hub (MASH), chaired by the local authority, which focuses on the coordination and discussion of complex safeguarding cases. Although there was a reduction in the number of cases discussed during the second half of the year, a total of 1,704 complex cases were reviewed through this forum.

As a result of these discussions, 378 Section 42 safeguarding enquiries were *'caused'* to the Trusts' adult safeguarding team. This requires the team to undertake internal enquiries and provide findings back to the local authority. This represents an increase from 322 to 378 enquiries, equating to a 17.39% increase over the course of the year.

Neave Kinsey
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Further safeguarding activity is outlined in figure 2.

Figure 2.

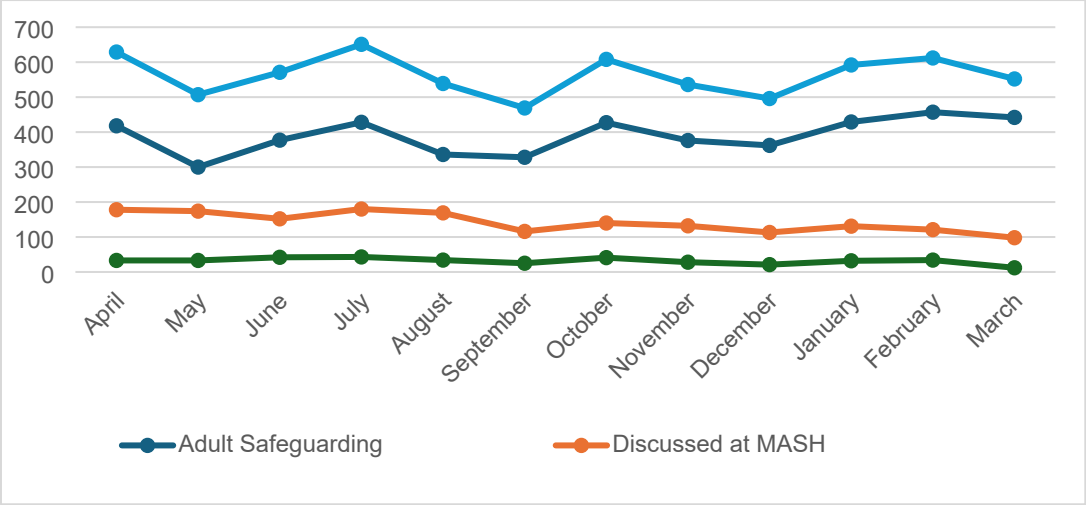
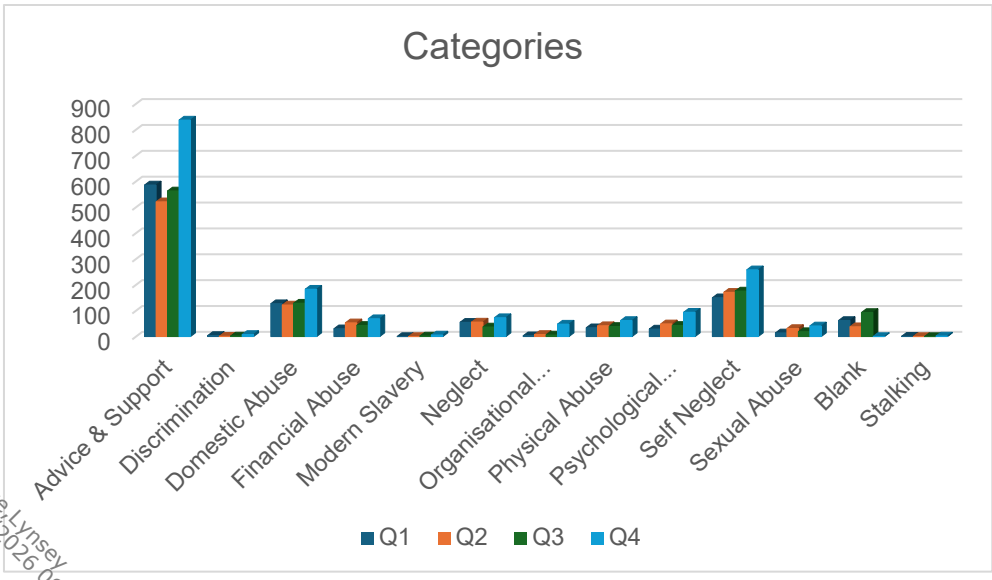


Figure 3 shows referrals broken down by category. Advice and support remain the key attribute to the work that is undertaken.

Several key points should be highlighted:

- self-neglect: a total of 755 referrals were received relating to self-neglect, reflecting continued high demand and complexity within adult safeguarding activity
- domestic abuse: 561 individuals were referred due to domestic abuse; evidence indicates that the prevalence of domestic abuse in Cornwall is significantly higher than referral data suggests, highlighting ongoing under-reporting and unmet need
- modern slavery: during the latter part of the year, 8 cases of modern slavery were identified and referred for safeguarding action.

Figure 3.



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2. Organisational abuse

During 2025/2026, the adult safeguarding team continued to strengthen its approach to identifying and responding to organisational abuse across both RCHT and CFT.

Following a recent service reorganisation, responsibility for reviewing and progressing organisational abuse concerns has shifted from a single point of contact to a group of appropriately skilled professionals. This new model aligns responsibilities with staff banding and experience, improving resilience and oversight. The revised process is still embedding but is already supporting more consistent decision-making.

Organisational abuse is a key category of harm under the *Care Act* 2014. It refers to neglect, poor practice, or failures in systems, policies, or processes that adversely affect one or more individuals. This can occur in any care setting, including hospitals, care homes, or a person's own home. The Care and Support statutory guidance describe organisational abuse as ranging from isolated incidents to persistent ill-treatment arising from the way an organisation operates.

When information is received by the team, it is allocated to a suitably experienced professional who reviews the concern, gathers further information, and determines the appropriate next steps. This includes sharing information with relevant teams, to review the incident and identify learning, supporting staff to make a safeguarding referral, or escalating directly to Cornwall's adult social care service where the safeguarding threshold is met.

Activity and themes

A total of 358 organisational abuse concerns were recorded in 2025/2026, compared with 265 in 2024/2025, an increase of 37.74%. A breakdown of this can be seen in figure 5.

Figure 5

	2025-2026											
	Qtr 1			Qtr 2			Qtr 3			Qtr 4		
Total referrals	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
CFT	8	14	12	18	8	10	14	8	10	11	10	5
RCHT	17	18	21	22	17	19	28	20	16	18	28	13
Joint	25	32	33	40	25	29	42	28	26	29	38	18

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Additional data on reasons for referral and outcomes across both trusts are shown in figures 6 and 7 below.

Figure 6

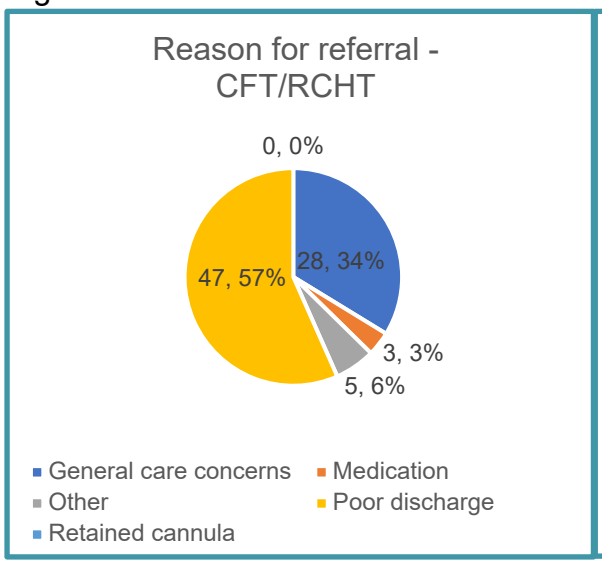
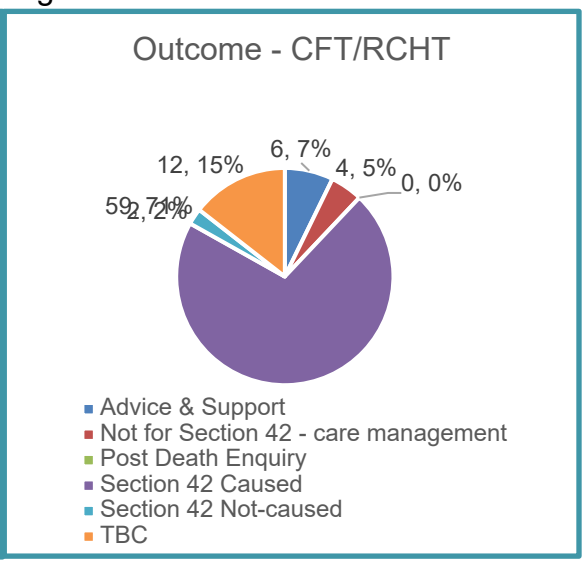


Figure 7



It is important to note that, due to changes in recording systems, detailed breakdowns are only available for the final quarter of the year. However, a consistent theme throughout 2025/2026 has been unsafe discharge processes across both trusts, which continue to feature prominently in organisational abuse referrals.

3. Multiagency Risk Assessment Conference (MARAC).

A MARAC is a regular multi-agency meeting where information is shared about adult victims at high risk of serious harm or homicide as a result of domestic abuse. The focus is on reducing risk, improving safety, and coordinating support. The adult safeguarding team represent RCHT and CFT at the weekly meeting. During 2025/2026 period, a total of 532 cases were discussed at MARAC.

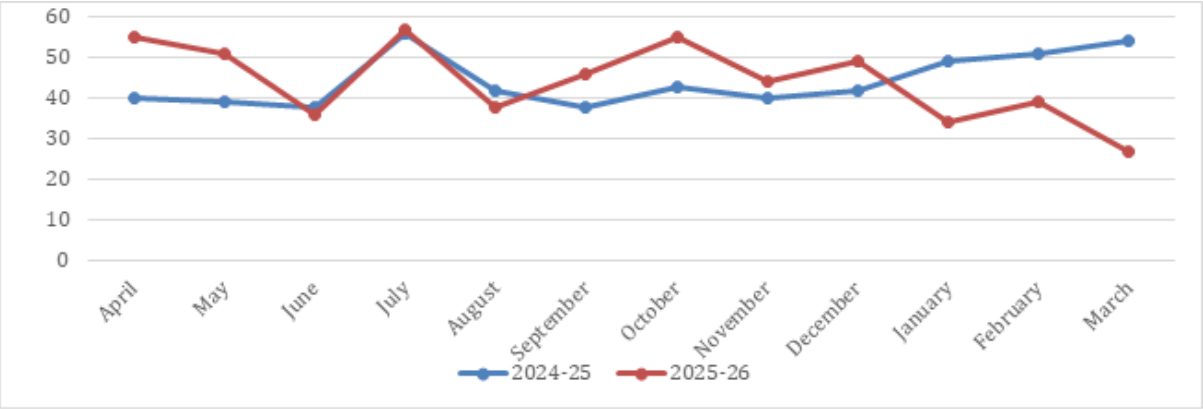
Over the past 2 years, MARAC activity has remained consistent. The Trusts' domestic abuse coordinator (DAC) and senior safeguarding practitioners regularly attend the MARAC Steering Group, which aims to develop and promote good practice and to challenge poor decision-making. In addition, a senior safeguarding practitioner attends the weekly MARAC referral assurance meeting to ensure referrals are appropriate and to reduce the number requiring rejection.

Each week, the safeguarding team collates detailed information relating to domestic abuse referrals and in preparation for MARAC. This includes information about both the victim and the alleged perpetrator, as well as any children or young people living within the household. This information is used at MARAC meetings, alongside a multi-agency perspective, to develop effective safety planning for individuals. In some cases, alerts are placed on patients' electronic records, which are reviewed after 1 year.

Neave Lonsdale 30/06/2026 09:31:26

Figure 8 below shows the total number of cases discussed at MARAC throughout the year and comparison with the previous year (2024/2025).

Figure 8.



4. Organisational change

During the past year, the adult safeguarding team has undergone significant organisational change. This period of transition has had a notable impact on individual staff members and on the team. The restructure has enabled practitioners to develop a broader, more flexible skill set and to adopt a wider professional perspective. While the changes have been challenging at times, the benefits of this new way of working are increasingly evident.

Staff have been supported to take on new responsibilities and develop new competencies, all while continuing to work collaboratively in a demanding and fast-paced environment. Alongside this, the team has placed a strong focus on creating a psychologically safe workplace, one that encourages constructive challenge, open consultation, and reflective practice with support from the CFT organisation development team. This approach is helping to strengthen safeguarding practice and improve outcomes for patients. Feedback from team members reflects these positive developments.

Safeguarding supervisory training for frontline practitioners continues to be offered; however, uptake has been lower than anticipated due to difficulties in identifying sufficient trainees. In response, the service is actively promoting the importance of safeguarding supervision and will be writing to all managers to encourage nominations for future training cohorts. Increasing participation will strengthen safeguarding knowledge and improve the quality and consistency of supervision across teams

Neave Lynsey
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5. Prevent and Channel

The aim of Prevent is to stop vulnerable people from becoming involved in terrorism or supporting terrorist activity. Prevent is one strand of the Government's overall

counter-terrorism strategy, CONTEST. The Trust has appointed a named Prevent lead to provide oversight and assurance.

Under the Counter-Terrorism and Security Act 2015, all specified authorities must have “due regard” to the need to prevent people from being drawn into terrorism. Following a comprehensive review of terrorism-related activity in 2023, the Prevent strategy placed increased emphasis on ideological drivers and the importance of early safeguarding intervention. The key mechanisms for delivering this are the Channel programme and workforce training.

The Prevent duty specifically requires authorities, including health organisations, to help prevent and reduce the risk of individuals becoming terrorists or supporting terrorist activities. This duty sits alongside established safeguarding responsibilities and should be applied within existing safeguarding frameworks.

The Trust’s responsibilities under Prevent include:

- making appropriate referrals
- sharing relevant information lawfully and proportionately, and
- providing advice and guidance to staff

Whilst national Prevent statistics for 2025/2026 are not expected to be published until later in 2026, there has been a significant increase in referrals across the UK. In some areas, this represents an increase of approximately 27% compared with the previous year. One contributing factor is understood to be the Southport incident in July 2024.

Phase 1 of the report into the fatal knife attack at a children’s dance event in Southport, Merseyside, highlighted that multiple warning signs were missed. The report identified repeated Prevent and safeguarding referrals that did not result in effective risk management, poor information-sharing between agencies, and a lack of clear risk ownership. It concluded that no single agency took responsibility for the escalating risk and that the attack was preventable.

For the year ending April 2025, Prevent referrals increased by 27% compared with the previous year, and further increases in 2026 are anticipated. Children and young people aged 11 to 15 years have become the largest single age group entering the Prevent system, accounting for 36% of referrals nationally. This trend often reflects concerns around a fascination with extreme violence.

Key issues highlighted through this report include:

- Right Care, Right Person
- Prevent escalation and threshold decision-making
- Risk ownership
- Effective information sharing

Neave Lynch
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5.1 Prevent activity and compliance (April 2025 – March 2026)

Between April 2025 and March 2026, the Trusts received 34 Prevent information-gathering requests, representing a significant increase compared with previous years.

Of these 34 cases, updated information was provided for 7 individuals who were subject to the Channel process during the same reporting period.

Adult safeguarding has attended all Channel meetings and the Prevent Board throughout this period. Both RCHT and CFT remain compliant with their statutory Prevent duties.

5.2 Prevent training compliance

Training compliance for Prevent for CFT and RCHT is demonstrated in the table below.

Figure 9 – Prevent training compliance

Organisation	Training Programme	Staff Trained	Staff Required	Compliance
CFT	Basic Prevent Awareness (Preventing Radicalisation)	1,881	2,074	**90.69%**
	Prevent Awareness Training	2,101	2,380	**88.28%**
RCHT	Basic Prevent Awareness (Preventing Radicalisation)	5,211	6,404	**81.4%**
	Prevent Awareness Training	5,184	6,471	**80.1%**

6. Deprivation of Liberty Safeguards (DoLs)

Deprivation of Liberty Safeguards (DoLS) is a legal framework within the Mental Capacity Act 2005 that protects adults who lack capacity to consent to their care arrangements. They apply in hospitals and care homes where a person is under continuous supervision and control and not free to leave. DoLS ensure that any deprivation of liberty is lawful, necessary, proportionate, and compliant with Article 5 of the Human Rights Act, with the right to challenge through the Court of Protection.

6.1 DoLS application and assessment process

Neave Hirst 30/06/2026 09:12:26

Hospitals and care homes, as the managing authority, must apply to the supervisory body (usually the local authority) where care arrangements may amount to a deprivation of liberty. The supervisory body commissions statutory assessments,

including those completed by a best interest's assessor and a mental health assessor, to confirm that the deprivation is lawful, necessary, proportionate, and in the person's best interests. Individuals retain the right to challenge DoLS authorisation through the Court of Protection. The Court of Protection makes decisions for individuals who lack capacity where complex, disputed, or ongoing welfare, health, or financial matters cannot be resolved through best interest decision making.

6.2 Trust DoLS Activity 2025/2026

The trend in DoLS applications demonstrates a sustained increase over recent years, reaching a peak in 2024/2025, followed by a notable reduction in 2025/2026. The Trust submitted 625 DoLS applications in 2025/2026, representing a decrease of approximately 16% compared to the previous year. CFT DoLs activity is managed by the CFT mental health act office.

This reduction is likely multifactorial and reflects internal organisational changes within safeguarding services, increased staffing pressures and clinical acuity, and reduced access to face-to-face DoLS training and ward-based support (improvement actions are outlined in section 6.5 of this report). Despite the overall decrease, the identification of potential deprivations of liberty and submission of applications remains embedded within Trust processes.

6.3 Distribution of DoLS applications across Trust sites

DoLS applications were primarily generated at RCHT Truro (85.6%), reflecting its acute setting, larger bed base, and higher patient complexity. West Cornwall Hospital accounted for 12.96%, with applications largely in relation to longer inpatient stays and delayed discharges, while St Michael's Hospital generated the lowest proportion (1.44%), consistent with its focus on elective, pre planned care.

6.4 DoLS authorisations and workforce challenges

Despite the number of applications submitted, only 1 DoLS authorisation was granted during the year, primarily due to staffing pressures within the local authority. Each application requires 5 statutory assessments, including an in-person assessment by a best interests assessor (BIA). A national shortage of BIAs, driven by the cost and time required for training and accreditation, has increased reliance on independent assessors, leading to commissioning pressures and delays in progressing applications. The responsibility currently sits with the local authority; this may change when the proposed *Liberty Safeguards* becomes statue in the next few years.

6.5 Planned improvements and mitigating actions

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To strengthen statutory compliance and improve workforce confidence in the application of the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS), the Trusts are working on the following actions:

- Mandatory online MCA and DoLS training for all relevant clinical and managerial staff, to ensure consistent understanding of capacity assessment, best interest decision making, and identification of potential deprivation of liberty.
- Action planning in response to a recent DoLS audit, with clear ownership, timescales, and monitoring through safeguarding governance structures to address identified gaps and improve practice consistency.
- Ongoing support from the Hospital DoLS practitioner, including provision of advice and guidance to clinical areas, particularly in relation to escalation and learning through DATIX incident reporting.

These measures are intended to strengthen staff competence, improve the quality of decision making, and ensure that restrictive care practices are lawful, proportionate, and fully aligned with Article 5 of the Human Rights Act, despite ongoing external system pressures.

6.6 Mental Health Act detentions – reporting arrangements

Over the past 10 years, mental health act (MHA) detentions at RCHT have been reported through the safeguarding annual report. This reporting arrangement is currently under review to ensure that oversight and assurance are located within the most appropriate governance framework, supported through CFT as a specialist mental health provider

RCHT, as the detaining hospital, holds statutory responsibility for MHA compliance, but recent assurance activity, including a CQC MHA monitoring visit (February 2026), a patient safety review and safeguarding reports have identified areas for improvement in MHA administrative capability. Current arrangements rely on non-specialist mental health staff, creating risks to patients' rights, safety, legal compliance and organisational reputation. CFT has established specialist MHA administration systems, and both Trusts agree that a clearly defined support offer from CFT represents the safest and most efficient model to address these risks.

It is proposed that CFT's MHA office extends support to RCHT through a revised service level agreement, covering core MHA administrative functions such as scrutiny of detention papers, Section 132 rights delivery, tribunal coordination, second opinion approved doctor request and renewal tracking, training, and assurance reporting, while RCHT retains overall statutory accountability.

Operational and corporate teams from both Trusts have agreed to a draft service level agreement, and the provision has been costed. This is currently with finance and contracting teams for final approval. The proposed model would significantly strengthen MHA compliance at RCHT, enhance patient experience and safeguards, and provide robust governance and assurance for both organisations.

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7. Homeless hospital discharge service

The homeless hospital discharge service provides targeted support to people experiencing homelessness to enable safe, timely discharge from hospital and to prevent avoidable admissions. The service operates across the hospital network in Cornwall, supporting both RCH and CFT.

The service is delivered by:

- 2 whole time equivalent (WTE) homeless patient advisors (HPAs) working across both Trusts
- 0.4 WTE team lead

7.1 Funding Arrangements

The service is jointly funded through a partnership approach:

- Cornwall Council funds 50% of the service costs through the Rough Sleeper Initiative (RSI), currently confirmed until March 2027
- RCHT and CFT each contribute 25%, covering the remaining costs for hospital-based provision

In addition, funding from the RSI and the Health and Social Care Local Hospital Discharge Fund supports:

- 17 dedicated homeless discharge beds
- 2 WTE outreach support workers, delivered by Harbour Housing

All referrals to Harbour Housing discharge beds are coordinated through the homeless hospital discharge service to ensure these resources are used solely to facilitate hospital discharge or prevent admission.

7.2 Demand and activity

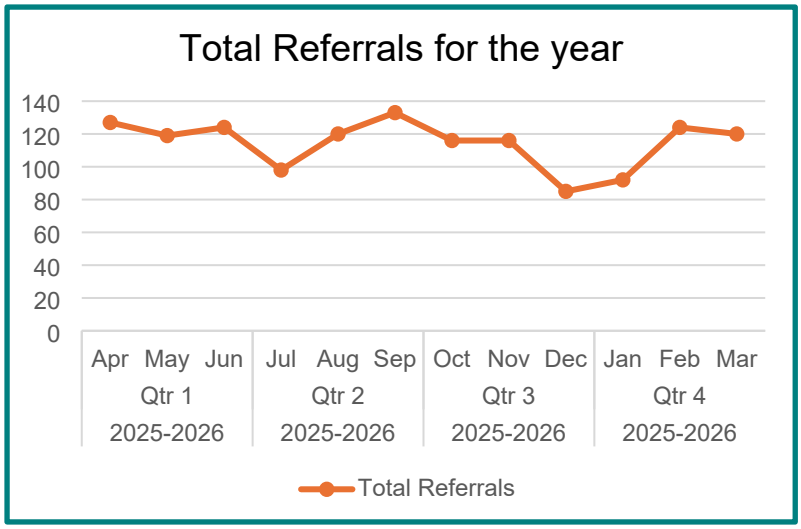
During 2025/2026, demand for the service continued to rise significantly.

Although referral activity varies between the 2 Trusts at the point of entry, the service supports many individuals across their full journey from acute hospital care through to community provision. This ensures a coordinated, system-wide response across both Trusts.

Referrals to the homeless hospital discharge service have nearly tripled since 2021/2022, reflecting increasing levels of homelessness and complexity. This year, the service received 1,374 referrals, with the highest volume recorded in quarter 2 as illustrated in figure 10 below:

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Figure 10



Despite this high demand, the team operated for much of the year with only 1 homeless patient advisor in post due to the Trust's current recruitment restrictions, placing sustained pressure on service delivery. During this period, the team lead provided frontline cover to maintain safe discharge pathways, impacting capacity for wider service development. The team is now fully staffed, with a second advisor commencing in April 2026.

7.3 Individuals supported and repeat attendances

The service worked intensively with 789 individual patients during the year. Referrals are often repeated, as the service is contacted every time an individual attends hospital.

- 204 individuals attended more than once
- these repeat attendances accounted for 790 admissions or presentations
- patients with the highest number of attendances were predominantly sleeping rough, often found in public spaces and brought to hospital by emergency services

This pattern highlights the cyclical nature of homelessness and the role of health services as a point of contact for highly vulnerable individuals.

7.4 Housing status and discharge outcomes

Of all referrals received:

- 84% related to individuals who were currently or had previously experienced homelessness, including rough sleeping, sofa surfing, temporary accommodation, refuge placements or pending rehousing by the local authority

At the point of attendance or admission:

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- 42% of referrals related to individuals who were street homeless (including rough sleeping, prison release, squats or night shelters), consistent with the previous year
- 18% were living in temporary accommodation or bed and breakfast placements

At discharge:

- 30% of patients were discharged without housing secured; however, this reduced significantly between December and February, reflecting the availability of severe weather provision during winter storms
- 32% of individuals who were sleeping rough on admission remained street homeless at discharge, highlighting ongoing system pressures and housing availability constraints

7.5 Impact on hospital flow

The service continues to play a critical role in reducing delayed discharges:

- 28 patients experienced delayed discharges totalling 172 bed days, a 70% reduction compared to the previous year
- The longest delay was 31 days after medical optimisation, primarily due to lack of accessible accommodation for a patient with mobility needs

This demonstrates improved discharge coordination, while also evidencing the ongoing impact of limited accessible housing options.

7.6 Learning, engagement and development

The service hosted a local broadcast of the Pathway Homelessness and Inclusion Health Conference for a second year, supporting learning and shared best practice across services working with people experiencing homelessness. Feedback was highly positive, and continuation of this offer is planned.

7.7 Risks and future sustainability

Cornwall Council has confirmed continuation of RSI funding for a further 12 months. However, reductions to the national RSI allocation mean this funding has not increased to meet rising salary and service costs, presenting a future sustainability risk and is being discussed at a national and local level.

The homeless hospital discharge service remains a vital component of system-wide efforts to reduce health inequalities, improve patient outcomes, and support effective hospital flow for some of the most vulnerable members of our community.

8. High intensity user (HIU) service

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Service overview

The High Intensity User (HIU) service supports people with the highest levels of unplanned hospital attendances, working closely with individuals and their care teams to improve outcomes and reduce unnecessary use of emergency services.

The service focuses on providing coordinated, person-centred care, ensuring individuals receive the right support at the right time.

Support is delivered through patient-specific multi-disciplinary team (MDT) meetings, bringing together hospital clinicians, community services and partner agencies to agree care plans and share information effectively.

The HIU service aims to reduce repeat attendances by addressing underlying contributing factors such as homelessness, alcohol and substance misuse, physical health needs and mental wellbeing. Strong partnership working and clear communication between professionals are central to this approach.

8.1 Staffing and Funding

The service is funded to provide:

- 0.6 WTE HIU specialist
- 0.8 WTE business support worker

However, the HIU business support role has remained vacant since March 2025 and has been held due to RCHT recruitment controls. The service funding is ring-fenced by the Integrated Care Board (ICB), and as the post remains unfilled, funding cannot be retained by the Trust and would need to be returned if not utilised.

8.2 Activity and impact

Since January 2021, the HIU service has provided targeted intervention and support for over 483 patients. During quarter 4, approximately 6 new patients were discussed, alongside individuals already known to the service. The total for 2025/2026 stands at 27, reflecting a 54% reduction from last year. This decrease is directly related to the ongoing business support vacancy.

8.3 Service pressures and risks

The prolonged business support capacity vacancy has adversely affected service responsiveness. Workforce and capacity pressures have led to delays in updating HIU attendance plans and a reduction in the frequency of patient-specific MDT meetings. At times, this has limited the service's ability to respond as promptly as usual to requests from emergency department (ED) staff.

MDT meetings remain essential for effective communication between professionals and patients; however, reduced capacity has constrained this function. The introduction of Microsoft Copilot has partially mitigated administrative pressures by improving the efficiency of meeting documentation and reducing the associated administrative burden.

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8.4 Workforce challenges

The HIU specialist also holds the homeless team manager role. Due to a separate vacancy within the Homeless Hospital Discharge service, alongside the wider recruitment freeze, the HIU specialist has been required to prioritise frontline cover

within homelessness services. Consequently, HIU activity has been constrained during parts of the year.

Despite workforce pressures, the service continues to demonstrate impact. Colleagues across hospital and community settings report that coordinated care planning has significantly reduced attendances for some individuals who had been frequent users of emergency services for several years. This has benefited both patient experience and system flow.

Future plans

The ICB has confirmed recurrent funding for the HIU service from the next financial year (from April 2026), providing greater stability and supporting longer-term service planning. The HIU specialist is currently reviewing the vacant business support role, with proposals to relocate the post within the emergency department (ED).

9 .Safeguarding children

During 2025/2026, the safeguarding children team has continued to experience sustained and increasing demand across all areas of practice. The duty practitioner function remains central to the service, supporting timely advice, guidance, safeguarding supervision, risk assessment and safety planning through the single point of access.

The safeguarding children team has maintained a core team of 3 band 7 senior specialist nurses and 3.7 WTE band 6 specialist practitioners. This has supported a visible safeguarding children service, with daily visits to paediatric in-patient areas. Positive feedback from the service leaders has indicated how valuable this visibility is.

9.1 Activity

Throughout 2025/2026, children's safeguarding managed a sustained and high volume of referral activity, with over 2,000 cases supported through the integrated duty practitioner function. The duty practitioner role ensures timely advice, guidance, urgent safeguarding supervision, risk assessment and safety planning. Access to the children duty practitioner is via the single point of access and are co-located with the safeguarding adult practitioner strengthening 'think family' approach to safeguarding patients. Figure 11 illustrates the total number of enquiries, supervision, advice and escalation from our workforce requiring safeguarding expertise to manage risk safely.

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Figure 11.

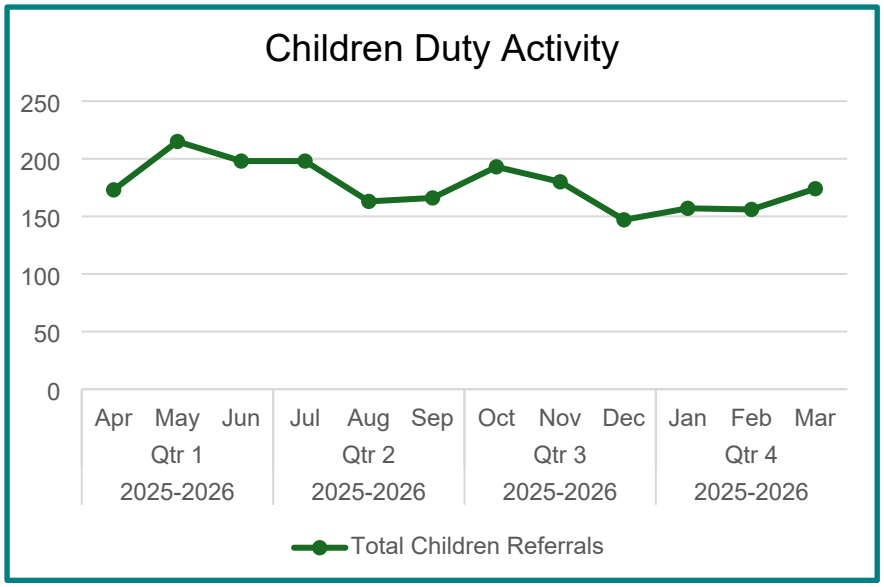
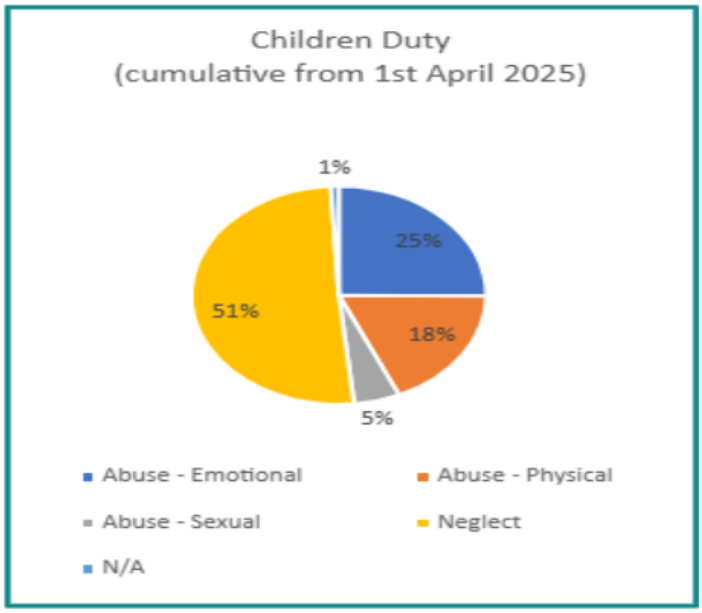


Figure 12 details the activity by category of abuse for annual 2025/2026. Neglect remained the most prevalent safeguarding concern, frequently linked to parental mental ill-health, domestic abuse and repeated non-attendance at health appointments. The nature of activity increasingly reflects high-risk and complex cases, demonstrated by substantial volumes of safeguarding supervision, MARU referrals, escalation and strategy meetings.

Figure 12



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In 2025/2026, safeguarding supervision structures have become embedded within practice. However, variation in supervision compliance across services, particularly

in high-pressure clinical areas, remains a challenge. The safeguarding children team continues to provide targeted support where compliance is low.

The team continues to offer and facilitate weekly group drop-in safeguarding supervision sessions and bookable 1:1 appointments. The safeguarding supervisors training continues to be available with dates planned for 2026/2027 to enable teams forward planning. All members of the safeguarding children team, including new members of staff, are fully trained to deliver safeguarding supervision. All the trained supervisors have access to the safeguarding supervisor Microsoft Teams channel and quarterly forum, supporting ongoing development and peer support.

In collaboration with service leads the team is currently refreshing the register of supervisors and in response to feedback a safeguarding supervisor update training is being developed for launch in October 2026.

The safeguarding children team continues to identity learning themes through, patient safety incident review, acuity of enquiries, supervision and local and national safeguarding reviews. These themes are used to inform our training, supervision and staff development. The trust governance meetings and safeguarding operational group are used as forums to share and cascade any learning with the wider workforce.

The learning themes of 2025/2026 include:

- child victims of domestic abuse
- professional curiosity
- exploitation
- ‘think family’ approaches
- impact and recognition of cumulative harm
- early escalation of the signs of neglect
- risks associated with disguised compliance
- injury to non-mobile babies

The learning lunches schedule for 2026 has been launched and this also includes a planned safeguarding conference on domestic abuse in November 2026, and an exploitation themed week of learning planned for July 2026.

9.2 Multi agency child protection

In July 2025, the children’s safeguarding team was formally identified within a local authority mitigation plan as the central point of coordination for all child safeguarding strategy meeting invitations. This action followed an identified system risk, escalated through the Safeguarding Children Partnership Board, that health information was not being consistently represented within statutory safeguarding decision-making forums, limiting the quality of multi-agency risk assessment and planning.

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To mitigate this risk and strengthen statutory safeguarding processes, the team assumed responsibility for coordinating and managing all health invites to strategy

discussions. Between July 2025 and March 2026, the team managed 2,408 strategy meeting invitations, ensuring the timely provision of relevant health information from the trusts, professional analysis and contribution to joint decision-making. The activity is illustrated in figure 13 below.

This represents a substantial increase in safeguarding involvement compared to previous years, far exceeding historic levels of health input into strategy discussions. The volume of strategy meetings itself provides clear evidence of the high level of risk, complexity and safeguarding need being experienced within the community.

Figure 13.



The safeguarding team's role has been pivotal in:

- ensuring health histories, patterns of non-attendance and medical neglect are consistently considered
- supporting robust threshold decision-making aligned with statutory expectations
- strengthening professional challenge and shared understanding of risk
- improving the quality, consistency and defensibility of safeguarding decisions

In response to national directives for child protection, a 12-month child protection health team pilot will commence in May 2026, developed collaboratively with:

- public health nursing
- the multi-agency referral unit (MARU)
- the RCHT/CFT children's safeguarding team

The pilot will operate through a co-located, rotational staffing model, ensuring dedicated, consistent and skilled health input into child protection activity, including strategy discussions and statutory processes. The ICB is supporting the pilot and is actively considering options for a sustainable, permanent model. This development is strongly aligned with national safeguarding reform expectations, including those set out within the families first / child protection reform agenda, strengthening our multi agency child protection processes.

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9.3 Child protection information sharing (CP-IS)

During 2025/2026, the children's safeguarding team has continued to lead work to embed child protection – information sharing (CP-IS) across all services delivering care to children, recognising its importance as a critical safeguarding control for the early identification of children subject to statutory safeguarding plans.

CP-IS is now fully implemented within CFT and has been well established within RCHT unscheduled care settings, including ED and urgent care areas.

Implementation is currently being extended within RCHT outpatient services and scheduled care areas, supported by a phased implementation plan. This work focuses on system readiness, staff awareness, and safeguarding practice rather than solely technical deployment, ensuring CP-IS alerts are understood, responded to appropriately, and embedded into routine care. The safeguarding children team continues to provide oversight, advice and assurance throughout the implementation process, working closely with clinical, digital and operational colleagues to support consistency and sustainability. An ongoing implementation plan includes an audit at the end of 2026 to ensure this has been embedded in line with national directive.

9.4 Key achievements and good practice

- **Section 11 audit**

During 2025/2026, the team submitted a comprehensive safeguarding assurance report to the Our Safeguarding Children Partnership (OSCP) as part of the Section 11 audit process. This audit provided independent assurance that statutory duties to safeguard and promote the welfare of children are being effectively discharged across health services.

Feedback from the OSCP highlighted multiple areas of good practice, including strong governance arrangements, effective safeguarding leadership, and clear evidence of practice that places the voice and lived experience of children at the centre of safeguarding responses. The findings reflected the Trusts' sustained commitment to creating a culture in which safeguarding is embedded as core business and where professional curiosity, information sharing and escalation are actively supported.

- **Routine enquiry**

The team has worked collaboratively to implement the voice of the child and routine enquiry as a core element of paediatric admissions at RCHT. This has involved supporting paediatric teams to confidently and consistently engage children and young people, ensuring their views, experiences, and wishes are actively sought, heard, and recorded as part of holistic assessment. By embedding routine enquiry into admission processes, we have strengthened the early identification of safeguarding concerns, promoted trauma-informed practice, and improved the quality of information shared across services. This work has helped ensure that the

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child's voice meaningfully informs clinical decision-making and safeguarding responses within acute paediatric care.

The ongoing projects for 2026/2027 are:

- transition of children to adult services
- development of safeguarding children service operational procedures (SOPS)
- multi-agency child protection team development
- refresher training for safeguarding supervisors
- domestic abuse: child centered
- exploitation: themed learning week
- domestic abuse themed conference

10. Maternity safeguarding

During 2025/2026, maternity safeguarding activity continued to rise, reflecting increasing levels of complexity and vulnerability among expectant families.

A total of 327 multi-agency referral unit (MARU) referrals were submitted for unborn babies, representing an 8% increase from 2024/2025 and continuing a 4 year upward trend. With 3,532 births recorded during the year, 9% of all pregnancies resulted in a referral to children's social care. There were 173 pre-birth social work assessments, a 5% increase from the previous year. Of these, 53% progressed to statutory involvement, indicating that most referrals were appropriate and met the threshold for action.

10.1 Complexity of need

The level of complexity within referrals remained high:

- 51% (n=168) of MARU referrals identified domestic abuse as the primary concern
- 32 pregnant people were discussed at MARAC due to high-risk domestic abuse, with a notable rise in non-fatal strangulation
- the team reviewed 163 PPNs relating to domestic abuse incidents involving a pregnant person
- 27% (n=89) of referrals involved substance and/or alcohol use by the pregnant person or partner

Most families presented with multiple vulnerabilities, including parental trauma histories and risks to adult wellbeing. This required daily liaison between maternity safeguarding, adult services, and children's social care to ensure coordinated safety planning.

There were 4 pregnant people identified with female genital mutilation (FGM) at booking during 2025/2026.

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10.2 Multi-agency working and contacts

The team attended 593 multi-agency safeguarding meetings, a 12% decrease from 2024/2025. This reduction reflects the service's significant capacity challenges rather than a reduction in need.

Daily contact with the maternity safeguarding team remained high, with 2,609 contacts recorded. Actual activity is likely higher due to limited capacity for accurate recording during periods of staffing pressure.

10.3 Outcomes of pre-birth assessments

Of the 173 pre-birth assessments:

- 118 unborn babies were subject to Child in Need or Child Protection Plans, an 11% increase from 2024/25 (n=105)
- 34 families were supported under Public Law Outline (PLO) or legal proceedings, a 44% increase from 2024/25 (n=19)
- baby-only placements reduced significantly to 4, whilst mother and baby/family placements increased to 19, reflecting a shift toward keeping families together, where safe
- three babies were relinquished following birth
- the remaining 55 families had cases closed before birth, moved out of county, or stepped down to early help

10.4 Safeguarding supervision

Safeguarding supervision compliance remained lower and inconsistent throughout 2025/2026. Capacity constraints meant that community team leaders delivered most supervision as part of short-term mitigation. Challenges with recording systems also affected data accuracy.

In quarter 4 2025/2026, the named midwife for safeguarding increased the supervision offer, introducing weekly drop-ins and sessions during maternity training week. This was in response to rising referral numbers, increasing caseload complexity, high staff turnover, and a growing number of less-experienced midwives requiring enhanced support.

10.5 Risk

Maternity safeguarding has remained an extreme risk (score 15, risk 9664) since 2024. Key challenges include:

- rising demand and increasing statutory responsibilities
- reduced team capacity and significant staff turnover
- no contingency cover for unexpected absences
- limited ability to attend all statutory meetings or progress service development work
- restricted capacity for guideline updates, audits, and improvement projects

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An action plan is in place, with both short and long-term mitigation measures. An investment request has been submitted to increase staffing and strengthen service resilience.

10.6 Key achievements and good practice

Despite significant pressures, the maternity safeguarding team contributed to several important developments:

- **Safer sleep initiative**

Following 8 sudden and unexpected infant deaths in unsafe sleep environments across Cornwall and the Isles of Scilly, the OSCP Sudden Unexplained Death in Infant (SUDI) task and finish group developed a multi-agency safer sleep risk assessment and plan. This has now been successfully implemented across maternity and perinatal services in both RCHT and CFT.

- **Support for parents at risk of child separation**

The named midwife for safeguarding continues to contribute to a Safer Cornwall working group focused on supporting parents at risk of separation from their children. This aligns with priorities across the 4 statutory safeguarding boards. The FERN (representing gentle steps and steady growth) pilot, launching in May 2026, will provide intensive support to families. The named midwife will sit on the decision-making panel, with the maternity safeguarding team supporting the wider multi-agency approach.

- **Non-fatal strangulation (NFS) response**

In response to rising cases of non-fatal strangulation in pregnancy, a multi-agency agreement was reached for all pregnant people experiencing NFS to be automatically discussed at MARAC as high-risk. The safeguarding team will continue to attend MARAC and will lead further awareness-raising and clinical training on NFS across both Trusts during 2026.

11.Safeguarding reviews

11.1 Domestic Homicide Reviews (DHRs) also known as Domestic Abuse Related Death Review (DARDR)

Domestic Homicide Reviews are statutory reviews established under Section 9 of the Domestic Violence, Crime and Victims Act 2004 and implemented in April 2011. The government has confirmed that the terminology will change from Domestic Homicide Review to Domestic Abuse Related Death Review to better reflect the full scope of deaths considered, including homicides and suicides.

Both CFT and RCHT contribute to DHRs through internal management reports and participation in multi-agency panels to ensure compliance with statutory duties.

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11.2 Current DHR activity

- 15 DHRs are currently in progress

- 3 relate to out-of-county cases
- 6 involve parallel processes, including safeguarding adult reviews (SARs), mental health homicide reviews, or local safeguarding practice reviews
- 2 referrals are awaiting allocation of a chair, with 1 paused pending a criminal investigation
- one thematic DHR is reviewing 4 linked cases
- there has been an increase in premature deaths of women by suicide linked to domestic abuse, prompting a thematic review by the Cornwall and Isles of Scilly Safeguarding Adults Board (CIoS SAB)

11.3 Key themes and learning

Recurring themes across DHRs continue to shape local safeguarding priorities:

- domestic abuse–related suicide: a thematic review of 4 cases was commissioned in June 2025 to strengthen systemic learning
- adult family homicide: 2 notifications in 2025/26 involved adult family violence meeting DHR criteria
- coercive control: present in 13 of 22 DHRs over the past 5 years, reflecting national trends
- capacity and decision-making: reviews highlight the impact of coercive control, trauma, and substance use on an individual's ability to make autonomous decisions

Action plans arising from DHRs are monitored through the DHR learning and implementation group, the domestic abuse and sexual violence steering group, the Home Office, and the CFT's safeguarding subcommittee.

11.4 Safeguarding adult reviews (SARs)

Safeguarding adult reviews examine how agencies worked together when an adult with care and support needs has died or experienced serious harm due to abuse or neglect.

11.5 Current SAR activity

- 16 SARs are currently in progress at the end of 2025/2026
- 1 case involves a parallel process (mental health homicide review)
- there are no referrals awaiting commissioning decisions or allocation of an independent chair

11.6 Key themes and learning

Themes emerging from SARs include:

- Mental Capacity Act: challenges in assessing executive capacity and the importance of clear documentation

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- Court of Protection: need for timely legal advice and clarity on application processes
- professional curiosity: importance of challenge, scrutiny, and exploration of risk
- support for carers: variability in the quality and consistency of support
- self-neglect: effective use of multi-agency procedures and the high-risk behaviour panel
- organisational abuse: instances where regulated services placed residents at risk due to systemic failings
- risk management: need for clear ownership, communication, and short, medium, and long-term planning
- transitions: ongoing challenges in transitions from children to adults' services
- trauma-informed practice: importance of recognising the impact of childhood trauma
- language and terminology: avoiding language that may stigmatise or imply blame

SAR action plans are monitored by the Safeguarding Adult Board (SAB) subgroup and internally through the CFT safeguarding subcommittee.

11. 7 Rapid reviews

Rapid reviews are undertaken following serious child safeguarding incidents to identify immediate learning within 15 days, in line with statutory guidance. The updated Working Together guidance was published in March 2026.

In 2025/2026, the Cornwall and Isles of Scilly OSCP completed:

- 7 rapid reviews, 5 of which were submitted by RCHT or CFT practitioners
- completed 4 learning from experience (LFE) reviews, providing learning where statutory thresholds were not met

11.8 Key themes and learning from rapid reviews

- professional curiosity: importance of exploring inconsistencies and understanding the child's lived experience
- accumulative harm: risks arising when low-level concerns are viewed in isolation
- safe sleeping: need for consistent messaging and culturally sensitive conversations
- information sharing: delays or gaps contributed to risk in several cases
- infant feeding: importance of recognising feeding concerns within a safeguarding context
- communication and cultural capability: ensuring families understand advice, particularly where language, disability, or neurodiversity are factors
- exploitation: need for stronger multi-agency responses to criminal and sexual exploitation
- domestic abuse: continued impact on children, including unborn babies

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- ‘think family’: importance of considering parental needs and risks alongside the child’s safety

A local child safeguarding practice review has been commissioned following instruction from the national panel and will commence in April 2026.

Two thematic reviews on sudden infant death and on transition to adulthood for care leavers were completed during the year, providing further insight into safeguarding complexities and informing future service development.

Learning from all reviews has been disseminated through multi-agency briefings, safeguarding supervision, and partnership learning events.

12. Professional allegations

In line with statutory safeguarding guidance, professional allegations against Trust practitioners may require a safeguarding response and oversight by the relevant local authority officer. This will be either the children’s local authority designated officer (LADO) or the adults persons in a position of trust (PiPoT) practitioner, both of whom are employed by the local authority and hold statutory responsibility for the oversight of such concerns.

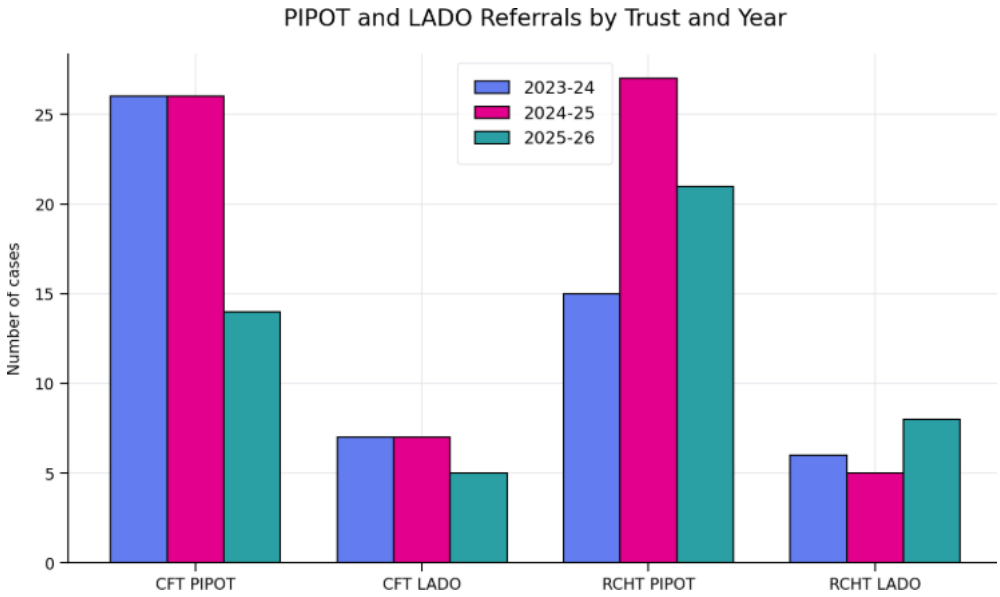
A referral to LADO or PiPoT must be made where information indicates that a Trust practitioner may present a transferable risk of harm to others through their professional role, including patients, children, or adults with care and support needs. Concerns may arise from the practitioner’s professional practice or from their personal life, where such matters raise safeguarding concerns or questions about suitability to work with vulnerable groups.

The head of safeguarding and deputy head of safeguarding provide expert safeguarding advice and leadership to Trust services in relation to professional allegations. This includes supporting decision-making regarding thresholds for referral, liaison with the local authority LADO or PiPoT service, and ensuring that safeguarding considerations are appropriately managed alongside internal human resources and disciplinary processes, in accordance with statutory guidance.

Figure 14 provides the number of PIPOT and LADO referrals across CFT and RCHT for the past 3 years.

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Figure 14



The data in figure 14 demonstrates variation in PiPoT and LADO referrals across both Trusts over the 3 year period. This includes a reduction in CFT PiPoT referrals in 2025/2026 and an increase in RCHT LADO referrals over the same period.

It should be noted that this variation may, in part, reflect a change in recording practice, as earlier data included safeguarding advice and consultation calls within reported figures. The most recent data set now includes PiPoT and LADO referrals only, ensuring clearer alignment with statutory reporting expectations.

Given the small number, there are no identifiable themes. Trends will continue to be monitored through established safeguarding governance and assurance structures, with ongoing oversight to ensure consistency, appropriate thresholds for referral, and compliance with statutory safeguarding guidance.

13. Domestic abuse and sexual violence (including sexual misconduct at work)

During 2025/2026, the domestic abuse coordinator (DAC) led delivery of the domestic abuse and sexual violence (DASV) strategy across RCHT and CFT. This included implementation of the NHS Sexual Safety Charter and the Sexual Misconduct Policy, ensuring a consistent, trauma-informed and zero-tolerance approach to abuse, harassment and sexual violence.

The DAC has acted as a central point of expertise, representation and assurance, maintaining active involvement at internal Trust forums and local and national partnership groups. A sustained focus has been placed on supporting frontline staff and creating safe, accessible routes for advice, disclosure and response.

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13.1 Activity and service delivery

Throughout the year, the DAC provided direct support and specialist advice to frontline teams including ED, minor injury units (MIUs), Isles of Scilly services, mental health services and paediatrics. This has contributed to improved staff confidence and reduced barriers to identifying and responding to domestic abuse and sexual violence.

Key activity highlights include:

- fourteen referrals were received through the DASV allies network, with timely and appropriate support provided in all cases
- the DAC completed pre and post-contact supervision for every referral, supporting staff safety, reflection and confidence
- an increase in direct referrals was noted following the inclusion of DASV allies information within return-to-work documentation, improving awareness and access to support

13.1 Training and awareness

A strong programme of training and awareness activity has supported cultural change and professional curiosity:

- mandatory sexual safety in the workplace e-learning rolled out Trust-wide
- emergency departmetn specific training delivered, with additional focus planned for 2026 on routine enquiry
- drop-in sessions delivered across MIUs, mental health services and paediatrics
- sexual safety embedded into Trust induction for all new staff across both organisations

This approach has ensured consistent messaging and increased visibility of DASV support and expectations.

13.2 Themes and emerging trends

Key themes identified during the year include:

- Increased staff engagement has been observed following the launch of the DASV allies network and the implementation of the Sexual Misconduct Policy.
- There has been a growing demand for staff focused support, particularly in relation to workplace sexual safety and disclosures, reflecting increased awareness and confidence in accessing support.

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- Attendance at the CFT/RCHT DASV steering group has been inconsistent, resulting in 2 meetings being stood down due to lack of quoracy. In response, the terms of reference are currently under review and are anticipated to be completed by quarter 2, to ensure appropriate representation, clearer accountability and improved engagement, strengthening governance and oversight of the DASV agenda.

13.3 Comparison with previous year

Compared to 2024/2025, there has been:

- A significant increase in staff-focused DASV enquiries, linked to the establishment of the allies network
- greater visibility of DASV information and resources through posters, intranet updates and induction materials
- more robust and structured governance arrangements, including MARAC supervision and revised Steering Group terms of reference

These developments reflect the following:

- introduction of the Sexual Misconduct Policy and Sexual Safety Charter, providing clearer standards, expectations and reporting routes
- the DASV allies network, which has increased accessibility of support and encouraged earlier disclosures
- enhanced training and communication, improving staff confidence to recognise and respond appropriately to DASV concerns

13.4 Risk

- Sustained workforce pressures in frontline services have limited engagement with scheduled training and drop-in support in some areas. In response, the DAC is exploring creative and flexible approaches to delivering training and support, to maximise accessibility and engagement while accommodating operational pressures
- Variation in confidence across services in routine enquiry and responses to disclosures. This will be a focus for audit in the forthcoming year.
- There is a risk of reduced oversight and consistency if attendance and engagement at the steering group does not improve. To address this, a SurveyMonkey consultation has been undertaken to better understand members' preferred meeting days, times and frequency, with the aim of improving accessibility, strengthening engagement and enhancing attendance.

13. 5 Learning from incidents and feedback

- Opportunities were identified to further support staff understanding of sexual misconduct processes. This has been strengthened through updates to the Sexual Misconduct Policy, including the introduction of a clear 72-hour response

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timeframe to help ensure concerns are managed in a timely, transparent and supportive way.
- Feedback on initial Allies posters prompted redesign to improve clarity, visibility and staff confidence
- It is identified that there is a need for continued alignment between DASV work, Freedom to Speak Up (FTSU) and suicide prevention, recognising overlapping risk factors

13.6 Key achievements and good practice

Establishment of the DASV allies network

- 34 trained allies, with 8 awaiting training, representing a diverse range of genders, departments and lived experience
- bespoke Barnardo's training delivered throughout the year to DASV Allies and comprehensive resource handbooks developed
- active senior leadership support, including participation from the Chief Executive
- redesigned posters, Microsoft Teams backgrounds and a new logo to strengthen visibility and access

Implementation of the Sexual Safety Charter and Sexual Misconduct Policy

- full commitment from both Trusts to the NHS England Sexual Safety Charter
- development of behaviour standards, resource booklets, easy-read materials and QR-linked support pages
- policy launched in September 2025, with strengthened timeframes and clearer support pathways
- embedded within induction for all new staff

Strengthened multi-agency and internal collaboration

- DAC representation at the MARAC Steering Group and introduction of MARAC supervision for staff
- close working with freedom to speak up (FTSU) and suicide prevention leads to align support and messaging
- regular drop-ins, training sessions, newsletters and intranet updates improving consistency across both Trusts

13.7 Future plans

The DASV agenda has seen significant growth in visibility, structure and staff engagement during 2025/2026. Priorities for 2026/2027 include:

- consolidating and expanding the DASV allies network
- improving engagement and effectiveness of the DASV Steering Group
- strengthening routine enquiry practice
- continuing to embed sexual safety as a core element of staff wellbeing, culture and organisational values

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14. Safeguarding training compliance

All registered healthcare staff, including agency, voluntary staff and contracted providers, who have regular contact with patients, service users, families, carers or the public are required to complete safeguarding training appropriate to their role. This applies across both NHS and non-NHS settings.

Safeguarding children's and adults training is mandatory, with nationally specified minimum learning requirements. Training is delivered and evidenced over a 3 year compliance cycle, in line with intercollegiate guidance. The training deliver model is as follows:

- level 1 and level 2 safeguarding adults and children training is delivered via e-learning, accessible through the electronic staff record (ESR)
- level 3 training requirements state that at least 50% of learning must be participatory, enabling reflection, discussion and learning with colleagues who have sufficient safeguarding expertise

Historically, level 3 safeguarding adults and children training was delivered directly by the safeguarding team. Following organisational change and the loss of the dedicated safeguarding training facilitator role, this model was no longer sustainable.

Level 3 training has therefore transitioned to:

- the NHS England recommended e-learning package hosted on the learning hub
- supplementary learning through local, regional and national continuing professional development (CPD) opportunities to meet participatory learning requirements

14.1 Compliance recording and data limitations

There is currently no interface between the NHS Learning Hub and ESR, resulting in challenges accurately recording level 3 safeguarding training compliance.

In response, safeguarding teams are working closely with education and training leads to:

- improve signposting to appropriate participatory learning opportunities
- implement a self-certification process within ESR to evidence completion of level 3 learning

This solution was implemented in quarter 4, providing improved oversight and assurance.

14.2 Current compliance position

Safeguarding training compliance for the year end 2025/2026 is outlined in figures 15 and 16 below. Across both Trusts, recorded compliance remains below the agreed Trust standard of 95% in all categories.

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It is important to note that level 3 compliance figures are likely under-reported, particularly due to:

- migration from Develop Me to ESR at CFT
- ongoing challenges in recording externally delivered participatory safeguarding learning; as reported above, a solution has been identified, which will result in a more accurate indication of training compliance in the next financial year

Figure 15: Safeguarding training compliance – CFT

Course	Staff Requiring Competence	Staff Compliant	Compliance
Safeguarding Adults Level 1	1,101	993	90.19%
Safeguarding Adults Level 2	804	704	87.56%
Safeguarding Adults Level 3	1,515	999	65.94%
Safeguarding Children Level 1	862	733	85.03%
Safeguarding Children Level 2	1,625	1,418	87.26%
Safeguarding Children Level 3	1,019	796	78.12%

Figure 16: Safeguarding training compliance – RCHT

Course	Staff Requiring Competence	Staff Compliant	Compliance
Safeguarding Adults Level 1	12,886	10,528	81.7%
Safeguarding Adults Level 2	8,842	7,225	80.4%
Safeguarding Adults Level 3	8,842	2,493	28.2%

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Safeguarding Children Level 1	12,886	10,629	82.5%
Safeguarding Children Level 2	8,990	7,441	82.8%
Safeguarding Children Level 3	1,277	861	67.4%

14.3 Risks, assurance and next steps

Whilst recorded compliance remains below the Trust target, current data does not fully reflect the safeguarding learning undertaken by staff, particularly at level 3. The planned ESR self-certification process is expected to significantly improve accuracy and provide stronger assurance to Boards and regulators.

Safeguarding, education and workforce teams will continue to:

- monitor compliance trends
- provide targeted communications and support to services
- ensure staff are clear on statutory safeguarding responsibilities

Improving safeguarding training compliance remains a key priority, supporting safe, effective and compassionate care for children, adults and families.

15. Learning disability and autism acute liaison service (RCHT)

The learning disability and autism acute liaison (AL) service provides specialist support to children and adults with a diagnosed learning disability and/or autism when accessing acute hospital services. The team plays a key role in ensuring that reasonable adjustments are identified, communicated, and implemented to support safe, equitable, and person-centred care.

15.1 Activity 2025/2026

The service continues to experience sustained growth in demand. During 2025/2026, the team supported 5,544 patients, representing a 6% increase compared to 2024/25 (5,211 patients). Activity has increased year on year, and this continued upward trend indicates that the current team structure/service provision will require review to ensure demand can be safely and effectively met.

15.2 Children and adult support

This year saw a 16% increase in the number of children supported and a 3% increase in adults compared with the previous year. This reflects both rising need and improved identification of patients requiring specialist support.

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15.3 Increase in autism-related support

The service has recorded a significant rise in the number of patients with autism (ASD) requiring support. Earlier diagnosis increased public awareness, and improved recognition by clinical teams have all contributed to this trend.

For the first time, ASD activity has been recorded separately to monitor this shift. Five years ago, the service supported approximately 25% ASD and 75% learning disability patients; this year, the split is close to 50/50, demonstrating a marked change in the profile of need.

15.4 Service developments

- **Triage and assessment tools**

To manage increasing demand and ensure equitable support, the team piloted a new triage tool to assess individual patient needs and allocate the appropriate level of support. This has now been implemented for all inpatients and outpatients.

In addition, the team developed a reasonable adjustment risk assessment (RARA), approved by the Trust, to guide ward teams in identifying and implementing personalised reasonable adjustments. The RARA is stored in the patient's nursing notes to ensure all staff have access to essential information.

- **Expansion of specialist support**

In April 2026, a Greenlight practitioner is due to commence in the inpatient mental health units, funded by CFT. This role mirrors the acute liaison function and is supervised by the same manager to ensure consistency and continuity across the integrated service.

- **Enhancing patient experience**

Charitable donations enabled the purchase of equipment to support sensory and communication needs, including a portable bed, ear defenders, radios, and sensory items. These resources help create a more positive and accessible hospital experience.

- **Hospital checks and co-production**

Hospital checks continued throughout the year, undertaken by the Cornwall Health and Making Partnerships (CHAMPS) team, who are a team of people with lived experience of learning disability and/or autism. Their feedback has highlighted both areas for improvement and examples of good practice, such as the use of easy-read materials, improved signage, and simple but impactful reasonable adjustments.

16. Integrated admiral nurse service

The admiral nurse service is delivered by RCHT in partnership with CFT and Dementia UA. The service provides specialist support to families and carers of people with a confirmed diagnosis of dementia across Cornwall.

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The multidisciplinary team comprises:

- one service manager
- three admiral nurses – fix term positions
- one assistant practitioner – fix term position

The service offers one-to-one telephone support and works across the whole health and care system, supporting carers:

- in acute hospital settings
- in community hospitals
- in people's own homes
- during transitions into care homes

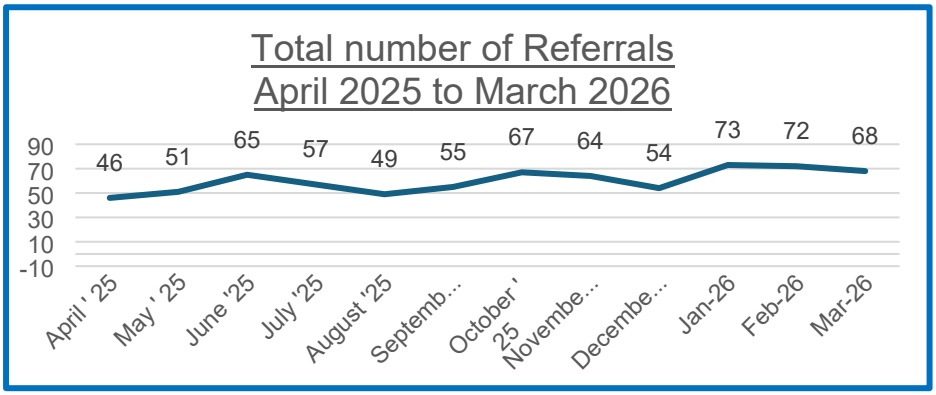
The service plays a key role in helping carers navigate complex care systems, supporting decision-making and promoting wellbeing throughout the dementia journey.

Currently the Admiral nurse service is joining a tender progress with Alzheimer's UK to fund the team's fix term roles for another 7 years.

16.1 Activity and demand

During 2025/2026, the service received 721 referrals, with a further 25 carers supported through the supporting ahead programme (SAP). This brings the total number of carers supported to 746, which is consistent with referral levels in 2024/2025. This is outlined in figure 17 below.

Figure 17.



Whilst overall referral numbers have remained stable, the complexity of referrals has increased significantly. Interventions increasingly focus on:

- emotional and psychological support to promote carers' mental health and wellbeing
- physical health management
- transitions between care settings

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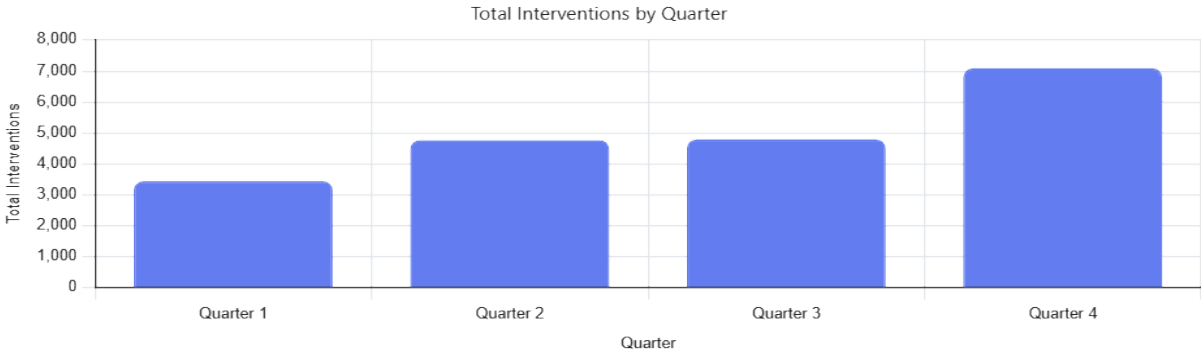
- advance care planning and best-interest decision making
- managing complex comorbidities
- supporting carers through loss, bereavement and adjustment

The team is increasingly involved in discharge planning from both acute and community hospital wards and regularly attends best interest and professional meetings to ensure care decisions are holistic and centred on carers' needs and experiences. There has also been a notable increase in safeguarding concerns, particularly relating to self-neglect.

16.2 Interventions delivered and service impact

Over the year, the team delivered a total of 20,094 clinical interventions to support carers. Activity increased significantly over the course of the year as summarised in the figure 18.

Figure 18



This represents a 105% increase in clinical interventions from quarter 1 to quarter 4, demonstrating a substantial growth in service capacity and responsiveness. The increase reflects the team's ability to adapt to rising demand and the increasing complexity of carers' needs, while maintaining timely access to support.

16.3 Risks and challenges

The current staffing model of 3 admiral nurses and 1 assistant practitioner places significant pressure on the service. As care pathways become more complex, each case requires greater time, depth of assessment and continuity of involvement. Without workforce expansion, this increases the risk of:

- delays in intervention
- reduced continuity of care
- increased pressure on staff resilience

To mitigate these risks, the service has developed and implemented an evidence-based care pathway, enabling more consistent decision-making and prioritisation. This approach has ensured there is currently no waiting list for the service. However, to sustain this position and deliver safe, timely care in the future, additional workforce capacity is likely to be required.

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16.4 Key achievements and service developments

During 2025/2026, the admiral nurse service achieved several notable successes:

- national recognition, winning the Best Dementia Outreach Award at the National Dementia in Care Awards
- development and publication of the Ellis-Johnstone Care Pathway, strengthening consistency and quality of care
- delivery of 2 Supporting Ahead Programme (SAP) events, bringing together professionals and agencies to provide carers with information, advice and a holistic referral access point
- hosting 2 ‘Care and Share’ events, supporting professional learning, networking and improved inter-service understanding, leading to more appropriate referrals and better outcomes
- the service manager chairs the Carers Corner Steering Group, overseeing 6 Carer Corners across Cornwall, supported by a strong multi-agency network

In summary the service continues to provide high-quality, specialist support to carers of people living with dementia across Cornwall. Despite increasing complexity and workforce pressures, the service has demonstrated resilience, innovation and impact, supporting more carers, delivering more interventions, and receiving national recognition for excellence in dementia care.

17. Conclusion

This report demonstrates the scale, complexity and breadth of safeguarding activity across CFT and RCHT during 2025/2026, delivered within a fully integrated model and under sustained system pressure. Despite rising demand, workforce constraints and increasing levels of risk and vulnerability, statutory responsibilities were met, governance and assurance remained robust, and safeguarding continued to be embedded as core business across both Trusts. Significant progress was made in early intervention, multi-agency collaboration, learning from reviews, trauma-informed and ‘think family’ practice, and responses to domestic abuse, sexual violence and organisational risk. Clear priorities for 2026/2027 have been identified to strengthen capacity, resilience and quality of assurance, supporting the continued delivery of safe, compassionate and effective care for children, adults, families and carers across Cornwall and the Isles of Scilly.

18. Recommendation

The committee is recommended to note the scale, complexity and impact of safeguarding activity delivered across the integrated CFT and RCHT services during 2025/2026, and to be assured that robust governance, statutory compliance and effective multi-agency working remain in place, with clear priorities and action plans identified to strengthen capacity, resilience and quality of safeguarding assurance in 2026/2027.

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Royal Cornwall Hospitals NHS Trust

Meeting: Trust Board In Public

Date of Meeting: 02 July 2026

Item Number: 21

Title of Report: Infection Prevention and Control Annual Report

Executive Director Lead: Louise Dickinson, Interim Chief Nursing Officer, CFT

Author and Job Title: Joanne Taylor, Director Infection Prevention and Control and Infection Prevention Control Consultant Nurse
Liam Button, Infection Prevention Control Lead Practitioner

Email Address: joanne.taylor93@nhs.net liam.button@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☐

To provide an overview and assurance of the annual activity and Infection Prevention outcomes for 2025/26.

Consultation:

The report has been to both RCHT and CFT Infection prevention and Control Committees and endorsed by the joint Quality Assurance Committee for onward approval in May 2026.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☐

Reputational ☐ **Legal / Regulatory** ☒

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Impact:

Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	
Quality Impact Assessment completed?			x	
Data Protection Impact Assessment completed?			x	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	The annual data of reportable infections and the related activity within the organisation of both outbreaks, reportable cases and risk reduction activity.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	The activity of the organisation in adherence to The Health and Social Care Act 2012.
Sustainable and efficient use of NHS resources by RCHT	

Recommendations:

The **Board** is r**ecommended** to:

- **Note** the Annual Report noting the end of year reportable Infection cases, noting improvements in meeting the *Clostridioides*. Difficile (C.Difficile) trajectory for the first time in a number of years.

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Director of Infection Prevention and Control

Annual Report

April 2025 – March 2026

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1. Situation / Executive Summary

The teams from Royal Cornwall Hospitals NHS Trust (RCHT) and Cornwall Partnership NHS Foundation Trust (CFT) have continued to work collaboratively throughout the year to ensure a seamless service for all patients.

There were two RCHT trust apportioned MRSA bacteraemia cases reported in 2025/2026. There were two CFT trust apportioned MRSA bacteraemia in 2025/26.

RCHT achieved its *Clostridioides* difficile (CDI) objective of no more than 95 hospital onset healthcare associated (HOHA) and community onset healthcare associated (COHA) cases. A total of 60 HOHA cases were reported and 34 COHA during the year. One HOHA and one COHA case were due to the new 'decision to admit' reporting criteria, taking into account where a patient attended the emergency department (ED) directly before the in-patient admission. There were 16 community HOHA CDI cases and two community COHA cases reported at CFT. This compares to a combined total of 28 in 2024/25.

There were 82 HOHA cases of Gram-negative bacteraemia attributed to RCHT against a tolerance of 118 cases, 46 of which were E.coli infections. There were 26 cases of E. Coli bacteraemia that were CFT attributable during 2025/26 this is a reduction of four cases compared to the previous year. This is the lowest total since the introduction of community nursing surveillance in 2022/23.

Under the terms of the mandatory surveillance scheme, the acute trust is required to submit data on orthopaedic surgical site infections for at least one quarter each year. Surveillance data was collected for quarter one and quarter two including total hip replacements, reduction of long bone fracture, total knee replacements and neck of femur repairs. At RCHT and SMH all surgeries except hip replacements achieved a 0% infection rate, hip replacements had an infection rate of 1% and 0.5% respectively.

Watch and reserve antimicrobial usage at RCHT remains low. RCHT continues to be one of the lowest total antibiotic-prescribing trusts in the southwest, but usage is increasing.

At CFT top prescribing by volume was driven by 'access' agents like amoxicillin and flucloxacillin alongside significant use of 'watch' agents like co-amoxiclav, ciprofloxacin, ceftriaxone, piperacillin, meropenem.

Cleaning standards across both trusts have remained predominantly above expected targets; where these have failed corrective action plans have been put in place.

PLACE audits have been carried out at CFT and RCHT, with progress being made on action plans. However, both trusts remain below the national average in the majority of categories.

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2. Infection prevention and control arrangements

a) **Director of infection prevention and control (DIPC)**

Throughout the first 3 quarters of the year the role of the DIPC was carried out by the Cornwall Partnership NHS Foundation Trust director of nursing, and AHPs, who also holds a joint role as the DIPC for both organisations. Due to retirement, the individual had a change in substantive role during quarter 4 however continued to hold DIPC position. The DIPC oversees infection prevention and control policies and their implementation. The DIPC is responsible for infection prevention and control within the trusts and reports directly to the chief executive and the trust board. An associate director of antimicrobial stewardship is in place at RCHT to support this important agenda.

b) **Infection prevention and control (IPAC) team**

The IPAC team provides specialist advice on matters relating to the identification, prevention, and management of infection across both trusts. The team works to an agreed annual programme of work, approved by the trust boards. In addition, a service level agreement is held with Cornwall hospice care.

i) **Infection prevention and control team structure 2025/2026 – funded workforce (see appendix 1)**

Dual deputy DIPC/ consultant nurse infection prevention (band 8c).	0.95 WTE.
Infection prevention and control lead practitioner (band 8a).	1.0 WTE.
Senior infection prevention and control practitioner (Band 7).	2.95 WTE (2025/26 Q4 -1.0 WTE for research post and -0.95 WTE due to maternity leave).
Infection prevention and control practitioners (Band 6).	7.6 WTE (of which 1.0 WTE temporary until December 2026).
IPAC admin lead (Band 5).	1.0 WTE.
Team administrator (band 3).	0.8 WTE.
Audit and surveillance support worker (band 3).	0.6 WTE.
Respiratory fit tester (band 4).	0.8 WTE.
IPAC doctor.	2 PA's (this has been vacant for the year however interim cover has been provided by one of the microbiologists).
Associate director antimicrobial stewardship (RCHT post only).	2 PA's.

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As well as the infection prevention and control doctor sessions, the team is supported by four substantive and two locum clinical microbiologists who play

an active role in the function of the team, providing an out of hours infection prevention and control advice service via the microbiology on call arrangements.

Additional microbiology support is provided by the microbiology laboratory which is accredited by Clinical Pathology Accreditation (CPA).

c) **Infection prevention and control reporting arrangements**

i) **Infection prevention and control steering group RCHT**

This group meets monthly, with the exception of the 4 months when the IPAC committee meeting is held, and reports to the IPAC Committee. The membership of the group comprises of:

- Consultant Nurse Deputy Director of Infection Prevention and Control (Chair).
- IPAC Lead Practitioner/Senior Specialist Practitioner.
- Infection Prevention and Control Doctor/Microbiologist.
- Antibiotic Pharmacist.
- Clinical representation from each Division - Clinical Matron, Unit/Ward Manager and/or Medical Clinical Champion.

In attendance:

- Consultant Nurse Director of Infection Prevention and Control CIOSICB.
- Co-opted members on an ‘as needs basis’ where particular qualities, knowledge expertise etc. are required.
- IPAC link practitioners when required.

ii) **Infection prevention and control committee/group**

During 2025/2026 the RCHT and CFT infection prevention and control committee/groups met on a quarterly basis and reported to the joint quality assurance committee. Membership of the group comprises of:

- Director of Nursing and AHPs for CFT, DIPC (Chair)
- Consultant Nurse/Dual Deputy DIPC (Deputy chair)
- IPAC Lead Practitioner
- Consultant Microbiologist/Clinical Scientist/Infection Control Doctor
- Area Director or nominated deputy (each locality CFT only)
- Head of Nursing from each division (RCHT only)
- Antimicrobial Pharmacist
- Director of Mental Health (CFT only)
- Head of Estates
- Decontamination Lead
- Head/Deputy Head of Facilities
- Health and Safety representative
- Occupational Health Nurse/Doctor

In attendance:

- UKHSA representative.
- Director of IPC CIOSICB.
- IPAC Administration Lead (minutes).

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- Members of staff are welcome to observe as agreed by the Chair of the Committee.
- Any other person as agreed by the Chair, to be noted as 'in attendance'.

iii) **Quality assurance committee**

During 2025/2026 the DIPC attended the trusts' joint quality and assurance committee on a six-monthly basis, providing the committees with a written update of infection prevention and control issues/activities. Exception reports are submitted and presented as required.

iv) **Trust Board**

During 2025/2026 the RCHT and CFT trust boards met separately on a bi-monthly basis; the DIPC provided data which was incorporated into the integrated performance report.

Both trust boards approved the respective annual reports 2024/2025 and the joint programme of work 2025/2026 which was presented by the DIPC.

v) **Infection prevention and control representation at relevant groups**

To provide infection prevention and control advice and ensure liaison between the IPAC team and key groups, IPAC representation was provided to the following key groups:

- antimicrobial stewardship committee
- care group/care directorate governance groups as requested
- clinical matron meetings
- clinical site development plan project teams and other estates refurbishment meetings
- decontamination risk assessment group
- health and safety leadership group / committee
- hospital cleaning operations group / hotel services group
- medical devices and clinical product review group
- operational water group
- patient safety incident, response, and learning group
- project water safety group
- quality assurance committee
- resilience committee (as necessary)
- sharps safety group
- system infection prevention alliance
- vascular access working group
- ventilation group
- ward leader meetings
- water safety group

3. Healthcare associated infection (HCAI) statistics and surveillance.

The IPAC team carries out an annual programme of surveillance to ensure compliance with mandatory requirements and to ensure that alert organism and conditions are identified in a timely manner to enable appropriate infection control measures to be put in place. The Department of Health requires mandatory surveillance of the following infections:

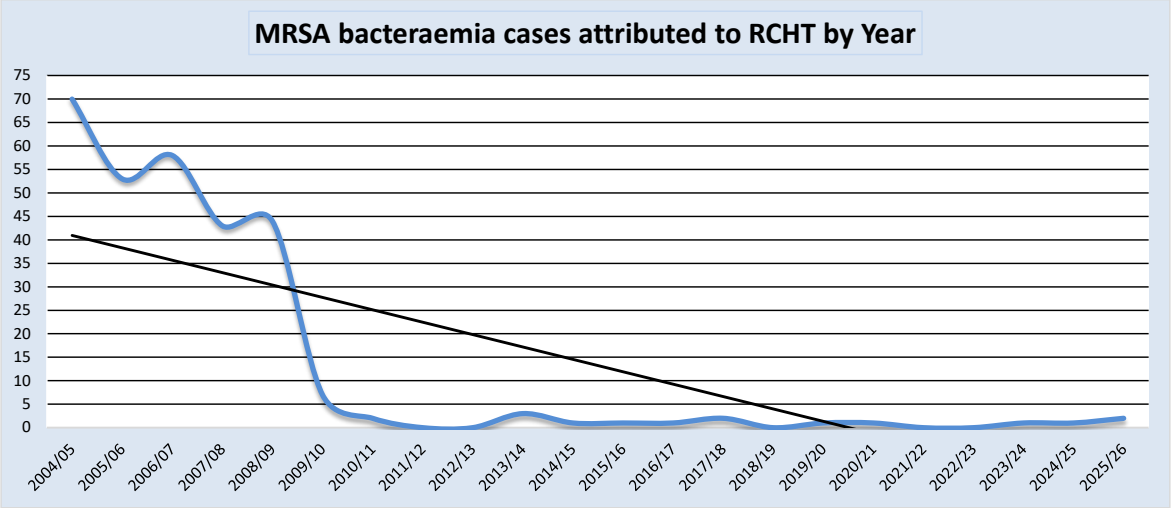
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- methicillin resistant *Staphylococcus* aureus (MRSA) bacteraemia
- methicillin sensitive *Staphylococcus* aureus (MSSA) bacteraemia
- Gram negative bacteraemia including *Escherichia* coli (E.coli), *Pseudomonas* aeruginosa (P. aeruginosa), *Klebsiella*
- *Clostridioides* difficile (C.difficile)
- infections associated with orthopaedic surgical procedures.

a) **Methicillin resistant staphylococcus aureus (MRSA) bacteraemia**

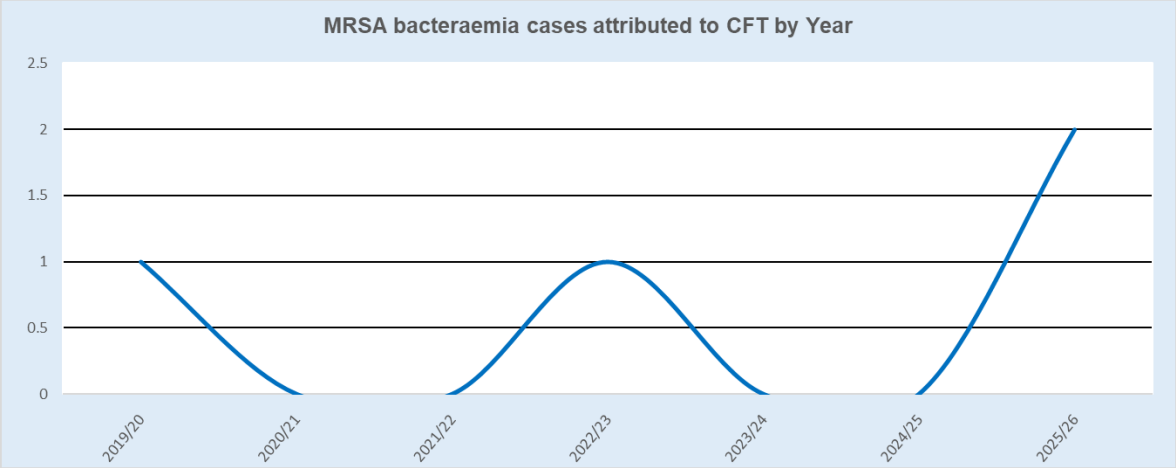
For the period April 2025 to March 2026, the target for MRSA blood stream infections was zero trust apportioned cases. There were two RCHT trust reported cases. Following investigation neither case was deemed attributable to the Trust through actions or omissions. Neither case had a single definitive source of infection.

The RCHT MRSA bacteraemia rate for all healthcare associated infections (HOHA and COHA) is 1.63 per 100,000 bed days compared to a southwest rate of 1.67 and a national rate of 1.29.



At CFT there were two trust apportioned MRSA bacteraemia, following investigation one of the cases was deemed moderate harm due to omissions in urinary catheter care. This outcome led to a 'justification of urinary catheters audit' as the infection was associated with an un-justified long term urinary catheter. The results of this audit are under investigation at present, but locally the clinical area have assigned a dedicated slot for continence in their clinical meetings.

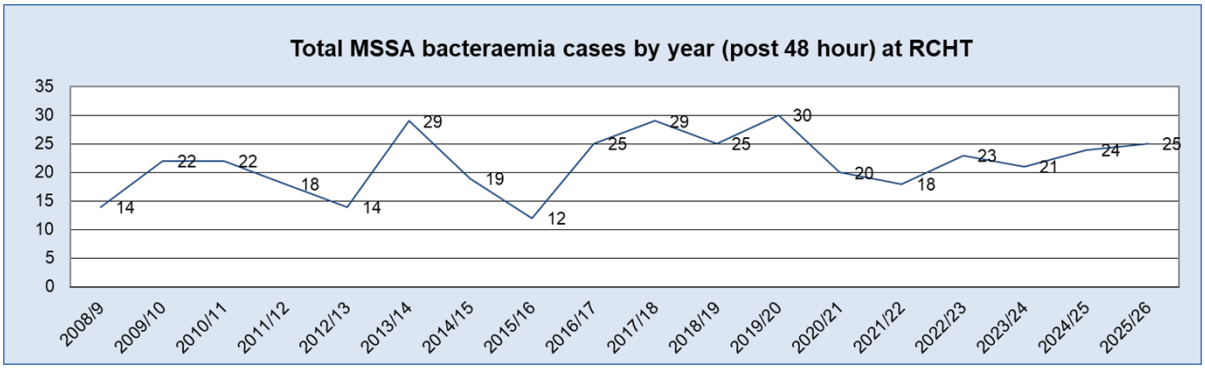
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b) **Methicillin sensitive staphylococcus aureus (MSSA) bacteraemia**

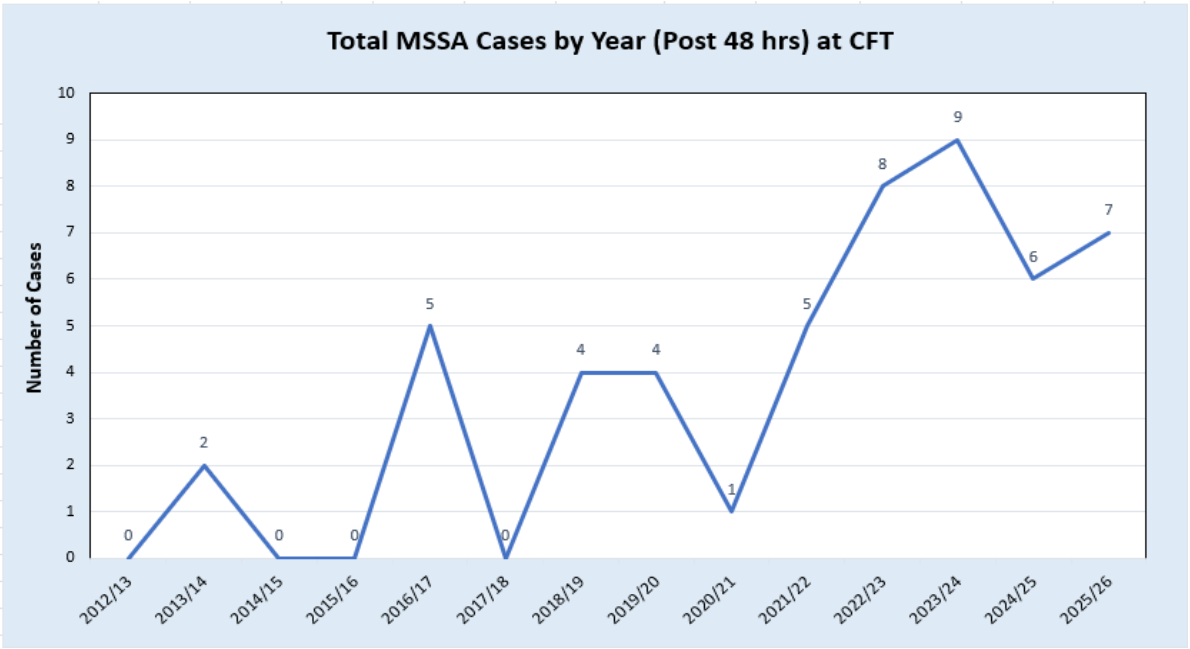
There were 25 MSSA bacteraemia reported that were acute trust apportioned during 2025/2026. This is an increase against the previous year by one but remains stable over several years.

The MSSA bacteraemia rate for all healthcare associated infections (HOHA and COHA) for the trust is 16.32 per 100,000 bed days; this compares with a southwest rate of 16.49 and a national rate of 13.15.



There were seven CFT apportioned MSSA bacteraemia in 2025/26, compared to six the previous year. This number has remained stable since 2022/23 when surveillance community nursing services was introduced.

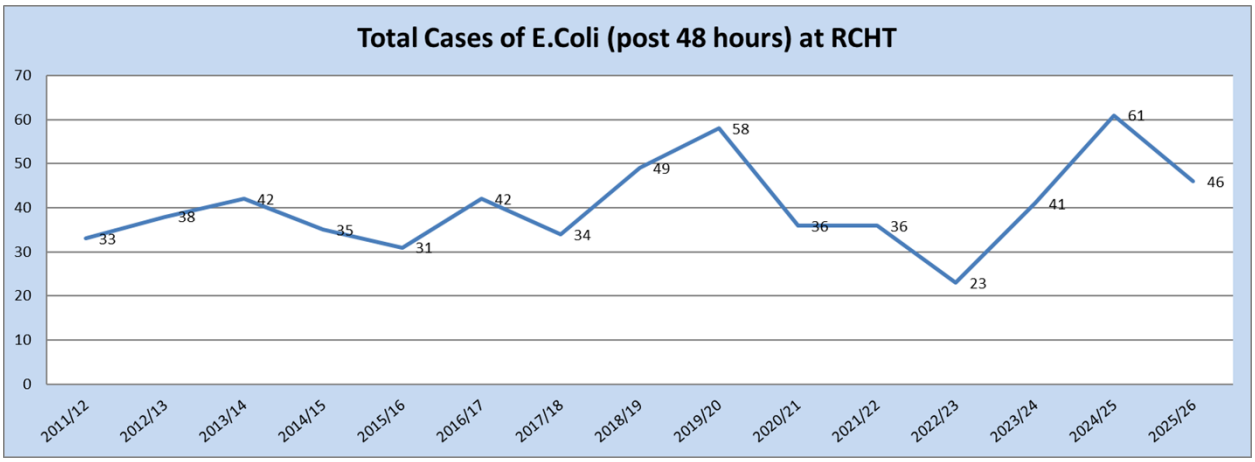
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c) **E. coli bacteraemia**

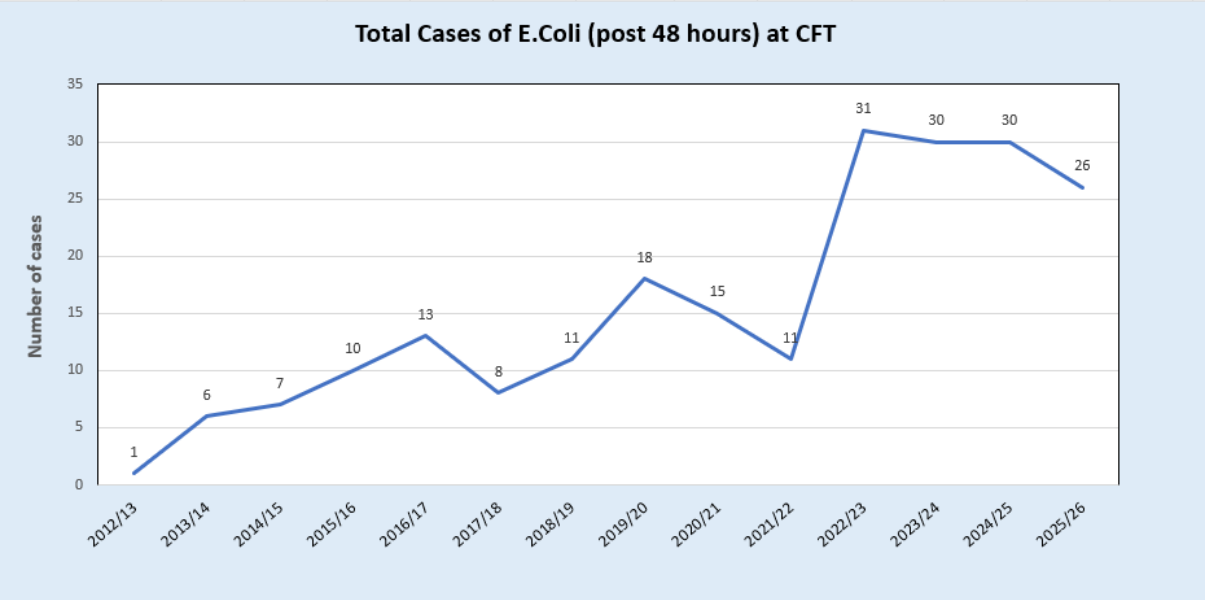
There were 46 cases of E. Coli bacteraemia cases that were acute trust (HOHA) attributable during 2025/2026 compared to 61 in the previous year. Three of these cases were due to the new 'decision to admit' reporting criteria, taking into account where a patient attended ED directly before the in-patient admission.

The E. Coli bacteraemia rate for all healthcare associated infections (HOHA and COHA) at RCHT is 37.94 per 100,000 bed days. This compares to the southwest rate of 40.66 and a national rate of 35.18.



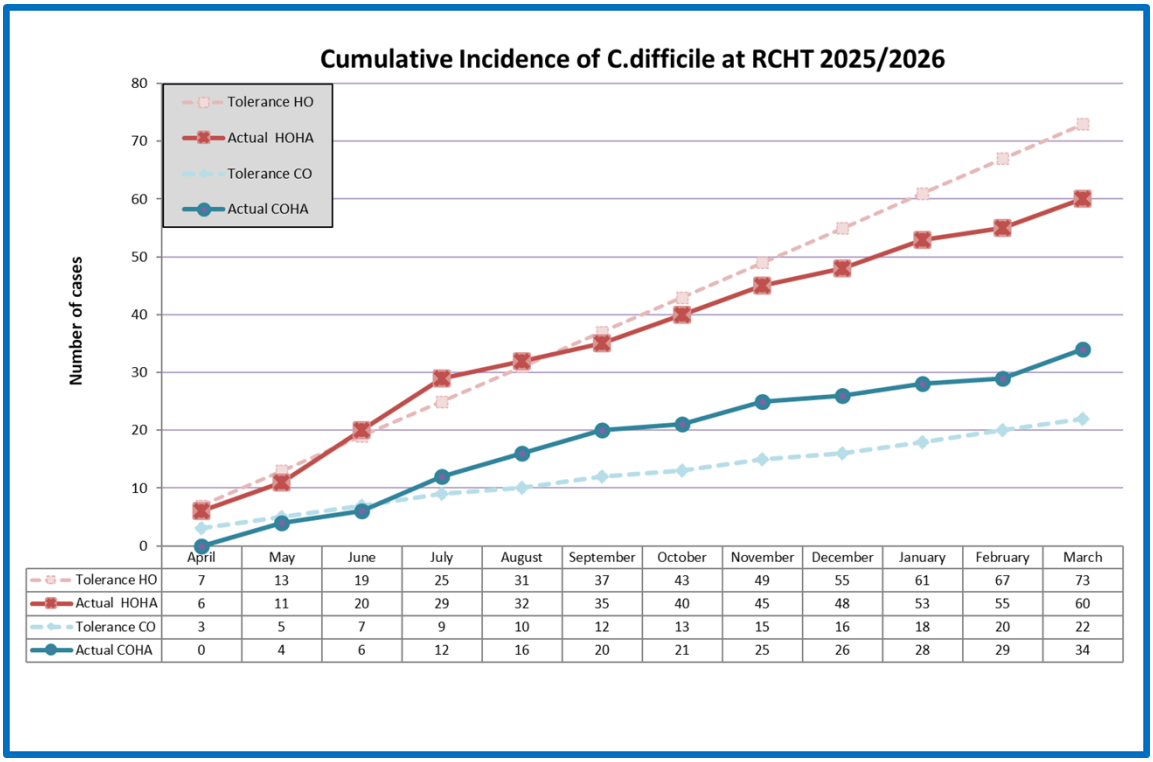
There were 26 cases of E. Coli bacteraemia that were CFT attributable during 2025/26 this is a reduction of four cases compared to the previous year. This is the lowest total since the introduction of community nursing surveillance in 2022/23. The IPAC team is collaborating with the preventing deconditioning harms work as regards urinary catheter use to further to reduce E Coli cases.

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d) **Clostridioides difficile (C. difficile)**

Between 1 April 2025 and 31 March 2026, RCHT recorded 60 hospital onset healthcare associated (HOHA) cases of C. difficile (cases occurring two days or more following admission), and 34 community onset healthcare associated (COHA) cases of C. difficile (cases that occur in the community [or within two days of admission] when the patient has been an inpatient in the trust reporting the case in the previous four weeks).



	April	May	June	July	August	September	October	November	December	January	February	March
Tolerance HO	7	13	19	25	31	37	43	49	55	61	67	73
Actual HOHA	6	11	20	29	32	35	40	45	48	53	55	60
Tolerance CO	3	5	7	9	10	12	13	15	16	18	20	22
Actual COHA	0	4	6	12	16	20	21	25	26	28	29	34

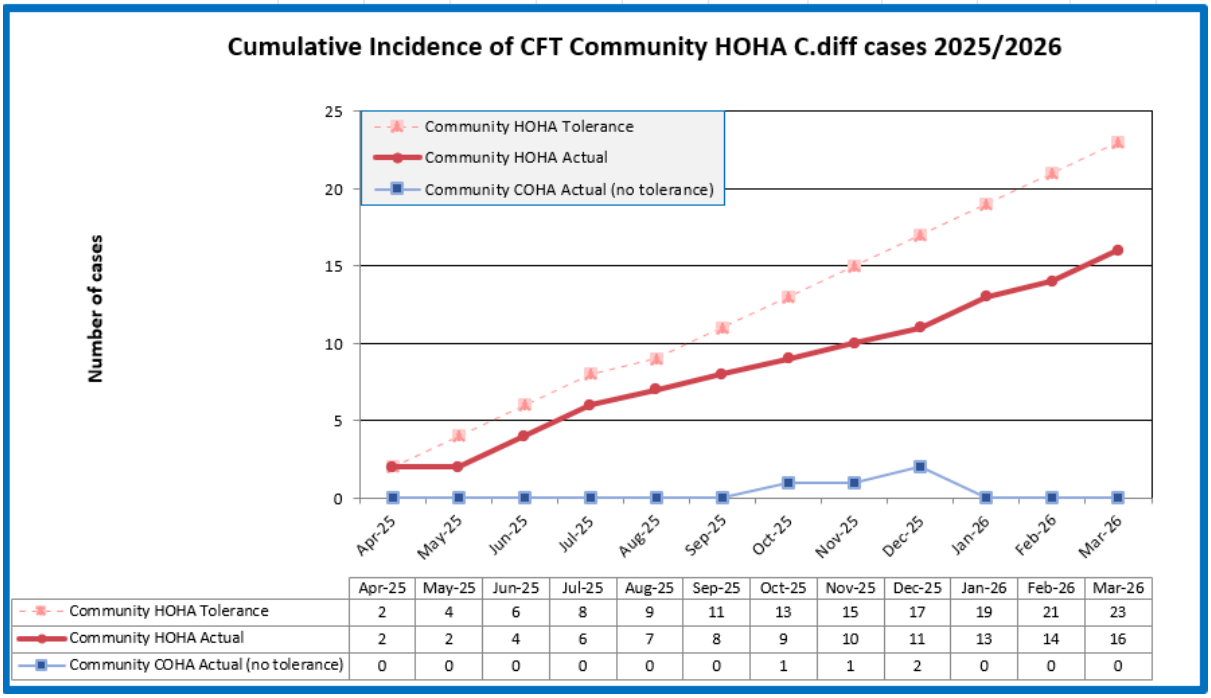
The total number of cases reported is 94 against a tolerance of 95 cases. This means that at year end the trust was 1 case below trajectory, this compares to a total of 115 cases for year 2024/5. Whilst the chart above appears to show 'COHA' cases above tolerance, this is an internally set benchmark and is not an external performance measure. One HOHA and one COHA case were due to the new

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'decision to admit' reporting criteria, taking into account where a patient attended ED directly before the in-patient admission. This is the first time in several years that the Trust has managed to finish the year under the trajectory. This outcome is being attributed to two actions taken by the IPAC team this year; changing alcohol hand gel to hypochlorous acid, as it can be used for C.difficile and Norovirus cases and also changing the cleaning products from chlorine to chlorine dioxide for all in-patient and high-risk areas.

The rate of C. difficile infections within the Trust for all healthcare associated cases (HOHA and COHA) is 38.35 per 100,000 bed days compared to the southwest rate of 31.53 and the national rate of 24.56.

CFT reported 16 cases of C. difficile 'community HOHA' (cases occurring two days or more after admission to the trust) in 2025/26, against 24 cases in 2024/25. There were two cases of C.difficile 'community COHA' (cases that occur in the community [or within two days of admission] when the patient has been an inpatient in the trust reporting the case in the previous four weeks) in 2025/26 compared to one in 2024/25. Close working with general service supervisors to utilise hydrogen peroxide disinfection systems and regular C.difficile ward rounds have contributed to this improvement.



	Apr-25	May-25	Jun-25	Jul-25	Aug-25	Sep-25	Oct-25	Nov-25	Dec-25	Jan-26	Feb-26	Mar-26
Community HOHA Tolerance	2	4	6	8	9	11	13	15	17	19	21	23
Community HOHA Actual	2	2	4	6	7	8	9	10	11	13	14	16
Community COHA Actual (no tolerance)	0	0	0	0	0	0	1	1	2	0	0	0

CFT was allocated local tolerances for 2025/26 for those patients that acquire an infection in a community hospital post 48h of admission and did not have a hospital stay at an acute trust with 28 day, 2026/27 tolerances are still under discussion. Laboratory testing for C.difficile has changed from the beginning of quarter four in line with national guidance. This will enable treatment of patients across Cornwall once it is identified that they have the C.difficile toxin gene present thereby preventing them developing a toxogenic infection. By preventing toxin production the patient has a better outcome and less cases will be included against the trajectory.

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3.1 **Patient safety incident response framework (PSIRF)**

During 2025/26 the IPAC team has continued to work closely with the patient safety teams at CFT and RCHT, further strengthening governance and learning responses to IPAC related incidents. The current process follows the recommendations outlined in the PSIRF has significantly reduced the amount of administration required from clinicians whilst maintaining a firm grip on common themes, infection trends, and allowing data to guide work streams.

3.1.1 Antibiotics

Antibiotic use is the leading contributor to C. difficile infections at both RCHT and CFT. Antibiotic use targets bacteria, in many cases it is non-specific meaning it will not only target the bacteria causing infection but also useful bacteria (e.g. those important in maintaining gut health). Some antibiotics have a broader spectrum of use and therefore can be considered higher risk for C. difficile development. In general, antibiotic use is appropriate for the patient's infection and the clinical severity of infection. Mostly, the condition being treated is the admission reason, as with gram-negative bacteraemia the infections requiring treatment with antibiotics are varied but follow a similar pattern with UTI, hepatobiliary, and gastrointestinal complications featuring. The epidemiology of COHA infections differs from the HOHA cases, with skin and soft tissue infections and conditions that require long term antimicrobial treatment such as endocarditis. The use of appropriate antibiotics in line with national guidance and targets is further evidenced by the pharmacy team's surveillance work that is presented within this report.

3.1.2 Gram-negative bacteraemia

At RCHT the source of gram-negative bacteraemia infections is varied, urinary tract infection (UTI), hepatobiliary, gastrointestinal / abdominal infection, and pneumonia are the most prominent sources. A theme at RCHT is delayed collection of blood cultures on admission. In the case of hepatobiliary and abdominal infections these issues tend to be the presenting complaint of the patient, whilst the patients receive appropriate antimicrobial therapy on admission, they do not always have blood cultures collected before or at the point of administration. If blood cultures were collected as close to attendance as possible or at the minimum when prescribing antimicrobial therapy, the organism could be identified sooner in the admission preventing the infection being classified as a HOHA, thus reducing the number of cases attributed to the trust. In 2025/26 the IPAC team worked closely with ED and other emergency areas to ensure stool sample collection and norovirus risk assessment in the department prior to transfer to base wards with good effect. A priority for 2026/27 will be to raise awareness of the importance of collecting blood cultures when indicated, particularly in the ED and other admission areas.

At CFT UTI's dominate not only in gram-negative bacteraemia's but also as a contributory factor in C.difficile infections. This is seen across ACS and community nursing teams. This year community nursing teams have embedded the practice of completing NEWS2 observations when attending an SOS call that relates to complications of a urinary catheter, this initiative came from learning identified in 2024/25. The addition of NEWS2 observations during these attendances has brought forward a further theme; typically, patients are 'well' with a normal NEWS2 on the community nurses' arrival / departure, however in the 6 – 48 hours following the event it is noted

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that the patient deteriorates, with some requiring admission to hospital. The IPAC lead has provided this theme to the continence working group for consideration, with the aim of reducing hospital admissions related to urinary catheter complications. Additional to this, the IPAC team carried out a justification of urinary catheters audit in March 2026, each ward was audited every week for a month. This was an important opportunity for education and discussion with clinical teams. Early results are available, the IPAC lead is fully considering the implications and potential for future projects. However, initial results are generally positive.

3.1.3 Environment

During 2025/26 planned work took place on GLU at RCHT following an extended period of increased incidence (PII) where two patients were identified as having genetically matching strain of C.difficile. The works, completed in conjunction with the estates team, focussed on minimising the number of harbours for bacteria to hide in. Grenville also experienced an episode of increased incidence with genetically matched cases, the IPAC team has highlighted that Grenville requires prioritisation for improvement works, appreciating the financial and operational difficulties of such projects there is no proposed start date. To further combat the impact of the environment on hospital associated infections at RCHT a new cleaning and disinfectant product has been introduced to admitting and emergency areas. The product had been trialled in areas such as West Cornwall Hospital and Lowen ward with what appeared to be good effect prior to rolling it out across the trust. It is believed that the environmental work at RCHT has been an influencing factor in meeting the C.difficile tolerance this year.

At CFT there have been no periods of increased incidence identified. Most refurbishment work that the IPAC team has been involved in has focussed on the development of same day emergency care units (SDECs), in particular St Austell SDEC where funding was agreed to install ventilation units. SDECs have been highlighted as a hotspot for the transmission of illnesses such as respiratory viruses as the persons infection status is often unknown and the departments lack isolation facilities. Rosewarne has required significant input from the water safety group due to ongoing positive *Pseudomonas* results from the water system. All affected outlets have appropriate mitigation in place; the water safety group continues to work with stakeholders to resolve the issues.

3.1.4 C.difficile relapse

Efforts have continued in reducing the incidence of C. difficile relapse however, this is a challenge in Cornwall with its aging population and areas of deprivation. The trust continues to provide a weekly C. difficile ward round involving the IPAC team, a microbiologist, and an antimicrobial pharmacist ensuring that specialist advice is routinely available across RCHT and CFT. The gastroenterology and endoscopy services have also improved access to faecal microbiota transplant for inpatients and outpatients; the delivery of this service is made difficult by the logistics of accessing the product due to Cornwall's geographic location. The lead antimicrobial pharmacist will undertake a review of all C. difficile cases that have relapsed in 2025/26 to

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ascertain whether they may have benefited from a different first line treatment for their infection. If it is thought that they may have benefited from alternative therapy a case will be put forward for the trusts to switch to Fidaxomicin as first line treatment over the current recommendation of Vancomycin.

4. Surgical site infection surveillance

Under the terms of the mandatory surveillance scheme, the acute trust is required to submit data on orthopaedic surgical site infections for at least one quarter each year. Surveillance data was collected for quarter one and quarter two including total hip replacements, reduction of long bone fracture, total knee replacements and neck of femur repairs. The data is summarised below:

RCHT SSI Data April 2025 - September 2025 (Q1 and Q2)

Type of Surgery	Number of Operations	Number of Infections	Rate of Infection
Hip Replacement	100	1	1%
Knee Replacement	9	0	0%
Long Bone	40	0	0%
Neck of Femur	374	0	0%

SMH SSI Data April 2025 - September 2025 (Q1 and Q2)

Type of Surgery	Number of Operations	Number of Infections	Rate of Infection
Hip Replacement	207	1	0.5%
Knee Replacement	175	0	0%
Long Bone	6	0	0%
Neck of Femur	0	0	0%

The rates of infection remain low and are in comparison with 2025/26. Nationally the infection rates are hip replacement 0.5%, knee 0.4%, neck of femur 0.7%, and long bone 0.8%. As a result of the IPAC team having the capacity to monitor orthopaedic rates over two quarters, a larger number of cases have been reviewed and therefore provides a more accurate reflection of the SSI rates for the two hospitals.

Additional SSI surveillance was carried out in dermatology, the first time this was carried out was in 2023/24 where the data was collected over the two months, October and February. The rates of infection in 2023/24 were 5% and 4% respectively. The results from 2025/26 included three months of surveillance and are outlined in the table below. There is no nationally set standard for dermatological surgery infection rates, however studies report an incidence between 0.7% and 8.7%.

RCHT SSI Data October 2025 - December 2025 (Q3)

Type of Surgery	Number of Operations	Number of Infections	Rate of Infection
Dermatology	1287	56	4%

In quarter four caesarean section SSI data has been collected but as the 30 day reporting period runs until the end of April 2026 this will be reported in the quarter one 2026/27 report.

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5. Antibiotic stewardship

5.1 RCHT (information provided by Dan Hearsey, advanced specialist clinical pharmacist - antimicrobials).

5.1.1 Priorities for the year:

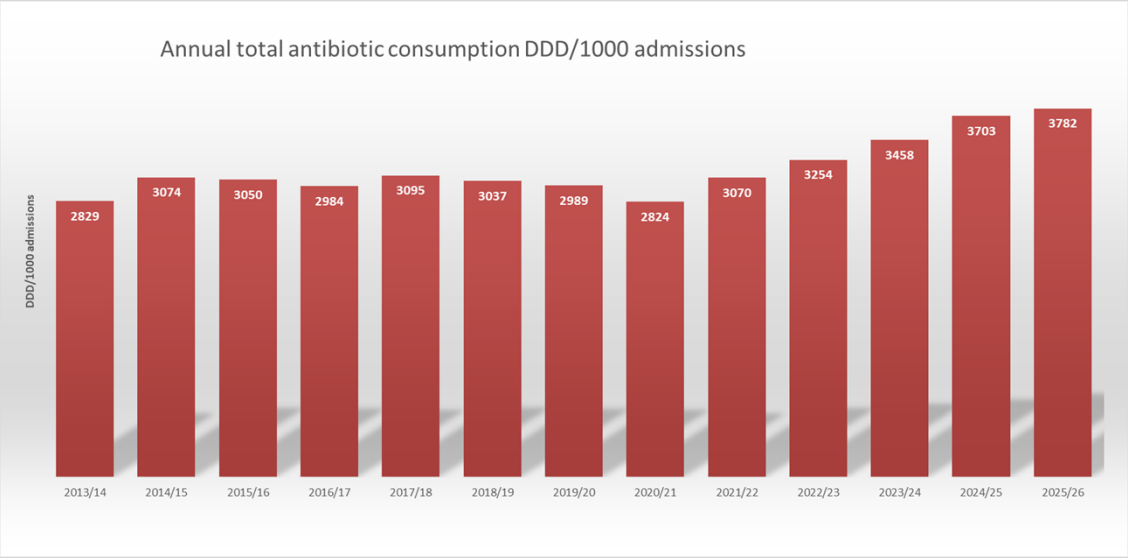
The key antibiotic stewardship priorities this year have been:

- Indication and stop/review date audits to continue, with a focus on ensuring oral antibiotics have a stop date.
- Optimisation of IV to oral switch for antibiotics.
- Overall reduction in consumption of 'watch' and 'reserve' antibiotics. Watch and reserve antibiotics, are monitored and held in reserve to reduce the growth of antimicrobial resistance. Generally, these are a broader-spectrum antimicrobial than those in the 'access' category which are narrower spectrum first-line agents and should be used preferentially where clinically indicated.
- Shortening antibiotic course lengths in line with NICE antibiotic prescribing guidelines.
- Implementation of penicillin allergy de-labelling (PADL) processes.
- Appropriate antibiotic prescribing for urinary tract infections (UTI), lower UTI and catheter-associated UTI in adults aged 16+ in-line with current CQUIN requirements.

5.1.2 Antimicrobial stewardship management committee.

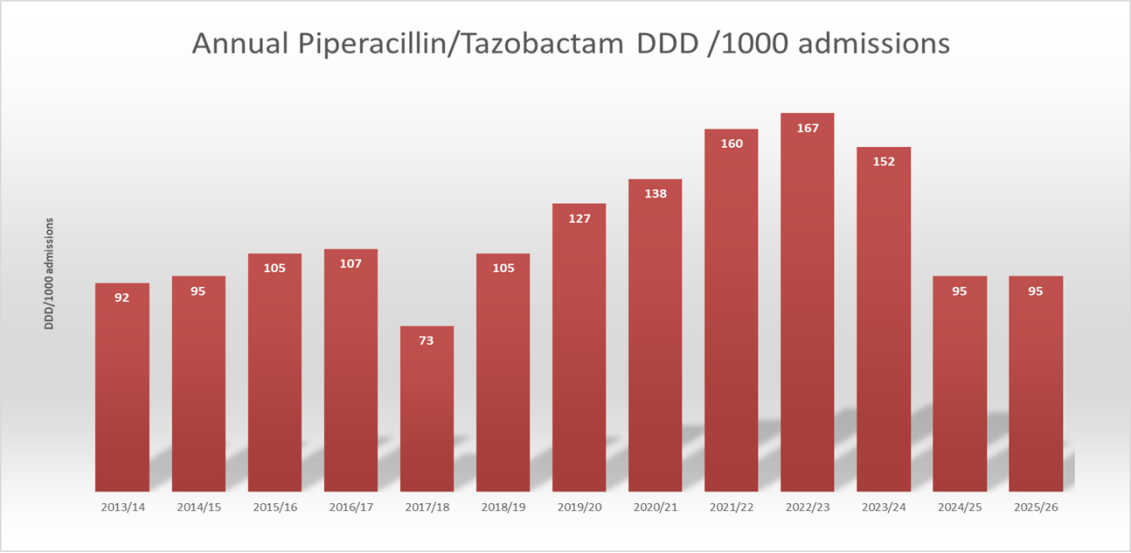
The RCHT antimicrobial stewardship audit programme is overseen by the antimicrobial stewardship committee and follows that set out in the start smart, then focus clinical management algorithm, which was updated in September 2023.

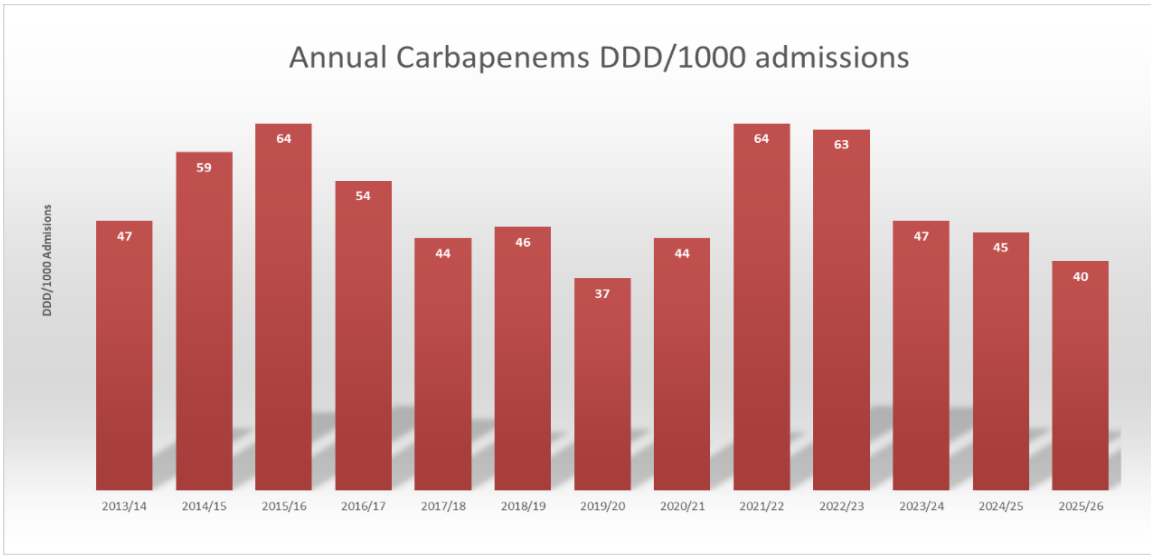
5.1.3 Antimicrobial consumption



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Antimicrobial consumption is monitored using defined daily doses (DDDs), a standardised metric that facilitates comparison across time and between trusts. Total antibiotic consumption monitoring has shown a 2% increase in total antibiotic use in 2025/2026 compared to 2024/2025. An increase in total antibiotic consumption was expected following the antimicrobial guideline updates which were launched at the beginning of February 2024. Changes within this update aimed to reduce the use of broad-spectrum agents including Tazocin, co-amoxiclav and meropenem. There has been a notable decrease in piperacillin/ tazobactam (Tazocin) and Meropenem use since the introduction of the new empirical guidelines (shown by the graphs below). Whilst this is a positive outcome, the guidelines advocate for multiple drug regimens (e.g. amoxicillin, metronidazole, gentamicin for sepsis management) in place of single drug options. It is expected that the increase in consumption would have plateaued out for 2025/26 compared to the previous year, and although the increase is not as significant, antimicrobial consumption continues to increase despite multiple interventions to reduce this.



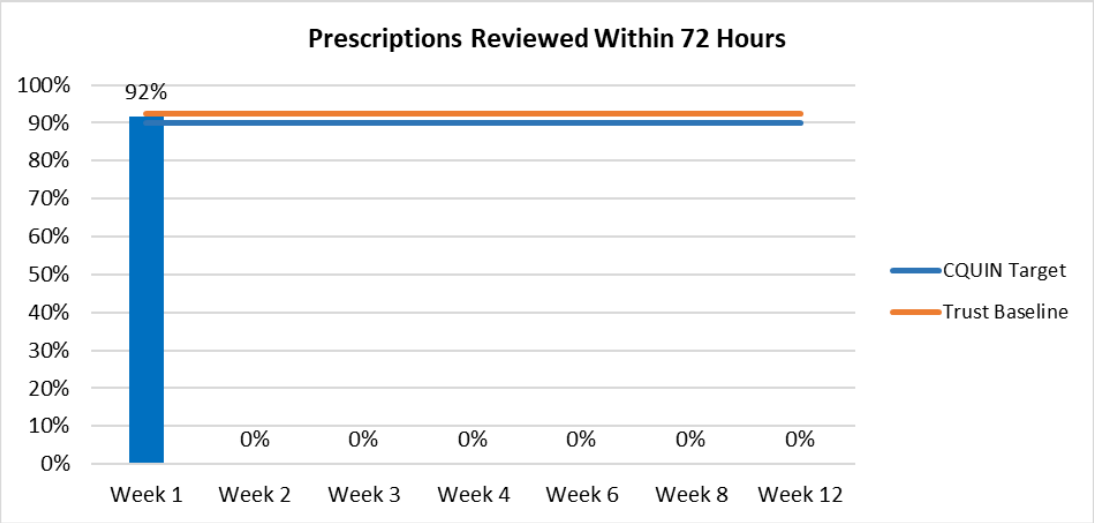


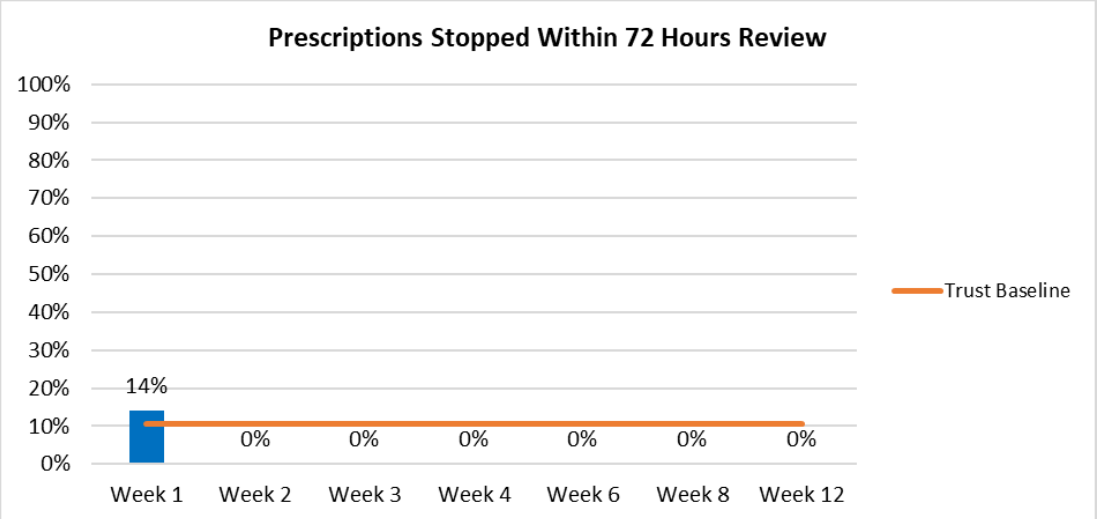
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5.1.4 Antimicrobial review kit study (ARK):

The ARK study has been rolled out in medical specialities in 25% of English hospitals, including RCHT. The aim of the study is early antibiotic cessation at the 72-hour antibiotic review facilitated by an antibiotic decision aid. The decision aid communicates clinician diagnostic certainty or uncertainty about infection diagnoses at the start of the antibiotic course. The primary outcome of ARK is the percentage of antibiotics stopped in the pre-72-hour period. The pre-72 hour stop rates before the introduction of the ARK study, were 10%. The trust's results fluctuate but achieve approximately 20% which is reasonable, however, there are opportunities to further increase this to 35-40%.

After a short pause in auditing of the ARK study, the ARK audits were re-launched in February 2026. The graphs below show that antibiotic review by doctors in the pre-72 hours was above the 90% target and the stop rate achieved was 14%, which is below the expected 30%. Re-audit and discussing results with specialist multi-disciplinary teams will continue. Incorporation of the ARK Toolkit within the EPMA prescribing system is planned for 2025/26.



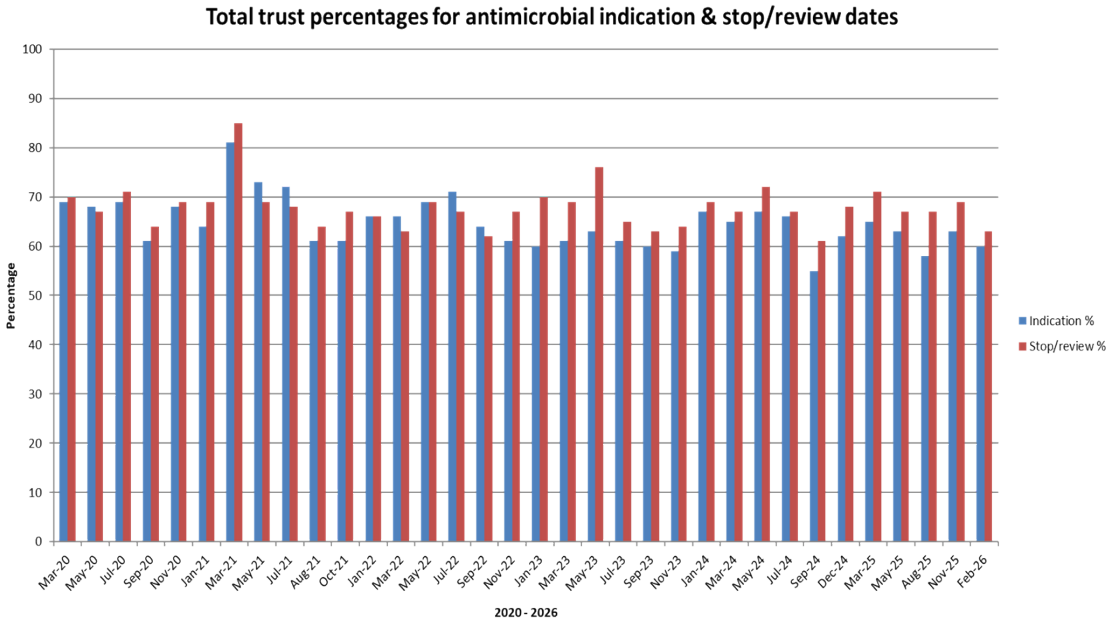


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5.1.5 Indication/stop review audit:

Compliance with indication and stop or review date documentation on the electronic prescribing (EPMA) system against each antibiotic prescription is reviewed every eight weeks. Compliance is emailed to individual prescribers. The data is also presented by specialty and care group and is communicated to specialty leads. The most recent compliance is currently 60% for indication documentation and 63% for stop or review date documentation. It is worth noting that the audit is taken just from the electronic system but does not consider if this has been recorded in the medical records.

This metric is included in the care group performance assurance framework (PAF) and has oversight and scrutiny by the executive team. The trust has visibly supported this as an important part of antimicrobial stewardship.



5.1.6 Embedding NICE antibiotic prescribing guidelines for common infections:

Shortening antibiotic course lengths.

The re-audit of course lengths in respiratory infections is currently being completed monthly to assess any change in prescribing behaviours relating to antibiotic course lengths for community and hospital acquired pneumonia.

5.1.7 Contractual requirement

There is currently no contractual requirement for reductions in access, watch and reserve antibiotics at present. the graph below represents percentage usage of access, watch and reserve antimicrobials compared to other trusts in the southwest, RCHT is Trust 157 in the table below.

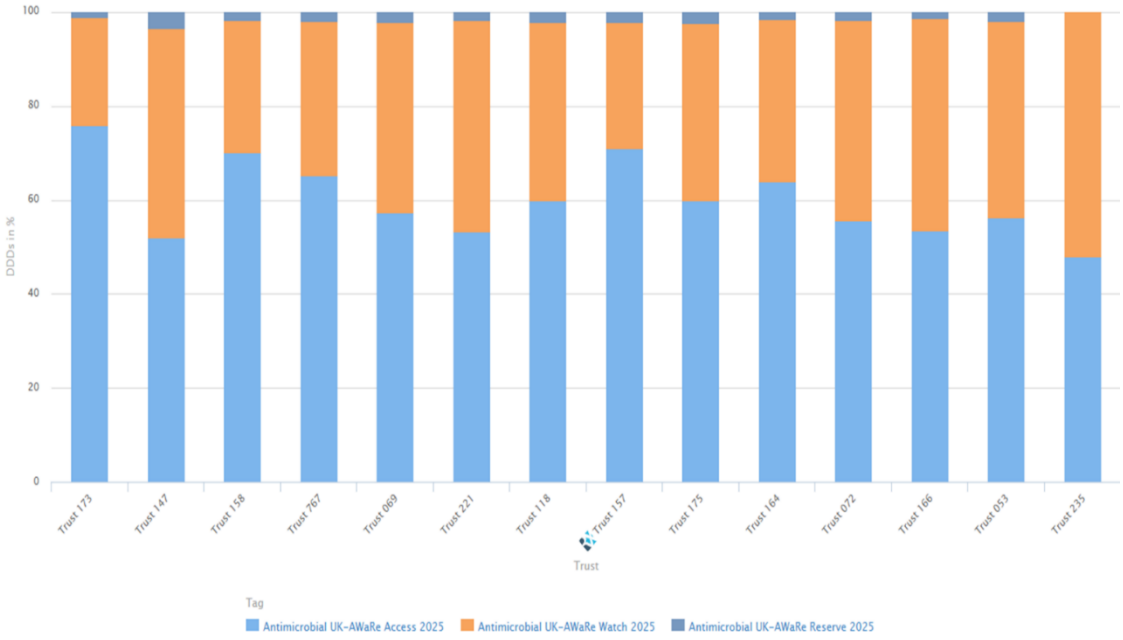
When the total prescribing of all antibiotics at RCHT is divided into access, watch and reserve proportions for 2025/26 (shown in the chart below), this demonstrates:

- 71% from access (69% in 2024/25)

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- 27% from watch (28% in 2024/25)
- 2% from reserve (3% in 2024/25)

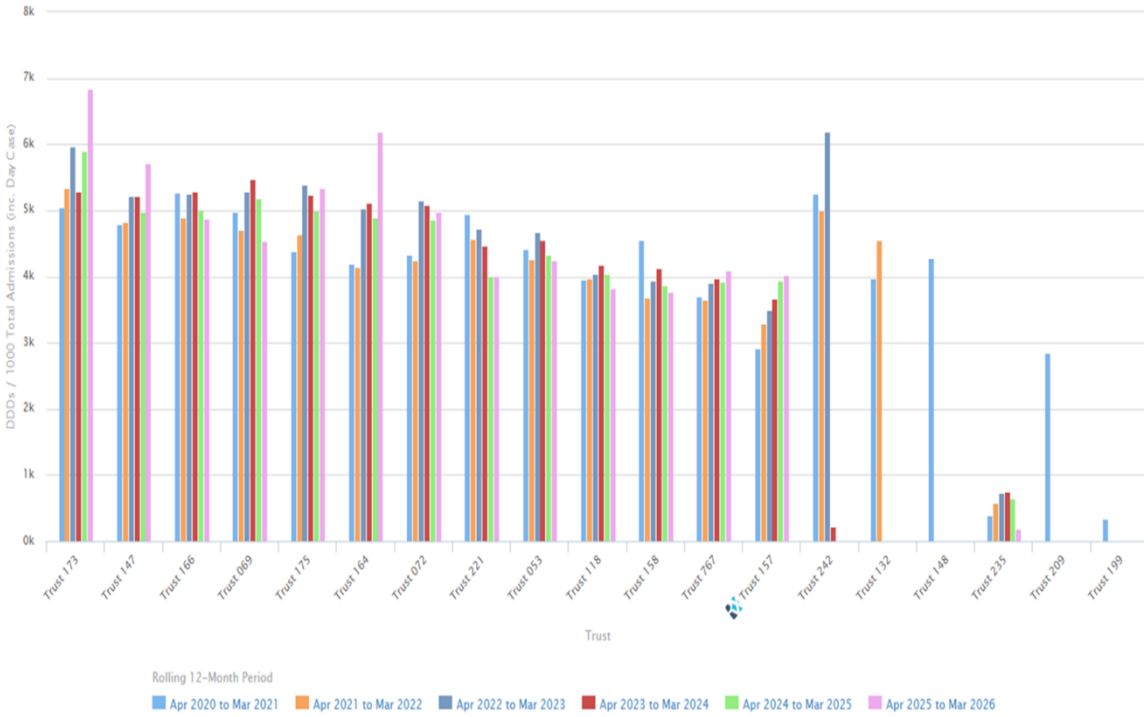
RCHT's performance in terms of consumption of the access, watch and reserve antibiotic categories indicates that the trust is achieving the expected target of at least 70% of antimicrobial consumption to be from the access group, and a reduction in watch and reserve groups.



5.1.8 Total antibiotic use (inpatients and outpatients)

The graph below highlights RCHT (Trust 157) performance compared to other hospitals in the southwest. The trust remains one of the lowest total antibiotic-prescribing hospitals in the southwest.

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5.1.9 Penicillin allergy de-labelling (PADL)

In-patient PADL programme continues with 349 inpatients de-labelled up to the end of January 2026 - around one third via direct oral challenge and the remainder by history-based risk assessment.

The outpatient PADL clinic, which had de labelled 110 patients before pausing, remains temporarily on hold but will resume when capacity improves, with plans to expand into paediatric pathways and potential skin testing.

5.1.10 Next steps

The focus for 2026/27 incorporates three actions which have been identified as part of the NHS England 'Act Now' call for action letter on AMR, and include:

- overall reduction in total antimicrobial consumption.
- overall reduction in antimicrobial consumption from the 'watch' and 'reserve' categories.
- shortening antibiotic course lengths in line with NICE antibiotic prescribing guidelines.
- optimisation of IV to oral switch for antibiotic therapy.
- indication and stop/review date audits to continue, with a focus on ensuring oral antibiotics have a stop date.
- appropriate antibiotic prescribing for urinary tract infections (UTI), lower UTI and catheter-associated UTI in adults aged 16+ in-line with previous commissioning for quality and innovation (CQUIN) requirements.

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- continuation of penicillin allergy de-labelling (PADL) inpatient work and implement permanent outpatient clinic and primary care de-labelling pathway.
- expansion of outpatient antimicrobial therapy (OPAT) services to improve bed utilisation whilst maintaining AMS expectations.
- increase delivery of seasonal and life-long vaccine delivery.

5.2 CFT (information provided by Cornelius Amadi Lead Pharmacist)

5.2.1 This annual antimicrobial stewardship report for Cornwall Partnership NHS Foundation Trust (CFT) covers the full financial year 2025/2026. It summarises current stewardship activity, highlights key prescribing signals, acknowledges data limitations (including DDD conversion challenges), and outlines next steps aligned to the NHS England AMR prescribing and medicines optimisation workstream call to action requirements. These are the main trends from 2025/26:

- Across the year, 'access' agents (amoxicillin, flucloxacillin, doxycycline, nitrofurantoin, trimethoprim, phenoxymethylpenicillin) constitute the highest prescribing volumes and broadly align with national stewardship goals.
- 2,953 antibiotic prescription scripts were issued across October 2025 – March 2026, with a monthly average of 492.
- Activity peaked in December 2025 and reduced progressively through to March 2026.
- Oral solid dosage forms tablet/ capsule accounted for 66% of prescriptions; injections accounted for 22%.
- North and east-facing community hospital ward data (UHP-facing) is not currently available in this Power BI dataset; CFT aligns benchmarking and pathway work with RCHT.

Reporting Note: This report spans from April 2025 to March 2026 datasets using different primary metrics 'DDDs' in quarters 1 and 2 and prescription (script) counts in quarters 3 and 4. This reflects a transitional period in CFT's reporting infrastructure following the introduction of Power BI. No direct numerical comparison can be made between these different reporting periods. From 2026/27 onwards, all reporting will adopt a unified methodology using Power BI software, enabling consistent year-on-year trend analysis.

5.2.2 Priorities for the year

The key antibiotic stewardship priorities for 2025/26 were:

Priority	Status

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Reduce use of 'watch' and 'reserve' antibiotics	Ongoing — formal targets set for 26/27
Indication and stop/ review date compliance audit	Sustained increase to 90%
Optimise IV-to-oral switch (IVOS) and timely IV review	Ongoing
Incorporate north and east wards data into dashboard	Re- confirmed priority for 2026/27
Review and align sepsis management guidance (incl. ceftriaxone governance)	PGDs updated; governance review ongoing

5.2.3 Prescribing activity.

Power BI indicates a total of 2,953 antibiotic prescriptions issued over the six months. Monthly totals are shown below:

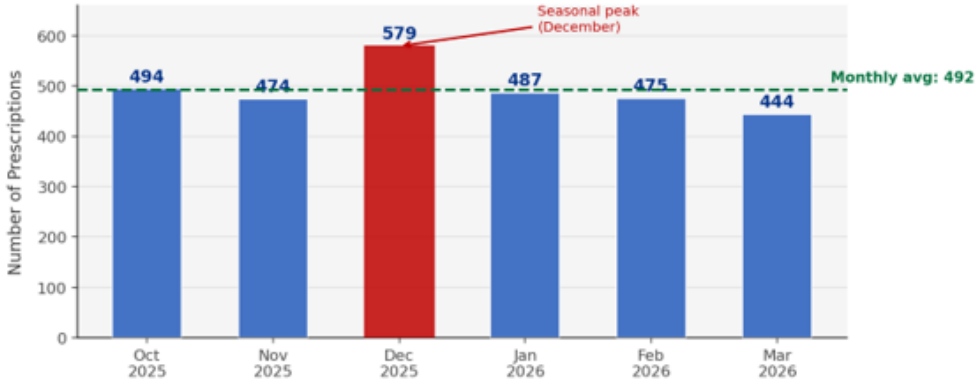


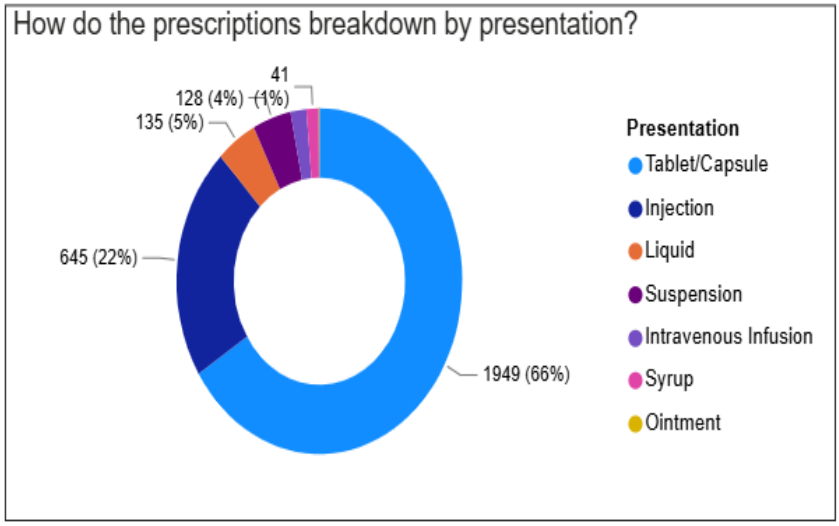
Figure: Monthly Antibiotic Prescriptions – October 2025 to March 2026 (script count via Power BI

The monthly pattern shows a peak in December 2025 (579 scripts) followed by a steady decline, reaching 444 scripts in March 2026. This peak in December may reflect seasonal infection patterns and prescribing demand, targeted stewardship messaging during winter peaks may offer additional benefit.

5.2.4 Prescriptions by presentation

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The Power BI dashboard indicates that most prescribing was oral tablet/capsule (66%) with injections forming 22% of prescriptions. Liquids and suspensions accounted for a smaller proportion, relevant to paediatrics, swallowing difficulties, and community settings. This is in line with IVOS messaging, which is oral antibiotics where applicable and switch from IV to oral if applicable, with reviews every 48-72hours and switch appropriately.



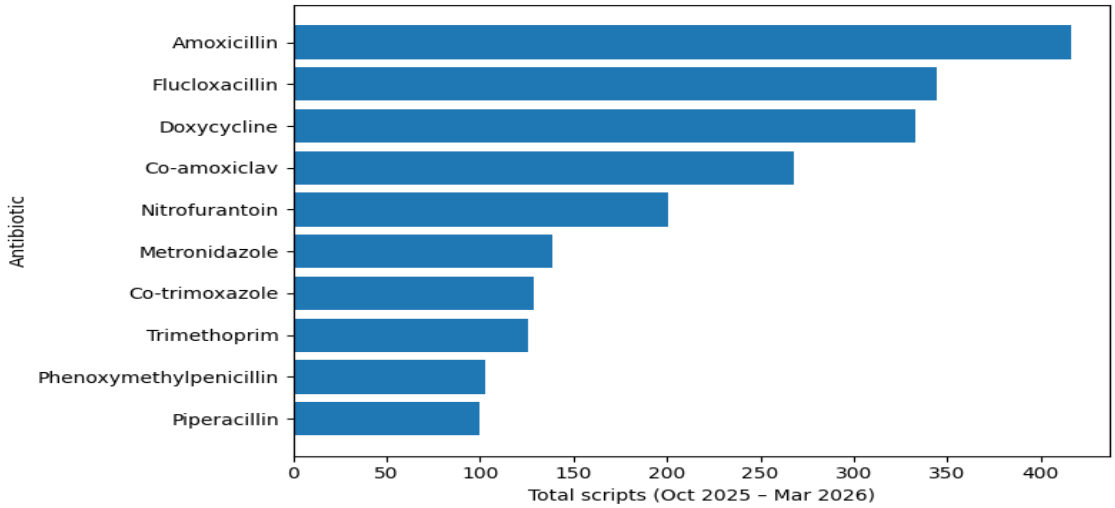
5.2.5 Top antibiotics by script count

Top 10 antibiotics by total script count (October 2025–March 2026):

S/NO	Drug	Total scripts
1	Amoxicillin	416
2	Flucloxacillin	344
3	Doxycycline	333
4	Co-amoxiclav	268
5	Nitrofurantoin	201
6	Metronidazole	139
7	Co-trimoxazole	129
8	Trimethoprim	126
9	Phenoxymethylpenicillin	103
10	Piperacillin	100

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High prescribing volumes were seen for amoxicillin (416), flucloxacillin (344) and doxycycline (333), which aligns with the Trusts stewardship goals. Co-amoxiclav (268) remains a high-volume agent and is a ‘watch’ antibiotic; this will remain a focus for stewardship review, particularly where PGD prescribing may contribute. Three of the top ten agents are in the ‘watch’ category (co-amoxiclav, co-trimoxazole, and piperacillin), collectively accounting for approximately 497 scripts (17% of all quarter 3 and 4 prescriptions). Co-amoxiclav (268 scripts) is the most prescribed ‘watch’ agent and will be a specific focus of the 2026/27 reduction target. PGD-driven prescribing of co-amoxiclav is being reviewed as a contributing factor.



5.2.6 Stewardship interpretation and comparison to previous quarter

Previous quarter reports have relied on issue/ supply data and/ or DDD-based measures. As a result, direct numerical comparison between previous quarters is not like-for-like. However, throughout 2025/26, ‘access’ agents (amoxicillin, flucloxacillin, doxycycline, nitrofurantoin, trimethoprim, phenoxymethylpenicillin) constitute the highest prescribing volumes and broadly align with national stewardship goals. ‘watch’ agents (co-amoxiclav, ceftriaxone, piperacillin–tazobactam, co-trimoxazole, metronidazole) show persistently elevated use, which is consistent across all reporting periods and will be actively managed against formal targets from 2026/27. Reserve agent use (colistin) was eliminated in 2025/26, which represents meaningful progress.

5.2.7 DDD conversion and drug-unit limitations.

CFT has explored converting prescribing to defined daily doses (DDDs) to support trend monitoring. However, this is challenging as prescribing and supply units vary significantly across formulations. For example, some liquid antibiotics are recorded as 100 ml packs, which are not directly equivalent to tablets/capsules or mg-based injections. In some cases, approximation has been applied (e.g., interpreting 5 ml doses within a 100 ml bottle) to estimate DDDs, but this approach is not consistently applicable across products and sites. Therefore, script count reporting plus targeted audits such as stop/review dates, IVOS and UTI compliance, remains the most reliable

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method for assurance, whilst DDD conversion is treated as an internal exploratory measure.

5.2.8 Data coverage and benchmarking approach

Power BI prescribing data currently does not include north and east-facing community hospital wards aligned to University Hospitals Plymouth (UHP). Those areas remain supported via UHP-facing reporting routes. For system benchmarking and pathway alignment, CFT aligns primarily with Royal Cornwall Hospitals Trust (RCHT), triangulating RCHT's national benchmarking outputs (ESPAUR/Model Health System) with CFT script-count surveillance and local audit findings. This supports a whole-pathway Cornwall narrative across the acute-to-community interface (admission, step-down, ACAH/CATU/Virtual ward, discharge).

5.2.8.1 Stop/review date and indication monitoring (dashboard)

CFT is using a prescribing dashboard to support real-time antimicrobial stewardship review. The dashboard lists antibiotic and antifungal prescriptions with key fields including drug, dose, route, frequency, first dose date/time, stop date, and recorded indication. It also provides visual prompts to support prioritisation. This dashboard is used by pharmacy staff to identify prescriptions missing a clear indication or stop/review date, provide prompt feedback to prescribers and clinical teams, target ward-based education, and support structured review of broad-spectrum/high-risk antibiotics and course duration. The use of this dashboard alongside pharmacist-led feedback and teaching has supported improved documentation practice, with an associated increase in compliance for indication and stop/review date recording particularly in CATU settings. Ongoing monitoring continues to identify outliers and trigger timely intervention to sustain performance.

5.2.9 Next Steps

The focus for 2026/27 incorporates three actions which have been identified as part of the NHS England 'Act Now' call for action letter on AMR, and include:

- Use Power BI to identify hotspots for 'watch' antibiotics like co-amoxiclav, ceftriaxone, ciprofloxacin, piperacillin and implement targeted review/ feedback.
- Strengthen IVOS protocols and embed prompt education for high-use IV agents.
- Continuing sepsis pathway alignment works across the Cornwall system, balancing safety and feasibility in community settings.
- Continue prescriber education including Eolas penicillin allergy and cephalosporin safe use updates to support first-line prescribing where safe.
- Business case for recruitment of an antimicrobial pharmacist and technician.

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6. Untoward incidents

6.1 Outbreaks

An outbreak is usually defined as two or more cases linked in time and/or place or more pragmatically, as a greater than expected number of cases. However, sporadic cases may occur by chance in the same place and at the same time but are not linked in any causal way.

The tables below are presented as RCHT first, then CFT.

i) **COVID-19**

Royal Cornwall Hospital NHS Trust Covid-19 outbreaks

There were 29 outbreaks of Covid-19 during the 2025/26 financial year with the majority reported in spring and autumn. This compares to 47 in the previous year.

Ward	Date	Total patients affected	Total staff affected	Total lost bed days
Med 2	April	3	0	1
Phoenix	June	4	3	8
Phoenix	June	4	3	2
Med 2	July	3	0	0
Med 1	July	4	0	0
Phoenix	Aug	8	8	4
Tintagel	Aug	11	4	0
Med 1	Sep	2	0	0
Kerensa	Sep	4	3	0
Wellington	Sep	3	2	0
Tintagel	Sep	2	0	21
AMU 1	Sep	2	0	1
Roskear	Sep	2	0	8
Zennor	Sep	10	6	2
Roskear	Oct	8	5	7
Lowen	Oct	13	3	10
Trauma 1	Oct	2	0	0
GLU	Oct	7	1	7
Phoenix	Oct	8	1	5
Pendennis	Oct	5	0	0
Tintagel	Oct	5	1	0
Roskear	Oct	5	0	3
Trauma 1	Nov	2	0	0
Zennor	Nov	2	0	0
St Mawes	Dec	8	5	7
Grenville	Dec	13	3	10
Med 1	Jan	5	0	7
Tintagel	Feb	2	0	0
CIU	Feb	3	0	3

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Cornwall Foundation Partnership NHS Trust Covid-19 outbreaks

During the 2025/26 financial year there were 10 outbreaks of Covid-19 at CFT compared to 24 in 2024/25

Ward	Date	Total patients affected	Total staff affected	Total lost bed days
Carbis	May	4	3	11
Launceston	July	3	0	5
Bodmin CATU	July	9	0	3
Fletcher	July	2	0	0
Rosewarne	Aug	13	6	5
Stratton	Sep	3	0	4
Heligan	Sep	5	2	7
Newquay	Oct	5	0	6
Harold White	Oct	5	0	2
Heligan	Oct	5	0	2

ii) **Norovirus**

At RCHT there were 3 norovirus outbreaks during the 2025/26 year, there were 15 in 2024/25. Conscious efforts were made by the clinical site team, ED, and admitting areas alongside the IPAC team to assess, isolate, and test patients at the beginning of their journey through the hospitals which has had a significant impact on the number of outbreaks occurring.

Ward	Date	Total patients affected	Total staff affected	Total lost bed days
CIU	April	2	0	6
Trauma 1	April	6	2	8
Med 1	April	8	5	71

In CFT there were five outbreaks of norovirus during 2025/26 financial year compared to four in 2024/25.

Ward	Date	Total patients affected	Total staff affected	Total lost bed days
Rosewarne	April	15	6	31
Bodmin CATU	Dec	11	8	35
Oak	Dec	8	3	27
Boscawen	Jan	8	11	24
Launceston	March	3	1	16

iii) **Influenza**

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During 2025/26 RCHT reported 4 outbreaks of Influenza. Despite early concern regarding ‘subclade K’, Influenza outbreaks reduced this year by 8 cases when compared to 2024/25.

Ward	Date	Total patients affected	Total staff affected	Total lost bed days
Pendennis	April	3	5	0
MRATS	Dec	2	0	0
St Mawes	Dec	2	2	0
Wellington	Jan	2	0	0

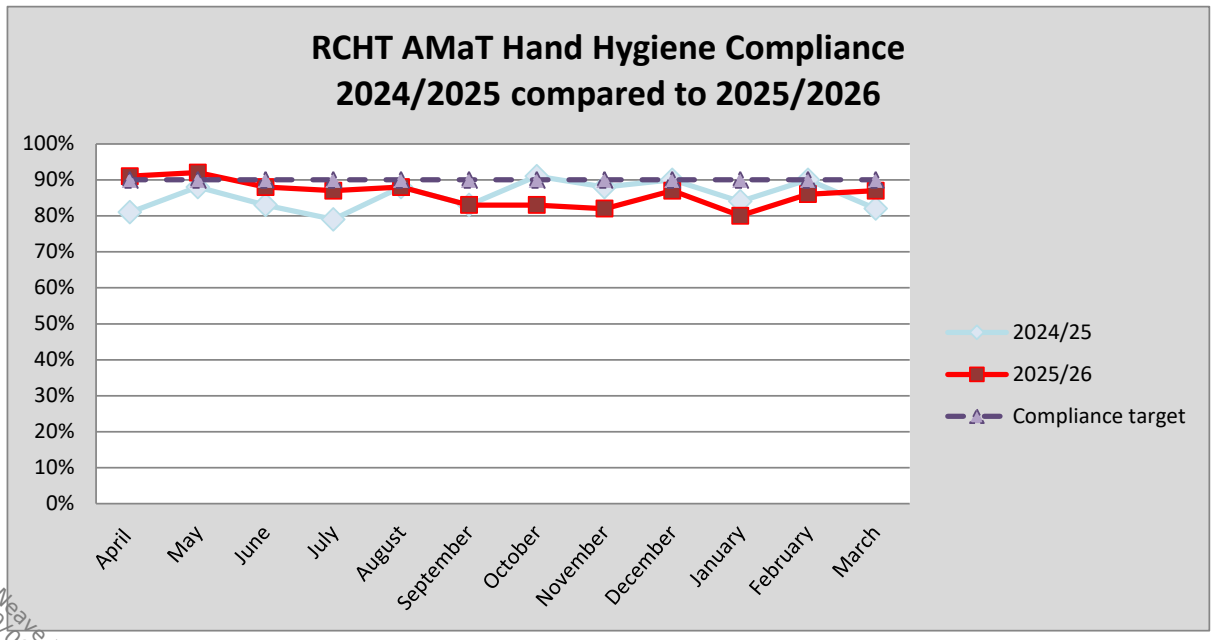
CFT had four outbreaks of influenza in 2025/26. Despite early concern regarding 'subclade K', there was a lower number of outbreaks this year (4) compared to last year (6).

Ward	Date	Total patients affected	Total staff affected	Total lost bed days
Heligan	Dec	2	0	2
Boscawen	Dec	7	6	0
Newquay	Jan	4	4	0
Cove	Jan	5	1	11

7. Hand hygiene

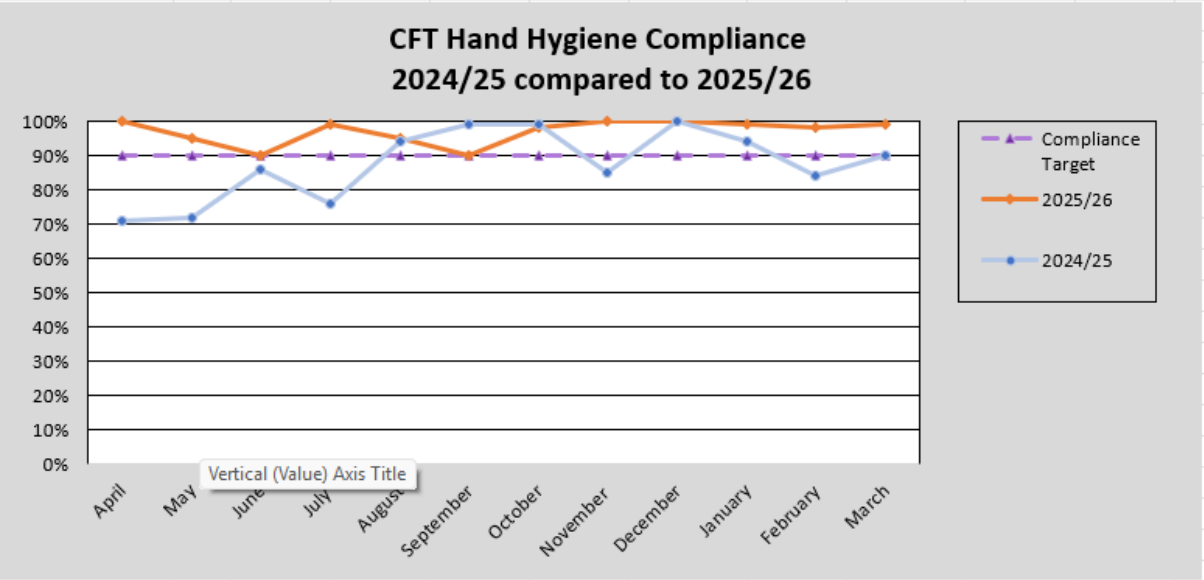
7.1 Audit results

Hand hygiene audits are carried out monthly by all clinical areas as part of the infection prevention and control key performance indicators. Hand hygiene average compliance reported by the clinical areas at RCHT for the year remains at 86% which is the same as the previous year and is below the target of 90%.To promote hand hygiene compliance and awareness the team regularly organise and provide training using UV paint and UV light sources to highlight the importance of good hand hygiene. The team are developing improved connection with IPAC link nurses, and this will be an area that link nurses are asked to focus on alongside 'gloves off' campaigns.



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At CFT the average hand hygiene compliance is 96%, an increase from 87% in last year's ward audits, the target compliance is 90%.



8. Hygiene code

The hygiene code is updated bi-annually for both trusts in quarters one and three. The code contains 10 main criterion that the trust is required to comply with, which are broken down to a further 49 compliance criteria.

The hygiene code covers a range of topics including infection control, antimicrobial use and stewardship, cleaning and maintenance, estates, policies, systems, laboratory provision and procedures. Of the 10 main criterion, RCHT were compliant in all 10. Of the 10 main criterion, CFT were non-compliant in three areas (see appendix 3) and have one area that requires further discussion. Both trusts have made positive steps towards improving compliance in comparison to 2024/25, however CFT has work to do in the areas of hard and soft facilities in terms of infection prevention and control requirements.

Action plans for RCHT and CFT can be seen in appendix 2 and 3, respectively.

9. Decontamination

(Information provided by Matthew Dyer, RCHT Decontamination Lead).

9.1 Sterile services department (SSD)

The Sterile Services Department (SSD) continues to operate within national decontamination standards and regulatory requirements and is subject to robust internal and external assurance processes.

The department is externally audited by the Authorised Engineer (Decontamination) (AED) and the Notified Body, Société Générale de Surveillance (SGS), an UKAS-accredited affiliate (SGS United Kingdom Ltd.), for UK Conformity Assessed (UKCA) certification.

The AED provides independent assurance that SSD operations comply with national decontamination standards and guidance, while the Notified Body provides certification against the UKCA Medical Device Regulations 2002 and ISO 13485:2016 quality management systems.

Key audit activity and outcomes during the reporting period include:

- The AED audit was undertaken in November 2025. Actions arising from this audit are subject to oversight and assurance through the RCHT Decontamination Risk Assessment Group, this is further discussed in 9.3 and 9.4.

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- The SGS recertification audit was completed in January 2025, with successful recertification awarded. The next surveillance audit is scheduled for May 2026.
- A significant estates capital investment programme is underway for the refurbishment of both the cleanroom and washroom, including replacement and upgrading of all associated mechanical and electrical systems, notably air handling systems. Construction commenced in April 2025 and is anticipated to be completed by September 2026.

This programme of investment will provide long-term assurance of compliance with decontamination infrastructure standards and resilience of service delivery.

9.2 Endoscopy decontamination

Endoscopy decontamination services at Royal Cornwall Hospital (RCHT) and West Cornwall Hospital continue to be managed by the Sterile Services Department, providing governance oversight and technical assurance.

9.3 West Cornwall hospital (WCH) endoscopy decontamination

The Institute of Healthcare Engineering and Estate Management (IHEEM) AED audit was undertaken in November 2025. Concerns were identified relating to ventilation and estates engineering support, please see summary below. A total of four actions remain open, all of which are monitored and reviewed through the RCHT Decontamination Risk Assessment Group.

		Comments including actions required or recommended	Rating Applicable
13.1	EWD[s]	EWDs are new. Test records and processes examined as satisfactory. For best practice, recommend create SOP for maintenance of EWDs.	green
13.2	Storage cabinets	Storage cabinets have been replaced as recommended, now drying cabinets. Test records examined as satisfactory.	green
13.3	Environment and ventilation	Ventilation report shows +4Pa on clean/unload side of washers with respect corridor. Recommend improving and addressing shortcomings in ventilation report 2025. For best practice, consider fitting low level extraction and emergency extraction system.	amber
13.4	Environment - Room layouts and general condition Including flows of endoscopes and staff	Good flow of endoscopes and staff, space adequate but limited. Decorative repair on walls could be improved.	green
13.5	Infection Prevention issues – safety (COSHH, PPE) – equipment levels	Good Recommend develop evacuation strategy to include guidance for safe re-entry to decon area. For best practice, consider adding ventilation to chemical storage cabinets	green
13.6	Procedures and Training	Good	green
13.7	Testing	Good. Test records examined for all equipment was satisfactory, EWDs, drying cabinets, water systems, flushing systems. Consider introducing log record to record each engineering activity (paper or electronic)	green
13.8	Assessment of key personnel. Appointments, certification, on-going training	AP(D) is Ian Whittaker. Recommend if time available, to review reports and sign as AP(D) going forward.	green

Figure: Summary of the IHEEM joint advisory group (JAG) audit WCH, November 2025.

9.4 Royal Cornwall hospital (RCH) endoscopy decontamination

At Royal Cornwall Hospital, the endoscopy decontamination unit faces ongoing operational risks due to the condition of existing infrastructure and equipment:

- The current BHT Automated Endoscope Re-processors (AERs) are beyond end of life and require frequent maintenance to remain operational.

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- The IHEEM AED audit raised concerns regarding reliance on external service providers, with a 48-hour call-out response which may negatively impact service capacity and resilience.
- Further concerns were identified regarding:
  - Ventilation verification reports, particularly decontamination room pressure differentials.
  - The location of the endoscopy suite air handling unit (AHU), which is not housed within a plant room and is therefore exposed to environmental contamination risks, including bird droppings.

AER Replacement Programme

To mitigate the risks associated with end-of-life equipment, a programme to replace existing AERs has been progressed:

- Five new AERs were purchased in 2024 to replace the current end-of-life units at RCHT.
- The first new AER was successfully installed and commissioned in May 2025.
- Installation of the second AER was delayed due to building drainage system issues. Following resolution of these issues, the second AER was installed and commissioned in April 2026.
- Installation and commissioning of the remaining three AERs is ongoing.
- The full replacement programme is expected to be completed by June 2026, at which point all five new AERs will be fully operational.

This investment will significantly strengthen service resilience, reduce reliance on ageing equipment, and improve overall compliance with decontamination standards.

		Comments including actions required or recommended	Rating Applicable
13.1	EWD[s]	BHT EWDs (3of) are 10 years old. Steris PTX (1of) is 1 year old. Remaining new Steris EWDs (stored onsite) are expected to be fully installed in 2026 to replace BHT EWDs. Test records and processes examined as satisfactory.	amber
13.2	Storage cabinets	Storage cabinets have all been replaced now with drying cabinets. Test records examined as satisfactory.	green
13.3	Environment and ventilation	Environmental controls are in place. For best practice, consider fitting low level extraction and emergency extraction system. Ventilation report indicates system not meeting requirements.	amber
13.4	Environment - Room layouts and general condition Including flows of endoscopes and staff	Good flow of endoscopes and staff, space adequate but limited.	green
13.5	Infection Prevention issues – safety (COSHH, PPE) – equipment levels	Good Recommend develop evacuation strategy. For best practice, consider adding ventilation to chemical storage room.	green
13.6	Procedures and Training	Good	green
13.7	Testing	Test records examined for all equipment was satisfactory, EWDs, drying cabinets, water systems, flushing systems. Consider introducing log record to record each engineering activity (paper or electronic)	green
13.8	Assessment of key personnel. Appointments, certification, on-going training	Satisfactory records. Recommend AP(D) sign technical reports and quarterly records going forward.	green

Figure: Summary of the IHEEM JAG audit RCH, November 2025.

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9.5 Trust wide decontamination

9.5.1 Ultrasound probes

The Trust has implemented a new Medical Equipment Services (MES) contract for ultrasound equipment across all applicable areas. As part of this contract, automated high-level disinfection units (Trophon) have been upgraded to Trophon 2, enhancing compliance with current decontamination standards and national guidance.

A small number of departments continue to use ultrasound probes outside of the MES contract. These services will be reviewed through the Decontamination Risk Assessment Group (DRAG) to ensure full compliance with the Health Technical Memoranda (HTM), manufacturer's instructions, and national best-practice guidance. Any risks identified will be mitigated through agreed actions and monitored through the appropriate governance structures.

Overall, the Trust continues to achieve the essential quality requirements for decontamination, with best practice demonstrated in the majority of areas. Targeted investment has been made within the Sterile Services Department (SSD) to support ongoing compliance with national standards and to strengthen resilience and service continuity.

Further improvement is required within the in-house engineering provision. This includes increasing the workforce capacity within the Estates Decontamination Team and ensuring that all engineers maintain up-to-date training, competencies, and qualifications. These improvements are necessary to support robust in-house breakdown maintenance, planned preventative maintenance, and periodic testing, in line with relevant standards and guidance.

10. Cleaning services

10.1 RCHT cleaning audit scores (Information provided by Helen Tyler)

Please see below a table detailing the respective cleaning audit scores for all three RCHT hospital sites according to functional risk for the financial year 2025/26.

'Functional areas' are devolved into; FR1, FR2, FR3, FR4, FR5, and FR6 (functional risk) categories. FR1 being the highest risk, requiring additional cleaning frequencies and having a higher target score when compared to FR6 for instance.

RCH	TARGET	Q1	Q2	Q3	Q4
FR1	98%	**98%**	**98%**	**99%**	**98%**
FR2	95%	**97%**	**97%**	**97%**	**96%**
FR3	90%	**94%**	**95%**	**98%**	**94%**
FR4	85%	**94%**	**95%**	**93%**	**96%**
FR5	80%	**84%**	**94%**	**94%**	
FR6	75%	**92%**	**84%**		

WCH	TARGET	Q1	Q2	Q3	Q4
FR1	98%	**99%**	**99%**	**98%**	**99%**
FR2	95%	**98%**	**97%**	**97%**	**97%**
FR3	90%	**No areas**	**No areas**	**No areas**	**No areas**

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FR4	85%	**94%**	**98%**	**97%**	**98%**
FR5	80%				**99%**
FR6	75%	**97%**	**98%**		

SMH	TARGET	Q1	Q2	Q3	Q4
FR1	98%	**98%**	**98%**	**98%**	**98%**
FR2	95%	**98%**	**98%**	**99%**	**99%**
FR3	90%	**No areas**	**No areas**	**No areas**	**No area**
FR4	85%	**100%**	**93%**	**99%**	**96%**
FR5	80%	**No areas**	**No areas**	**No areas**	**No areas**
FR6	75%		**80%**		

The RCHT has achieved quarterly and annual compliance with the nationally set thresholds for cleaning scores when audits have been completed.

The hospital cleaning operations group (HCOG) meets bi-monthly to review performance and consists of key stakeholders, including IPAC, clinical leads, and estate representatives. The minutes and actions of these meetings are tabled at the infection prevention and control committee.

Following a full-service review and the introduction of a new dedicated deep clean team, the department has increased its compliance with the national standards of cleanliness 2025 from 50% to 80%.

The domestic services department received 23,355 ad hoc requests during this reporting period. These requests include post-infection cleans, cleaning following outbreaks, UV cleans, and hydrogen peroxide vapour treatments.

A new window cleaning contract commenced in March 2026.

A maintenance contract is now in place for all electrical cleaning equipment.

10.2 CFT cleaning audit scores (information provided by Bobbie Phillips)

Please see below a table detailing the respective average cleaning audit scores for all CFT sites according to functional risk for financial year 2025/26.

CFT					
Functional Risk Area	**Target score**	**Q1**	**Q2**	**Q3**	**Q4**
FR1	**98%**	**98.68%**	**99.25%**	**99.23%**	**99.18%**
FR2	**95%**	**98.06%**	**98.30%**	**98.47%**	**98.32%**
FR3	**90%**	**97.25%**	**97.05%**	**97.58%**	**96.43%**
FR4	**85%**	**98.37%**	**97.56%**	**97.82%**	**97.72%**
FR5	**90%**	**No areas**	**No areas**	**No areas**	**No areas**
FR6	**75%**				**96.56%**

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983 out of 1118 national standards of healthcare cleanliness (NSC) 2021 audits have been completed. The table highlights the average percentages of the audits that were

completed. Audit compliance has been monitored throughout the year. The hotel services committee meets quarterly and has had good attendance, however issues such as staffing, resources and workload have impacted the ability for some areas to complete audits.

Missed audits				
Functional Risk Area	**Q1**	**Q2**	**Q3**	**Q4**
FR1	37	18	18	18
FR2	14	4	4	4
FR3	2	7		1
FR4	4	2		
FR6				2

Internal audits are completed by the general service assistant supervisors. The hotel services manager is responsible for reviewing audit compliance and reporting the assurance of standards. Improvement plans are requested for any sites scoring below 3 stars.

Audits 3 stars or below requiring an improvement plan				
Functional risk area	**Q1**	**Q2**	**Q3**	**Q4**
FR1	9	1	2	5
FR2	3	2	1	
FR3	1	1		1
FR4				
FR6				

Implementation of the NSC 2021 continues. All sites are using electronic auditing software and generating a rectification report and re-auditing the elements to show rectifications have been completed. The audits are generated at the required frequency with a monthly report highlighting audits not completed within the required time. The star rating posters are automatically generated on completion of the audit and sent to clinical matrons and department leads to be placed at the entrance of each ward or department. Functional risk areas, responsibility groups and frequencies determined by the NSC have been agreed across CFT, whilst we are achieving the frequencies in the FR4 and FR6 areas, we are not achieving the frequencies in FR1, FR2 and FR3 due to staff capacity. A GAP analysis is required for each site to recommend required staffing levels to fully implement the cleaning frequencies and schedules required within the national standards 2021, there is currently no expected completion date. Whilst there has been additional recruitment within the hotel services team, the priority remains meeting the legislative requirements of waste management.

Efficacy audits have been completed by sites during 2025 with action plans emailed on completion of the audit. Efficacy audits focus on all the elements of the cleaning in hospital rather than the physical cleanliness. Sites will be asked to report actions taken at the cleaning committee meeting.

Contracted cleaning

Bodmin CDC - NHSPS					
Functional Risk area	**Target score**	**Q1**	**Q2**	**Q3**	**Q4**

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FR1	**98%**	**98%**	**98.35%**	**98.25%**	**98.57%**
FR2	**95%**	**98.30%**	**98.4%**	**98.5%**	**97.83%**
FR4	**85%**	**97%**	**98.2%**	**98.27%**	**97.33%**

Community Sites - Crystal					
Functional Risk area	**Target score**	**Q1**	**Q2**	**Q3**	**Q4**
Blended	**95%-75%**	**97.7%**	**97.78%**	**98.18%**	**97.93%**

11. Patient led assessment of the care environment (PLACE)

The patient led assessments of the care environment (PLACE) are a national annual assessment of the non-clinical aspects of the patient environment. PLACE assesses several non-clinical aspects of the healthcare premises which have been identified as being important by patients and the public. These domains include:

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

11.1 **RCHT** (information provided by Phil Bond)

PLACE 2025 concluded towards the end of November 2025. RCHT assessments covered Royal Cornwall Hospital, West Cornwall and St Michael's meeting the national requirements for PLACE. The formal results were published in February 2026 along with the National Average for all areas assessed. The assessments are undertaken by volunteers and managed by the Estates and Facilities Governance Team.

The assessment data entry was signed off by the Head of Performance Improvement, Governance and Compliance as the lead for PLACE. There have been improvements in many areas such as Condition, Appearance and Maintenance. However, the Trust average scores lag behind the national averages.

Domain	**Site % (Percent change indicated)**			**Trust Ave %**	**Nat Ave %**
	RCH	**WCH**	**SMH**		
Cleanliness	95.87 (↓2.21)	99.61 (↑0.62)	100.00 (↑0.59)	96.44 (↓)	98.55
Condition, Appearance and Maintenance	93.66 (↑0.79)	98.72 (↑4.28)	96.35 (↑2.97)	94.22 (↑)	97.00
Food and Hydration (combined)	90.61 (↑1.66)	86.63 (↓7.35)	91.57 (↑1.16)	90.40 (↑)	92.13
Privacy, dignity and wellbeing	83.39 (↑0.72)	86.53 (↑2.34)	75.00 (↓2.78)	83.01 (↑)	89.37
Dementia	79.97 (↓0.59)	88.57 (↑5.71)	83.66 (↑1.11)	80.85 (↓)	85.68
Disability	78.60 (↑2.61)	87.91 (↑8.43)	82.22 (↑1.51)	79.53 (↑)	87.12

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There are 231 recommendations identified, this is fewer than the 289 in 2024. The 2025 recommendations were shared with the Care Groups at the time, work is required to

update these in accordance with the new Divisional structure. However, actions can still be undertaken, and the Estates and Facilities Governance Team will still work towards closing the recommendations.

Of the PLACE 2024 recommendations 15 recommendations remain open, a reduction of 17 from the previous report. This shows 95% complete with the majority that remain open requiring Estates intervention.

PLACE-lite (internal assessment of a single area) continues monthly and demonstrates continued good engagement with the wards and departments. The recommendations are tracked and followed up monthly. These results are not reported nationally but are provided to the ward or department when completed.

11.2 CFT (information provided by Bobbie Phillips, Hotel Services Manager)

CFT completed 7 PLACE assessments in 2025. The quality assurance committee agreed that CFT could introduce a 2-year programme. In 2025 the following sites received a PLACE assessment.

- Bodmin ACS
- Sowenna
- Launceston
- St Marys
- St Austell
- Newquay
- Longreach

CFT's PLACE group meet on a quarterly basis to monitor and review PLACE action plans. The committee is well attended by CFT governors, clinical matrons, mental health clinical managers, patient representatives, and estates.

Action plans have been issued to all clinical matrons to progress, and updates are given quarterly at the PLACE Group committee meetings.

The trust's performance against the national average for PLACE 2025 are shown in the tables below, by hospital first then as a Trust. The percentages within the brackets are the variance from the national average, green is where the Trust has exceeded or equalled national average, and red highlights where the Trust has not met the national average.

PLACE 2025 RESULTS

The table below details % against the national average

Site	Cleanliness	Combined Food	Condition, Appearance and Maintenance	Privacy, Dignity and Wellbeing	Dementia	Disability	combined food: Organisation Food	combined food: Ward Food
St Austell Hospital	98.55% (+0.00)	93.88% (+1.75%)	91.63% (-5.37%)	88.57% (-0.80%)	66.76% (-18.92%)	63.06% (-24.06%)	90.43%	97.06%
Newquay Hospital	99.58% (+1.03%)	95.26% (+3.13%)	84.97% (-12.03%)	77.92% (-11.45%)	74.17% (-11.51%)	73.50% (-13.62%)	91.49%	98.96%
St Mary's Hospital	99.65% (+1.10%)	90.34% (-1.79%)	91.13% (-5.87%)	78.79% (-10.58%)	63.96% (-21.72%)	66.09% (-21.03%)	88.30%	92.68%
Sowenna Unit	100.00% (+1.45%)	89.52% (-2.61%)	93.15% (-3.85%)	93.62% (+4.25%)	N/A	88.89% (+1.77%)	90.10%	88.89%
Longreach House	89.78% (-8.77%)	89.88% (-2.25%)	89.31% (-7.69%)	88.24% (-1.13%)	N/A	72.69% (-14.43%)	88.83%	90.51%
Bodmin Hospital	98.91% (+0.36%)	84.69% (-7.44%)	88.68% (-8.32%)	79.22% (-10.15%)	61.08% (-24.60%)	59.20% (-27.92%)	89.36%	80.39%
Launceston Hospital	99.48% (+0.93%)	88.52% (-3.61%)	90.73% (-6.27%)	89.55% (+0.18%)	65.82% (-19.86%)	68.16% (-18.96%)	89.89%	87.25%

The table below details Trust % against the national average

	Cleanliness	Combined Food	Condition, Appearance and Maintenance	Privacy, Dignity and Wellbeing	Dementia	Disability
Trust Overall CFT Score	96.62%	90.67%	89.84% (-7.16%)	86.19% (-3.18%)	66.54% (-19.14%)	68.73% (-18.39%)
National average 2025	98.55%	92.13%	97.00%	89.37%	85.68%	87.12%
Variance	-1.93%	-1.46%	-7.16%	-3.18%	-19.14%	-18.39%

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Key observations

- Cleanliness: several sites achieved above the national average, notably Sowenna Unit (100%), St Mary's (99.65%), Newquay (99.58%), Launceston (99.48%). However, Longreach (89.78%) brought the overall trust score down to 96.62%, this was due to staffing issues the week of the assessment.
- Combined food: Newquay (+3.13) and St Austell (+1.75) both exceeded the national average.
- Privacy, dignity and wellbeing: Sowenna Unit (+4.25) and Launceston (+0.18) are above the national average. Some sites struggle with this domain due aging buildings and overheard conversations in small waiting areas and receptions.
- Disability: Sowenna Unit (+1.77) is above the national. All sites except Sowenna Unit are below the national average; Bodmin (-27.92) and St Austell (-24.06) have the largest deficits. The score reflects small departments where no larger toilet is available, seating in small waiting rooms do not offer a choice seating or a place for a wheelchair. Signage reviews are required to improve wayfinding.
- Dementia: all reporting sites are below the national average (largest gaps include Bodmin -24.60, St Mary's -21.72). There is an ongoing dementia program with the aim to improve our hospitals environment.
- Condition, appearance and maintenance: all sites are below the national average; Newquay (-12.03) is the biggest gap. This reflects the trusts aging estate.

12. Infection prevention and control audit programme

Infection prevention and control performance indicators

Each clinical area at RCHT and CFT is required to undertake a series of audits based on the department of health saving lives campaign. These include:

- hand hygiene
- peripheral Line insertion and on-going care
- urinary catheter insertion and on-going care

These results are reviewed by the clinical matrons and action plans put into place where non-compliance has been identified. Results are reported at the monthly IPAC steering group.

Additional to the above audits, the IPAC team develops additional audits based on themes or findings from patient safety events. This year additional audits have included a point prevalence survey of hospital associated infections, justification of urinary catheter usage, isolation space utilisation, stool chart, and carbapenemase producing Enterobacterale / Candidozyma auris.

13. Infection prevention and control policies

As part of the annual programme of work, the IPAC team has a programme of development and revision of infection prevention and control policies.

During 2025/2026 the following policies were completed at RCHT:

- Urinary Tract Infections in Adults Clinical Guideline V4.0
- Joint Microbiological Air Sampling in Conventional Operating Theatres (including Cardiac Cath Lab / Interventional radiology) Standard Operating Procedure V1.0
- Decontamination Policy V2.1 - minor updates

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- Urinary Tract Infections in Adults Clinical Guideline
- Joint Therapeutic Animals and Pets in Hospital Policy V1.1 - minor updates
- Joint Panton-Valentine Leukocidin (PVL) Policy V1.0
- Joint Creutzfeldt-Jakob disease (CJD) Policy V1.0
- Carbapenemase-producing Enterobacterales Policy V2.1 - minor updates
- Joint Prevention and Management of Clostridioides difficile Infection Policy V1.1 - minor updates
- Management of Patients with confirmed or suspected Influenza Policy V2.3 - minor updates
- Use of Intravascular Catheters in Adults Clinical Guideline V5.2 - minor updates
- Sharps Safety Policy
- Joint Methicillin Resistant Staphylococcus Aureus (MRSA) Policy V1.0

The following policies were completed at CFT:

- Microbiological Air Sampling in Conventional Operating Theatres Standard Operating Procedure V1.0
- Air Scrubber Standard Operating Procedure
- Joint Therapeutic Animals and Pets in Hospital Policy V1.1 – minor update
- Joint Panton-Valentine Leukocidin (PVL) Policy V1.0
- Joint Creutzfeldt-Jakob disease (CJD) Policy V1.0
- Carbapenemase-producing Enterobacterales Policy V2.1 - minor updates
- Joint Prevention and Management of Clostridioides difficile Infection Policy V1.1 - minor updates
- Management of Patients with confirmed or suspected Influenza Policy V2.3 - minor updates
- Decontamination Policy
- Joint Methicillin Resistant Staphylococcus Aureus (MRSA) Policy V1.0

14. Education and training

Educating and training colleagues is fundamental to the infection prevention and control programme. The IPAC team organises and contributes to training activities within the trusts. The following table summarises compliance with infection prevention and control level 1 and level 2 training. Expected compliance is above 80% in all areas, the IPAC training needs analysis has been completed in the last 12 months. Mandatory training compliance is an agenda item at the IPAC steering group.

14.1 RCHT mandatory training figures (data from learning and development, RCHT)

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Staff Group	Level	Compliance %
Add Prof Scientific and Technic	Level 1	90%
	Level 2	83%
Additional Clinical Services	Level 1	90%
	Level 2	75%
Administrative and Clerical	Level 1	89%
	Level 2	n/a
Allied Health Professionals	Level 1	91%
	Level 2	80%
Estates and Ancillary	Level 1	82%
	Level 2	55%
Healthcare Scientists	Level 1	87%
	Level 2	73%
Medical and Dental	Level 1	83%
	Level 2	60%
Nursing and Midwifery Registered	Level 1	88%
	Level 2	75%
Trust Total	**Level 1**	**88%**
	Level 2	**72%**

14.2 CFT mandatory training figures (data from education and training, CFT)

Service	Percentage trained
ACS Services	84%
Corporate Services	79%
Medical Services	75%
Mental Health Services	85%
Trust Total	**81%**

14.3 Fit testing

At CFT fit testing for respiratory protective equipment is provided by the IPAC team via the respiratory fit tester. At RCHT fit testing is held by health and safety. In 2025/26 CFT underwent a mandatory training review, fit testing respiratory protective equipment is not part of the core skills framework, as such was not included in the initial migration to ESR. During this time the IPAC team has continued to provide fit testing as it is a requirement for the Trust to provide adequate training in personal protective equipment. The impact has been a lack of reporting capability for over several months, with ongoing issues for some teams where the IPAC team does not have an accurate staff list for. In May 2026 the IPAC lead will be presenting a case for fit testing to be added to the mandatory training portfolio of staff who are deemed to require it, this will improve assurance that the Trust is providing adequate protection for staff at risk of exposure to biological agents. Using available information the average compliance in 'red and amber' areas is 74% at years end (n.b. this only includes teams that have available data).

14.4 Additional training

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The infection prevention team has a rolling training programme as part of their annual programme of work this includes attendance at mandatory training, preceptorship training, bi-annual link practitioner events, and a quarterly newsletter. Additional to these activities in 2025/26 the infection prevention team responded to reactive demands for

training, continued monthly link forum meetings, maintained pre-registration nursing placements, and attended several care group / locality educational events.

15. Infection prevention and control in the built environment/estates

15.1 Capital and refurbishment projects

RCHT

Ensuring infection prevention and control advice is sought for the development of any new service, capital build or refurbishment is essential in reducing reservoirs of infection. The trust has a “Building and Refurbishment: Infection Prevention and Control in the Built Environment” policy which sets out responsibilities for all parties involved in building or refurbishment projects. During 2025/2026, the IPAC team has been involved in multiple projects.

CFT

During 2025/2026, there has been limited engagement with projects across CFT, this refers to the involvement of IPAC at design, building, implementation and monitoring stages. The project team within Estates has not been able to provide regular updates to essential groups such as the water safety group. This has been raised via the health and safety subcommittee; team structures have changed therefore it is anticipated that engagement with key stakeholders will improve.

15.2 Water sampling

At RCHT there is a programme for the testing of water throughout the hospital sites. The water results for the trust continue to evidence good systems of control. Where there are positive results, these are dealt with in line with the water safety plan.

Similarly, at CFT there is a programme of testing throughout the year, provided through the respective landlords i.e., private finance initiatives or NHS property services, and CBRE. CFT and CBRE have been managing one situation in relation to water throughout 2025/26, this is Rosewarne stroke unit.

All water results are reviewed and scrutinised at each of the organisations water safety management group meetings.

15.3 Ventilation

RCHT has a ventilation safety group which is chaired by the estate’s performance and governance manager. Currently CFT does not have a ventilation group, but an authorising engineer has been appointed, and initial audits are underway, with a ventilation safety group planned to commence in quarter one 2026/27. RCHT holds risk 5180, recorded as extreme in relation to ventilation safety. It is an aggregated risk for several independent ventilation systems across the trust, it is monitored by the ventilation safety group and progress is dependent on annual funding.

Due to the identification across both RCHT and CFT of many of the areas having less than ideal or no ventilation, additional investment is advised when planning works. This has been put into practice during the St Austell SDEC works, where semi-permanent air handing devices have been integrated into the ceiling. In the 2025/26 winter months, emergency care areas were identified nationally as transmission hotspots for respiratory viruses. Additional air exchange in these areas will improve safety for colleagues and patients.

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16. Inoculation injuries (information provided by Beth Howard, OH Clinical Lead Nurse)

Needle stick injury (NSI) and body fluid exposure (BFE) incident reduction remains a key agenda item for occupational health (OH), for the trust board and the trust as a whole. OH, monitors and reports on NSI/BFE incidents and a representative attends the sharps safety group (RCHT) to assist the trust to operate in line with the reporting of injuries, diseases, and dangerous occurrences regulations 2013 (RIDDOR) legislation in collaboration with the trust health and safety team.

Occupational health and RCHT health and safety team meet fortnightly to collate incidents reported and OH reported NSI / BFE's; this is to act as a safety net for non-reporting, and to identify trends.

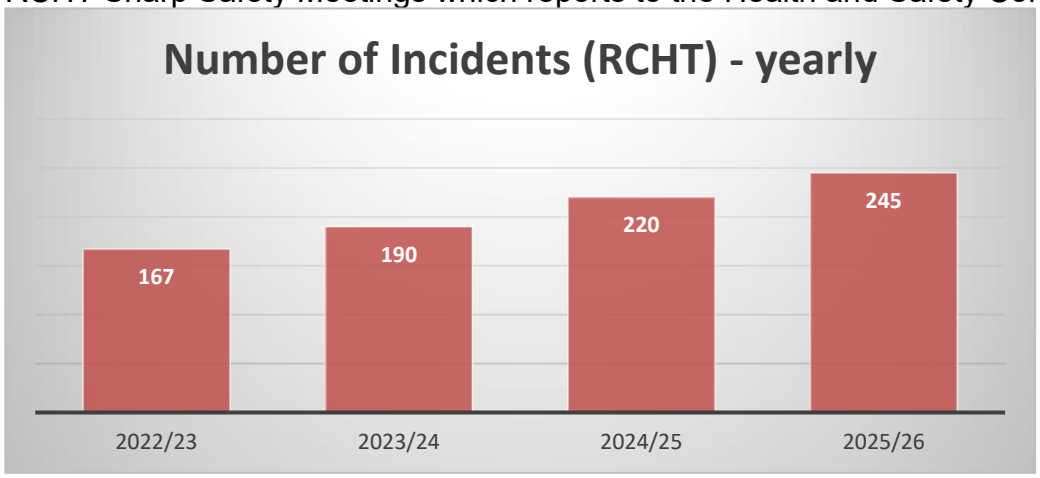
Inoculation injuries for CFT are presented and discussed at the health and safety committee.

Number of incidents

There has been a consistent year-on-year increase in reported inoculation injuries at RCHT over the four-year period.

Overall, this represents an increase of 78 cases from 2022/23 to 2025/26, equating to a 46.7% rise.

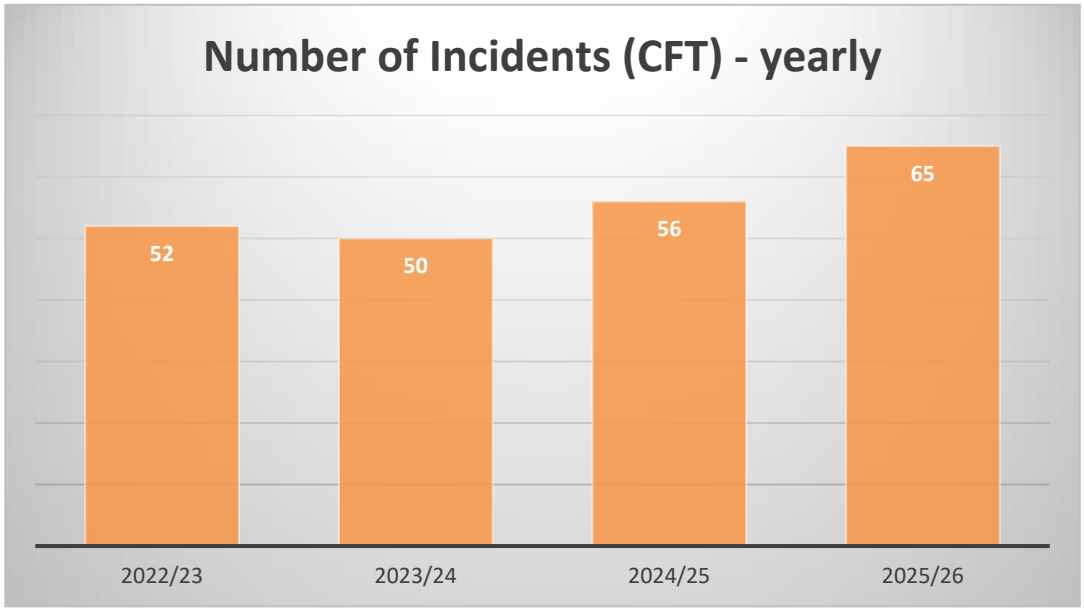
No significant themes have been identified, but the situation is being monitored via the RCHT Sharp Safety Meetings which reports to the Health and Safety Committee.



Inoculation injuries at CFT have fluctuated over the four-year period, decreasing slightly from 52 cases in 2022/23 to 50 in 2023/24, before rising to 56 cases in 2024/25 and further increasing to 65 cases in 2025/26. This represents an overall increase of 25% from the baseline year.

While the initial reduction is encouraging, the subsequent upward trend over the past two years indicates a resurgence in incidents. This suggests a need to reinforce preventative measures and ensure sustained adherence to safe working practices to mitigate further increases. Similar to RCHT, needlestick injuries are monitored by the Health and Safety Sub-Committee. Following the increase in cases in 2024/25, a three-year review was conducted, which identified that actual injuries involving needles had reduced, but 'other' and 'splash' incidents had increased. Similar to RCHT, inoculation injuries are monitored by the health and safety sub-committee.

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17. Vaccination

Flu staff Campaign for 2025/26

In 2025, the winter Flu vaccination programme for staff commenced in October 2025.

Flu vaccinations continued until the end of February 2026. The final uptake figures are:

- RCHT frontline HCW uptake: 38.31% Flu.
- CFT frontline HCW uptake: 47.81% Flu.

Measles

Due to an increase in measles cases in certain areas of the UK, NHS trusts have been required to take actions. The OH team continues to screen patient-facing staff and new employees to the trusts to ensure that there is either:

- evidence of two doses of measles, mumps, and rubella (MMR) vaccine

or:

- evidence of immunity

The vaccine status of many staff is unknown; there is continuing ongoing work from OH to ensure this will be rectified.

18. Risks

18.1 RCHT

- **Risk ID 2944 – 9 (high). Hospital acquired infections.** Risk reduced from 12 to 9. Mitigating factors include performance monitoring at the IPAC steering group and committee. The antimicrobial committee ensure that Trust complies with most recent guidelines as regards antimicrobial prescribing. The IPAC team undertakes surgical surveillance. Gold standard cleaning processes are available but not always utilised due to emergency department pressures. The IPAC teams completes bi-annual assessment against the Hygiene Code and put in place mitigations in unmet areas.

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In 2025/26 C.difficile cases were below tolerance for the first time in several years. Target is 6.

- **Risk ID 9848 – 6 (moderate). Electronic patient care record. Transition to E-care may reduce the effectiveness and safety of the infection prevention and control programme.** Decision for a tiered transition to E-care, the IPAC team will maintain ICNet for 12 months whilst the rest of the Trust documentation transfers. It is anticipated that this will enable additional time to ensure E-care provides modules for outbreak management, mandatory surveillance, and alerts. Target is 4.

18.2 CFT

- **Risk ID 4148 – 12 (moderate) - Limited fit tested staff**. There is a risk of infectious disease transmission because of limited fit tested staff. As per fit testing section in report. Target is 8.

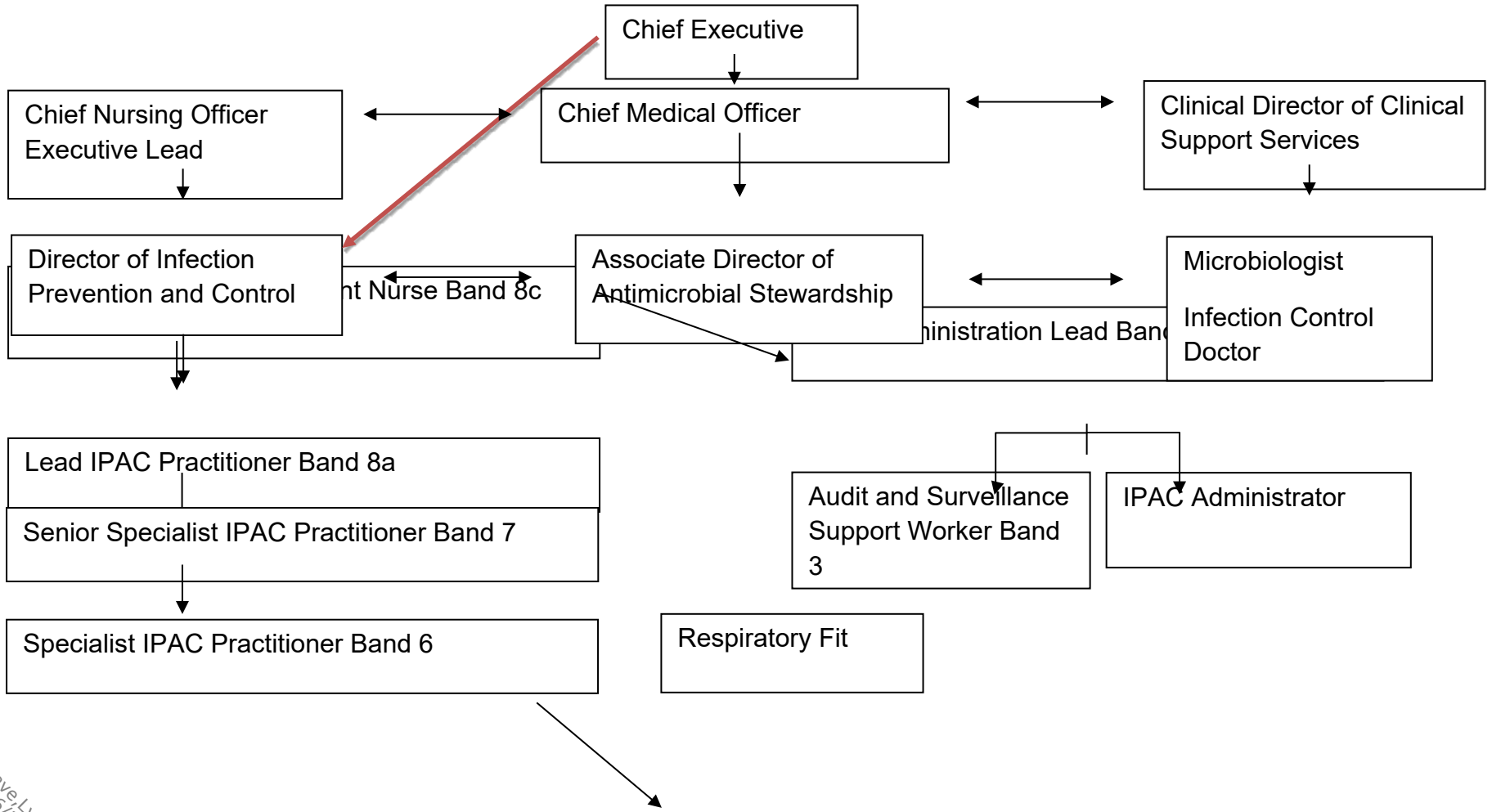
- **Risk 4957 – 5 (low – target met). There is a risk that a person could present to a CFT service (MIU/UTC) with a suspected high consequence infectious disease (HCID) as defined by the UKHSA.** Currently HCIDs are rare in Cornwall. There are good relationships with key stakeholders who share relevant information. The system has processes in place for their management (evidenced with recent increase in Mpox cases in the UK 2023). The consequence could be major, HCIDs typically have a high-case fatality rate, are difficult to detect, are highly infectious and therefore present a significant public health risk.

- **Risk 4956 – tolerated above target – 8 (moderate). Isolation facilities within Trust estate.** There is a risk of increased infectious disease transmission due to a lack of isolation facilities. Reviewed at CNO risk meeting and agreed to tolerate above risk due to mitigations being built into the role of the IPC team.

- **Risk 4207 – target met – 6 (low). Nosocomial spread of CPE.** CPE risk assessment and screening is engrained practice across CFT, evidenced by audit results. Low prevalence of CPE identified in 2024 project carried out by RCHT microbiology service.

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Appendix 1: Infection prevention and control structure



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Appendix 2: RCHT hygiene code action plan (updated January 2026)

Criterion	Key Evidence	Current position	Action required	Action lead	Completion Date
2.1	Minimising infection risk – clean linen is supplied and processed via an agreed contractor.	Contract in place but annual duty of care visit has not been completed for a number of years. Plans in place to arrange this with provisional date February 2026.	Duty of care visit taken place.	Julie Rapson.	
7.1	Provision of Isolation facilities.	ICU and HDU do not have enough isolation rooms to provide isolation to all the patients who should be isolated. Isolation unit in place but number of patients requiring isolation far out ways the 14 rooms available. Not sufficient side rooms in clinical areas for all patients with an infection that requires isolation.	Considered as part of all new builds. Mitigation for existing estate is: Isolation of highest priority is isolated and cohorting used when several patients with the same infection. Lack of isolation is on risk register.	Joanne Taylor and Brian Johnson	

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Appendix 3: CFT hygiene code action plan (updated January 2026)

Criterion	Key Evidence	Current position	Action required	Action lead	Completion Date
1.1	1. Ventilation safety group functioning.	1. Ventilation safety group to take place in March 2026 with recruited AE.	1. VSG to meet.	1. Steve Teale.	1. March 2026
2.1	1. Hotel Services hold cleaning schedules for each area in line with the National Cleaning standards.	1. Cleaning responsibilities agreed and new cleaning schedules in line with the national cleaning standards we are not at the point of printing & distribution. Auditing software implemented. 'Gap analysis' required.	1. Continue to progress schedules with matrons and GSA supervisors. Complete 'gap' analysis.	1. Karen Parsons & Bobbie Phillips.	1. April 2025 (date not changed due to multiple lapses).
2.4	1. Cleaning schedules and roles and responsibilities for cleaning and Nursing staff are available. Ward cleaning schedules developed in line with National cleaning standards.	1. Cleaning schedules and roles and responsibilities for cleaning and Nursing staff are available. Ward cleaning schedules being developed in line with National cleaning standards.	1. 'Gap analysis' requires completion to be able to achieve frequencies.	1. Bobbie Phillips & Karen Parsons.	1. January 2025 (date not changed due to multiple lapses).
9.3	1. Safe handling and disposal of waste.	1. Waste management policy expired June 2023.	1. Review and upload policy on to document library.	1. Karen Parsons.	1. April 2025 (date not changed due to multiple lapses).

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Appendix 4: Integrated service review against the IPAC educational framework

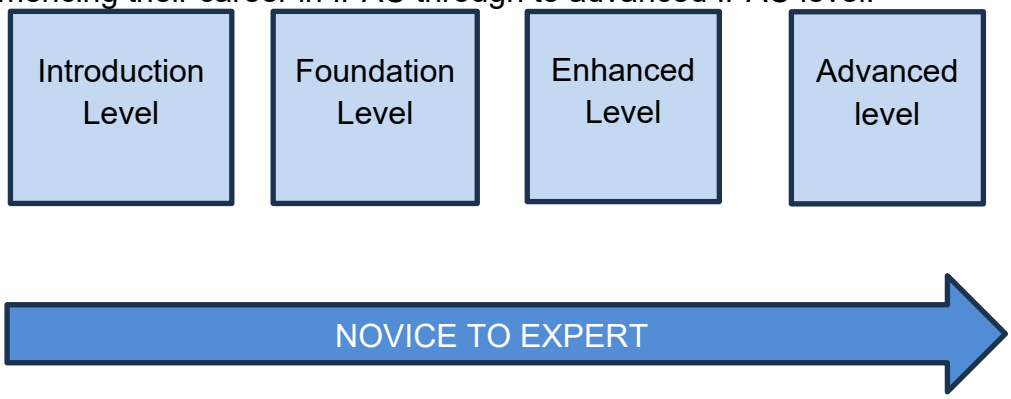
Review of the Integrated IPAC service against the NHSE/I educational Framework for Infection prevention and control (IPAC) Practitioners – 2026 update

1. Introduction

In October 2023 NHSE published an educational Framework for the Infection Prevention and Control practitioner (IPAC) workforce. The development of the document was prompted by the recognition during Covid-19 of the importance of a knowledgeable IPAC workforce and was supported by all of the UK infection societies. Furthermore, during Covid-19 many IPAC teams were supported by staff who previously hadn't worked within the specialty, and the framework therefore ensures that IPAC services are fit for purpose and able to have the required knowledge and skills to face any future threats. The framework supports the NHS Long Term Workforce plan and acknowledges the role IPAC plays in the delivery of the antimicrobial resistance agenda and action-plan. The document sets out to establish a baseline of the educational standards required at the different levels within the IPAC team. The full framework can be reviewed here NHS England » Education framework for the infection prevention and control practitioner (IPAC) workforce

2. Interpretation of the framework for the RCHT/CFT IPAC service

The framework identifies four distinct levels of practice. Beginning with someone commencing their career in IPAC through to advanced IPAC level.



The levels have been reviewed to identify the roles within the RCHT/CFT IPAC team and where they sit within these four levels of practice.

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Introductory level – link practitioners, SSI surveillance administrator and 2 administration posts

Foundation level – members of the team who range from commencing their first IPAC role, those working towards an IPAC qualification and, those who have gained the qualification but continue to work under a level of supervision (band 5 and 6 practitioner roles)

Enhanced Level – these staff have an IPAC qualification and some autonomy to work independently. They have some leadership responsibility and actively take part in quality improvement (band 7 roles)

Advanced Level - high degree of autonomy and complex decision making. Have responsibility for IPAC performance and service development (lead practitioner and deputy DIPC/consultant nurse roles).

The framework provides further examples of the role of IPAC practitioners through identifying four domains: IPAC practice, quality improvement, research and safety, leadership and management, and education. For each of these domains there are outcomes that are broken down to identify the areas where staff at the four levels should be working. The framework identifies that these outcomes are not prescriptive for IPAC roles but can be used to support staff development. Within the Trusts IPAC team these form part of the team development reviews and will be used to support the way future development of the team is supported.

In addition to the main IPAC roles being discussed, the framework identifies that the role of the DIPC is undertaken by professionals whose role may not have always been within IPAC. To ensure that the DIPC role is carried out in a uniform manner and in order to meet the legislation that comes within the role the framework clearly identifies the outcomes required for the role and further breaks the requirements down into the four domains used for the rest of the IPAC workforce.

3. Discussion

In previous years the team has been fortunate to receive NHSE money earmarked for IPAC education and have used this to provide a county wide conference. This was not possible in 2025/6 financial year as additional funding was not received and the wider financial constraints across both organisations, however alternative revenue sources are being reviewed to hopefully deliver a conference again in 2026/27. At the beginning of the 2025/26 all existing members of the team were at the level of education needed to meet the framework requirements. During the year 2 new members of the team were appointed one was appointed with a master's qualification in IPC and the second, who is on a 1 year fixed-term until January 2027, will undertake the IPAC module at the University of Plymouth commencing in September 2026. Although the team is integrated there are still 2 separate budgets and the members of the team are employed by one of the organisations rather than both. To support service delivery all IPAC team members now hold an honorary contract with the other organisation. RCHT does have a training budget, but this is not the case for CFT. Due to the current financial situation, it is unlikely the CFT IPAC team will be allocated a training budget. Therefore, any new substantive role would need the cost of the required course included to the on costs to ensure the framework is met.

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4. Recommendations

- The framework domain and outcome documentation is used to guide the development and education of the team.
- The CFT budget requires the addition of a training budget. Pro rata this should be in the region of 8k. Alternatively any substantive role that is advertised would need the cost of the required course adding in as start-up costs.

Joanne Taylor
Deputy DIPC and IPAC Consultant Nurse
30 March 2026

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Appendix 5: Annual Programme of Work

CFT/RCHT Infection Prevention and Control Programme of Work 2026-2027

Red	No action plan or target date
Amber	Risk of not achieving actions as planne
Green	On target
✔	Complete

Domain	Key Area		Action	Target Date	Accountable	Status	Measure of success	Progress / update	Date Completed	Evidence / outcome
1. Enteric infections and AMR	**1.Sustaining/ reducing the number of cases of Clostridium difficile** Expected outcome: The number of reported cases of Clostridium difficile will be less than anticipated target figure of 73 HOHA cases.	**1.01**	Monitor compliance of requirement to document indication for use and stop/review dates against antibiotic on EPMA/eCare.	31.03.27	Antimicrobial pharmacist/Ward pharmacists.		Audit results will indicate sustained compliance with recording stop/review dates and indication for use. Stretch target 90% compliance.			Audit results.
		1.02	Promote optimal pro-calcitonin use in ITU setting.	31.03.27	Antimicrobial pharmacist.		Education package delivered and ward rounds in place to monitor.			Training attendance sheets, review and feedback.
		1.03	Annual update on antimicrobial stewardship to be completed by all prescribers and pharmacists.	31.03.27	Divisional; Area Directors.		All prescribers will receive antimicrobial stewardship updates annually.			Training records.
		1.04	Maintain a Trust-wide Antimicrobial Stewardship ward round programme to optimise antimicrobial prescribing.	31.03.27	Antimicrobial pharmacist.		Audit data for AMS ward round activity, including patients reviewed and outcome data.			Audit results.
		1.05	Monitor compliance with appropriate diagnosis and management of lower UTI and catheter-associated UTI in patients over 16 years of age.	31.03.27	Antimicrobial pharmacist.		Audit data for appropriate management of UTIs in over 16s.			Audit results.
	AMR/IPC targets	**1.06**	AMR Call for Action Priority 1: Reduce Total Antibiotic Consumption.	31.03.27	Antimicrobial pharmacist.		Ark audit results will indicate sustained compliance with recording stop/review dates and indication for use. CAP/HAP course length audit results Proportion of IV antibiotic of overall antibiotic usage.			Audit results.
		1.07	AMR Call for Action Priority 2: Increase Access Antibiotic Percentage consumption ratio through penicillin allergy de-labelling:	31.03.27	Antimicrobial pharmacist.		Patient outcome date for penicillin allergy de-labelling. Consumption reports will indicate reduction in use of second-line and third-line antibiotics.			Audit results.
		1.08	AMR Call for Action Priority 3: Comprehensive Vaccination programme	31.03.27	Chief Pharmacist		Vaccination uptake rates.			Audit results.

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	Appropriate management of patients with Diarrhoea Expected outcome: Patients will have a diarrhoea risk assessment completed, Bristol stool chart completed, isolated and appropriate samples sent.	**1.09**	Where a CDI period of increased incidence (PII) is declared in a clinical area, undertake bespoke training addressing the issues identified within the clinical area.	31.03.27	IPAC team.		All areas with a PII (including community onset healthcare acquired) will have bespoke sessions provided for all staff.			Attendance sheets.
		1.10	Complete audit of compliance with CPE screening, Diarrhoea risk assessment completion and stool chart monitioring.	31.03.27	IPAC team.		Spot checks completed with compliance above 85%.			Audit results.
		1.11	Undertake a weekly MDT review of patients with CDI (including PCR positive cases).	31.03.27	IPAC team/ Microbiologists/ Pharmacy.		All RCHT/CFT inpatients with on-going symptoms covered by RCHT microbiologists will have an MDT review weekly (in person where Geography and personnel allow).			Passport available.
		1.12	Prepare Norovirus packs for delivery to all wards and ensure all information is at ward level prior to October, including safety briefing delivered.	30.09.26	IPAC team.		All wards will have packs that have been signed for by the ward leader or deputy and checked by IPAC.			Packs available on the ward.
Domain	**Key Area**		**Action**	**Target Date**	**Accountable**	**Status**	**Measure of Success**	**Progress / update**	**Date Completed**	**Evidence / outcome**
2. Devices	**The management and care of devices will improve** Expected outcome: reduction in device related bacteraemia's.	**2.01**	Clinical areas will only use devices when essential and when used will deliver care to Patients with devices in line with policies.	31.03.27	Ward leaders with support from IPAC team.		Audit in June 2026 will show % of PVC needed device and IPC audit of Urinary catheters will identify the same . Areas where % is less than 90% of devices appropriate will be asked to develop an audit to reduce unnecessary devices.			PSIRF thematic feedback.Audit results, action plans.
		2.02	The Deputy DIPC will chair the Trust Vasucular access group and sharps safety group meetings.	31.03.27	Group members.		Minutes which will include discussions of incidents and actions, improvements to practice, training or devices.			Meeting minutes.
		2.03	Where the infection has been identified as being line related carry out bespoke training sessions on the ward addressing the issues identified.	31.03.27	Ward Leaders with support from care group educator, IPAC team.		Where identified training delivered as part of the PSIRF action plan.			Attendance sheets.

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Domain	Key Area		Action	Target Date	Accountable	Status	Measure of Success	Progress / update	Date Completed	Evidence / outcome
3. Audit	**Infection Prevention and Control environmental and clinical audits** Expected Outcome: There will be a standard audit programme that is delivered in accordance with a standard audit process which meets requirements of the Health and Social care Act.	**3.01**	A schedule of audits will be in place that reflect the requirements of the hygiene code.	30.06.26	IPAC team.		Audit schedule in completed.			Written audit schedule.
		3.02	The IPC team will undertake a point prevelance survey in Q1 and activity for the rest of the year will be based on the findings.	30.06.26 (Survey)	IPAC team.		Survey completed and results shared.			Point prevalance audit findings shared in Q1 IPC report.
		3.03	The IPC team will undertake additional audits in response to periods of increased incidents.	31.03.27	IPAC team.		Audit process in place that provides feedback and timely response to actions required with scrutiny and oversight provided by the Infection Prevention and Control Committee/group.			Divisional evidence of improvement, including audit cycle.
		3.04	The IPC team will work with the sepsis lead to undertake a review of blood culture samples taken in a timely manor of AMG administration, where sepsis is being considered and develop an action plan to address any shortfall.	30.09.26	IPC/Sepsis lead/ Clinical leads.		Audit completed. Action plan in place (if required). Improvement in timely samples			Audit completed and improvement in timely samples if identified.
		3.05	Clinical areas to complete AMAT audits.	31.03.27	Ward leaders.		Audits will be completed with scores above 85%.Oversight at the IPC sterring group.			Audit scores submitted.
Domain	**Key Area**		**Action**	**Target Date**	**Accountable**	**Status**	**Measure of success**	**Progress / update**	**Date Completed**	**Evidence / outcome**
4. Communication	**Consistent messages are communicated across both organisations:** Expected outcome: There will be a set of leaflets available across both organisations, staff will be aware of the findings of investigations into HCAIs.	**4.01**	Produce a quarterly IPC newsletter which includes learning from PSIRF and audit results.	31.03.27	Lead Practitioner IPAC.		Sharing of learning process in place.			Newsletters.
		4.02	Promote IPC and the work of the team in the wider community, locally, regionally and nationally.	31.03.27	Consultant Nurse IPC.		Events delivered, Posters, Presentations, Awards.			Events, Posters, Awards.
		4.03	IPC team will visit clinical settings regularly and actively increase visibility through engaging with other teams/events.	31.03.27	Senior IPC practitioners.		Events, clinical feedback, work schedule.			Events Work schedule.
Domain	**Key Area**		**Action**	**Target Date**	**Accountable**	**Status**	**Measure of success**	**Progress / update**	**Date Completed**	**Evidence / outcome**
5.PPE	**The organisations will be in a state of readiness for potential outbreaks with PPE needs and use.**	**5.01**	PPE donning and doffing training will be delivered to high risk areas to ensure competency maintained for outbreaks.	31.12.26	IPAC team.		Information sheet complete and standardised across RCHT and CFT.			Record sheet.
		5.02	Within CFT provide a fit testing service across all sites to staff identified as requiring training.	31.03.27	Ward Leaders.		All staff who may undertake AGPs, be at increased risk of exposure to airborne pathogens, or identified as part of pandemic preparedness have been fit tested against the current available FFP3 masks.			Record sheet.
Domain	**Key Area**		**Action**	**Target Date**	**Accountable**	**Status**	**Measure of success**	**Progress / update**	**Date Completed**	**Evidence / outcome**
6. Education	**Education will meet current local need** Expected outcome: Training will be aligned across the organisations that is reflective of the current local issues.	**6.01**	Training compliance in IPC will be above 90% in both organisations.	31.03.27	Ward leaders.		Compliance figures show over 90%.			Compliance figures.
		6.02	Work with UHP to deliver the Management of Infection Prevention and Control Service Module.	31.12.26	Consultant Nurse.		Module delivered.			Module programme.
		6.03	Deliver joint 6 monthly Link Practitioner sessions.	31.03.27	IPAC team.		Sessions successfully delivered.			Agenda for the day.
		6.04	Develop the role of the Link practitioner.	31.12.27	Senior IPC practitioners.		Role specification and delivery plan in place.			Activity feedback included in steering group minutes.
		6.05	Annual measurement of the IPC team against the NHSE/ IPC educational framework and action any areas of improvement required.	31.03.27	IPAC team.		Audit completed and action plan in place to show plan of work, as required.			Audit, Improvement plan.

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Domain	Key Area		Action	Target Date	Accountable	Status	Measure of success	Progress / update	Date Completed	Evidence / outcome
7. Surgical Site Surveillance	**The organisations will carry out mandatory Surgical Site Infection Surveillance** Expected outcome: Orthopaedic surgical site infection surveillance will be completed for at least one quarter with infection rates monitored and appropriate interventions put in	**7.01**	Complete data collection and upload onto PHE system for a minimum of 1 quarter during the 2026/27 year.	31.03.27	Surveillance co-ordinator.		Data collected and evident from PHE reports.			PHE reports.
		7.02	Ensure details are shared with the relevant surgical team.	31.03.27	Surgical Site Surveillance Co-ordinator.		Information successfully shared.			Email correspondence.
		7.03	Ensure any deep SSI is investigated and any actions/ interventions shared with clinical team.	31.03.27	Consultant Nurse ICD.		RCA completed and information shared.			RCA and minutes of discussion at speciality governance.
Domain	**Key Area**		**Action**	**Target Date**	**Accountable**	**Status**	**Measure of success**	**Progress / update**	**Date Completed**	**Evidence / outcome**
8. Governance	**Education will meet current local need Expected outcome: Training will be aligned across the organisations that is reflective of the current local issues.**	**8.01**	A gap analysis of both RCHT and CFT is undertaken against the hygiene code which covers the NHSE/I AMR requirements.	31.03.27	Consultant Nurse IPAC.		Revised gap analysis completed and presented to ICC and QAC.			Document presented to ICC.
		8.02	Action plan to identify any gaps in the hygiene code, reviewed at ICC.	31.03.27	Service leads.		Action plans developed and addressed.			ICC/QAC minutes.
		8.03	All positive cases of CDI and mandatory surveillance bacteraemia's are reviewed and incident reported.	31.03.27	IPC lead/Clinical teams.		Incidents and outcomes reported in-line with the IPAC PSIRF process.			PSIRF reviews.
Domain	**Key Area**		**Action**	**Target Date**	**Accountable**	**Status**	**Measure of success**	**Progress / update**	**Date Completed**	**Evidence / outcome**
9. Facilities/Estates	**The organisations will be able to meet the environmental expectations /legislation of a healthcare provider** Expected outcome: Facilities and estates functions/ developments are in line with national standards.	**9.01**	Governance of Ventilation safety is assured, including a ventilation safety group.	31.03.27	Head of Estates.		Ventilation safety group in place.			Meeting minutes.
		9.02	Governance of decontamination across the organisations.	31.03.27	Decontamination Manager.		Decontamination meetings taking place.			Meeting minutes.
		9.03	Governance of water safety is assured; including suitable water testing and water flushing processes.	31.03.27	Responsible person for Water.		Clear, contemporaneous water flushing results available. Water testing meets legal requirement with clear SOP for management of results being enacted.			Water safety policy in place with spot checks on processes to give assurance.

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Meeting: Trust Board

Date of Meeting: 02 July 2026

Item Number: 21

Title of Report: Health and Safety Annual Report

Executive Director Lead: Robin Jones, Chief Operating Officer

Author and Job Title: Gavin Griffiths, Head of Health and Safety

Email Address: gavin.griffiths@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☒ **Assurance** ☐ **Information** ☐

This report details health and safety performance of the Trust with regard to compliance with UK Health and Safety Legislation, including but not limited to The Health and Safety at Work etc Act 1974 and The Management of Health and Safety at Work Regulations 1999.

Consultation:

The presentation of this report to the Executive Leadership Team will be the first reading of this report, which will then subsequently be presented at the Quality Assurance Committee and Trust Board. The report has been approved by the Chief Operating Officer.

The annual report was presented and considered at the April Quality Assurance Committee as a starred item, the report was not requested to be unstarred.

The report presented to the Quality Assurance Committee is provided in full for Trust Board consideration as a starred item.

Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☐

Reputational ☐ **Legal / Regulatory** ☐

Impact:

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Assessment	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			x	
Quality Impact Assessment completed?			x	
Data Protection Impact Assessment completed?			x	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – or reports requesting decisions only:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its **decisions** on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

Considerations	Summary of considerations (if one or more does not apply state 'not applicable')
Health and wellbeing of the population, including inequalities and wellbeing	Not applicable
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	Not applicable
Sustainable and efficient use of NHS resources by RCHT	Not applicable

Recommendations:

The Board **is recommended to:**

- **Note** the Health and Safety Annual report.

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Health and Safety Annual Report

1. Situation / Executive Summary

This Health and Safety Annual Report provides an overview of the Trust's health and safety performance, key developments, statutory compliance, and areas requiring further focus during the reporting period. All statistical information within this report covers the period from 1 April 2025 to 24 March 2026 and therefore excludes the final week of the financial year.

The report outlines progress against the Trust's Health and Safety Improvement Plan, summarises interactions with the Health and Safety Executive (HSE), and provides updates on priority risk areas including nitrous oxide exposure, Control of Substances Hazardous to Health (COSHH), and Helicopter Landing Site (HLS) safety. It also presents Trustwide incident data, highlights performance trends, and identifies emerging risks requiring managerial and executive oversight.

The report is provided to ensure organisational compliance with statutory duties under the Health and Safety at Work etc. Act 1974, associated regulations (including COSHH 2002 and Reporting of Injuries, Diseases and Dangerous Occurrence Regulations – RIDDOR), and Trust Policy. The purpose of this report is to inform the Board of current performance, ensure appropriate scrutiny of issues and risks, and seek support for strategic decisions — specifically the request for Executive and Committee discussion regarding the development of a new elevated Helicopter Landing Site adjacent to the Emergency Department.

2. Background

2.1 Health and safety improvement Plan
This plan was created in response to several inspections and audits from the Health and Safety Executive, Assurance South-West and a review of health and safety from IDP, an independent review.

2.2 Health and Safety Executive Interventions
The Health and Safety Executive have powers granted under sections 18-26 of the Health and Safety at Work etc Act 1974 to inspect business premises and issue enforcement action for breaches of UK Health and Safety Law. It is an offence under section 31 (1) (g) to fail to comply with an enforcement order.

2.3 Management of Nitrous Oxide Exposure
The Trust is obligated under the Control of Substances Hazardous to Health Regulations (COSHH) 2002 to limit the release of hazardous substances, control and monitor exposure and make appropriate emergency arrangements. The Trust has retained its status as an exemplar Trust for the management of Nitrous Oxide by both the HSE and NHS(England), both of whom have recommended over a dozen other Trusts to seek advice from RCHT on management strategies.

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2.4 The Control of Substances Hazardous to Health (COSHH)
In December 2021 the Trust received Improvement Notice JVH/17/12/202/02 following an observed breach of controls in the facilities department. As a response to the breach, the health and safety team retained the use of the Alcumus Sypol COSHH management system for the management of COSH Trust-wide.

The continued use of Alcumus Sypol was accepted by the HSE as a suitable response, subject to the training and implementation being effectively managed at departmental level. Training commenced immediately, delivered by the health and safety team, and continues weekly. On the appointment of a health and safety auditor in late 2022, a Trustwide audit programme commenced which included COSHH as a core subject.

2.5 Helicopter Landing Site (HLS) Safety
RCHT operates a single HLS facility for the reception of critically ill patients by air from a number of service providers. The Emergency Department Helicopter Landing Site was closed to facilitate Trelawney wing roofing works and was permanently closed due to the risk to pedestrians from helicopter downwash following a fatal incident at Derriford hospital.

The rear of the hospital houses a large HLS, operable day and night for the reception of all helicopter types in use by various air ambulance operators. Bristow Search and Rescue (SAR) no longer land at RCHT due to the risk of downwash injuries to pedestrians and conduct land transfers of patients following a landing at Newquay airport.

The HLS requires a significant upgrade to achieve compliance with CAP 1264, the standard for Hospital Helicopter Landing Sites. The fatal incident at Derriford is 2023 has increased concerns over HLS safety, particularly in respect of high winds and flying debris produced by the downwash of the rotor blades of the helicopter. Category one hurricane strength wind can be experienced 50 meters from the HLS in normal operations.

Jordan et al (2008) concluded that half of people aged 50 and above exposed to a 40 KPH gust of wind would become dislodged. For the S-92 search and rescue helicopter, which is experienced at 58 meters from the HLS, and 36 meters for the air ambulance AW-169 aircraft.

An upgrade programme is under development, with potential funding agreed from the HELP Appeal, a national charity that funds hospital HLS provision.

2.6 Health and Safety Leadership Team (HSLT)
The HSLT meet bi-monthly to increase care group awareness of emergent health and safety issues, gather feedback from care groups on health and safety performance and enact on decisions made by the bi-monthly Health and Safety Committee.

3. Assessment

3.1 Health and Safety Improvement Plan (HSIP)
The HSIP is a live document that tracks the development of identified health and safety improvements Trustwide. At the end of each financial year, closed actions are archived and open actions transferred to the current document. There are currently 7 open actions on the plan, with one off track for completion for increased staffing in the security team. The Director of Estates and the Local Security Management Specialist (LSMS) continue to develop the business case for appropriate staffing levels within this vital team.

Next Level Security Group 3106 2026

The second major development concerns the upgrade of the Helicopter Landing Site (HLS) to CAP 1264 standard compliance. A significant amount of effort has been applied to gain funding from the HELP Appeal, a Hospital HLS (HHLS) charity that's major purpose is to fund this type of activity. A consultation group consisting of representatives from the Trust (Health and Safety, Estates Projects, Facilities, Patient Leaders, Clinical teams), aircraft operators and the HELP Appeal meet on a regular basis to progress the

development and have a planned completion date of the 31st of October 2026. The HLS will be closed for approximately 8 weeks during the upgrade, while consists of new lighting, marking and safety control measures to reduce the risk of incidents due to downwash for the rotor disc.

It is further planned to scope the possibility of constructing an elevated platform in the location of the previous HLS located adjacent to the Emergency Department (ED). This development would enable the immediate delivery of critically ill patients to ED without the need for a secondary transfer. Outline timings for this development are likely to be in the region of 10 years, subject to the completion of the New Hospital Programme, other hospital developments and a reassessment of the need at the appropriate time.

ACTION: ELT / QAC requested to discuss the request for consideration of a new Helicopter Landing Site Elevated Platform adjacent to ED.

Goal	Title	Open actions	Off track	Comments
1	Leadership	1	1	Business case for increased security staffing.
2	Safe People	3	0	IQM for H&S management, DSE development, manual handling training.
3	Reduce Harm	1	0	Health Surveillance.
4	Working with Others	1	0	Contractor management development.
5	Consultation and Communication	0	0	
6	Safe Premises	1	0	Plant Room Control.
7	Continual Improvement	0	0	

3.2 Health and safety Executive (HSE) Interventions
There have been no formal HSE interventions in the last 12 months. The HSE have however requested follow up information regarding 2 Asbestos related incidents. One included a protected disclosure to the HSE from a staff member who believed they had been exposed to an uncontrolled risk and one related to an asbestos incident involving a contractor. Both occasions have been managed informally and the HSE are currently content with Trust processes and procedures.

3.3 Management of nitrous oxide exposure
The Trust remains an exemplar organisation for the management of nitrous oxide exposure to staff. There has been one overexposure this financial year with a recorded reading of 119.5 parts per million (ppm) over an 8-hour time weighted average shift due to a faulty bottle valve that is now out of service. There are no long-term health effects associated with a single over exposure. The level of exposure needs to be more than the Workplace Exposure Limit (WEL) of 100ppm for a prolonged period (months) before ill health effects such as a risk to vitamin B12 deficiency, bone density and fertility is increased. The staff member was offered health surveillance as a precaution but declined the offer.

The health and safety department continue to monitor exposure at a rate that far exceeds the rate recommended by the HSE (13events in 12 months, as opposed to the recommendation of one event every 9 months) and average exposure for the year is recorded at 53.5 ppm, up from last year's average of 28.6 ppm. This rise in exposure is attributable to a small number of events where the patient has been unable to tolerate the facemask that is used to deliver the pain-relieving gas. For any overexposure event, an informal investigation is completed to determine causation factors and identify early indicators of areas for improvement.

The health and safety team are investing in new monitoring equipment this term, owing to the aging nature of the current G200 monitoring devices and an increase in unreliability to monitor the required shift length due to persistent battery issues. It will be more cost efficient to replace the devices with a newly sourced item than to maintain the existing equipment. The new devices should be in use before the end of May 2026 and the safety advisor will increase the rate of monitoring for 3 months with the new device to increase Trustwide knowledge on its use and re-emphasize the importance of monitoring staff safety.

3.4 The Control of Substances Hazardous to Health (CoSHH)
The safety advisor acts as the CoSHH lead for the health and safety team and continues to deliver training to designated CoSHH Administrators throughout the Trust. To aid in increasing awareness and to control the implementation of new substances to the Trust, the Head of Health and Safety (HHS) has created a CoSHH Safety Group (CSG), chaired by the CoSHH lead and attended by the Trust CoSHH administrators, Infection Prevention and Control (IPAC) lead, Facilities and Occupational Health (OH). The purpose of the group is to ensure the four pillars of health and safety management are implemented effectively.



Risk assessment forms the basis of sound health and safety management, and the Trust uses the Alcumus SyPol system to produce suitable and sufficient CoSHH risk assessments. These assessments are completed by the departmental CoSHH administrators following training from the CoSHH lead.

During the CSG, INFORMATION on a required change to or introduction of a new substance will be presented by the department requiring the change. Material Safety Data Sheets (MSDS) will be issued to enable the production of the Alcumus assessments. The chair will issue a formal INSTRUCTION for each department using the new/substitute substance to complete their exposure scenarios and assessments by a negotiated date. TRAINING requirements will be formalised and agreed so that effective training is delivered before the substance is introduced and supervision requirements agreed on the introduction and use of the substance.

The CSG will also review the introduction of previously introduced items and any incidents associated with their use.

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3.5 Helicopter Landing Site (HLS) Safety
The Trust is engaged with the HELP Appeal, a national charity that fund Hospital HLS improvements to the standard dictated in the design document CAP 1264. The Chief Operating Officer (COO) chairs an HLS Consultation Group to lead on the development.

The HELP appeal have agreed in principle to fully fund the HLS improvements, with Cornwall Air Ambulance (CAA) also providing funding for additional resources such as a fuel bowser, to increase response capacity to incidents county wide.

The project is currently at RIBA stage 3 and is planned for completion by the end of October 2026. The specification for the new HLS and associated equipment is extensive and available to the Board upon request.

3.6 Health and Safety Committee/Leadership team (HSC/HSLT)
the HSC and HSLT and currently being reformatted following the organisational restructure. Membership lists and terms of Reference are being rewritten to reflect the new structure, and the next meeting of the HSC is programmed in for May 2026. The previous committee membership requested that the HSLT focus on review and approval of the 24 health and safety policies ahead of approval by the committee.
The HSLT will continue to act upon instruction from the committee and prioritise health and safety improvements accordingly.

3.7 Anti Ligature Developments
The HHS met in March 2026 with the associate director of nursing, estates build lead and patient safety lead investigator to discuss the Ligature Point Policy that currently has no ownership. The four members agreed to review the current policy, making clear the roles and responsibilities of key stakeholders in addressing the required actions to place the Trust in a position of safety regarding the risk to patients and staff of ligature events. It is recognised that the Trust is not a mental health facility, but that all patients with poor mental health will attend the Trust for their acute clinical needs to be met.

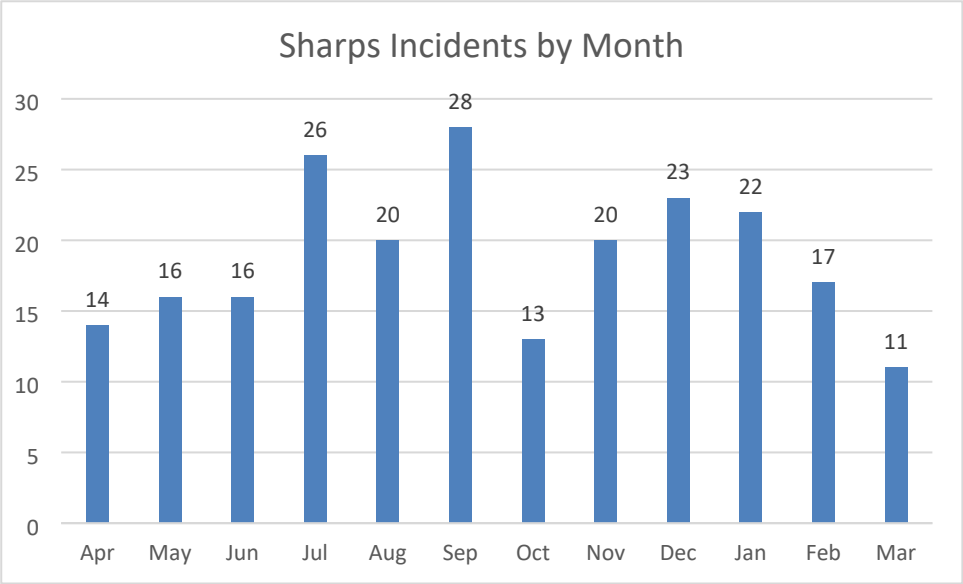
Whilst it is not feasible to make the entire site ligature safe, it will be possible to create a number of areas that have reduced opportunities for ligature-based harm events to occur. The group have created a plan to address these issues and whilst the policy will be reviewed and published within less than 3 months, the actions required could take up to 12 months to deliver.

3.8 Trust Health and Safety Performance

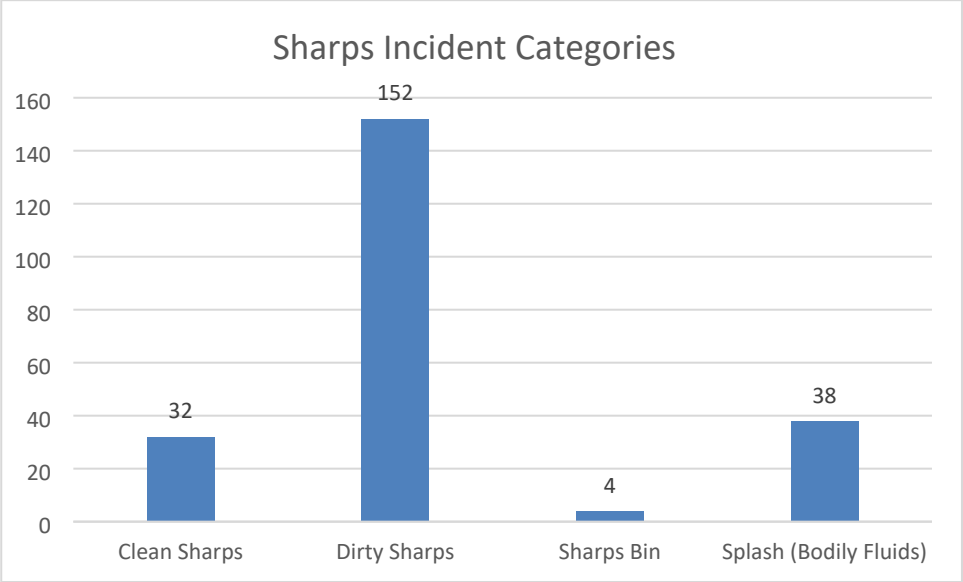
3.8.1 Sharps Safety
This reporting period has seen an increase in reported sharps incidents from 208 to 226. The Sharps Safety Group has not identified any common causes for sharps incidents throughout the Trust and continues to research methods of improving sharps safety. A Sharps Safety Campaign was launched in 2025 which focussed on reducing sharps incidents, accurate reporting and the completion of health surveillance following an incident. There has been an increase in the accuracy of reporting since the campaign, which is a potential cause of the increase in the number of reports, with the correct options being selected in Datix.

The Emergency Department (21), Delivery Suites (10) and Critical Care (9) received the highest numbers of sharps incidents this period and should be supported with bespoke training and support.

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Incidents due to dirty sharps was again the leading cause of sharps incidents and of the four categories, is the one of most concern.



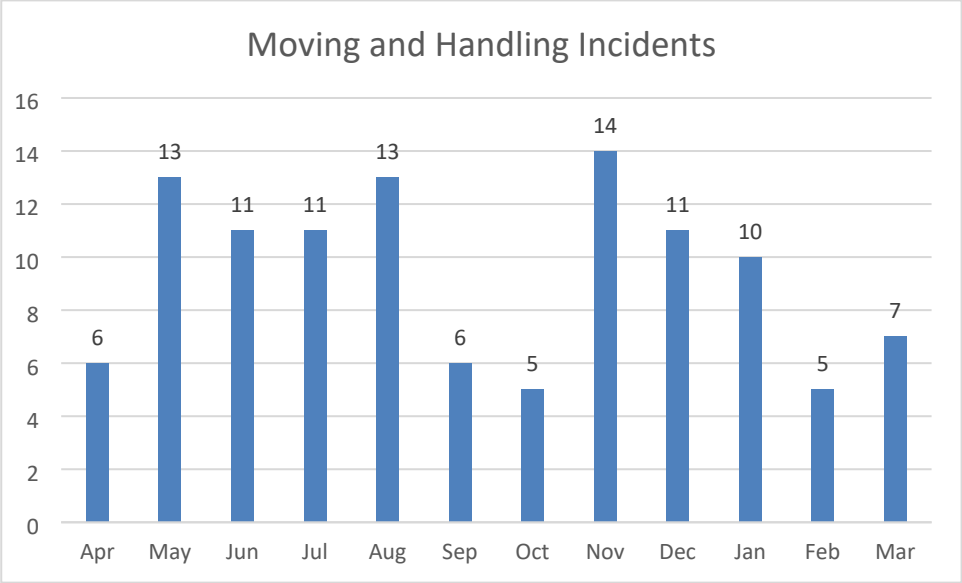
3.8.2 Moving and Handling Incidents

Moving and handling incidents have risen by 11% from 101 to 112 this year. 52 of the incidents fall in the category of either inappropriate handling of a patient or lifting or moving a patient or other person. This figure is consistent with previous reporting periods. Whilst there has been an increase in level one moving and handling training (79.8% compliance v 72.1% last year), the level of compliance for level two training (patient handling) has decreased from 71.7% to 62.4%. Learning and development have been providing training at a rate that exceeds attendance by almost 50% throughout the year and many clinical staff report that they cannot leave the ward environment to attend training as the wards are often at critical staffing levels. A review of the accuracy of this claim was made by the HHS, reviewing Datix reports (discussed at the health and safety committee) of low staffing levels with Safer Staffing records and in every case, the Datix report was accurate and justified, with the wards being recorded as with at risk or risk accepted.

There is a national push to deliver training in house, but it is recognised that this presents issues with training quality as staff are often diverted from training in the work environment

to attend patient needs. It is also noted that moving and handling training has been suspended for three months to accommodate training in the use of the new eCare system. Learning and development are investigating methods to deliver training in situ during this period.

Row Labels	Count of Subcategory
Inappropriate handling of patient	27
Injury arising from pushing / pulling a load	18
Injury caused by repetitive movements	9
Lifting in the course of moving a load or machinery	10
Lifting or moving a patient or other person	25
Skin tear (patient own action)	9
Skin tear (staff intervention)	7
Stretching or bending injury, other than lifting	7
Grand Total	**112**

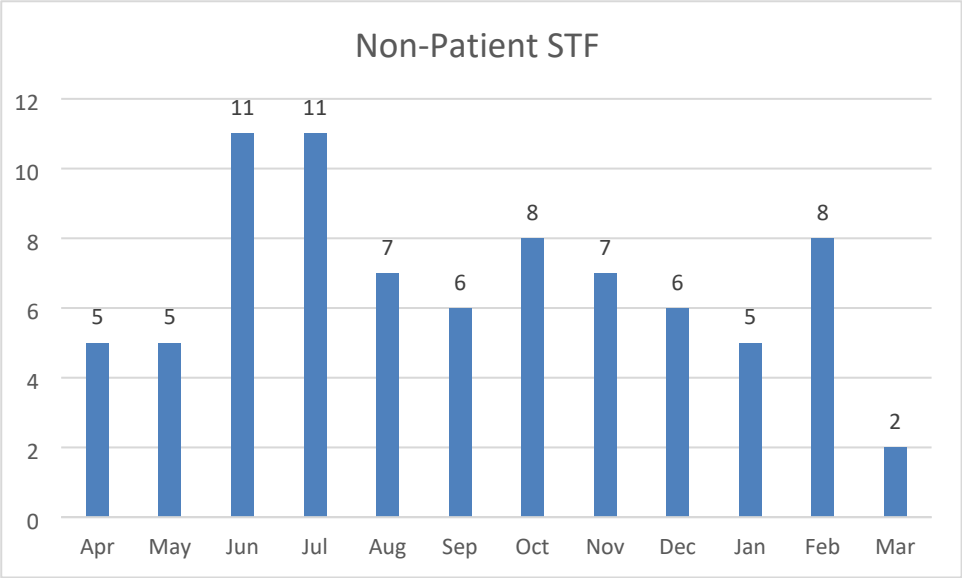


3.8.3 Slips, Trips and Falls
Slips, Trips and Falls (STF) incidents have fallen dramatically this year from 1586 to 1389 (12.4%). Of these, there were 81 non-patient STF incidents, consistent with the 76 incidents last year.

Of the 1389 incidents, 736 were for unwitnessed falls by patients, which remains the leading cause of STF incidents within the Trust. Patient falls remains under the remit of the Falls Safety Group, which reports separately to the Quality Assurance Committee.

Data for non-patient falls is presented below.

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Row Labels	Count of Subcategory
Fainting / Dizziness / collapse	6
Fall downstairs	1
Fall from bed / trolley	1
Fall from chair / commode	1
Fall on level ground	4
Fall on wet floor	15
Fall Other	27
Slips on ice or snow	2
Tripped over an object	15
Unwitnessed fall	9
Grand Total	**81**

The operational estates department have completed a Trustwide STF review and are engaged in a programme of safety developments, replacing cracked paving with tarmac as the preferred solution across the site. Operational estates have also proactively engaged with the Accessibility Advisory Group to improve access and safety in areas where those with mobility challenges may have trouble on our site.

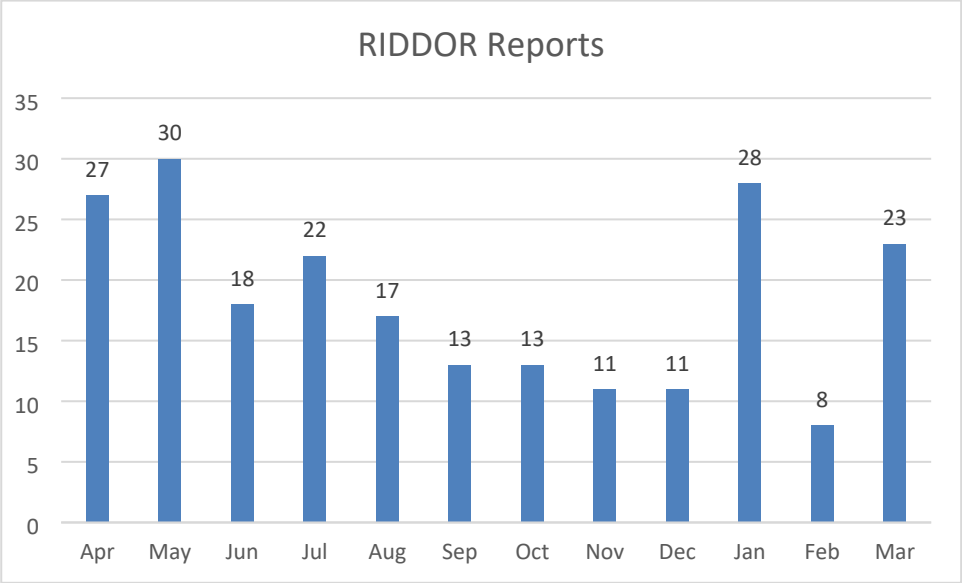
3.8.4 General Health and Safety Incidents
There has been a 26.2% rise (from 576 to 727) in reported incidents under the category of general health and safety this year. Many of these incidents are miscategorised and include patient incidents that would be better categorised under other headings, but a significant number (315) relate to an unsafe environment. Causes under this category include unsafe staffing, personal safety, heat, lighting, noise and any other factor that a staff member may feel makes the environment unsafe. When combined with the 99 reported lone working incidents, these make up over 50% of the incidents raised.

Line managers retain a responsibility to ensure their working environments are fit for purpose and safe for staff, patients and others in the area. The HHS continues to deliver health and safety management training to educate leaders, managers and supervisors in their responsibilities for managing the health, safety and welfare of all those affected by their activities.

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3.8.5 Reporting of Injuries, Diseases, Dangerous Occurrence Regulations (RIDDOR)

The Trust registered 221 RIDDOR reports this year, an increase of 57 from the previous year, but closer aligned to the 229 in 2024. The largest increase was in the subcategory for occupational ill health, with work acquired dermatitis the leading cause. Healthcare is a high-risk industry for work acquired dermatitis due to the nature of frequent handwashing and safer alternatives to hand sanitisers and soaps are constantly sought by IPAC. There was a change in sanitiser provider this year that precipitated numerous allergic reactions, along with a change to a cleaning agent. These incidents lead to the creation of the CoSHH Safety Group, detailed in section 3.4 of this report.



Type	Count
Aggression or violence by staff	1
Aggression or violence towards staff (Physical)	7
Aggression or violence towards staff (Verbal)	1
Confidential	1
Health and Safety	9
Manual Handling	10
Occupational Ill Health confirmed or suspected	137
Other / Miscellaneous	2
Patient Transport	1
Slips Trips & Falls	52

3.9 Significant Events
There have been no significant events this year, other than the protected disclosure to the HSE mentioned in section 3.2 of this report.

4. Risk

The significant risks faced by the Trust regarding health and safety relate to compliance with various articled of health and safety law. The Trust must show a considered response to the hazards presented by its activity and control the significant risks accordingly. In doing so, the Trust will reduce incidents of harm and ill health, protecting patients, staff, contractors and visitors.

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5. Accountability

The Head of Health and Safety is accountable to the Chief Operating Officer as the competent person for providing health and safety advice to the Trust. The responsibility for health and safety management remains at individual departmental level.

6. Recommendations

The Board **is recommended to:**

- **Note** the Health and Safety Annual report.

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Meeting: Trust Board in Public

Date of Meeting: 02 July 2026

Item Number: 23

Title of Report: Register of Interests for the Trust Board of Directors and Decision-making Staff

Lead: Lynsey Neave, Company Secretary

Author and Job Title: :Lynsey Neave, Company Secretary

Email Address: lynsey.neave@nhs.net

Purpose of the Report:

Decision ☐ **Discussion** ☐ **Assurance** ☒ **Information** ☒

The Board is invited to note the registers of interest for the Board of Directors and Decision-making Staff which have been published to the Trust's website, and to seek any assurances on how the declarations are made and registers prepared. This report will be submitted to the Trust Board to note publication of the registers.

Individual members of staff make their declarations via the Electronic Staff Record, in line with the Trust's Gifts, Hospitality, Sponsorship and Declaration of Interests Policy. The Audit and Risk Assurance Committee last received an annual report on implementation of the policy in February and May 2026 and noted assurance and the actions being taken to improve compliance.

The registers which have been published are for:

- The Trust's Board of Directors
- Other decision-making staff, as defined by the Policy

In support of transparency of the NHS, there is a requirement on the Trust to publish the registers on an annual basis. The data provided for decision-making staff is as at 31 March 2026. The data for the Trust Board of Directors is updated throughout the year and was last updated in June 2026.

Consultation:

Audit and Risk Assurance Committee monitor implementation of the Trust's Gifts, Hospitality, Sponsorship and Declarations of Interest Policy, and related processes.

Individual members of staff are responsible for their own declarations of interests, gifts, hospitality and sponsorship.

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Key Risks (please tick one or more):

Clinical ☐ **Financial** ☐ **People** ☐

Reputational ☐ **Legal / Regulatory** ☒

Impact:

	Yes	No	N/A	Summarise any adverse impacts identified
Equality Impact Assessment completed?			X	
Quality Impact Assessment completed?			X	
Data Protection Impact Assessment completed?			X	

Health Inequalities, Health Outcomes and Sustainability ('triple aim') – *for reports requesting decisions only*:

As an NHS Provider, under the Health and Care Act 2022, the Trust has a duty to ensure that it considers the effects of its decisions on the health and wellbeing of the population, quality of care and sustainable use of NHS resources. If your report is proposing a policy, strategy, business case or other matter for decision, please complete the boxes below to set out considerations in regards one or more of those three areas (known as the 'triple aim').

	Summary of considerations *(if one or more does not apply state 'not applicable')*
Health and wellbeing of the population, including inequalities and wellbeing	Not applicable – the registers are for information in support of transparency within the NHS.
Quality of services provided or arranged by RCHT, including inequalities in benefits from those services	
Sustainable and efficient use of NHS resources by RCHT	

Recommendation(s):

The Board **is recommended to:**

- **note** publication of the Trust's registers of interest for the Trust Board of Directors and other decision-making staff.

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Royal Cornwall Hospitals NHS Trust

Protocol for Questions from Members of the Public

When the Trust is using Teams Live to live stream the meeting the following Protocol applies to questions from members of the public:

- Members of the public are invited to join the Trust's Board in Public meetings via the live stream using MS Teams. A link for each meeting is available on the agenda or on the Trust's website.
- Members of the public are welcome to log questions throughout the meeting via the Q&A function and, subject to meeting the requirements below, will be taken at the end of the meeting at item 25. The functionality to raise a question will not be available from item 16. A maximum of 15 minutes is allocated for questions from the public.
- The Trust's Company Secretary will read the questions submitted by members of the public on their behalf.
- Members of the public are welcome to provide their name to the question they wish to ask.
- Questions at the meeting must relate to papers being presented on the day and must relate to the role and remit of Royal Cornwall Hospitals NHS Trust.
- No supplementary questions are allowed.
- Questions should be kept brief and to the point.
- Questions may be submitted in advance or via the Q&A function on MS Teams Live during the meeting. If a question is logged during the meeting it may mean that it is not always possible to provide an answer at the meeting. In that case, the questioner's contact details will be requested for response.
- Questions will be taken in rotation, to ensure those wishing to raise questions have equal opportunity, within the limited time available – if a member of the public asks more than one question their first question will be asked and then their remaining question/questions returned to if no other members of the public wish to raise one and if it is within the time allocated for the item.
- We will endeavour to provide a response at the meeting which will be offered by a member of the Board to the Chair.
- An answer to an oral question under this procedure will take the form of either:
  - A direct oral answer; or
  - If the information required is not easily available a written answer will be sent

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to the questioner, circulated to all members of the Trust Board and included in the minutes of the meeting.

- Questions and answers will be reflected in the minutes of the meeting.
- Questions need not be answered if the Chair considers that they:
  - Are not on any matter that is within the powers and duties of the Trust.
  - Are defamatory, frivolous or offensive.
  - Are substantially the same as a question that has been put to a meeting of the Trust Board in the past six months.
  - Would require the disclosure of confidential or exempt information.
- The Chair's determination on whether or not to accept a question is final.

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